HCA, Members Make Final Push for Urgent Relief in State Budget

In the final, frenzied days of state budget negotiations, HCA continues to press for urgently needed home care regulatory relief and other priority measures.

Now is officially crunch time, and the Senate and Assembly are expected to print their final budget bills this weekend in order to give the bills the required three-day “aging” process before passing a final enacted budget at some time next week – well ahead of the April 1 deadline. The final budget legislation will likely build upon the one-house bills advanced in each chamber earlier this week and previously detailed in an E-alert to the membership.

Throughout the week, HCA has been in routine contact with key committee staff, legislative offices in both houses, and the Executive to ensure that the better components of each chamber’s one-house bill are married in the

See BUDGET p. 2

HCA Heads to D.C. Next Week to Oppose Cuts, Advocate Home Care Priorities

HCA’s advocacy efforts in the coming week will branch out on two important fronts: in Albany, for the wind-down of state budget negotiations, and in Washington as HCA Policy staff, the HCA Board, our contract government affairs firm Winning Strategies Washington, and individual members engage New York’s Congressional Delegation offices on key federal home care policies.

As in prior years, next week’s federal advocacy effort coincides with the National Association for Home Care and Hospice (NAHC) March on Washington and policy conference – a great time and
final enacted budget. While the Assembly one-house measure seeks to directly provide regulatory relief for home care providers contracting with managed care, the Senate one-house measure includes a workgroup to: revisit the regulations, address overlapping duties, and recommend streamlining of roles between managed care and home care. Both provisions reflect parts and variations of HCA’s proposals in an attempt to advance critical HCA-sought measures for regulatory realignment.

In addition, either or both of the Assembly and Senate one-house measures contain variations of other HCA-developed proposals, including provisions for: home telehealth continuity; payment adequacy for home care providers; collaboration between managed long term care and hospice; and changes to the Long Term Home Health Care Program (i.e., the Assembly bill proposes to eliminate LTHHCP slot limits, while the Senate language does not explicitly address LTHHCP regulatory change other than the extent to which its workgroup proposal might consider such changes).

HCA has prepared a chart comparing the Assembly and Senate one-house budget bills, which are the basis for continued negotiations between the two houses and Governor throughout the weekend. The chart, which was reviewed during a statewide budget conference call with members on Tuesday, shows how each one-
Continued from p. 2

House bill varies in relation to HCA’s advocacy proposals and in relation to the Governor’s proposed Executive Budget.

The chart is available at http://www.hca-nys.org/documents/BudgetBillComparisonChart.pdf.

The Senate and Assembly budget bills are surely a welcome starting point. And conceptually, the Senate, Assembly and Executive have all signaled to HCA that they appreciate the purpose of our regulatory-realignment proposals; the Assembly in particular, has clearly seen the need to embrace HCA’s proposals, albeit in varied forms, as part of the one-house budget bills.

And yet, even considering the urgent need for regulatory relief and the recognition expressed by legislators that such relief is needed, the state budget process and negotiations engender a mix of variables that have challenged HCA’s effort to advance urgently needed legislative changes just as the window for advocacy is closing.

To further engage the full continuum of health care partners and work to overcome these and other challenges to our proposals, HCA held a conference call late Wednesday afternoon with leaders of HCA’s Managed Long Term Care (MLTC) plan members to conduct a specific briefing with MLTCs about how our regulatory-relief proposal will provide significant help to MLTCs in their contracting with all types of home care providers.

HCA explained to the MLTC leaders that our proposal creates a uniform regulatory base in home care which would free providers from elements of the federal Conditions of Participation (CoPs) – addressing frequency of supervision requirements, OASIS reporting, reassessment intervals and other requirements that are unnecessary, costly, and incompatible in an MLTC contract environment. HCA’s regulatory-realignment proposal would ensure continuity of care for patients that are moving into MLTCs, and it would avoid needless costs for providers and, ultimately, the plans who must account for those costs in their per-member per-month premiums.

In an E-alert to the membership on Thursday, HCA urged MLTCs to join the home care community in outreach to the Legislature, seeking to enlist their vocal support for HCA’s proposals which offer uniformity, consistency, and, most importantly, flexibility to providers and plans alike.

Given the fast-closing window for budget action, HCA sent a third E-alert to members this morning and asked for a final big advocacy push before the week is through. Legislative leadership staff will be working throughout the weekend and we ask that you continue to keep up your advocacy calls to the leadership offices. We refer you to the E-alerts sent earlier this week with further advocacy instructions. (See http://www.hca-nys.org/action.cfm.)

HCA will keep the membership apprised of all significant developments.

For more information, please contact a member of HCA’s Policy staff.
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opportunity for HCA’s Board leaders to meet in Washington and for HCA to tap the advocacy participation of HCA’s mutual provider members who are attending the NAHC program.

Budget issues remain at the forefront of next week’s advocacy message, now that Sequestration will go into effect and as the fiscal debate in Washington enters a new phase, with elected officials drawing their positions over the 2014 federal budget.

In the latest budget development, the House passed its continuing resolution to fund the government for the remainder of the federal fiscal year – until October – and the Senate is expected to soon do likewise.

Notably, the continuing resolutions do not alter the Sequestration cuts expected to hit the provider payment delivery system very soon. HCA this week obtained further information from the U.S. Centers for Medicare and Medicaid Services (CMS) on the timing of the payment reductions which are expected to happen sometime in April. (See related p. 5 story.)

Meanwhile, both the House and Senate Majorities this week issued new or updated budget proposals for the 2014 federal fiscal year.

The House proposal, by Budget Committee Chairman Paul Ryan, includes no new tax revenue and would cut spending by $5 trillion over a decade, preserving many of the ten-year cuts in effect under Sequestration for non-defense measures.

A major part of the deficit-reduction target assumed by the Ryan plan involves a proposal to repeal significant portions of the Affordable Care Act (ACA); although, Rep. Ryan has indicated that his plan would preserve ACA’s roughly $700 billion in Medicare spending cuts. And, as he has proposed in the past, Ryan’s plan also includes Medicare privatization (also known as premium-support) starting in 2024 and an effort to block-grant the Medicaid program.

The Senate measure, meanwhile, involves a mix of tax increases and cuts, including $975 billion in spending reductions as an alternative to Sequestration and a similar amount (about $975 billion) in increased revenue, largely by repealing tax breaks, along with $100 billion in economic stimulus spending, mainly for infrastructure projects. For health care specifically, the Senate plan calls for $275 billion in cuts, largely to Medicare. The specifics of those cuts, however, have not yet been spelled out.

Regardless of whether Sequestration remains in effect for the long haul or whether Congress reaches a successor alternative to Sequestration, these budget proposals indicate that Medicare clearly remains in the cross-hairs, and HCA is resolute in our position that any further reductions to Medicare home health services are untenable given the current fiscal state of the industry.

As previously reported, the Sequestration cuts would uniformly hit all New York Medicare home health services with across-the-board reductions of approximately $17 million per year – a critical blow at a time when New York home care providers are operating in negative Medicare margins for the tenth consecutive year.

These cuts follow $19.3 million in cuts to New York Medicare home health providers under the 2013 Medicare Prospective Payment System (PPS), which is just one-year’s installment of ACA’s total $1.9 billion Medicare hit for New York home care agencies over ten years.

In addition to fiscal issues, HCA will continue to seek more flexibility in the documentation requirements and timeframes for the onerous face-to-face regulation, as well as solutions for other mandates, such as Third Party Liability (TPL) billing, which continues to burden providers in absence of a long term successor to the TPL Demonstration Project.

HCA’s federal advocacy briefing documents are available in the Resource Library of HCA’s website at http://www.hca-ny.org/clips.cfm. (See the link for “2013 Federal Advocacy Resources” under “HCA Briefing Documents and Talking Points.”) HCA thanks the HCA Board leaders and members who are participating in next week’s federal advocacy. We will provide the membership with further updates and action items in the coming weeks.

For more information, please contact a member of HCA’s Policy staff.
CMS to Use “End Date” on Sequestration Reduction for Home Health Payments

The U.S. Centers for Medicare and Medicaid Services (CMS) this week clarified that the two-percent Sequestration reduction will take effect April 1, 2013 and will be applied to episodes with end dates of April 1 and later.

CMS stated that the Medicare home health Sequestration reduction will work just like the annual update to the home health prospective payment system (PPS) in that Medicare will use the “claim through” date on the claim to apply the two-percent reduction. For home health services, that is considered the end-of-episode date.

This means that the two-percent reduction will be applied to the final Medicare PPS episode payment. The PPS rates will not be reduced due to Sequestration.

Similarly, for hospices payments, CMS will use the claim “through date” to apply the reduction beginning April 1, 2013.

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

New Executive Compensation Rule Released

This week, the state Department of Health (DOH) and other state agencies released a revised proposed rule that limits the administrative allocations and executive compensation of organizations that receive state funds or state-authorized payments.

The proposed rule is at: http://w3.health.state.ny.us/dspace/propregs.nsf/4ac9558781006774852569bd00512fda/879fa87a6ed1887a85257b2d0051fbb3?OpenDocument. Comments will be accepted until April 12.

HCA is analyzing this version of the rule and will provide additional information once we have completed our review; however, many major concerns remain.

According to DOH’s “Summary of Assessment of Public Comments,” some of the revisions made to the prior rule include: delaying the effective date of the limits to the first day of the covered provider’s reporting period after July 1, 2013; not applying, in certain cases, the limits to the covered provider’s contracts or other agreements with covered executives agreed to prior to July 1, 2012 (instead of April 1, 2012); requiring the reporting of subcontractors and agents upon the request of the entity that is authorizing the funds (rather than as a categorical requirement); clarifying that the covered provider will not be held responsible for a subcontractor’s or agent’s failure to abide by the regulations; acknowledging that not all entities have a board of directors or other governing body; and adding a definition for “covered reporting period.”

Given the potential effects of the rule on home care providers and services, HCA has pressed for full reconsideration of the previous two versions of the rule. HCA has also provided and urged major revisions through meetings with Administrative officials (see the February 8 edition of ASAP for details of the most recent meeting with the Governor’s Counsel) as well as through comprehensive comments in the rulemaking process.

For more information, contact the HCA Policy staff.
MLTC Implementation Updates

This week, the state Department of Health (DOH) announced that, starting today, individuals needing personal care on Long Island and Westchester (new cases) have to first enroll in Managed Long Term Care (MLTC) plans. The Department also posted marketing guidelines for MLTC plans and service providers, held a Fully Integrated Duals Advantage (FIDA) information program, updated its MLTC application list, and issued information on private duty nursing (PDN) services.

Personal Care

Starting today, March 15, dual-eligible consumers 21 and older in Nassau, Suffolk and Westchester who require more than 120 days of personal care or consumer directed personal assistance services and who are “new” to the system (not under care) will have to enroll into an MLTC before they can receive such services. DOH has sent instructions to those counties about this change. DOH has already sent notices to individuals receiving personal care, adult day health care, and certified home health services in these counties about the requirement to enroll into an MLTC.

Marketing guidelines

The posted marketing guidelines for MLTC plans and home care and other service providers relate to permissible and prohibited marketing practices, materials and activities. Of note is the following:

- Medicaid recipients may never be told by their provider that they have to join a plan. Recipients have to make a selection when they receive their official notice from the state or its designee or are seeking community based long term care services in mandatory counties.

- Marketing materials must accurately reflect general information that is applicable to the average consumer, such as which plans the provider has contracts with. HCA has been advocating that providers be allowed to list the plans with which they have contracts.

- Providers may not provide mailing lists of their patients to plans. Providers may not disseminate any information regarding mandatory enrollment requirements.

- In the event a provider is no longer affiliated with a particular plan but remains affiliated with other participant plans, the provider may notify his or her patients of the new status and the impact of such change for the patient.

- Plans must provide any potential enrollee not referred by New York Medicaid Choice with information describing managed long term care, a list of available plans and information on how to reach the enrollment broker. Plans must utilize managed long term care information and plan lists provided by the Department of Health’s website.

Last year, DOH had shared with HCA an earlier draft of marketing guidelines that would have only applied to service providers and HCA had submitted extensive comments. HCA’s comments questioned the basis and necessity for separate provider guidelines when the state already requires plan adherence to marketing guidelines and plans are required to ensure compliance through their agreements with participating providers.

We also sought clarification on whether the marketing document is intended to apply as voluntary criteria or as a set of provider requirements. Lastly, we also expressed concern that the language is vague and inconsistent with certain statutory requirements and professional obligations applicable to providers.

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We had never heard back from the state on our comments and these guidelines were released without our knowledge. HCA will be reviewing the revised document to determine if any of our concerns are addressed and to decide on our next action.


**FIDA**

This week, DOH held a webinar to update HCA and other stakeholders on New York’s proposed FIDA program. Under FIDA, the state is seeking federal approval to enroll dually eligible beneficiaries into plans for their Medicare and Medicaid physical health care, behavioral health care, and long term supports and services. The FIDA proposal would affect about 124,000 of the state’s dual-eligible population in New York City, Long Island and Westchester that are in the process of being enrolled into MLTC plans.


On the call, DOH made the following points:

- The FIDA proposal was submitted to the U.S. Centers for Medicare and Medicaid Services (CMS) on May 25, 2012; DOH expects CMS to respond with a request for additional information (RAI), but it has not done so yet.

- New York has requested implementation support from CMS under a planning grant and hopes to be notified about the status of this request by early April.

- Health plans and entities wishing to establish a FIDA plan were required to submit their applications to CMS by February 21, and no more applications will be accepted.

- While DOH won’t disclose the number of applicants, officials did indicate a “robust” level of interest and noted there is no specific limit on the number of plans the state will approve.

- CMS has asked New York to review Ohio’s Memorandum of Understanding (MOU) for consideration in developing its own MOU.

- Programs of All-inclusive Care for the Elderly (PACE) will be deemed to meet the FIDA requirements but still had to submit applications to CMS if they wanted to participate.

- New York will begin plan selection in late spring.

- New York expects voluntary enrollment to start October 2013, with enrollment effective in January 2014.

- “Passive” enrollment (into all plans except PACE) of those individuals who don’t choose a FIDA plan is anticipated to start January 2014, with enrollment effective in April 2014. (Individuals who are passively enrolled can opt out anytime and return to an MLTC plan.)

- Participants in programs that are currently not required to enroll into MLTCs (i.e. Nursing Home Transition and Diversion, Traumatic Brain Injury) will not be passively enrolled into FIDA plans. This would include the Long Term Home Health Care Program (LTHHCP) if CMS does not approve New York’s amendment that would allow for mandatory enrollment of the LTHHCP population in mandatory enrollment counties.

- FIDA plans will not at this time be required to use New York’s new Uniform Assessment System (UAS), but that may change based on implementation of the UAS.

- The appeals system to be utilized will consolidate the current Medicare and Medicaid processes.

- FIDA benefits will be those listed in appendix C of New York’s proposal (http://www.health.ny.gov/facilities/long_term_care/docs/2012-05-25_final_proposal.pdf), but plans can supplement those with non-covered services to address a participant’s needs.

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FIDA Report

Meanwhile, Milliman, Inc. has prepared a report that examines rate-setting considerations for New York’s FIDA proposal. The report does not recommend or promote any particular decision related to FIDA nor prescribe any particular capitation rate-setting methodology, but it provides general comments and considerations intended to educate stakeholders in the decisions that face the development of FIDA.


Application list

DOH has posted an updated list of entities that have applied to establish or expand an MLTC. The document includes the counties proposed to be served, the type of MLTC plan (Medicaid Advantage Plus, partial cap or Program of All-inclusive Care for the Elderly), and the effective date of any action on the application.


Private Duty Nursing

DOH has posted background information on fee-for-service private duty nursing (PDN) services in preparation for the requirement that individuals receiving PDN services enroll into MLTCs. The information does not cover whether there will continue to be a prior approval process by the state or county or how often recertifications need to be conducted.

The instructions are at http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_13_07_private_duty_nurse.pdf.

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

Introduction to Healthcare Quality: April 8

The National Association of Healthcare Quality (NAHQ) is partnering with HCA to deliver a brand new course, Introduction to Healthcare Quality. This course will provide health care quality professionals who are new to the profession with an understanding of quality and patient safety principles, methodologies, and tool-sets to enable them to advance their knowledge and skills in their health care practice setting. This full-day course will be held on April 8, at Rochester General Hospital, and is limited to only 30 participants.

Discussion questions are interspersed throughout the presentation. This course includes six modules.

For more information and to register, visit the NAHQ website at http://www.nahq.org/education/events/intro-to-quality-april.html or call 800-966-9392.

DOH Releases Mobile HCS Prototype

The state Department of Health (DOH) has released a Health Commerce System (HCS) mobile device application prototype. This initial application includes the HCS System Notices, Health Notifications, and the HCS Applications list.

The announcement of this new service, including information on how to use it, is in a Quick Reference Card on the HCS at https://commerce.health.state.ny.us/hcsportal/hcs_home_portal (go to Newsroom Highlights).

To open the Prototype on your mobile device, go to https://mcommerce.health.state.ny.us.
Nominations for HCA Awards Due in Two Weeks!

The best organizations have individuals within their ranks who pursue every lead, apply every skill or talent, and display unparalleled personal drive and commitment in service to the cause at hand.

For individuals working in home care, that cause is patient care, whether the person is directly involved in serving patients at home, or whether he or she speaks with strength and conviction to advocate on behalf of patients.

HCA’s 2013 Annual Awards are a perfect opportunity to recognize such incredible people at your organization. HCA offers award opportunities for: paraprofessional and professional direct-care staff (the “Caring Award”); home health agency leaders (the prestigious “Ruth F. Wilson Award”); and for home care advocates (the “Advocacy Award”). As you review these three award categories, please consider all of the exceptional people at your organization who rise to the top of the list in serving patients.

Use the nomination process to tell us about each candidate in detail...

- What extra steps has this person taken to help patients with their clinical, social, emotional or family support needs?

- What distinguishes this person as a skilled care provider or as a critical source of support for patients?

- What have your patients or families said about this person that shows how unique they are?

- How has this person shaped New York’s home care system for the better, by strengthening the practice of home care or by demonstrating its importance to legislators and other stakeholders?

Award nominations are due March 29. The winners will be recognized at HCA’s Annual Conference in May.

This is an excellent opportunity to recognize the great work of your staff, and the great work of your organization; we encourage all home care providers to take a moment to make nominations.

To learn more about the awards, please see the nomination form here: http://www.hca-nys.org/documents/HCA2013AwardNominationsForm.pdf.

For further information, contact Laura Constable at (518) 810-0660 or lconstable@hcanys.org.
PHHPC Establishment and Project Review Committee Agenda Posted

The state Department of Health has posted the agenda for the March 21 Public Health and Health Planning Council (PHHPC) Establishment and Project Review Committee which includes applications by some entities to establish a new or expand an existing Certified Home Health Agency (CHHA).

At this time, all of the CHHA applications cover the New York City, Long Island and Westchester areas, and applications to serve other parts of the state will have to be considered at a future meeting.


The agenda so far includes applications by eight entities to establish a new CHHA, six existing CHHAs to expand their service areas (including one to convert its special-needs CHHA to a general-purpose CHHA), one Long Term Home Health Care Program (LTHHCP) to convert to a CHHA, and one CHHA to establish a new LTHHCP.

It is possible that DOH will add additional CHHA applications to the agenda before the March 21 meeting.

The applications resulted from a Request for Applications issued by DOH last January for purposes of implementing the Medicaid Redesign Team initiatives, as well as special provisions included in last year’s state budget for LTHHCPs to provide a CHHA.

HCA will report on the disposition of these applications in a future edition of ASAP.

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

DOH Schedules Webinar on LTHHCP and Medicaid Managed Care

The state Department of Health (DOH) has announced a webinar entitled “Long Term Home Health Care Program Transition to Medicaid Managed Care” to be held on Monday, March 18 from 12:30 to 2 p.m.

Registration is at: [https://www1.gotomeeting.com/register/577089952](https://www1.gotomeeting.com/register/577089952).

DOH had originally agreed to hold an in-person program covering LTHHCP transition to mainstream Medicaid Managed Care and Managed Long Term Care as part of HCAs LTHHCP Statewide Forum previously scheduled on March 7. That program was forced to be postponed due to inclement weather.  

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National Provider Call on PECOS Edits

**Wednesday, March 20, from 3 to 4 p.m.**

The U.S. Centers for Medicare and Medicaid Services (CMS) will hold a national provider call on March 20 from 3 to 4 p.m. on the “Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DMEPOS, and Part A Home Health Agency Claims.”

For call-in information, you must register at [http://www.eventsvc.com/blhtechnologies](http://www.eventsvc.com/blhtechnologies). Registration will close at 12 p.m. on March 20 or when available space has been filled.
Issues for DOH

HCA previously solicited a list of concerns and recommendations from LTHHCPs on the interaction between LTHHCPs and managed care plans and submitted this list to DOH for response at the then-scheduled March 7 Forum. This list can be accessed at [http://www.hca-nys.org/documents/LTHHCPConcernsIssuesRecs.pdf](http://www.hca-nys.org/documents/LTHHCPConcernsIssuesRecs.pdf).

It is anticipated that DOH will be responding to items on this issue list during the March 18 webinar. Consequently, members should be prepared to actively engage the Department in a full discussion of any or all items that are at issue, including issues or concerns not on the list. Members should advance any additional items to the Department at mltcworkgroup@health.state.ny.us.

This is a pivotal opportunity for LTHHCPs to convey your issues and views to the Department. It is absolutely essential that providers are fully open and freely vocal despite the lack of an in-person venue. HCA will be rescheduling its LTHHCP Forum and will, as always, invite DOH representatives to participate.

If there are additional issues (beyond the given list) that providers intend to raise during the webinar, please also share them with HCA at info@hcanys.org, under the subject line “DOH LTHHCP Managed Care Transition Webinar.”

HCA CFO Forum Covers High Priority Fiscal Issues

Key home care fiscal issues dominated the discussion at HCA’s CFO Forum on Wednesday in Albany, including updates on the latest state budget negotiations, the state’s Medicaid Global Spending Cap, highlights of the Medicaid Episodic Payment System (EPS) for Certified Home Health Agencies (CHHAs), federal advocacy initiatives, and critical home health financial benchmarking data.

HCA President Joanne Cunningham and Executive Vice President Al Cardillo provided home care financial managers and executives with the latest details of HCA’s ongoing state advocacy efforts amid an incredibly fast-moving budget process, including the Legislature’s consideration of language incorporating critical regulatory relief for CHHAs, and Long Term Home Health Care Programs (LTHHCPs) and health plans, as the state transitions home and community based patients needing long term care services into a mandatory managed care environment.

HCA’s Vice Presidents Patrick Conole and Andrew Koski provided Forum attendees with updates on HCA’s work in many other critical areas including: the state’s reconciliation of the CHHA per patient spending limits; the implementation and key features of CHHA EPS; the latest on Third Party Liability (TPL) billing; the state’s mandatory transition to managed care; the home care wage parity mandate; the status of the Department of Health (DOH) review and processing of CHHA applications; and priority items for HCA’s federal advocacy day next week (see p. 1 story).

In addition to HCA staff presentations, Timothy Casey, from DOH’s Bureau of Long Term Care Reimbursement, provided updates from the state’s perspective on: 1) home care issues within the Governor’s 2013-14 proposed Executive Budget; 2) the Medicaid Global Spending cap; 3) the Department’s reconciliation...
of the CHHA per-patient spending limits; 4) data from the first ten months of CHHA EPS; and 5) DOH’s issuance of the 2013 LTHHCP, Personal Care and non-EPS hotline rates for CHHAs.

Robert Simione, Vice President of Simione Consultants’ Financial Monitor, updated participants with the latest aggregate Medicare and Medicaid EPS home health benchmarking data from Financial Monitor clients in New York and across the country. The benchmarking data/reports included data on: direct cost per visit, distribution of cost by discipline, total costs per patient by payor, indirect cost as a percent of revenue, gross and net margins by payors, days outstanding by payer, Medicaid EPS visits per episode, and percent of outliers and low utilization payment adjustments under CHHA EPS. (See related sidebar for more information on how you can subscribe to the Financial Monitor tool.)

September retreat for financial managers

CFOs seeking more information on these and other critical topics related to fiscal and reimbursement issues should save the date for HCA’s Senior and Financial Managers Retreat, which will be held at the Mohonk Mountain House in New Paltz on September 10 and 11. Registration is coming soon.

HCA greatly appreciates the participation of our presenters and HCA members at this week’s CFO Forum and we look forward to our continued work on fiscal and reimbursement matters.

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

Learn More about New Home Care Financial Benchmarking Tool during April 1 Webinar

At HCA’s CFO Forum this week, Simione Healthcare Consultants featured several data reports available from its Financial Monitor benchmarking tool.

Want to learn more about this new tool and how it can work for your organization?

Simione is holding a free webinar on April 1 at 1 p.m. that will delve further into the Financial Monitor from the provider perspective, demonstrating how you can use this tool to size up your own agency’s financial performance.

The Financial Monitor allows agencies to report their financial performance and compare their data to the most up-to-date industry benchmarks. Simione has additionally enhanced this reporting tool for New York State home health agencies by also including the opportunity to compare Medicaid Episodic Payment System (EPS) information.

In a special agreement with HCA, Simione is offering all HCA members a discounted annual fee for your subscription to this data-reporting service. As an added benefit, Simione will in turn provide HCA with aggregate benchmark data from subscribers to be used in our advocacy efforts.

To register for the April 1 webinar, please sign up using the link below. If you have any questions or need additional information, please e-mail or call Rob Simione at robsimione@simione.com or (800) 949-0388.

HRA Modifies Renewal Process for Long Term Care Services

The New York City Human Resources Administration (HRA) has modified its renewal process for consumers receiving home care services through: Managed Long Term Care (MLTC) plans; Long Term Home Health Care Programs; the Assisted Living Program; Care At Home; and the Community Alternate Systems Agency (CASA).

HRA’s Home Care Services Program (HCSP) now utilizes the MAP-909e form, the same renewal form mailed to Medicaid aged, blind and disabled consumers, including individuals in the Medicare Savings Program, who are not receiving home care services. Form M11-G is no longer in use.

The protocol for consumers receiving services via Certified Home Health Agencies (CHHAs) remains the same.

Form MAP-909e (which is bar-coded) is pre-printed with the consumer’s demographic and income information. It is mailed to all HCSP consumers approximately three to four months prior to the end of their Medicaid authorization period, along with a pre-paid business reply envelope. Consumers or those assisting them must update the pre-printed information, include copies of all required documentation (if any), and then mail in their completed package. The consumer or authorized representative must sign the Renewal Form before returning it.

These renewals will be received by Vanguard, HRA’s mail house vendor. Vanguard will scan the cases and send a daily file to HRA. This file will then be used to update the Medicaid Renewal Tracking System, which electronically marks the renewal as “received” and stops the case from closing, due to failure to respond. The renewal and all supporting documentation are also scanned by Vanguard for upload to HRA’s EDITS Renewal System. Home care staff will then receive all images electronically for processing.

The Alert is available at http://www.nyc.gov/marc. (Registration is required.)

Governor Submits Plan for Storm Recovery

This week, Governor Cuomo submitted New York State’s proposal for housing and business recovery programs to help New Yorkers devastated by Superstorm Sandy, as well as Hurricane Irene and Tropical Storm Lee. These programs will use funding from the $60 billion Sandy Aid package approved by Congress and signed by the President in January.

For businesses impacted by the storms, the state proposes to use $415 million to help businesses replace or repair lost or damaged inventory and equipment, repair and mitigate damaged facilities, and cover working capital needs.

Grants of up to $50,000 to cover eligible, uncompensated losses are proposed to enable an affected business to purchase or repair needed equipment, repair or rebuild facilities that were damaged or destroyed in the storm, and/or provide the working capital necessary to sustain and grow the business. The state may extend grants up to $100,000 for businesses that suffered physical damage and are at risk of closure or significant employment loss without an increase in grant size.

New York State will also create a low-interest loan program to help small businesses and non-profits that are at risk because they suffered losses of inventory, or physical assets as a result of the storm.

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HCA continues to work closely with Cuomo Administration officials on post-Sandy emergency preparedness policy issues. As part of the budget process, HCA provided the Senate and Assembly with draft language that would deem home care staff as “essential personnel” for purposes of reaching patients in restricted regions during emergencies. Legislators have favorably responded to HCA’s proposal, with interest in its inclusion either in the final budget or for introduction post-budget. HCA will continue to advocate the adoption of this change.

HCA is also working with state officials on the development and implementation of an assessment and patient categorization plan for the evacuation of individuals prior to an emergency. This project, under a Federal Emergency Management Agency (FEMA) initiative, assesses and classifies patients according to standardized transportation levels by their needs, type of transportation necessary for evacuation, level of personnel required to assist, and the number of such assistance per type of patient. HCA and the state Department of Health (DOH) are working closely to create an educational program for providers on this new system, which will ultimately be tailored and applied to all sectors of the health care system. Members can expect to see more information about this particular initiative soon.

**Hospice Quality Reporting Program Deadline April 1**

*Deadline quickly approaching to avoid two-percentage-point reduction to APU for FY 2014*

The U.S. Centers for Medicare and Medicaid Services (CMS) this week issued a reminder to hospices that the deadline to submit the National Quality Forum (NQF) Measure No. 0209 data is approaching. Hospices that fail to submit and attest to their data will receive a two-percentage-point reduction in their Annual Payment Update (APU) for the 2014 fiscal year.

To comply with the Payment Year 2014 Hospice Quality Reporting Program (HQRNP) requirements, providers should currently be entering their NQF No. 0209 data on the data entry and submission website. Providers that have not already created a data entry account should do so now.

The deadline for reporting the data for Payment Year 2014 is **April 1, 2013**. In order to avoid a reduction in their APU, providers must have submitted their structural measure data by January 31, 2013 and must submit their NQF No. 0209 data by April 1.

Hospice providers that may have missed the structural measure deadline can create an account and enter their NQF No. 0209 data on CMS’s data entry website at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Data-Submission.html.


**User account deactivation requests**

Users needing a deactivation for their HQRNP account should submit the user account deactivation request to the Technical Help Desk via fax at 888-477-7871 or e-mail at help@QTSO.com prior to March 25, 2013.
Deactivation requests received on or after March 25 puts a hospice organization at risk for missing the NQF No. 0209 deadline, which is April 1.

For further information, contact HCA Policy Staff.

DOH Reminds Agencies to Submit Wage Parity Certification Forms

Medicaid funding at stake

Late today, the state Department of Health (DOH) issued a Dear Administrator Letter (DAL) advising certain agencies affected by the state Wage Parity Law that they were required to submit certification forms and if they don’t, their organization is out of compliance and “non-compliance will result in non-payment of services rendered, as required by Public Health Law 3614-c(2).”

The forms were due March 1 but the DAL states that agencies can still submit their forms to HCWorkerWageParity@health.state.ny.us.

Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), and managed care organizations (MCOs) must certify prospectively to DOH on an annual basis their compliance with the Wage Parity Law. The second set of certification forms from New York City providers was due to the Department on March 1, 2013 for the March 1, 2013 to February 28, 2014 period and the first set of certifications for Long Island and Westchester providers was due on March 1, 2013 for the March 1, 2013 to February 28, 2014 period. These certification forms are available at http://www.health.ny.gov/health_care/medicaid/redesign/2013-02-21_wageparity_alert.htm.

The DAL is posted at https://commerce.health.state.ny.us/hcsportal/hcs_home_portal.

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

Upcoming NGS Education Sessions

National Government Services (NGS), New York’s Medicare Administrative Contractor (MAC), has posted the following news to its website on upcoming education sessions. The sessions are free but registration is required.

- **Hospice Scenarios: Site of Service Codes** – On Monday, April 8, from 1 to 2:30 p.m., NGS will conduct a session that will focus on the different Healthcare Common Procedure Coding System (HCPCS) codes reported on hospice claims to describe the location where the levels of care are provided.

- **Utilizing NGS Connex Web Application** – On Tuesday, April 9, from 12 to 1 p.m., NGS will conduct a webinar on accessing NGSConnex and how the web-based application can help Medicare providers save time and money. The webinar will demonstrate how to check: claim status, beneficiary eligibility, financial data, provider demographics, and submitting redeterminations and re-openings via Connex.

HCA members can register via NGS’s website at www.NGSMedicare.com by clicking on “HHA.” Once at the Home Health Agency page, select the “Training Events Calendar” option under the Education and Training category (on the left hand side). Your registration is complete only when you receive a confirmation at your e-mail address immediately after submitting your registration.

For further information, contact Patrick Conole at (518) 810-0661 or pconole@hcany.org.
CMS Issues Updated ICD-10 Resources

The U.S. Centers for Medicare and Medicaid Services (CMS) has released updated ICD-10 Implementation Guides in PDF format for small and medium practice providers, large practice providers, small hospitals and payers. These guides are step-by-step resources for providers and payers looking for help with their ICD-10 transition. They are available on the CMS website along with other materials for providers and payers.

The Guides provide a complete overview of ICD-10 and how to prepare for the transition to the new codes. The transition process is broken down into phases: planning, communication and awareness, assessment, implementation, testing, and transition. Each phase is described in detail and includes steps tailored to your practice or organization type.

Additional ICD-10 information is below.

• Visit the CMS ICD-10 website for the latest news and resources to help you prepare for the October 1, 2014 deadline at: http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10

• Read recent ICD-10 e-mail update messages at: http://www.cms.gov/Medicare/Coding/ICD10/CMS_ICD-10_Industry_Email_Updates.html

• Access the ICD-10 continuing medical education modules developed by CMS in partnership with Medscape at http://www.cms.gov/Medicare/Coding/ICD10/Downloads/MedscapeModulesAvailableonICD10.pdf

For further information, contact the HCA Policy Staff.

Publications


• “When Documentation of Resources and Income is Required for Medicaid Applications & Renewals – and When is ‘Attestation’ Enough;,” by the Evelyn Frank Legal Resources Program of Selfhelp Community Services

  http://www.wnylec.com/health/print/30/

• “The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program,” by the U.S. Centers for Medicare and Medicaid Services


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