HCA Continues to Press on Wage Parity, Regulatory Streamlining & other Priorities as Budget Deal is Imminent

State budget negotiations have deepened over the past several days with high-level internal talks now occurring among legislative leaders and the Governor’s office. It is expected that the budget bills will be printed very soon, with voting on the bills to occur by Monday in an effort to pass an on-time budget.

As of ASAP press time, the Medicaid and home care provisions still remain open and largely in flux. HCA and our government-affairs team are in regular outreach with Legislative and Executive offices, pressing the urgent needs.

See BUDGET p. 2

HCA Engages Congressional Delegation on Federal Issues

U.S. House acts on doc-fix bill which delays ICD-10 implementation for another year, among other provisions

While Congress staged a vote this week on Medicare legislation to temporarily fix the physician fee schedule cuts, HCA policy staff, our federal government-relations firm Winning Strategies Washington, and HCA members made the rounds on Capitol Hill for our Federal Advocacy Day program to ensure that home care providers were not harmed by the pending physician payment legislation, while we also pursued other federal home care priorities.

These priorities included regulatory relief from the federal face-to-face (F2F) requirement and Third Party Liability (TPL) billing, and the need for Congressional action to delay Medicare home health rebasing.

See D.C. p. 3
need for resolution on priority areas such as wage parity, regulatory streamlining, home care financing and more.

In last week’s ASAP, HCA shared a chart comparing each of the one-house legislative proposals alongside provisions in the Governor’s proposed budget. The final column of the chart outlines HCA’s position and action plan to date.

The chart is delineated in terms of:

- Items we support in the budget, including areas where the Legislature or Governor propose to use HCA-developed budget language;

- Items that concern us, especially the system’s regulatory misalignment and streamlining needs, the severe underfunding to plans and providers for mandates like wage parity, and the absence of a fiscal pass-through to providers for these mandates; and

- Areas where more work needs to be done to reconcile and/or improve the various budget proposals under consideration.

HCA is especially concerned that none of the three proposals by the Governor, Assembly or Senate go far enough to financially support wage parity or other regulatory mandates like the Department of Health’s Dear Administrator Letter on the federal Conditions of Participation, and we continue our full-court press on these and other critical issues.

The HCA budget chart (at http://www.hca-nys.org/documents/HCABudgetAnalysisandRecommendations.pdf) provides a useful reference point for the current known status of key issue areas affecting all providers in the budget; however, developments are fast-moving.

HCA will inform the membership as soon as we hear further details of a consensus budget in the coming hours or days.

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

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D.C. continued from p. 1

This week’s federal effort was held in conjunction with the National Association for Home Care and Hospice (NAHC) Policy Conference where HCA also participated in important multi-association strategic planning discussions about national home care priorities. (See sidebar story on F2F.)

Recent federal Medicare legislation

Coinciding with HCA’s advocacy effort, the U.S. House of Representatives this week passed a short-term bill to avoid a 24 percent payment cut to physicians that was set to go into effect on April 1. The scheduled cuts were part of the Sustainable Growth Rate (SGR) – a provision of the Balanced Budget Act of 1997 that establishes targets for physician services under Medicare.

Since 2003, Congress has enacted a series of short-term patches (also known as the “doc-fix”) to prevent the draconian SGR cuts from going forward and slamming physician payments. While there was recent talk of a permanent doc-fix, this prospect of a longer-term package was stymied by political differences over how to fund it: Republicans sought to tie a longer-term doc-fix to a delay of the Affordable Care Act while a Democratic proposal sought to fund it through offsets from reduced spending on military activities in Afghanistan.

In the past, Congress has looked to fund the doc-fix through offsets in other areas of health care, continually raising the risk of home health copayments, taxes, cuts, or some other reduction or revenue action. Notably, this week’s doc-fix legislation includes none of these harmful proposals for home care, though it would make out-year changes to the sequester reductions that were recently extended through federal fiscal year 2024. Under the House legislation, the additional sequester reduction would be added to the first six months of the 2024 federal fiscal year (for a total 4 percent reduction) allowing for no reduction in the remaining six months of the fiscal year.

Of more immediate significance to New York’s home care community and all Medicare providers, the bill also delays for one year the transition to the ICD-10 code set – until October 1, 2015. Providers have been gearing up for implementation of ICD-10 just six months from now, on October 1, 2014; the delay, if approved by the Senate, would offer more time for implementation planning, which could affect providers differently depending on their readiness. In light of this

HCA and National Partners
Keep up Pressure on F2F

HCA and our association allies nationally are keeping up pressure to resolve the federal face-to-face (F2F) requirement. This issue was a prominent area of discussion during strategy meetings at both the National Association for Home Care and Hospice (NAHC) policy conference and the Forum of State Home Care Associations meeting in Washington this past week.

The conference and forum meetings coincided with HCA’s federal advocacy program and Congressional Delegation visits where HCA Policy staff and members advocated on a range of pressing federal issues. (See related p. 1 story.)

In perhaps the boldest new development on F2F, NAHC, with support from the NAHC Board of Directors, is proceeding with the filing of a lawsuit challenging the F2F requirement. (HCA President Joanne Cunningham serves as a member of the NAHC Board of Directors.)

Under F2F, a home care provider cannot bill Medicare for services to a home health patient until the provider has obtained a signed narrative documentation from the certifying physician indicating that the patient had a face-to-face encounter with that physician 90 days prior to the start of home care or 30 days after the start of home care.

Among NAHC’s arguments, to be articulated in the lawsuit are: 1) the F2F narrative requirement is outside the authority granted to the U.S. Centers for Medicare and Medicaid Services (CMS) by the Affordable Care Act (ACA); 2) the
development, HCA is seeking input from the membership on the impact of an ICD-10 delay on your operation, especially for providers, vendors and billing partners who have already invested money, time and personnel resources under the assumption of an October 2014 readiness target. Please let HCA know how this change in the deadline for ICD-10 readiness would affect your organization, negatively or positively, by sending an e-mail to HCA Vice President for Finance Patrick Conole at pconole@hcanys.org. Your perspectives will be critical for our next phase of advocacy in concert with NAHC and other federal partners.

All of the provisions in the House bill are subject to Senate approval and the President's signature, which had not occurred as of ASAP press time. (Senate action is expected soon, given the March 31 deadline for the doc-fix.)

**HCA advocacy**

Amid all of these developments, HCA this week continued our push on major home care priorities during meetings with New York's Congressional Delegation, including the offices of Senators Charles Schumer and Kirsten Gillibrand, as well as Reps. Michael Grimm, Grace Meng, Dan Maffei, Joe Crowley and Nita Lowey.

Foremost among the issues was our push for legislation to suspend the home health rebasing cuts – now in effect – and to create a process for CMS to recalculate its rebasing formula using more complete, accurate and up-to-date data. Such legislation has already been advanced by NAHC. In February, Congressional Representatives Ralph Hall (R-TX), Doris Matsui (D-CA), Tom Price (R-GA), and David McKinley (R-WV) sent a letter to the U.S. House leadership urging passage of the NAHC rebasing fix. HCA has been working to promote support for the bill among New York's Congressional Delegation.

Also, as reported in last week's ASAP, HCA has redoubled our efforts for a solution on the longstanding TPL problem, urging the direct intervention of CMS chief Marilyn Tavenner for a solution. We are also keeping up pressure on the F2F issue with several new developments, including a pending NAHC lawsuit, multi-association strategic planning on F2F advocacy, engagement with Medicare Administrative Contractors, and more. (See related p. 2 story.)

On TPL, HCA President Joanne Cunningham wrote a letter last week to Ms. Tavenner stating that “The need for a solution is long overdue,” urging direct intervention on a range of possible fixes to TPL.

She noted that the TPL issue has become especially pressing now that the state Office of the Medicaid Inspector General is requiring providers to submit an even higher number of demand-bill claims for appeals purposes than in prior years, “creating a massive new burden on agencies who are already stretched to capacity,” wrote Ms. Cunningham.

Federal Advocacy briefing documents on these and other issues can be downloaded from our website at http://www.hca-nys.org/2014FedAdvocacyDocs.pdf.

HCA wishes to thank and recognize the following members who participated in the NAHC conference and/or meetings with New York's Congressional Delegation this week, including: Visiting Nurse Association of Hudson Valley President and CEO Michele Quirolo and VNA of Hudson Valley COO Rae Szynanski, who is a member of HCA’s Board; Judy Duhl, Senior Vice President for Government Affairs, Visiting Nurse Service of New York, and Christopher Palmieri, President of VNSNY Choice Health Plans; June Castle, Chief Financial Officer at VNA Home Care in Syracuse; At Home Care CEO Laurie Neander and At Home Care Senior Director Of Clinical Operations Maria DeMott; Renee Picard Walsh, Vice President of Strategic Accounts for Byram Healthcare; and Barbara Citarella, President and CEO of RBC Limited Healthcare & Management Consultants.

HCA will continue to keep the membership apprised of any new developments on the federal advocacy front.
current unclear and conflicting guidelines for F2F documentation fail to provide due-process for providers seeking to understand and comply with the requirement; and 3) Medicare claims shouldn’t be denied for lack of physician documentation if the rest of the medical record otherwise certifies the need and suitability of home care.

In an effort to continue to generate Congressional engagement to force CMS to solve the F2F issue, HCA, joined by six other state home care associations representing Massachusetts, Pennsylvania, North Carolina, South Carolina, Texas, and Kentucky organized a special briefing at which providers from the seven states spoke to a group of Congressional staff and Members of Congress about the major problems with the implementation of the F2F regulation.

During the briefing, HCA Member June Castle, Chief Financial Officer at VNA Home Care in Syracuse, discussed her agency's experiences with F2F compliance and claims issues, including a high rate (50 to 60 percent) of Medicare claims that were being held due to various F2F documentation issues. The session closed with remarks from Massachusetts Rep. Jim McGovern who pledged to assist the home care community on this issue.

HCA and our partner state associations have been engaging with Congress regularly on this issue over the past several months. New York Representatives Tom Reed (R) and Paul Tonko (D) took a special leadership role on this issue last year by penning a Congressional letter, co-signed by more than 75 Members of Congress, urging CMS to adopt a streamlined approach to the F2F requirement that would allow the requirement to be met through the use of the existing 485 form.

The Reed/Tonko-led letter states that the “complicated, confusing and overlapping documentation requirements … exceed the intent of the law passed by Congress.”

HCA pressed and reinforced these critical arguments during meetings with the New York Congressional Delegation offices throughout our advocacy program on Tuesday where we also discussed other critical issues like rebasing and copays. (See related p. 1 story.)

**MAC Discussions**

In addition to the NAHC lawsuit, the HCA-led Congressional briefings, and the association-level strategy discussions on F2F, HCA also led a Forum of State Associations discussion in Washington with a representative from one of CMS’s Medicare Administrative Contractors (MACs), Palmetto, which has seen some of the highest rates of F2F-related claims denials.

While the Palmetto representative indicated that MACs are working on process instructions to assist agencies, HCA and association representatives noted that many home care agencies have already adopted fairly rigorous internal protocols for F2F
compliance that can only go so far in succeeding if the physicians who are also burdened by F2F nevertheless remain unbound by any financial incentive to accurately complete the F2F documentation.

The problem of physician compliance and documentation is reinforced by a national provider survey on F2F conducted in the fall by the Forum of State Home Care Associations, which is chaired by Ms. Cunningham. For 52 percent of the survey respondents who experienced F2F claim denials, the denials primarily resulted from MACs determining that the physician documentation was “inadequate,” even though care was provided and the physician did sign the certification. The standards for compliance continue to be byzantine and difficult to navigate.

As a next step in our aggressive campaign on F2F, HCA will: convene a group of state associations from across the country to strategize on a multi-state federal legislative strategy to ask Congress to act legislatively to fix the F2F regulation; renew our efforts to engage the Medical Society of the State of New York (MSSNY) to educate physicians on the F2F regulation; continue an aggressive campaign to remind federal policymakers of the F2F burden and to urge their engagement with CMS to solve this issue; continue to urge CMS to find a reasonable and workable solution to minimize the provider burden of F2F.

HCA will keep the membership informed of any further developments on these efforts.

For more information, please contact the HCA Policy staff.

Award Nominations are Due April 3

Download the nomination form at: www.hca-nys.org/Award.pdf
In Memoriam: Sister Virginia Hanrahan

HCA was extremely saddened to learn this week about the passing of Sister Virginia Hanrahan, 78, a past HCA Board Member and President and CEO of Dominican Sisters Family Health Service (DSFHS) from 1974 until her retirement in 2009.

Sr. Virginia made an indelible mark on New York’s home care system, serving as a compassionate and passionate advocate for patients and their families throughout her time with DSFHS, an agency she helped to certify during the 1970s. Sr. Virginia’s early work and legacy helped set the foundation for the care and services that DSFHS provides patients and clients today.

Sr. Virginia (formerly Sister Catherine Joseph) entered the novitiate of the Dominican Sisters of the Sick Poor in September 1953 and soon earned her BS in Nursing from Hunter College and, later, an MS in Nursing from Catholic University. She was awarded an Honorary Doctor of Humane Letters from the College of New Rochelle in 1980.

Upon completion of her studies, Sr. Virginia served as community health nurse and Assistant Supervisor with the Dominican Sisters of the Sick Poor in the Bronx. She then became a team nurse and, later, the Director of Nursing at Dr. Martin Luther King, Jr. Neighborhood Health Center in the Bronx.

In 1998, Sr. Virginia received HCA’s Ruth F. Wilson Award, HCA’s highest accolade. In 1999, she was awarded the Ellis Island Medal of Honor for “exceptional humanitarian efforts and outstanding contributions to our country.”

HCA extends our deepest condolences to the team at DSFHS who worked with Sr. Virginia and to many others in the HCA community who considered her a great colleague and friend.

Donations can be made in Sr. Virginia’s memory to Dominican Sisters Family Health Service, 299 North Highland Avenue, Ossining, NY 10562.
Register for HCA Conference by April 6 to Net the Best Discount

Early-bird registration, hotel discount, half-price opportunity for first-time attendees joining a colleague – all due by April 6

Register now for HCA’s 2014 Annual Conference (on May 7 to 9 in Saratoga Springs) to get the best possible deal and net some major savings.

If you register within the next week, you’ll be able to take advantage of the low early-bird registration rate (a $70 discount), the special hotel discount rate, a half-price discount for one of your colleagues who is attending for the first time (limited to one person per agency), and an opportunity to enter a drawing for a $50 American Express Gift Card through HCA’s mobile phone app. (See details here: http://tinyurl.com/mz9wta4.)

All of these opportunities will expire on April 6, so why wait?

HCA’s Annual Conference covers the issues and offers the popular speakers you’ve been asking for.

Our pre-conference session on Discharge Planning: The Elements and Incentives for Effective Care Transitioning is a robust program that will help you fill the gap in the care-transition process. (See related story, this page.)

Other sessions throughout the conference will focus on strategies for enhancing care-collaboration, palliative care, lessons learned from the largest-ever nationwide survey on home care, new data tools and more.

We also have two popular speakers on hand who are worth the price of admission alone: nationally recognized health care consultant Dr. Brian Wong, who will share strategies on care coordination, and acclaimed speaker Liz Jazwiec, RN, who will provide lessons on creating an accountable culture at your organizations. Both speakers come highly recommended from HCA members.

Everything you need to know about these programs, our list of vendors, HCA’s PAC reception, our awards program, our smartphone app, our online registration and more can be found on our conference website at www.hcaannualconference.com.

Discharge Planning – Just One of the Engaging Learning Sessions Offered at HCA’s Annual Conference, May 7 to 9

Discharge Planning: The Elements and Incentives for Effective Care Transitioning will be an intensive, thought-provoking and engaging workshop to kick off HCA’s Annual Conference on May 7. This extended pre-conference session is complimentary to members who register for the full conference.

To help your organization serve the needs of patients before and after hospital discharge, HCA has harnessed a team of experts from the quality improvement, hospital and a managed care plan sectors to bring valuable and proven information ready for implementation at your organization.

Sharing extensive research and data, Sara Butterfield, RN, BSN, CPHS, CCM, Senior Director of Health Care Quality Improvement at IPRO, will demonstrate how home care is in a key position to bridge the gaps in caring for patients from one health care setting to another. Diane Nanno, MS, CNS, RN, Director of Transition Care
Services at SUNY Upstate University Hospital, will discuss how processes can be improved and partnerships enhanced in an effort to improve patient transitions across the continuum.

Closing out the workshop, Marianne Grady, Director of Managed Long Term Care at Health Plus, an Amerigroup Company and an HCA member, will highlight the benefits of solid care-transition know-how when becoming a partner in the delivery of services under Managed Long Term Care. Ms. Grady will also discuss proven new models and payment incentives, including Fully Integrated Duals Advantage (FIDA) programs.

For one low registration fee, attendees will receive three days of informative, useful and inspired learning at HCA's Annual Conference. For the best value, members are encouraged to take advantage of the early-bird discount that shaves $70 off the full registration fee for those who sign up by April 6. As an added bonus for someone who has never attended the conference before, HCA is offering one member from your organization the opportunity to attend at half-price if they register by April 6, for the full conference.

This special offer will require a registration form to be faxed or mailed in. The brochure and form are available at www.hcaannualconference.com.

Safe and secure online registration is available for all other registrants at www.eventville.com/hcanys.

Take a moment to look through the extensive Annual Conference brochure and see how your home care association is helping to harness the power of home care for members across the state and in your communities.

Better yet, download the smartphone app to keep you informed throughout the conference. Visit www.hcaannualconference.com to download the app and enter a drawing for a $50 gift card for using the app – which also closes on April 6.

Don't wait – take advantage of these money and time saving opportunities right now!

For further information, contact Lynda Schoonbeek at (518) 810-0656 or Lschoonbeek@hcanys.org.
HCA Conference Helps You to Explore New Models of Care on April 23

The Affordable Care Act has been the stimulus for new health care delivery and payment models that are expected to improve outcomes, decrease costs and restructure reimbursements. However, learning about these new care models – not to mention the fine points of contracting and adjusting to new or different payment systems – can be a daunting task for any home health agency wanting to partner in a model that works best.

HCA to the rescue! On April 23, HCA is offering a full-day conference on Engage, Collaborate and Partner, an education program on innovative new models of service delivery and payment, to be held at the Hilton Hotel in Albany.

In addition to learning about the state’s strategy for incentivizing new care models, members will be able to hear from the leaders of three innovative models and how home health is a valuable spoke in their wheels of operation. The day will include a session on how to position your agency for a positive partnership and information on lessons learned from programs already in operation.

View the full lineup of expert policymakers, consultants and panelists and their topics in the brochure posted at the back of this week’s ASAP.

Take the time out of your busy schedule to explore how home care providers can successfully position themselves to engage, collaborate and partner. Early registration is encouraged to guarantee your seat along with valuable handout materials.

For further information, contact Lynda Schoonbeek at (518) 810-0656 or Lschoonbeek@hcanys.org.

Revised Home Care Registry FAQs Posted

The state Department of Health (DOH) has posted a revised Frequently Asked Questions (FAQs) document about the state’s Home Care Registry (HCR).

The document is on the Health Commerce System (Newsroom Highlights) at https://commerce.health.state.ny.us/public/hcs_login.html.

Some of the new information includes: 1) actions to take if the HCR includes incorrect information; 2) whether an individual can have more than one registry number; 3) when a registry number is assigned; 4) timeframes for data entry (chart and question); 5) charging for duplicate certificates; 6) whether employers can enter information on convictions and findings; 7) applicability of HCR to Assisted Living Programs; and 8) hiring aides with certificates from training programs no longer on the state’s list of approved programs.

After the HCR was established, HCA worked with a group of affected members to identify any problems and worked with DOH to improve the Registry. HCA is interested in learning about any outstanding issues that members are still facing.

For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcanys.org.
Clarification Issued Regarding PECOS Web Application

The U.S. Centers for Medicare and Medicaid Services (CMS) has issued a clarification about its Internet-based provider enrollment application process, known as the Provider Enrollment, Chain and Ownership System (PECOS).

When completing a PECOS web application and signing the application, users can choose to electronically sign the enrollment application, but they should not submit the Paper Certification Statement. The Paper Certification Statement option is intended as a hardcopy for the provider’s own records.

Since January 6, CMS has activated the PECOS Medicare claims edit so that home health claims will be denied if the ordering physician is not enrolled in the PECOS database or if the physician has not officially opted-out of Medicare. In order to prevent Medicare claim denials, agencies should verify enrollment of all ordering physicians.

To learn more about PECOS, go to https://pecos.cms.hhs.gov/pecos/login.do.

A similar requirement applies under Medicaid. The Medicaid billing edit has been activated and is called the Ordering, Prescribing, Referring and Attending (OPRA) edit. More information on OPRA is at https://www.amedny.org/Notice/DEC2013_MEDUPDATE-OPRA.pdf.

CMS Coordination Office Releases Report

The U.S. Centers for Medicare and Medicaid Services (CMS) Medicare-Medicaid Coordination Office (MMCO) has released its fiscal year 2013 Report to Congress.


In the report, MMCO makes the following three legislative recommendations:

• Provide the Secretary of the U.S. Department of Health and Human Services the authority to integrate the Medicare and Medicaid appeals processes;

• Ensure retroactive Medicare Part D drug coverage of newly-eligible low income beneficiaries; and

• Extend the Program for All-Inclusive Care for the Elderly (PACE) to individuals age 21 to 55 as part of a pilot project that would be evaluated.

The report also describes two other areas that MMCO is examining. They are: coverage standards for Medicare-Medicaid enrollees under state Medicaid and federal Medicare policies; and cost-sharing rules for Qualified Medicare Beneficiaries (QMBs).

In addition, the report summarizes activities in 2013 that include: 1) Medicare-Medicaid financial alignment initiatives and state demonstrations (encompassing New York’s Fully Integrated Duals Advantage or FIDA program); 2) an initiative to reduce avoidable hospitalizations among nursing home residents; 3) integrated Medicare and Medicaid denial notice; 4) quality improvement; and 5) improving access to Medicare and Medicaid data.
VA Again Delays Release of Home Care Rate Methodology

The Veterans Administration (VA) has again delayed the effective date of a final rule to change the billing methodology for non-VA providers of home health and hospice services from April 1 to **June 1, 2014**.


According to the VA, the delay is necessary to "accommodate difficulties in the outreach and implementation of standardized processes for VA staff involved in the process of approving and paying for home health services and hospice care."

Under this rule, the VA will pay non-VA providers of home health and hospice care the Medicare prospective payment system amount or fee schedule unless the VA negotiates other payment amounts with such providers. Based on 2010 levels, the VA estimates that this change will result in a loss of up to $1,346.28 annually for each home health provider that does not separately negotiate a payment rate with the VA.


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

Guidance Issued on ‘Shared Living’ Programs and Companion Exemption

Late today, the U.S. Department of Labor (DOL) issued guidance on how the final companionship exemption rule affects “shared living” programs.

A fact sheet on this issue is at [http://www.dol.gov/whd/regs/compliance/whdfs79g.htm](http://www.dol.gov/whd/regs/compliance/whdfs79g.htm) and an “Administrator’s Interpretation” is at [http://www.dol.gov/whd/opinion/adminIntrprtn/FLSA/2014/FLSAI2014_1.htm](http://www.dol.gov/whd/opinion/adminIntrprtn/FLSA/2014/FLSAI2014_1.htm).

Shared living programs are those that provide supports and services allowing people with disabilities and older adults to live in their own homes or in family homes in their communities, as opposed to in congregate settings like group homes or institutions, and in which the individual receiving assistance and the worker providing it live and share a life together. These programs are referred to by various titles, such as “adult foster care,” “host home,” “paid roommate,” “supported living,” or “life sharing.”

On October 1, 2013 DOL issued a final rule that eliminates the federal Fair Labor Standards Act (FLSA) “companionship exemption” for certain “domestic service” workers, including home care aides employed by agencies. Under this rule, starting January 1, 2015, agencies in New York will have to pay overtime to their aides at time-and-a-half of the aide’s regular wage rate, rather than time-and-a-half of minimum wage.

DOL’s fact sheet and Administrator’s Interpretation provide guidance on how the FLSA’s requirements may apply to home care services that occur in shared living arrangements. HCA will be reviewing these guidance documents to determine if they affect the delivery of home care services in New York.

Additional information on the effects of the changes to the FLSA companionship exemption are at [http://www.dol.gov/whd/homecare/](http://www.dol.gov/whd/homecare/) and in an HCA Guidebook posted in the Resource Library of our website.

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

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

• **Reminder on Deleting Revenue Code Lines in the FISS Direct Data Entry System** – NGS reminds providers on the correct process for deleting a revenue code line or lines in the Fiscal Intermediary Standard System Direct Data Entry (FISS/DDE) System. If providers have a line that is non-covered and they would now like to make that line covered, it is important to follow the steps below. (This does not apply to a line that is non-covered due to a medical denial.)

To delete an entire revenue code line: Tab down to the revenue code line that you wish to delete and place a “D” on the first position of the revenue code; Press the “Home” key; and Press “Enter.”

• **Top 10 Appeals Questions and Answers** – This week, NGS posted to its website the Top 10 Appeal Questions and Answers (Q&As) they receive from providers. The following are the top three Q&As:

  **Q:** How much time do I have to submit my appeal request?

  **A:** 120 days from the date of the original Medicare remittance advice. Multiple resubmissions of a claim will not extend the 120-day time limit. The time limit begins with the original denied/processed claim.

  **Q:** Can an appeal be filed past the 120-day limit?

  **A:** The time limit may be extended if good cause for late filing is shown. If good cause is not found, the request for appeal will be dismissed. The issue of ‘good cause’ is addressed in the U.S Centers for Medicare and Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 29, Section 240.

Nursing Home to Supportive Housing RFA Released

The state Department of Health (DOH) has released a request for applications (RFA) for the Nursing Home to Independent Living Supportive Housing program.


Under the RFA, DOH is seeking to fund up to two projects to provide supportive housing services – including the provision of rental subsidies to seniors and individuals with physical disabilities who require a nursing-home-level of care and who currently are homeless, reside in the community or in nursing homes, or those who are at risk of nursing home placement. The funded projects will develop, implement and provide supportive services to participants in order to sustain the participants’ ability to live in the community independently, and to avoid unwanted institutional care. The funded projects will also develop and implement a system to provide rental subsidies on behalf of participants of this project.

Letters of interest are due **April 4** and the deadline to submit questions is the same. Applications are due **May 15**.

This RFA is different from the Senior Supportive Housing Services RFA covered in last week’s ASAP.

MEVS/DVS Manual Updated

Q. Must a redetermination request have a signature, and what type of signature is needed?

A: Yes, a full signature (first and last name) is required on the redetermination request form in order for it to be valid.

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

Transition of Nursing Home Benefit to Managed Care Delayed

The state Department of Health (DOH) has delayed from April 1 to June 1 the date on which new nursing home residents age 21 and older will have to enroll into a Managed Long Term Care (MLTC) or mainstream Medicaid managed care (MMMC) plan. This new date is contingent on approval from the U.S. Centers for Medicare and Medicaid Services.

Under this new timeframe, those dually eligible for Medicare and Medicaid in New York City, Long Island and Westchester who enter a nursing home on or after June 1 will have to enroll into an MLTC, and those eligible for Medicaid only in those downstate areas who enter a nursing home after June 1 will have to enroll into an MMMC plan.

HCA is checking if the former timetable still holds for enrollment of new nursing home patients in the rest of the state (previously set at October 1).

All current long term custodial care beneficiaries in a Medicaid certified skilled nursing facility prior to any managed care phase-in date will remain in fee-for-service Medicaid and will not be required to enroll in an MLTC or MMMC plan.

For more information on the nursing home transition to managed care, go to http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm.

Security Risk Assessment Tool Available for HIPAA Compliance

The Department of Health and Human Services has released a new security risk assessment (SRA) tool to help guide health care providers in small to medium sized offices conduct risk assessments of their organizations under the Health Insurance Portability and Accountability Act (HIPAA) Security Rule.

The application, available for downloading at www.HealthIT.gov/security-risk-assessment also produces a report that can be provided to auditors.

HIPAA requires organizations that handle protected health information to regularly review the administrative, physical and technical safeguards they have in place to protect the security of the information. By conducting these risk assessments, health care providers can uncover potential weaknesses in their security policies, processes and systems. Conducting a security risk assessment is a key requirement of the HIPAA Security Rule.

Risk assessments also help providers address vulnerabilities, potentially preventing health data breaches or other adverse security events. A vigorous risk assessment process supports improved security of patient health data.

The SRA tool's website (http://www.healthit.gov/providers-professionals/security-risk-assessment) contains a User Guide and Tutorial video to help providers begin using the tool. Videos on risk analysis and contingency planning are available at the website to provide further context.
Publications

- “Communicating With Your Medicare Patients,” by the U.S. Centers for Medicare and Medicaid Services

- “Medicaid for Immigrants who are Not Permanent Residents (Do Not have Green Cards) – PRUCOL Status and Procedure,” by the NY Legal Assistance Group
  http://www.wnylc.com/health/entry/33/

Education

- “Balancing Incentive Program Innovation Webinar,” by the state Department of Health, on April 8, 10 a.m.
  https://meetny.webex.com/meetny/onstage/g.php?t=a&d=641214728

For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcany.org.
The new health care marketplace, prompted by federal and state policy changes, is encouraging the development of new models of service delivery, care provision and payment. As the provider of high quality services to chronically ill, frail and elderly patients, home care providers are well positioned in this new marketplace to offer hospitals, health systems, physician practices and health plans a value proposition for expertise and service delivery. This new market offers the home care community many new opportunities for partnership and collaboration.

Hear from expert policymakers, consultants and panelists about new models in New York’s health care marketplace, as well as how home care providers can successfully position themselves to engage, collaborate and partner with other parts of the health care continuum.
Tentative Agenda

APRIL 23

8:30am – 9:20am Registration
9:20am Welcome
9:30am to 10:30am New York State’s Innovative Service and Delivery Reforms Overview of New Models & Description of the State’s Policy and Program Directions
Greg Allen, Director, Division of Program Development and Management, New York State Department of Health

10:30am to Noon Home Care’s Role in New Models – How to Position Your Agency for Positive Partnerships
Joe Pofit, Cicero Consultants

Noon to 12:45pm Networking Lunch

12:45pm to 2:45pm Successful Planning and Execution – Panelists Share Descriptions of their Innovative Models in the New Health Care Marketplace

Accountable Care Organizations
Hope Glassberg, Director of Public Policy
The Care Management Company,
Montefiore Medical Center

Patient Centered Home
John Rugge, MD, Executive Director, Hudson Headwaters Health Network

Primary Care/Home Care/Hospital Partnership
Sumir Sahgal, Medical Director, EssenMed House Calls

3:00pm to 4:00pm Cross-Model Analysis, Preliminary Findings, Lessons Learned
Gregory C. Burke, Director, United Hospital Fund

4:00 pm Closing Comments

Special Accommodations: In accordance with the Americans with Disabilities Act or special meal needs, please let us know how we can accommodate you:

Cancellation Policy: Cancellations received by April 14 will receive a full refund, less 25% of total due as an administrative fee. Cancellations received on April 15 or later will forfeit their registration fee, as will those who register and do not attend. Substitutions are permitted.

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