**HCA Continues Full Court Press to Secure F2F Fix**

HCA President Joanne Cunningham continued HCA’s aggressive and strategic advocacy this week aimed at securing a simple and concise legislative fix to streamline the onerous and duplicative federal face-to-face requirement imposed on Medicare home health agencies.

This fix, drafted by HCA, is being considered by the U.S. House Appropriations Committee for inclusion in the House Omnibus Appropriations legislation. That legislation must be passed and sent to the President for his signature by the start of the fiscal year on October 1.

In several meetings at the Capitol this week, HCA discussed the F2F appropriations fix with New York Members of the House Appropriations Committee as well as New York Members of the House Ways & Means and Energy

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**HCA Bills Gain Legislative Approval**

This week, several HCA-developed bills gained legislative approval by the Senate, Assembly or both, setting the stage for remaining approvals next week.

Thursday, June 19 is set as the last regularly scheduled day of the 2014 State Legislative Session, but there remains the possibility that session will continue past the pre-set calendar, as has frequently been the case.

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**State Posts Changes to DSRIP Materials and Community Needs Assessment Guidance**

Feedback on Letters of Intent also provided, along with a host of other important DSRIP updates

The state Department of Health (DOH) has posted comments it received along with changes to the application materials for Delivery System Reform Incentive Payment (DSRIP) program

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**Summer Schedule: ASAP will be published every other week for the summer, starting after the July 3 issue (published on a Thursday). Look for more details in next week’s ASAP.**
& Commerce Committees. Each Member and office responded favorably to our request that the Delegation contact House Committee leaders to ask that the F2F appropriations fix be included in any final Omnibus Appropriations bill.

HCA met directly with Rep. Nita Lowey (D-NY), Ranking Member of the House Appropriations Committee, to ask for her support this week. Rep. Lowey was extremely supportive and indicated that she would be working to secure this language in any final bill. HCA was also joined on Capitol Hill by Kentucky Home Care Association Executive Tim Rogers whose House Delegation member, Rep. Hal Rogers (R-KY), is Chair of the House Appropriations Committee.

The National Association for Home Care and Hospice (NAHC) has also engaged in an aggressive national grassroots advocacy campaign aimed at assisting in securing the HCA F2F language. In coordination with NAHC, the Forum of State Home Care Associations has likewise mobilized state home care associations and their members on the F2F advocacy strategy. The Forum, chaired by Ms. Cunningham, is an affiliate of NAHC and is comprised of home care associations from every state.

HCA, NAHC and the Forum have held bi-weekly calls to share information about actions taken by each state home care association to encourage Members of Congress to support the F2F appropriations fix. The Forum has also developed advocacy materials (co-branded with NAHC) to assist members of the Forum with their own advocacy efforts. Those materials are available in the “Resource Library” section of HCA’s website at http://www.hca-nys.org/clips.cfm. Go to the “HCA Briefing Documents and Talking Points” section on this page. There you’ll see the newest of these documents, titled F2F Advocacy Strategy Cheat Sheet: Update and Next Steps. (A direct link to this document, which has the newest information, is at http://www.hca-nys.org/documents/F2FAdvocacyStrategyCheatSheetNextSteps.pdf.)

Using these materials as a guide, HCA urges members to call their Representatives on this issue. Please ask...
your Representative to contact Rep. Lowey with a simple message: Support the F2F appropriations fix.

HCA’s legislative fix for F2F is most likely to survive a very contentious appropriations process only if Rep. Lowey is bolstered by the support of her fellow colleagues in the New York Congressional Delegation to push hard on this fix.

NAHC lawsuit also advanced

As a companion to the legislative route, NAHC has also advanced a lawsuit to trigger changes in CMS’s implementation of the F2F rule. (See last week’s ASAP, p. 1, for details.)

This lawsuit is part of a multi-channel campaign by the home care community nationwide to leverage changes in the duplicative F2F requirement.

NAHC’s lawsuit has been filed in U.S. District Court. It claims that CMS violated the underlying authorizing law of F2F by requiring a narrative component for documentation of F2F. It also claims that CMS violated the U.S. Constitution and the Medicare Act by failing to provide reasonable and clear guidance on the requirement, and that CMS further violated Medicare law by retroactively denying payment based solely on the ‘sufficiency’ of the physician narrative requirement.

HCA will continue to keep the membership briefed on developments with both the legislative fix and the NAHC lawsuit.

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

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**CMS Reverses its Medicare Advantage (MA) Face-to-Face Encounter Policy**

The U.S. Centers for Medicare and Medicaid Services (CMS) this week informed our colleagues at the National Association for Home Care and Hospice (NAHC) that it is reversing its position on the face-to-face (F2F) encounter requirement for Medicare beneficiaries who receive home health services through a Medicare Advantage (MA) health plan.

CMS stated in a letter to MA plans earlier this year that they should apply the same certification requirements as fee-for-service (FFS) Medicare to plan beneficiaries that receive home health services. This directive would also require that the MA plans apply the same home health F2F requirement that is needed in the Medicare FFS benefit.

Because of serious concerns with this directive throughout the entire home care industry, NAHC met with officials at CMS and questioned the rationale behind the requirement, given that MA plans have a preauthorization process which would negate the need to follow Medicare FFS certification requirements. As a result of NAHC’s advocacy, CMS issued the following memorandum to MA plans on June 11, 2014, which revises its previous directive:

This memorandum is to correct the Final Call Letter of April 7, 2014 regarding Medicare Advantage organization’s (MAO’s) certification of enrollees for home health services. We (CMS) are clarifying that an MAO’s authorization for home health services may substitute for the Original Medicare face-to-face certification requirement for the authorization of home health care services.

In certain circumstances, MAOs are not required to follow original Medicare documentation requirements for the provision of Medicare covered services, but may substitute methods they deem appropriate for ensuring that the services provided are medically necessary, so long as they are not more restrictive than the coverage standards that apply in Original Medicare.

While this updated CMS memorandum is very helpful for home health agencies contracting with MA plans, it is still possible the MA plans may voluntarily require network home health agencies to obtain F2F encounter documentation.

HCA is very appreciative of NAHC’s advocacy and outreach to CMS on this issue at a time when HCA, NAHC and other partners in the home care community are pressing for a fix to the onerous F2F requirement. (See related p. 1 story.)

For further information, contact the HCA Policy staff.
projects. It has also posted new guidance for conducting Community Needs Assessments (CNAs) and feedback on the Letters of Intent submitted as an initial step in the applications process.

The application changes are to Attachments I (Funding and Mechanics Protocol) and J (Strategies Menu and Metrics). Revised versions of these Attachments – with highlighted changes – are at the links below.


A summary of comments is at http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_summary_comments_i_and_j_with_notes.pdf.

Attachment I includes the following changes:

- The state will review each proposed Performing Provider System (PPS) and may require additional linkages to other medical, behavioral health, long term care, developmental disabilities or social service providers, as required, to build a comprehensive regional performance network.

- As part of the PPS approval process, the state will articulate a set of standards that each lead entity must follow, including rules on project oversight, performance payment distribution and other legal/operational obligations.

- Each PPS will be approved for a specific geographic area based on its application and the state’s review.

- The state is working on a more detailed and revised ‘attribution’ method for assigning patients – one that is population-specific (e.g. long term care, behavioral health, etc.).

- Attribution results will be shared with each approved PPS for review prior to finalization.

- Medicaid managed care plans should not use the attribution process as a way to steer members to certain contracted providers but are instead encouraged to work with the PPS network and individual providers to align contracting with member access patterns.

- Barring any unforeseen circumstances, the targets set for each measure will not change during the DSRIP performance period.

- PPS networks must include evidence of consumer engagement in the needs assessment and planning process.

- A state contractor will conduct a consumer education campaign for Medicaid and uninsured members about the benefits of DSRIP and services available through local PPS networks.

- Each Learning Collaborative will include key personnel from PPS networks and selected stakeholders, including provider association representatives.

Community Needs Assessment

The purpose of the CNA guidance document is to assist emerging PPS networks to plan, undertake and complete an effective Community Needs Assessment. The Community Needs Assessment should be a comprehensive
assessment of the demographics and health needs of the population to be served and the health care resources and community based service resources currently available in the service area.

According to DOH, the PPS needs a solid understanding of the current health status of the population and components of the health care system in its geographic region in order to choose the most appropriate projects for the PPS to undertake.


The CNA must include: health care and community resources; demographics and health status of the targeted community; main health and health service challenges; summary of the assets and resources that can be used to address the DSRIP strategies and projects; a summary chart of the projects to be implemented; and documentation of the processes and methods used to conduct the assessment.

The CNA guidance also includes resources for conducting community health needs assessments and data sources.

**Letters of Intent feedback**

DOH has also posted feedback on the letters of intent submitted by providers who expressed interest in participating in DSRIP.

The feedback is at http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_loi_received/emerging_pps/#cap_reg (see the link under each region).

The feedback, provided by various state agencies, includes general comments as well as comments about network adequacy, potential missing partners, and other consolidation opportunities.

**Additional updates**

Some more updates to the DSRIP web page include:


As a reminder, the DSRIP Project Design Grant application is due June 26. More information is at http://www.health.ny.gov/health_care/medicaid/redesign/dsrip_design_grant_appl.htm.

**Post-Acute webinar**

HCA members are invited to register for “Identifying Post-Acute DSRIP Partners and Examples of Cross-Setting Transition Initiatives,” a webinar being held by the Healthcare Association of New York State (HANYS) and LeadingAge NY on June 20, from 10 to 11 a.m.

It will focus on ways that post-acute providers can identify and highlight their value for prospective PPS networks. Discussion will also include examples of cross-setting initiatives that would be attractive for DSRIP project domains.

Diane Nanno, MS, CNS, RN, Director of Transition Care Services at SUNY Upstate University Hospital in Syracuse, will discuss opportunities for post-acute providers to be identified as PPS partners.

Registration is at http://tinyurl.com/m7645fn.

**Safety net appeals**

This week, HCA, along with other provider associations, sent a letter to State Medicaid Director
Jason Helgerson expressing concerns about the DSRIP safety net provider appeal threshold. (See related p. 7 story.)

HCA is part of a working group of state associations (HANYS, the Community Health Care Association of New York, LeadingAge NY, the Mental Health Association of New York State, the Adult Day Health Care Council, the New York Association of Psychiatric Rehabilitation Services, the state Council for Behavioral Healthcare, and others) that has been coordinating efforts to help facilitate provider participation in DSRIP education, planning and development.

The group identified several eligibility issues that impact the safety net provider status of Licensed Home Care Services Agencies, Certified Home Health Agencies, Assisted Living Programs, Adult Day Health Care programs, Behavioral Health Providers, Primary Care and Federally Qualified Health Centers.

HCA has also been in close contact with DOH to obtain guidance and clarification on the safety net appeal process and form. We raised several issues with the form itself and its incompatibility with the operation of home care agencies and their programs.

HCA reminds providers that they still can participate in a PPS as a “non-qualifying” provider if they did not submit a safety net provider appeal (the deadline was June 11) or if your safety net provider appeal is ultimately denied. However, non-qualifying safety net providers in a PPS are only eligible to receive DSRIP payments totaling no more than 5 percent of a project’s total valuation.

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

HCA Communications Director Selected for City & State ‘40 Under 40’ Honors

HCA’s Communications Director Roger Noyes was chosen by City & State Magazine as one its 2014 “40 Under 40 Rising Stars.”

“It is sometimes easy to overlook just how many extraordinarily bright and talented people work in the state capital and elsewhere in New York politics and government,” writes City & State in its June 9 edition. “Each year City & State is deluged with so many worthy nominations for our annual Rising Stars list that the most difficult part of our task becomes not identifying the state's up-and-coming leaders but winnowing the roster to just 40 women and men.”

Noyes, 36, started his career in journalism as a reporter and editor for a group of weekly newspapers in the Capital Region. After teaching college English and writing for two years at Champlain College and SUNY Plattsburgh, he began working for the State Senate Minority Leader’s office in 2006, first under David Paterson and then under Malcolm Smith, where he served as Assistant Press Secretary. He has been HCA’s Communications Director for almost seven years.

To read his profile and learn about the other ‘40 Under 40’ honorees, please visit http://www.cityandstateny.com/2/92/rising-stars/albany-rising-stars-2014.html#.U5l1Y46I1S8.
HCA, Health Associations Seeking DSRIP Eligibility Adjustments

This week, HCA and a multi-association working group prepared and submitted to the state Department of Health a memorandum outlining several circumstances either inadvertently or otherwise unfairly preventing certain categories of providers from qualifying for safety net provider status under the Delivery System Reform Incentive Payment (DSRIP) program.

The specific provider categories we addressed in the memorandum included: Licensed Home Care Services Agencies, Certified Home Health Agencies, Long Term Home Health Care Programs, assisted living programs, adult day care programs, non-clinic based behavioral health providers, and primary care and federally qualified health centers.

The memo is on HCA’s Policy Positions page at http://www.hca-nys.org/polpos.cfm.

The Department’s individual provider appeal deadline for DSRIP safety net qualification was this past Wednesday, June 11. In addition to pressing for broad-based accommodation on the eligibility threshold for safety net status, the memo will hopefully also help bolster individual appeals that have been filed.

HCA will keep the membership apprised of the Department’s response and any associated developments with this issue. (Please see the related p. 1 story for the latest developments on DSRIP.)

For further information, please contact Al Cardillo at acardillo@hcanys.org or Andrew Koski at akoski@hcanys.org.

Get Connected at HCA’s Technology Symposium on June 24

Engineers, developers and policy leaders have made tremendous progress in building the foundation for interoperable health information exchange technologies that enhance quality of care and promote greater efficiencies. Still, we have a long way to go, particularly in connecting home care to these important systems.

HCA’s Technology Symposium on June 24 in Tarrytown aims to bring providers up to date on these and other state and federal initiatives while providing some concrete cases examples showing some of the many technological opportunities available.

To help sketch out the federal and state policy landscapes, our dynamic speakers include Tim Rowan, Publisher of The Home Health Technology Report, Patrick Roohan, Director of Quality Management for the New York State Department of Health, and D. Scott Momrow, Vice President of Marketing and Outreach for HIXNY.

In addition, several of your peers in the home care provider community will share what specific technological tools they have implemented within their organizations. They will also tell why they chose a particular technology, the outcomes achieved, and plans for future use. Meanwhile, Rob Simione of Simione Consulting will provide insights on how technology can play an important role when it comes to improving processes and cost efficiencies within your organization.

This packed one-day symposium includes informative speakers, valuable handout materials, lunch and the opportunity to connect with your peers, HCA staff and the sponsors of this event. Register today and get connected. See the back of this week’s ASAP for details.

For further information contact Lynda Schoonbeek at 518-810-0656 or Lschoonbeek@hcanys.org.
What follows is a status summary of HCA bills, each of which has been previously detailed in past editions of ASAP and in other HCA communications.

HCA’s memos of support for these bills are posted on our Policy Positions page: http://www.hca-nys.org/polpos.cfm.

‘Essential Personnel’ Status for Home Care and Hospice

The Assembly unanimously passed the ‘Essential Personnel’ bill for home care and hospice, A.6530-B by Assemblyman Michael Cusick. The Senate bill, S.4719-B, by Senator Andrew Lanza, is in the Senate Finance Committee from which it can be advanced for a full Senate vote next week.

Passage of this bill would address a major priority in home care and hospice emergency preparedness and response. It would also bring home care’s needs to the forefront as part of the local and state emergency management planning process.

The legislation ensures that home care and hospice personnel, as well as physicians and other specified health practitioners, have ‘essential personnel’ status for access to patients in geographically restricted or curfew areas in declared emergencies. It also requires consideration of home care and hospice input by municipalities developing local emergency management plans. HCA members should continue to call and e-mail their support to Senator Lanza and to Senate Finance Committee Chair John DeFrancisco.

Health IT Infrastructure Workgroup

Both the Senate and Assembly unanimously passed HCA legislation to provide for home care representation on the state’s Health Information Technology Infrastructure Workgroup, which was newly created in this year’s state budget to examine and make recommendations for the system’s health information technology needs. The legislation, S.7592/A.9801, by Senator Kemp Hannon and Assemblyman Richard Gottfried, passed the Assembly and Senate on Wednesday, and will subsequently be delivered to the Governor for his signature.

Adequate and fully interoperable systems of electronic health records and other health information technology are critical for home care and all sectors, especially as the health care system moves toward fuller integration. Home care’s participation in this new state initiative is an essential step.

Palliative Care Council and Education-Training Legislation

HCA legislation stemming from the HCA Hospice and Palliative Care Forum (see related page 12 story) unanimously passed the State Senate on Wednesday. Its Assembly counterpart was reported from the Assembly Health Committee to the Assembly Calendar where it is positioned for Assembly passage.

The legislation, S.7601-B by Senator Hannon and A.9966 by Assemblyman Gottfried, would help advance palliative care education, training, practice and policy. The legislation would add home care and social work (alongside nursing and hospice) for representation on the State Palliative Care Council and would charge the council to examine and make recommendations to the Legislature regarding the need, approaches and resources to provide for palliative care education and training in state certified schools of nursing and social work, as well as in practice settings at the health care provider level. (The Council’s current charge is focused on medical student education and training.)

Hospital-Home Care-Physician Collaboration Program

HCA legislation to support the development and operation of collaboration programs among hospitals, home care agencies and physicians is on the Senate Calendar and positioned for a full Senate
vote. Its Assembly counterpart is in the Assembly Health Committee.

The legislation, S.5258 by Senator Hannon and A.7899 by Assemblywoman Aileen Gunther, is also incorporated within another developing bill. HCA continues to urge passage of the standalone legislation while simultaneously working to ensure its inclusion in the more comprehensive package, should the Legislature opt for this alternate route.

**Managed Care-Home Care Regulatory Realignment and Streamlining**

HCA continued its discussions with the Governor’s office and Legislature this week in an effort to gain approval of HCA-LeadingAge NY legislation, S.7600 by Senator Hannon. The legislation provides for desperately needed managed care-home care regulatory realignment, streamlining and clarification of duties. HCA will continue pressing throughout the remaining days of the session for passage of this bill as well as a parallel state administrative remedy.

*For more information, please contact a member of HCA’s Policy staff.*

**New DAL Restates CHHA Requirements for Physician Orders, Fair-Hearing Process**

*DAL stems from court case involving practice patterns in home care*

The state Department of Health (DOH) yesterday issued a new Dear Administrator Letter to Certified Home Health Agencies (CHHAs) on physician orders for home care and the fair hearing process.

HCA has posted the letter to our website at [http://www.hca-nys.org/documents/PhysicianOrdersCHHADAL061214.pdf](http://www.hca-nys.org/documents/PhysicianOrdersCHHADAL061214.pdf). It is also available on the Health Commerce System.

The letter is characterized as a “reminder” about regulatory requirements governing the acquisition of physician orders by CHHAs as well as

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**Labor Law Program Offered for HCC Members**

HCA will be holding a program entitled *Understanding Labor Laws and Regulations that Apply to Home Care Agencies* for Home Care Council (HCC) of HCA members.

HCC of HCA members include home-attendant program Licensed Home Care Services Agencies who were previously served by the HCC, which is now under the membership umbrella of HCA.

The program will be on Thursday, July 10 from 9:30 a.m. to noon in New York City.

Two representatives from the U.S. Department of Labor – David An, Assistant Director of the Wage Hour Division, and Jorge Alvarez, Federal Wage Hour Investigator of the Wage Hour Division – will provide vital information to help agencies ensure that they are compliant with certain labor requirements.

Federal labor officials will specifically address changes under the federal “companionship exemption” rule, effective January 1, 2015. They will also review rules related to payment in the following areas: 24-hour and split-shift cases; reimbursement to workers for travel; time off requirements for meals/sleep; recordkeeping responsibilities of agencies and employees; employer responsibility to pay for employee training; allowable payroll deductions; on-call pay; and more.


*For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcanys.org, or Joseph Campanella at (212) 481-4409, (914) 393-2024 or homecarecouncil@hccnyc.org.*
physician and patient involvement in the plan-of-care process. “It also reiterates, and expands upon, prior guidance” relating to fair hearings for CHHA patients, the DAL states.

This restatement of existing policy prompted HCA to contact the Department and inquire about the impetus behind releasing a new DAL that simply reiterates longstanding regulations. DOH indicated that the letter is in response to two legal matters, Johnson v. Shah and Spitzer v. Shah, involving practice patterns in home care concerning aid-continuing and fair hearings. The outcome of those cases is as of yet unknown. HCA covered these lawsuits in the April 29, 2011 edition of ASAP. (See p. 5 at http://www.hca-nys.org/documents/asap042911.pdf.)

As such, the DAL largely summarizes existing regulations at issue in the aforementioned court cases, and provides little in the way of new regulatory information. HCA will immediately inform the membership of any significant developments from these court cases affecting care authorization and planning in home care.

On the issue of fair hearings, the letter cites a previous DAL (HCBS 11-03, issued on April 15, 2011) and additionally advises CHHAs that:

They may be notified of fair hearings that Medicaid recipients have requested to review proposed reductions or discontinuances of home health services. At the hearings, recipients might present evidence of subsequent physician orders that would increase or restore care … CHHAs are encouraged to attend and participate in the fair hearing and are expected to comply with any decision after fair hearing that is issued.


On the issue of physician orders more broadly, the transition of longer term Medicaid cases to managed care and Managed Long Term Care has raised myriad procedural questions regarding care-authorization and planning, supervision requirements and similar issues now that substantially greater numbers of patients are enrolled in provider-plan networks with sometimes overlapping lines of responsibility for compliance, documentation, billing and care oversight.

HCA will be discussing with DOH the ramifications of this guidance in a managed care environment as we further press for regulatory streamlining through the legislative process (see related p. 1 story) and as part of the Home Care Regulatory Workgroup process which has been examining many of the requirements at issue in the DAL.

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

Managed Care Update

At this week’s Managed Care Policy and Planning Meeting, HCA obtained updates on the Quality Incentive/Vital Access Program Pool (QIVAPP) and Fully Integrated Duals Advantage (FIDA) program.

QIVAPP

The state Department of Health (DOH) announced that it expects to issue guidance in the next week or two about QIVAPP. According to the state’s April 23 Dear Administrator Letter (DAL), this program will provide up to $70 million for Managed Long Term Care (MLTC) plans to pass through to their network home care providers in
cases where the network providers meet certain “quality” standards in service to patients in New York City (where the Home Care Worker Wage Parity Law has been fully implemented).


MLTCs will have to file an application for the monies and supply recent information, including the number of aide hours provided by their contractors.

As reported in recent editions of ASAP, HCA has raised several major concerns about the proposed QIVAPP, objecting to specific funding criteria that we don't consider indicative of quality measures.

In fact, last month HCA sent a letter with LeadingAge New York and the New York State Association of Health Care Providers that requested important clarifications on the criteria and operation of QIVAPP and raised critical issues with QIVAPP and the broader matter of wage parity financing.


**FIDA**

The FIDA developments include:

- The final Interdisciplinary Team (IDT) policy was issued on June 5 and will be in effect for year one.
- The next meeting of the plans with the state Department of Health (DOH) and U.S. Centers for Medicare and Medicaid Services (CMS) will take place on June 23 and will cover the draft enrollment guidance, enrollment scenarios, and an enrollment frequently asked questions document.
- CMS will send a revised three-way contract to plans on or about June 18 and plans must return signed contracts by July 9.
- DOH/CMS are reviewing pre-enrollment validation submitted by plans, and the results will be included in the readiness review reports to be sent in early August.
- Marketing guidance and three template chapters were issued to plans in May.
- Marketing materials not impacted by the IDT must be submitted by June 16.

Under FIDA, dually eligible individuals in New York City, Long Island and Westchester will be enrolled into fully capitated managed care plans for all their Medicare and Medicaid benefits. Many of these beneficiaries are already enrolled in MLTC plans and will have the choice of: staying with their current plan, if it is a FIDA-approved plan; enrolling into another FIDA plan; or not selecting a FIDA plan and staying in their current partial-cap MLTC for Medicaid services and remaining in Medicare fee-for-service.

The state intends to start voluntary enrollment for both community based and nursing home populations on October 1, 2014 and “passive enrollment” on January 1, 2015 (over a five-month period) for those that have not voluntarily enrolled.

FIDA contract and operational details, unanswered questions and concerns were among the major issues discussed at HCA’s May 22 MLTC Member Forum meeting.

For more information, contact the HCA Policy staff.
HCA Hospice & Palliative Care Forum Focuses on Major Developments

The HCA Hospice and Palliative Care Forum met last Friday, taking up a long agenda of critical developments in the field. The Forum was hosted in Tarrytown at the VNA of Hudson Valley, whose system includes a hospice, a palliative care program, and multiple models of home care.

The Forum discussion addressed state, federal and field-level issues, including:

- Key state legislation;
- Implications and opportunities under the state’s $8 billion Medicaid reinvestment waiver and Delivery System Reform Incentive Program (DSRIP);
- Managed care/Managed Long Term Care interface with hospice and palliative care;
- An update on the Department of Health’s (DOH) plans related to hospice Certificate of Need (CON) revision;
- Major federal developments, including the proposed 2015 payment updates, Medicare Part-D drug coverage issues (See related p. 13 story), proposed “definitional changes,” prospects for reimbursement reform, quality reporting changes, and others;
- Model hospital-home care-palliative care programs; and
- Hospice emergency preparedness.

Special Forum presenters included: Rebecca Fuller Gray, Director of the Division of Home and Community Based Services; Theresa Forster, Vice President for Hospice and Palliative Care for the National Association for Home Care and Hospice and Executive Director of the Hospice Association of America; Robert Swidler, Vice President for Legal Services for St. Peter’s Health Partners; Dr. Lynda Karig Hohman, MD, PhD, from the DOH Division of Program Development and Management; and Diane Nanno, Director of Transition Care Services for Upstate University Hospital.

Forum participants were invited to provide input on state and federal policy and operational issues. Members stressed the continued need for public, clinician and payor education, as well as continued program innovation.

Participants especially emphasized the increasingly valued and instrumental role of palliative care and hospice care in the changing health care system. On this point, HCA discussed legislation we developed in response to the Forum’s policy and education recommendations. (See related page 1 story.) We also discussed the launching of additional initiatives in support of hospice and palliative care goals.

Forum members were given an up-close view of how to incorporate palliative care within the new DSRIP paradigm, yielding important insights for provider planning and follow-up.

The agenda also provided an opportunity to discuss a package of Family Decision Making Act (FDMA) improvement bills currently before the Legislature, as well as the recommendations of the state Task Force on Life and Law to expand the FDMA to the home care setting.

Follow-up initiatives are planned on all of these key areas.

For further information, please contact Al Cardillo at acardillo@hcanys.org.
Organizations Seek Change in Federal Hospice Requirements Limiting Rx Access for Beneficiaries

The National Association for Home Care and Hospice (NAHC) and the Visiting Nurse Associations of America (VNAA) are among nearly thirty organizations seeking changes in federal requirements that currently limit access to important medications for hospice beneficiaries. HCA is a NAHC and VNAA member and has been participating in national discussions and communications on hospice issues.

In a June 11 letter to U.S. Centers for Medicare and Medicaid Services (CMS) Administrator Marilyn Tavenner, the organizations urge CMS to suspend its recent guidance entitled “Part D Payment for Drugs for Beneficiaries Enrolled in Hospice – Final 2014 Guidance.”

Medicare hospice providers are required to pay for drugs that are associated with the patient’s terminal illness or related conditions. All other drugs for hospice patients – namely, those unrelated to the terminal illness – are processed under Part D.

To prevent Part D from picking up the cost of drugs that should be covered by the hospice provider, CMS issued a guidance requiring prior authorization for all prescribed medications that are billed to Part D for hospice patients. Practically speaking, this means that a beneficiary or caregiver attempting to fill a prescription at the pharmacy must pursue a lengthy prior-authorization appeals process in the event that the prescribed medication is deemed unrelated to the beneficiary’s terminal illness.

“The Guidance assumes that beneficiaries will be appropriately educated at the pharmacy counter about how to secure a coverage determination from their Part D plan when prior authorization is required,” the letter states. “In our experience, Medicare beneficiaries denied a medication at the pharmacy counter are often confused by how to move forward and are unaware of their appeals rights.”

“While we appreciate that CMS seeks to ensure that the appropriate entity pays for medications, we believe this policy places an undue burden on hospice patients,” the letter states. “Most importantly, we are concerned that the Guidance places the beneficiary at the center of potential disagreements between hospice providers and Part D plans – essentially requiring dying patients to navigate payer disputes.”

The letter urges CMS to bring together relevant stakeholders to sort out this issue in a way that maintains appropriate payer responsibilities without placing undue procedural burdens on hospice patients.

HCA discussed this issue at length with members during last week’s Hospice and Palliative Care Forum in Tarrytown (please see related p. 12 story) and we share the concerns of our partner associations at the national level. NAHC’s Vice President for Hospice and Palliative Care, as well as representatives from the state Health Department and other experts, also participated in the Forum.

HCA will immediately inform the membership of any new developments in this area.


For more information, contact a member of HCA’s Policy staff.
Expanding the Resource and Reach of “Gold STAMP”

The state’s Gold STAMP coordinating committee, of which HCA is a member, met this week to discuss 2014 updates to the goals, objectives, and further initiatives related to this best practice quality program for the prevention of pressure ulcers.

The Gold STAMP model, which the committee is also examining for application to other health care conditions and interventions, is formulated on “Success Through Assessment Management and Prevention.”

The State Department of Health, SUNY School of Public Health and the committee are working together on web and resource updates, a toolkit for Gold STAMP model replication and provider collaboration, provider and clinician education initiatives, research, funding/sustainability options, and more.

The Department’s Medicaid Redesign Team and Medicaid waiver processes have been specifically supportive of the Gold STAMP initiative. Those policy supports have yielded improvements in pressure ulcer management from hospital-nursing home-home care collaborative networks, reducing Medicaid costs by millions of dollars.

HCA, the Department and other associations on the steering committee have been working jointly to extend the information and reach of Gold STAMP. HCA hosted the Department’s Gold STAMP project director at the May 20 meeting of the HCA Quality Committee, and likewise joined the Gold STAMP director for presentations to the State Medical Society’s Quality Committee.

HCA will update the membership on next steps, including announcements of educational and program development opportunities, and the soon-to-be updated Gold STAMP web and resource site.

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

LITTLE SISTERS OF THE ASSUMPTION FAMILY HEALTH SERVICE, INC

Little Sisters of the Assumption Family Health Service of East Harlem seeks a Director of Patient Services to head its Home Nursing Program as administered through its Certified Home Health Agency. Since 1958, the Program has served the neediest families of East Harlem, a poor and immigrant community. Young pregnant/post-partum parents and their infants are a specialty focus of our work within general CHHA services. The Director provides oversight to the program, develops and manages service and managed care contracts, and ensures compliance with all relevant federal, state, local and third-party requirements; the Director animates, inspires and leads. She/he must be a creative innovator in the midst of a challenging time of health care change. She/he will work collaboratively with the Center’s staff and mutually with our families to innovate and support programming that upholds human dignity and fosters health. She/he will oversee and monitor service and operational performance metrics as well as ensuring accountability for the budget, billing practices and service information collection, faithful to the core values of commitment to the poor, support of family strengths, mutuality and empowerment. She/he must have knowledge of community health principles, practice and administration, sensitivity to people of diverse backgrounds, and analytical skills to understand and address complex service and funding-related issues. NYS nursing license and a Master’s degree in nursing, public health or related professions required. Spanish language facility is a plus.

“See, I am doing something new! Now it springs forth, do you not perceive it?”

Come join us!
If interested in applying, email or fax cover letter and resume to:
Email: CHHA@lsafhs.org Fax: 212-348-8284
For a full description of all LSAFHS’s programs, see www.littlesistersfamily.org
Revised Rule Issued on ADHC Programs and MLTCs

This week, the state Department of Health (DOH) released a revised proposed rule that would, according to DOH, enable adult day health care (ADHC) programs to contract and work effectively with Managed Long Term Care (MLTC) plans.

The rule amends the current regulations and would allow ADHC programs to offer an Unbundled Services/Payment Option in which individuals requiring ADHC services and individuals requiring less than the full range of ADHC services can both receive services in the ADHC program space. In order to exercise this new option, the ADHC program would have to notify DOH, in writing, 30 days in advance of implementation.

The proposed regulations are posted at http://w3.health.state.ny.us/dbspace/proregs.nsf/4ac958781006774852569bd00512fda/a5400ce1b5fa13b785257cf30058403d?OpenDocument.

The amendments would allow an MLTC plan, based on an enrollee's medical needs as determined by the plan's assessment, to order less than the full range of adult day health care services, and to enter into reimbursement arrangements with the ADHC program that take into account a program registrant’s receipt of less than the full range of adult day health care services.

The rule clarifies that the full range of ADHC services are available to MLTC plan enrollees with a medical need for such services in order to ensure that Medicaid-covered ADHC services provided through an MLTC plan remain equal in amount, duration and scope to ADHC services available to Medicaid fee-for-service recipients.

Under the amendments, an MLTC which refers an enrollee to an ADHC program will be responsible for some requirements which are currently the responsibility of the ADHC program, consistent with the MLTC plan’s responsibility to manage and coordinate the enrollee's health care needs.

Initial regulations were proposed in August 28 and the June 11 New York State Register includes a summary of the rule and an assessment of public comments received on that draft and DOH’s response. The June 11 issue is at http://docs.dos.ny.gov/info/register/2014/june11/pdf/rulemaking.pdf (see page 12).

March Report: Home Health, Personal Care Finish 2013-14 Well Below Cap

Total state Medicaid expenditures for State Fiscal Year 2013-14 are $39 million (or 0.2 percent) less than the amount projected under the state’s Medicaid Global Cap, according to the March 2014 Medicaid Global SpendingCap Report issued this week by the state Department of Health (DOH). Spending through the month of March was $16.382 billion compared to the projection of $16.421 billion for this period.

For home care, personal care and assisted living – which the Department includes in the "Other Long Term Care" category of service – the report shows actual spending at $1.030 billion, which is $110 million (or 10 percent) lower than the Department’s estimated spending of $1.140 billion. DOH once again states that the difference appears to be related to the transition of certain fee-for-service populations into the Managed Long Term Care (MLTC) program.

DOH also reiterates that it will continue to monitor the movement of fee-for-service populations into managed care settings and evaluate the effect on payment rates. Under last year’s state budget, the Medicaid Global Spending
Cap increased from $15.9 billion to $16.4 billion for fiscal year 2013-14 – a 3.2 percent increase. The cap on Medicaid spending was extended in the final 2014-15 state budget through March 2016.

DOH’s March report also indicates that the accounts receivable (AR) balance for retroactive rates owed to the state through the end of March was $230 million. This represents a reduction of $170 million since April 2013.

In other report highlights, total Medicaid enrollment moved to 5,697,529 at the end of March 2014. This reflects an increase of roughly 446,451 enrollees, or 8.5 percent, since March 2013. Medicaid managed care enrollment in March 2014 reached 4,116,758 enrollees – an increase of 180,327 enrollees, or 4.6 percent, since March 2013.

The recently enacted state budget will in the future require HCA-supported provisions for more detailed, comprehensive and transparent reporting on global cap expenditures and savings, specifically with regard to home care.

Global cap shared-savings initiative

As previously and extensively reported to the membership, the final 2014-15 budget includes an initiative to reinvest, back into the provider system, savings achieved under the global cap, as well as to discontinue the two percent across-the-board Medicaid cut beginning April 1, 2014. Leading up to the budget, both of these initiatives were discussed during meetings of the state’s Global Cap Workgroup, of which HCA is a member.

HCA will immediately share with the membership any new developments on this important initiative.


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

CMS to Conduct Survey of Medicaid Enrollees

The U.S. Centers for Medicare and Medicaid Services (CMS) plans to conduct a nationwide survey of adult Medicaid recipients that will include measures of access, barriers to care, satisfaction with providers, customer service ratings, and experiences in obtaining care from managed care providers.

The contractor, NORC at the University of Chicago, will survey about 29,000 enrollees from each state and about 1.5 million nationwide. The modified version of the Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) will be distributed to four adult subgroups who are: eligible for Medicare and Medicaid; disabled but not dually eligible; neither disabled nor dually eligible and enrolled in a managed care organization; and neither disabled nor dually eligible and obtaining care from a fee-for-service provider.

CMS and NORC will be holding webinars for the states during the summer and provide them with technical assistance.

Error Causes Some Medicare Demand Bills to Process without ADRs

NGS asks providers to adjust affected claims

National Government Services (NGS), New York’s Medicare Administrative Contractor (MAC), reports that, due to a Medicare system issue, some properly submitted home health demand claims with condition code 20 are not triggering an Additional Documentation Request (ADR) as is customary. Instead, these claims have incorrectly been rejected with reason codes 39934 or 39929.

This issue affects only a small fraction of demand bills received on April 1, 2014 and later. Also, this group of claims is spread throughout NGS’s jurisdictions – not just in New York State, where providers have undergone an extensive demand bill submission process stemming from the expiration of the Third Party Liability (TPL) Demonstration project.

According to NGS, agencies should simply adjust any demand claims received on or after April 1 that: 1) did not trigger a request for medical review; and 2) were rejected with reason codes 39934 or 39929. Providers should not resubmit these claims.

To adjust the claim, agencies have to submit a 3X7 bill (this indicates the claim is adjusting the originally submitted claim) with a D9 condition code and remarks that state “Adjusting TPL demand claim for ADR.” No coding needs to be changed on the claim. The adjustment reason code and remarks are sufficient for the claim to be reprocessed correctly so it can be sent to the appropriate status/location for an ADR to be issued.

This issue has been sent to the Fiscal Intermediary Standard System (FISS) for review and resolution. HCA will update the membership as NGS provides additional information.

Navigator Funding Available

This week, the U.S. Centers for Medicare and Medicaid Services (CMS) announced the availability of funding totaling $60 million, to support Navigators in federally-facilitated and State Partnership Marketplaces in 2014 to 2015. Letters of intent are due June 30 and applications are due July 10.

Navigators provide information to consumers about health insurance, the Health Insurance Marketplace, qualified health plans, and public programs including Medicaid and the Children’s Health Insurance Program.


Navigators will now be required to maintain a physical presence in the Marketplace service area, so that face-to-face assistance can be provided to consumers. Navigator grant applicants will also be encouraged to perform background checks for all Navigator staff handling sensitive or personally identifiable information. In addition to quarterly and annual reporting, Navigators will be required to submit to CMS weekly and monthly progress reports detailing their progress and activities in their target communities.

To access the funding opportunity announcement, visit http://www.grants.gov and search for CFDA # 93.332.

For more information about Navigators, visit: http://cciio.cms.gov/programs/exchanges/assistance.html.
**NGS Issues Last Call for 2014 Annual User ID Recertification**

All users of the Direct Data Entry (DDE) and DME (Durable Medical Equipment)/Claim Status Inquiry Systems are required by the U.S. Centers for Medicare the Medicaid Services (CMS) to recertify their access annually. NGS began the 2014 recertification initiative in January of this year.

Due to the number of users who did not respond, NGS has extended the deadline to allow more time for users to act before their logon IDs are terminated.

For a limited time, beginning June 2, NGS has made available an online portal where users can recertify their logon ID if they have not done so already. The portal is at [http://apps.ngsmedicare.com/applications/recert_2014cont.aspx](http://apps.ngsmedicare.com/applications/recert_2014cont.aspx).

There you will be asked to enter your logon ID. The regions of access for your ID will be listed on separate rows and you will need to check “Yes” or “No” to indicate if access to that region is still needed. Checking “No” will result in the loss of access to that region and the ability to submit claims via the DDE application.

Providers will also need to enter the most current demographic information for the logon ID. On June 16, 2014, NGS will begin the process of disabling IDs that have not yet been recertified.

If you have not recertified your ID by June 16, 2014, your access will be interrupted and will not be reinstated until that ID has been recertified. You will have until July 21, 2014 to recertify. If you have not recertified your ID by July 21, 2014, your access will be terminated from NGS’s system.

If you use a third party billing agency, please forward this information to them so that they can recertify their IDs. If you do not know your DDE or DME/CSI logon ID, please send an e-mail to the electronic data interchange (EDI) Enrollment team at ngs.edi.setups@wellpoint.com. Please include the following information in your email: User Name; Primary Provider Transaction Access Number (PTAN); Primary National Provider Identifier (NPI) and facility or agency name. All e-mails will receive a response within 48 hours. Do not include any protected health information (PHI) or personally identifiable information (PII).

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

**OMB Begins Review of CY 2015 Proposed Rule for Medicare PPS**

This week, an article in the Bloomberg BNA announced that the Office of Management and Budget (OMB) has received a proposed rule from the U.S. Centers for Medicare and Medicaid Services (CMS) which would set the calendar year (CY) 2015 Medicare payment rates for home health agencies.

According to the article:

- “The rule (CMS-1611-P), would update the 60-day national episode rate based on the applicable home health market basket update and case-mix adjustment, the OMB said. The proposal also would update the national per-visit rates used to calculate low utilization payment adjustments and outlier payments under the Medicare prospective payment system for home health agencies.”

*Continued on next page*
The changes would apply to services furnished on or after January 1, 2015. There is no schedule for when the proposal might be released. A final rule is due November 1, the notice said. A proposed rule covering 2014 payments was published in July 2013.

CMS has estimated that about 3.5 million beneficiaries received home health services from nearly 12,000 home health agencies in 2012, costing Medicare about $18.2 billion, according to the article.

Our colleagues at the National Association for Home Care and Hospice (NAHC) noted that this is the normal timetable of such a rule. While the submission to OMB gives the home care industry no detail on content, HCA and NAHC fully expect that the proposed rule will be consistent with the rebasing phase-in from last year.

HCA will provide the membership with a detailed policy memorandum when the proposed rule for 2015 home health Medicare rates is posted to the Federal Register sometime in the next two to three weeks.

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

Publications

- “Key Payer and Provider Operational Steps to Successfully Implement Bundled Payments,” by Healthcare Incentives Improvements Institute

- “List of Pooled SNTs in New York State,” by the New York Legal Assistance Group
  [http://www.wnyc.org/health/entry/4/](http://www.wnyc.org/health/entry/4/)

Education

- “Developing a Compliance Plan,” by the U.S. Centers for Medicare and Medicaid Services

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

An educational event that explores opportunities for greater efficiencies, cost savings and enhanced quality.

June 24, 2014
DoubleTree by Hilton Hotel
455 South Broadway
Tarrytown, New York

Registration form available online at www.eventville.com/hcanys
HCA’s Technology Symposium

Home care technology is a big, bold world of possibilities, encompassing everything from patient medical devices to health information exchange networks. As a provider, you know how important it is to keep on top of the latest technology trends and tools, especially as you strive for greater efficiencies and enhanced patient care. But the hardest part, of course, is finding time to explore what’s available, understanding the various state and federal initiatives that have a hand in guiding the use of these technologies, and overcoming the challenges you may face in implementation.

This is why HCA is offering a packed one-day Technology Symposium to provide the answers you need all in one place. For this program, HCA identified some of the most successful, creative and ingenious uses of technology by several of our provider members who will share their organizations’ novel program designs and get you thinking about ways to employ technology for better communication, care-transitions and health delivery. We are also bringing you national thought leaders and state policy leaders to provide additional insights on the current state of affairs in home care technologies.

AGENDA

June 24, 2014
DoubleTree Hotel
Tarrytown, New York

8:30am Registration

9:00am to 10:30am
Home Care Technology – The Current State of Affairs
Tim Rowan, Editor, Home Care Technology Report
As the editor of a respected nationally published newsletter on home health technologies, Mr. Rowan will share his perspective on the current state of affairs in home care technologies, including what is happening on the federal front, and what your agency must do to stay ahead of the curve in an effort to showcase your organization as a leader in quality and as a valuable partner in today’s health care collaborations.

10:30am to 11:00am
Increasing Your Operating Margins Through Technology
Rob Simione, Simione Consulting
In a rapidly changing home health environment with reduced reimbursement and increased regulations, providers must be as efficient in their operations and costs as possible. From the patient care encounter to the back-office analysis of final outcomes data, technology is a key part of your operation. In this session, learn how technology can play a critical role in creating better processes and cost efficiencies within your organization.

11:15am to 12:45pm
Provider Technologies Showcase
Learn from your peers as they share the latest technologies within their organization, the challenges they have addressed and the successes they have achieved.

Continued...
11:15am to 12:45pm  Provider Technologies Showcase - Continued

**The Future of Telehealth**
Jewish Home Lifecare (JHL) will share how its organization enhanced communication between the aide and case manager as well as client and case manager through highly customizable, user friendly iPad icons. JHL will also share its developmental work with a telehealth vendor on making a patient's home television a vehicle for telehealth dialogue.

**eReferrals**
Through electronic medical records data, patients can be directly referred to the Visiting Nurse Service of New York (VNSNY) by a large multi-specialty physician group that serves Long Island, New York City and the Hudson Valley area. This eReferral exchange provides improved efficiencies and compliance in the referral workflow. The system is currently live at one facility, but VNSNY plans to roll out its eReferral infrastructure to a total of 18 facilities. Learn how they made the connection.

**A Virtual Senior Center**
Learn how an innovative Virtual Senior Center engages and reconnects vulnerable homebound elderly with their community and enables them to meet new friends – reducing social isolation. The Virtual Senior Center uses a special purchase all-in-one computer, a senior friendly interface and senior tailored discussion-based classes to engage participants. Classes range from an “anatomy of a musical” to “you be the judge” along with many others.

12:45pm to 1:30pm  Lunch
Take advantage of lunchtime networking opportunities to share with your colleagues what you have done to improve efficiencies, reduce costs and enhance care within your agency through the use of technologies. Bring your business cards!

1:30pm to 2:45pm  New York State’s Investments and Priorities
*Patrick Roohan, Director of Quality Management, NYS Department of Health*
Hear from a policymaker on how New York State is prioritizing and investing in quality-driven home health technologies. Learn what opportunities are ahead for your organization and the patients you serve.

3:00pm to 4:00pm  Health Information Exchanges
*Mark McKinney, MBA, Chief Executive Officer, HIXNY*
The Governor’s latest budget sets aside funding to expand the Statewide Health Information Network of New York (SHIN-NY). A key goal of this legislation is to increase adoption of the health information network through Regional Health Information Organizations (RHIOs). Learn how you can assist in expanding this network of health information that will benefit all health care professionals and support the Affordable Care Act’s “triple aim” of achieving better care for individuals, better health for populations and cost-reductions.
HCA’s Technology Symposium
June 24, 2014
DoubleTree by Hilton Hotel
455 South Broadway
Tarrytown, NY
Tel: 914-631-5700

Register online at: www.eventville.com/hcanys
Or FAX this form to (518) 426-8788.

Registration
Registration Deadline is June 18.

_______________________________________________
Name
_______________________________________________
Title
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Agency
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Address
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City/State/Zip
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Email (Required)

Payment

$219 HCA Member __________
$299 Non-Member __________

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Credit Card No.__________________________________
Expiration Date:________ Sec. Code:________
Card Billing Address:____________________________
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Name on Card:________________________
Signature:________________________

Special Accommodations: In accordance with the Americans with Disabilities Act or special meal needs, please let us know how we can accommodate you:
____________________________________________________________________________
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Cancellation Policy: Cancellations received by June 13 will receive a full refund, less 25% of total due as an administrative fee. Cancellations received on June 13 or later will forfeit their registration fee, as will those who register and do not attend. Substitutions are permitted.

Or, make checks payable to: HCA Education and Research and mail to 388 Broadway, 4th Floor, Albany, NY 12207

FAX TO: (518) 426-8788
A light breakfast will be provided.

As of January 1, 2015 your agency has to pay overtime at a higher rate to your home care workers among other expenses. If you have a collective bargaining agreement some wage language has to change to conform to this regulation. It is also important to note your rates are not expected to be increased to meet this mandate. It will be the agency responsibility to manage overtime.

At this July 10 program, officials from the U.S. Department of Labor will address changes due to the “companionship exemption” rule that is effective January 1, 2015 and also review rules related to payment on topics such as: 24 hour and split shift cases; reimbursement to workers for travel; time off requirements for meals/sleep; recordkeeping responsibilities of agencies and employees; employer responsibility to pay for employee training; allowable payroll deductions; on-call pay; and independent contractor status of certain employees (e.g. nurses, occupational therapists, physical therapists, etc.).