HCA, LeadingAge Submit Proposals to Regulatory Workgroup

HCA and LeadingAge New York have partnered to develop, and last week provided, a matrix of priority regulatory issues and reform proposals for action by the Home and Community-Based Care Regulatory Workgroup.

The Home and Community-Based Care Workgroup was established and charged by this year’s state budget legislation to examine and make recommendations on critical areas of home care regulation, including:

- State and federal regulatory requirements and related policy guidelines, including the applicability of the federal Conditions of Participation (CoPs).

See WORKGROUP p. 3

HCA Meets With New Deputy Secretary for Health on Home Care Issues

This week, HCA President Joanne Cunningham met with Governor Cuomo’s new Deputy Secretary for Health, Courtney Burke as well as Sally Dreslin, Assistant Secretary for Health, to discuss the current home care environment in New York State and the need for transition assistance to the home care community.

Ms. Burke, who was appointed to the Deputy Secretary position earlier this summer, replaced Jim Introne, who retired from his position after the conclusion of the 2013 Legislative Session. Ms. Burke comes to the Governor’s
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Office following her tenure as Commissioner of the New York State Office for People with Developmental Disabilities.

During the meeting, Ms. Cunningham outlined the challenges and uncertainties facing New York’s home care providers in the transition to managed long term care and discussed some of HCA’s efforts to seek regulatory clarity and guidance throughout the past year – a major, ongoing focus of our advocacy efforts.

In the most recent development on these issues, HCA and LeadingAge have compiled and jointly submitted a matrix of regulatory relief and reform proposals for consideration by the Cuomo Administration and the Home and Community-Based Care Workgroup. The Workgroup was established by this year’s state budget legislation to examine and make recommendations on critical areas of home care regulation (See related p. 1 story.)

Ms. Cunningham shared these and other ideas with Ms. Burke and Ms. Dreslin who were very receptive to assisting and working closely with HCA to seek positive changes that would provide stability to providers facing a new system.

HCA will keep the membership updated on our efforts to achieve these changes through the regulatory and/or legislative process.

For more information, please contact a member of HCA’s Policy staff.
The eleven-member workgroup was established to be comprised of providers, plans and representatives of consumers and direct caregivers, and to be chaired by the Commissioner of Health or the Commissioner’s designee. The workgroup includes several HCA provider and Board members, including Ann Frisch of the New York City Health and Hospitals Corporation, Emma DeVito of Village Care of New York and Joseph Twardy of the Visiting Nurse Service of Schenectady and Saratoga Counties.

Following the first (and, to date, only) workgroup meeting on June 21, workgroup members asked HCA and other state associations to identify up to five priority areas on which the workgroup should initially focus. HCA and LeadingAge coordinated to develop a matrix laying out these initial priorities, identifying obstacles and providing proposed actions for the workgroup’s consideration.

HCA and LeadingAge keyed in on:

- **Regulatory Reform** – align home care/managed care regulation across managed care plan and home care program types; review and eliminate excessive regulation, and regulation incompatible with a managed care model, for all home care provider types; limit and/or provide flexibility in the applicability of federal CoPs/standards under a managed care delivery model; and sorting of roles and responsibilities on the part of providers and managed care plans.

- **Adequacy of Financing** – ensure that, whatever regulatory structure is decided upon and maintained, that adequate financing is provided for home and community based care providers and for managed care plans, including wage parity.

- **Expeditious and Streamlined Contract Capability and Program Approvals** – establish clear and streamlined timeframes for processing of home care/health plan contracts and for providers’ applications for new program approval and/or program structuring.

- **Addressing the Home Telehealth “Cliff”** – provide continuity and appropriate incorporation and reimbursement of the home telehealth program within managed care.

- **Implementation of the Uniform Assessment System** – provide guidance, training, recognition of cost, and a reasonable timetable for implementation.

The HCA-LeadingAge matrix detailing these issue areas and corresponding proposals can be accessed at [http://www.hca-nys.org/documents/Top5RegIssuesMatrixHCALeadingAgeNY.pdf](http://www.hca-nys.org/documents/Top5RegIssuesMatrixHCALeadingAgeNY.pdf).

In submitting these priorities, HCA and LeadingAge stressed the urgency for patients, providers and plans alike, and appealed to the workgroup to act now to secure these changes. The workgroup’s charge in the enacted state budget provides for a March 1, 2014 report date for workgroup recommendations, but HCA, LeadingAge and a number of the workgroup members have emphasized that key reforms cannot wait until next March.

This Wednesday, September 4, the state Department of Health held a conference call with workgroup members (only) to discuss the HCA-LeadingAge submission, along with other workgroup items, and to suggest next steps for a September 25 workgroup meeting. HCA and LeadingAge plan further debriefing with the Department and workgroup members in preparation for the September 25 meeting.

For further information, please contact Al Cardillo at acardillo@hcanys.org.
HCA, DOH Collaborate on Regulatory Flexibility in Emergency Response

HCA and the state Department of Health’s Office of Health Emergency Preparedness (OHEP) met last week for a monthly working session in support of emergency preparedness in home and community based care in the state. This month’s session, held on August 26, was devoted extensively to collaboration on a template for easement/waiver of regulations and procedures for home and hospice care provided in emergency circumstances.

During the 2012-13 response to Hurricane Sandy, HCA worked extensively with DOH and federal officials to identify areas where flexibility in strict regulation was necessary to ensure access to services and direction of necessary resources to patient care. This work during Superstorm Sandy has served as a substantial starting point for the now-progressing template that could be activated for home and hospice care during emergencies.

The template is one of a series of 2013-14 goals for emergency preparedness and response being pursued through a collaborative between HCA, OHEP and the New York State Association of Health Care Providers. The goals of the collaborative were outlined for the HCA membership in the July 26 edition of ASAP. (See p. 18.) HCA will be reaching out to the membership for input as our joint work on this template progresses.

Meanwhile, HCA also continues our regular, close work with the Executive Committee of the Home Based Care Alliance (HBCA), and will likewise be reaching out to Health Emergency Preparedness Coalitions throughout the state, to simultaneously pursue a wide range of emergency preparedness and response objectives. Our current work with HBCA includes, for example, activities in education and training, policy advocacy, recommendations for streamlined reporting, the issue of home care/hospice access in restricted geographic zones during emergencies, and other key Alliance priorities.

Over the coming months, HCA will be engaging home and community-based care providers across the state in a multifaceted emergency preparedness and response effort that will include all of the above goals, as well as the HCA-DOH collaborative goals previously outlined in ASAP. Please stay tuned for further details.

Meanwhile, HCA encourages members’ ongoing comments and recommendations for critical programing and/or state and federal policy improvement in support of emergency preparedness and response. Your input can be submitted anytime to the HCA Policy Team, directed to the attention of HCA Executive Vice President Al Cardillo.

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

Helgerson to Speak at Sept. 24 LTHHCP Forum

One of the state’s top health care policymakers, State Medicaid Director Jason Helgerson, is confirmed to speak at HCA’s Statewide Long Term Home Health Care Program (LTHHCP) Forum on September 24 in Albany.

All LTHHCP members should register for this important program. Simply complete the brief registration form at the end of this week’s ASAP and send it back to HCA today.

HCA’s members-only Forums are an important benefit of your membership in HCA, and this month’s LTHHCP Forum is especially important at such a critical juncture for the LTHHCP.

The September 24 Forum will specifically focus on the status and future of the LTHHCP as the state continues implementation of its mandatory enrollment policy, including the recent federal approval of the state’s plan for a Fully Integrated Duals Advantage (FIDA) model.

This Forum is an important opportunity for LTHHCP provider representatives to hear from Mr. Helgerson, other state health officials, HCA Policy staff and other experts on the latest issues related to the state policy environment, LTHHCP program and operational issues, and next steps and options for the LTHHCP.
State Issues Policies on Personal Care, Telehealth Continuity in Managed Care

Late last week, the state Department of Health (DOH) issued policy guidance (MLTC Policy 13.22) related to personal care contracting and Managed Long Term Care (MLTC) plans. This week it issued Policy 13.23 on coverage of telehealth services in MLTC plans.

**Personal Care**

Policy Guidance 13.22 states that MLTCs are required to pay personal care service provider agencies the posted Human Resources Administration (HRA)/local department of social services (LDSS) rate updated by any changes that took place since July 1, 2012. “Therefore, whenever the published rate paid by HRA or LDSSs changes, the MLTCs must comply with this rate change and pay the newly published rate commencing with the effective date of the change.”

This new policy is in effect until **March 1, 2014**.

Under prior MLTC Policy 13.04, MLTCs were directed to pay personal care service provider agencies the posted HRA/LDSS rate on July 1, 2012.

HCA has written to DOH for clarification on this new policy and will update members when we obtain further information. The policy is at [http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_13_22_pers_care_contract_rates.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_13_22_pers_care_contract_rates.pdf).

**Telehealth**

MLTC Policy 13.23 clarifies that individuals in receipt of telehealth services through a Certified Home Health Agency (CHHA) or Long Term Home Health Care Program (LTHHCP) who are mandatorily enrolled into an MLTC must be provided telehealth services under the 90-day continuity-of-care requirements. Also, the CHHA or LTHHCP must be paid its state rate for those 90 days. The guidance includes the following information on when telehealth services are covered:

- Telehealth services are covered when provided by agencies approved by the Department for enrollees who have conditions or clinical circumstances requiring frequent monitoring and when the provision of telehealth services can appropriately reduce the need for on-site or in-office visits or acute or long term care facility admission. To be eligible for reimbursement, approved agencies must obtain any necessary prior approvals and services must be deemed medically necessary by the MLTC Plan. Approved agencies must assess the enrollee in person, prior to providing telehealth services, using an approved patient risk assessment tool.

HCA has repeatedly sought clarification on telehealth coverage under managed care and was asked to review an earlier draft of this guidance on which we submitted revisions. The final version incorporated some of our proposed changes; we continue to work with DOH on coverage for the period after the first 90 days with adequate reimbursement for health plans, and on incorporating telehealth with managed care as outlined in Public Health Law Section 3614.3-c.

During last year’s state budget deliberations, HCA worked with Assembly Majority Leader Joseph Morelle and Senate Legislative Commission on Rural Resources Chair Catharine Young on legislation that would ensure the integral role of telehealth in a managed care environment.

*Continued on next page*
Updated managed care plan list

eMedNY has updated its list of managed care plans reflecting four recently approved MLTC plans. The list also includes links to “model” contracts between the state and the plans.

The list is at https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf.

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

DOH to Begin One Week Payment Hold for Claims Failing OPRA Edit

Beginning October 1, claims with non-enrolled OPRA referring providers will be denied

The state Department of Health (DOH) recently announced claim edits which begin this month to place a one-week payment hold on Medicaid claims in cases where the referring provider is not enrolled as an “ordering, prescribing referring and attending” (OPRA) provider.

This claim-withhold is a transition step before DOH initiates denials for non-OPRA claims beginning in October, pursuant to a provision of the Affordable Care Act (ACA) and subsequent federal regulations.

The new edit codes are: Edit 02216, Remark Code N286; Edit 02218, Remark Code N31; and Edit 02219, Remark Code N265. The edit is associated with a determination of whether or not an ordering provider’s National Provider Identifier (NPI) matches an NPI in the OPRA database. Therefore, the message for these edits will state “NPI – Not Matched” and “Missing/Incomplete/Invalid” referring, prescribing, or ordering provider identifier.

Claims failing these edits this month will be released for processing after a one-week payment hold. The remittance advice will indicate the edit failed and the pend status of these claims. Beginning October 1, 2013, the Department will turn on the edit that will deny Medicaid fee-for-service claims where the ordering, referring or prescribing NPI is not included in the state’s OPRA system.

For more information about this edit, please see the Frequently Asked Questions found here: https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/Core_OPRA_FAQs.pdf.

In response to HCA and other organizations’ requests, DOH has created a streamlined application process for OPRA practitioners to enroll in Medicaid. That application for physicians is at https://www.emedny.org/info/ProviderEnrollment/physician/Option2.aspx.

DOH reports that most enrollments are processed within 30 to 45 days of receipt of a completed application.

Also, at HCA’s urging, DOH created a database whereby home care and other providers can check, using the NPI, to see if their OPRA practitioner is enrolled in Medicaid. DOH has stated that the list is updated daily. The database is at https://www.emedny.org/info/opra.aspx.

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

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For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcany.org.
Influenza Webinar Scheduled for Home Care and Hospice Providers

DOH posts new forms and resources

After discussions with HCA and other provider associations, the state Department of Health (DOH) has scheduled a webinar for home care and hospice providers on the new influenza mask regulations. The webinar will be held on September 30 from 10 to 11:30 a.m. Registration information will be available shortly.

As reported in numerous editions of ASAP, DOH recently promulgated a rule that requires home care and other providers to: document whether their personnel have been vaccinated against influenza for the influenza season; and ensure that those individuals who were not vaccinated for influenza wear a surgical or procedure mask, during the influenza season, while in areas where patients or residents may be present.

DOH has issued two Dear Administrator Letters (DALs) and two Frequently Asked Questions (FAQs) documents on this new requirement. The first DAL explained the new requirements and the second focused on the need to report the number and percentage of vaccinated personnel via a Healthcare Personnel Influenza Vaccination Report. While the report is not due until November 15 and agencies cannot start to complete it online until November 1, HCA advises agencies to review the sample Healthcare Personnel Influenza Vaccination Report, instructions and FAQs and begin to compile the necessary information.


On this website, DOH has also posted new forms: Influenza Vaccine Medical Exemption Statement for Health Care Personnel and Declination of Influenza Vaccination for Health Care Personnel; a Seasonal Influenza and Pneumococcal Prevention Campaign Educational Materials Order Form; and an Influenza Immunization Toolkit.

HCA has already solicited and continues to request member concerns/questions/comments about the new requirements. These have been forwarded by HCA and members to DOH’s mailbox at flumaskreg@health.state.ny.us. (Please copy Andrew Koski at akoski@hcanys.org if you send any communication).

HCA had initially submitted comments and revisions to the draft rule, including a recommendation that various provisions be set-aside for home care until made more workable and reimbursable for home care providers. The rule, however, was adopted by the State Public Health and Health Planning Council without any changes. HCA subsequently participated in a multi-association meeting with DOH in July at which we again raised and were invited to share important implementation issues and recommendations specific to home care providers and their patients.

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

HCA Prepares FAQs on Flu Mask Requirement

HCA has prepared a Frequently Asked Questions (FAQs) document on the flu mask requirement. (See related article this page.) The FAQs are based on a series of questions submitted by HCA members and HCA staff to the state Department of Health (DOH) along with DOH’s responses to those questions. The FAQs are posted on HCA’s website at http://www.hca-ny.org/documents/InfluenzaVaccineFAQs090613.pdf.

HCA will be updating this document as new information becomes available and we remind members to check the DOH website at http://www.health.ny.gov/diseases/communicable/influenza/seasonal/providers/prevention_of_influenza_transmission/ for additional information.
CMS Approves New York’s FIDA Plan

Last week, the U.S. Centers for Medicare and Medicaid Services (CMS) announced approval of New York State’s request to establish the Fully Integrated Duals Advantage (FIDA) program for about 170,000 dual eligible individuals living in New York City, Long Island and Westchester.

To provide further information on this development, New York State officials held, and HCA participated in, a FIDA stakeholder webinar on August 29.


Under FIDA, eligible individuals will be enrolled into fully capitated managed care plans for all of their Medicare and Medicaid benefits, including physical health, behavioral health, long term supports and services (LTSS) and other services. Many of these beneficiaries are currently or will soon be enrolled into Medicaid Managed Long Term Care (MLTC) plans and will have the choice of staying with their current plan, if it is a FIDA-approved plan, or enrolling into a FIDA plan.

Those who are eligible include individuals 21 and older who are entitled to Medicare Part A, enrolled in Medicare Part B and D, receiving Medicaid, and living in a FIDA demonstration county. They must also: require community-based LTSS; be eligible for the Nursing Home Transition and Diversion program; or be clinically eligible for a nursing facility and receiving facility-based LTSS.

Beneficiaries receiving community-based LTSS will be able to receive coverage under a FIDA plan beginning no earlier than July 1, 2014. Starting September 1, 2014 (at the earliest), eligible individuals who have not enrolled into a FIDA plan will be “passively” enrolled into a plan. According to its Memorandum of Understanding (MOU) with CMS, the state will develop an “intelligent assignment” algorithm that will consider the participant’s previous Medicaid managed care enrollment and historic provider utilization. Once passively enrolled,
participants will have the option to disenroll from a FIDA plan and return to a Medicaid partial capitated MLTC plan and Medicare fee-for-service or join a different FIDA plan or the Program of All-Inclusive Care for the Elderly (PACE).

Based on a preliminary analysis of the MOU and information presented at the webinar, HCA notes the following important points:

- The FIDA demonstration is scheduled to run from July 1, 2014 to December 31, 2017, but New York can request an extension.

- Individuals receiving services from the state Office for People with Developmental Disabilities (OPWDD) are not eligible for this demonstration; however, the state has also applied for a FIDA demonstration for about 10,000 consumers who are receiving services from OPWDD.

- Individuals in the Traumatic Brain Injury (TBI) program are currently not eligible to participate in FIDA (HCA will seek further clarification about the status of TBI); participation of individuals in the Nursing Home Transition and Diversion (NHTD) waiver program is contingent upon submission and approval of an amendment to New York’s existing Partnership Plan and an amendment to the NHTD waiver.

- Individuals receiving hospice services (at the time of enrollment) cannot enroll in FIDA, but those who don’t need hospice upon enrollment can stay in the FIDA plan and access hospice through Medicare fee-for-service.

- Those in nursing homes can enroll into a FIDA plan no earlier than July 1, 2014 with coverage starting October 1, 2014; those who don’t select a plan by October will be passively enrolled into a plan no earlier than January 1, 2015.

- A comprehensive assessment must be completed by a registered nurse within 30 days of enrollment and reassessments must be done as warranted but at least every six months.

- Covered benefits include those currently covered by Medicaid, Medicare and home and community-based waiver services.

- By December 1, 2014, FIDA plans must develop a plan for a fully integrated payment system under which providers

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**Medicare Open Enrollment Approaches**

The fall open enrollment period or annual coordinated election period, during which Medicare beneficiaries can change their Medicare health and drug coverage options, begins on October 15 and runs through December 7.

During open enrollment, Medicare beneficiaries can switch from Medicare fee-for-service (FFS) to a Medicare Advantage (MA) managed care plan (with or without drug coverage); switch MA plans; or disenroll from an MA plan and return to Medicare FFS and select a “stand alone” drug plan. Their selection will be effective January 1, 2014.

Medicare beneficiaries also have a special enrollment period (SEP) to enroll in MA or a prescription drug plan with a “five-star” rating. The SEP can be used at any time during the year, but only once per year. Beneficiaries also have an MA Disenrollment Period (MADP) that runs from January 1 to February 14 of each year. During this MADP, those enrolled in an MA plan can switch from their MA plan to Medicare FFS and select a stand-alone drug plan.

For more information, contact the Medicare Rights Center at 800-333-4114 or your local office for the aging.
would not be paid under fee-for-service but would be paid on an alternative basis such as pay for performance or a bundled payment. After state approval, and no earlier than January 2015, FIDA plans will be required to use the alternative payment system.

- An independent, “conflict-free” entity (ombudsman) will provide participants free assistance in accessing care, understanding and exercising their rights and responsibilities, and appealing adverse decisions.

- FIDA plan enrollees will have an integrated appeals process that includes certain Medicare and Medicaid protections.

- For all items and services other than nursing facility services, FIDA plans must allow participants to maintain current providers and service levels, including prescription drugs, at the time of enrollment for at least the later of 90 days after enrollment, or until a care assessment has been completed by the FIDA plan. For nursing home services, FIDA plans must allow participants to maintain current providers for the duration of the demonstration.

- An interdisciplinary team will provide “person-centered” care coordination and care management to participants.

- Plans will receive separate monthly risk-adjusted payments for the Medicare Parts A, B and D components and a monthly risk-adjusted payment from New York for the Medicaid component.

- DOH hopes to complete its FIDA readiness review process for 25 approved MLTC plans in the FIDA area by the first quarter of 2014.

- DOH applied for implementation funding from CMS in January and expects to be awarded the funding soon. DOH has also applied for funding for a participant ombudsman program and CMS will make a decision by September 13.


The MOU, which provides much more detail, is at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NYMOU.pdf.


Questions about FIDA can be sent to FIDA@health.state.ny.us.

Since New York announced that it would apply to develop the FIDA program, HCA has provided input to the state Department of Health through various venues, including our participation on several workgroups. After we complete our analysis of the final MOU, HCA will consult with members and continue to advocate for any concerns expressed by home care and MLTC providers. HCA will also be planning informational, educational and other supportive efforts for HCA member providers and health plans on ways to best prepare for and participate under the FIDA paradigm.

For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcany.org.
HCA Offers Workshops to Help You Prepare, Transform and Lead

HCA is offering several learning opportunities with “just-in-time” information that you can’t afford to miss as you prepare your organization for change, transform your business model, and continue your work to provide the best patient care.

Corporate Compliance Symposium

To support members in their work to understand the complexities of home care compliance requirements, HCA is offering our annual Corporate Compliance Symposium on October 1 and 2 in Albany. This year’s program is designed to help you better understand the intricacies and emerging compliance requirements as New York continues the transition to managed care while helping you learn what to expect when it comes to audits and appeals.

For this year’s Symposium, HCA is pleased to open the program with James Cox, New York State’s Medicaid Inspector General. Mr. Cox will share the state’s audit activities and compliance expectations in a managed care plan environment.

Several health law attorneys will also be on hand to provide their expertise on a wide variety of compliance topics. Frank Serbaroli, Shareholder, Greenberg Traurig, LLP and Carol Cullen, CHC, Vice President, Compliance and Regulatory Affairs at Affinity Health Plan will share compliance tips that should be a focus for home care providers as they contract with managed care plans. Washington, D.C. attorney Elizabeth Hogue, meanwhile, will address several thorny compliance issues from a practical perspective, including new survey sanctions as well as rules related to obtaining referrals and discharge planning. Also, health law expert Philip Rosenberg of Nixon Peabody will discuss elements of Executive Order No. 38 limiting executive compensation and administrative expenditures; further developments in the legal action challenging the executive order; and information on the Wage Parity Law.

Review the entire lineup of expert speakers in the Corporate Compliance Symposium brochure available at www.hcanys.org/events.cfm. Seating will be limited at this affordable two-day event, so early registration is encouraged.

Positioning for Success in an MLTC Arena

On October 16, HCA will provide our latest education session to help you prepare for and adapt to the transition of patients into Medicaid Managed Long Term Care. Positioning for Success in a Managed Long Term Care Arena: Part 2 is the second in a series of conferences that will offer practical and useful advice to help home care leaders fine-tune their transition plans for the success of home care-MLTC partnerships. Sessions will focus on the mechanics of MLTC reimbursement; achieving better care and greater efficiencies in an MLTC environment; and lessons learned thus far from the MLTC transition.

Registration details for these and other programs are at www.hcanys.org/events.cfm. Easy and secure online registration for both the Corporate Compliance Symposium and the MLTC program are available at www.eventville.com/hcanys.

You can’t afford to miss these educational offerings that provide you with insight into hot topics and trends to sustain your organization and continue to provide the best care.

For more information, contact Lynda Schoonbeek at lschoonbeek@hcanys.org or (518) 810-0656.
HCA Submits LTHHCP/UAS Issues to DOH

This week, HCA submitted a number of questions/issues to the state Department of Health (DOH) for inclusion in an upcoming webinar on the Uniform Assessment System (UAS-NY).

The webinar will be held on September 20 from 10 to 11 a.m. Registration is at https://uasny.webex.com/uasny/onstage/g.php?t=a&d=665580156m

The issues, collected from LTHHCP members, included:

- Whether or not “physician overrides” will be allowed;

- Which assessment forms are used for LTHHCP patients enrolled into mainstream Medicaid managed care plans;

- Which assessment forms are used during the 90-day transition period and afterwards;

- When the DMS-1 will no longer be required in certain counties that “piloted” the UAS tool;

- How the UAS will affect “alternate entry”;

- The role of local departments of social services in conducting assessments, authorizing

New Memo Provides Updates on Executive Comp. and Administrative Cap Rule

HCA General Counsel Mark Thomas has prepared a detailed analysis of the Cuomo Administration’s final rule for Executive Order No. 38, which sets limits on executive compensation and administrative expenditures for certain covered providers receiving state funds.

The analysis is in a memo at http://www.hca-nys.org/documents/ExecutiveCompensationRuleMemo090613.pdf. It explains many of the intricacies of the rule as well as any additional clarification or updates culled from a new Guidance document posted by the Administration on a website devoted to the Executive Order at http://executiveorder38.ny.gov.

HCA members are encouraged to review this memo carefully to assess how Executive Order No. 38 and the corresponding Guidance document affect your organizations.

In June, a group of home care providers filed a lawsuit challenging the constitutionality of the executive compensation regulations; the plaintiffs requested an injunction barring the implementation and enforcement of any rules and regulations adopted pursuant to the Governor’s executive order. On July 10, State Supreme Court Judge Emily Pines issued a ruling denying the plaintiff’s motion for a preliminary injunction. Now that the preliminary injunction has been denied, it is likely that the plaintiffs will appeal to the Appellate Division, Second Department, to ask that Judge Pines’ decision be overturned. More details on these developments are expected in the coming weeks.

Learn more at upcoming Compliance Symposium

Executive Order No. 38 will be one of several topics discussed at HCA’s upcoming Corporate Compliance Symposium on October 1 and 2 in Albany. The session, led by health law expert Philip Rosenberg of Nixon Peabody, will discuss elements of Executive Order No. 38, further developments in the legal action challenging the executive order, and information on the Wage Parity Law.

Details and online registration are available on the home page of HCA’s website at http://www.hca-nys.org.
program participation, and other tasks once an LTHHCP patient is enrolled into a managed care plan and the UAS is used; and

- Whether agencies can generate a UAS report that shows scores for completed assessments.

HCA thanks members who submitted issues. We also thank DOH for agreeing to hold this special program for LTHHCP providers.

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

**OMIG Resumes Semiannual TPL Process Using Traditional Appeals**

The state Office of the Medicaid Inspector General (OMIG) is resuming its semi-annual demand billing process for the first half of Federal Fiscal Year (FFY) 2013.

With the expiration of the Third Party Liability (TPL) Demonstration Project after FFY 2010, OMIG has returned to a traditional Medicare appeals process for FFY 2011, 2012 and 2013 claims.

Details of this ongoing traditional appeals process are outlined in a letter that most Medicare-certified home care providers (Certified Home Health Agencies and Long Term Home Health Care Programs) should have received from OMIG and its TPL contractor, the University of Massachusetts Medical School (UMMS).

The letter identifies which cases have been selected to undergo appeals. The “Case Selection Report” accompanying the OMIG/UMMS letter will seek demand bills for cases that occurred in the first and second quarter of FFY 2013 only (October 1, 2012 through March 31, 2013).

If your agency is selected for future quarterly initiatives, a separate notification letter and “Case Selection Report” will be sent at that time.

For specific questions about the letters, contact UMMS’s Laurie Burns at (866) 626-7594.

**HCA’s advocacy**

HCA has stressed to federal officials at the U.S. Centers for Medicare and Medicaid Services (CMS) that a permanent solution is needed to mitigate the continued burden of this traditional appeals process. We will keep the membership closely apprised of all developments in this process.

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

**NGS Home Health Advisory Meeting Provides Updates**

National Government Services (NGS), New York's Medicare Administrative Contractor (MAC), held a Home Health Advisory Meeting today via conference call for state associations. HCA participated in the meeting and received critical updates, posed questions and advocated on behalf of the membership.

HCA will be sending the membership a detailed *Public Policy Memorandum* summarizing key updates provided by NGS staff at the meeting as well as information acquired by HCA on issues of particular importance to New York State, including updates on the MAC Jurisdiction 6 transition process; home health Medicare Prospective Payment System (PPS) data; Comprehensive Error Rate Testing (CERT) data; education offerings and more.

*For further information, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org.*
June 2013 Report: Medicaid Spending Continues Below Cap Projections

Total state Medicaid expenditures through May for fiscal year (FY) 2014 are $7 million (or 0.2 percent) less than the amount projected under the state's Medicaid Global Cap, according to the June 2013 Global Spending Cap Report issued recently by the state Department of Health. Spending through the month of June was $4.152 billion compared to the projection of $4.159 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 $350 million) to be slightly lower than estimated spending (at $360 million).

However, similar to the April and May reports, the Department’s June report did not itemize the individual subcategories within “Other Long Term Care,” so it is unknown how the estimated and projected home care spending compares with personal care and assisted living. HCA has requested that DOH provide these details at a future meeting with the Department's Division of Health Care Financing.

Under this year’s state budget, the Medicaid Global Spending Cap increases from $15.9 billion to $16.4 billion in FY 2014 – a 3.2 percent increase. The cap on Medicaid spending is extended through March 2015.

The June report also indicates that the accounts receivable (AR) balance for retroactive rates owed to the state through the end of May is $305 million. This represents a reduction of $96 million since April 2013. In July, DOH issued a Dear Administrator Letter (DAL) to initiate a program in which providers are given some options to voluntarily pay outstanding liabilities on a schedule that avoids provider interest costs while helping to bring down the state’s AR balance. (See the July 12 edition of ASAP for details.)

In other report highlights, total Medicaid enrollment reached 5,308,550 enrollees at the end of June 2013. This reflects an increase of roughly 59,589 enrollees, or 1.1 percent, since March 2013. Medicaid managed care enrollment in May 2013 reached 3,999,187 enrollees – an increase of around 62,800 enrollees, or 1.6 percent, since March 2013.

HCA is a member of the state Global Cap Workgroup which is expected at some point to be asked to explore global cap methodology issues as well as recommendations for savings and reinvestment, including discussions about the status of the 2 percent across-the-board cut.


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

PHHPC Committee Agenda Posted

The state Department of Health (DOH) has posted the agenda and supporting documents for the September 12 Public Health and Health Planning Council (PHHPC) Establishment and Project Review Committee Meeting. The meeting materials are at http://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2013-09-12/index.htm.

The agenda includes an application by: an existing Certified Home Health Agency (CHHA) to expand into eleven upstate counties; an existing Long Term Home Health Care Program (LTHHCP) to establish a CHHA
to serve three counties in western New York; and five entities to establish Licensed Home Care Services Agencies (LHCSAs).

The CHHA applications are the result of a Request for Applications issued by DOH in January 2012 as well as special provisions included in the 2012-13 state budget for LTHHCPs to provide a CHHA.

HCA has inquired with DOH whether any CHHA establishment or expansions will be part of the November PHHPC Committee meeting.

HCA has updated our chart of approved CHHA applications and expansions; it is at http://www.hca-nys.org/documents/CHHARFARrecommendationschart090513.pdf.

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

**OMIG Recommends Self-Assessment for Compliance Programs**

The state Office of the Medicaid Inspector General (OMIG) reminds health care providers to conduct an annual self-assessment of their compliance programs so that they can make any improvements, corrections or refinements prior to the required December 2013 certification period.

Home care and certain other providers are required to have compliance programs and to certify each December that they have “adopted, implemented and maintained an effective compliance program.” Each compliance program must include the eight elements as outlined at http://www.omig.ny.gov/images/stories/compliance/compliance_program_assessment_form-revised.doc.

Additional information, including a Frequently Asked Questions (FAQs) document and the certification form, are at http://www.omig.ny.gov/compliance/certification. OMIG plans to update its certification form and will hold a webinar on the new form in November 2013.

Questions can be directed to OMIG’s Bureau of Compliance at (518) 408-0401 or compliance@omig.ny.gov.

**Updated compliance program reviews**

OMIG has also updated its listing of the following compliance program reviews initiated through March 31, 2013: Observed Best Practices in Compliance; Observed Opportunities for Enhancement; and Observed Insufficiencies.

The lists are at http://www.omig.ny.gov/compliance (see OMIG Assessment Results).

The lists do not identify particular providers or provider types, but the observations listed offer guidance to Medicaid providers on what OMIG has found to exist in compliance programs that: exceed the mandatory requirements (Best Practices); meet the mandatory requirements, but could be improved (Opportunities for Enhancement); or do not meet the requirements (Insufficiencies).

For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcanys.org.
October Deadline for Foreign Language HHA Training Programs

The state Department of Health (DOH) has set an October 1 deadline for home health aide training programs (HHATPs) taught in non-English to submit certain information to the DOH regional office.

According to a June 24 Dear Administrator Letter (DAL), the information for such HHATPs includes documentation of the English text book currently approved to be used, the formal permission granted by the publisher to translate the materials, and documentation of the certified translations of a test bank of questions (mandatory) and instructor materials (if applicable).

This DAL stems from a collaborative effort among HCA, a small workgroup of HCA members and DOH to address how to construct guidelines for such training programs that are satisfactory to the state and agencies, allowing for the training of aides in languages spoken by many of their patients. HCA thanks DOH for its willingness and time committed to address such an important issue.


According to the DAL, HHATPs must use an approved English textbook but are not required to obtain a textbook written in the foreign language that is being taught. Secondly, the program must use tests obtained from publishers who publish textbooks for training home health aides, and the tests must be from a bank of test questions.

HHATPs are required to consult with the publisher of an approved English textbook to obtain permission to translate test questions into a foreign language. All translations must be completed by a “certified” translation service.

When requesting DOH approval (initial and re-approval) to conduct training in a foreign language, the training program will be required to provide documentation of the textbook to be used, the certified translation attestation (a signed statement that the translation is an accurate and complete rendering of the original document) and the formal permission granted by the publisher to translate their materials.

The Paraprofessional Healthcare Institute (PHI) has been approved to receive funding from the New York City Council to translate the HHATP test questions into five languages: Russian, Chinese (Mandarin and Cantonese),

POSITION: DIRECTOR OF PATIENT SERVICES
ORGANIZATION: Acacla Home Care

Under the direction of the Executive Director, the Director of Patient Services, is responsible for the delivery of safe comprehensive professional care services in accordance with the philosophy, objectives and directives of the agency. This will include planning, developing, implementing and evaluating programs and patient care activities.

QUALIFICATIONS: Master’s Degree in Nursing, public health, business administration or another health related field and two years of home care experience; OR Baccalaureate Degree in Nursing (BSN) and two years of experience as a supervising community health nurse; OR Associate’s Degree or Diploma in Nursing plus four years of certified home health care nursing experience and six credit hours of education/training in public health and principles of management.

Please submit résumés to montanaj@masoniccommunityny.org
Korean, Haitian-Creole and Italian. PHI hopes to complete the translations by mid-September and send them to Hartman Publishers, a publisher of the HHATP English textbook. HCA’s understanding is that DOH has agreed that these translated test questions will meet its requirement in the June 24 DAL for documentation of the certified translations of a test bank of questions.

Once the translations have been completed, HCA will notify members.

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

**Changes Proposed to Adult Day Regulations**

Last week, the state Department of Health proposed changes to the adult day health care (ADHC) regulations in order “to enable such programs to contract and work effectively with managed long term care (MLTC) plans . . . as more Medicaid recipients are required to enroll into MLTC plans.”

The proposed changes are at [http://w3.health.state.ny.us/dbspace/propregs.nsf/4ac9558781006774852569bd00512fda/df8cfe8fc5beb4385257bd400676a9e?OpenDocument](http://w3.health.state.ny.us/dbspace/propregs.nsf/4ac9558781006774852569bd00512fda/df8cfe8fc5beb4385257bd400676a9e?OpenDocument).

Some of the proposed changes include the following:

- In cases where an MLTC refers an enrollee to an ADHC program, MLTC plans will need to meet certain requirements that are currently the responsibility of the ADHC program operator (i.e. care coordination, health education, referral to other community resources) consistent with the MLTC plan’s responsibility to manage and coordinate the enrollee’s health care needs. This is intended to avoid duplication of services between the ADHC program operator and the MLTC.

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

- Allow an MLTC plan, based on an enrollee’s individual medical needs, as determined in the comprehensive assessment performed by the MLTC plan, to order less than the full range

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**CMS Seeking Provider Input on Hospice Quality Reporting**

The U.S. Centers for Medicare and Medicaid Services (CMS) this week announced it is seeking input from providers on the Hospice Quality Reporting Program (HQRP) established by the Affordable Care Act.

CMS’s vendor, Health Care Innovation Services (HCIS), is seeking providers who will voluntarily participate in a brief interview to assess the HQRP, how providers can ensure the accuracy of submitted data, how the HQRP has impacted patient services and outcomes, and what CMS can do to improve the program and processes in the future.

Interviews will be conducted by telephone. Information provided in any reports or summaries will not be linked to a particular provider.

If you are interested in participating, please contact Pat Hanson at phanson@hcareis.com.
of adult day health care services, and to enter into reimbursement arrangements with the ADHC program operator that take into account a program registrant’s receipt of less than the full range of adult day health care services.

- Allow ADHC programs to offer a hybrid model, in which individuals requiring ADHC services and individuals requiring only social adult day care services can both receive services in the ADHC program space. The proposed rule impact statement notes that this will have the effect of increasing the capacity of social adult day care programs, which is currently insufficient to meet the anticipated demands of MLTC plans in certain parts of the state.

- Allow ADHC programs that have chosen the hybrid option to admit up to 30 percent over their approved capacity.

In order to exercise the hybrid option, the ADHC program will have to notify the Department in writing thirty days in advance of implementation.

Currently, there are about 165 ADHC programs in New York State, including 41 in rural counties.

Effective August 1, 2013, mainstream Medicaid managed care plans began covering ADHC and AIDS ADHC services. Information on that change is at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm.

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

**ALP Conversion Deadline Extended**

The state Department of Health (DOH) has extended to October 18 the due date in a recent solicitation for up to 4,500 Assisted Living Program (ALP) beds.

Under this initiative, Transitional Adult Homes – those adult homes with a certified capacity of 80 beds or more, of which 25 percent or more of the residents are persons with serious mental illness – can apply for additional beds.

While questions from interested parties were due August 14, DOH has also extended the date of its response to those questions to September 11.


**NGS Updates**

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

Article on home health F2F encounter

NGS has recently posted to its website an article clarifying the home health face-to-face physician (F2F) encounter requirement for initial episodes or start of care (SOC) episodes.

*Continued on next page*
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For patients receiving Medicare home health services, the U.S. Centers for Medicare and Medicaid Services (CMS) requires a F2F encounter with the certifying physician for the initial episode. NGS issued the article because CMS recently clarified that the F2F is required for all initial episodes or start of care (SOC) episodes—a change from instructions in CMS’s question and answer (Q&A) material. CMS will be updating its Q&A answers soon.

To download the F2F article, go to NGS’s website at www.ngsmedicare.com and click on the “Home Health & Hospice” homepage (not the Part A homepage). Once at the Home Health & Hospice homepage, go to the “Resource” button at the top of the page and click on “Tools & Materials.” The recently posted F2F article is under “Coverage & Documentation.”

**NGS to sunset PC-ACE Pro32 Version 2.45**

NGS is consolidating all PC-ACE Pro32 users to one version of the free Medicare billing software. Currently, NGS supports versions 2.45 and 2.46. Soon, NGS will no longer support version 2.45 and will be consolidating the software under the 2.46 version. Version 2.45 is being removed from NGS’s website.

Version 2.46 supports the submission of both Institutional (Part A) and Professional (Part B) claims.

NGS encourages 2.45 version users to upgrade to version 2.46 prior to October when version 2.48 will be available. To determine if this applies to you, open your PC-ACE Pro32 software and from the ‘Help’ option on the task bar, select ‘About PC-ACE’ for the version installed. If the version identified is ‘2.45,’ then this initiative applies to you. For specific questions contact NGS’s EDI Help Desk at (877) 273-4334.

**EDI system outages**

NGS has scheduled a series of planned system outages affecting all contracts on September 6, October 18 and October 25 from 5 to 9 p.m. With each temporary outage, Electronic Data Interchange (EDI) Trading Partners for all contracts will be unable to access the EDI Gateway for batch file transfer activities, including claim submissions.

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

**Health Reform Update**

The U.S. Department of Treasury and Internal Revenue Service (IRS) have issued a final rule on the “individual mandate” provision of the Affordable Care Act and a proposed rule on a tax credit for small employers.

Starting in 2014, the individual “shared responsibility” provision calls for each individual to have basic health insurance coverage (known as minimum essential coverage), qualify for an exemption, or make a payment when filing a federal income tax return.

Those who qualify for an exception from making a payment include:

- Individuals who cannot afford coverage;
- Taxpayers with income below the filing threshold;
• Members of Indian tribes;
• Individuals who suffer hardship;
• Individuals who experience short coverage gaps;
• Members of religious sects or divisions;
• Members of a healthcare sharing ministry;
• Incarcerated individuals; and
• Individuals who are not lawfully present.


At the same time, the Treasury Department and Internal Revenue Service have released two notices related to minimum essential coverage. The first notice provides guidance on when, for purposes of a premium tax credit, an individual is treated as already eligible for specific types of minimum essential coverage and therefore is not eligible for a tax credit.

Conversely, the Guidance also provides unique examples where an individual is not considered already eligible for minimum essential coverage and, therefore, is eligible for a tax credit: i.e. when an individual is subject to a waiting period before enrollment in the Children’s Health Insurance Program (CHIP). This individual is not treated as eligible for CHIP and therefore may receive a premium tax credit during that waiting period.

The second notice provides transition relief for individuals offered employer-sponsored coverage that follows a non-calendar plan year. Under this transition relief, employees and dependents eligible for such coverage are generally exempt from the individual shared responsibility provision until the new plan year begins in 2014.


Employer tax credit

To be eligible for a small-employer tax credit, an employer must cover at least 50 percent of the cost of single (not family) health care coverage for each of its employees and have fewer than 25 full-time equivalent employees (FTEs) whose average wages are less than $50,000 (as adjusted for inflation beginning in 2014) per year. More information is at http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers.

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

Treasury Department Proposes Rule on Employer Health Reporting

Yesterday, the U.S. Department of the Treasury and the Internal Revenue Service issued a proposed regulation to implement the information reporting requirements for insurers and certain employers under the Affordable Care Act (ACA).

The proposed rule describes a variety of reporting options, including:

• Replacing section 6056 employee statements with Form W-2 reporting on offers of employer-sponsored coverage to employees, spouses, and dependents.

Continued on next page
• Eliminating the need to determine whether particular employees are full-time if adequate coverage is offered to all potentially full-time employees.

• Allowing employers to report the specific cost to an employee of purchasing employer-sponsored coverage only if the cost is above a specified dollar amount.

• Permitting health insurance issuers, employers, and other reporting entities to forgo reporting the specific dates of coverage (instead reporting only the months of coverage), the amount of any cost-sharing reductions, or the portion of the premium paid by an employer.

Once the final rules have been published, reporting entities will be encouraged to voluntarily implement information reporting in 2014 (when reporting will be optional), in preparation for the full application of the reporting provisions in 2015.

In July, the Obama Administration announced a one-year delay (until January 2015) of the ACA employer mandate which requires businesses with 50 or more full-time “equivalent” employees to provide health insurance to their workers or pay a $2,000 fine per employee. Under another ACA provision, employers with 50 or more employees will also face penalties if they offer health insurance but the insurance is either not “affordable” or does not provide “minimum value,” and if at least one full-time employee obtains a premium credit or cost sharing reduction in a Health Insurance Exchange plan.


Publications


• “Transitional Care Management Services” Fact Sheet, by the U.S. Centers for Medicare and Medicaid Services http://tinyurl.com/ljw82sa

• “Home Health Face-to-Face Encounter & Therapy Reassessment Requirements Virtual Room Question & Answer Summary, July 30, 2013,” by the U.S. Centers for Medicare and Medicaid Services http://www.medicarenhnic.com/RHHI/billing/QAF2F073013.pdf


• “Medicare Recovery Audit Contractors and CMS’s Actions to Address Improper Payments, Referrals of Potential Fraud, and Performance,” by the Office of Inspector General http://go.usa.gov/D48I


For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcansy.org.
On Tuesday, September 24, HCA will convene a statewide meeting of the LTHHCP Forum.

The focus of the Forum will be on the state’s continued implementation of its mandatory managed care enrollment policy, including recent federal approval of the state’s plan for a Fully Integrated Duals Advantage model, and the status and future of the LTHHCP in this evolving paradigm. Please join us for this critically important Forum meeting.

Registration
Once complete, please fax to (518) 426-8788. You must provide us with an email address in order to receive your confirmation.

Name
Title
Agency
Phone
Email (Required)

Additional Registrants from same organization:
Name Email (Required)
Name Email (Required)
Name Email (Required)

Preliminary Agenda Includes:

• LTHHCP update and discussion of current environment.
• Status, activities and other aspects of mandatory enrollment roll out.
• Legislative and HCA advocacy efforts on behalf of LTHHCPs.
• Next steps, opportunities and options for LTHHCPs.
• LTHHCP program and operational issues.
• Presentations by DOH officials and key legislative offices invited.