E-Alliance Extra

Missouri Alliance for **Home Care**

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10/14/2015

FLSA Rule Changes--Toolkit Available

From NAHC

With the rejection of NAHC's stay request at the U.S. Supreme Court, the new Fair labor Standards Act (FLSA) rules on minimum wage and overtime compensation under the companionship services and live-in domestic services exemptions will go into effect on October 13, 2015. While the Department of Labor has indicated that it will not enforce those rules for 30 days thereafter, NAHC strongly recommends that home care companies begin to comply during the workweek that includes October 13 as private enforcement is not postponed.

To help companies achieve compliance, NAHC's co-counsel in the litigation, the Littler law firm, has developed an extensive compliance Toolkit That Toolkit can be found at http://www.littler.com/products-and-services/home-care-toolkit. Compliance approaches can vary greatly from one company to the next. The Toolkit does not provide everything needed, but is a great start for businesses looking at customizing their changes.

William A. Dombi, Esq.

SESCO - Week In Review

DOL's home care rule to be enforced beginning November 12

Since 1974, federal law has exempted home care workers hired through third-party staffing agencies from minimum wage and overtime requirements. In 2013, the Department of Labor (DOL) announced new regulations that would remove that exemption. Earlier this year, a federal district judge invalidated the regulations after finding that the DOL had overstepped its authority. In August, however, a panel of federal appellate judges had reinstated those regulations. The three-judge panel concluded that the Fair Labor Standards Act gave the DOL authority to determine which in-home care services are exempt from minimum wage and overtime protections. Clearing the way for the DOL' s final home care rule to go into effect, last week Chief Justice John Roberts denied an application to stay the D.C. Circuit's decision upholding the regulation. As a result, the ruling will be effective October 13 and the DOL will begin enforcing the rule on November 12, 2015.

Congress passes measure revising definition of small businesses under the ACA

Congress has passed the Protecting Affordable Coverage for Employees Act (PACE).

PACE amends the definition of small businesses and protects them from possible increases in health care premiums under the Patient Protection and Affordable Care Act (ACA). Under the ACA, the definition of the state-based small group markets was scheduled to change in 2016 from 50 to include employers with up to 100 employees. This change would have required many small and midsized businesses to be subject to different rating rules and requirements, with the potential of increasing the health insurance premiums for small businesses and their employees. The PACE Act keeps the 50-definition in place, but states have the option of expanding the definition of small employer to cover employers with up to 100 employees.

Missouri law prohibits local living wage ordinances

Missouri has adopted a rule that prohibits political subdivisions from establishing, mandating, or otherwise requiring an employer to provide a minimum or living wage rate or other benefits to an employee that exceed the requirements of federal or state laws, rules, or regulations. The provision does not preempt any state law or local minimum wage ordinance requirements in effect as of August 28, 2015. (From Mary S: St. Louis's ordinance was passed prior to August 28th)

SESCO recommends that clients review all applicable policy and practices to ensure compliance. For assistance, contact us at 423-764-4127 or by email at sesco@sescomgt.com

Fair Labor Standards Act - Webinars

NATIONAL RESOURCE CENTER *for*
PARTICIPANT-DIRECTED SERVICES

Hi Everyone,

Registration is now open for our remaining six webinars on the Fair Labor Standards Act (FLSA) Home Care Rule. This webinar series is aimed at helping employers, payers, and other stakeholders understand how to comply with the rule.

Because these webinars are an unfunded NRCPDS activity, we are charging a nominal fee to cover the webinar costs. Single user registration for each

webinar is $25 and group registration (with unlimited participants from a single organization) for each webinar is $200. You can also purchase all six webinars at a discounted rate of $125 for single users or $1000 for group registration. NRCPDS FMS and Program Members can attend the webinar free of charge.

The webinar schedule includes:
Overtime Rates & Third Party Allocation. October 15th from 3:00-4:00 PM (EST)
Live-In Exemption Deeper Dive. October 23rd from 3:00-4:00 PM (EST)
Tax Reporting and Medicaid Claiming/FMAP. October 28th from 3:00-4:30 PM (EST)
Emerging Issues: Workers' Comp, I-9, ACA. November 4th from 3:00-4:00 PM (EST)
Models for Compliance. November 20th from 3:00-4:30 PM (EST)
Open Q&A. December 3rd from 3:00-4:30 PM (EST)
To register, please click here and select "Webinar". After you submit your payment, we will send you a confirmation email with the log-in information.

If you are a NRCPDS member, please email membership@participantdirection.org to register rather than using the link above.

Please don't hesitate to email us if you have any questions.

Sincerely,

Your team at the National Resource Center for Participant-Directed Services (NRCPDS).

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Missouri's Community Paramedic and Mobile Integrated Health Care Program

In 2013, the Missouri Legislature passed a law authorizing community paramedic (CP) programs throughout the state. The statute, 190.098 RSMo, has two main components: who may be certified as a community paramedic, and what is required of entities that establish community paramedic programs. While the Missouri Department of Health and Senior Services has not yet published the rules for this program many communities are developing these programs.

Members may want to get in touch with your local ambulance districts, hospitals, or EMS programs to see what, if anything, they are considering as it related to this new law.

MAHC, along with MONA, and many of the paramedic, emergency and ambulance associations worked together to develop a Joint Statement of Principles for the programs being developed. The Statement of Principles is intended to build on available national resources to help define key principles and elements for CP/MIH programs in Missouri.

I hope you will read the Statement and follow-up in your community. This locally designed program, should be developed with the input of local health care providers and EMS/Paramedic programs. Home care (home health, hospice, in-home and private duty) needs to be at the table.

Click here to visit the MAHC home page where there is a link to the Statement of Principles:
http://www.homecaremissouri.org/documents/FINALJointStatementonCommunityParamedic-PartnershipforCommunityCareSummer2015.pdf

IN FOCUS: Hospice/Medicaid Issues

From NAHC

Hospice Payment Reform/Medicaid: In response to the Centers for Medicare & Medicaid Services (CMS) proposed hospice payment reforms that, by law, are applicable to fee-for-service Medicaid hospice benefits, there was widespread concern that hospices, vendors, Medicare Administrative Contractors (MACs), and state Medicaid programs would not be ready for the anticipated Oct. 1, 2015, implementation. As part of the final hospice payment rule and out of particular concern for state Medicaid programs, CMS delayed implementation of the two-tiered payment system for Routine Home Care (RHC)/Service-intensity Add-on (SIA) until Jan. 1, 2016.

In recent months the National Association for Home Care & Hospice (NAHC) examined billing requirements for some state Medicaid programs to ascertain whether Medicaid programs required sufficient information on hospice claims to allow for the payment reform changes and discovered that a number of states do not currently require hospices to report sufficient detail (including skilled visits, which are essential for implementation of the SIA) on claims to facilitate implementation of the payment changes. NAHC contacted officials at CMS to convey these concerns, and CMS conducted outreach to select states to ascertain their states of readiness. Our understanding is that as part of the calls CMS was able to ascertain that all states are not currently securing information on hospice claims that would facilitate implementation of the payment reforms. As a result, CMS is planning on sending information to state Medicaid offices to assist them in implementing the changes that are needed to be able to move forward with payment reform on the Medicaid side.
At this stage it is unclear whether state programs will be able to change billing processes in time for the scheduled January 1, 2016, implementation or whether CMS will need to allow more time; it is also unclear whether states will use a uniform process or choose their own method (including some type of work-around) for securing the information required for payment reform implementation. NAHC will provide additional details as they are available.

Medicaid Hospice/Managed Care: States are at different points in their development of Medicaid managed care contracts that include the hospice benefit. On the fee-for-service side, Medicaid programs are required, under Section 1902(a)(13)(B), to pay for hospice care based on existing Medicare rates. NAHC has had inquiries relative as to whether this same requirement applies when hospice care is provided by a managed care organization. NAHC has posed specific questions to CMS, to which we received the following response:

Under Medicaid fee-for-service (FFS), the State plan payment must meet the requirements specified in Section §1902(a)(13)(B). However, under Medicaid managed care, as specified in 42 CFR §438.6(c)(2), CMS only requires that payment rates between the State and health plans be actuarially sound. Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs) may negotiate different payment amounts with providers, unless the State requires the MCO, PIHP, or PAHP (specified in the contract) to pay at the same rate as the Medicaid State plan.
Legal research conducted by NAHC staff concluded that, because of the way Medicaid MCO authorizing language is crafted, payments for hospice services provided through a MCO likely are not required to follow Medicare reimbursement requirements. NAHC has submitted follow up questions to CMS and will report on additional findings as they become available.

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