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Home Care Advocacy Day

If you have not signed up to attend this important annual event it is not too late. Print the registration form and get ready to make your voice hear for Home Care in Jefferson City.
Registration form: http://www.homecaremissouri.org/eventfiles/event_276_288.pdf

Slap Shot Night for Nurses – Mark your calendar

Blues vs. Anaheim Ducks
Thursday, March 8, 2012 at 7:00 pm
You are invited to bring family & friends to join the fun and cheer on the Blues! $5 of your ticket purchase will go to the Scholarship Fund of the Home Care Research and Education Foundation for nursing and therapy scholarships.
Ticketing information will be coming soon!!

Spend Down Changes Proposed

Medicaid Spend Down is a program where individuals whose income is over the limit to qualify for Medicaid ($772 a month for an individual or $1042 for a couple) can qualify through the "Spend Down" program. Persons qualify for Medicaid through Spend Down if the amount of their medical bills exceeds the difference between their net income and

Medicaid income eligibility limits. The amount that exceeds the Medicaid eligibility limit is known as the Spend Down amount.

This fall the state (specifically the Family Support Division FSD) told their case workers to change the way they interpreted the Spend Down eligibility policy and to no longer accept medical bills that might be covered by Medicare, private insurance or another 3rd party payer. The case workers were guessing as to what amount of a bill would be covered by another payer and then counting only the remaining amount as the patient/client's responsibility (liability). This change meant many patients/clients no longer were able to qualify for Medicaid services early in the month or in some cases they were never able to qualify.

The state backed off this new interpretation - for now - and are in the process of collecting information from providers, patients and others about its impact.

At a meeting this week the state presented two alternative policies that will help some people. In the first "Incurred Cost – Retrospective" FSD will use Medicare fee schedules, history, information from providers, Medicaid, etc. to establish the amount of reimbursement that would be allowed by Medicare and then apply the deductible and co-payment amounts that are the client responsibility toward the Spend Down requirement. Basically this would mean that FSD will attempt to do a better and more consistent job of determining what amount of a bill is the clients responsibility and give the client credit for this amount. The second "Incurred Cost – Prospective" would allow clients who have ongoing bills for services (mostly chronic patients) be considered eligible at the 1st of the month even if the qualifying medical expense will be incurred later in the month. The client's portion will be used to satisfy the Spend Down amount on the 1st of the month. This will mean that providers will be liable for the Spend Down amount for each client who qualifies this way. Providers will basically submit a bill to the client at the beginning of the month for services to be delivered that month totaling at least the client Spend Down amount. This bill will serve as an incurred expense for the client to use with FSD to become eligible on the first day of the month. Medicaid will create a receivable against this provider and only pay for the services delivered minus the Spend Down amount. It will be the responsibility of the provider to collect from the client.

Please take a minute to complete a survey MAHC is conducting about your Medicaid Spend Down Clients. The survey is available at:
http://www.surveymonkey.com/s/6Q3LL9S

Fingerprint Background Check – Gone for this year

After several meetings and much discussion about the terrible impact on workers and providers of potential legislation that would have required all LTC workers to have a fingerprint criminal background check conducted in order to work in LTC, the state has decided to back off for this year and continue to work with the Highway Patrol, providers and CMS on alternatives. This proposal was untenable for everyone. It would have cost over $50 per fingerprint check, taken up to several weeks to obtain results and required potential workers to drive, perhaps up to 50 miles each way to the location of the vendor who has the "contract" to provide the fingerprint checks.

MAHC will continue to work with DSDS and the other departments to find a realistic solution.

Senate Appropriations Hears Testimony

The MO Senate Appropriations Committee met yesterday to hear public testimony about the Dept. of Health's budget. MAHC testified about the SynCare experience, its impact and aftermath on clients, potential clients and providers. MAHC expressed hope that the Committee, through the appropriations process, will have a positive response to alternatives being proposed and will work with the association to develop a plan that can move the system forward with a timely, uniform and understandable way to manage the In-Home, CDS, and all LTC programs. The committee chair, Senator Schaefer, (R) Columbia, was familiar with the situation and expressed his interest and willingness to work with MAHC during the session.

Impact of OT Rule Changes:

The U.S. Dept of Labor has developed proposed changes to the existing exemption from overtime for companionship services. MAHC is conducting a survey of members to see what impact, if any, you would expect to see if this rule was changed. The survey is available at:
http://www.surveymonkey.com/s/PMDG5NP

Bundled Payment Applications Deadline Moved To April *Change Impacts Models 2-4*

From NAHC Report

As a result of the unprecedented public response to the Bundled Payment initiative and the need for additional preparation time to accommodate the extraordinary degree of provider interest, the Centers for Medicare & Medicaid Services (CMS) says the deadline for applications for the Bundled Payments for Care Improvement Models 2-4 has been extended to April 30, 2012. CMS also said the target date for supplying limited data sets is Feb. 28, 2012 for those who successfully completed a Research Request Packet and Data Use Agreement to request historical Medicare claims data. All other instructions regarding submission of application materials remain the same.

Bundling payment for services that patients receive across a single episode of care is one innovation resulting from the Affordable Care Act. The Bundled Payments for Care Improvement Initiative is being undertaken to reduce costs and replace fragmented care.

In August, CMS invited providers to apply to help test and develop four different models of bundling payments. According to CMS, through this initiative providers will have flexibility to determine which episodes of care and which services would be bundled together.

Applicants for each model must define the episode of care as the acute care hospital stay only (Model 1), the acute care hospital stay plus post-acute care associated with the stay (Model 2), or just the post-acute care, beginning with the initiation of post-acute care services after discharge from an acute inpatient stay (Model 3). Under the fourth model,

CMS would make a single, prospective bundled payment that would encompass all services furnished during an inpatient stay by the hospital, physicians and other practitioners.

Three of the models involve a retrospective bundled payment arrangement, and one model would pay providers prospectively. Applicants must propose the target price, which would be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants in these models would be paid for their services under the traditional fee-for-service (FFS) system. After the conclusion of the episode, the total payments would be compared with the target price. Participating providers may then be able to share in those savings.

Organizations are welcome and encouraged to apply for and participate in one or more models. Applicants will be required to plan and implement quality assurance and improvement activities as a condition of participation in this initiative and participate in CMS quality monitoring. During the demonstration, CMS will carefully monitor the program to ensure improved clinical quality, patient experience, and outcomes of care throughout participation in the initiative. Applicants will be required to propose strong patient protections that preserve beneficiary choice in seeking care from the provider of their choice.

CMS will provide historical Medicare claims data to potential applicants planning to apply for Models 2-4 to enable potential applicants to develop well-defined episodes and discount proposals based on the experience of providers in the applicant's area. In order to be considered for receipt of data, applicants must submit a Research Study Protocol along with their letter of intent (LOI) and will later be expected to submit and comply with a Data Use Agreement (DUA). Both of these forms are available on the Bundled Payments for Care Improvement website.

For more information please refer to the RFA and application found at www.innovations.cms.gov or email at BundledPayments@cms.hhs.gov.

CMS Provides Guidance on 5010 Discretionary Enforcement Period for Medicare Fee-for-Service *Agency Answers Inquiries on Requirements To File 4010 Claims*

From NAHC Report

Medicare Fee-for-Service (FFS) announced earlier this month its plan for the 90-day Discretionary Enforcement Period for non-compliant HIPAA covered entities.

According to that announcement, the Centers for Medicare and Medicaid Services (CMS) provided a 90-day discretionary period for compliance with planned January 1, 2012, 5010 transaction set requirements. However, it was unclear whether CMS would continue to accept claims in the 4010 format during the discretionary period.

In response to inquiries, CMS provided the following Q&As to spell out requirements that must be met in order to qualify for continued submission of 4010 claims between January 1st and March 31st.

Q: Will submitters who have not tested 5010 be able to continue to submit 4010 claims after January 1st while their transition plan is being reviewed by the MAC and if the plan is approved how much grace time will they be granted?

A: Submitters who have not tested will need to submit their transition plan within 30 calendar days of the date of the notice from the MAC. Those who submit a transition plan by the deadline will have until April 1, 2012 to complete their transition to the 5010 formats.

Q: What will happen if submitters don't submit a test plan? Will their 4010 claims be rejected as of the 31st day?

A: If no transition plan is submitted Medicare FFS may direct the Medicare Administrative Contractors (MACs) to reject 4010 claims. The MACs have not been directed to reject 4010 claims at this time.

Q: Is Medicare going to release information about exactly what a compliance plan will look like?

A: Medicare will not specify the format of the transition plan. Submitters should outline the steps they have taken and the steps they still need to take to successfully achieve compliance.

Q: Are the 30 day deadlines stated in the Medicare FFS announcement working or calendar days and does the 30 day clock start with notification or on January 1?

A: The thirty day deadlines are calendar days and the 30 day clock starts with the date of the notification from the MAC.

Q: Will the MACs be able to accept a mix of 5010 and 4010 claims during the grace period?

A: Yes, MACs will be able to accept a mix of 5010 and 4010 claims during the 90 day non-enforcement period.

Q: Who notifies providers that submit directly? What is the difference between a submitter and a provider?

A: The MACs notify providers that submit directly. A submitter is a clearinghouse, vendor or biller that submits to Medicare on behalf of one or more providers. The Medicare 90 Day Discretionary Enforcement announcement requires submitters to test with their MACs, submitters to take action in regards to this plan and submitters to send it their transition plans. Medicare has developed the incremental steps in this plan to support the provider's efforts in working with their submitters.

Note: Although Medicare Fee-for-Service will accept 4010 claims during the 90 day discretionary period if the transition plans are submitted, other payers have announced plans to accept 5010 only and to reject all 4010 transactions.

Winter Driving

Are Your Vehicles Ready for Winter?

By John Schaper, Enterprise Fleet Management

No matter how we may long for the warm days of summer, winter has arrived. Whether its snow, sleet, ice or rain, you don't want to be caught unprepared when it comes to your vehicles. A little effort on your fleet now can save you a lot of time and money down the road. Even in areas where the climate does not fluctuate very much, it is still a good idea to take advantage of seasonal changes to keep the company fleet in good shape.

Business owners and fleet managers who make sure their vehicles are ready for winter can drive down costs while increasing the operating efficiency of their fleet. With routine maintenance, a company's fleet can become one of the most controllable expenses, especially for companies with mid-size fleets that depend on every vehicle operating at peak capacity. According to the experienced mechanics and accredited Automotive Service Excellence (ASE) technicians at Enterprise Fleet Management, a good place to start is by following some simple maintenance tips:

- **Winter Check**. Inspect wiper blades and make sure windshield washers are working and washer fluid reservoirs are full. Check each vehicle's battery for load capacity and the electrical/charging system for proper operation to avoid getting stranded. Also, check all belts and hoses for softness and wear.

- **Oil Changes**. Most people know that a vehicle's oil should be changed at certain mileage intervals. Intervals for vehicles that idle for long periods of time, such as service or delivery vehicles, should also be measured using hours of running time. For vehicles that spend more time idling than driving, a general rule of thumb is change the oil every 200 hours of engine operation.

- **Transmission Maintenance**. Electronically controlled transmissions require more maintenance to continue operating at peak efficiency. A rule of thumb is to change the transmission filter and fluid every 30,000 miles or less for vehicles hauling heavy loads, pulling trailers, or doing mostly stop-and-go driving. Check the owner's manual for specific intervals for your vehicles and always use the correct type of transmission fluid recommended by the manufacturer. Under certain conditions, such as a major internal component failure, it may be cost effective to replace the entire transmission with a unit remanufactured by the vehicle manufacturer. A remanufactured transmission generally offers better reliability and a longer warranty, and the vehicle can be taken to any appropriate dealer for the repairs, eliminating the trouble of seeking out a shop for future repairs.

- **Warranty Repairs**. Failing to adhere to specific use and preventive maintenance guidelines established by the manufacturer may jeopardize your warranty coverage. Check your vehicles owner's manual to ensure you are keeping up with necessary preventive maintenance checks.

- **Filter Changes**. Replace the oil filter, air filter, fuel filter, automatic transmission filter and crankcase filter at regular intervals to prolong the service life of the vehicle and lower repair costs. Consult your owner's manual or fleet services company for information on the correct intervals for specific vehicles.

- **Tire Replacement**. Match dimensions indicated on the tire information decal for new tires. This will help avoid inaccurate speedometer/odometer readings, ABS brake

malfunctions and multiple engine and transmission errors. If a vehicle's tires reach 3/32 of an inch or less in tread depth, it's a sign to replace them. Some vehicles with all-wheel drive require replacement of all tires at the same time because of potential driveline problems. Consult your owner's manual or fleet services company to determine if this is the case with your vehicles.

- **Tire Maintenance**. Use a quality air pressure gauge to check pressure at least once a week. Correct tire pressure helps extend tire tread life and gas mileage and contributes to good traction and handling. Incorrect tire pressure can lead to premature tire wear, lessened fuel economy or possible tire failure up to and including a blowout. Rotation of the tires, recommended every 10,000 miles, will also extend the tire life further. This is especially true for front wheel drive vehicles.

- **Engine Oil**. Always use equivalently rated API (Automotive Petroleum Institute) oil that is recommended by the vehicle manufacturer. This will ensure proper protection of vital engine components at all temperatures and running speeds, assist in starting on cold days and help you get the most from your vehicle.

- **Gasoline Selection**. The gas you choose can directly affect fleet cost and vehicle performance. When choosing a grade or octane of fuel for your company's vehicle, consult your owner's manual. Gasoline that is too low in octane can drastically affect vehicle performance, while gasoline that is too high in octane can drive up expenses unnecessarily.

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John Schaper is an Account Executive for Enterprise Fleet Management in Missouri and can be reached at 314-889-8528. John is supported by an experienced team of veteran mechanics and accredited Automotive Service Excellence (ASE) technicians to serve the fleet maintenance needs of businesses with mid-size fleets. In addition to maintenance management programs, Enterprise's services include vehicle acquisition, fuel management and insurance programs, as well as vehicle registration, reporting and remarketing. Visit the company's web site at www.efleets.com or call toll free 1-877-23-FLEET.

Accountable Care Organizations (ACO's) – Why Hospitals Need Post-Acute Providers

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Section 302 of the Affordable Care Act (ACA) includes provisions related to Medicare payments to providers of services and suppliers that participate in Accountable Care Organizations (ACO's). Providers of services and suppliers who participate in ACO's will

continue to receive payments under Parts A and B of the Medicare Program, but will also be eligible for additional payments if they meet certain requirements related to quality of care and cost savings. The Secretary of the U.S. Department of Health and Human Services has published final regulations establishing ACO's as early as April, 2012.

As indicated above, ACO's will share in cost savings if they meet performance standards for both quality of care and cost savings. Specifically, there are thirty-three required quality measures for use in establishing performance standards that ACO's must meet in order to share in savings for at least the first year of three years.

Performance criteria include measures related to Care Coordination/Patient Safety as follows:

Risk-Standardized, All Condition Readmissions

Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease – AHRC Prevention Quality Indicator (PQI) #5

Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure – (AHRC Prevention Quality Indicator (PQI) #8

Medication Reconciliation: Reconciliation After Discharge From an Inpatient Facility

Falls: Screening for Fall Risk

Hospital discharge planners/case managers will undoubtedly play a key role in achieving success on the above performance measures. In order to succeed, they must establish and maintain effective working relationships with post-acute providers of all kinds who can assist them to meet the above goals. The crucial role of post-acute providers to the success of ACO's must be immediately recognized and acted upon by providers that wish to establish them.

Disaster Prep Training Opportunity

The MO office of Homeland Security, Texas Engineering Extension Service, St. Louis County EMA, and the St. Louis County Dept of Health are sponsoring a disaster preparedness training program for hospitals and health care organizations. The class is limited to 40 participants and is being held July 18 – 19, 2012. If you are interested, complete the application and follow the directions to submit your application. The application is available at: http://www.homecaremissouri.org/mahc/documents/1-11-12OHSBlankStudentEnrollmentApplicationform.pdf . The announcement is available at: http://www.homecaremissouri.org/mahc/documents/1-11-12MGT341DisasterPreparednessTraining.pdf

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