MEDPAC CUTS

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The Situation REPORT

HCA HOME CARE ASSOCIATION OF NEW YORK STATE

Your Source for HOME CARE News, Policy and Advocacy Vol. 4, Issue 25| June 24, 2019

UPCOMING PROGRAMS

PDGM Bootcamp For Clinical Managers and Quality Staff
July 11
(Suffern, NY)

Blueprint for OASIS Accuracy – OASIS D Data Set

September 23-24 (Workshop);
September 25 (Optional COS-C Exam) in NYC

***Editor's note**: HCA will resume our schedule of biweekly summer newsletters afTer next week's edition. There will be no editions on July 8, July 22, August 5 and August 19. We will alert you, as always, by e-mail for breaking news.*

The State Legislature Adjourns with Passage of HCA In-Service, Sepsis Bills

The state Legislature extended its session past Wednesday's scheduled adjournment date to close a string of priorities, including rent control, a bill replacing criminal penalties with fines for possessing small amounts of marijuana (but no agreement on out-right legalization), protections for farm workers, and other measures that passed in the eleventh hour.

Two HCA bills cleared both houses with votes in the Assembly last week, following earlier passage in the Senate. They include HCA's aide in-service tracking bill and our sepsis legislation, the first of its kind in the nation. (Read our report on bills that passed both

See BILLS p. 4

HCA Hospice Comments Take on RHC Cuts, Wage Index Irrationalities, Proposed Changes to Election Statement & More

In comments to the U.S. Centers for Medicare and Medicaid Services (CMS) last week, HCA targeted major concerns with the proposed Medicare hospice payment methodology, limits on the Service and Intensity Add-on (SIA), and continued inconsistencies and irrationalities in the hospice wage index. We also offered recommendations to scale back some of the new cost-sharing and coverage notification requirements proposed for the hospice election

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INSIDE

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statement. And we provided a statement on baseline considerations for any new payment model in hospice, in response to a CMS Request for Information on the subject, noting that: "Great care should be taken in ensuring that new payment models are consistent with the tenets of hospice – i.e., holistic, cross-setting and interdisciplinary care – and sensitive to differences in the durational and spiritual dimensions of this care modality, as distinct from other settings where payment experiments have different stakes, outcomes and purposes."

HCA has reported on the CMS proposal and issues in previous editions of the *Situation Report*. Our comments address many of those core issues, most notably CMS's decision to reduce payments for Routine Home Care (RHC) as a "budget-neutrality" correction for rebasing the Continuous Home Care (CHC), Inpatient Respite Care (IRC) and General Inpatient Care (GIP) rates with upward adjustments.

We point to specific data gaps at the root of CMS's proposed rebasing and RHC cuts. RHC, which would be cut by 2.71 percent, accounts for the vast majority of home care services, while the upward rate adjustments for largely institution-based services may otherwise be absorbed by contract costs, we note.

CMS based its proposed payment decisions on cost report accounting that even CMS says is in need of improvement. The agency has said that as many as 66 percent of cost reports would not meet the higher standards for data accuracy (and would thus be rejected) under Level I edits that are now under consideration. "CMS should wait on any rebasing actions until accounting changes (including possible new Level I edits) are reflected in the cost report data that CMS has already suggested is inadequate to accurately account for costs," we note. "The Level I cost report edits, now under consideration, will require several hospice providers to address existing gaps in data collection and allocate costs more appropriately to better inform their own financial management as well as CMS's rate determinations."

We add: "At a time when the average hospice operating margin (based on net patient revenue) is negative-16.57 percent in New York State, HCA is concerned about the financial toll of such

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reductions to RHC, even considering CMS's assurances of budget neutrality."

Meanwhile, our wage index comments again point to irrationalities in the methodology, such as the inclusion of New Jersey townships in the New York City Metropolitan statistical area used for the wage index, which artificially drives wage reimbursement downward for New York providers by including a less costly market in the calculation. Similar inconsistencies are embedded throughout the wage index.

In addition, CMS is proposing significant and impractical changes to the hospice election statement by requiring: 1) notification to beneficiaries about cost-sharing and potential non-covered services; as well as 2) the availability of an addendum containing a list and rationale for the conditions, items, services, and drugs that the hospice has determined as unrelated to the terminal illness and related conditions.

"Not all outside spending is within the control of the hospice," we note. "Hospice providers in New York and around the country have indicated that it can sometimes take upwards of nine days for a hospice notice of election to process through the CMS software systems so that non-hospice providers have access to the information, are aware of hospice coverage, and know the implications on hospice of furnishing non-covered items or services."

We call for specific changes in this proposal as well as a delay in the implementation date for any new election statement – no earlier than January 1, 2020, and not October 1, 2019 – since hospices need time to develop not only a form for a list of unrelated diagnoses but also the processes for dissemination of the form and any accompanying literature.

Members can download HCA's comments at https://tinyurl.com/y3nmpprs.

▾ **BILLS from p. 1**

houses, one house or which remain in committee in a table here: https://tinyurl.com/y49uu565.)

HCA also participated in a hard push for transformation fund investment in home care and community care, holding a press conference and media outreach, along with representatives from 20 other community-based provider associations and Assembly Health Committee Chairman Richard Gottfried on A.7977A/S.6376.

That bill would have assured a minimum of 25 percent of transformation funds are dedicated to community-based providers, including home care. Earlier this year, $675 million of such funds – budgeted from an assessment on the conversion of Fidelis Care to Centene – were used for a Medicaid rate increase to hospitals and nursing homes across New York; but no such funding has yet been dedicated to community care providers.

HCA's Director for Public Policy and Advocacy Alyssa Lovelace addresses reporters at a news conference in support of A.7977A/S.6376, sponsored by Senator Gustavo Rivera and Assembly Member Richard Gottfried, who joined advocates speaking in favor of the bill (second from right). The legislation, pursued by a coalition of 21 associations representing community based organizations, calls for a minimum 25 percent of health care transformation funds (in an existing account) for community care providers.

The coalition's press outreach was covered by *Politico New York*, *Crain's Health Pulse* and the *Albany Times Union*. Members can read the coalition's press release at https://hca-nys.org/press-releases/21-organizations-urge-immediate-action-on-community-care-investment-bills. HCA had also created a messaging campaign for our members and the coalition to use in support of this bill, through our *Legislative Action Center*, which netted over 1,200 letters sent to legislators from participants across community-based sectors.

Although not passed prior to adjournment, the legislation gained important ground for the next state budget thanks to a hard push from advocates and strong sponsorship. Very important progress was made on this bill to give legislative direction to otherwise discretionary funding decisions that now reside with the Executive as a result of the state budget agreement.

The in-service bill (S.5605/A.7854), sponsored by Assemblyman Gottfried and Senate Health Committee Chairman Gustavo Rivera, was recommended by HCA members to ease agency administration and compliance via the submission and tracking of mandatory annual in-service hours for home health aides and personal care aides in the Home Care Worker Registry. This achievement shows classically how HCA members and HCA policy experts combine talents to improve home care programming.

Our sepsis legislation, S.1817 (Rivera)/A.3839 (Assemblyman John McDonald), would be a national-first legislative vehicle to make sepsis programming developed by HCA a constituent part of Article 36, recognizing that, far from only a hospital problem, 80 to 90 percent of sepsis cases presented in hospitals actually originate in the community setting. It would specifically buoy the state Department of Health's action in support of home care sepsis interventions in numerous ways, including: clinician training on the sepsis screening tool pioneered by HCA; integration of screening data and outcomes within electronic health records; and authority to approve funds for supporting home care sepsis intervention goals through grants or rate supplements. HCA sent a press release with quotes from both bill sponsors (https://hca-nys.org/press-releases/ny-legislature-passes-nations-first-sepsis-education-and-support-initiative-for-home-care) that gained traction in the overall reporting about

session's end, including a segment on WRGB News Channel 6 which you can view on HCA's YouTube at https://youtu.be/3qTExmIe3QI.

On the eve of the bill's passing, HCA also connected HCA Board Member Amy Bowerman, RN BSN, with the health reporter at the Utica Observer-Dispatch, which covers the region where Ms. Bowerman serves as Executive Director at MVHS-Senior Network Health. A report in today's edition of the paper, "Local nurse helped launch sepsis program adopted statewide," describes HCA's program, the new legislation that will support it, and Ms. Bowerman's fundamental role as the lead HCA clinician in the development of HCA's tool. You can read the article at https://tinyurl.com/yylt7hdy.

Bills that pass both houses must be delivered to the Governor to be acted upon.

HCA greatly appreciates the work of bill sponsors to shepherd these important measures through the process and standing with us on messaging. Thousands of bills are advanced each legislative session, and the passage of two HCA priority measures sets a strong milestone for home care support, along with the introduction of other HCA measures on rate stabilization, workforce support and public health and disparities this session that set a solid foundation for the next stages of the budget process and legislative strategy going forward.

HCA will soon be providing the membership with a more detailed summary of the session outcome and other bills that affect home care and health care.

For questions, please contact Alyssa Lovelace at alovelace@hcanys.org.

MedPAC Calls for New Payment System, Rate Cut for Home Health

The Medicare Payment Advisory Commission (MedPAC) has issued its annual Report to Congress titled "Medicare and the Health Care Delivery System," which examines a variety of Medicare payment system issues.

As long-discussed, the report proposes a possible unified payment model for four post-acute care (PAC) providers, including home health agencies, as well as recommending a five-percent rate cut for Medicare home health payments.

The full report is available at: http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.

MedPAC considered an episode-based design for post-acute payment, but rejected it on the grounds that it "would result in large overpayments for relatively short episodes and underpayments for long ones." Instead,

MedPAC "believes that a stay-based design is the better initial strategy for the U.S. Centers for Medicare and Medicaid Services (CMS) to pursue."

Expanding on this, the report noted that past provider behavior "suggests that some providers would respond to the financial incentives by avoiding beneficiaries who would likely require extended PAC and by basing treatment decisions (such as whom to admit and when to discharge or transfer a patient) on financial considerations rather than what is best for the beneficiary."

Under the stay-based design favored by MedPAC, the payment-to-cost ratio of home health services would be reduced from 1.18 to 1.12, resulting in about a five-percent rate cut. (A 1.0 to 1.0 ratio would result in providers receiving one dollar for every one dollar of care they provided.)

The Commissioners listed the benefits of a stay-based design:

- Payments are aligned with costs for most patient groups;
- Less likely to result in stinting on care if provider can generate additional stays;
- Streamlines four Prospective Payment Systems (PPSs) to one;
- Easier for CMS to implement;
- Involves less change for providers;
- Encourages shorter stays; and
- Should result in more handoffs to other providers.

Therefore, the Commission recommends a stay-based payment system combined with "a value-based purchasing (VBP) policy that includes sufficiently large rewards and penalties to influence provider behavior," and "strengthening incentives for entities that take on the financial risk for all of the care received by their beneficiaries – specifically, accountable care organizations (ACOs)."

The report also noted that in 2016, about 43 percent of Medicare fee-for-service (FFS) patients discharged from an acute care hospital were discharged to PAC, and, in 2017, the program spent about $60 billion across the following four PAC settings: home health, skilled nursing facility, inpatient rehabilitation facilities and long term care hospitals.

The report has twelve chapters including the following that may also be of interest to HCA members:

- Beneficiary enrollment in Medicare: Eligibility notification, enrollment process, and Part B late-enrollment penalties;
- Ensuring the accuracy and completeness of Medicare Advantage encounter data;
- Redesigning the Medicare Advantage quality bonus program;
- Payment issues in post-acute care; and
- Promoting integration in dual-eligible special needs plans.

The various MedPAC reports, issued each year, are non-binding. These reports reflect advisory recommendations that would require legislation from Congress and/or administrative action from CMS.

HCA has long challenged the underlying assumptions of MedPAC's data analysis, in position papers to Congress and in our direct advocacy with both MedPAC and CMS.

HCA's federal advocacy efforts with Congress have sought to counter many of MedPAC's home health recommendations, including reductions in home health payments, and we will continue to focus our activities in this area.

MEETINGS & DEADLINES

Requirement/Change/Meeting	Effective/Due Date	More Information
Fiscal Intermediary Workgroup meeting	June 26, 2019, 11 a.m. to 2 p.m.	akoski@hcanys.org
Nassau County Health & Medical Multi-Agency Coordinating Group (Emergency Preparedness) meeting	June 27, 2 to 4:30 p.m.	nfischer@nassaucounty.ny.gov
Electronic Visit Verification (EVV) Public Listening Session in Lake Placid	June 27, 2019, 1 to 4 p.m.	https://www.eventbrite.com/e/lake-placid-electronic-visit-verification-evv-regional-listening-session-registration-61174344110
Revised Home Health Change of Care Notice (HHCCN)	July 1, 2019	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HHCCN.html
EVV Public Listening Session in New York City	July 9, 2019, 1 to 4 p.m.	https://www.eventbrite.com/e/nyc-electronic-visit-verification-evv-regional-listening-session-registration-63108415971
Fiscal Intermediary Workgroup meeting	July 10, 2019, 11 a.m. to 2 p.m.	akoski@hcanys.org
EVV Public Listening Session via webinar	July 11, 2019, 6 to 9 p.m.	https://www.eventbrite.com/e/electronic-visit-verification-evv-regional-listening-session-webinar-tickets-63563471053
EVV Public Listening Session in Buffalo	July 17, 2019, 1 to 4 p.m.	https://www.eventbrite.com/e/buffalo-electronic-visit-verification-evv-regional-listening-session-tickets-63561169168
EVV Public Listening Session in Syracuse	July 18, 2019, 1 to 4 p.m.	https://www.eventbrite.com/e/syracuse-electronic-visit-verification-evv-regional-listening-session-tickets-63561282507
Interoperable Communications Drill Webinar	July 23, 2019, 1 to 2 p.m.	https://meetny.webex.com/meetny/j.php?MTID=m723113b30ca6e58d5355e043d4e40cdf
EVV Public Listening Session via webinar	July 24, 2019, 9 a.m. to 12 p.m.	https://www.eventbrite.com/e/electronic-visit-verification-evv-regional-listening-session-webinar-registration-62614410387
CHHA Cost Report Due	July 29, 2019	https://commerce.health.state.ny.us/public/hcs_login.html; CHHA-Rates@health.ny.gov
Interoperable Communications Drill Webinar	July 30, 2019, 1 to 2 p.m.	https://meetny.webex.com/meetny/j.php?MTID=mde10f4cb2c8638945550a240a130549c
Fiscal Intermediary Workgroup meeting	August 7, 2019, 11 a.m. to 2 p.m.	akoski@hcanys.org
Emergency Preparedness Coalition of Manhattan (EPCOM) meeting	August 7, 2019, 12 to 1:30 p.m.	Caitlin.Flynn@nyulangone.org
Comments due on CMS Request for Information on Regulatory Relief	August 12, 2019	https://www.cms.gov/newsroom/press-releases/cms-seeks-public-input-patients-over-paperwork-initiative-further-reduce-administrative-regulatory
Personal Care Cost Report	August 27, 2019	https://commerce.health.state.ny.us/public/hcs_login.html; PersonalCare-Rates@health.ny.gov
Transition Period for Using Health Insurance Claim Number (HICN) or new Medicare Beneficiary Identifier (MBI)	April 1, 2018 to December 31, 2019	https://www.cms.gov/Medicare/New-Medicare-Card/index.html
Changes in MLTC-LHCSA Contracting Limits	October 1, 2019	https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policy/lhsca_contract_guidance.htm
Medicare will only accept claims submitted with the Medicare Beneficiary Identifier (MBI)	January 1, 2020	https://www.cms.gov/Medicare/New-Medicare-Card/index.html

FI Workgroup to Meet Wednesday Amid Core Payment Issues

On Wednesday, HCA will be participating in the second meeting of the Fiscal Intermediary (FI) Workgroup, of which HCA is a member.

The Workgroup is charged with discussing many issues, including FI best practices, new criteria for selecting and contracting with entities for FI services, FI quality measures and transition plans for consumers who switch FIs. A major issue outside of the group's purview – but of core concern to plans and FIs – is the proposed Per Member Per Month (PMPM) payment for FI administrative expenses.

HCA had a conference call with the state Department of Health (DOH) recently on this issue to discuss whether or how plans' PMPM premiums would be adjusted to account for the reduction in FI administrative expenses. These discussions remain fluid and will continue to be addressed in HCA outreach to the Department as we raise concerns about rate adequacy across the continuum of payors and FIs.

At the first meeting of the FI Advisory Group, DOH agreed to discuss the FI administrative proposal at the second meeting. HCA will keep members updated on the proceedings of the Workgroup, including anything new related to PMPM or other financing issues that occur as a result of Wednesday's meeting or other formative discussions with the Department.

Legislature Passes Major Changes to Harassment Laws

Jackson Lewis, HCA's legal counsel, has published an article online summarizing measures passed this state legislative session to lower the standard of review for sexual harassment cases and other provisions.

Governor Cuomo is expected to sign the bill (S.6577/A.8421) and a related amendment (S.6594/A. 8424).

The legislation removes the so-called "severe and pervasive" standard, making it an unlawful discriminatory practice for an employer to subject an employee to harassment "regardless of whether the harassment would be considered severe or pervasive under precedent applied to harassment claims."

The measures also:

- Eliminate the defense that an employee didn't follow internal procedures;
- Allow courts to award punitive damages in all cases of employment discrimination claims involving private employers;
- Expand the 2018 prohibition on non-disclosure agreements (NDA) in sexual harassment settlements to apply to all discrimination and harassment claims, unless it is the plaintiff's preference to enter into an NDA;
- Extend the statute of limitations to three years for sexual harassment claims;

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- Expand arbitration clause prohibition; and
- Expand sexual harassment policy requirements.

HCA members should read the article online to determine follow-up actions with regard to your policies and procedures in consultation with your organization's counsel. Read the article at: https://www.jacksonlewis.com/publication/new-york-expands-harassment-laws.

Managed Care Providers Not Enrolled in Medicaid to be Terminated

Providers who contract with managed care organizations (MCOs) and have not enrolled in Medicaid will face termination of their contracts.

This is due to federal legislation (21st Century Cures Act) – reported by HCA in many articles – that requires all Medicaid Managed Care and Children's Health Insurance Program network providers to be enrolled with state Medicaid programs.

While the requirement was effective January 1, 2018, the state has been working with the U.S. Centers for Medicare and Medicaid Services and providers to implement this change.

The state Department of Health (DOH) instructed MCOs on May 10 to begin the termination process for those providers whose termination would not cause access-to-care deficiencies. MCOs are required to give providers 60 days of prior written notice of termination and the right to request a hearing or review.

An update on this issue is at https://www.emedny.org/info/ProviderEnrollment/ManagedCareNetwork/Century_Cures_Act_Update_-_6-18-2019.pdf.

More information on this requirement, including a link to those providers who have enrolled in Medicaid, is at https://www.emedny.org/info/ProviderEnrollment/ManagedCareNetwork/index.aspx.

No Registration Needed for IOC Drill Webinars

The state Department of Health (DOH) has clarified that no registration is required to participate in the webinars it will hold in July to help home care and hospice agencies outside of New York City prepare for an Interoperable Communications (IOC) drill to be held at some unannounced time in August.

You can access the webinar of your choice using the links below on the day of the program:

- July 23 webinar (https://meetny.webex.com/meetny/j.php?MTID=m723113b30ca6e58d5355e043d4e40cdf)
  Meeting Number: 644 122 680
  Meeting Password: welcome2
- July 30 webinar (https://meetny.webex.com/meetny/j.php?MTID=mde10f4cb2c8638945550a240a130549c)
  Meeting Number: 649 589 371
  Meeting Password: welcome2

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The objectives of the IOC drill are to demonstrate the ability to use a primary and back-up communication system to communicate with coalition partners and complete a Health Commerce System (HCS) Health Emergency Response Data System (HERDS) survey within a specified timeframe.

The drill, though voluntary, can be used to fulfill federal and/or state requirements for agencies to hold emergency preparedness exercises.

For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcanys.org; or Alyssa Lovelace at (518) 810-0658 or alovelace@hcanys.org.

House Passes Longer-Term Extension of MFP, Spousal Protections

The U.S. House of Representatives passed legislation last week (H.R. 3253) extending for four-and-a-half years the Money Follows the Person (MFP) initiative, which is intended to help Medicaid recipients transition from a nursing home or institution back into the community.

The bill, which was previously extended on a short-term basis in February, also extends Medicaid Spousal Impoverishment Protections for the same period. These provisions allow for the protection of a large portion of a couple's income and resources when one spouse needs Medicaid long-term care at home similar to the protections afforded couples when one spouse must enter an institution.

MFP allows certain Medicaid recipients to more seamlessly transition from a nursing home or institution back to a home setting. To be eligible, participants must be Medicaid beneficiaries residing in an institution for 90 days or more who then move to a "qualified residence in the community." Once enrolled, the beneficiary is eligible for qualified home and community-based Long Term Services and Supports, among other services. The program began in 2005 and has supported an estimated 88,000 individuals.

As noted in last week's newsletter, the state has posted a Request for Applications (RFA) related to MFP. Its intent is for a single vendor to administer a statewide Transition Center infrastructure, providing education about community living options, transition assistance, peer outreach and support, and education and outreach to nursing homes to support the transition of individuals from institutional to community-based settings.

Also, a new proposed regulation in *the State Register* would codify the roles and responsibilities of nursing home facilities to ensure that individuals know their right to receive services in the least restrictive setting, including work with MFP program transition specialists to assist individuals that wish to return to the community.

HCA will report back to the membership on any action in the Senate on this measure.

TBI HCSS Rates Posted

The Traumatic Brain Injury (TBI) home and community support services (HCSS) rates for January 1, 2018 and January 1, 2019 are now posted to eMedNY.

The announcement is in a memorandum at https://hca-nys.org/wp-content/uploads/2019/06/TBI-Waiver-Minimum-Wage-Billing-Guidance-FINAL.pdf.

As presented in the approved April 10, 2019 1915(c) waiver amendment, these rates reflect an adjustment for the state minimum wage law (inclusive of wage parity requirements in the NYC region), which is added to the Fair Labor Standards Act (FLSA) adjustment that was previously provided to TBI providers. In order to implement these rates, four new rate codes are now assigned to an agency's TBI Waiver Medicaid Management Information System (MMIS) ID.

TBI HCSS will no longer be billed under rate code 9863. Instead, the memorandum includes four new rate codes which will be used based on the waiver participant's county of residence.

Rate code 9863 will continue to be active for a period of time while the state resolves all the retroactive payment issues associated with these rate increases, but providers are told they should **cease using rate code 9863 immediately**.

With respect to claims already submitted under rate code 9863, going back as far as January 1, 2018, a provider will have two options to adjust the claims: 1) agencies may adjust each 9863 claim by changing the rate code to the appropriate one of the four new rate codes using the locator code and zip+4 criteria; or agencies can do nothing and wait for DOH to adjust the 9863 claims back to January 1, 2018, using the eMedNY "special input" process.

Additional information regarding the timetable for these adjustments is forthcoming.

Questions can be submitted to alan.maughan@health.ny.gov.

HCA Memo on NGS Home Health Advisory Updates

HCA's Vice President for Finance and Management Patrick Conole has prepared a policy memo containing updates from a recent home health advisory meeting with National Government Service (NGS), the Medicare Administrative Contractor (MAC) for New York State.

The meeting yielded key updates on: upcoming NGS education; the substance of Medicare appeals letters in the case of an unfavorable determination; medical review and appeals data; Comprehensive Error Rate Testing (CERT) results; and more.

Download the memo at https://hca-nys.org/wp-content/uploads/2019/06/062019NGSHomeHealthMemo.pdf.

Election Leave Notices Must Be Posted

Given the upcoming election primaries, HCA reminds members that they must post a notice of an employee's right to have up to three hours to vote without loss of pay under a provision in the final state budget.

Employers must post the notice at least 10 days before an election. Since primaries are on June 25, 2019, that notice was supposed to be posted on **June 15.**

Under this budget provision, employers must allow employees to take time off to vote at either the beginning or the end of a working shift, as the employer may designate, unless there is a different mutually agreed time; and employees who need time off to vote must give their employers at least two working days' notice of the intent to take leave.

More information, including a model notice, is at https://www.elections.ny.gov/NYSBOE/elections/AttentionEmployees.pdf.

Rule Proposed on Workers' Compensation Board-Authorized Providers

Due to a provision in the 2019-20 State Budget, starting January 1, 2020, licensed clinical social workers, nurse practitioners and acupuncturists, as well as current ancillary providers, including physician assistants, occupational therapists and physical therapists, may apply to become a Workers' Compensation Board (WCB)-authorized provider.

To implement the new law, the Board is proposing a new regulation (12 NYCRR 323.1) that describes the process for applying for Board authorization to treat injured workers. Also proposed are amendments to Part 324 and 325-1.4 to integrate the new providers into the Medical Treatment Guidelines variance (Attending Doctor's Request for Approval of Variance and Carrier's Response: Form MG-2) and prior authorization (Attending Doctor's Request for Authorization and Carrier's Response: Form C-4AUTH) processes.

The proposed regulation and amendments are in the June 19, 2019 *State Register* (https://www.dos.ny.gov/info/register/2019/jun19.pdf). Public comments will be accepted for 60 days through August 18, 2019, and may be sent to regulations@wcb.ny.gov.

Settlement Conference Facilitation Renewed

The National Association for Home Care and Hospice (NAHC) reports that the U.S. Department of Health and Human Services (HHS) has renewed its Settlement Conference Facilitation (SCF) program.

The SCF is available to all Medicare Part A and Part B providers and suppliers with appeals pending at the Administrative Law Judge (ALJ) or the Medicare Appeals Council (Council) level. The appeals must have been filed on or before **March 31, 2019**.

A facilitator uses mediation principles to assist the appellant and the U.S. Centers for Medicare and Medicaid Services (CMS) in working toward a mutually agreeable resolution. The facilitator does not make

official determinations on the merits of the claims at issue and does not serve as a fact finder, but may help the appellant and CMS see the relative strengths and weaknesses of their positions.

Information on SCF eligibility criteria and the SCF process, along with forms and frequently asked questions, can be found at https://www.hhs.gov/about/agencies/omha/about/special-initiatives/settlement-conference-facilitation/index.html.

Guidance Issued on Medicaid Program Integrity

The U.S. Centers for Medicare and Medicaid Services (CMS) has issued guidance to state Medicaid agencies that outlines the necessary assurances that states should make to ensure that program resources are reserved for those who meet eligibility requirements.

The guidance is at https://www.medicaid.gov/federal-policy-guidance/downloads/cib062019.pdf.

The guidance discusses mutual obligations and accountability on the part of the state and federal governments for the integrity of the Medicaid program and the program safeguards necessary to ensure proper and appropriate use of both federal and state dollars, particularly with respect to coverage of the Medicaid adult expansion group (adults age 19 or older and under the age of 65 with household incomes at or below 133 percent of the federal poverty level) and for other expenditures that are claimed at an enhanced federal matching rate.

Included in the guidance is a program readiness checklist to help states make accurate eligibility determinations and ensure appropriate financial claiming on an ongoing basis. The checklist can assist states in preparing for potential audits and/or program reviews.

The following are highlights of the components of this program readiness checklist:

- Development of necessary program integrity expectations for contractors;
- Implementation of appropriate system and financial oversight controls;
- State plans that continually assess the ongoing accuracy of eligibility determinations and claiming of federal funding; and
- State eligibility systems that are capable of, and ready to submit, required performance indicator data to CMS, including information regarding the timeliness and accuracy of eligibility determinations.

Providers Required to Submit New MOA with Livanta

Home care and hospice providers are required to submit a new Memorandum of Agreement (MOA) with Livanta, the Medicare Quality Improvement Organization.

The MOA, along with other helpful information, is at https://www.livantaqio.com/en/provider/moa.

Agencies need to complete and sign an MOA for each U.S. Centers for Medicare and Medicaid Services (CMS) Certification Number (CCN) under which they operate. You may list multiple CCNs on a single MOA If

your organization has multiple CCNs but also has a central office that handles all record requests, appeals and QIO correspondence.

Under Medicare law, Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs, or QIOs) review patient medical records to determine whether services delivered to these beneficiaries meet professionally recognized standards of care, are medically necessary, and are delivered in the most appropriate setting.

In addition, these organizations conduct reviews generated by requests from Medicare beneficiaries that include appeals related to notices of discharge and/or notices of service terminations, and written complaints about the quality of Medicare services they have received.

While the MOA was supposed to be submitted by June 8, Livanta has advised us that it is still accepting the form.

Guidance Issued on Shortage of PPD for TB Skin Testing

On June 19, the state Department of Health (DOH) issued a health advisory on a shortage of purified protein derivative (PPD) solution for tuberculin skin testing (TST).

The Advisory is at https://hca-nys.org/wp-content/uploads/2019/06/Notification_101619-1.pdf.

DOH notes that it is important to maintain tuberculosis (TB) testing capability for persons at risk of tuberculosis. At this time, state regulations (NYCRR Title 10) still require serial TB testing for health care personnel in home care and hospice and various other clinical settings. However, DOH is temporarily recommending an adjustment to tuberculosis testing procedures for employee testing programs if institutions experience a shortage of testing products as defined in the advisory. For persons with appropriate baseline testing and no new risk for infection or disease on annual assessment, repeat testing can be deferred.

Please read the full advisory for further information about the requirements, the temporary recommendations and other protocols for TB screening.

Questions about TB testing or the DOH advisory can be directed to DOH's Bureau of Tuberculosis Control at (518) 474-4845 or tbcontrol@health.ny.gov.