Federal Policy Update
Home Health, Hospice and Palliative Care

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Hospice Payment Rates and Aggregate Cap

Hospice Cost Report Data Analysis

Total Cost Per Day by Level of Care FY2016

	Median Cost	Rate
Routine Home Care	$125	**$161.89**
Continuous Home Care (hourly)	$51	$39.37
Inpatient Respite	$343	$167.45
General Inpatient Care	$879	$720.11

Trends in Hospice Utilization

CMS Monitoring - Data

- Length of stay
- Live discharges
- Skilled visits in last days of life
- Non-hospice spending

Hospice Utilization

- $17.5 billion Medicare spending on hospice care
- Expected to grow 8 percent annually
- Central Budget Office (CBO)
    - all Medicare spending expected to grow 7% annually through 2028
    - 5% due to cost

Hospice Quality Reporting Program

HQRP Update

- No new measures
- Changes to public reporting
  - Removal of routine reporting of 7 HIS measures
  - Adding public use file (PUF) data to Hospice Compare
- Data review and correction timeframes for HIS data
- Extension of CAHPS Hospice Survey requirements
- Procedures:
  - Announce QM ready for public reporting
  - Public reporting timelines

Meaningful Measures

Improving Patient Outcomes and Reducing Burden Through Meaningful Measures

- CMS initiative: Patients Over Paperwork
- Aimed at identifying the highest priority areas for quality measurement and quality improvement in order to assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes

HQRP - Measures

Previous CMS Comments: Measure concepts under consideration

- Access to levels of hospice care
- Potentially Avoidable Hospice Care Transitions

  Live discharges

  - Shortly followed by death or acute stay
  - Comparison of performance to peers
  - Would be risk adjusted

- Claims-based measures

HQRP – Measures

Transitions From Hospice Care, Followed by Death or Acute Care

- Live Discharges followed by:
  - Death within 30 days
  - Acute care within 7 days
    - hospitalization/ER visit/observation
- CMS requested feedback recently

Comprehensive Patient Assessment Instrument

HEART – Hospice Evaluation & Assessment Reporting Tool

CMS currently in early stages of development of comprehensive patient assessment instrument tool

Tool would serve two primary objectives

- provide the quality data necessary for HQRP requirements and the current function of the HIS; and
- provide additional clinical data that could inform future payment refinements

Other

Physician Assistants Recognized as Attending Physicians

- PAs recognized as attending physicians
- January 1, 2019
- **PAs Cannot:**
  - Certify or recertify a hospice patient
  - Conduct F2F encounters
  - Fulfill the physician role on the Interdisciplinary Group (IDG)
- PA services reasonable and necessary for beneficiaries who elect the PA as their attending will be paid by Medicare at 85% of the physician fee schedule
- CR 10517/Transmittal 246: Chapter 9 Benefit Policy Manual Updates

Changes to Billing

CR 10573/Transmittal 4035 (April 2018)

- Effective 10/1/18
- Option to report aggregate monthly charges on claims for drugs, infusion pumps, and infusion drugs (may continue line-item reporting if desired)
- FISS will provide claim record info on days paid at high/low RHC rate

Hospital Discharges to Hospice

- Post Acute Transfer Policy - 10/1/18
- FY2019 Hospital payment rule – CR 10602/Transmittal 2094 (6/20/18):
  - Immediate discharge to hospice (hospitals use patient status code 50 or 51)
  - SAME DATE FOR Hospital discharge and hospice admit
  - HOSPITAL payment changed to per diem basis if hospital stay is 1 day or more shorter than geometric mean for DRG

  - MedPAC Study

Medicare Care Choices Model

- January 2016 - 2020
- Evaluate whether eligible Medicare and dually eligible beneficiaries would elect to receive supportive care services typically provided by hospice if they were able to also receive curative care, and
- Determine whether providing both palliative and curative care concurrently impacts care quality and patient and family satisfaction
- Approx. 100 hospices in two phases
- Approx. 1100 beneficiaries as of June 30, 2017
- Limited findings

Hospice Regulatory Relief

MLN Article SE18007

- Submitting Notices of Election via Electronic Data Interchange
- Correcting Election or Revocation Dates using Occurrence Code 56
  - Note that these correction processes only apply to election or revocation dates on and after January 1, 2018.
- New Election Period File and Screen
- Making Changes to Election and Benefit Periods

Hospice Regulatory Relief

Hospice "Safe Disposal of Unused Medication Act"

- Physician, PA, nurse or other person licensed to provide medical or nursing services may dispose onsite following death of patient or if drug expired
- DEA-registered physician who is treating patient may dispose of drugs when care plan changes
- "Disposers" must be trained by hospice

Hospice Regulatory Relief - Proposed

Proposed Changes to Hospice CoPs:

- Eliminate requirement at 418.76 that state licensure include aide competency or aide training/competency requirements
- Eliminate requirement at 418.106(a)(1) that hospice employ or contract with expert in drug management
- Modify requirement at 418.106(e)(2) to provide written policies and procedures regarding drug use/disposal (eliminate hard copy)
- Modify 418.112(f) such that method for ensuring SNF/NF staff orientation can be agreed upon through hospice/facility agreement

Hospice Regulatory Relief - Proposed

Emergency Preparedness:

- Biannual* review of emergency preparedness program
- Eliminate requirement to document efforts to contact local tribal, regional, state, federal officials and participation in collaborative/cooperative planning efforts (process for cooperating/collaborating as part of EP plan still required)
- Biannual* training
- Changes to testing requirements – outpatient and inpatient

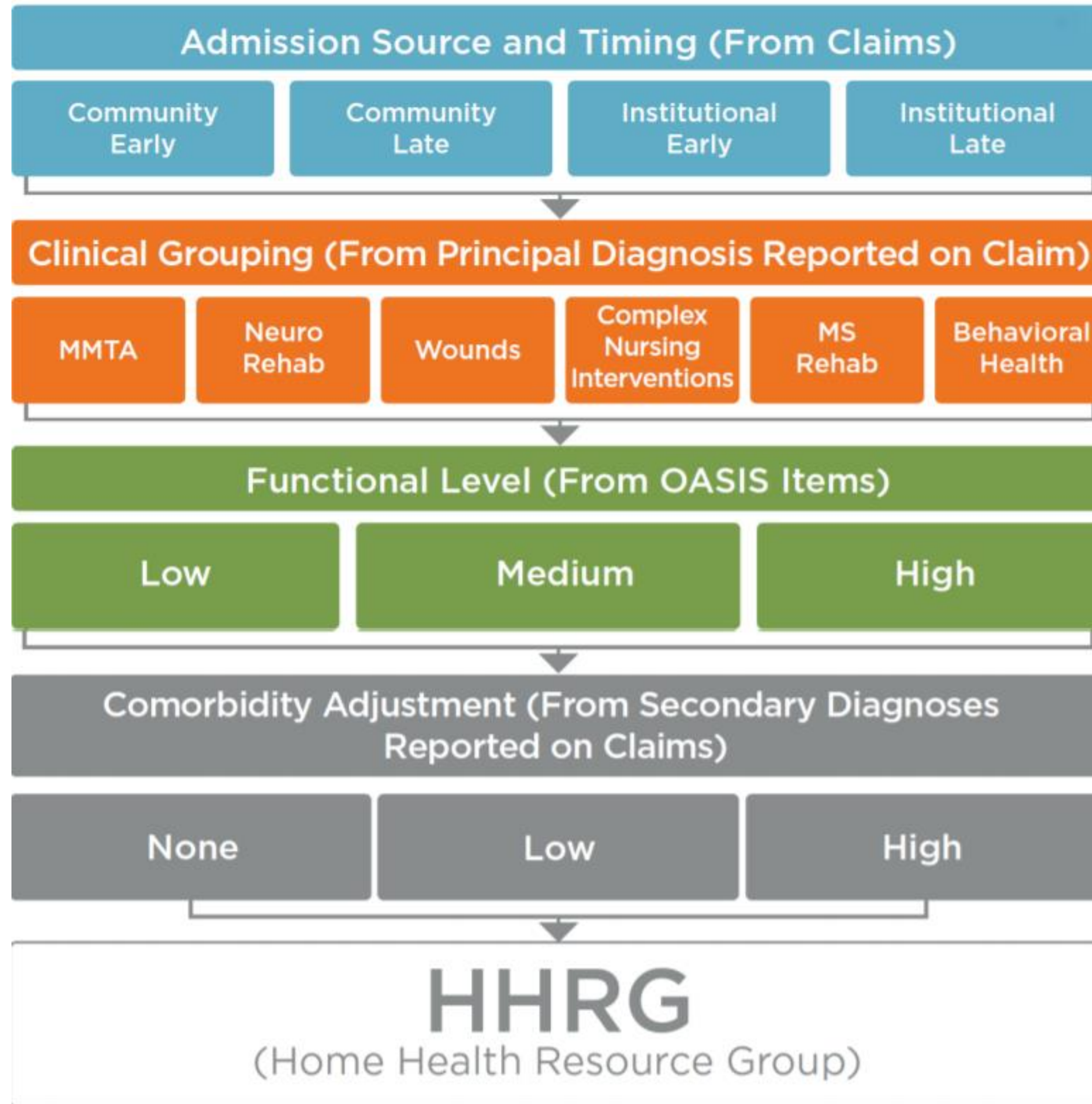
Home Health

CY2019 Home Health Proposed Rule

- Payment rates
- Case-mix adjustments
- Value based purchasing model
- HH Quality Reporting Program requirements
- Home infusion therapy benefit
- Training requirements for AO surveyors
- Supported Bipartisan Budget Act of 2018 physician certification

Payment Rates and PDGM

- Longstanding concerns about payment and need for reform
- Bipartisan Budget Act of 2018 (BiBA)
  - Mandates payment model reform – 2020
  - Budget neutral transition
  - Behavioral adjustment guardrails
  - Stakeholder involvement
  - Prohibits therapy volume thresholds for payment amount
  - 30-day payment unit


Admission Source and Timing (From Claims)
Community Early
Community Late
Institutional Early
Institutional Late
Clinical Grouping (From Principal Diagnosis Reported on Claim)
MMTA
Neuro Rehab
Wounds
Complex Nursing Interventions
MS Rehab
Behavioral Health
Functional Level (From OASIS Items)
Low
Medium
High
Comorbidity Adjustment (From Secondary Diagnoses Reported on Claims)
None
Low
High
HHRG
(Home Health Resource Group)

Value Based Purchasing

- Nine states 2016 – national roll out planned
- Changes in quality measures
- Changes in weights

Recommend CMS delay implementation by 6 months to a year and reconsider the weight for unplanned hospitalization measure

Physician Certification

Codify that documentation from the HHA medical record may be used to support eligibility if:

- Documentation can be corroborated by other documentation in the physician's record
- Certifying physician signs and dates the HHA documentation
- HHA documentation can include:
  - POC and the initial and/or comprehensive assessment

Physician Recertification

- Eliminate the statement that estimates how much longer skilled services will be needed as part of the recertification
- Efforts to reduce burden/ Patient over Paperwork initiative

Infusion Therapy Benefit

If a beneficiary is receiving home health services by a home health agency that is also a qualified home infusion supplier, CMS will permit the HHA to bill for the infusion therapy services separately under new Part B home infusion benefit.

Negative impact on beneficiaries:

- 20% co-pay
- Potential to limit availability of HH benefit –Supplier providing qualifying service
- Two service providers –quality of care at risk.

Home Health Quality Reporting Program

HHQRP

- Alignment with Meaningful Measures
  - Remove 7 existing measures
- IMPACT Act Measures
  - Transfer of Health Information and Care Preferences
  - Continued development of the measures
  - Intend to adopt no later than January 1, 2020
    - Data collection 2021
    - HH QRP 2022
- Not all OASIS data required for HHQRP

HHQRP

7 measures to be removed 2021

- Depression Assessment Conducted
- Diabetic Foot Care and PT/CG Education Implemented
- Multifactor Fall Risk Assessment Conducted For All Patients Who Can Ambulate
- Pneumococcal Polysaccharide Vaccine Ever Received
- Improvement of Status of Surgical Wounds
- ED Use Without Hosp. Readmission 30 days
- Re-hospitalization First 30 Days SAA

Other

Review Choice Demonstration

Choices:
- 100% Pre-claim review
- 100% Post-claim review/prepayment
- Opt out-25% payment reduction and subject to RAC referral

Five states-five years with option to expand:
- Illinois
- Ohio
- North Carolina
- Florida
- Texas

Home Health CoPs

Final interpretive guidelines

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-25-HHA.pdf
- Changes to survey process
- Changes
  - HCA assignment and supervision
  - Use of pseudo-patient
  - Question whether CMS followed proper procedures with changes in guidance

Home Health CoPs

- G574 §484.60(a)(2) The individualized plan of care must include the following:
- G536 §484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy
- G570 §484.60 Condition of participation: Care planning, coordination of services, and quality of care.

Home Health CoPs

- G710 §484.75(b)(3) Providing services that are ordered by the physician as indicated in the plan of care;
- G590 §484.60(c)(1) The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.

Assessments **Plan of care** **Coordination of Care**

Regulatory Relief - Proposed

Proposes to eliminate:

- Oral notification of patient rights
- Clinical record retrieval by the next visit
- Repeat full competency evaluation when aide concern identified

Home Health, Hospice, Palliative Care

Changes on the Horizon

- Medicare Advantage
- Bundled payment initiatives
- Palliative care

Request for Information

Interoperability

- Possible Establishment of CMS Patient Health and Safety Requirements for Hospitals and Other Medicare-Participating Providers and Suppliers for Electronic Transfer of Health Information
- Conditions of participation/Conditions for coverage
- Patient and provider access

Targeted Probe and Educate

- October 1, 2017
- Targets providers – based on data
- Purpose
  - Identify and prevent inappropriate payment
  - Identify potential risk to the Medicare trust fund
  - Educate providers
  - Appropriately pay for covered services
- Can be MAC-specific

Documentation

- Certification/recertification
- Eligibility
  - Program
  - Hospice level of care
  - Home health services
  - Continuing eligibility
- Length of stay/number of episodes
- Hospice -unbundling

Compliance Program

- Have one!
- EFFECTIVE implementation
- Beyond regulatory compliance

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