National Update: Federal Legislative and Regulatory Issues Affecting Home Care and Hospice

William A. Dombi, Esq.
President
Home Care & Hospice Landscape

• Medicare home health
  – Stagnant number of HHAs
  – Spending growth is flat ($18B)
  – Utilization trend shows slight decline in visits per episode and episodes per patient
  – Increasing community admissions

• Medicaid home care
  – States shifting to Managed LTSS
  – Tightening utilization and tighter rates
  – $70B annually, primarily personal café services in HCBS

• Medicare Hospice
  – Growing number of providers
  – Growing spending
  – Growing utilization
Private Duty Home Care Landscape

- Endless growth
- New models of operation
- No uniform data
- Licensure variations
- Quality measures absent
- Demand exceeding supply
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<td>Skilled nursing</td>
<td>14.1</td>
<td>10.5</td>
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<td>-25%</td>
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<td>Therapy (physical, occupational, and speech-language pathology)</td>
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<td>36</td>
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<td>Home health aide</td>
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<td>-64</td>
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<td>Medical social services</td>
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<td>Home health agencies</td>
<td>10,917</td>
<td>7,528</td>
<td>12,204</td>
<td>11,844</td>
<td>-31%</td>
<td>62%</td>
<td>-3%</td>
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<td>Total spending (in billions)</td>
<td>$17.7</td>
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<td>-52%</td>
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<td>Users (in millions)</td>
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<td>Number of visits (in millions)</td>
<td>258.2</td>
<td>90.6</td>
<td>108.3</td>
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<td>Visit type (percent of total)</td>
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<td>Skilled nursing</td>
<td>41%</td>
<td>49%</td>
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<td>48%</td>
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<td>Home health aide</td>
<td>48%</td>
<td>31%</td>
<td>10%</td>
<td>9%</td>
<td>-37%</td>
<td>-68%</td>
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<td>Therapy</td>
<td>10%</td>
<td>19%</td>
<td>41%</td>
<td>43%</td>
<td>101%</td>
<td>112%</td>
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<td>Medical social services</td>
<td>1%</td>
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<td>1%</td>
<td>-25%</td>
<td>&lt;0.1%</td>
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<tr>
<td>Number of visits per user</td>
<td>73</td>
<td>37</td>
<td>31</td>
<td>31</td>
<td>-49%</td>
<td>-15%</td>
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<tr>
<td>Percent of FFS beneficiaries who used home health services</td>
<td>10.5%</td>
<td>7.4%</td>
<td>8.9%</td>
<td>8.8%</td>
<td>9.4%</td>
<td>22%</td>
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**Table 9-4**

Number of participating home health agencies declined in 2017 but remained high relative to earlier years

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<td>Active home health agencies</td>
<td>7,651</td>
<td>9,787</td>
<td>12,311</td>
<td>12,346</td>
<td>12,204</td>
<td>11,844</td>
<td>60%</td>
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<td>Number of home health agencies per 10,000 FFS beneficiaries</td>
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<td>2.8</td>
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<tr>
<td>Share of beneficiaries using home health care</td>
<td>7.2%</td>
<td>9.4%</td>
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<td>8.9%</td>
<td>8.8%</td>
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<td>Episodes (in millions):</td>
<td>4.1</td>
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<td>6.5</td>
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<td>Per home health user</td>
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<td>Per FFS beneficiary</td>
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<td>0.18</td>
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<td>Per home health user</td>
<td>3,783</td>
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<td>Per home health episode</td>
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<td>by a hospitalization or PAC stay</td>
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<td>Number of episodes not preceded</td>
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<td>by a hospitalization or PAC stay</td>
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<td>by a hospitalization or PAC stay</td>
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<td>Medicare margin</td>
<td>Share of home health agencies, 2017</td>
<td>Share of episodes, 2017</td>
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<td>All</td>
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<td>Majority urban</td>
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<td>For profit</td>
<td>16.8</td>
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<td>First (smallest)</td>
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<td>Second</td>
<td>10.8</td>
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<td>Third</td>
<td>11.6</td>
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<td>20</td>
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<td>Fourth</td>
<td>14.5</td>
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<td>20</td>
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<td>Fifth (largest)</td>
<td>17.4</td>
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### TABLE 12-2

**Use of hospice continues to increase**

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<td>All beneficiaries</td>
<td>22.9%</td>
<td>47.9%</td>
<td>48.6%</td>
<td>49.7%</td>
<td>50.4%</td>
<td>1.7</td>
<td>0.7</td>
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<td>FFS beneficiaries</td>
<td>21.5</td>
<td>46.8%</td>
<td>47.6%</td>
<td>48.7%</td>
<td>49.5%</td>
<td>1.7</td>
<td>0.8</td>
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<td>MA beneficiaries</td>
<td>30.9</td>
<td>50.9%</td>
<td>51.1%</td>
<td>51.9%</td>
<td>52.4%</td>
<td>1.3</td>
<td>0.5</td>
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<td>Dual eligibles</td>
<td>17.5</td>
<td>42.6%</td>
<td>43.1%</td>
<td>44.1%</td>
<td>44.9%</td>
<td>1.7</td>
<td>0.8</td>
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<td>Medicare only</td>
<td>24.5</td>
<td>49.6%</td>
<td>50.3%</td>
<td>51.5%</td>
<td>52.1%</td>
<td>1.7</td>
<td>0.6</td>
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<td>Age</td>
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<td>&lt;65</td>
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## Table 12-3

**Increase in total number of hospices driven by growth in for-profit providers**

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</thead>
<tbody>
<tr>
<td>All hospices</td>
<td>2,255</td>
<td>3,250</td>
<td>4,199</td>
<td>4,382</td>
<td>4,488</td>
<td>5.4%</td>
<td>3.4%</td>
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<td>For profit</td>
<td>672</td>
<td>1,676</td>
<td>2,729</td>
<td>2,940</td>
<td>3,097</td>
<td>13.9</td>
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<td>Nonprofit</td>
<td>1,324</td>
<td>1,337</td>
<td>1,294</td>
<td>1,274</td>
<td>1,230</td>
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<td>Government</td>
<td>257</td>
<td>237</td>
<td>176</td>
<td>168</td>
<td>160</td>
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<td>-3.8</td>
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<td>Freestanding</td>
<td>1,069</td>
<td>2,103</td>
<td>3,163</td>
<td>3,369</td>
<td>3,519</td>
<td>10.1</td>
<td>5.4</td>
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<td>Hospital based</td>
<td>785</td>
<td>683</td>
<td>517</td>
<td>501</td>
<td>471</td>
<td>-2.0</td>
<td>-3.4</td>
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<td>Home health based</td>
<td>378</td>
<td>443</td>
<td>494</td>
<td>487</td>
<td>475</td>
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<td>1.1</td>
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<td>25</td>
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<td>Urban</td>
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<td>2,237</td>
<td>3,235</td>
<td>3,474</td>
<td>3,587</td>
<td>6.6</td>
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<td>Rural</td>
<td>757</td>
<td>965</td>
<td>920</td>
<td>901</td>
<td>878</td>
<td>3.5</td>
<td>-0.8</td>
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</tr>
<tr>
<td>Total spending (in billions)</td>
<td>$2.9</td>
<td>$15.9</td>
<td>$16.8</td>
<td>$17.9</td>
<td>11.9%</td>
<td>6.0%</td>
<td>6.4%</td>
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<td>Number of hospice users (in millions)</td>
<td>0.534</td>
<td>1.381</td>
<td>1.427</td>
<td>1.492</td>
<td>6.5%</td>
<td>3.3%</td>
<td>4.6%</td>
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<td>Number of hospice days for all hospice beneficiaries (in millions)</td>
<td>25.8</td>
<td>95.9</td>
<td>101.2</td>
<td>106.3</td>
<td>9.1%</td>
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<td>Average length of stay among decedents (in days)</td>
<td>53.5</td>
<td>86.7</td>
<td>87.8</td>
<td>88.6</td>
<td>3.3%</td>
<td>1.3%</td>
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<td>Median length of stay among decedents (in days)</td>
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<td>0 days</td>
<td>1 day</td>
<td>0 days</td>
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<td>All</td>
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<td>7.4%</td>
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<td>13.3</td>
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<td>3.6</td>
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<td>Freestanding</td>
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<td>6.4</td>
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<td>10.4</td>
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<td>7.3</td>
<td>5.9</td>
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</table>
MedPAC Recommendations: 2019

• Home Health
  – Cut base rate by 5%

• Hospice
  – Reduce inflation update by 2%
2019 Home Care & Hospice Policy Priorities

- Develop Medicare home health payment model reforms
- Extend Medicare home health rural add-on/develop targeting approach if needed
- Initiate workforce expansion supports
- Address Medicare pre-claim review
- Expand flexibility in the use of home health and telehealth in Medicare innovation models
- Stop Medicaid per capita caps/block granting
- Permit Non-physician Practitioners to certify Medicare home health eligibility (S.296)
- Reform Medicare Face-to-Face documentation requirements
- Reform Medicaid EVV requirements
- Address efforts at integration of hospice into Medicare Advantage
- Hospice improvements
  - Rural support
  - Staffing support
• Published October 31, 2018

• Includes:
  – CY 2019 rates (2.2% increase over 2018)
  – Rural add-on
  – HHVBP demonstration program fine tuning
  – Quality measures modifications
  – 2020 Payment Model Reform
  – Home Infusion Therapy benefit
  – Physician certification/recertification documentation standards
Rural add-on

• Revised by BiBA 2018 (P.L. 115-123, Section 50208)
  – Low Population Density HHAs (counties with 6 or fewer people per square mile)
    • 4% add-on in 2019
    • 3% add-on in 2020
    • 2% add-on in 2021
    • 1% add-on in 2022
  – High utilization counties (top quartile of utilization on average)
    • 1.5% add-on in 2019
    • .5% add-on in 2020
  – All other rural areas
    • 3% add-on in 2019
    • 2% add-on in 2020
    • 1% add-on in 2021
Rural Add-on

- **CY 2019 through CY 2022 Rural Add-on Payments: Analysis and Designations [ZIP, 479KB]**

- **High Utilization (2015 data)**
  - Top quartile in episodes per 100 enrollees
  - 510 rural counties (778 total)

- **Low Population Density [not otherwise “high utilization” (2010 Census data)]**
  - 6 or fewer people per square mile
  - 334 counties

- **All Other**
  - 1162 counties
Medicare Home Health Payment Reform: 2020

• Planning ongoing for several years

• New model intended to address:
  – Access to care for vulnerable patients
  – Elimination of therapy volume as payment rate determinant

• Longstanding MedPAC, CMS, Congressional, and Industry concerns
Bipartisan Budget Act of 2018 (BiBA)

- P.L. 115-123, Section 51001
- Mandates payment model reform
  - 2020
  - Budget neutral transition
  - Behavioral adjustment guardrails
  - Stakeholder involvement
  - Prohibits therapy volume thresholds for payment amount
  - 30-day payment unit
- MBI (inflation update) set at 1.5% in 2020 (P.L. 115-123, Section 53110)
PDGM Model: HHGM Revisited

- **Patient-Driven Groupings Model (PDGM)**
  - 432 payment groups
  - Episode timing: “early” or “late”
  - Admission source: community or institutional
  - Six Clinical groupings (7 subgroups in MMTA)
  - Functional level (OASIS based)
  - Comorbidity adjustment: secondary diagnosis based
PDGM NOTABLES

- Therapy volume domain eliminated
- Cost per minute + NRS approach to resource use
- 30 day periods within 60 day episode
- Regression analysis (2017 base)
PDGM NOTABLES

• Budget Neutral transition
• Behavioral Adjustments (6.42%???)
  – Diagnosis coding
  – Comorbidities
  – LUPA avoidance

• $1753.68 “unit of payment” ($1607 w/HHGM) if at 2019 (2020 TBD)
• LUPA: 2-6 visits @ 10th percentile value of total visits in payment group
• RAP continues except for new HHAs
• Outlier based on 30 day unit of payment
Concerns/Issues

• Impact on therapy patients
  – Regression-based methodology includes therapy volume
  – Change in costing methodology reduces case weights, i.e. payment amounts

• Incentives to focus on inpatient discharges and avoid community admissions

• LUPA structure change

• Clinical groupings heavy on MMTA

• Big swings for some HHAs

• Behavioral adjustment “wild card”
PDGM ADVOCACY

• Focus on the behavioral adjustment

• S. 433 (Collins, Kennedy, Stabenow, Cassidy, Shaheen, Jones)
  – Only permits adjustments after changes occur
  – 2% max or phase-in required

• House bill in late April
2019 Final Rule: Other Changes

• Physician certification/ recertification
• Remote monitoring
• HHVBP
• HHQRP
• Home Infusion Therapy Benefit
• Changes to AO Requirements
Physician Certification

Codify in the regulation:
Physician’s medical record to determine patient eligibility for HHS

• Documentation from the HHA medical record may be used to support eligibility
  – Documentation must be corroborated by other documentation in the physician’s record
  – Certifying physician signs and dates the HHA documentation

• HHA documentation can include: POC or the initial or comprehensive assessment

CMS accepted our recommendation that the POC with information to support eligibility be permitted as the sole documentation for the physician to sign and date.
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
Remote monitoring

• Allow as administrative cost on the cost report

• May not substitute a HH visit

• Cost of remote monitoring will factor into the cost per visit
Home Infusion Therapy Benefit

• New benefit under Part B (2021)
• New supplier designation
• Coverage for associated professionals services for infusion on a pump in the home
• Currently professionals services (nursing services) are not covered under Medicare for beneficiaries receiving home infusion outside the HH benefit
Life Continues!: Oversight in Home Health

- Claims Oversight: 17.6% improper payment rate (2016-17): significant reduction in last two years
- Five-year, five-state HH preclaim review demonstration; starting again in Illinois (start date: 6/1/19)
  - Ohio; North Carolina; Texas; Florida; and Illinois
  - Illinois PCRD show high HHA error rate on documentation
  - 10-15% spending reduction throughout state
  - Industry suggests alternatives
    - Targeted reviews
    - Probe and Educate
    - Predictive modeling—PEPPER reports
- MA Plans initiate retrospective reviews
- Medicare reviews increase nationwide
Review Choice Demo (RCD)


- Revised PCR that was paused in April, 2017

- GAO report issued 4/20/2018

- 100% Pre-claim review

- 100% Post-claim review/prepayment

- Opt out-25% payment reduction and subject to RAC referral
RCD

• CMS has ignored what it could have learned from its earlier demonstration program, PCRD, to shape future program integrity measures.

• PCRD showed that there are common characteristics of HHAs at risk of improper claims that would permit efficient targeting of claims reviews.

• Viable alternatives to RCD readily exist that are far less costly and burdensome with potentially more effectiveness.
Probe and Educate Audits

• P&E medical review - began 10/2017
• Provider specific issues based on analytics
• 20-40 claims
• Notified by letter
• One-on-One Education
  – Intra probe education
• Post probe education
  – Three rounds of review before further action is taken
Conditions of Participation = Conditions of Payment

• Plan of Care 42 CFR 484.60/409.43
  – CERT audits focused on POC inclusion of:
    • Advance directives
    • Authorized representative
  – Some HHAs may not have included sufficient information on Ads on POC
  – Began 1/13/18
  – Opportunity to correct
Medicare Hospice Issues

• Much quieter than home health
• Pattern developing that hospice follows home health experiences
  – Increasing claim oversight
  – Expanded quality and utilization data
  – Publication of quality of care rankings
  – Potential reforms
    • New payment model in the future?
Proposed FY 2020 Update to Base Payments Plus More


- FY 2020 rate update
  - Recalibrating CHC, Respite, and GIP rates
  - Reducing RHC to achieve budget neutrality
  - Hospice cap at $29,993.99

- Shifting to current wage index, eliminating time lag

- Significant changes in the patient election statement with focus on “unrelated” services

- RFI re: hospice in Alternative Payment Models
Proposed FY 2020 Update to Base Payments

• **Market Basket Index Update**
  – Hospital Market Basket Update 3.2%
  – Productivity Adjustment 0.5
  – TOTAL 2.7%

• **Wage Index** – Hospital Wage Index for current year (FY2020)
## Proposed FY 2020 Hospice Payment Rates

### Proposed FY2020 Hospice RHC Payment Rates

<table>
<thead>
<tr>
<th>Description</th>
<th>Proposed FY 2019 Budget-Neutral RHC Payment Rates*</th>
<th>SIA Budget Neutrality Factor</th>
<th>Wage Index Standardization Factor**</th>
<th>Proposed FY 2020 Hospice Payment Update</th>
<th>Proposed FY 2020 Payment Rates</th>
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</thead>
<tbody>
<tr>
<td>Routine Home Care (days 1-60)</td>
<td>$190.93</td>
<td>X 0.9924</td>
<td>X 1.0054</td>
<td>X 1.027</td>
<td>$195.65</td>
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<td>Routine Home Care (days 61+)</td>
<td>$150.03</td>
<td>X 0.9982</td>
<td>X 1.0054</td>
<td>X 1.027</td>
<td>$154.63</td>
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# Proposed FY 2020 Hospice Payment Rates

## Proposed FY 2020 Hospice CHC, IRC, and GIP Payment Rates

<table>
<thead>
<tr>
<th>Description</th>
<th>Proposed FY2019 Rebased Payment Rates</th>
<th>Wage Index Standardization Factor*</th>
<th>Proposed FY2020 Hospice Payment Update</th>
<th>Proposed FY2020 Payment Rates</th>
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<tbody>
<tr>
<td>Continuous Home Care</td>
<td>$1,363.26</td>
<td>X 1.0041</td>
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<td>Full Rate = 24 hours of care</td>
<td>($56.80 = hourly rate)</td>
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<td>Inpatient Respite Care</td>
<td>$435.82</td>
<td>X 1.0049</td>
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<td>General Inpatient Care</td>
<td>$994.45</td>
<td>X 1.0060</td>
<td>X 1.027</td>
<td>$1,027.43</td>
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</table>
Proposed Election Statement
Changes

• Information about the holistic, comprehensive nature of the Medicare hospice benefit;
• A statement that there could be some necessary items, drugs, or services that will not be covered by the hospice because the hospice has determined that these items, drugs, or services are to treat a condition that is unrelated to the terminal illness and related conditions;
• Information about beneficiary cost-sharing for hospice services; and
• Notification of the beneficiary’s (or representative’s) right to request an election statement addendum that includes a written list and a rationale for the conditions, items, drugs, or services that the hospice has determined to be unrelated to the terminal illness and related conditions and that immediate advocacy is available through the BFCC-QIO if the beneficiary (or representative) disagrees with the hospice’s determination.
• Condition of Payment
Proposed Election Statement Addendum

- Specifics on the list and rationale of unrelated services
- At beneficiary’s (or rep’s) request
- At request of non-hospice treating providers and Medicare contractors
- Within 48 hours of request (exceptions)
- Updating required
- Required information set
RFI on Hospice in APMs

- CMS seeks input on the interaction of the hospice benefit and various alternative care delivery models, including:
  - Medicare Advantage (MA)
  - Accountable Care Organizations (ACOs)
  - Other future models
- VBID MA Plan Demo comments
  - Recognizes potential limit on patient choice
  - Lower rates may change quality and type of services
Hospice Quality Reporting Update and Changes

- Claims-based and outcome measure development for future years
- Update on claims-based measure development
- CAHPS Hospice Survey
- Hospice assessment tool
BBA 2018: PAs as Attendings

• Effective 1/1/19, PAs may serve as hospice attending physicians and bill for medical services:
  • Normally performed by physician
  • Must be “reasonable and necessary”
  • NOT related to certification of terminal illness
  • Whether or not PA is employed by hospice
  • Paid at 85% of fee schedule

• No authority to:
  • Conduct face-to-face
  • Certify eligibility
  • Take physician’s role on IDT

• CR 10517/Transmittal 246: Chapter 9 Benefit Policy Manual Updates
BBA 2018: Hospital Discharges to Hospice

• Effective 10/1/18, apply post-acute transfer policy to inpatient discharge to hospice (approx. 280 hospital DRGs)

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

• MedPAC Study
Regulatory Relief and System Upgrades

– Response to FY2018 Hospice Rule RFI:

  • Effective 10/1/18, hospice may opt for reporting of aggregate monthly charges on claims for drugs, infusion pumps, and infusion drugs (may continue line-item reporting if desired)

  • Beginning 10/1/18, FISS will contain info on days paid on stored claim record:
    • High/Low RHC Rate
    • Supports accuracy in financial monitoring

  • Transmittal 4035 issued 4/27/18
Spending Outside of Hospice

• Parts A and B – dropped over 2012 – 2017 time period

• Part D
  – “Uptick” in spending on “maintenance drugs”
    • Hospice industry needs better data from CMS to understand what’s happening
  – Hospice, Part D plans, and Pharmacy need better understanding of various processes in place, better means for coordination of benefits
    • NCPDP educational opportunities
  – Part D/hospice under further examination by OIG
Hospice Cost Report

• FY2019 Rule – CMS reviewing new cost report data with eye toward revising:
  • Costs by level of care
  • Labor/Non-labor portions
• FY2019 Rule – CMS found that 66% of hospices failed at least 1 of the NAHC/HHFMA recommended Level I edits – with SIGNIFICANT implications for future payment decisions
Issues on Horizon

• Expansion of MA supplemental benefits to include palliative care
• S. 1334/H.R. 2797 -- Patient Choice and Quality Care Act
  • FFS advanced illness model
  • Quality measures
  • Advanced care planning
• Innovative FFS Physician Payment models – CTAC/AAHPM models before CMMI
• Future threat: Hospice/MA benefit
HOSPICE COMPLIANCE

• Concerns and Oversight Increasing
• Claims compliance
  – Election Statement
  – Certification
  – Live discharges
  – Non-cancer diagnosis
• Referral relationships
• Patients in Nursing Facilities
CONCLUSION

• Lots going on!
• Opportunities and challenges—as usual
• Strong policy-based support
• Strong political support
• Reality—much of home care and hospice is bought by the government
• Notable—the rest of health care is shifting to community care