E-Alliance Extra

***Missouri Alliance for* Home Care**
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In This Edition:

MAHC Gearing Up for 2019 Legislative Session

Now that our new Governor has had some time to settle into his new role, we are hopeful for a "drama" free legislative session. 2019 not only brings a new Administration it also brings eight freshman Senators and 63 freshman House members.

Unfortunately, the home care industry will once again be facing many challenges due to the state's continuing bleak fiscal outlook along with the newly passed minimum wage increase that takes effect January 1, 2019. We have already been engaged in talks with the Administration, legislators and Department Directors on addressing this issue.

On the federal level, Home Health agencies will be gearing up for the most consequential changes to impact home health in decades – the Patient Driven Groupings Model (PDGM). We will continue to address this issue with members of Congress.

MAHC highly encourages all members to continue with your advocacy efforts.

Nominations Being Solicited for MAHC Board Candidates
Are you an active member of a MAHC committee? Are you interested in serving on the MAHC Board of Directors? If you would like to be considered by the nominating committee, now is the time. Visit the following link for the nomination form.
https://homecaremissouri.org/mahc/documents/WebsitePacket_002.pdf

Home Care Awards – Nominate Today
Don't delay. Nominate your outstanding employee or member of your community who has advanced home care. The process is easy. Visit the following link for the award criteria and application. http://homecaremissouri.org/events/awards.php

MAHC Annual Conference – "Shifting Gears; Ready…Set…GO!"
The MAHC Annual Conference Planning Committee has been busy pulling together another spectacular conference. The theme "Shifting Gears; Ready…Set…GO" indicates that the home care industry will need to "shift gears" to prepare for the ever changing culture. With the development of new payment models and many collaborative initiatives, no longer can home care agencies survive by status quo; they must be willing to change practices and prepare to align with other healthcare industries and work together to provide the most cost effective and best quality of care. As always, the conference will include many expert speakers on home care and hospice "hot" topics. Be watching your email for more details.

Mark your calendars for April 23-25, 2019 at Tan-Tar-A.

MAHC Member Regional Meetings Held in October
MAHC again this year held membership meetings in 5 regions across MO. The meetings were split into two sessions – Home Health and Hospice; and HCBS and Private Duty. These meetings are a great way to stay up-to-date on home care issues and MAHC's involvement. It is also a priceless opportunity to network with other members and discuss best practices and/or concerns.

Home Health/Hospice topics addressed included:

- CY2019 Home Health Proposed Rule
  - 2019 payment update
  - Rural Add-On
  - Value Based Purchasing
  - PDGM and the lobby efforts underway
  - Home Infusion Therapy
  - Remote Monitoring
- COP's Interpretive Guidelines
- Red Tape Reduction
- Targeted Probe and Educate
- Medicare Advantage
- FY2019 Hospice Payment Rate Updates
- Change to Hospice Attending Physician Definition
- Patients and Communities Act
- Palliative Care
- Medicaid F2F
- HB1350 – Background checks and Good Cause Waivers
- FY2019 Legislative Priorities
- State Revenues Forecast
- Upcoming Election

- What MAHC is Doing for Members

HCBS and Private Duty topics addressed:

- 2018 State Legislative Session Recap
- 2019 State Legislative Priorities
- State Revenues Forecast
- Upcoming Election
- HB1350 – Background checks and Good Cause Waivers
- 21st Century Cures Act – Electronic Visit Verification (EVV)
- Level of Care assessment
- Combined Personal Care Regulations
- Call Center Delays
- Private Duty Nursing
- Private Duty – host "listening sessions"
- What MAHC is Doing for Members

MAHC Task Forces Continue to Meet

CDS Task Force

The CDS Task Force continued their work on language for our CDS bill. Senator-elect Lincoln Hough has filed the bill in the Senate (SB70) and Representative Hannah Kelly will be filing in the House (HB?). This bill will help support the true intent of the CDS program and ensure quality services are being delivered; supports MMAC in their ability of provider oversight and provider accountability; and ensures ethical and responsible use of tax payer dollars. Click here for a copy of the bill.

The State Programs/Medicaid Task Force

This task force continues to discuss issues such as hiring quality employees and agency struggles; level of care assessment; GHE's; assessment and reassessment issues; combined personal care regulations; advocacy issues and much more.

Both Task Forces advocacy efforts will focus on increasing provider rates and dealing with the minimum wage increase. CDS will also focus on eliminating the 60% cost cap.

Pediatric Task Force

The Pediatric Task Force is committed to developing a universal standardized curriculum for Private Duty nurses. Jodi Carter MSN, RN, CPNP, Nurse Practitioner, Pediatric Pulmonary/Home Ventilator Program, Washington University School of Medicine will lead the charge. MAHC will be sending out a survey related to your current PDN training. Please be watching your email.

The task force is also gearing up for the legislative session by lining up families to testify at budget hearings, addressing provider rates and bringing many Managed Care issues to the table. MAHC has been able to address and resolve these issues with MO HealthNet.

Home Health Task Force

The Home Health Task Force continues to discuss issues related to PDGM including advocacy efforts and education. Also addressed are issues with CGS and the need for accurate cost reports. The Task Force is in the initial stages of developing a Social Media/PR campaign emphasizing the importance of home care and that the patient's voice must be heard.

If you are interested in serving on any of MAHC's committees or task forces, click here for a sign-up sheet.

MMAC Audit – PA Special Project / State Auditor Reviews HCBS Programs
MAHC recently sent out an alert to personal care providers related to MMAC's PA Special Project. Click here to see the alert.

MMAC's PA Special Project was a result of Missouri State Auditor Nicole Galloway's audit of the Department of Health and Senior Services (DHSS) Home and Community Based Services (HCBS) findings related to Provider Overpayments.

The report sites weaknesses in the Department of Health and Senior Services and MO HealthNet Division systems that prevent the proper execution of MO HealthNet Division system edits to timely detect and prevent overpayments to some providers.

The Auditor's recommendation is that the DHSS and MHD implement changes to provide for more effective execution of MHD system edits to prevent and detect potential overpayments of HCBS benefits. In addition, the MMAC should investigate the potential overpayments identified and recoup any resulting overpayments. This is the area that MAHC had concerns and addressed those with MMAC which resulted in a temporary halt to the special project audits.

Other findings of the audit included issues with Budgetary Estimates; Level of Care Scores and Authorized Services; and Trends in Expenditures and Assessments and Reassessments.

To access the full report, click on the following link:
https://app.auditor.mo.gov/Repository/Press/2018125101429.pdf

PDGM Advocacy – MO Delegation Storms Capitol Hill on Multiple Visits
MAHC Executive Director, Carol Hudspeth, along with MAHC Board members Elisa Pellham, Integrity Home Care & Hospice, Valerie Noblitt, Citizens Memorial Home Health/Hospice and Brad Evans, VNA of Kansas City and MAHC members Teresa McCulloch, VNA of Southeast MO and Cale Bradford, Elara Caring were again in Washington DC on Wednesday, November 28th meeting with some of Missouri's congressional delegation (Congresswoman Vicki Hartzler, Congressmen Billy Long, Jason Smith, and Emanuel Cleaver and Senator Roy Blunt) to discuss the importance of homecare and the need to advance legislation to protect services for America's seniors.

This was Carol and Brad's second trip to Capitol Hill this fall. On September 20th they met with healthcare legislative staff to Missouri's congressional delegation to advocate for improvements to homecare payment reforms, the importance of homecare and the need to protect services for America's seniors.

Click here to access talking point resources that were used on the hill visits.

PDGM National Summit Coming to Kansas City, January 24, 2019!
Is your agency prepared to deal with the biggest changes to impact home health in decades? The Patient-Driven Groupings Model (PDGM) will revolutionize the payment methodology for all Medicare Home Health agencies in the United States. PDGM, created by CMS, is slated to debut on January 1, 2020.

Agencies must prepare immediately for these important regulatory changes.

Significant operational and organizational changes must be made by your agency in early 2019 to successfully transition to PDGM.

It is critical for you to have the tools and knowledge necessary to understand and adapt your business to these important changes. This in-depth one-day summit will cover all facets of managing change to PDGM-operations; clinical; financial; data analytics; and technology. Join us on January 24, 2019 to help prepare your Medicare Home Health Agency for the PDGM revolution.

Click here for more information and registration Brochure.

21st Century Cures Act – EVV

MAHC continues to meet with MO HealthNet staff on the implementation of the 21st Century Cures Act as it relates to EVV. MAHC will continue to ensure that home care providers voices are heard as final decisions are being made.

Medicaid F2F

MAHC continues to work with MO HealthNet staff on draft regulations related to Medicaid F2F. MO HealthNet staff have been very supportive of our recommendations and changes. Draft regulations should be released soon.

Do I Still Need A Good Cause Waiver Training and Resource Guide

Effective August 28, 2018, Missouri House Bill 1350 established modified provisions related to criminal history records for Home Health, In Home & CDS providers by changing the background screening disqualifiers from "any FCSR finding" to a defined list of findings.

MAHC developed a training to help home care providers further understand the implications of the new requirements of HB1350 and to assist in determining what may require a good cause waiver and in updating your internal hiring policies & procedures. Included with the recording is a resource guide/chart that lists the disqualifying factors requiring a good cause waiver pursuant to section 192.2495, RSMo.

As a member benefit this valuable training is FREE to MAHC members; however an order form is required. Click here for the order form.

Alzheimer's Training

With the New Year, why not give your staff a new Alzheimer's training.

MAHC heard from many members that their staff loved our first Alzheimer training, *At Home with Dementia Care*; however they were getting a little burned out watching the same film each year. MAHC continues to be committed to providing a quality Alzheimer's and Dementia Training program so we listened and are proud to announce that we have partnered with the AGE-u-cate Training Institute to bring home care agencies a new 60 minute training, *Dementia Core Skills Training*.

Together, this training and handouts meet the Department of Health & Senior Services, the Bureau of Home Care and Rehab Standards and the Division of Senior & Disability Services regulatory requirements related to employee Alzheimer training.

Click here to order your copy today.

Level of Care – New Assessment Tool

The Department of Health and Senior Services (DHSS) held their final Nursing Facility Level of Care Stakeholder Meeting on November 27th. We are grateful to the Department for listening to stakeholder concerns and comments and for taking a common sense and transparent approach to developing this tool. Providers will have the opportunity to test the new algorithm and provide feedback on their results. MAHC will be establishing a workgroup to test the algorithm and submit comments. Be watching your email for more information.

Medicaid Fraud and Abuse Task Force

MAHC Executive Director, Carol Hudspeth has been invited to serve on Governor Parson's newly formed Medicaid Fraud and Abuse Task Force.

The Task Force was established to improve Medicaid program integrity to ensure taxpayer dollars are used to promote enrollee health and make Missouri a leader in addressing Medicaid fraud and abuse.

The Task Force will develop effective legislation and policies to combat fraud and abuse and create a governance group to oversee the Task Force goals, objectives, performance measures, and timelines. They will identify opportunities to strengthen policy, find ways to prevent fraud and abuse through data analytics and cost-effective deterrence measures, make policy and legislative recommendations and create processes to optimize the prosecution and collection of improper Medicaid payments.

MAHC is looking forward to working with the Governor and other members of the task force to improve Medicaid integrity in Missouri.

House Approves Key Bill to Extend Money Follows the Person, Spousal Impoverishment Protection *(from NAHC Report)*

On Tuesday, December 11th, the U.S. House of Representatives approved legislation reauthorizing two Medicaid Home and Community Based Services (HCBS) programs and established a new Medicaid program designed to move pediatric patients with medically complex conditions from institutional settings into community settings.

Titled the *Improving Medicaid Programs and Opportunities for Eligible Beneficiaries (IMPROVE) Act* (H.R. 7217), the legislation extends for three months the Money Follows the Person (MFP) program, and provides a three month extension for protections for recipients of HCBS against spousal impoverishment. Both of these programs are currently set to expire at the end of December. The three month extensions suggest Congress intends to craft longer extensions or make them permanent, but needs more time to address outstanding points of concern.

The MFP program is designed to help with rebalancing of care from institutional settings in favor of the community. Funds are eligible to be used on home modifications, equipment, and services, such as home care, to keep people in their homes.

Spousal impoverishment protections were initially established to allow the spouse (community spouse) of a Medicaid recipient (institutional spouse) to maintain specified levels of assets and income when the institutional spouse was admitted to a skilled nursing facility within Medicaid. The Affordable Care Act extended these protections to situations where the institutional spouse was receiving HCBS. In the absence of these protections, the community spouse ends up impoverished, or the couple may pursue a divorce.

Both the MFP and spousal impoverishment protections have proven to be quite popular and enjoyed backing from disability, aging, beneficiary, and provider groups.

In a newly created benefit, at their option, states will be able to develop "health homes" where children with medically complex conditions will be the recipients of care coordination based in the community, as opposed to multiple providers in differing settings. Home health agencies are considered a designated provider in the legislation making them eligible for reimbursement in this model. Further, home care will be an important center point to care coordination for many patients. Palliative care services will also be involved in care coordination should a state opt to include it. Coordination will be allowable beyond state lines to out-of-state providers.

The National Association for Home Care and Hospice (NAHC) is in full support of these measures and has worked with Members of Congress on their legislative success. The bill will now proceed to the Senate where it has not yet garnered consideration. NAHC will advocate for its success there as well and hopes to see it go the Senate floor for a vote before the end of December when the 115thCongress completes and the 116th begins in January 2019.

Home Health Agencies May Continue to Provide Part B Infusion Therapy in 2019-20 *(from NAHC Report)*

The Centers for Medicare and Medicaid Services (CMS) will permit home health agencies to continue to provide Part B infusion therapy during the transition period (2019 – 2020) for the new home infusion therapy benefit.

The 21st Century Cures Act (Act) included a provision that called for the development of new home infusion therapy benefit under Medicare Part B. The benefit would provide professional services to beneficiaries receiving home infusion therapy through a pump that is an item of durable medical equipment (DME). Medicare covers a limited number of home infusion drugs under the Part B, DME benefit when the drug requires infusion by a pump. These drugs include chemotherapy, inotropic medications, certain pain medications, immunoglobulin therapy, and anti-fungal medications.

In accord with Act, CMS has established a new Medicare supplier designation called "Home Infusion Therapy Suppliers" to administer the new benefit. A qualified home infusion therapy supplier is defined as a pharmacy, physician, or other provider licensed by the state where services are provided. Home health care and hospice providers are eligible to be accredited as home infusion therapy suppliers when the benefit becomes a permanent program.

The new benefit includes the professional service, such as nursing services, under a physician established plan of care that is periodically reviewed; training and education on infusion therapy; remote monitoring; and 24/7 availability by the supplier. CMS would permit remote monitoring to be follow-up telephone calls or on-site visits.

Home infusion therapy suppliers will need to be accredited by a CMS approved accrediting organization, enroll in Medicare Part B, and bill the services on a professional claim. (1500/837P).

Full implementation of the home infusion therapy benefit will begin in 2021, once the benefit becomes a permanent program; beneficiaries will not be able to receive Part B home infusion

therapy services under the home health benefit. Beneficiaries will only be able to receive the services through a home infusion therapy supplier.

The 2018 Bipartisan Budget Act (BiBA) included a provision that provides payment for home infusion therapy services, under the new benefit, during a transitional period (2019-2020) to select providers. Only licensed pharmacies enrolled as a DME supplier will be eligible to offer the benefit to beneficiaries during the transitional period.

In the final rule for the 2019 Home Health Proposed Payment System rate update rule, CMS indicated, in a response to comments, that home health agencies (HHAs) would not be permitted to provide infusion therapy for Part B drugs beginning January 1, 2019 when the transitional period begins.

"Home infusion therapy is excluded from the Medicare home health benefit, and separately payable, beginning January 1, 2019."

The National Association for Home Care & Hospice (NAHC) disagreed with CMS' interpretation that the 2018 BiBA requires home infusion therapy of Part B drugs be excluded from the home health benefit beginning in 2019. The exclusion from the home health benefit does not begin until 2021 with full implementation of the benefit.

NAHC brought its concern to CMS who ultimately agreed to permit HHAs to provide the professional services associated with Part B infusion drugs during 2019 and 2020 transitional period. However, since certain pharmacies are also eligible to provide the professional services, HHAs might have to coordinate services with home infusion suppliers.

NAHC plans to work with Congressional members to permit home infusion therapy of Part B drugs to remain under the home health benefit when the program becomes permanent in 2021.

Improper Payment Rates Fall for Home Health and Hospice Providers *(from NAHC Report)*

Improper payments to home health providers fell by almost 15 percent and to hospices by three percent, according to the 2018 Medicare Fee-for-Service Improper Payment Data report.

As NAHC has stated previously, these sharp reductions in improper payments demonstrates that Center for Medicare & Medicaid Services' (CMS) plan to initiate the Review Choice Demonstration is unwarranted because improper payment rate for agencies is decreasing without such a drastic measure that is very likely to lead to disruption of patient care.

"It is clear home health agencies have figured out what documentation is required to support valid Medicare claims," says NAHC President William A. Dombi. "While the 'improper payment' rate is down dramatically, Medicare coverage of home health services has not declined. We believe recent improvements in documentation requirements by CMS that will take effect on January 1 will bring even better results in 2019."

The improper payment data report is issued annually, and for the 2018 report, includes claims data from July 1, 2016-June 30, 2017. The improper payment rate is determined by claim reviews conducted by the Comprehensive Error Rate Testing (CERT) Program for both

PART A and Part B providers and suppliers. The report breaks down improper payments by provider type and the common reasons for improper payments.

Home health had an overall improper payment rate of 17.6 percent, a decline of 14.7 percent from the previous year. According to the report, 62 percent of those improper home health payments caused by insufficient documentation. Hospice providers had an overall improper payment rate of 11.7 percent, a decline of three percent. Again, over 60 percent of those payments were related to insufficient documentation. Overall, the Medicare program had a 91.9% payment accuracy rate with 8.1 percent improper payments, reflecting a decrease in overall improper payments of 1.4 percent from last year's report.

The report cites five common causes for improper payments:

- insufficient documentation;
- medical necessity;
- incorrect coding;
- no documentation; and
- other

The report further breaks down insufficient documentation into more detailed categories that include:

- certification/ recertification;
- inconsistent records;
- missing/inadequate orders;
- missing/ inadequate plan of care;
- missing/ inadequate records;
- and multiple universal errors (a combination of any of these categories).

The report also includes data that combines the improper payment rates for home health and hospice providers across several states; the majority of which show a decline in improper rates from last year.

CMS Delays Publication of Discharge Planning Rule *(from NAHC Report)*
The Centers for Medicare & Medicaid Services (CMS) has announced a one-year extension, until November 3, 2019, to publish the discharge planning final rule for home health agencies.

The CMS announcement came as a notice in the Federal Register for the final rule titled: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies.

On November 3, 2015, CMS published a proposed rule that requires specific discharge planning requirements that Hospitals, including Long-Term Care Hospitals and Inpatient Rehabilitation Facilities, Critical Access Hospitals, and Home Health Agencies must meet in order to participate in the Medicare and Medicaid programs. The proposed rule also implemented the discharge planning requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014.

In the proposed rule, CMS outlines an elaborate discharge planning process for home health providers when patients are discharged to another post-acute care provider. Additionally,

CMS would require a lengthy list of information to be provided to a receiving facility or practitioner whenever a patient is discharge from home health services.

In its comments on the proposed rule, the National Association for Home Care & Hospice (NAHC) highlighted concerns with the burden the proposed requirements would have on home health providers. CMS also failed to recognize the uniqueness of home health care providers in its proposals for discharge planning.

Based on both public comments received and stakeholder feedback, CMS determined that there are significant policy issues that need to be resolved in order to address all of the issues raised by public comments to the proposed rule and to ensure appropriate coordination with other government agencies. Therefore, CMS is not able to meet the 3-year timeline for publication of the final rule and are instead extending the timeline for publication.

CMS Issues Rural Add-On Instructions *(from NAHC Report)*
The Centers for Medicare & Medicaid Services (CMS) has issued Change Request 10782 which provides instructions to the Medicare Administrative Contractors (MACs) on the rural add-on for home health claims as required by Section 50208 of the 2018 Bipartisan Budget Act (BiBA).

Beginning January 1, 2019 payment increases will be applied to home health services furnished in rural areas based on county designation. In the CR, CMS notes that the BBA requires that "in the case of home health services furnished on or after January 1, 2019, the claim contains the code for the county (or equivalent area) in which the home health service was furnished". Therefore, all home health claims must include the county code. CMS received approval for a new value code (85) to be place on claims that is defined as "County Where Service is Rendered"

The rural add-on amounts were revised by the 2018 BiBA as follows:

- 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 2021
- 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

When home health services are provided in rural (non-Core Based Statistical Area (CBSA)) areas for episodes and visits ending on or after January 1, 2019, and before January 1, 2023, a county-based rural add-on is applied to:

– The national, standardized episode rate;
– National per-visit payment rates;

– Low Utilization Payment Adjustment (LUPA) add-on payments; and
– The Non-Routine Supplies (NRS) conversion factor.

In response to this requirement, the MAC have been instructed to:

- Accept value code 85 and an associated FIPS State and County Code on home health claims, Type of Bill (TOB) 032x, received on or after January 1, 2019.
- Apply rural payment rates based on whether the FIPS State and County Code is in the list of codes associated with one of three categories of rural counties.
- Return the claim for correction when the FIPS State and County Code is missing or invalid.

To view the State and County FIPS code list click here.

OIG Adds Hospice Item to Work Plan *(from NAHC Report)*
Recently the HHS Office of the Inspector General (OIG) added a hospice item to its work plan, Protecting Medicare Hospice Beneficiaries From Harm. The OIG is planning a study to determine the extent and nature of hospice deficiencies and complaints and identify trends. This study is a companion to Trends in Hospice Deficiencies and Complaints (OEI-02-17-00020), and the OIG plans to use hospice survey reports to provide more detail about poor-quality care that resulted in harm to beneficiaries. The OIG indicates it will describe specific instances of harm to Medicare hospice beneficiaries and identify the vulnerabilities in Medicare's process for preventing and addressing harm.

There are other active items related to hospice on the OIG Work Plan and include:

- Medicare Payments Made Outside of the Hospice Benefit
- Duplicate Drug Claims for Hospice Beneficiaries
- Trends in Hospice Deficiencies and Complaints
- Hospice Home Care – Frequency of Nurse On-Site Visits to Assess Quality of Care and Services
- Review of Hospices' Compliance with Medicare Requirements
- Medicare Payments for Chronic Care Management

One item on the Work Plan that has already been completed and final report issued is Medicare Hospice Benefit Vulnerabilities and Recommendations for Improvement: A Portfolio. In this report, some of the recommendations made by the OIG are for strengthening the survey process, seek statutory authority to establish additional remedies for hospices with poor performance, strengthen oversight, provide more information to beneficiaries and specifically to include on Hospice Compare deficiency data from surveys, including information about complaints filed and resulting deficiencies. Clearly, the OIG has concerns about the survey process for hospices and how the information from the surveys is used by CMS as well as the information being made available to and used by beneficiaries.

The Work Plan for the OIG contains projects the OIG is currently working on or plans to work on in the future. The Plan itself is dynamic and updated with new projects as they arise. Providers can view active and archived Work Plan items here.

There is one recently released report providers may be interested in and that is the OIG 2018 Top Management and Performance Challenges.

The HHS OIG is the largest inspector general's office in the federal government working to combat fraud, waste and abuse in the Medicare and Medicaid programs. The two work plan items mentioned above fall under the OIG's Office of Evaluation and Inspections (OEI). This particular office conducts national evaluations of HHS programs from a broad, issue-based perspective. The evaluations offer practical recommendations to improve the efficiency and effectiveness of HHS programs, with a focus on preventing fraud, waste, and abuse. The OEI also:

- monitors the impact its recommendations and evaluations have on HHS programs by tracking legislative or regulatory changes, documented savings, improved coordination efforts and other benchmarks;
- provides congressional staff with technical assistance and briefings on proposed or completed work;
- works in concert with other components to identify vulnerabilities in HHS programs and recommend changes; and
- oversees the state Medicaid Fraud Control Units, which investigate and prosecute providers for Medicaid fraud as well as patient abuse and neglect.

Home Health and Hospice Quality Measures Under Consideration *(from NAHC Report)*

The list of quality Measures Under Consideration (MUC) for the home health quality reporting program (HH QRP) and the hospice quality reporting program (HQRP) were recently released. There was a short window of time in which to make comments on the measures. NAHC submitted its comments December 6, 2018, a copy of which is available HERE.

NAHC submitted comments on the following measures:

- MUC18-101: Transitions from Hospice Care, Followed by Death or Acute Care
- MUC18-131: Transfer of Health Information to Patient — PostAcute Care
- MUC18-135: Transfer of Health Information to Provider — PostAcute Care

To briefly summarize, NAHC finds problems with MUC18-101 because it does not include a consideration of whether the acute care a patient may seek after hospice care is aligned with the patient's goals. We believe that measures assessing goal attainment and specifically whether a patient's goals of care align with the care received are more meaningful and could be utilized for hospice performance improvement and consumer education much more efficiently and effectively than the proposed transitions of care measure. If the measure is used in the hospice quality reporting program it is critical that a dry run be implemented and results critically analyzed before any public reporting. If this measure is used for public reporting there must be a clear explanation of the measure, in layman's terms, that accompanies the posting.

The third of these measures, MUC18-135, includes the transfer of medication information when a patient is being transferred to settings including:

- Private home/ apartment (),
- Board/care,
- Assisted living,
- Group home,
- Transitional living or
- Home under care of organized home health service organization or hospice

It is unclear as to why a home health agency would need to provide a medication profile to the patient, family and/or caregiver in a transfer to another home health service organization or hospice as the patient would continue to receive care by the other home health service organization or hospice and the medication profile would be shared with this provider as a matter of practice.

The Measures Application Partnership (MAP) is a group convened by the National Quality Forum (NQF) to review the measures as part of the pre-rulemaking process. In the first calendar quarter of 2019, the recommendations on the measures under consideration will be available. Based in part on the recommendations, CMS will determine which, if any, of the measures will be used in the quality reporting programs.