E-Alliance Extra

***Missouri Alliance for* Home Care**

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In This Edition:

Are You Ready for the Changes Ahead?
2020 MAHC Annual Conference & Home Care Exhibition – "*A Season of Change*"

Be sure to mark your calendars for MAHC's 2020 Annual Conference and Home Care Exhibition. The 2020 conference will be held April 22-24, 2020 at the Lodge of Four Seasons, Lake Ozark, MO.

2020 will truly be a season of change! Not only because MAHC has moved the conference location to The Lodge of Four Seasons but for the many changes coming to the home care industry. Home Health will see a new payment model (PDGM) starting January 1 that will require many process changes to be implemented and Home & Community Based personal care providers will see changes in Electronic Visit Verification requirements with the implementation of the 21st Century Cures Act, just to name a few.

Sometimes, how we embrace change is what determines how successful we will be. MAHC will continue to provide our members with the information and resources needed to be successful. We stand ready for the challenge.

Kansas City Chosen as a Location for PDGM 2.0 National Summit

We are excited to announce that Kansas City, MO has once again been chosen as a site for the National PDGM Summit. The PDGM 2.0 National Summit will be held in 12 locations (*CA, FL, LA, MA, MN, MO, NC, OH, PA, TX, UT, WA*) between March 30 – April 10 and will focus on early and consistent "lessons learned" from the PDGM experiences and operational adjustments that are working or not working for HHAs.

MAHC is looking forward to working again with the National Association of Home Care and Hospice (NAHC) to bring Home Health providers this important educational opportunity. More information will be sent once we receive the final date for the Kansas City location. Be sure to watch your email.

Provider Reassessment Training

The Division of Senior and Disability Services (DSDS) has scheduled the 2020 Home and Community Based Services (HCBS) provider reassessment training. The training is for HCBS providers wanting to send qualified staff to become reassessors for their participants.

Attendees must register for the training and submit proof of qualification prior to training. The registration site is located at the following link:
https://www.surveymonkey.com/r/Registration_Provider_Reassessor_Class_2020

Proof of qualification must be submitted to DSDS prior to the training. Proof for RNs shall be a verification report from Nursys Quick Confirm and can be obtained at the following link:
https://www.nursys.com/LQC/LQCTerms.aspx

Proof for persons with a bachelor's degree is the submission of their college transcript or diploma. Send proof to reassessortraining@health.mo.gov

The training dates are listed below:
- February 05-07, 2020, Harry S. Truman Building, 301 West High, JCMO
- April 01-03, 2020, Harry S. Truman Building, 301 West High, JCMO
- June 03-05, 2020, Harry S. Truman Building, 301 West High, JCMO
- August 05-07, 2020, Harry S. Truman Building, 301 West High, JCMO
- October 07-09, 2020, Harry S. Truman Building, 301 West High, JCMO
- December 09-11, 2020, Harry S. Truman Building, 301 West High, JCMO

Any questions regarding this memorandum should be directed to the Bureau of Long Term Services and Supports via e-mail at reassessortraining@health.mo.gov or by phone at (573) 526-8557.

MedPAC Staff Recommend 7 Percent Cut in Medicare Payment to Home Health Providers

On December 5, the Medicare Payment Advisory Commission (MedPAC) convened for a session titled *Assessing Payment Adequacy and Updating Payments: Home Health Care*. This is an annual process where the commission receives a presentation evaluating payment adequacy for services rendered, as well as a report on patient access to home health services, and quality of care. MedPAC staff began their presentation with a few fast facts of the Medicare home health landscape. In 2018 there were 11,500 certified agencies providing 6.3 million episodes of care to 3.4 million fee-for-service (FFS) beneficiaries. This totaled $17.9 billion in spending accounting for 2.6 percent of overall FFS Medicare spending. These figures are consistent with recent years.

Staff went on to present that margins have averaged 16.3 percent since 2001, and that the supply of providers remains high, and that beneficiaries have "good access to care." In reviewing profit margins from 2018, staff reported an average of 15.3 percent in Medicare FFS. When accounting for all payers, the average margin dropped to 4.3 percent.

Following this report, MedPAC staff offered their recommendation on home health payment adequacy. For 2021, MedPAC staff suggested a recommendation to the Congress of a seven percent reduction of the 2020 base payment rate. MedPAC has recommended a five percent reduction for the last several years.

In the following discussion commissioners questioned the differences in FFS Medicare and Medicare Advantage rates, and why FFS Medicare reimburses more than other payers. Staff stated that just about every other payer pays less that FFS, and that the base payment rate was developed it was derived from 1998 utilization data. They went on to state that there has been a gap between cost and reimbursement since 2001. Another commissioner questioned how the seven percent was decided upon. Staff responded that the Affordable Care Act related rate rebasing did not have a serious effect. As such, they believe a more significant reduction would be necessary to close the gap between costs and reimbursement. MedPAC Executive Director stated that seven percent is a conservative reduction given that a 17 percent profit margin is projected for 2020 with the PDGM regulatory changes accounted for. MedPAC Chairman Francis Crosson said the commission would take the seven percent recommendation and vote on it officially in January 2020.

The National Association for Home Care and Hospice (NAHC) strongly disagrees with this recommendation and will advocate against it in Congress. There are various flaws in the MedPAC's calculations. These include certain exclusions in calculating costs, such as marketing, telehealth, and taxes. The MedPAC also limits their data to free-standing agencies, omitting those that are hospital based. Lastly, while reported in the presentation, the MedPAC does not seem to give much consideration to the all-payer profit margin, instead solely focusing on the Medicare FFS alone. In many instances, a 7% payment reduction would prove devastating to

home health agencies across the nation, forcing many out of business and leaving patients without the ability to enjoy the Medicare benefit to its full extent. NAHC will continue to monitor the MedPAC's work in this space and work with Congress to ensure these excessive and unnecessary cuts do not make their way into official Medicare policy.

CMS Releases Info on New Home Infusion Therapy Benefit

A MLN SE article regarding the new Home Infusion Therapy (HIT) Benefit under Medicare Part B was recently released. MLN SE19029 Medicare Part B Home Infusion Therapy Services With The Use of Durable Medical Equipment is intended for entities seeking accreditation to become qualified suppliers that furnish HIT services in coordination with the furnishing of home infusion drugs administered through an item of durable medical equipment (DME) beginning in calendar year 2021 and in subsequent years.

As reported previously, 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 Medicare HIT benefit is for coverage of HIT services for certain drugs and biologicals administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual, through a pump that is a DME item. This benefit is effective January 1, 2021.

Once the home infusion therapy supplier benefit becomes a permanent coverage for Part B, infusion services will be carved out of the home health benefit. Therefore, only accredited home infusion therapy suppliers will be able to bill Medicare for these services. While it will still be possible for home health agencies to provide these professional services under contract with a Part B HIT supplier, a home health agency wanting to bill Medicare directly for these services will need to enroll in Medicare Part B as a home infusion therapy supplier and bill the services on a professional claim (1500/837P).

The new **HIT benefit** covers the service component, meaning the professional services, training and education (not otherwise covered under the DME benefit), and monitoring furnished by a qualified HIT supplier needed to administer the home infusion drug in the patient's home. The **DME benefit** covers three components: the external infusion pump, the related supplies, and the infusion drug. Additionally, this benefit covers the related services required to furnish these items (e.g., pharmacy services, delivery, equipment set up, maintenance of rented equipment, and training and education on the use of the covered items) by an eligible DME supplier. No payment is made under the HIT benefit for these DME items and services.

Qualified HIT suppliers can only bill and be paid for the HIT services furnished on the day on which a professional is physically present in the patient's home and an infusion drug is being

administered on such day. Medicare payment for an infusion drug administration calendar day is separate from the payment for DME items and services.

This MLN SE article provides a detailed summary of the HIT benefit, including a graphic that depicts what is covered under the HIT benefit and what is covered under the DME benefit as well as a table that outlines the billing codes to be used. CMS provides examples of the types of services that would be considered professional services covered by the HIT.

A qualified home infusion supplier must be accredited by a CMS approved accreditation organization prior to providing services under the HIT benefit. To locate or inquire about an approved accreditation organization, you may submit a question to the CMS HIT Accreditation mailbox at HITaccreditation@cms.hhs.gov Accrediting organizations have until February 2020 to apply for authority to accredit HIT suppliers.

Changes to Emergency Preparedness Requirements

A recent final rule released by the Centers for Medicare & Medicaid Services (CMS) relating to burden reduction includes welcome changes to emergency preparedness requirements. The final rule, Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care is effective November 29, 2019.

The changes to the emergency preparedness requirements apply to both home health and hospice providers and are outlined below.

1. Removal of the requirement to document efforts to contact local, tribal, regional, State and Federal emergency preparedness officials and removal of documentation of facility's participation in collaborative and cooperative planning efforts.

   The removal of the documentation requirement does not remove the requirement that providers develop and maintain an emergency preparedness plan that includes a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.

2. Revision of the provider's review of their emergency preparedness program from annually to every two years.

   The biennial review includes a review of the emergency plan, policies and procedures, communication plan, and training and testing program. CMS expects that providers will

update their program more frequently as needed (for example, if staff changes occur or lessons-learned are acquired from a real-life event or exercise).

3. Revision of the training requirement from annually to every two years after the provider has conducted initial training and to provide additional training when the emergency plan is significantly updated.

4. Revision and clarification of the emergency preparedness testing requirements as follows:
    a. Inpatient providers, including hospice inpatient units, must conduct two testing exercises annually.
        i. one of the two annually required testing exercises could be an exercise of the hospice's choice, which could include one community-based full-scale exercise (if available), an individual facility-based functional exercise, a drill, or a tabletop exercise or workshop that included a group discussion led by a facilitator.
    b. Outpatient providers, including freestanding/home-based hospices and home health agencies, must conduct one testing exercise annually.
        i. Either a community-based full-scale exercise (if available) OR
        ii. Conduct an individual facility-based functional exercise every other year. In the opposite years, outpatient providers can conduct the testing exercise of their choice which may include either a community-based full-scale exercise (if available), an individual, facility-based functional exercise, a drill, or a tabletop exercise or workshop that includes a group discussion led by a facilitator.

CMS clarified that if a provider experiences an actual natural or man-made emergency that requires activation of their emergency plan, inpatient and outpatient providers will be exempt from their next required full-scale community-based exercise or individual, facility-based functional exercise following the onset of the actual event. An organization's communication plan is part of their emergency plan, as is coordination with other community emergency preparedness officials (for example, emergency management and public health), and CMS expects that these elements, along with the completion of a corrective action plan, are part of the activation of their emergency plan.

A **full-scale exercise** is a multi-agency, multijurisdictional, multi-discipline exercise involving functional (for example, joint field office, emergency operation centers, etc.) and ''boots on the ground'' responses (for example, firefighters decontaminating mock victims). CMS expects organizations to engage in such comprehensive exercises with coordination across the public health system and local geographic area, if possible.

A **functional exercise** examines or validates the coordination, command, and control between various multiagency coordination centers (for example, emergency operation center, joint field

office, etc.). A functional exercise does not involve any ‘‘boots on the ground’’ (that is, first responders or emergency officials responding to an incident in real time).

GO HERE for the Home Health Emergency Preparedness Conditions of Participation Interpretive Guidelines, and Survey Procedures.

GO HERE for the Hospice Emergency Preparedness: Applicable E-Tags and Excerpts from the Interpretive Guidelines.

New Standards for Handling Hazardous Drugs in Health Care Settings

Effective December 1, 2019, all health care providers are required to follow standards for the safe handling of hazardous drugs (HDs).

The U.S. Pharmacopeia (USP) chapter 800 is set of standards for handling of hazardous drugs (HDs) where there is a risk of exposure to patients, healthcare workers, and the environment. USP General Chapter 800 describes requirements including responsibilities of personnel handling hazardous drugs; facility and engineering controls; procedures for deactivating, decontaminating and cleaning; spill control; and documentation.

The need to help ensure a quality environment and to protect healthcare personnel from hazardous drugs has been a topic of concern for decades. Growing evidence highlights that acute and chronic health effects can occur due to occupational exposure to over 200 hazardous drugs used commonly in health care settings.

These standards apply to all health care personnel who receive, prepare, administer, transport or otherwise come in contact with hazardous drugs and all the environments in which they are handled. The standards related to preparing, administering, and disposing of HDs are areas that will most likely apply to home health and hospice providers.

Like other hazardous chemicals, HDs are regulated under the Occupational Safety and Health Administration’s (OSHA’s) Hazard Communication standard, which requires **information about the hazards of the chemicals in the workplace be available and understandable to workers. The** USP developed standards for handling these hazardous drugs to minimize the risk to public health. The goals of these standards are to help increase awareness, provide uniform guidance to reduce the risk of managing hazardous drugs, and help reduce the risk posed to patients and the healthcare workforce.

Provider will need to assign a person within the organization to oversee the compliance with the standards and to conduct a risk assessment to determine if alternative containment strategies and/or work practices are necessary. If the agency is working with HDs than

standards for engineering controls and procedures to protect patient and staff might need to be implemented.

Click here for the list of HDs developed by the National Institute for Occupational Safety and Health. Click here for updates to the list of HDs.

Click here for more information of the HDs standards in the healthcare setting.

Hospice Quality Reporting Program Update

HOSPICE ITEM SET (HIS) AND HOPE INSTRUMENT

Recruitment Announcement – Alpha Test for the Hospice Outcomes & Patient Evaluation (HOPE) assessment instrument

PLEASE NOTE UPDATE TO BELOW ARTICLE: 12-17-19 - CMS and the HOPE contractor, Abt Associates, just announced that the deadline for application to be part of the alpha testing for HOPE has been extended. The deadline is now **February 21, 2020** with notification to those providers chosen being made on or about March 5, 2020. An honorarium will be provided to participating providers. The full announcement, including eligibility requirements and all the details, can be found here.

Abt Associates is currently recruiting hospice providers to participate in a field test (called an alpha test) of the new hospice patient assessment instrument, titled Hospice Outcomes & Patient Evaluation (HOPE). Data collection is anticipated to begin in February 2020.

CMS is seeking a representative group of hospices, with a range of characteristics, including ownership (profit, nonprofit); and rurality (urban, rural, both). The goal is to include hospices that provide care for a wide range of patient populations, including people with cancer and non-cancer diagnoses, for example.

Recruitment ends 12/20/2019. CMS will notify each applicant on or about 12/31/2019 whether they have or have not been selected to participate in the HOPE alpha test. Providers interested in participating must fill out a survey which can be accessed here.

The detailed recruitment announcement with additional information about the alpha test is available here.

Hospice Quality Reporting Program Compliance Tip Sheet Now Available
CMS has developed a Hospice Quality Reporting Program Compliance Tip Sheet. The purpose of the tip sheet is to provide hospice agencies new to the HQRP with an overview of the basic requirements providers must meet in order to achieve a full Annual Payment Update (APU). The HQRP Compliance Tip Sheet also contains links to numerous resources available to assist providers in meeting those requirements.

Hospice Comprehensive Assessment Measure – One Pager Now Available
CMS has posted a document that articulates key information about the Hospice Comprehensive Assessment Measure. This one pager provides a visual to understand how the seven HIS measures contribute to the one Comprehensive Assessment Measure, and how to stay on target by completing all seven HIS measures for each patient. The document is available here.

CAHPS HOSPICE SURVEY

CAHPS Hospice Survey Response Rate
The CAHPS Hospice Survey response rate for the current reporting period, first quarter of 2017 through the fourth quarter of 2018 (1/1/2017 through 12/31/2018) is 32%.

Case-Mix Adjustment Methods for CAHPS Hospice Survey Measures Document Posted
Updates to the Case-Mix Adjustment (CMA) Methods document which describes refinements to the CMA model, updated coefficients and means from Quarter 2 2017 to Quarter 1 2019 for CAHPS Hospice Survey is available here. The CAHPS Hospice Survey list of ICD-10 codes used for the Case-Mix Adjustment calculations is available here.

CAHPS Hospice Survey State Scores Posted
The CAHPS Hospice Survey state score document for the upcoming public reporting period (second quarter of 2017 through the first quarter of 2019) is available here.

CAHPS Hospice Survey National Percentiles Posted
The CAHPS Hospice Survey National Percentiles document for the upcoming public reporting period, second quarter of 2017 through the first quarter of 2019 (04/01/2017 through 3/31/2019), is available here. Percentiles for top-box and bottom-box scores were calculated for the 2,913 hospices for which CAHPS Hospice Survey measure scores were publicly reported on Hospice Compare for April 1, 2017 through March 31, 2019. Scores have been adjusted for survey mode and case mix.