E-Alliance Extra

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Electronic Visit Verification Delay Passes Congress

The United States Senate unanimously approved bipartisan legislation on Tuesday, July 17, to delay until 2020 the start of the electronic visit verification program to document when personal care services are provided.

An identical bill passed the House of Representatives last month and now the legislation goes to the White House for President Trump to sign into law. The president has 10 days from Tuesday to sign the bill into law.

Congress mandated electronic visit verification (EVV), to begin in January 2019, as part of the 21st Century Cures Act, in order to crack down on fraudulent Medicaid billing.

The legislation passed by Congress allows for a one-year delay of EVV and requires the Centers for Medicare & Medicaid Services (CMS) to hold at least one public meeting by the end of 2019 to solicit comments from stakeholders such as state health officials, caregivers, and patients.

CMS Open Door Forum Reviews CY2019 Home Health Payment Rule

The Centers for Medicare & Medicaid Services (CMS) held its most recent Home Health, Hospice and DME Open Door Forum on Wednesday, July 11. A large majority of the call was dedicated to the 2019 proposed home health prospective payment system (HHPPS) rate update rule. Following is a summary of those provisions and other matters of interest to home health providers.

2019 HHPPS rate update
CMS projects that Medicare payments to HHAs in CY 2019 would be increased by 2.1 percent, or $400 million, based on the proposed policies. The proposed increase reflects the effects of a 2.1 percent home health payment update percentage ($400 million increase); a 0.1 percent increase in payments due to decreasing the fixed-dollar-loss (FDL) ratio in order to pay no more than 2.5 percent of total payments as outlier payments (a $20 million increase); and a -0.1 percent decrease in payments due to the new rural add-on policy mandated by the Bipartisan Budget Act of 2018 for CY 2019 ($20 million decrease). The new rural add-on policy requires CMS to classify rural counties into one of three categories based on: 1) high home health utilization 2) low population density and 3) all others. Rural add-on payments for CYs 2019 through 2022 vary based on counties' category classification.

Physician certification/recertification
CMS proposes to codify into the regulations the physician certification provision that allows the physician to incorporate documentation from home health agency into his /her medical record by signing and dating the documentation. CMS is also proposing to eliminate the statement that estimates how much longer skilled services will be needed as part of recertification for home health services.

Value based purchasing program
CMS proposed to remove the OASIS based measures Influenza Immunization received and Pneumococcal Polysaccharide vaccine ever received. CMS is also proposing to replace the three ADL measures (improvement in bathing, transfer and ambulation) with two composite measures. The composite measures: Total Normalized Composite Change in Mobility and Total Normalized Change in Self Care. Further, CMS is proposes to revise the weights for the measures included in the HHVBP

Home Health Quality Reporting Program (HHQRP)
In accord the CMS' Meaningful measure initiative CMS is proposing to remove 7 measures from HHQRP in 2021

- Depression assessment conducted
- Diabetic foot care and PT/CG education
- Fall risk assessment conducted
- Pneumococcal Polysaccharide Vaccine ever received
- Improvement of status of surgical wounds
- ED use without hospital readmissions during the first 30 days
- Rehospitalization during the First 30 days

Home infusion therapy benefit
The 21 Century Cures Act requires CMS to implement a home infusion therapy benefit that provides separate payment to qualified home infusion therapy suppliers for the professional service associated with intravenous or subcutaneous infusions by a pump that is an item of durable medical equipment (DME).

A qualified home infusion therapy supplier is defined as a pharmacy, physician, or other provider of service or supplier licensed by the state where service are provided.

The professional services under the benefit Include: professional services (nursing); plan of

care; training and education; and remote monitoring. The beneficiary must also be under the care of a physician, nurse practitioner, or physician assistant.

The Act requires CMS to establish standards for accrediting organization (AO) that will be accrediting entities as home infusion therapy suppliers.

Full implementation begins 2021 with a transitional payment period that begins January 1, 2019. Only DME companies with pharmacies and pharmacies currently providing home infusion therapy may be eligible to provide and be paid for the new benefit during the transition period.

CMS clarified during the question and answer portion of the call that home health and hospice providers may provide home infusion therapy under the new benefit beginning in 2021, but must be accredited by a CMS approved AO.

Quality of Patient Care (QoPC) Star Rating
On June 27, CMS and its contractors held a Medicare Learning Network webinar to discuss proposed changes to the home health QoPC star rating system algorithm. CMS proposes to eliminate the measure "Drug Education on All Medications Provided to Patient/Caregiver" and add the "Improvement in Management of Oral Medications" measure. A transcript of the call should be available soon. Public comments on the proposed changes are due July 26, and are to be sent to HH_QM_Comment@abtassoc.com

Outcome and Assessment Information Set (OASIS) D
A draft of the OASIS D manual has been posted to the CMS web site. CMS will be hosting two webinars on the changes to the OASIS D data set. The webinars are scheduled for August 28 and September 5, 2018. Both events are scheduled for 2:00pm-4:00pm ET. Each webinar is limited to 1,500 attendees. Click here to register.

CMS informed participants that they are waiting for approval from the Office of Management and Budget for the official release of the OASIS D data set.

Upcoming Webinar: Hospice Provider and Medicare Part D Walk Through

In recent years the Centers for Medicare & Medicaid Services (CMS) and other policymakers have been closely tracking spending under Medicare Parts A, B and D while a patient is on a hospice election out of concern that these programs may be inappropriately covering items and services connected to the hospice terminal condition and any related conditions. Spending outside of hospice under Parts A and B has diminished over the past five years, but spending under Part D increased during 2016 and 2017.

In an effort to improve understanding of the interaction of hospice coverage for drugs and Medicare Part D, the National Council for Prescription Drug Programs' Hospice Task Group (of which the National Association for Home Care & Hospice and other hospice and part D stakeholders are members) is developing FREE education on this important topic. The first such educational offering is scheduled as follows:

WHAT: Webinar – Hospice Provider and Medicare Part D Walk Through
WHEN: July 24, 2018, at NOON Eastern
FACULTY: Mary Perez, Medicare Part D Senior Systems Analyst, Enrollment for Magellan Rx Management and Nancy Bridgman, Director of Medical Billing for Remedi SeniorCare

Attendees of the webinar will:

- Learn how the hospice provider helps the beneficiary start their hospice journey with Medicare Part A;
- Understand the communication processes with CMS and the Medicare Part D plan;
- Understand the financial responsibility for medications in hospice care;
  - Hospice Medication Coverage,
  - Medicare Part D payment for drugs for patients enrolled in hospice,
  - Retroactivity; and
- Review the hospice Information for Medicare Part D Plans form, also known as A3, used to facilitate communication between Medicare Part D plans, hospices, prescribers, and pharmacists who serve beneficiaries enrolled in hospice.

Click here to register for this free webinar**.**

Recording Available - Webinar on Proposed CMS Home Health Rule

The National Association for Home Health & Hospice (NAHC) held a webinar on the new CMS proposed home health rule and the Patient Directed Grouping Model (PDGM) Friday, July 13.

If implemented, the proposed rule could make major changes to payment rates in 2019, along with creating a new payment model in 2020. NAHC anticipates these proposals would represent some of the most significant changes in the home health payment system in nearly 20 years**.**

If you were unable to participate in the live webinar, below is information on how to access the recording and handouts from the event:

Recording: https://nahc.webex.com/nahc/onstage/playback.php?RCID=43917585bd3183c756f48cdb8287cd3a

Handouts: https://www.nahc.org/wp-content/uploads/2018/07/WebEvent_18-07-13-1300_Handout.pdf

Recording Available - Hot Topics in Labor Law Part II

The National Association for Home Care & Hospice (NAHC) and the Private Duty Home Care Association (PDHCA) held a webinar called **Current Trends in Regulatory & Legal Issues: An Update on Private Duty** on Thursday, July 12, 2018. This webinar provided private duty providers with regulatory and legal updates, as well as a discussion of other timely topics of importance to the industry.

If you were unable to participate in the live webinar, below is information on how to access the recording and handouts from the event along with Part I which was held on April 12th:

July 12th
Handouts - https://www.nahc.org/wp-content/uploads/2018/07/WebEvent_18-07-12-1400_Handout.pdf

Recording -
https://nahc.webex.com/ec3300/eventcenter/recording/recordAction.do?siteurl=nahc&theAction=poprecord&recordID=17460587&internalRecordTicket=4832534b00000004a0f0a851ae7759f95e1f296c5dc12ce9264d5f719d8ac4ba7fd9e4e75837a878

April 12th
Handouts - https://www.nahc.org/wp-content/uploads/2018/04/WebEvent_18-04-12-1400_Handout.pdf
Recording -
https://nahc.webex.com/ec3300/eventcenter/recording/recordAction.do?siteurl=nahc&theAction=poprecord&recordID=17013552&internalRecordTicket=4832534b00000004a03e894ab7cfd96bc07b27a25d054b076b18722f9ce66dc436856ad23227abd4

MedPAC Report Considers Unified PAC Payment System, Finding Best Providers

The Medicare Payment Advisory Commission (MedPAC) report released on June 15, 2018 included refinements to their proposed unified post-acute care prospective payment system and for greater patient usage of high quality post-acute care providers.

The refinements to a unified post-acute care prospective payment system would focus on increasing Medicare payment accuracy for patients involved in sequential post-acute care. While Medicare currently employs separate and distinct prospective payment systems for stays across the post-acute sector, Congress called for a unified PAC payment system, with MedPAC recommending implementation of the new system to begin in 2021.

Payments to home health agencies would decline over the course of a sequence of stays under a unified PAC payment system, but the fall in costs would more than make up for the lower payments, making home health stays in a sequence more profitable than they previously, according to MedPAC's new report.

The report reads: "higher profitability for later home health stays suggest the need for an adjustment to payments based on the timing of the stay to more closely align payments with costs. Otherwise, (HHAs) could generate additional profits by referring beneficiaries for additional home health care, assuming the beneficiary continued to meet coverage rules."

Choosing the Best Provider
The report emphasizes MedPAC's concern that patients discharged from hospitals rarely choose the best home health provider and frequently choose one substantially inferior to the best. Advocating for the use of higher quality post-acute care providers, the Commissioners wrote that at "discharge from an inpatient stay, the selection of a provider within a PAC category can be crucial because the quality of care varies widely among providers."

According to the report, 94 percent of home health beneficiaries do not choose the highest-quality provider and about 70 percent have at least five home health providers within a 15-mile radius with higher quality care than the one they choose.

What's more, the differences in quality between the agencies are often quite stark. "The magnitude of the quality difference between the higher performing nearby providers and the provider selected was substantial in many cases," noted MedPAC in its report.

Hospitals are not permitted to recommend specific agencies and MedPAC suggests patients and their families may be too stressed and/or distracted by medical issues to properly choose among the various providers in their area.

Helping patients choose higher quality providers should be a goal of the Medicare program, the report recommends. Interestingly, the report also suggests hospitals should play a bigger role in assisting patients to choose the right post-acute care provider.

MedPAC concedes concerns about potential conflicts of interest in allowing hospitals to recommend home health agencies are real and safeguards would be needed to prevent that.

"Concern about protecting patient choice … makes some discharge planners cautious in the assistance they provide, even when patients ask for their opinion," the Commissioners wrote. "Hospital and health system representatives have been concerned that [CMS' conditions of participation] do not adequately define permissible educational activities that respect the beneficiary's freedom to select a PAC provider."

However, the MedPAC report also found that existing tools to assist patients in choosing a provider, such as Home Health Compare, are not significant factors in helping patients make an informed choice. It turns out that the best performing home health agencies have increased their market share by an average of less than one percent since home health quality data became publicly available on the Medicare website.

"While provider quality information can be useful for consumers, it has had limited or minimal success in getting beneficiaries to select higher quality providers," the Commissioners found.

While choosing the best provider is a top consideration, the National Association for Home Care & Hospice notes that other factors – such as convenience, and cultural issues, like language, are also properly considered by patients when choosing a provider. MedPAC concedes this point in its report.

MedPAC is considering new policies for managed care plans for Medicare and Medicaid beneficiaries to encourage the creation of plans that integrate care.

Considering fee-for-service Medicare and Medicare Advantage plans, the Commission wrote that coverage "policies are often based on little evidence and usually do not include an explicit considering of a service's cost-effectiveness or value relative to existing treatment options. As a result, the coverage process does not prevent the use of low-value services."

The Commission recommended various tools to reduce usage of low-value care by Medicare beneficiaries.

MedPAC is an independent government agency created by the Balanced Budget Act of 1997 and charged with advising Congress on issues related to the Medicare Program. The Commission considers issues related to quality of care, access to care, payment systems and other subjects relevant to Medicare. Congress is encouraged to take MedPAC recommendations under consideration, but is not required to follow those recommendations and frequently does not.

OIG to Review Home Health Claims and MA Plans

The Department of Health and Human Services (HHS), Office of Inspector General (OIG) has issued a revised work plan that includes a review of home health claims with episode having 5-10 visits and a plan to review Medicare Advantage plans for inappropriate denials. This review would involve multiple provider types.

Review of Home Health Claims for Services With 5 to 10 Skilled Visits
If a home health agency (HHA) provides four or fewer visits from a skilled service provider that are included under home health coverage (excluding visits providing only services listed in 42 CFR § 409.49) in an episode, the HHA will be paid a standardized per-visit payment based on visit type. Such payment adjustments, and the episodes themselves, are called Low Utilization Payment Adjustments (LUPA). Once a fifth visit is provided, an HHA will instead receive a full 60-day payment based on episode of care. Since OIG has not reviewed payments for LUPA, we will review supporting documentation to determine whether home health claims with 5 to 10 skilled visits in a payment episode in which the beneficiary was discharged home met the conditions for coverage and were adequately supported as required by Federal guidance.

Inappropriate Denial of Services and Payment in Medicare Advantage
Capitated payment models are based on payment per person rather than payment per service provided. A central concern about the capitated payment model used in Medicare Advantage is the incentive to inappropriately deny access to, or reimbursement for, health care services in an attempt to increase profits for managed care plans. We will conduct medical record reviews to determine the extent to which beneficiaries and providers were denied preauthorization or payment for medically necessary services covered by Medicare. To the extent possible, we will determine the reasons for any inappropriate denials and the types of services involved.

Heightened CMS Medicaid Oversight Could Lead to Audits, Red Tape

The Centers for Medicare & Medicaid Services (CMS) announced Tuesday, June 26, that it is moving forward with an initiative "to strengthen Medicaid program integrity," with plans for stricter enforcement of federal rule compliance, tighter regulation of contracts between sates and private insurance, greater oversight of beneficiary eligibility, and a beefed-up audit system.

Medicaid spending has risen to an estimated $576 billion in 2016 from $456 billion in 2013, with the federal contribution rising $100 billion to $363 billion.

This new CMS initiative comes only a few weeks after the late May proposal from the agency that pre-claim review be revived later this year. Clearly, restraining spending is a priority for

CMS and the administration.

The new initiative will strongly feature audits of state claims for federal matching funds and state determinations of beneficiary eligibility, particularly states found by the Office of Inspector General to be high risk, as well as auditing for medical loss ratios, and rate setting by the states. States will be audited on the basis of spending on quality and services compared to profit and administration, according to the CMS.

CMS will also validate “the quality and completeness” of claims and provider data it receives from the states.

“As we give states the flexibility they need to make Medicaid work best in their communities, integrity and oversight must be at the forefront of our role,” said CMS Administrator Seema Verma in a statement accompanying the announcement. “Beneficiaries depend on Medicaid and CMS is accountable for the program’s long-term viability.”

In 2022, the CMS can begin issuing disallowances to states based on Payment Error Rate Measurement conclusions.

“The initiatives released today are essential to help strengthen and preserve the foundation of the program for the millions of Americans who depend on Medicaid’s safety net,” said Verma. “With historic growth in Medicaid comes an urgent federal responsibility to ensure sound fiscal stewardship and oversight of the program. These initiatives are the vital steps necessary to respond to Medicaid’s evolving landscape and fulfill our responsibility to beneficiaries and taxpayers.”

Administrator Verma set forth three pillars to guide CMS’ work in the Medicaid program: Flexibility, Accountability, and Integrity. Emphasizing these, she expanded on the role of CMS saying, “As we give states the flexibility they need to make Medicaid work best in their communities, integrity and oversight must be at the forefront of our role. Beneficiaries depend on Medicaid and CMS is accountable for the program’s long-term viability. As today’s initiatives show, we will use the tools we have to hold states accountable as we work with them to keep Medicaid sound and safeguarded for beneficiaries.”

New Home Health Agency PEPPER Available

The Q4CY17 release of the Home Health Agency (HHA) Program for Evaluating Payment Patterns Electronic Report (PEPPER) with statistics through December 2017 is now available for download through the PEPPER Resources Portal. To obtain your agency's PEPPER, the Chief Executive Officer, President, Administrator or Compliance Officer should:

1. Review the Secure PEPPER Access Guide.
2. Review the instructions and obtain the information required to authenticate access. Note: A new validation code will be required. A patient control number (UB04 form locator 03a) or medical record number (UB04 form locator 03b) from a claim for a traditional Medicare FFS beneficiary with a claim "from" or "through" date between October 1 - December 31, 2017, will be required.
3. Visit the PEPPER Resources Portal.
4. Complete all the fields.

5. Download your PEPPER.

The HHA PEPPER will be available to download for approximately two years. A webinar to review the new PEPPER is scheduled for Thursday, July 25, at 2 p.m. CDT. For more information visit the HHA Training and Resources page.

About PEPPER
PEPPER is an educational tool that summarizes provider-specific data statistics for Medicare services that may be at risk for improper payments. HHAs can use the data to support internal auditing and monitoring activities. Visit the HHA Training and Resources page at PEPPERresources.org to access resources for using PEPPER, including recorded web-based training sessions, a sample HHA PEPPER and the current HHA PEPPER User's Guide. PEPPER is distributed by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services.

Do you have questions or comments about PEPPER or need help obtaining your report? Visit our Help Desk to request assistance with PEPPER. Provide your feedback or suggestions regarding PEPPER through our feedback form.

House Committee Approves Key Hospice Bill Supported by NAHC

The Energy and Commerce Committee of the U.S. House of Representatives approved on Thursday, July 12, 2018, the Palliative Care and Hospice Education and Training Act (H.R. 1676), a piece of legislation the National Association for Home Care & Hospice (NAHC) has supported and helped guide through Congress for months.

The Palliative Care and Hospice Education and Training Act (PCHETA), authored by Reps. Eliot Engel (D-NY), Tom Reed (R-NY), and Buddy Carter (R-GA), passed the committee by a voice vote.

PCHETA would increase the number of permanent faculty in palliative care at accredited medical, nursing, and social work schools, and other programs; promote education and research in palliative care and hospice and support the development of faculty careers in academic palliative medicine.

Intended to address the anticipated need for trained palliative care professionals, PCHETA has swiftly attracted bipartisan support in the House and in the Senate, where it has been sponsored by Sens. Tammy Baldwin (D-WI) and Shelley Moore Capito (R-WV).

“This bill is particularly important to me, and one that I have heard about its potential impact from specialists and disease advocates from across my home state of Oregon,” said Committee chair Rep. Greg Walden (R-OR).

“This bill not only increases palliative care awareness and workforce training to improve quality of life in those final days, but hospice care lowers health care cost — making this legislation a win-win we should all support,” wrote Rep. Reed on Twitter.

PCHETA would strengthen training for existing and new physicians, as well as other providers who are part of the palliative care team. The Act also boosts palliative care teaching and research. The Act would also create a national education campaign to inform medical professionals, patients, and families about the benefits of palliative care and hospice.

The legislation would direct the National Institutes of Health (NIH) to use existing funds and authority to expand palliative care research.

In addition, the Act would create academic and career incentive awards by providing grants or contracts to health professionals who agree to teach or practice in the palliative care field for at least five years.

Studies indicate that patients receiving earlier exposure to palliative care had:

- Lower rates of inpatient admissions in the last 30 days of life (33 percent vs. 66 percent)
- Lower rates of ICU use in the last month of life (5 percent vs. 20 percent)
- Fewer emergency department visits in the last month of life (34 percent vs. 39 percent)
- Fewer deaths within three days of hospital discharge (16 percent vs. 39 percent)
- Lower 30-day mortality rates post hospital admission (33 percent vs. 66 percent)

In 2000, less than 25 percent of U.S. hospitals had a palliative care program, but 13 years later that had increased to about 75 percent. However, in the 2014-15 academic year, a mere 265 physicians were trained by accredited programs in palliative and hospice medicine. Meanwhile, reliable estimates indicate the United States needs thousands of palliative care experts merely to serve current needs, to say nothing of the future.

(from NAHC Report)