E-Alliance Extra

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In This Edition: *(from NAHC Reports)*

Important Home Health and Hospice News in Latest CMS Open Door Forum

The Centers for Medicare & Medicaid Services (CMS) held a Home Health, Hospice & DME Open Door Forum (ODF) on April 3, 2019. Below is a summary of the ODF topics pertaining to home health and hospice.

Home Health

REVIEW CHOICE DEMONSTRATION - CMS representatives indicated that the start date for the Review Choice Demonstration (RCD) is June 1, 2019 for Illinois. According to CMS, the RCD incorporates more choice and less burden for providers while allowing CMS to be better positioned to identify and prevent fraud, protect beneficiaries from harm, and safeguard taxpayer dollars to empower patients while minimizing unnecessary provider burden. The RCD will begin in Illinois and is then slated to begin in four other states – Florida, Ohio, Texas, and North Carolina – at a later date . CMS will provide 60 days notice before the RCD begins in any of the other states.

SYSTEMS READINESS FOR PDGM -In the last ODF CMS drew attention to change request (CR) 11081 and indicated it was a down payment on the transmittals to come in 2019 in preparation for the PDGM. However, no transmittals have been released other than the CR11081. CMS indicated it expects others to be released soon as there are updates to the systems and the corresponding CMS Manuals relative to the 30-day episodes of care and diagnosis coding instructions raised on a national provider call in February among others. Providers should be watching for new CR releases.

HH CAHPS and HH QRP - The quarterly HH CAHPS newsletter posted on January 1, 2019 and the April edition is now posted.

CMS also reminded home health agencies that they must participate monthly in the HH CAHPS survey in order to receive the full annual payment update. For agencies that have not participated and need to sign up to do so as well as for agencies that stopped participating in the HH CAHPS and now need to participate again, now is a good time to begin that registration process. Agencies starting now will not miss the first month of participation which is April 2019; however, the data collection does not begin until later in May 2019. Providers should reach out to RTI, the CMS contractor, to begin the HH CAHPS registration process at HHCAHPS@rti.org

The CY2018 fourth quarter data submission deadline is April 18, 2019. Providers are encouraged to begin verifying their agency's data submission through their vendor now. Providers can contact vendors directly for this information or go to the HH CAHPS survey website portal (ID and password required) where the data submission history for the agency is housed. Even if a vendor does not submit data on behalf of a home health agency, it is the agency's responsibility to ensure the data is submitted and it is the agency that will then be subject to the 2% financial penalty for the applicable annual payment update.

Some home health agencies are eligible for an exemption from participation due to size.

Require HHAs to do monthly survey participation to receive the full APU and if a very small agency and quality for a HHCAHPS exemption should complete this for 2021 APU. Your home health agency (HHA) can request an exemption if you served 59 or fewer HHCAHPS-survey eligible patients between April 1, 2018, and March 31, 2019. Every fall, CMS reviews all participation exemption requests to evaluate, with other data, whether your agency will receive an exemption. If an agency knows now, however, that is exempt for CY2021 annual payment update, it should submit its form now. Exemptions are only good for one year. More information about the exemption and the exemption form are available on the HH CAHPS Survey webpage.

CMS is developing an updated OASIS instrument – OASIS D-1 – to be implemented January 2020. The updated instrument is expected to be released in early summer 2019. The updates were needed to align with the CY2020 home health changes.

CMS released a fact sheet, Understanding OASIS Function M & GG Item Coding Fact Sheet which can be found here. There was also an OASIS D Q&A document released which can be found here.

As of March 22, 2019 providers can download the latest Provider Preview reports and Star Rating Preview Reports for the July 2019 Home Health Compare refresh. Reports remain in the CASPER folders and are available to providers for 60 days only. The Star Ratings Provider Preview Reports remain in the CASPER folders and are available to providers for 90 days only. Providers are encouraged to save a copy of their preview reports for later reference.

There are three new artifacts posted to the Home Health Star Ratings webpage. They are:
HH Quality of Patient Care Star Rating July 2019 Sample Provider Preview
Quality-of-Patient-Care-Star-Ratings-FAQs-updated_for_Apr_2019_20190206
QoPC-Fact-Sheet-For-HHAs_for_April_2019_20190206

Hospice

CMS announced in the final FY2019 hospice payment rule its intent to display the "Visits when Death is Imminent" Measure Pair on Hospice Compare some time during FY2019. Earlier this week CMS announced its intention to move forward with public display during summer 2019 of Measure 1 – the percentage of patients who receive at least one visit from a registered nurse, physician, nurse practitioner, or physician assistant in the last three days of life. However, at this time CMS will **NOT** display Measure 2 – the percentage of patients receiving at least two visits from a medical social worker, chaplain or spiritual counselor, licensed practical nurse, or hospice aide in the last seven days of life — as additional testing is needed to ensure the measure's accuracy and reliability. Once CMS has conducted the additional testing it will decide whether to adapt Measure 2 or modify how the measure would be displayed on Compare.

Quality Measure (QM) scores for Measure 1 and Measure 2 will be available in each hospice's CASPER folder but scores for Measure 2 will not be included on the forthcoming Provider Preview report since Measure 2 will not be placed on Compare. Hospices must continue to collect data for both measures.

Additional information about public reporting of the "Visits when Death is Imminent" Measure is available Here, and a Q & A document on Measure 2 is available Here.

As of April 1 hospice providers can now access their Hospice Review and Correct reports through CASPER. The purpose of these reports is to give hospices a chance to correct QM data if needed. The reports contain 12 months of data at the hospice level and patient level for all measures based on HIS submissions. CMS will conduct training on the Review and Correct reports in June 2019. A specific date has not yet been finalized and more information will be forthcoming.

The May 2019 refresh of Hospice Compare will post new provider demographic data. This addition to Compare was part of the FY2019 Hospice Final Rule and the data will come from the Medicare Hospice Provider Utilization and Payment Data files (PUF). This will be under a new General Information section on Compare. The data is based on claims that have been adjudicated al # of patients cared for by hospice on average each day which is the average daily census (ADC), levels of hospice care provided, medical conditions treated, and location of care provided. The zip code search functionality will also be updated.

The next CAHPS Hospice Survey data submission deadline is May 8, 2019. Providers are encouraged to start checking the Survey Data Warehouse long before the deadline to ensure data is submitted by your vendor. Hospices are also encouraged to make the CAHPS survey available in languages that your patients typically use. The written survey is currently available in the following languages:

- English
- Russian
- Traditional and Simplified Chinese
- Spanish
- Portuguese
- Vietnamese
- Polish
- Korean

And, the phone survey is available in the following languages:

- English
- Spanish
- Russian

CMS representatives encouraged hospice providers let them know if a questionnaire needs to be translated into another language.

The CAHPS Hospice Survey Technical Corrections and Clarifications to the CAHPS Hospice Survey *Quality Assurance Guidelines V5.0 (QAG V5.0)* document has been posted. Revisions were made to the Russian Mail Survey Instructions for all three survey versions. CMS has released a Russian translation of the CAHPS Hospice Survey Telephone Script. This document may be accessed by clicking here.

New content has been added to the following Hospice CAHPS Survey podcasts: Selecting and Authorizing a Survey Vendor, Data Hospices Must Provide to their Survey Vendor, Changing Survey Vendors and Public Reporting. Podcasts can be accessed here.

CMS to Publish MAC "Cost Report Acceptability Checklists" in Medicare Manual

The Centers for Medicare & Medicaid Services (CMS) has published a transmittal (Transmittal 2273/Change Request 10920) indicating intent to publish (as Exhibits in a forthcoming revised Chapter 8 of the Medicare Financial Management Manual) Cost Report Acceptability Checklists for Hospitals, SNFs, Home Health Agencies/Hospices, and Home Offices that are currently used by the Medicare Administrative Contractors (MACs) to assess the completeness of submitted provider cost reports. CMS has also updated the Checklists to include new information regarding electronic submission of cost reports and to reflect a recent requirement that MACs make direct contact with a provider within 24 hours of a cost report rejection to notify the provider of rejection and payment suspension.

The Checklists have previously not been publicly available because they contained "post acceptability instructions" that contain confidential information. CMS will "delink" the Checklists from the post acceptability instructions to allow for publication, and rename the post acceptability instructions as instructions for a "Modified Desk Review."

The changes become effective for cost reports received on or after 7/01/2019.

Short-Term Extension of Key Medicaid Programs Passes Congress

The United States Senate joined the House of Representatives in overwhelmingly approving a short-term extension of the Medicaid Money Follows the Person Program and the spousal impoverishment protections under Medicaid home and community-based services (HCBS).

The Senate voted to approve the extensions on April 2, 2019; just a few days after the House approved the bill on March 25. The bill will now be sent to President Donald Trump, who is expected to sign is quickly.

In addition to funding Money Follows the Person and extending spousal impoverishment protections, the *Medicaid Services Investment and Accountability Act of 2019 (H.R. 1839) also ACE Kids Act, which e*xpands access to patient-centered, pediatric-focused coordinated care models tailored for children with medically complex health problems. This provision is designed to help coordinate care, improve quality, and reduce costs through the creation of health homes. Home health agencies are eligible providers in such a model.

The Money Follows the Person program provides funding to state Medicaid programs to take steps allowing Medicaid beneficiaries to remain in their homes instead of placement in an institutional setting. These steps could include, but are not limited to personal care services, transportation, and home modifications.

Historically, spousal impoverishment protections were put in place so that the spouses of Medicaid institutional long-term services and supports (LTSS) recipients were able to maintain certain levels of incomes and assets without counting against the Medicaid status of the institutional LTSS receiving spouse. These protections were not allowable in cases of patients receiving home and community based services. The Affordable Care Act extended these protections to HCBS scenarios; however they were not made permanent and have needed ongoing extensions to continue.

Both Money Follows the Person and spousal impoverishment protections recently expired at the end of 2018, but in January of 2019 were extended until the end of March.

Following the House's approval, the bill proceeds to the Senate, where it is expected to be fast-tracked through the chamber. These extensions are projected to last through September 2019, at which point they will need to be addressed again.

CMS Releases Transmittals to Update Manuals to Reflect Home Health Final Rule 2019 Changes

The Centers for Medicare & Medicaid Services (CMS) released two transmittals on March 22, 2019 that update CMS manuals to reflect changes made by the CY2019 Home Health Final Rule to the updated plan of care requirements and the elimination of the requirement that the physician estimate the length of home health services at recertification.

Both Transmittals are part of Change Request (CR) 11104, Manual Updates Related to Home Health Certification and Recertification Policy Changes. Transmittal 870 updates the Program Integrity Manual, Chapter 6 to reflect that the physician does not need to estimate the length of home health services on recertifications. Transmittal 258 updates the Benefit Policy Manual, Chapter 7 to reflect the same and to reflect the requirements of the updated plan of care that were outlined in the Final Rule for 2019. The changes are effective for recertifications made on or after January 1, 2019 and the Medicare Administrative Contractors (MACs) and home health agencies have been observing them.

The update to Chapter 6 of the Program Integrity Manual states:
Medicare does not limit the number of continuous episode recertifications for beneficiaries who continue to be eligible for the home health benefit. The physician certification may cover a period less than but not greater than 60 days. Because the updated home health plan of care must include the frequency and duration of visits to be made, the physician does not have to estimate how much longer skilled services

will be needed for the recertification.

The recertification statement must indicate the continuing need for services.

The update to Chapter 7 of the Benefit Policy Manual states in Section 30.2.1 Content of the Plan of Care: *For HHA services to be covered, the individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment. In addition, the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in 42 CFR 484.60(a) that establish the need for such services. All care provided must be in accordance with the plan of care.*

And in Section 30.5.2 Recertification the list of what the physician must certify (attest) is updated with: *Because the updated home health plan of care must include the frequency and duration of visits to be made, the physician does not have to estimate how much longer skilled services will be needed for the recertification.*

Of particular note is the policy change in the Benefit Policy Manual, chapter7, section 30.2.1, where it states "*In addition, the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in 42 CFR 484.60(a) that establish the need for such services.*" The National Association for Home Care& Hospice has confirmed with CMS that the policy requires the plan of care (POC) contain elements within §484.60(a) that support medical necessity, but the POC does not need to include all the items in §484.60(a) if not material for payment. CMS also confirmed that this policy applies to any claim submitted since the January 13, 2018 effective date for the revised home health conditions of participation.

Therefore, agencies do not need to re-bill claims if all of the items listed in §484.60(a) are not on the POC, as long as the item is not required to support medical necessity, for example, the patent's advanced directives. Although, all of the items in §484.60(a) must be included on the POC for compliance with Conditions of Participation, all of the items may not be necessary as a condition for payment.

CMS also clarified that the implementation and effective date of April 22, 2019 in the CR reflects the date for when the manuals are to be updated.

Home Health Quality Reporting Program Update

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Updated OASIS-D Q&A Document

An updated question and answer (Q&A) document containing responses to questions from CMS OASIS-D trainings is now available. The Q&A document was originally posted on December 4, 2018 but did not contain answers to questions that required additional research. Those answers have now been updated. The questions were posed during the following OASIS-D trainings:

- The Introduction to the OASIS-D Webinar that occurred on August 28, 2018;

- The Section GG: Functional Abilities and Goals Webinar that took place on September 5, 2018; and
- The November 2018 Home Health Quality Reporting Program Provider Training that occurred on November 6 and 7, 2018, in Baltimore, MD

Preview Reports and Star Rating Preview Reports Now Available

Providers can now download the latest Preview Reports from CASPER. The data in these Preview Reports are for the July Home Health Compare refresh. There are two – Preview Reports and Star Rating Preview Reports. *Please note:* the Preview Reports are only available to providers for 60 days and the Star Rating Preview Reports are only available to providers for 90 days. We suggest you print or save a copy of both Reports for future reference.

Revised HH CAHPS Spanish Materials

Providers using Spanish materials need to update them. The HHCAHPS Survey Spanish translations with the corrected use of the accent on the word "cuándo" in multiple questions have been posted to the website as standalone documents and as an appendix in the HHCAHPS Protocols and Guidelines Manual, v 11.0. As a reminder, the accent was removed from the word "cuándo" in Q2, Q3, Q4, Q5, Q22, and Q23 and from the cover letters. The accent was retained on the word "cuándo" in Q13 and Q15.

MedPAC Recommends Cut in Hospice Base Payments for FY2020

The Medicare Payment Advisory Commission (MedPAC) has recommended to the U.S. Congress a two percent reduction in hospice base payments for fiscal year 2020 in its 2019 Report to Congress.

Given recent historical data trends, implementation of the MedPAC recommendation for FY2020 would result in – roughly – no update to payment rates, which is comparable to MedPAC's recommendations for a hospice payment freeze as part of its recommendations over the last few years. However, it is unclear at this time whether or not Congress will take action during 2019 to implement MedPAC's recommendations.

In arriving at its recommendations, MedPAC analyzes payment adequacy, quality of care, providers' access to capital, and Medicare payments and providers' costs. During 2017 approximately 1.5 million Medicare beneficiaries received hospice care, accounting for over 50 percent of decedents. The number of Medicare-certified providers has risen in each of the last 10 years, and in 2017 the number rose by 2.4 percent (to nearly 4,500). Medicare hospice outlays totaled $17.9 billion. Average profit margins in 2016 were 10.9 percent, up from 9.9 percent in 2015. Freestanding, for-profit, and urban hospices generally averaged higher margins than rural, non-profit, home-health and hospital-based settings. MedPAC projects that the 2019 hospice Medicare margin will be approximately 10.1 percent, although margins vary widely by hospice type. This margin calculation does not include costs for bereavement or volunteer services, which if included would reduce average margins by as much as 1.7 percent (combined).

The hospice chapter generally provides updates to information provided on an annual basis; readers interested in a more in-depth view of the data elements are encouraged to review the hospice

chapter directly. However, the chapter does provide some items of specific note that are referenced below:

Hospice and Medicare Advantage

Given the Centers for Medicare & Medicaid Innovations' (CMMI's) recent announcement of plans to test inclusion of hospice under the Medicare Advantage (MA) benefit package as part of the Value-Based Insurance Design (VBID) model, it is interesting to note that MedPAC's hospice utilization data for MA and fee-for-service decedents are roughly comparable — 49.5 percent of fee-for-service decedents utilized hospice in 2017, as compared with 52.4 percent of MA beneficiaries. This is an indication that fee-for-service decedent utilization of hospice is closing what was previously a significant gap. Further, MedPAC notes that "Hospice length of stay is generally similar for hospice decedents in FFS Medicare and MA."

New Models and Services Related to End-of-Life Care

Given the number of advances that have occurred in recent years related to end-of-life care, the 2019 chapter includes an overview of key changes in this area and some preliminary findings related to their impact.

Margins for Over-Cap Providers

In recent years MedPAC and others have closely monitored data related to the hospice aggregate cap and characteristics of over-cap providers. As part of the 2019 chapter MedPAC notes that for the first time in 2016 average margins of over-cap hospices (after return of overpayments) exceeded those of non-cap hospices (12.6 percent vs. 10.7 percent, respectively). MedPAC notes that this may be an indicator that above-cap hospices are "becoming better at bringing their utilization closer to the cap."

MedPAC will continue to meet in the coming months and will likely begin discussion of its charge to study the impact of extension of the post-acute transfer policy to hospital discharges to hospice, which began October 1, 2018.

MedPAC Calls for Home Health Rate Cut, NAHC Objects

MedPAC, the Medicare Payment Advisory Commission, released its annual March report to Congress on March 15, 2019. MedPAC is required to produce this report; however, Congress is not required to act upon all the recommendations contained in the report and historically has not done so.

MedPAC is recommending a five percent cut in the Medicare home health base payment rate for 2020 and indicated that this cut would also need to be accompanied by a rebasing of the rate in order to align Medicare payments with providers' actual costs. MedPAC indicated that the planned revisions to the home health PPS likely will alter the mix and level of services HHAs provide and future rebasing should reflect the new patterns of care. Those data will not be available until mid-2021.

MedPAC cited adequate payment, as evidenced by the following, as the basis for the payment cut recommendation.

- Beneficiaries' access to care
- Quality of care
- Providers' access to capital
- Medicare payments and provider's costs

The Report indicates over 98 percent of beneficiaries lived in a ZIP code where an HHA operated in 2017, and 84 percent lived in a ZIP code with five or more HHAs. NAHC notes this is a decline from the past and no information about the 2% of the Medicare population (nearly 1 million people) who do not have any access to home health services is provided in the Report.

"The recommendations from MedPAC on home health services and hospice are no surprise as the commissioners voted on them at their January meeting," said NAHC President William A. Dombi, in response to the report's release on the afternoon of Friday, March 15. "We disagree with those recommendations in all respects. The March Report sets out the MedPAC analysis and basis for its recommendations. As in past years, the report falls short of a full disclosure and presentation of the facts relevant to Medicare payment rates. While there are some improvements in the way data is presented, the report continues to rely on simple averages that do not display the wide range in financials for providers, gives short shrift to hospital-based providers, and essentially ignores the overall financial status of home health agencies and hospices. Notably, the report presents trend analyses that do not focus on recent times in evaluating changes that are vital to whether care is accessible and in full use.

"We will be working with Congress to provide all the needed information to assure a full understanding of the current state of home health services and hospice care," said Dombi.

In 2017 freestanding HHAs' marginal profit—that is, the rate at which Medicare payments exceed providers' marginal cost—was 17.5 percent according to MedPAC calculations and suggests a significant financial incentive for HHAs to serve Medicare patients. The Medicare margins for freestanding agencies averaged 15.2 percent. The projected margin for 2019 is 16 percent. However, MedPAC also indicates that HHA volume dropped 3.1 percent in 2017, the total number of FFS users also fell slightly, and the average number of episodes per home health user declined by 1.4 percent.

NAHC and other industry stakeholders have had concerns about HHA profit calculations used by MedPAC. MedPAC specifies its marginal profit and Medicare margin calculations are for freestanding agencies only and also provides an average all-payer margin of 4.5 percent. This differs from the NAHC calculation which shows an average all-payer margin of 2 percent. NAHC has asked for an explanation of the MedPAC calculation.

Two factors were cited in the Report for payments exceeding costs:

- Agencies have reduced episode costs by decreasing the number of visits provided, and
- cost growth in recent years has been lower than the annual payment updates for home health care.

It is important to note, however, that home health agencies have incurred cost increases. Some cost increases were referenced by MedPAC as it relates to the PPACA (Patient Protection and Affordable Care Act) changes to home health payment, but MedPAC focused more on the "net payment reduction" impact of the PPACA. Congress has legislated an annual update formula for home health agencies that

is intended to reflect cost increases, not simply to raise rates for no valid reason.

In the Report, MedPAC indicates that ensuring appropriate use of home health care is challenging. MedPAC acknowledges that skilled care and the homebound requirement are the primary determinants of home health eligibility; yet, MedPAC continues to focus on length of home health care and a shift in focus to episodes not preceded by a hospitalization. The home health benefit is a skilled care benefit without a durational limit provided the patient meets the skilled care and homebound eligibility criteria Congress constructed, maintained, and reinforced several times that the benefit is not limited in terms of a length of stay. Additionally, healthcare has changed significantly in the last decade and no longer are hospitalizations the starting point of care.

The quality of care is also addressed in the Report with MedPAC relying more on claims-based measures than provider-reported measures. MedPAC indicates that there has not been a significant change in patients who were hospitalized or received treatment in the emergency room during an episode in 2017, while measures of functional status, such as improvement in walking and transferring, increased.

Throughout the Report, MedPAC provides a comparison of financial and utilization data for home health agencies over time. Much of the comparison in trends is for a span of well more than 5-7 years, not the norm for what most parties would use for trend comparison. Overall, MedPAC estimates that home health margins will remain high for 2019 – 16 percent margin for freestanding agencies. It also acknowledges that home health care can be a high-value benefit when efficiently and appropriately delivered.

CMS Issues Transmittal on Guidelines for Determining Immediate Jeopardy

The Centers for Medicare & Medicaid Services (CMS) released Transmittal 187, Revision to the State Operations Manual (SOM 100-07) Appendix Q, dated March 6, 2019. The purpose of the Transmittal is to add a new appendix, Appendix Q – Core Guidelines for Determining Immediate Jeopardy, to the CMS State Operations Manual to standardize the key components of the Immediate Jeopardy (IJ) designation into a "Core" document that can be applied to all certified Medicare/Medicaid entities.

There are some slight variations in the definitions used to form the basis of the IJ designation and these are based on provider type. Within this Appendix, however, the determinants for determining if IJ is present are narrowed to the following three components for all provider types:

- Noncompliance: An entity has failed to meet one or more federal health, safety, and/or quality regulations; AND

- Serious Adverse Outcome or Likely Serious Adverse Outcome: As a result of the identified noncompliance, serious injury, serious harm, serious impairment or death has occurred, is occurring, or is likely to occur to one or more identified recipients at risk; AND

- Need for Immediate Action: The noncompliance creates a need for immediate corrective action by the provider/supplier to prevent serious injury, serious harm, serious impairment or death from occurring or recurring.

Each of these components is described in more detail in the new appendix.

Survey teams must use the IJ Template attached to Appendix Q to document evidence of each component of IJ and to convey information to the provider being surveyed. In order to determine that IJ exists, the team must verify that all three components of IJ have been established. The survey team must use its professional judgment and evidence gathered from observations, interviews, and record reviews to carefully consider each of the key components.

When the surveyor/survey team determines the entity's noncompliance has caused a serious adverse outcome, or has made a serious adverse outcome likely, and immediate action is needed to prevent serious harm from occurring or recurring, the survey team must consult with their State Agency (SA) for confirmation that IJ exists, and seek direction. In some cases, it may be necessary for the survey team to stop all other investigations due to the need for additional investigation into the IJ situation. When there is agreement from the SA (and/or RO) that IJ exists, the survey team must immediately:

- Notify the administrator (or appropriate staff member who has full authority to act on behalf of the entity) that IJ has been identified and provide a copy of the completed IJ template to the entity; and
- Request a written IJ removal plan, which is the immediate action(s) the entity will take to address the noncompliance that resulted in or made serious injury, serious harm, serious impairment, or death likely.

The removal plan identifies all actions the entity will take to immediately address the noncompliance that has resulted in or made serious injury, serious harm, serious impairment, or death likely by detailing how the entity will keep recipients safe and free from serious harm or death caused by the noncompliance. Unlike a plan of correction, it is not necessary that the removal plan completely correct all noncompliance associated with the IJ, but rather it must ensure serious harm will not occur or recur. The removal plan must include a date by which the entity asserts the likelihood for serious harm to any recipient no longer exists. Specifically, the removal plan must:

- Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and
- Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

The removal plan will be evaluated and approved by the SA or by the survey team in consultation with the SA. A determination must be made as to whether, if implemented appropriately, the removal plan will remove the likelihood that serious harm will occur, or recur. Approving the written removal plan does not mean the IJ is removed. To remove IJ, the entity must implement the removal plan, and the survey team must verify through observation, interview, and record review, that all actions the facility took were effective in removing the likelihood that serious injury, serious harm, serious impairment or death would occur or recur. This means the survey team will return to the entity to conduct this verification. In cases where the entity alleges the IJ was removed prior to the current survey, the survey team must verify the action taken by the entity to remove IJ, and at what point the IJ was removed.

Removing the IJ does not ensure that substantial compliance has been achieved. Once IJ has been removed, the SA will issue a completed Form CMS-2567 and request a plan of correction that achieves substantial compliance.

Frequently Asked Questions About Home Infusion Therapy

The Centers for Medicare & Medicaid Services (CMS) has posted on its web site a frequently asked questions document related to the temporary transitional payment period for the new home infusion therapy benefit.

The FAQ document provides general information on the structure of the benefit and CMS' policies for implementation.

The FAQs address the provision of Part B home infusion therapy when a patient is under a home health POC. CMS will permit home health agencies to continue to provide infusion therapy for Part B drugs during the transition period (2019-2020); however this will change when the benefit becomes a permanent program in 2021. Also during the transition, beneficiaries are not able to receive services under the home health benefit and home infusion therapy benefit simultaneously, but sub-contracting arrangements are permitted.

When the program becomes permanent in 2021, home health agencies will not be able to provide Part B infusion therapy services under the home health benefit. Only a home infusion therapy supplier may provide these services. Beginning in 2021, home health agencies may be certified as home infusion therapy suppliers.