Hospice Provisions in the CY 2024 Home Health Proposed Rule

July 13, 2023
Theresa M. Forster, VP for Hospice Policy & Programs, NAHC
Katie Wehri, Director of Home Health & Hospice Regulatory Affairs, NAHC

Agenda

• Program integrity and provider enrollment
• Special focus program
• Informal dispute resolution
• Medicare coverage – lymphedema therapy
Hospice Program Integrity Concerns

- MedPAC has tracked state-by-state growth in hospice agencies
  - Top growth states: California, Texas, Arizona
- LA Times Hospice expose (December 2020)
- California State Auditor’s Report (March 2022)
  - Legislative moratorium on hospice licenses
- New Yorker/Pro Publica Investigation (November 2022)
Industry Response

• Series of 34 recommendations put forth by four national associations: NAHC, NHPCO, LeadingAge, and NPHI
• Meeting with OIG
• Meeting with CMS Administrator Chiquita Brooks LaSure, and high-level Center for Program Integrity and Center for Clinical Standards and Quality Officials, subsequent CPI, CCSQ discussions
• Meetings with key Congressional offices
• Joint NAHC/NHPCO State Working Group – Hospice Licensure and Regulatory Oversight

Provisional Period of Enhanced Oversight

• Under Section 1866(j)(3)(A), CMS may impose enhanced oversight on new providers during a Provisional Period of Enhanced Oversight – PPEO – of between 30 days and 1 year
• Historically CMS issued information around imposition of PPEOs through sub-regulatory issuances (Home Health RAP suppression for new agencies)
• Based on issues that have arisen during development of such policies, CMS is proposing regulations to govern PPEOs
Provisional Period of Enhanced Oversight

• Proposals:
  • Define “new” provider or supplier for PPEO purposes at Section 424.527(a) as:
    • A newly enrolling Medicare provider or supplier (including enrollment as a new
      provider due to change in majority ownership)
    • A certified provider or certified supplier undergoing a change of ownership
      consistent with 42 CFR 489.18
    • A provider or supplier (including an HHA or hospice) undergoing a 100 percent
      change of ownership via a change of information request
  • Effective date of a PPEO’s commencement under Section 424.527(b)
    will be the date on which the new provider or supplier submits its first
    claim
    • To keep providers from withholding billings during PPEO to avoid increased
      oversight

© 2023 National Association for Home Care & Hospice

Provisional Period of Enhanced Oversight

• MLN7867599 July 2023 Fact Sheet
• Effective July 13, 2023, “new” hospices in Arizona, California, Nevada, and Texas will be placed under a PPEO of between 30
  days and one year
• “New” providers:
  • Newly enrolling in the Medicare Program (starting July 13, 2023)
  • Submitting a change of ownership (CHOW) that meets all the
    regulatory requirements under 42 CFR 489.18
  • Undergoing a 100% ownership change that doesn’t fall under 42 CFR 489.18

© 2023 National Association for Home Care & Hospice
Provisional Period of Enhanced Oversight

- Impacted providers:
  - Received final approval for Medicare enrollment on or after July 13, 2023
  - Started the enrollment or certification process before July 13, 2023, but haven’t received a final approval letter from your Medicare Administrative Contractor (MAC)
  - Got approval on a change of ownership request on or after July 13, 2023

Retroactive Provider Agreement Terminations

- Under current policy, a provider may request a retroactive effective date of its voluntary termination from Medicare (for example, retroactive to the provider’s facility closing)
- Proposal:
  - Incorporate into regulations as Section 489.52(b)(4) authority for a provider to request a retroactive termination effective date BUT ONLY if no Medicare beneficiary received services from the facility on or after the requested termination date
Provider Enrollment -- Background

- State requirements (licensure, CON)

- Federal Requirements
  - NPI (National Provider Identifier)
  - Enrollment Application
  - MAC (Medicare Administrative Contractor) screens provider/supplier and processes application
    - Requirements vary depending on “risk” category of provider

- Enrollment Application
  - Initial Enrollment
  - Change of Ownership
  - Revalidation (every 5 years)
  - Reactivation
  - Change of Information

Categorial Risk Screening – HOSPICE

- Limited: MAC does the following:
  - Verifies that entity meets all federal and state requirements
  - Conducts license verifications
  - Conducts database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type

- Moderate: MAC does the following:
  - Performs the “limited” screening
  - Conducts an on-site visit

- High: MAC does the following:
  - Performs the “limited” and “moderate” risk screening activities
Categorial Risk Screening – HOSPICE

High Risk (cont.)

• Requires the submission of a set of fingerprints for a national background check from all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider/supplier
• Conducts a fingerprint-based criminal history record check of the FBI’s Integrated Automated Fingerprint Identification System on all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider/supplier

• Proposal:
• Revise Section 424.518 such that “new” hospices and those submitting applications to report any new owner will be moved into the “high” level of categorical screening
• Revalidating hospices continue to be subject to “moderate” screening requirements

36-Month Rule -- HOSPICE

• Proposal:
• CMS proposes to expand Section 424.550(b)(1) to require that when a hospice undergoes a change in majority ownership (CIMO) (more than 50 percent) by sale within 36 months after the effective date of its initial enrollment or within 36 months following the hospice’s most recent CIMO, the provider agreement and Medicare billing privileges will not convey
• Prospective provider/owner of the hospice will be required to:
  • Enroll in Medicare as a new (initial) hospice
  • Obtain a state survey or an accreditation from an approved accreditation organization
36-Month Rule -- HOSPICE

• Exceptions: 36-month rule does not apply when:
  • The organization submitted two consecutive years of full cost reports since initial enrollment or the last CIMO, whichever is later
  • The organization’s parent company is undergoing an internal corporate restructuring, such as a merger or consolidation
  • The owners of an existing agency are changing the business structure (for example, from a corporation to a partnership – general or limited – and the owners remain the same)
  • An individual owner of the agency dies

Revisions to 855A – Pending Change

• Under separate action, CMS has proposed revisions to CMS 855A as follow:
  • Requiring provider/supplier/hospice to identify via checkbox whether a reported organizational owner is owned by another organization or individual
  • Requiring the provider/supplier/hospice to identify whether a listed organizational owner/manager does or does not fall within the categories of entities listed on the application (holding company, investment firm, etc.) CMS has added “private-equity company” and “real estate investment trust” to the list of organization types
Hospice Ordering and Certifying Physicians – Pending Change

• As part of FY2024 Hospice Payment rule:
  • Physicians who order or certify hospice services for Medicare beneficiaries must be enrolled in or validly opted out of Medicare as a prerequisite for payment of the hospice services

Deactivation for Non-Billing

• Under Section 424.540(a), CMS may deactivate billing privileges under eight circumstances, including when the provider/supplier has not submitted Medicare claims for 12 consecutive months
• CMS has identified providers that inappropriately bill under one number, come under investigation or are subject to overpayment, terminate the billing number and bill under a dormant billing number
• Proposal: Revise Section 424.540(a)(1) to reduce the 12-month time frame to 6 months
Definition of “Managing Employee” -- HOSPICE

• “Managing Employee” must be reported on enrollment application

• Current definition of “managing employee” at Section 424.502:
  • A “general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier (either under contract or through some other arrangement) whether or not the individual is a W-2 employee of the provider/supplier.”

• Proposed change under proposed SNF/NF Ownership regulations (February 2023):
  • A managing employee also includes a general manager, business manager, administrator, director or consultant, who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

• As part of pending CY2024 Home Health Payment Rule, CMS further proposes to revise the definition of “managing employee” by adding the following language:
  • “For purposes of this definition, this includes, but is not limited to, a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director”

• Any individual who meets the definition of “managing employee” must be reported
Previously Waived Fingerprinting of High-Risk Providers/Suppliers

• During COVID-19 PHE, CMS waived requirement for fingerprint-based background checks (FBCBCs) for high-risk providers/suppliers
• CMS plans to conduct the checks as part of the revalidation process for affected providers/suppliers
• CMS currently lacks authority to conduct the checks at revalidation because all revalidation applications are screened at the moderate risk level
• Proposal: Add Section 424.518(c)(1)(viii) to classify providers/suppliers who missed background check at initial enrollment as High-Risk providers/suppliers

Previously Waived Fingerprinting of High-Risk Providers/Suppliers

• Proposal (cont.)
• Establish a revised regulation reclassifying High Risk providers/suppliers as Moderate Risk if they underwent background checks at initial enrollment or upon revalidation after CMS waived the background check requirement
Expansion of Reapplication Bar

• Under Section 424.530(f), CMS may prohibit a prospective provider/supplier from enrolling in Medicare for up to 3 years if the application is denied because entity submitted false or misleading information or omitted information as part of its application

• Proposal: CMS proposed to extend the reapplication bar from 3 years to 10 years

Ordering, Referring, Certifying, and Prescribing Restrictions

• Proposal: Expanding Section 424.530(f) such that any provider/supplier subject to a reapplication bar may not order, refer, certify, or prescribe Medicare-covered services, items, or drugs

• Further, Medicare will not pay for any otherwise covered service, item, or drug that is ordered, referred, certified, or prescribed by a provider/supplier under a reapplication bar

• Proposal: New Section 424.542 specifying that a physician or other eligible professional who has a felony conviction within the previous 10 years determined to be detrimental to the best interests of Medicare and its beneficiaries may not order, refer, certify or prescribe Medicare-covered services, items, or drugs
Ordering, Referring, Certifying, and Prescribing Restrictions

- Further, regulation will specify that Medicare will not pay for any otherwise covered service, item, or drug that is ordered, referred, certified, or prescribed by a physician or other eligible professional who has had a felony conviction within the previous 10 years that CMS determines is detrimental to the Medicare program and its beneficiaries.
Special Focus Program

- Consolidated Appropriations Act of 2021
  - Enforcement remedies
  - Special Focus Program
- SFP
  - Monitor hospices identified as poor performers based on selected quality indicators
  - Additional oversight in the form of surveys to enable continuous improvement
  - Could include enforcement remedies
  - Can be imposed instead of, or in addition to, termination of the hospice program’s participation from the Medicare program
- Technical Expert Panel 2022

Special Focus Program

- 18-month cycle
  - Surveys every 6 months
  - Terminate or graduate
- State agencies
- Enforcement remedies
SFP Algorithm

- Identify all Medicare certified hospices
- Remove any hospices that do not meet the following:
  - is an active provider that has billed at least one claim to Medicare FFS in the last 12 months as captured in iQIES; and
  - has data for at least one algorithm indicator
- Identify a subset of 10 percent of hospice programs based on the highest aggregate scores determined by the algorithm.

Criteria

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Hospice Surveys</th>
<th>Hospice Quality Reporting Program (HQRP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicators</td>
<td></td>
<td>Claims Data</td>
</tr>
<tr>
<td></td>
<td>Quality-of-Care Condition-Level Deficiencies</td>
<td>Hospice Care Index (HCI)</td>
</tr>
<tr>
<td></td>
<td>Substantiated Complaints</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Quality of Life Conditions of Participation

<table>
<thead>
<tr>
<th>Tag</th>
<th>Condition of Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>§418.52</td>
<td>Patient rights</td>
</tr>
<tr>
<td>§418.54</td>
<td>Initial and comprehensive assessment of the patient</td>
</tr>
<tr>
<td>§418.56</td>
<td>Interdisciplinary group, care planning &amp; coordination of services</td>
</tr>
<tr>
<td>§418.58</td>
<td>Quality assessment and performance improvement</td>
</tr>
<tr>
<td>§418.60</td>
<td>Infection control</td>
</tr>
<tr>
<td>§418.64</td>
<td>Core services</td>
</tr>
<tr>
<td>§418.76</td>
<td>Hospice aide and homemaker services</td>
</tr>
<tr>
<td>§418.102</td>
<td>Medical director</td>
</tr>
<tr>
<td>§418.108</td>
<td>Short-term inpatient care</td>
</tr>
<tr>
<td>§418.110</td>
<td>Hospices that provide inpatient care directly</td>
</tr>
<tr>
<td>§418.112</td>
<td>Hospice that provide hospice care to residents of a SNF/NF or ICF/IID</td>
</tr>
</tbody>
</table>

## Surveys & Complaints

- Quality of life (QOL) condition level deficiencies (CLD) in the previous 3 years
  - Hospices surveyed at least once every 36 months
  - CLD – noncompliance with all or part of a condition of participation
  - Post-survey revisit or follow-up survey for CLD

- Substantiated complaints
  - Total number within the previous 3 years
  - SA or BFCC-QIO
HQRP - Claims Data

• Hospice Care Index (HCI) – overall score

• Standardized – focus is on how likely the hospice is to receive the score it did if it were an average hospice

HQRP – CAHPS Hospice Survey

• Scores from survey questions
  • Help for pain and symptoms
  • Getting timely help
  • Willingness to recommend
  • Overall rating

• CAHPS hospice survey index
  • CMS created
  • Single score for each hospice using weighted sum of bottom-box scores
SFP Eligibility

- Data from the Provider Data Catalog (PDC)
  - [https://data.cms.gov/provider-data/topics/hospice-care](https://data.cms.gov/provider-data/topics/hospice-care)
- Data - November 2023
  - 2020-2023 survey data
  - 2022 HQR prepared data

- Adjustments
  - Standardize indicators for surveys, substantiated complaints and HCI
  - Averaging the total number of data indicators used to derive the score

Calculation

- With CAHPS Hospice Survey

\[
CLDs\ over\ 3\ years + Complaints\ over\ 3\ years - HCl + 2(CAHPS\ Index) = \frac{Score}{5}
\]

- Without CAHPS Hospice Survey

\[
CLDs\ over\ 3\ years + Complaints\ over\ 3\ years - HCl = \frac{Score}{3}
\]
Selection

- Methodology is only one component

- Number of SFP hospices determined in first calendar quarter each year
  - Subset of 10 percent of hospice programs based on the highest aggregate scores determined by the algorithm
  - Hospices selected for the SFP from the 10 percent would be determined by CMS

- CMS planning for SFP to be implemented in 2024

Graduation or Termination

- Graduation criteria
  - have no CLDs cited or immediate jeopardy citations for any two 6-month SFP surveys, and
  - have no pending complaint survey triaged at an immediate jeopardy or condition level,
  - OR have returned to substantial compliance with all requirements

- Termination criteria
  - Fails any two SFP surveys by having any CLDs on the surveys, or
  - Pending complaint investigations triaged at IJ or condition level
Public Display
Hospice Special Focus Program Website
• General SFP information
• Guidance
• List of hospices in the 10 percent subset
• List of hospices selected for the SFP
• SFP status
  • Level 1 – in progress
  • Level 2 – completed successfully
  • Level 3 – terminated from the Medicare program


Informal Dispute Resolution
• Informal opportunity to resolve disputes related to condition-level survey findings
  • provider can dispute surveyor’s findings or provide additional information
• Based on IDR process for home health agencies
• State agency and accrediting organization
• Instructions would be included with the delivery of the Statement of Deficiencies (CMS-2567)
Informal Dispute Resolution

• Does not delay effective date of enforcement action
• Is NOT
  • Formal hearing
  • Available prior to the receipt of the Statement of Deficiencies (CMS-2567)
  • Used to refute enforcement remedy/action
  • Used to dispute SFP placement

Informal Dispute Resolution

• Instructions would be included with the Statement of Deficiencies (CMS-2567)
• Request for IDR
  • Must be submitted in writing (hard copy or electronically)
  • Must include the deficiencies being disputed
  • Must be submitted within the 10-day period available for the plan of correction
• Plan of correction still completed
Informal Dispute Resolution

• Meeting with SA or AO
• CMS reviews decisions
• If survey deficiencies are revised or removed, the CMS-2567 is updated accordingly
  • Adjust any enforcement actions imposed solely due to those cited and revised deficiencies

LYMPHEDEMA THERAPY
Lymphedema Therapy Benefit

- Consolidated Appropriations Act of 2023
- Medicare coverage for lymphedema compression treatment items
  - Custom fitted gradient compression garments
  - Other approved items prescribed by a physician or other specified health care professional to treat lymphedema

Contact Information

Theresa M. Forster
VP for Hospice Policy & Programs
NAHC
tmf@nahc.org

Katie Wehri
Director of Home Health & Hospice Regulatory Affairs
NAHC
Katie@nahc.org