AGG Hospice Quarterly

CMS Announces Hospice Capitation Rates for Medicare Advantage

The U.S. Centers for Medicare and Medicaid Services (CMS) recently released the capitation rates for hospice care through the value-based insurance design model (VBID), often referred to as the Medicare Advantage hospice carve-in.

During the first month of a patient's stay, Medicare Advantage organizations (MAOs) will receive Medicare A/B capitated payments, a Medicare Advantage rebate, and a monthly prescription drug payment. MAOs will also receive a capitation payment corresponding to the number of days the patient spent in hospice during that month.

This payment would total $1,764 for the first six days of the patient's hospice stay and $3,330 for days seven through 15. The MAO would then receive $5,291 for day 16 through the end of the first month. For the second month of the hospice stay through the end, the monthly capitation payment would total $5,187.

Hospice capitation rates were determined using policies that govern rate setting under Medicare Advantage, including the use of base experience for multiple years, localized rates developed through use of an average geographic adjustment, and base data trended to contract year.

Medicare Advantage plans currently pay a capitated monthly rate for services provided under Medicare Parts A and B, exclusive of costs related to hospice care. However, under the hospice carve-in, Medicare Advantage plans will provide more benefits than they presently do. These changes are designed to increase access to hospice services and facilitate better coordination of care between hospice providers and clinicians.

The Medicare Advantage program has experienced significant growth in recent years. According to CMS, the number of participating beneficiaries tripled to nearly 1.2 million enrollees in 30 states from 2019 to 2020. The program will be available in all 50 states and U.S. territories in 2020.

President's Budget for HHS in FY 2021

The White House presented its FY 2021 budget to Congress in early February. The budget included HHS budget provisions reflecting the Trump Administration's views on policy areas affecting hospice. Though not legally binding, the President's budget request serves as a platform on which he can recommend his policy preferences to Congress. The budget proposes to reduce spending on CMS-administered programs by $1.6 trillion over the next ten years, including $500 billion from Medicare and $920 billion from Medicaid. This article discusses highlights in the FY 2021 budget affecting hospice.

Pay for Outcomes

The Trump Administration intends to pay clinicians and providers to help patients stay healthy and to eliminate regulatory barriers to effective care coordination. Addressing regulations that impede care coordination is part of a much broader regulatory reform effort at HHS.

In 2019, the CMS Innovation Center released an updated Medicare Advantage Value-Based Insurance Design Model, which tests the impact of allowing Medicare Advantage organizations to develop plan benefit designs that are targeted to specific groups of enrollees based on socioeconomic status, health conditions, or both. The model also expands the scope of rewards and incentives programs, includes requirements for wellness and healthcare planning (advanced care planning), and in FY 2021 will allow for an integrated hospice benefit.

Modify Payment for Hospice Care Provided to Beneficiaries in Skilled Nursing and Nursing Facilities

Medicare pays hospices the same rate for routine home care provided in skilled nursing facilities and nursing facilities as it does for other settings, such as private homes. The Administration claims the approach results in an overpayment to hospice providers since skilled nursing facilities and nursing facilities often receive payment for this care from third-party payers, such as Medicaid. The proposal reduces Medicare payment for hospice services under the routine home care level of care when furnished in skilled nursing facilities to account for separate Medicare and Medicaid payments already provided for personal care services in the facility. The Administration believes reducing the payment rate will align hospice payment between nursing facilities and other settings, and reduce the incentive for hospices to seek out beneficiaries in nursing facilities. The modification is estimated to save $4.5 billion over 10 years.

Enhance Quality Improvement Oversight of Post-Acute Care Facilities and Hospice Providers

When a hospice or inpatient rehabilitation facility has a serious deficiency, CMS's only recourse is the drastic step of terminating them from Medicare. The proposal allows CMS to implement intermediate remedies on hospices and other post-acute care facilities, such as levying civil monetary penalties. The Administration claims the approach offers CMS a greater opportunity to address poor performance and quality of care concerns.

Improve Safety and Quality of Care by Publicly Reporting Medicare Survey and Certification Reports Conducted by Accreditation Organizations

Accreditation organizations currently do not make their survey reports and accompanying Plans of Corrections publicly available, and CMS is prohibited from disclosing the results of accreditation surveys that are not home health agency surveys or related to an enforcement action. This proposal would provide CMS with the authority to publish survey results for all accredited facilities, including hospitals, hospices, ambulatory surgical centers, outpatient physical therapy and speech language pathology services, and rural health clinics. The change is an effort to increase transparency and accelerate value.

Survey and Certification

The Budget requests $442 million for Survey and Certification. The Administration believes this level of investment will enable CMS to maintain non-statutory survey frequency levels to prevent serious violations of safety standards and avoid patient harm. Survey volume and cost are said to have increased due to the growing number of participating facilities, higher levels of complaints, and increasing costs to conduct surveys.

Approximately 90 percent of the request for Survey and Certification will go directly to State Survey Agencies to perform health and safety oversight of Medicare certified providers. CMS expects states to complete over 25,000 initial surveys and re-certifications and over 65,000 visits in response to complaints in FY 2021. Surveys include mandated federal inspections of long-term care facilities (i.e., nursing homes), home health agencies, hospices, and federal inspections of other key facilities. All facilities participating in the Medicare and Medicaid programs must undergo inspection when entering the program and on a regular basis thereafter. CMS is implementing a new five-part strategy to ensure quality and safety. The strategy includes survey and certification improvements such as enhanced oversight of the State Survey Agencies that perform nursing home surveys, timely response to patient quality complaints, greater transparency about nursing home performance, and development of outcomes-based quality measures.

The Budget requests two year budget authority for the Survey and Certification program. The Administration believes the request increases administrative flexibility, enhances oversight and quality of care, and ensures funds are available early enough in the state FY to enable more effective planning, staffing, and funding of survey agencies to accomplish required survey workloads.

House Introduces HOSPICE Act

On February 10, 2020, Congressman Jimmy Panetta (D-CA) and Congressman Tom Reed (R-NY) introduced the Helping Our Senior Population in Comfort Environments Act or HOSPICE Act (H.R. 5821). The HOSPICE Act is a bipartisan response to the July 2019 Office of Inspector General (OIG) reports that identified concerns in the hospice program related to oversight and enforcement of quality of care.

The HOSPICE Act will make several changes to the hospice survey process and introduce intermediate remedies into the hospice program. The bill addresses hospice survey transparency, frequency, consistency, and the authorization of new remedies. This article highlights key provisions of the legislation.

Transparency

The July 2019 OIG report found that from 2012 to 2016 more than 80 percent of hospices had at least one deficiency leading to beneficiary harm. In response to its findings, OIG made the following recommendations aimed at increasing transparency of survey and certification information: (1) CMS should expand deficiency data reported by accrediting organizations; (2) CMS should seek statutory authority to make information from accrediting organizations publicly available on Hospice Compare and make them publicly available once authority is obtained; and (3) CMS should include on Hospice Compare survey reports or a compilation of important survey findings from State agencies.

The HOSPICE Act implements all of the OIG's recommendations. The bill requires State and local surveyors and accrediting organizations to submit any inspection report related to all surveys and certifications, any enforcement actions taken as a result of such survey or certification, and any other information determined appropriate by the Secretary. Notably, accrediting organizations must now submit the same information as State and local surveyors so that information available to consumers is comparable across entities. The Secretary must publish the data on CMS's website "in a manner that is prominent, easily accessible, readily understandable, and searchable." The bill also instructs the Secretary to implement programs to measure and reduce inconsistency of surveys.

Survey Frequency

The HOSPICE Act would change the frequency of surveys for all hospice providers from three (3) years to two (2) years. The bill also requires the Secretary to establish a special focus program to enforce requirements for hospice programs substantially failing to meet hospice program requirements. The Secretary must also conduct surveys of every hospice program included in the special focus program at least once every six (6) months.

Survey Teams

The bill requires each survey to be conducted by a multidisciplinary team of professionals, including a registered professional nurse. The survey team may not include any individual who is serving or has served within the previous two (2) years as a staff member of or consultant to the hospice program being surveyed or who has a personal or familial financial interest in the hospice program being surveyed.

Survey or Training

The HOSPICE Act mandates development of a comprehensive training program for State and Federal surveyors, including training on the review of written plans for providing hospice care. The bill also requires all individuals serving on a survey team to complete a training and testing program on survey and certification techniques that has been approved by the Secretary.

Remedies

The OIG recommended that CMS seek statutory authority to establish additional, intermediate remedies for poor hospice performance. The HOSPICE Act provides this authority and instructs the Secretary to develop and implement a range of remedies in the hospice program along with appropriate appeal procedures. The remedies include civil monetary penalties not to exceed $10,000 for each day of noncompliance, suspension of all or part of payments, and appointment of temporary management to oversee operation of the hospice program.

The bill also directs the Secretary to develop and implement specific procedures for applying the remedies. The procedures should be designed to minimize the time between identification of deficiencies and the imposition of remedies as well as provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.

Markup

The bill underwent markup by the Ways and Means Committee on February 12, 2020. Only two small changes were made during the markup, which included adding "national accrediting organizations" to the surveyor training program and mandating that the GAO complete its report on quality and remedies within 36 months following enactment of the Act. The Committee passed the bill by a voice vote the same day, and the bill is now available for consideration and a vote by the House.

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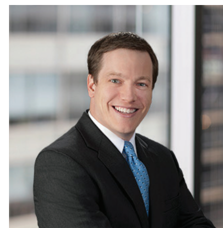

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