**CHAPCA**

**March 2024 Regulatory Update**

## Proposed Rules

- **Seeking comments:** CHAPCA is preparing a comment letter in response to the Accrediting Organization Oversight proposed rule, which CHAPCA analyzed in a Regulatory Alert. The CHAPCA Public Policy Committee will be considering comments for the comment letter, which is due on April 15, 2024. If you have comments or concerns that should be included in the CHAPCA letter, please send to Education@calhospice.org with "AO Rule" in the subject line.

- **FY 2025 Hospice Wage Index and Quality Reporting proposed rule:** We are watching daily for the publication of the FY 2025 hospice proposed rule. When it is published, we will write a Regulatory Alert with analysis of the components in the rule.

## Hospice Compliance and Implementation of New Regulations

- **New Model Election Statement and Addendum – PAY CLOSE ATTENTION:** On March 11, 2024, CMS issued updated versions of the *Hospice Model Election Statement* and the *Patient Notification of Hospice Non-Covered Items, Services, and Drugs*. Note that the forms have a "Last Updated: March 2024" date on them. Having the date on the forms will help providers avoid confusion about which form is the most up to date one. **CHAPCA strongly encourages providers to switch to this new form as soon as possible.**

  Also note the specified timeframes for the issuance of the addendum, consistent with the regulatory changes for timeframes:

  - Within the first 5 days of the election start date, the hospice must furnish the written addendum within 5 days of the request date.
  - During the course of hospice care (that is, after the first 5 days of the hospice election start date), the hospice must furnish this written addendum within 3 days of the request date.

- **Home Health, Hospice & DME Open Door Forum:**

  **Wednesday, April 3, 2024, PM at 2:00 PM – 3:00 PM Eastern Time (ET).**

**NEW and UPDATED Open Door Forum Participation Instructions:**
This call will be a Zoom webinar with registration and login instructions below.
Register in advance for this webinar:
https://cms.zoomgov.com/webinar/register/WN_vfsU5LSKR3atiW9T_AhrDg
Meeting ID: 160 823 4591
Passcode: 200020

- **Managing Employee Definition Update:** CMS encourages hospice providers to update the 855 A paper application or online via PECOS as soon as possible, as the new requirement took effect on January 1, 2024. Every hospice administrator and medical director is, by definition, a managing employee.

- **Latest Reminder – Physician Enrollment in PECOS or Opt-Out:** Another reminder to ensure that every hospice physician and attending physician must be enrolled in PECOS or validly opted-out of Medicare. CMS has now given HHH MACs the following guidance in CR13342:

  Effective May 1, 2024, or as otherwise directed by CMS, **FISS shall deny the hospice claim if the physician in the Attending field is not on the file**. CMS will update the existing ordering and referring file on Data.CMS.Gov with an additional column for hospice ordering and referring eligibility. CMS will be applying the edit only to the Attending physician NPI field and will be moving directly to hard edits…. That is, claims will be denied if the field does not meet the requirements.

- **CMS Issues Special Focus Program User's Guide**

  Abt Associates, under a contract with CMS, prepared a *Special Focus Program User's Guide: Algorithm and Public Reporting (cms.gov)* for providers to review the components of the Hospice Special Focus Program (SFP). At this time, CMS is expecting to identify hospices in the lowest 10 percent of providers, based on the algorithm in this guide, in Q4 2024 and release the provider names on this list before identifying a small group of hospices which will be included in the Hospice SFP for 2025.

- **MedPAC Releases March 2024 Report to Congress**

  As CHAPCA reported in the CHAPCA MedPAC Regulatory Alert, the hospice chapter provides data on hospice utilization in Medicare, hospice margins, and a special section on spending outside the benefit. The MedPAC recommendation to the Congress for a FY 2025 payment update is 0%.

- **CMS Issues Guidance on Medicare Hospice Benefit and VA Services**

  Recently CMS issued CR 13523, which clarifies the responsibilities of the Medicare hospice provider and the VA for patients nearing the end of life. CHAPCA issued a Regulatory Alert about this clarification on March 7, 2024. There has been confusion about the wording in the transmittal, specifically around the "Veteran's eligible beneficiaries." CHAPCA reached out to the VA to get additional clarification for CHAPCA members in California and got the following important clarification:

*The intent is for a dually eligible veteran (meaning eligible for both Medicare and VA benefits) to be able to access hospice under Medicare and their other benefits under the VA. It is not referring to beneficiaries of the veteran.*

- **Medical Services Authorized by the Veteran's Health Administration: OIG Report Issued to Avoid Duplicate Payments**

  In a report, the Office of the Inspector General found that Medicare paid providers for medical services authorized and paid for by Veteran Administration community care programs, resulting in duplicate payments of up to $128 million. We do not pay for services authorized under Veteran's Health Administration benefits.

  More information to bill correctly:

  • Medicare Secondary Payer (PDF) booklet
  • Medicare Overpayments (PDF) fact sheet
  • Section 50.1.1 Medicare Benefit Policy Manual, Chapter 16 (PDF)

- **National Hospice Audit 2023 Survey Report Released**

  LeadingAge, the National Association for Home Care & Hospice ("NAHC"), the National Hospice and Palliative Care Organization ("NHPCO"), and the National Partnership for Healthcare and Hospice Innovation ("NPHI") have released their National Hospice Audit 2023 Survey Report. This report is based on a survey of hospice provider members conducted in late 2023.

  **Key Findings included:**

  - Improper targeting of surveys resulting in sector inefficiencies and provider burdens, ultimately impacting beneficiary care.
  - Contractors' inability to properly target providers for surveys harms beneficiaries.
  - Poorly trained auditors exhibit limited knowledge of critical aspects of hospice operations and do not follow proper policies and procedures, leading to inaccurate, error-riddled audits.
  - Audit contractor activities, processes, and application of policy are opaque, inconsistent, and uneven – which results in significant inefficiencies and impacts beneficiaries' access to care.
  - Inefficient resolution processes for technical claim denials leave provider no options other than to engage in lengthy, time-consuming appeals processes.
  - Poorly trained auditors exhibit limited knowledge of critical aspects of hospice operations and do not follow proper policies and procedures, leading to inaccurate, error-riddled audits.
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The report makes the following recommendations:

1. CMS should re-focus its audit contractors on patterns and practices characteristic of providers that aim to minimize or avoid therapeutic care and supportive services that are required under the hospice benefit and fully reimbursed through the per diem payment.
2. CMS should require substantive education and training for all auditors that is consistent with the education given to providers to minimize inconsistencies.
3. CMS should increase transparency of audit contractor activity, including the number and types of audits being conducted, audit recovery amounts, results of audits by specific audit contractors, including reversal rates, top denial reasons and compliance with required timeframes for notification and review.
4. CMS should implement an informal mechanism to enable MACs and hospice providers to resolve technical claims denials prior to engaging in the formal appeal process.
5. CMS should require audit contractor medical reviewers to have an equivalent level of expertise and training in hospice care as the hospice medical director who certified a patient's terminal illness.

The report is available here.

- **OIG Announces the Next Anticipated Compliance Program Guidance Documents:** Last year, OIG announced an initiative to update existing compliance program guidance documents (CPGs) and deliver new CPGs. OIG intends to publish industry segment-specific CPGs (ICPGs) focused on Medicare Advantage and nursing facilities in 2024. After addressing these segments, OIG anticipates publishing updated ICPGs for hospitals and clinical laboratories. If you would like to provide feedback related to any of these industry segments before the publication of these ICPGs, please contact Compliance@oig.hhs.gov.

  **NOTE: The hospice compliance program guide is not on the list to be updated in 2024 or 2025**. The Compliance Program Guidance for Hospices (64 Fed. Reg. 54031; October 5, 1999) is **still in effect.**

  Learn more by visiting the Compliance Guidance webpage.

## Hospice Finance and IT Updates

- **Aggregate Cap Calculation:** The formula for the hospice aggregate cap calculation was extended by one year, from 2032 to 2033, in the latest Consolidated Appropriations Act, 2024, signed by President Biden to help fund the government until the end of FY 2024. The formula uses the hospice payment update percentage to update the aggregate cap amount, rather than the older calculation, which used the medical care component of the Consumer Price Index for Urban Consumers (CPI-U).

- **Cap Liability Obligations:** CGS, NGS, and Palmetto have all accepted the policy of accepting an ERS Request once a demand notice is issued regarding the CAP liability obligations. We applaud the MACs for this position as a consistent approach to addressing the self-determined CAP liability of the respective hospice.

  Source: The Health Group, Hospice Alert 24.03

- **More Hospices Entitled to Cap Repayment Refunds:**
  Hospices which have been subjected to claim denials and which have incurred CAP liabilities need to be keenly aware of refund opportunities to which they may be entitled.

  Claims denials related to services rendered in a CAP Year for which a CAP liability occurred may entitle the provider to a partial refund of a CAP liability previously paid. The denied claims triggering a repayment by the hospice may represent a second recovery of funds from the hospice and, accordingly, a partial refund of CAP repayments may be appropriate.

  As claim reviews and denials become more prevalent, we see more potential CAP liability recoveries by hospices. Depending on the CAP Year impact, the hospice may not be notified by the MAC of the recovery potential. Hospices may need to request a refund to secure the excessive repayment to the Medicare program.

  Source: The Health Group, Hospice Alert 24.03

- **Limits on Recouping Overpayments:** CMS issued a MLNC article on February 22, 2024 with options for payment overpayment recoupment, effective July 1, 2024. Review information on limits on recouping overpayments (PDF), 2024, including:

  - When to request an extended repayment plan or choose an immediate recoupment
  - How CMS pays interest

## Hospice Quality Reporting Program

- **Care Compare Quarterly Refresh – February 2024**

  The February 2024 quarterly refresh for the Hospice Quality Reporting Program is now available on Care Compare.

  For additional information, please see the FY2024 Hospice Wage Index Final Rule at https://www.cms.gov/Center/Provider-Type/Hospice-Center. Please visit the Hospice Background and Announcements webpage to review the Claims-Based Measures Questions and Answers downloadable (PDF) for more information on the HCI and HVLDL.

- **HQRP Provider Toolkit**: CMS has released a new hospice quality toolkit, which includes:

- Getting Started with the HQRP_Feb_2024 (PDF)
- Getting_Started_with_HQRP_CASPER_QM_Reports_Feb_2024 (PDF)
- Getting Started with Review and Correct Reports_Feb_2024 (PDF)
- Third Edition HQRP Public Reporting Tip Sheet_Aug 2022 (PDF)

## Innovation

➢ **VBID Hospice Component Sunsets on December 31, 2024**

On March 4, 2024, CMS announced that the hospice component of the value-based insurance design model ("VBID") will end on December 31, 2024. The hospice component was recently extended until 2030; however, CMS has issued the following, "After carefully considering the feedback about the increasing operational challenges of the Hospice Benefit Component and limited and decreasing participation among MAOs that may impact a thorough evaluation, CMS has decided to conclude the Hospice Benefit Component as of December 31, 2024, 11:59 PM." "CMS will not accept applications to the previously released CY 2025 Request for Applications for the Hospice Benefit Component of the VBID Model."

Additional information is available here. CHAPCA continues to watch for what is next, paying special attention to this sentence in the CMS release:

> *CMS has also gained valuable insights into creating a seamless care continuum in the MA program for Part A and Part B services,* ***inclusive of the Medicare hospice benefit****.*

➢ **CMS Releases 2024 Value-Based Care Strategy Blog**

March 14: A new CMS blog titled "Update on the Medicare Value-Based Care Strategy: Alignment, Growth, Equity" provides a progress report on accomplishments and a look toward the future for CMS' Value-Based Care Strategy. It also covers CMS' strategy to move toward value-based payment, a focus on alignment across payers, growth in accountable care, and promoting equity. Among other topics, CMS aims to scale model learnings, support primary care providers in value-based care, improve quality measurement, and improve the flexibility of practitioners to work with community-based organizations to address social needs, while also emphasizing the importance of value-based data transparency and fostering competition within Medicare Advantage.

➢ **Learning about Accountable Care Organizations**

As a part of our continuing learning about various forms of value-based care, we are including a couple of articles on Accountable Care Organizations (ACOs), which may be thought-provoking and helpful as we look toward the future.

- **Improving Post-Acute Care Provider participation in ACOs:** The National Association of ACOs and the American Health Care Association recently released a set of recommendations entitled *Considerations for Long-Term Care Providers Participating*

*in Value-Based Care Models* designed to increase long-term and post-acute care providers' participation in accountable care organizations (ACOs).

- **Next Generation Accountable Care Organization Model Final Evaluation Report released**

  Across its six years, ACOs in the Next Generation ACO Model (NGACO) were associated with an approximate $1.7 billion decline in Medicare Parts A and B spending without exhibiting declines in quality as measured by adverse events. Many Next Gen ACOs have now joined the current *Realizing Equity, Access, and Community Health (REACH) Model.* Reading this final evaluation report will begin to bring the value-based care models into clearer focus.

  *Related content:*

  Findings-At-A-Glance (PDF) | Appendices (PDF) | Next Generation ACO Model