Need to Know

Federal Regulatory Update January 2024

1. **Updates from the FY 2024 Hospice Wage Index Final Rule**
   A. **Verifying Hospice Physician and Attending Physician Enrollment in PECOS or a valid Opt-Out**

   The FY 2024 Hospice Wage Index Final Rule requires hospice certifying physicians to be Medicare enrolled or to have validly opted-out. This includes hospice medical directors, other hospice physicians, and attending physicians.

   1. **Effective date: April 30, 2024**
   2. **Options for hospice and attending physicians:** To meet this regulatory requirement, the physician must be either enrolled in PECOS with an 855O or have a valid opt out of Medicare affidavit. A CMS 855I is NOT required.
      - **CMS 855I**
        - Completes enrollment to treat beneficiaries and **bill and be paid by Medicare.**
      - **CMS 855O**
        - Credentials the physician so that he/she can **order/certify Medicare covered services.**
      - **Opt Out**
        - Allows the physician to treat beneficiaries and bill them directly; none of the services will be payable by Medicare.
   3. **Use CMS NPI Look Up ("Find a Provider")** – to verify the status of each hospice physician and each attending physician. Referring physicians **DO NOT** need to be verified. Nurse practitioners **DO NOT** need to be verified because they do not certify terminal illness for hospice patients.
      - First name
      - Last name
      - NPI
      - City
      - State
   4. **Deadline for verification: April 30, 2024. Start now as the process, if not enrolled, could take 2-3 months.**
   5. **CMS implementation date: May 1, 2024. CMS will begin denying claims if the physician is not enrolled or opted out.**
   6. **Regulatory text added to eCFR:** https://www.ecfr.gov/on/2024-01-16/title-42/chapter-IV/subchapter-B/part-424/subpart-P/section-424.507 (b)

B. Organizational Providers: Do You Need to Revalidate Your Medicare Enrollment Record Soon?

Use the Medicare Revalidation List to find out if you must revalidate your enrollment record. CMS usually posts revalidation due dates 6–7 months in advance; but CMS will establish the date for your agency at least 90 days in advance. A due date of "TBD" means that CMS has not set your due date, and you do not need to do anything now.

Currently, only organizational providers must revalidate; individual providers do not. CMS will let providers know if this changes.

See Revalidations (Renewing Your Enrollment) for more information.

2. Updates from CY 2024 Home Health Final Rule – Effective January 1 unless otherwise noted

As published in the CY 2024 HH final rule on November 2, 2023, the following hospice provisions were finalized and took effect on January 1, 2024.

A. Informal Dispute Resolution at § 488.1130

CMS finalized the IDR proposal as proposed and will allow hospices with condition level deficiencies identified in a survey to request an informal dispute resolution to resolve disputes about survey findings.

The process includes:

1. The hospice is notified in writing that they have received a condition level deficiency and that they have a right to informal dispute resolution (IDR).
2. Hospices must submit a request for IDR within the 10 calendar days allowed for submitting a plan of correction.
3. If the state or CMS removes/revises any of the findings, they will update the Form 2567 and revise related enforcement actions, as necessary.

B. Special Focus Program: No changes from proposed rule with algorithm and choosing hospices for the Special Focus Program. However, implementation is delayed until the fourth quarter 2024 and will use the November refresh for data to be included in the algorithm.

C. Provider Enrollment Requirements

1. **Moving Hospices to High-Risk Screening** as specified in § 424.518 if the hospice is initially enrolling in Medicare or reporting a new owner. Providers would submit fingerprints of the 5% or greater direct or indirect owners for an FBI criminal background check.
2. **Deactivation of Billing Privileges:** Billing privileges will be deactivated for the provider or supplier who does not submit any Medicare claims **for 6 consecutive calendar months**. The 6-month period will begin on the 1st day of the 1st month without a claims submission through the last day of the 6th month without a submitted claim.
3. **Change in Majority Ownership (36 Month Rule)**
   Definition: Change in majority ownership occurs when an individual or organization acquires **more than a 50 percent direct ownership interest** in an HHA or hospice during the **36 months following the HHA's or hospice's initial enrollment** into the Medicare program **or the 36 months following**

the HHA's or hospice's most recent change in majority ownership (including asset sale, stock transfer, merger, and consolidation). This includes an individual or organization that acquires majority ownership in an HHA or hospice through the cumulative effect of asset sales, stock transfers, consolidations, or mergers during the 36-month period after Medicare billing privileges are conveyed or the 36-month period following the HHA's or hospice's most recent change in majority ownership.

In § 424.550 Prohibitions on the sale or transfer of billing privileges, § 424.550(b)(1) states:

If a Hospice undergoes a change in majority ownership (occasionally referenced as a "CIMO") by sale within 36 months after the effective date of the Hospice's initial enrollment in Medicare or within 36 months after the Hospice's most recent CIMO, the **provider agreement and Medicare billing privileges do not convey to the Hospice's new owner.** The prospective provider/owner of the HHA or hospice must instead do both of the following:

- Enroll in the Medicare program as a new (initial) HHA or hospice under the provisions of § 424.510 of this subpart and
- (ii) Obtain a State survey or an accreditation from an approved accreditation organization.

Four exceptions:

- The Hospice submitted two consecutive years of full cost reports since initial enrollment or the last CIMO, whichever is later.
- The Hospice's parent company is undergoing an internal corporate restructuring, merger, or consolidation.
- The owners of an existing Hospice are changing the hospice's business structure and the owners remain the same.
- An individual owner of a Hospice dies.

4. **Managing employee**

42 CFR 424.502 "Managing employee" (Jan. 16, 2024)

Definition:

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 or supplier.

A. 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**.

Reporting:

B. Consistent with sections 1124 and 1124A of the Act, providers and suppliers are required to report their managing employees via the applicable Medicare enrollment application to enroll in Medicare.

3. **Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC) Added to Hospice Regulations – FAQs Released**
   - **A.** Marriage and family therapists and mental health counselors were added to the Medicare Hospice Conditions of Participation on January 1, 2024, as disciplines for the IDG in addition to social workers. Earlier this week, CMS issued the long-awaited FAQs for the addition of MFTs and MHCs to the hospice interdisciplinary team, along with personnel requirements. The FAQs are a very helpful clarification about how to implement this addition of MFTs to the interdisciplinary group and how they may add services to the hospice team. Please read the FAQs carefully for more details.
   - **B.** Next steps in adding this provision to regulations and the survey process will be the issuance of a CMS Quality Safety and Oversight Group (QSOG) memo as soon as possible. Readers may review previously released QSO memos at https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/policy-memos-states-and-cms-locations. Eventually, the new provisions will be added to the State Operations Manual, Appendix M and will be part of the survey process.

   - **C.** **NOTE:** The State of California is reviewing the requirements for mental health counselors. Pending further clarification, that discipline is not recognized in California. Hospices should consider only marriage and family therapists at this time.

4. **Enforcement Penalty Amounts Updated for 2023**
   HHS has adjusted the dollar amount for civil monetary penalties for inflation. This is the first year hospice CMP values have been released, in a separate section of the CMP adjustments chart.

5. **Hospice PEPPER Updates for 2024**
   Updates to the Program for Comparative Billing Reports (CBRs) and Evaluating Payment Patterns Electronic Report (PEPPERs) Coming Soon

   There will be a temporary pause in distributing CBRs and PEPPERs for all Medicare provider types as CMS works to improve and update the program and reporting system. This pause will remain in effect through the fall of 2024. We recognize the importance of these reports to your practice. Therefore, during this time, CMS will be working diligently to enhance the quality and accessibility of the reports.

   In fulfilling this commitment, your feedback is requested. In the near future, CMS will release a Request for Information (RFI) to obtain information from you, the provider community, about how the program can better serve you. CHAPCA will be watching for the RFI on PEPPER and will solicit your feedback.

6. **Value-Based Insurance Design (VBID) Model: Hospice Benefit Component**
   - **A.** **Background:** Currently, when a patient enrolled in Medicare Advantage (MA) elects hospice, Fee-for-Service Medicare becomes responsible for coverage and payment of most services, while the MA plan remains responsible for certain services like supplemental benefits. Under the Hospice Benefit Component of the Value-Based Insurance Design (VBID) Model, participating MA plans are financially responsible for all Part A and B benefits, including the hospice and supplemental benefits. CMS is assessing how this affects care delivery and quality of care, especially for palliative and hospice care.

B. **Participating Plans for CY 2024:** 13 participating MA organizations offer 78 plan benefit packages through the Model. A Frequently Asked Questions (FAQs) document has been prepared if your hospice has further questions.
C. **Note to admissions and billing teams:** Even though there may not be a MA plan participating in VBID in your area, you will still need to know how to check a beneficiary's enrollment in VBID and follow the plan's guidelines for billing.
D. **NOE submission and billing for services:** See the instructions to your Medicare Administrative Contractor (PDF).

E. CMS Issues a VBID Request for Information (RFI) on Health Equity and Expanding Hospice Access

CMS has issued an RFI in preparation for the CY 2026 VBID application process. CMS states that they are seeking "comment from interested parties on how to structure the future access to hospice care policies, how to continue to encourage comprehensive, high-quality networks, and how to continue to implement Model-specific network adequacy standards."

There are two sections to the RFI:

- Advancing Health Equity by Best Identifying and Meeting Needs
- Expanding Access to Higher Quality Hospice Care

CMS is looking for feedback on the five questions listed below and are especially important to hospice providers. This is our opportunity to submit comments on questions about the hospice component in VBID which could be expanded to MA in general.

1. How can CMS implement **network access policies** for hospice providers in line with current MA program policies (e.g., the ability for health maintenance organizations (HMOs) to limit access to in-network providers) while minimizing confusion among enrollees/patients, caregivers, and hospice and non-hospice providers?
2. How should statutory protections ensuring access to covered benefits, even out of network, where services are **"medically necessary and immediately required because of an unforeseen illness, injury, or condition, and it was not reasonable given the circumstances to obtain the services through the organization"** be potentially applied in the context of the hospice benefit?
3. To what extent should CMS **implement new or additional access safeguards** specifically in the VBID Model Hospice Benefit Component to address situations when an enrollee may want to elect hospice in situations when hospice care is urgently needed?
4. To what extent should CMS modify the current Model-specific network adequacy standards, including the **minimum number of providers requirement and the comprehensive network development strategy**? For example, should CMS include any **special consideration for states with certificate of need for hospice providers** or use alternative datasets to set and implement the network adequacy standards?
5. To what extent should CMS **maintain its Model-specific requirement to not allow any prior authorization requirements for hospice care?** If CMS should change the policy, what would the alternative look like and how could it be operationalized?

Please submit written comments to the VBID Mailbox at VBID@cms.hhs.gov by **February 16th, 2024**.

7. Hospice Quality Reporting Program

A. The next Care Compare refresh is in February 2014. Preview reports were released in November 2023.

B. CAHPS Hospice data submission deadline – Feb 14, 2024, for CAHPS from July through September 2023.

C. The hospice HOPE tool development is still in progress. Updates will be provided in upcoming rulemaking. Watch for possible publication in the FY 2025 Hospice Wage Index proposed rule later this spring.

D. CMS HQRP Hospice Outreach - December 2023. On December 27, CMS posted a Hospice Outreach Email with important updates on the HQRP, including compliance reminders, HQRP webpage updates, and links to HQRP trainings. Providers are strongly encouraged to download the email and sign up for Quality Reporting Updates.

If you would like to receive these quarterly update emails, reach out to QRPHelp@swingtech.com with your organization's name, CCN, and desired email contacts.

E. To run the algorithm for the Hospice Special Focus Program, CMS will use November 2024 Hospice Quality Reporting Program (HQRP) refresh data, and survey data from May 1, 2021, through April 30, 2024.

F. Contact information for help from CMS:

For Hospice Quality help desk: HospiceQualityQuestions@cms.hhs.gov
For Hospice Special Focus Program: QSOG_hospice@cms.hhs.gov
iQies Technical Help Desk: iqies@cms.hhs.gov; Phone:1-877-201-4721 (Monday-Friday 7:00 a.m. - 7:00 p.m. Central Time)