

National Hospice and Palliative Care Organization

Policy Alert

Status of H.R. 5821 Markup in Ways & Means Committee and Hospice Provisions in President's FY 2021 Budget

TO: NHPCO Provider and State Members
FROM: NHPCO Policy Team
Date: February 12, 2020

Summary at a Glance

1. H.R. 5821, the HOSPICE Act, was considered during a House Ways and Means Committee markup today and passed the committee with no objections.
2. The President's FY2021 Budget for HHS was released and hospice is impacted by several budget items.

- 1. H.R. 5821 passes House Ways & Means Committee:** On Wednesday, February 12, 2020 NHPCO staff attended the House Ways and Means Committee markup of the HOSPICE (*Helping our Senior Population in Comfort Environments*) Act, [H.R. 5821](#). The bill was passed favorably by the committee. This bipartisan bill was introduced by Congressmen Jimmy Panetta (D-CA-20) and Tom Reed (R-NY-23) on Monday February 10, 2020, and [NHPCO issued a policy alert then](#) with the details of the legislation.

Two small changes were made to the bill during markup including;

- adding "national accrediting organizations" to the surveyor training program
- mandating that the GAO report about quality and remedies to be completed "36 months after the date of the enactment of this Act."

In addition, Ways & Means staff announced that the bill received a CBO score which demonstrates savings of \$180 million over a 10-year period.

During the markup several members of Congress voiced their support for improving the quality for hospice by giving CMS more tools to help improve quality, but also a desire to improve access and pass the *Rural Access to Hospice Act* H.R. 2594/S.1190.

NHPCO supports the policies in the bill that closely track some of NHPCO's recommended Hospice Program Integrity Initiatives especially relating to increased education and competency for surveyors, but also has some serious concerns about the increase in frequency of hospice surveys and the inclusion and imposition of some remedies including civil monetary penalties.

Next steps for H.R. 5821: After passing markup, the bill is now available to be listed for full consideration and a vote by the House. NHPCO is continuing to work to make changes to the legislation and will remain in touch with membership as the bill moves through the process.

2. FY 2021 President's Budget for HHS

President Submits FY 2021 Budget (Including HHS Budget Provisions) to Congress: The White House, in their [HHS budget release for FY 2021](#), identified policy areas that impact hospice and reflect the current Administration's policy views. The President's budget request, though not legally binding, does provide recommendations to Congress about the policy preferences of the Administration. NHPCO/HAN will be advocating against some of these changes with policymakers, with additional information on the impact to beneficiaries. The impacted items are below.

A. Pay for Outcomes (p. 71)

This Administration is putting patients at the center by paying clinicians and providers help patients stay healthy and eliminating regulatory barriers to effective care coordination. Addressing regulations that impede care coordination is part of a much broader regulatory reform effort at HHS. In FY 2018, HHS accounted for more than half of the Administration's deregulatory savings, at more than \$12 billion, with five deregulatory actions for every one new regulatory action.

In the past year, the CMS Innovation Center announced testing a number of new, innovative models that seek to transform the way healthcare is delivered and financed. These include the Primary Care First Model, which builds on the Comprehensive Primary Care Plus model to offer physicians a set of voluntary, innovative payment options that reward value and quality, and support delivery of advanced primary care. The new Direct Contracting Model focuses on primary care redesign as a platform for payment reform and will test whether population-based payment arrangements encourage

better care and align financial incentives to reduce unnecessary use of high-cost settings and services in Medicare Fee-for-Service. In 2019, the Innovation Center also 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.

B. Modify Payment for Hospice Care Provided to Beneficiaries in Skilled Nursing and Nursing Facilities (p. 83)

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. This 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. This 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. 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. [\$4.5 billion in savings over 10 years].

C. Enhance Quality Improvement Oversight of Post-Acute Care Facilities and Hospice Providers (p.85)

When a hospice or inpatient rehabilitation facility has a serious deficiency, CMS's only recourse is the drastic step of terminating them from Medicare. This proposal allows the Secretary to implement intermediate remedies on hospices and other post-acute care facilities, such as levying civil monetary penalties. This proposal also redirects from the general fund to the Medicare Trust Fund penalties currently levied against skilled nursing facilities and home health agencies, as well as penalties proposed for other post-acute care providers under this proposal. These changes will give CMS more tools to address poor performance and quality of care concerns. [Budget impact not available]

D. Improve Safety and Quality of Care by Publicly Reporting Medicare Survey and Certification Reports Conducted by Accreditation Organizations (p.86)

Accreditation organizations currently do not make their survey reports and accompanying Plans of Corrections publicly available, and the Secretary 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. This change will increase transparency and accelerate value. [Budget Neutral]

E. SURVEY AND CERTIFICATION (p. 136-137)

The Budget requests \$442 million for Survey and Certification. This level of investment will enable CMS to maintain non-statutory survey frequency levels in order to prevent serious violations of safety standards and avoid patient harm. Survey volume and cost 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 & 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 care provided in America's nursing homes is both safe and at the highest possible quality. This 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. This approach 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. This approach is particularly important since many states operate on FYs that are different from the federal FY. This proposal will further facilitate CMS's existing ability to reallocate funding between states when appropriate.

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For questions about either of these issues, please contact Mark Slobodien, Director of Legislative Affairs at mslobodien@nhpco.org or Judi Lund Person, Vice President of Regulatory and Compliance at jlundperson@nhpco.org.