The Connecticut Association for Healthcare at Home supports its members in the provision of exceptional quality and accessible services through collaboration, leadership, provision of information, advocacy and education.

HOME HEALTH

Investigate translation service options, prepare for proposed patient rights CoP

Source: HHL Oct 3, 2016

Select a translation service if your agency hasn't done so already. Such a service will help your agency better communicate patients' rights and other information to patients and their caregivers in the event your clinicians don't speak the same language as your patients.

That's one step your agency should take even before the revised Conditions of Participation (CoPs) are finalized. Industry experts speculate the CoPs will be released in the fall, or at least by year's end.

Within CMS' current proposal, one requirement calls for agencies to verbally inform patients and their representatives of patients' rights in a language and manner the individual understands during the initial evaluation. Moreover, language assistance services or auxiliary aids must be provided to patients or their representatives at the agency’s expense.

Although the requirement to properly communicate rights has existed in federal limited English proficiency regulations for years, adding it to the CoPs is expected to raise scrutiny by state surveyors, industry experts say.

Continue Reading

Wait before getting your patient rights forms translated into various languages

Source: HHL, Oct 3, 2016
Agencies should act now to determine what languages they'll need their patient rights forms translated into once the proposed home health Conditions of Participation (CoPs) are finalized. They'll need to adapt their documents to meet the language needs of patients and caregivers.

But when it comes to paying to get forms translated now into additional languages, it would be prudent to wait until the CoPs are finalized, contends Bill Dombi, Vice President for Law for the National Association for Home Care & Hospice (NAHC).

To help ensure proper communications, the American Hospital Association has suggested CMS create a consumer website to provide information about patient rights in layperson's terms in multiple languages. In a Jan. 5, 2015, letter, the hospital association reasoned that a CMS-sponsored website would ensure standardization as the regulatory language is translated and disseminated to a wide audience.

The association also suggested CMS provide similar resources, such as templates in multiple languages for other requirements, including templates for discharge and transfer policies.

Costs to get forms into the languages you need could add up.

Clearwater, Fla.-based translation service Stratus charges $20 or less for translating the first page of a document, then by the word on subsequent pages. Charges for translations depend on the length, technicality and target language. Languages spoken by fewer people generally cost more to interpret or translate because there are fewer people available to provide that service.

**Quality of Patient Care Star Ratings Preview Reports Now Available**

The Home Health Quality of Patient Care Star Ratings Preview Reports and the Home Health Compare Provider Preview Reports are now available in the Provider CASPER folders. These reports contain data that will be publicly reported on the Home Health Compare website in January 2017. The deadline to submit a request to have the Quality of Patient Care star rating data suppressed is October 24, 2016. Please follow the directions laid out in the Quality of Patient Care Star Rating Preview Report to submit a suppression request.

**Visit the Home Health Quality Initiative webpage for more information.**

**Stop Calling Inpatients Outpatients: Medicare Created Observation Status - Ask Them to Change It!**

*Source: Center for Medicare Advocacy*
This summer, the New York Times article "New Medicare Law to Notify Patients of Loophole in Nursing Home Coverage"* told the story of one of many people who contact the Center for Medicare Advocacy for help with hospital "outpatient" Observation Status. These patients stayed in the hospital for multiple days receiving skilled care, but were coded for billing purposes as "outpatients," often with disastrous financial consequences for the individual.

Ms. Cannon was a patient in a hospital outside Philadelphia where she was said to be an "outpatient" on Observation Status for six and a half days. After discharge from the hospital, Ms. Cannon spent nearly five months in a nursing home for rehabilitation and skilled nursing care at a cost of over $40,000. Unfortunately, the hospital insisted that Ms. Cannon had never been formally admitted as an inpatient, despite being treated inside the hospital. This distinction has far reaching implications under federal rules; in short, Medicare would not pay for her nursing home stay. She was responsible for the entire cost.

The Center for Medicare Advocacy and the National Committee to Preserve Social Security and Medicare are fighting to fix this. Sign the petition urging Medicare to stop the misuse of "Observation" status today.

The Center hears stories like Ms. Cannon's every week. **Outpatient Observation Status hurts Medicare beneficiaries and reduces trust in the Medicare program and between patients and their physicians.** We know that, but we need to make sure the Medicare agency knows it too. For example:

- So-called "outpatient" Observation Status is not about the location or care a patient actually receives. It's a billing code used by hospitals to protect from overzealous auditors.
- Medicare beneficiaries in "outpatient" Observation Status cannot get any Medicare coverage for post-hospital nursing home stays, resulting in huge, unexpected expenses that beneficiaries think Medicare will cover. Too often, people go without this care because they can't afford it.
- Medicare beneficiaries in "outpatient" Observation Status do not have a right to hospital discharge planning, so must figure out next steps on their own.
- Medicare beneficiaries in "outpatient" Observation Status usually must pay for prescription drugs in the hospital - another surprise cost.
- Medicare beneficiaries in "outpatient" Observation Status cannot appeal after-the-fact to try to change their status from hospital outpatient to inpatient.

"Observation Status" may seem like just a matter of paperwork, but for Medicare beneficiaries it can ruin lives - and it can happen to anyone.

That's why you need to urge the Medicare agency to protect beneficiaries. Sign our petition today.

Thank you,
Judith Stein, J.D.
Executive Director
Center for Medicare Advocacy, Inc.
Max Richtman, J.D.
President/CEO
National Committee to Preserve Social Security and Medicare
HOSPICE

Hospice Update: Claim Adjustments for RHC Payment Errors Suspended

Source: NAHC

Since implementation of the two-tiered payment system for hospice routine home care (RHC) on January 1, 2016, a number of issues have arisen relative to the proper processing of hospice claims, and CMS has taken steps to correct these issues. CMS announced in the August 18, 2016, MLN Connects Provider E-News that a correction related to two such systems issues -- under which RHC days were being miscounted on hospice claims -- was implemented on July 25, and that the Medicare Administrative Contractors (MACs) would be adjusting hospice claims to correct payment. No provider action was necessary.

It is NAHC's understanding that despite the July correction, payments for these claims are not processing correctly. As a result, the MACs are suspending adjustments to correct these claims until a solution is implemented. CMS has issued notice of this in the September 29, 2016 MLN Connects Provider E-News.

NHPCO: New "Moments of Life" Video Features Latina Patient

The latest video, "A Dance for Gloria," from the Moments of Life: Made Possible by Hospice campaign features Sangre de Cristo Hospice patient Gloria Maestas, an 85 year-old former schoolteacher from Pueblo, Colorado. In the video viewers get a glimpse of the special ceremony that was organized just for Gloria.

View Video

CMS Issues Hospice CAHPS Information

Source: NAHC, September 27, 2016

CAHPS Hospice Survey September 28 Training Materials are Now Available

To view or download the agenda or PowerPoint slides for the September 28, 2016 CAHPS Hospice Survey Training session, please click on Training Materials. Please note that the Sept. 28 CAHPS Hospice Survey Training is geared toward Hospice CAHPS Survey vendors and registration for the session is no longer available.

CAHPS Hospice Survey Quality Assurance Guidelines V3.0 (QAG V3.0)

The CAHPS Hospice Survey administration protocols are contained in the CAHPS Hospice Survey Quality Assurance Guidelines Version 3.0 (QAG). This document has been developed by the Centers for Medicare & Medicaid Services (CMS) to standardize the survey data collection process and to ensure comparability of data reported through the CAHPS Hospice Survey. Please click here to view or download the QAG V3.0.
CAHPS Hospice Survey Quality Assurance Guidelines V3.0 Summary of Updates and Emphasis

The CAHPS Hospice Survey Quality Assurance Guidelines V3.0 Summary of Updates and Emphasis document is a reference tool that highlights the major changes from the CAHPS Hospice Survey Quality Assurance Guidelines Version 2.0 to V3.0. Please click here to view or download this document.

CMS Issues Advance Care Planning Fact Sheet

Source: NAHC, September 23, 2016

On October 30, 2015, the Centers for Medicare & Medicaid Services (CMS) made public a final rule governing Medicare Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY2016, which includes information on payment for advance care planning (ACP) services. As part of the final rule, CMS announced activation of:

- CPT code 99497 [Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed) by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate] ; and
- An add-on CPT code 99498, [Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; each additional 30 minutes (List separately in addition to code for primary procedure)].

ACP services may be provided by a hospice physician or hospice-employed nurse practitioner (NP) designated to serve as the hospice patient’s attending physician.

Most recently, CMS issued additional information related to ACP in the form of an Advance Care Planning Fact Sheet, which contains:

- Information on how to code ACP services
- Provider and beneficiary eligibility information
- How to bill ACP services
- An example of ACP in practice
- Resources

CMS has also issued a Frequently Asked Questions (FAQs) document that was updated in July 2016; it is available here.

Previous NAHC Report coverage on the rule is available here, here, and here.