



Hospice Proposed Rule

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HOSPICE FY2018 PROPOSED RULE – PAYMENT RATES AND HOSPICE QUALITY

REPORTING PROGRAM Late Thursday, April 27 the proposed hospice rule – **FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements** – was posted. The rule contains the proposed FY2018 payment rates, aggregate cap, and hospice quality reporting changes. The proposal is also an opportunity for CMS to provide comments on various other issues and solicit feedback. The proposed rule is open for inspection and CMS is accepting comments from hospices, stakeholders, and the public until June 26. CMS will review the comments and the final rule is anticipated to be released at the end of July. A detailed summary of the proposed rule and CMS comments is below. **PAYMENT RATES** For FY2018 the hospice payment update percentage is 1 percent. Tables depicting the proposed base rates for RHC and the remaining levels of care are below. These numbers represent the national base rate for each level of care not adjusted by CBSA. They also do not reflect the 2% annual payment update reduction for those hospices not meeting quality reporting submission requirement or not participating in the Hospice Quality Reporting Program. Those interested in seeing their specific area's wage index can find it [here](#).



The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amended section 1814(i)(1)(C) of the Act such that for hospice payments for FY 2018, the market basket percentage increase, after application of the productivity adjustment and the 0.3 percent reduction, if applicable, shall be 1 percent. In the proposed rule CMS outlines the labor portion of the rates and indicates that it will consider the results of its analysis of new cost report data for future adjustment of the labor portion. Such an adjustment would be in future rulemaking which includes opportunity for public comment. **AGGREGATE CAP AMOUNT** The hospice cap amount for the 2018 cap year will be \$28,689.04, which is equal to the 2017 cap amount (\$28,404.99) updated by the FY 2018 hospice





payment update percentage of 1.0 percent. For accounting years that end after September 30, 2016 and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the consumer price index for urban consumers (CPI-U) as was done in the past. **HOSPICE QUALITY**

REPORTING PROGRAM (HQRP) No new HIS measures are proposed for addition and no measures are proposed for removal. However, CMS has measure concepts under consideration for future years. These are grouped into two high priority areas:

- Priority Area 1 – Potentially avoidable hospice care transitions – Potentially avoidable hospice care transitions at end of life are burdensome to patients, families, and the healthcare system at large, because they are associated with adverse health outcomes, lower patient and family satisfaction, higher health care costs, and fragmentation of care delivery. CMS believes that encouraging hospice providers to assess and manage patients’ risk of care transitions, this measure concept has the potential to improve quality care at the end of life by reducing potentially avoidable hospice care transitions.
- Priority Area 2 – Access to levels of hospice care – The goal of this measure concept is to assess the rates at which hospices provide different levels of hospice care. Measuring use of levels of care will incentivize hospice providers to continuously assess patient and caregiver needs and provide the appropriate level of care to meet these needs.

CMS indicates these two high priority areas will be addressed by claims-based measure development. The concept of a claims-based measure focusing on transitions of care was first introduced in the FY 2016 Hospice Wage Index final rule. CMS indicates comments received during this rule were overall supportive of efforts to develop more robust quality measures that capture hospice performance and show links to patient and family outcomes. These two measure concepts are under development, and details regarding measure definitions, specifications, and timeline for implementation will be communicated in future rulemaking. **CMS is soliciting comments**

regarding high priority concept areas for future measure development There were two new measures added to the HIS in last year’s final rule, Hospice Visits When Death is Imminent (measure pair) and the Composite Process Measure. These two measures have not yet been approved by the National Quality Forum (NQF) and CMS plans to submit the measures for NQF endorsement once sufficient measure data are available and analyses necessary to support NQF submission for endorsement is complete. It typically takes at least 4 quarters worth of data to conduct the analyses. The Composite Process Measure does not require any additional data so it has already been submitted to NQF and is under review. Four quarters worth of data for the Measure Pair will end





March 31, 2018 and then analyses would be completed and the measure submitted. To be compliant with the HIS submission requirements, **beginning January 1, 2018 through December 31, 2018, hospices must submit no less than 90 percent of their total number of HIS-Admission and HIS-Discharge records no later than 30 days from the event date** or be subject to a 2 percentage point reduction to their market basket update for FY 2020. Hospices can determine their compliance with timely submissions through the Hospice Timeliness Compliance Threshold Report in the Certification and Survey Provider Enhanced Reports (CASPER) system. In the FY 2015 Hospice Wage Index final CMS finalized the proposal to allow hospices to request, and for CMS to grant, exemptions/extensions for the reporting of required HIS quality data when there are extraordinary circumstances beyond the control of the provider. Currently, hospices must request such an exemption or extension within 30 days of the date that the extraordinary circumstances occurred. CMS is proposing to extend the deadline for submitting an exemption or extension request to 90 calendar days from the qualifying event and to also extend this policy to the submission of the CAHPS Hospice Survey data. For the CAHPS Survey data submission, CMS finalized in previous rule that hospices must collect survey data monthly for each calendar year through 2018 to avoid the 2% annual payment update penalty. This year, CMS is **proposing to extend this methodology through calendar year 2020. For the CAHPS Hospice Survey, CMS is proposing to adopt eight survey-based measures for the CY 2018 data collection period and for subsequent years.** These eight measures are comprised of six CAHPS Hospice Survey composite measures and two global measures as follows:

Six composite measures:

- Hospice Team Communication
- Getting Timely Care
- Treating Family Member with Respect
- Getting Emotional and Religious Support
- Getting Help for Symptoms; and
- Getting Hospice Care Training

Two global measures:

- Rating of Hospice; and
- Willingness to Recommend Hospice





These measures were included in the NQF measure review process and they were supported for rulemaking. **CMS further proposes that CAHPS Hospice Survey scores for a given hospice be displayed as “top-box” scores**, with the national average top-box score for participating hospices provided for comparison. Top-box scores reflect the proportion of caregiver respondents that endorse the most positive response(s) to a given measure, such as the proportion that rate the hospice a 9 or 10 out of 10 on a 0 to 10 scale, or the proportion that report that they “always” received timely care. The top-box numerator for each question within a measure is the number of respondents that endorse the most positive response(s) to the question. The denominator includes all respondents eligible to respond to the question, with one exception. The exception is the Getting Hospice Care Training measure; for this measure, the measure score is calculated only among those respondents who indicated that their family member received hospice care at home or in an assisted living facility. CMS is considering risk adjusting some of the CAHPS Hospice Survey data. Please see the PUBLIC REPORTING section for additional information. **Comprehensive Patient Assessment Instrument – HEART** In last year’s proposed rule CMS solicited comments on the use of a comprehensive patient assessment tool in hospice. In this year’s proposed rule, CMS indicates it is in the early stages of the development of such a tool (but the tool is not yet available). The tool would serve two primary objectives:

1. provide the quality data necessary for HQRP requirements and the current function of the HIS; and
2. provide additional clinical data that could inform future payment refinements.

CMS is calling this tool HEART – Hospice Evaluation & Assessment Reporting Tool. It would include current HIS items, as well as additional clinical items that could also be used for payment refinement purposes or to develop new quality measures. HEART would not replace existing requirements set forth in the Medicare Hospice CoPs (such as the initial and comprehensive assessment), but would replace the current HIS. The tool would be completed and admission and discharge with interim data collection possible. Details about HEART will be included in future rulemaking. **PUBLIC REPORTING** The timeline has not changed, but more clarity on what measures will be included was made in this proposal. CMS still anticipates that **public reporting of HQRP data on the CMS Compare website will begin sometime in the summer of CY 2017**. CMS has previously stated that all 7 current HIS quality measures be included in public reporting. Results would be calculated based on a rolling 12-month data selection period and to be eligible for public reporting must have a minimum denominator size of 20 patient stays. **CMS proposes to begin public reporting of CAHPS® Hospice Survey measures in**





2018. Specifically, CMS proposing to publicly report data in winter CY 2018 on all eight CAHPS Hospice Survey measures (See HQRP section for more information on the CAHPS measures). Scores would be displayed based on eight rolling quarters of data and would initially use CAHPS Hospice Survey data collected between April 1, 2015 and March 31, 2017. CMS proposes that the display of these scores be updated quarterly, and that scores be displayed only for those hospices for which there are 30 or more completed questionnaires during the reporting period. Scores will not be displayed for hospices with fewer than 30 completed questionnaires during the reporting period. To the delight of many hospices, CMS believes it is necessary to risk adjust the CAHPS survey-based measures. This is to ensure fair comparisons in public reporting, and would adjust the measures for factors that are not directly related to hospice performance, such as patient mix. The survey based measures will be adjusted for decedent and caregiver characteristics including

- lag time between patient death and survey response;
- decedent's age,
- payer for hospice care,
- decedent's primary diagnosis,
- decedent's length of final episode of hospice care,
- caregiver's education,
- decedent's relationship to caregiver,
- caregiver's preferred language and language in which the survey was completed, and
- caregiver's age

CMS will also adjust for patient mix (patient characteristics) and mode of survey administration (mail, telephone, or mixed-mode). Before Hospice Compare goes live, CMS will provide hospices an opportunity to preview their quality measure data. These quality measure data reports or "preview reports" will be made available in the CASPER system and will offer providers the opportunity to preview their quality measure data prior to public reporting on the CMS Hospice Compare website. CMS indicated in a webinar earlier this week that these preview reports will be available June 1, 2017. Hospices will have 30 days to review the preview report beginning from the date on which they can access the report. Hospices will have an opportunity to request review of their data by CMS during the 30- day preview period if they believe that errors in data submitted to CMS may have resulted in incorrect measure scores and can submit proof along with a plan describing how the errors will be corrected. If CMS confirms that the errors have affected the measures and agree to correct the measure, the measure will be





suppressed on the Hospice Compare website for one time only and display the corrected measure during the subsequent quarterly refresh of the Compare website. CMS will post the policies and procedures for providers to submit requests for reviewing of their data when the preview reports are available. Like other CMS Compare websites, the Hospice Compare website will, in time, feature a quality rating system that gives each hospice a rating of between 1 and 5 stars. Hospices will have prepublication access to their own agency's quality data, which enables each agency to know how it is performing before public posting of data on the Hospice Compare website. Public comments regarding how the rating system would determine a hospice's star rating and the methods used for calculations, as well as a proposed timeline for implementation will be announced via future rulemaking. In the past, CMS has indicated that it may take longer than a year for the hospice star rating system to be developed and implemented. CMS continues to seek public comment on whether it should account for social risk factors in measures in the HQR, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors and which social risk factors might be most appropriate for reporting stratified measure scores and/or potential risk adjustment of a particular measure. Examples of social risk factors include, but are not limited to, dual eligibility/low-income subsidy, race and ethnicity, and geographic area of residence.

CMS CONCERNS – CERTIFICATION OF TERMINAL ILLNESS CMS has continuing concerns about certification of the patient for hospice care and notes that the source of clinical information to be used by certifying physicians in determining a patient's eligibility is not clear in the requirements. This raises the question as to what clinical information the hospice medical director (or hospice physician designee) is relying on to support his or her certification that the individual is terminally ill and from where this information was obtained. The expectation is that the hospice physician certifying the terminal illness will be thorough and accountable in his review of clinical information. As a result CMS is seeking comment on the following:

- Amending regulations at 418.25 to specify that the referring physician's and/or the acute/post-acute care facility's medical record would serve as the basis for initial hospice eligibility determinations. Clinical information from the referring physician and/or acute/post-acute care facility supporting a terminal prognosis would be obtained by the hospice prior to election of the benefit, when determining certification and subsequent eligibility. This potential clarifying regulatory text change would be in alignment with benefit eligibility criteria that the individual must be certified as terminally ill prior to receiving hospice services, and fundamentally could not be determined by hospice documentation obtained after admission.





- Amending the regulations text at §418.25 to specify that documentation of an in-person visit from the hospice Medical Director or the hospice physician member of the interdisciplinary group could be used as documentation to support initial hospice eligibility determinations, only if needed to augment the clinical information from the referring physician/facility’s medical records.
- Comments on current processes used by hospices to ensure comprehensive clinical review to support certification and any alternate suggestions for supporting clinical documentation sources

Table 12: Proposed FY 2018 Hospice RHC Payment Rates

Code	Description	FY 2017 Payment Rates	SBNF	Wage Index Standardization Factor	FY 2018 Proposed Hospice Payment Update	FY 2018 Proposed Payment Rates
651	Routine Home Care (days 1-60)	\$190.55	X 1.0018	X 1.0000	X 1.01	\$192.80
651	Routine Home Care (days 61+)	\$149.82	X 1.0005	X 1.0001	X 1.01	\$151.41

Table 13: Proposed FY 2018 Hospice CHC, IRC, and GIP Payment Rates

Code	Description	FY 2017 Payment Rates	Wage Index Standardization Factor	FY 2018 Proposed Hospice Payment Update	FY 2018 Proposed Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care \$40.68 = FY 2018 hourly rate	\$964.63	X 1.0022	X 1.01	\$976.42
655	Inpatient Respite Care	\$170.97	X 1.0006	X 1.01	\$172.78
656	General Inpatient Care	\$734.94	X 1.0017	X 1.01	\$743.55

SUMMARY OF CMS MONITORING CMS uses the proposes rule to describe current trends in hospice utilization and provider behavior, such as lengths of stay, live discharge rates, skilled visits during the last days of





life, and non-hospice spending. Utilization data on these metrics were examined to determine the potential impacts related to the hospice reform policies finalized in the FY 2016 final rule. **Length of Stay** CMS examined the average length of stay and lifetime length of stay (sum of all days of hospice care across all hospice elections). In FY 2016, the average length of stay in hospice was 79 days and the average lifetime length of stay in hospice was 96.1 days. This is essentially the same as FY 2015. The median length of stay in FY 2016 was 18 days. The median length of stay has remained relatively constant over the past several years, the average length of stay has typically increased from year to year. CMS also analyzed the average lifetime length of stay by site of service and principal diagnosis for those patients at the RHC level of care. Beneficiaries with chronic, progressive neurological diseases such as Alzheimer's disease and related dementias, and Parkinson's disease had the longest average lifetime lengths of stay at 165.3 days in FY 2015. Beneficiaries with Chronic Kidney Disease and cancer had shorter average lifetime lengths of stay, 57 and 63.7 days, respectively. For all diagnoses, the average lifetime length of stay was 113.5 days in FY 2015 when level of care at admission is RHC. **Days of Hospice Care by Level of Care and Site of Service** Consistent with previous data, the overwhelming majority (98%) of all Medicare hospice days are at the RHC level of care. Most of this care is still provided in the patient's home (56%), with 41% being provided in a nursing home or assisted living facility. **Live Discharges** Overall, there has been a decreasing trend in live discharges. Live discharges accounted for 17 percent of all discharges for hospices in FY2016. Of this 17 percent, revocations represented 38 percent whereas 51 percent were instances where the beneficiary was discharged because due to no longer being considered terminally ill, and 11 percent were instances where beneficiaries transferred to other hospices. While there was an increase in live discharges between FY2015 and FY2016, there has been a reduction in the live discharge rate of 22.8 percent between FY2007 and FY2016. Twenty-six percent of the live discharges occurred within 30 days of the start of hospice care, 13 percent between 31 to 60 days, 14 percent between 61 to 90 days, 19 percent between 91 to 180 days, and 28 percent of live discharges occurred after a length of stay over 180 days of hospice care. This is consistent with the past three years of data. **Skilled Visits in Last Days of Life** On any given day during the last 7 days of a hospice election, nearly 44 percent of the time the patient has not received a skilled visit (skilled nursing or social worker visit). This is an incremental improvement when compared to the last available data – FY 2014 claims showed approximately 46 percent for this metric. Additionally, approximately 21 percent of beneficiaries did not receive a skilled visit (skilled nursing or social work visit) on the day of death in FY 2016. This value also indicates an improvement compared to the FY 2014 claims data, in which nearly 26 percent of hospice beneficiaries did not receive a skilled visit on the day of death. In an assessment of FY 2015 claims, CMS estimates that the total number of hours of skilled services,





including skilled nursing (as reported with code G0154) and medical social services visits, provided to Medicare hospice beneficiaries in the RHC level of care in the 7 days preceding death was approximately 1.61 hours per day. The same holds true for FY2016 claims data. Per the analysis, CMS believes that there are no immediate concerns regarding behavior changes among hospices, and it appears that beneficiaries are receiving similar levels of care when compared to time periods prior to the implementation of the payment policy reforms. CMS will continue to monitor the provision of services at end-of-life and impacts of the SIA payment and other policies. **Non-hospice Spending** CMS continues to have concerns about services paid for outside of the Medicare Hospice Benefit when a patient is actively receiving hospice care. Analysis seems to suggest the unbundling of items and services that perhaps should have been provided and covered under the Medicare hospice benefit. Non-hospice spending for Part A and Part B items and services has decreased each year since CMS began reporting these findings. Overall, from FY 2012 to FY 2016 non-hospice Medicare spending for Parts A and B during hospice election declined 25 percent. However, there continues to be a non-trivial amount of non-hospice Parts A and B spending on beneficiaries under a hospice election, and CMS will continue to monitor data regarding this issue. In contrast to non-hospice spending during a hospice election for Medicare Parts A and B items and services, non-hospice spending for Part D drugs increased in FY 2016 compared to FY 2012. Recent analyses of Part D prescription drug event (PDE) data suggest that the current prior authorization (PA) process has reduced Part D program payments for drugs in the four targeted categories (analgesics, anti-nauseants, anti-anxiety, and laxatives). However, under Medicare Part D there has been an increase in hospice beneficiaries filling prescriptions for maintenance drugs. **Revised Hospice Cost Report Data** Preliminary analysis of the new cost report data (CMS Form 1984-14) for freestanding hospices with cost reporting periods in FY 2015, which totaled 2,675 reports was completed. CMS calculated preliminary estimates of total costs per day by level of care. There is substantial variation in the reported cost per day. Because of this wide range of values in the distribution, CMS used the median as well as the mean values weighted by the number of days by level of care as reference points. When compared with the FY 2015 per diem payment rates, the calculated median and weighted mean costs associated with providing RHC are lower than the base payment rates. CMS concluded that any interpretations regarding the overall alignment between costs and payment would likely be premature given the newness of the data. CMS also noted that this preliminary analysis did not incorporate factors that merit consideration in future analyses, such as the exclusion of providers surpassing the hospice inpatient and aggregate caps as well as the application of a more robust trimming process to the cost report dataset. Of course, CMS will continue to gather more data, and plans to conduct more thorough analyses of the cost report data and fully assess Medicare-related hospice costs as compared with Medicare hospice





payments by level of care. It is essential that hospices submit accurate cost reports and that hospices include all required data on claims (i.e. visits, drugs). *Editor's Note: This post was originally published April 27, 2017 and is continually updated to keep you informed with the latest information available from CMS.*

