FY 2018 Hospice Final Rule Summary

Hospice Data Trends

- Medicare beneficiaries receiving hospice services has grown from 513,000 in FY 2000 to nearly 1.4 million in FY 2016
    - Expenditures have risen from $2.8 billion to $16.5 billion
- Most common principal diagnoses FY 2016, together comprising about 30% of all claims-reported diagnoses this year:
    - Alzheimer's disease, Heart Failure, Chronic Obstructive Pulmonary Disease, Lung Cancer, and Senile Degeneration of the Brain
- CMS points out that 49% of claims reported only one principal diagnosis
- For FY 2016, 86% submitted at least two diagnoses, 77% percent included at least three
- Reminds hospices required to report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual, effective October 1, 2015

Commentary on Inappropriate Billing

- Commenters suggested CMS take action to educate other Medicare provider types to increase understanding of benefits coverage and claims processing after a beneficiary has elected hospice
    - Encouraged Medicare systems changes that could shorten the time frame for updates to the beneficiary's status in all systems
- CMS noted they are currently working on a process to allow NOEs to be submitted via electronic data interchange while simultaneously working on a redesign of hospice benefit period data in our systems
    - Felt this should help with more timely beneficiary status updates in the Medicare systems

FY 2018 Rate Increase

- 1% increase for FY2018—mandated by section 411(d) of the MACRA
- Other Medicare providers, such as nursing homes and inpatient rehab facilities, also have a 1% maximum increase under MACRA

Aggregate Cap

- Cap amount: **$ 28,689.04**
    - Annually updated by hospice payment update (1%) instead of the consumer price index
- Accounting year aligned with Federal Fiscal Year (10/1-9/30)
- Cap self-report now due **February 28, 2018**.

For Providers Submitting Quality Data:

Level of Care	FY2017 Payment Rates	FY2018 Final Payment Rates
Routine Home Care (Days 1-60)	$190.55	$192.78
Routine Home Care (Days 61+)	$149.82	$151.41
Continuous Home Care (Hourly rate)	$40.19	$40.68
Inpatient Respite Care	$170.97	$172.78
General Inpatient Care	$734.94	$743.55

For Providers that DO NOT Submit Required Quality Data:

Level of Care	FY2017 Payment Rates	FY2018 Proposed Payment Rates
Routine Home Care (Days 1-60)	$190.55	$188.97
Routine Home Care (Days 61+)	$149.82	$148.41
Continuous Home Care (Hourly rate)	$40.19	$39.88
Inpatient Respite Care	$170.97	$169.36
General Inpatient Care	$734.94	$728.83

Sources of Clinical Information for Certifying Terminal Illness

- Currently, §418.25 requires hospice medical director to consider diagnosis of the terminal condition of the patient, other health conditions (whether related or unrelated) and current clinically relevant information supporting all diagnoses
- CMS discussed a potential proposal for a regulatory text change at §418.25:
    - Would clarify that the documentation used for the initial certification must come from the referring physician's or acute/post-acute care facility's medical records
- Also discussed potential benefit of an initial face-to-face visit by the hospice medical director or physician designee to support the clinical documentation
- Commenters said CMS should consider obtaining and analyzing medical records from the referring provider to be best practice
    - Expressed concerns that obtaining clinical documentation from outside physicians or facilities would delay hospice admission and service
- CMS: "*We understand from commenters that hospices already obtain and analyze clinical information from a variety of sources, including referring providers, and we agree that the regulations at §418.22(b) require such information to accompany the certification of terminal illness. While we are not proposing a change in the regulations at this time, we plan to work with our Medicare Administrative Contractors (MACs) to confirm whether they are requesting such information when claims are selected for medical review and, if not, whether such information should be included in any additional documentation requests*."

- Noted that this clinical information can be obtained orally from the referring entity and documented in the patient's chart within the 2 day time-frame needed for certification
    - Also, referring entity's clinical documentation may arrive later for retention in the patient's medical record
- Have not changed the requirement that the medical documentation that accompanies the initial written certification be obtained prior to submitting a claim
- CMS clarified they are not proposing or implementing a requirement for face-to-face visit with medical director or referring physician before the third benefit period recertification,
    - Their intent in including this discussion in the proposed rule was to determine whether such optional visits could be useful to augment the referral source's clinical documentation to support a medical prognosis of 6 months or less

HQRP

- No new measures, no removal of current measures
- Reminder for new providers: Must begin submitting HIS data on the date listed in the letterhead of the CCN Notification letter received from CMS but will be subject to the APU reduction based on whether the CCN Notification letter was dated before or after November 1 of the reporting year involved.
    - Example—Provider receives their CCN notification letter, date in the letterhead is November 5, 2017; Provider will begin submitting HIS data for patient admissions occurring after November 5, 2017. Since letter was dated after November 1st, they would not be evaluated for, or subject to any payment penalties for the relevant FY APU update (which in this instance is the FY 2019 APU)
- **CMS considering two measures for later**:
    - Potentially Avoidable Hospice Care Transitions
        - Rationale: hospice care transitions at end of life are burdensome to patients, families, and the health care 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
    - Access to Levels of Hospice Care
        - Rationale: potential to improve access to various levels of care for patients and caregivers; also appropriate use of CHC and GIP increases the likelihood of a hospice patient dying in his or her location of choice, decreases health resource utilization resulting in potential cost savings, and increases patient and caregiver satisfaction
- Commentary on these measures:
    - CMS agrees it is critical to ensure that quality measures are understandable to the public, especially prior to public reporting of measures
        - Will provide resources through the Hospice Compare Web Site to aid the public in interpreting publicly displayed quality data
    - Many commenters conditionally supported both items, and just want more info and more engagement as they are developed
    - Measure specifications have not yet been finalized

Hospice Evaluation & Assessment Reporting Tool (HEART)

- Meant to facilitate progress towards the requirements set forth in Affordable Care Act:
    - (1) To 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
- Tool would include current HIS items, additional clinical items
- Would not replace existing requirements set forth in the Medicare Hospice CoPs (such as the initial and comprehensive assessment)
- Would replace the current HIS, but not other HQRP data collection efforts (CAHPS® Hospice Survey), nor would it replace regular submission of claims data
- CMS envisions data collected upon a patient's admission to and discharge from any Medicare-certified hospice provider
    - Additional interim data collection efforts are also possible
- RTI International, CMS contractor, has begun preliminary HEART development activities
- Once we move past the preliminary phases of development and conceptualization, we will communicate a timeline for the HEART development, testing, and proposed implementation in future rulemaking cycles
- Commentary on HEART:
    - Many commenters, including MedPAC supported HEART
    - CMS clarified HEART's role in future payment refinements is not definite, must undergo rigorous testing to investigate whether data items are reliable and valid predictors of resource utilization
    - CMS "wholeheartedly agree" regarding the unique nature of hospice care, will continue to keep the hospice philosophy as the foundation of the HEART patient assessment
    - Seek to develop an assessment that reflects team-based, multi-disciplinary approach addressing the holistic nature of hospice, incorporating medical, psychosocial, spiritual, and other aspects of care that are important for patients and their caregivers.
    - Anticipate making data completion and submission software available to providers at no cost so that providers can complete and submit HEART data free of charge, without the need to purchase an EMR or vendor software

Hospice Compare

- Anticipated in August 2017
- Includes current HIS:
    - Treatment Preferences - NQF #1641
    - Beliefs/Values Addressed- NQF #1647
    - Pain Screening- NQF #1634
    - Pain Assessment- NQF #1637
    - Dyspnea Screening- NQF #1639
    - Dyspnea Treatment- NQF #1638
    - Patients treated with opioid who are given a bowel regimen- NQF #1617
- Will offer opportunities for stakeholder engagement and education prior to the rollout

- “Preview reports” will be made available in the CASPER system prior to public reporting and will offer providers the opportunity to preview their quality measure data prior to public reporting
    - Provide hospices 30 days to review the preview report and have an opportunity to request review of their data by CMS
- Hospice Compare website will, in time, feature a 1-5 star quality rating system
- Minimum denominator size of 20 patient stays for HIS data