CMS Issues Final FY2017 Hospice Payment Rule with Slight Bump Up in Payments

(from NAHC Report 8-1-16)

Late July 29, 2016, the Centers for Medicare & Medicaid Services (CMS) issued its final rule governing Medicare hospice payment and quality reporting requirements for Fiscal Year (FY2017). As expected and represented in the proposed rule issued April 21, the principal focus of the FY2017 rule is issues related to the Hospice Quality Reporting Program (HQRP), while also including information related to the FY2017 wage index, payment rates, and cap amount. Overall, CMS estimates the rule to increase payments to hospice programs by $350 million during FY2017. As with the proposed FY2017 rule, the regulation contains information related to the history of the hospice benefit and trends in hospice utilization. A NAHC summary of the proposed FY2017 rule is available here.

FY2017 Hospice Wage Index and Rate Update

Effective October 1, 2016, CMS will transition to full adoption of the new Office of Management and Budget (OMB) delineations for Metropolitan Statistical Areas (MSAs), representing the 2010 Core-Based Statistical Area (CBSA) values. As of this writing, the final wage index values applicable for FY2017 were not publicly available, but they are expected to post at the following site in the near future: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html. It should be noted that in FY2016 hospices experienced the final year of the seven-year phase out of the Budget Neutrality Adjustment Factor (BNAF), so that will not be an issue for FY2017.

Hospices will see a payment increase of 2.1%, an increase of 0.1% over what was projected in the proposed rule. The 0.1% differential is due to changes in estimates as follow:

	Proposed	**Final**
Hospital market basket	2.8%	2.7%
Productivity adjustment	0.5%	0.3%
Add'l ACA reduction	0.3%	0.3%
NET MARKET BASKET	2.0%	2.1%

NOTE: for hospices that fail to submit the required quality data, the payment update will be 0.1%

Following are the base payment rates that CMS is finalizing for FY2017:
(these values assume compliance with quality reporting requirements)

Code	**Description**	**FY2016 Payment Rates**	**SBNF**	**Proposed Wage Index Standardization Factor (SBNF)**	**FY2017 Proposed Hospice Payment Update Percentage**	**FY2017 Payment Rates (proposed)**
651	Routine Home Care (days 1-60)	$186.84	X 1.0000	X 0.9989	X 1.021	**$190.55** ($190.41)
651	Routine Home Care (days 61+)	$146.83	X 0.9999	X 0.9995	X 1.021	**$149.82** ($149.68)
652	Continuous Home Care	$944.79	N/A	X 1.0000	X 1.021	**$964.63** ($963.69)

	Full rate = 24 hours of care $40.19=FY2017 hourly rate					
655	Inpatient Respite Care	$167.45	N/A	X 1.0000	X 1.021	**$170.97** ($170.80)
656	General Inpatient Care	$720.11	N/A	X 0.9996	X 1.021	**$734.94** ($734.22)

Hospice Cap

CMS has moved forward with a transition of the Cap year to the federal fiscal year, effective for the 2017 Cap year.

Following are the hospice Cap values as calculated by CMS:

2016 Cap: $27,820.75 (2016 Cap year runs from Nov. 1, 2015, through Oct. 31, 2016)
2017 Cap: $28,404.99 (2017 Cap year runs from Oct. 1, 2016, through Sept. 30, 2017)

Following is a table that provides an explanation of the transitional time frames for counting beneficiaries based on whether a hospice utilizes the streamlined or proportional method for calculating its Cap.

	Streamlined		**Patient-by-patient (Proportional)**	
	Patients	**Payments**	**Patients**	**Payments**
2016	9/28/15-9/27/16	11/1/15-10/31/16	11/1/15-10/31/16	11/1/15-10/31/16
2017	9/28/16-9/30/17	11/1/16-9/30/17	11/1/16-9/30/17	11/1/16-9/30/17
2018	10/1/17-9/30/18	10/1/17-9/30/18	10/1/17-9/30/18	10/1/17-9/30/18

<u>Quality</u>

As anticipated, much of the final rule deals with the hospice quality reporting program (HQRP)

CMS proposed and finalized:

- Two new hospice quality reporting program (HQRP) measures:
    1. **Hospice Visits When Death is Imminent**- assessing hospice staff visits to patients and caregivers in the last week of life; and
    2. **Hospice and Palliative Care Composite Process Measure**- assessing the percentage of hospice patients who received care processes consistent with existing guidelines
- To codify at §418.312 that if the National Quality Forum (NQF) makes only non-substantive changes to specifications for HQRP measures in the NQF's re-endorsement process CMS would continue to utilize the measure in its new endorsed status.

- That hospices that received their CCN after January 1, 2017, are exempt from the FY 2019 APU Hospice CAHPS® requirements due to newness. This exemption will be determined by CMS. The exemption is for 1 year only.
- That hospices that received their CCN after January 1, 2018, are exempted from the FY 2020 APU Hospice CAHPS® requirements due to newness. This exemption will be determined by CMS. The exemption is for 1 year only.

Two New HQRP Measures: Collection of the two new measures would impact payments in FY2019 and hospices will begin collecting the data for these measures for all patients admitted on or after April 1, 2017 via four new HIS items.

The Hospice Visits When Death is Imminent Measure Pair addresses whether a hospice patient and their caregivers' needs were addressed by the hospice staff during the last days of life. This measure is specified as a set of two measures as follows:

- **Measure 1**--assesses the percentage of patients receiving at least 1 visit from registered nurses, physicians, nurse practitioners, or physician assistants in the last 3 days of life and addresses case management and clinical care.
- **Measure 2**-- assesses the percentage of patients receiving at least 2 visits from medical social workers, chaplains or spiritual counselors, licensed practical nurses, or hospice aides in the last 7 days of life and gives providers the flexibility to provide individualized care that is in line with the patient, family, and caregiver's preferences and goals for care and contributing to the overall well-being of the individual and others important in their life

CMS received many comments related to both measures. For Measure 1 many concerns were expressed about how closely the number of visits at the end of life relates to quality hospice care. CMS stated it recognizes that some patients may decline services and that rapid and unanticipated patient declines do occur; thus, a score of 100% is not the expectation for this measure pair. The Hospice Visits when Death is Imminent Measure Pair will be calculated and reported as two separate measures.

CMS submitted a request for approval to the Office of Management and Budget (OMB) for the Hospice Item Set version 2.00.0 that incorporates the four new HIS items. Prior to implementation of the HIS V2.00.0, CMS will provide hospices with guidance and training materials, including an updated version of the HIS Manual. These training materials will further clarify the types of visits included in this measure pair and other item coding information. The proposed HIS V2.00.0 can be viewed in the Hospice Quality Reporting Program: Specifications for the Hospice Item Set Based Quality Measures document.

For Measure 2 data on a total of seven individual care processes will be captured, which include the six NQF-endorsed quality measures and one modified NQF-endorsed quality measure currently part of the HIS. This measure calculates the percentage of patients who received all care processes at admission. These individual component measures address care processes around hospice admission that are clinically recommended or required in the hospice Conditions of Participation. To calculate this measure, the individual components of the composite measure are assessed separately for each patient and then aggregated into one score for each hospice.

Comprehensive Patient Assessment Instrument. CMS is considering developing a new data collection mechanism for use by hospices as previously reported. CMS is not proposing a hospice patient

assessment tool at this time; it is still in the early stages of development of an assessment tool to determine if it would be feasible to implement under the Medicare Hospice Benefit. In the development of such a hospice patient assessment tool, CMS stated it will continue to receive stakeholder input from MedPAC and ongoing input from the provider community, Medicare beneficiaries, and technical experts. It is of the utmost importance to CMS to develop a hospice patient assessment tool that is scientifically rigorous and clinically appropriate. Additionally, it is of the utmost importance to CMS to minimize data collection burden on providers; in the development of any hospice patient assessment tool, CMS states it will ensure that patient assessment data items are not duplicative or overly burdensome to providers, patients, caregivers, or their families.

CMS received numerous comments on the development and content of a comprehensive patient assessment instrument, which are summarized in the final rule. Many centered around creating an assessment tool tailored to the unique needs and characteristics of hospice. CMS believes the initial input received regarding the content and process for development of a patient assessment tool is aligned with its vision and guiding principles for moving forward with developing this new data collection mechanism. CMS stated it would like to assure the provider community that it wholeheartedly agrees with commenters regarding the unique nature of hospice care, and intends to keep the hospice philosophy as the foundation of the patient assessment tool. CMS further states it will continue to inform stakeholders on any progress and proposals regarding the patient assessment tool through future rulemaking cycles.

Public Reporting and Hospice Compare Site: CMS confirmed that public reporting will begin in calendar year 2017, likely spring/summer. CMS received comments indicating the importance of CAHPS Hospice Survey data being publicly reported with HIS data. In response, CMS indicated that it is currently evaluating the best method to include both the Hospice Item Set measures and the results of the Hospice CAHPS Survey. CMS also plans to report an eight-quarter rolling average for Hospice CAHPS public reporting. For the initial report, fewer quarters may be included, but will build up to eight quarters and continue on an ongoing basis. These plans are intended to counterbalance concerns about variability of the data while at the same time including as many hospices as possible on the Compare site. CMS indicated it plans to include both the hospice rating question and the willingness to recommend question as part of the Hospice CAHPS data reported on Hospice Compare. Data analysis of HIS outcomes indicates that there is not a great deal of variance between providers in performance on individual measures although no hospice has achieved 100% for each measure and a few providers have very low scores. CMS acknowledged the skewed distribution, and commented that presenting hospice scores in formats like percentiles may provide misleading information. Presenting hospices' quality scores may provide information that is more straightforward for consumers and providers

CMS reiterated in this final rule that the Hospice Compare Web site will, in time, feature a star rating system of 1 to 5 stars for each hospice. 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 Web site. The methods used for star rating calculations, as well as a proposed timeline for implementation will be announced via regular CMS HQRP communication channels, including postings and announcements on the CMS HQRP Web site, MLN eNews communications, provider association calls, and announcements on Open Door Forums and Special Open Door Forums.

CMS will announce the timeline for development and implementation of the star rating system in future rulemaking.

HQRP Measures and Timely Reporting Thresholds:

As noted in the NAHC summary of the proposed rule, CMS is not removing any current HQRP measures. Relative to the retention of HQRP measures, through this final rule CMS is codifying its policy that once a quality measure is adopted, it be retained for use in the subsequent fiscal year payment determinations until otherwise stated. CMS further indicated it will propose a measure for removal if meaningful distinctions in quality of care can no longer be made from the measure due to high and unvarying performance

Quality measures selected for the HQRP must be endorsed by the NQF unless they meet the statutory criteria for exception under section 1814(i)(5)(D)(ii) of the Act. CMS finalized that if measures currently used in the HQRP undergo non-substantive changes in the specifications as part of their NQF re-endorsement process, CMS will subsequently utilize the measure with the new endorsed status in the HQRP without going through new notice-and-comment rulemaking. In response to a few comments expressing concern about provider and vendor availability to prepare for changes, CMS clarified that once a non-substantive change is endorsed by NQF, CMS will consider the time necessary for providers and vendors to implement the change. If newly endorsed non-substantive changes require updates to data collection mechanisms (for example, updates to HIS specifications) or associated training materials, CMS will allow ample time for providers and vendors to prepare and implement such changes. CMS will communicate the endorsement of non-substantive changes, decisions about whether to adopt non-substantive changes, and timeline for implementation of non-substantive changes through regular HQRP communication channels.

CMS may modify one or more of the following aspects of a NQF-endorsed measure: (1) numerator; (2) denominator; (3) setting; (4) look-back period; (5) calculation period; (6) risk adjustment; and (7) revisions to data elements used to collect the data the data required for the measure. CMS will continue to use rulemaking to adopt substantive updates made by the NQF to the endorsed measures adopted for the HQRP.

Of the seven measures currently part of the HIS (Hospice Item Set) and the two new measures, all but one had a length of stay exclusion of 7 days for the measure denominator. CMS explained in this final rule, after receiving comments of concern about excluding patient with a short length of stay (LOS), that testing was done on HIS records submitted from July 1, 2014 – March 31, 2015 to determine the impact of removing the LOS exclusion from the measure denominators. The testing revealed that excluding stays with LOS less than 7 days prevents some hospices from being included in quality measure score calculations because they do not have any qualifying patient stays. Therefore, removing the LOS exclusion criteria will increase the number of patients included in the measures, and thus the number of hospices that are included in the quality measure calculation. The impact of the LOS exclusions on the distribution of hospices' scores is generally small for all of the quality measures. In addition, the analyses revealed that the care processes targeted by the measures s are performed on the day of, or within one day of, admission for the vast majority of patient stays. However, CMS will consider risk adjusting the measures for short lengths of stay in future measure development.

In this final rule, CMS repeated some 2016 and 2017 HQRP information and finalized the reporting requirements that were proposed. Beginning in CY2016, hospices need to meet a timeliness threshold for HQRP HIS reporting in order to avoid a 2% payment penalty. The timeliness threshold is currently set at 70% and will jump to 80% for the FY 2019 APU determination and to 90% for the FY 2020 APU determination and subsequent years. The threshold corresponds with the overall amount of HIS records received from each provider that fall within the established 30-day submission timeframes. Beginning with the FY 2018 payment determination and for each subsequent payment determination, CMS finalized its policy that a new hospice be responsible for HQRP HIS quality data submission beginning on the date of the CCN notification letter. CMS retained its prior policy that hospices not be subject to the APU reduction if the CCN notification letter was dated after November 1 of the year involved

To meet participation requirements for the FY 2019 APU, hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2017 through December 2017 (inclusive). Data submission deadlines for the 2019 and 2020 annual payment updates can be found in the table below. The data must be submitted by the deadlines listed in the table by the hospice's authorized approved CMS vendor. If the vendor does not submit the data, the hospice is held responsible.

CAHPS® HOSPICE SURVEY DATA SUBMISSION DATES FY 2018 APU, FY 2019 APU, AND FY 2020 APU

Sample months (month of death) [1]	Quarterly data submission deadlines [2]
FY2018 APU	
January – March 2016 (Q1)	August 10, 2016
April – June 2016 (Q2)	November 9, 2016
July – September 2016 (Q3)	February 8, 2017
October – December 2016 (Q4)	May 10. 2017
FY2019 APU	
January – March 2017 (Q1)	August 9, 2017
April – June 2017 (Q2)	November 8, 2017
July – September 2017 (Q3)	February 14, 2019
October – December 2017 (Q4)	May 9, 2019
FY2020 APU	
January – March 2018 (Q1)	August 8, 2018

April – June 2018 (Q2)	November 14, 2018
July – September 2018 (Q3)	February 13, 2019
October – December 2018 (Q4)	May 8. 2019
[1] Data collection for each sample month initiates 2 months following the month of patient death (for example, in April for deaths occurring in January)	
[2] Data submission deadlines are the second Wednesday of the submission months, which are August, November, February, and May.	

Hospices that have fewer than 50 survey -eligible decedents/caregivers in the calendar year reporting period are exempt from CAHPS® Hospice Survey data collection and reporting requirements for the applicable fiscal payment determination. To qualify, hospices must submit an exemption request form for each year it believes it qualifies for the exemption.

Hospices that want to claim the size exemption are required to submit to CMS their total unique patient count for the period of January 1, 2016 through December 31, 2016. The due date for submitting the exemption request form for the FY 2019 APU is August 10, 2017.

CMS finalized that hospices that receive their CCN after January 1, 2017, are exempted from the FY 2019 APU Hospice CAHPS and those receiving their CCN after January 1, 2018 are exempted from the FY 2020 APU Hospice CAHPS Survey requirements due to newness. This exemption will be determined by CMS. The exemption is for 1 year only as it is now.