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***Missouri Alliance for* Home Care**

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Hospice News and Updates from Theresa Forster, VP Hospice Policy & Programs, NAHC

In This Edition:

Two quick notes – CMS is delaying implementation of the two-tiered RHC rate system until January 1, 2016 to ensure appropriate systems operations. CMS has also eliminated the prohibition against the SIA being payable for patients in nursing facilities/SNFs. More detail later!

NAHC Summary: CMS Finalizes FY2016 Hospice Payment Rule
Following is a quick summary of the final hospice payment rule.

Late Friday, July 31, the Centers for Medicare & Medicaid Services (CMS) released the final hospice payment rule for fiscal year 2016 (FY2016); the final rule is available here: https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-19033.pdf. The rule is scheduled to be published in the Federal Register on August 6, 2015 and will, at that time, be available at **http://federalregister.gov/a/2015-19033**.

The overall impact of the final rule is an estimated net increase in federal Medicare payments to hospices of $160 million; hospice payments will increase an average of 1.1 percent over FY2015.

NAHC is very pleased that CMS has decided to allow SIA payment to be applied to all patients -- including those residing in nursing facilities and skilled nursing facilities; NAHC is also supportive of CMS' plans to delay implementation of the new payment system until January 1, 2016, to allow

hospice providers, vendors, MACs, and state Medicaid programs to ensure that systems are prepared for the changes.

SUMMARY – Payment Reform/Payment Changes

PAYMENT FOR ROUTINE HOME CARE: As anticipated, CMS is finalizing the proposal to establish a two-tiered payment system for RHC, with an effective date of January 1, 2016. This delay in implementation from October 1, 2015 to January 1, 2016 will allow for state Medicaid agencies to make the necessary systems and software changes. Between October 1, 2015 and December 31, 2015, hospices will continue to be paid a single FY2016 RHC per diem payment amount. Effective January 1, 2016, a higher RHC rate for days 1 through 60 of a hospice episode of care and a lower RHC rate for days 61 and beyond of a hospice episode of care will replace the single RHC per diem payment rate (the RHC per diem rates are listed in the table below). An episode of care for hospice RHC payment purposes is a hospice election period or series of election periods separated by no more than a 60 day gap in hospice care. For hospice patients who are discharged and readmitted to hospice within 60 days of that discharge, a patient's prior hospice days would continue to follow the patient and count toward his or her patient days for the new hospice election. CMS will calculate the patient's episode day count based on the total number of days the patient has been receiving hospice care separated by no more than a 60 day gap in hospice care, regardless of level of care or whether those days were billable or not. This calculation would include hospice days that occurred prior to January 1, 2016.

SERVICE INTENSITY ADD-ON: CMS is finalizing the SIA proposal as proposed; however, CMS **will** include episodes in SNF/NF as eligible for the SIA payment. CMS is finalizing the SIA proposal with an effective date of January 1, 2016 in order to coordinate implementation of the hospice payment reforms, including the finalization of the new RHC rates discussed above. Finally, CMS will also finalize its proposal to continue to make the SIA payments budget neutral through an annual determination of the SIA budget neutrality factor (SBNF), which will then be applied to the RHC payment rates. The SBNF for the SIA payments will be calculated for each FY using the most current and complete fiscal year utilization data available at the time of rulemaking.

WAGE INDEX: CMS is implementing the hospice wage index with a 1-year transition period as proposed, meaning the counties impacted will receive 50 percent of the rate from the current CBSA and 50 percent from the new OMB CBSA delineations for FY 2016 effective October 1, 2015.

FY2016 Proposed and Final Hospice Payment Rates*

Code/Description	Proposed FY2016 Rate	Final FY2016 Rate
651 (10/1 - 12/31/15)	**-**	**$161.89**

651/RHC days 1 - 60 (eff. 1/1/2016)	**$ 188.20**	**$186.84**
651/RHC days 61+ (eff. 1/1/2016	**$ 147.34**	**$146.83**
652 -- CHC	**$ 946.65 ($39.44/hr.)**	**$944.79 ($39.37)**
655 -- Inpatient Respite	**$ 167.78**	**$167.45**
656 -- GIP	**$ 721.53**	**$720.11**

*hospices failing to meet quality reporting requirements will be paid 98% of these values; these rates are not wage-adjusted

CMS also provided the following information in its response to payment-related comments as part of the final rule:

- CMS plans to monitor the impact of the two-tiered RHC payment system, including trends in discharges and revocations, and propose future refinements if necessary. CMS reminds hospices that patients may only be discharged due the patient moving out of the service area, for cause when the patient or others living in the home are disruptive, or if the hospice determines the patient is no longer terminally ill. Program integrity efforts are being considered to address fraud and abuse.

- CMS believes that the higher RHC rate in conjunction with the proposed SIA payment will mitigate some of the financial concerns associated with very short stay patients.

- CMS believes it is not appropriate to reset all hospice episodes back to day 1 on January 1, 2016; nor does CMS believe allowing existing patients to continue on service at the single RHC rate is appropriate.

- Hospices will not be required to change how they bill for RHC days to comply with the payment changes; CMS' claims processing system will be responsible for the count of days and will pay the appropriate rate accordingly.

- While CMS is not eliminating the sequential billing requirements at this time they will consider whether it is appropriate at some time in the future.

- When a patient transfers hospices and there is no gap in care, the transfer day will only be counted as 1 day.

- In cases where a hospice exceeds its GIP cap, CMS will reduce the GIP rate to the tier 2 hospice payment rate (rate for days 61 and after).

- CMS estimates that the payment changes will increase payments for hospices that are below the aggregate cap by 0.14 percent and decrease payments for over-cap hospices by 5.40 percent.

- CMS will release the contractor's 2015 Technical Report later this year (although CMS indicated that the technical report does not contain payment reform analysis); all analysis in support of hospice payment reform can be found in section III.B of the final rule.

SUMMARY: IMPACT ACT CHANGES

- **Aggregate cap calculation and**
- **aggregate and inpatient cap accounting year changes**

The final rule implements changes mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), in which the aggregate cap for accounting years that end after September 30, 2016 and before October 1, 2025, will be updated by the hospice payment update percentage rather than using the consumer price index for urban consumers (CPI-U). Specifically, the 2016 cap year, starting on November 1, 2015 and ending on October 31, 2016, will be updated by the FY 2016 hospice update percentage for hospice care. This will continue through any cap year ending before October 1, 2025 (that is, through cap year 2025). The hospice payment update percentage has risen at a slower pace than the CPI-U. Therefore, it is anticipated that the result of this change is more hospices going over the allowed aggregate cap and by a greater amount than in the past.

In addition, CMS is aligning the cap accounting year for both the inpatient cap and the hospice aggregate cap with the fiscal year for FY 2017 and later. The federal fiscal year runs from October 1 through September 30. The cap accounting year as well as the timeframe for counting the number of beneficiaries will, therefore, have the same start and end date beginning FY2017. Hospices are required to file a self-determined inpatient and aggregate cap determination 5 months after the end of the cap year. This is per last year's final rule. Based on this, hospices will then have to file their self-determined inpatient and aggregate cap determinations on or before February 28, 2018 for the 2017 cap year (on or before March 31, 2017 for the 2016 cap year).

SUMMARY: Updates to the HQRP

CMS is finalizing the updates as laid out in the proposed rule. Those are:

- Beginning with the FY 2018 payment determination, for the purpose of streamlining the rulemaking process, when CMS adopts

measures for the HQRP beginning with a payment determination year, these measures are automatically adopted for all subsequent years' payment determinations, unless CMS proposes to remove, suspend, or replace the measures.

- Quality measures may be considered for removal by CMS if:
  - Measure performance among hospices is so high and unvarying that meaningful distinctions in improvements in performance can be no longer be made;
  - Performance or improvement on a measure does not result in better patient outcomes;
  - A measure does not align with current clinical guidelines or practice;
  - A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available;
  - A measure that is more proximal in time to desired patient outcomes for the particular topic is available;
  - A measure that is more strongly associated with desired patient outcomes for the particular topic is available; or
  - Collection or public reporting of a measure leads to negative unintended consequences.

  For any such removal, the public will be given an opportunity to comment through the annual rulemaking process. However, if there is reason to believe continued collection of a measure raises potential safety concerns, CMS will take immediate action to remove the measure from the HQRP and will not wait for the annual rulemaking cycle. The measures will be promptly removed and CMS will immediately notify hospices and the public of such a decision through the usual HQRP communication channels, including listening sessions, memos, email notification, and Web postings. In such instances, the removal of a measure will be formally announced in the next annual rulemaking cycle.

- CMS did not propose to remove any measures for the FY 2017 reporting cycle. However, in the proposed rule CMS did identify priority areas for future measure enhancement and development and invited comment regarding these.
  - Patient reported pain outcome measure that incorporates patient and/or proxy report regarding pain management;
  - Claims-based measures focused on care practice patterns including skilled visits in the last days of life, burdensome transitions of care for patients in and out of the hospice benefit, and rates of live discharges from hospice;
  - Responsiveness of hospice to patient and family care needs;
  - Hospice team communication and care coordination

CMS indicated these measure concepts are under development, and details regarding measure definitions, data sources, data collection approaches, and timeline for implementation will be communicated in future rulemaking. In this final rule, CMS summarized the comments received on the priority areas and responded to some of those comments. Overall, commenters were supportive of all priority areas except the claims-based measures.

- New providers will be required to begin reporting quality data under for the HQRP beginning on the date they receive their CCN Notification Letter from CMS. This will begin with the FY 2018 payment determination and for each subsequent payment determination. Currently, new hospices that receive their CCN Notification Letter from CMS on or after November 1st of the preceding year are excluded from any payment penalty for quality reporting purposes for the following fiscal year and would begin reporting their quality data on January 1 of the next calendar year. CMS clarified in this final rule that providers are required to begin reporting data on the date that they receive their CCN notification letter. For example, if a provider receives its CCN notification letter on November 5, the provider would need to begin submitting its HIS data for all admissions occur on November 5 and later. Since the hospice did not received its letter until after November 1 it would not be subject to any payment penalties for the relevant fiscal year.
- Hospices must submit all HIS records within 30 days of the Event Date (admission or discharge) as proposed
- CMS is implementing the proposed timeliness threshold requirement beginning with all HIS admission and discharge records that occur on or after January 1, 2016, in accordance with the following schedule.
    - Beginning on or after January 1, 2016 to December 31, 2016, hospices must submit at least 70 percent of all required HIS records within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2018.
    - Beginning on or after January 1, 2017 to December 31, 2017, hospices must score at least 80 percent for all HIS records received within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2019.
    - Beginning on or after January 1, 2018 to December 31, 2018, hospices must score at least 90 percent for all HIS records received within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2020.

- Codifies the HQRP Submission Extension and Exemption Requirements at §418.312.
- To meet participation requirements for the FY 2019 APU, hospices must collect data on an ongoing monthly basis from January 2017 through December 2017 (inclusive). Data submission deadlines for the 2019 APU will be announced in future rulemaking.
- Hospices that have fewer than 50 survey-eligible decedents/caregivers in the period from January 1, 2016 through December 31, 2016 are exempt from CAHPS®
- CMS will add CASPER as an additional communication mechanism for disseminating notifications of noncompliance, as well as publish a list of compliant hospices on the HQRP Web site.

SUMMARY: Diagnoses codes on claims

CMS clarifies that hospices must report all diagnoses of the beneficiary on the hospice claim as a part of the ongoing data collection efforts for possible future hospice refinements. CMS believes that reporting of all diagnoses on the hospice claim aligns with current coding guidelines as well as admission requirements for hospice certifications. The purpose of collecting this data, which is required in every other healthcare setting as per coding guidelines, is to have adequate data on hospice patient characteristics. This data will help to inform thoughtful, appropriate, and clinically relevant policy for future rulemaking. In order to consider any future refinements, such as a case mix system which utilizes diagnosis information as a few commenters suggested, it is imperative that detailed patient characteristics are available to determine whether a case mix payment system could be achieved.

Final Hospice Wage Index:

CMS has posted notice on its Hospice Center web page with a link to the final hospice wage index tables for FY2016. Here's a link to the Hospice Center web page: https://www.cms.gov/Center/Provider-Type/Hospice-Center.html

CMS Presentation on Hospice Item Set Manual Changes Available

CMS has asked that we distribute this notice relative to the 6/17 National Provider Call on the Hospice Item Set manual changes.

6/17 MLN Connects National Provider Call presentation slides, recording, transcription and FAQ document now available for provider download

CMS hosted an HIS-focused MLN Connects National Provider Call on June 17th, 2015. This presentation covered updates that were made to the HIS Manual from V1.01 to V1.02. There are several downloads available from this call:

- **Slide presentation with speaker notes-** http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html
- **FAQs document-** http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html
- **Written transcript-** http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2015-06-17-Hospice.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending
- **Audio recording-** http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2015-06-17-Hospice.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending
- **YouTube videos (audio and slides)-** http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2015-06-17-Hospice.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

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