To: NHPCO Members
From: NHPCO Health Policy Team
Date: August 5, 2014

Provisions of FY2015 Hospice Wage Index Final Rule

On August 4, 2014, CMS posted the FY2015 Hospice Wage Index final rule on public inspection with the Federal Register. [http://www.ofr.gov/OFRUpload/OFRData/2014-18506_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2014-18506_PI.pdf) The official publication of the final rule is now scheduled for August 22, 2014, with an effective date of October 1, 2014. The detailed summary below outlines the changes for hospice practice that will be important for providers to read for ongoing compliance, once the changes become effective on October 1, 2014.

<table>
<thead>
<tr>
<th>Summary of Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective October 1, 2014</strong></td>
</tr>
<tr>
<td>1. The hospice Notice of Election (NOE) and Notice of Termination/Revocation (NOTR) must be filed within 5 calendar days.</td>
</tr>
<tr>
<td>2. The penalty for not filing the NOE timely is “provider liable” days where the hospice is responsible for providing care and services to the patient from effective date of election until the date the NOE is filed.</td>
</tr>
<tr>
<td>3. The patient or their representative must choose their attending physician and indicate that choice on the NOE. The hospice must provide a “change of attending physician” form for the patient/representative to complete when the attending physician changes.</td>
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<tr>
<td>4. Quality reporting requirements remain as proposed. HIS implementation July 1, 2014 and CAHPS survey implementation in 2015.</td>
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<tr>
<td>5. Hospices will be required to self-report the aggregate cap 5 months after the end of the cap year, or March 31 of each year. Overpayments will be required to be paid when the report is submitted, although options for an extended repayment plan are available.</td>
</tr>
<tr>
<td>6. FY2015 rates include an increase of 2.1%, slightly higher than the 2.0% in the proposed rule. The wage index values have also been updated.</td>
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</table>

The NHPCO state/county rate charts and the Medicare calculator will be available from NHPCO in the coming days.
Filing of Notice of Election (NOE) and Notice of Termination/Revocation (NOTR)

1. Timely filing of NOE and NOTR: Effective October 1st, hospices will have a maximum of 5 days to have the NOE and/or the NOTR submitted and accepted by their Medicare contractor.

2. When to submit the NOE or NOTR: CMS strongly encourages hospices to file the NOE as soon as possible after the election or the revocation/discharge, not waiting until the fifth day.

3. Late filing penalty for NOE: Late filing for NOE will incur “provider liable” days – from effective date of election until date NOE is filed.

4. Provider liable days: This new term applies when the hospice fails to file the NOE within 5 calendar days. The hospice remains responsible for providing all care and services to the patient as detailed in the plan of care, without reimbursement from the Medicare Hospice Benefit.

5. Exceptions to the timely filing of an NOE or NOTR:
   CMS lists the following exceptions to the timely filing requirement:
   - fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice’s ability to operate;
   - an event that produces a data filing problem due to a CMS or Medicare contractor systems issue that is beyond the control of the hospice;
   - a newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its Medicare contractor; or,
   - other circumstances determined by CMS to be beyond the control of the hospice.

6. Documentation of exception: The hospice must document the circumstance to support a request for an exception, which would waive the consequences of filing the NOE late. Using that documentation, the hospice’s Medicare contractor will determine if a circumstance encountered by a hospice qualifies for an exception to the consequences for filing an NOE more than 5 calendar days after the effective date of election.

7. Exceptions not allowed: CMS states that exceptions to the timely NOE filing requirement will not be allowed for “personnel issues; internal IT systems issues that the hospice may experience; the hospice not knowing the requirements; and failure of the hospice to have back-up staff to file the NOE.” In these circumstances, the hospice may incur “provider liable” days.

8. Establish contingency plans for timely filing: CMS encourages hospices to establish “contingency plans for situations where administrative staff who normally file the NOEs or NOTRs are on vacation, unavailable due to illness, or are unexpectedly unavailable.” CMS will be monitoring the timely filing issue and may consider shortening the timeframe in future rulemaking.

9. Direct Data Entry (DDE) or Other Options: While NHPCO requested a review of options other than the DDE entry of the NOE, CMS determined that there would be “significant implementation challenges .... for creating an interface for a new non-claim format in the Medicare claims processing system.” CMS agreed to explore options in electronic batch submission of hospice NOEs.

Patient designation of attending physician

1. Attending physician defined for the Medicare hospice benefit: In the Medicare hospice benefit, “attending physician” has a specific definition found in the Social Security Act at 1861(dd)(3)(B) that the term means, with respect to an individual: “the physician (as defined in subsection (r)(1)) or nurse practitioner (as defined in subsection (aa)(5)), who may be employed by a hospice program, whom the individual identifies as having the most
significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care.

We define it as either 1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs that function or action; or 2) a nurse practitioner who meets the training, education, and experience requirements described elsewhere in our regulations.”

2. Patient’s right to choose his or her own attending physician: The hospice patient (or his/her representative) has the right to choose their own attending physician. The Medicare Hospice Conditions of Participation specify, at §418.52(c)(4), that the patient has the right to choose their own attending.

3. Intent of provision: CMS states that the intent of this new requirement is to safeguard and protect the patient’s choice of attending physician.

4. Non-compliance risks for the hospice:
   - Hospice changes the patient’s attending physician when the patient moves to an inpatient setting for GIP care, often to a nurse practitioner.
   - Hospice assigns an attending physician to the patient, based on whoever is available.
   - Hospice does not get the signature of the attending physician on the initial certification, unless attending is a NP.

Hospices who do not change their practice to ensure that the patient’s right to choose their own attending physician may be at risk for survey deficiencies or non-compliance audits.

5. Hospitalist as patient’s attending: We are pleased that CMS has clarified the option of the hospitalist as the patient’s attending physician. CMS states: “We do not prohibit a patient (or representative) from choosing a hospitalist as the attending physician, though we suggest that the hospice explain to the patient (or representative) that a hospitalist only follows patients who are hospitalized.” However, CMS notes that often the hospital will assign a hospitalist to be the patient’s “attending physician” for purposes of the hospital’s inpatient care. The hospitalist does not meet the hospice definition of “attending physician” unless the patient chooses the hospitalist to be their attending physician.

6. Choosing an attending physician: CMS states that “there are many legitimate reasons for the patient to change their attending physician. However, the choice belongs solely to the patient/representative. A patient cannot be required or coerced to change the attending physician.”

7. When the attending physician is no longer willing or available to serve: The hospice should use the medical record to document instances where the attending physician is no longer willing or available to follow the patient. In those situations, the hospice should then inform the patient (or their representative) that they may choose someone else to serve as their attending physician. The information should include that the patient/representative can choose a physician or nurse practitioner from the hospice or from the community.

8. Hospital privileges and the attending physician: If a patient is admitted to an inpatient setting where the attending physician does not have privileges, or does not wish to continue to care for a patient in an inpatient setting, the Medicare Hospice Conditions of Participation apply. Based on §418.64(a)(3), the hospice physician or NP must provide any needed physician services.

9. Attending physician added to Notice of Election (NOE) form: CMS now requires the name of the attending physician on the NOE, along with an acknowledgment that the identified attending physician was his or her choice. The new regulation can be found at §418.24(b)(1). CMS states that hospices have “the flexibility to include this information on their election statement in whatever format works best for them, provided the content requirements in §418.24(b) are met.”

10. New “Change in Attending” form required: CMS envisions that the “Change of Attending Physician” form would be developed by the hospice. The patient/representative must provide the hospice with a signed document when the patient chooses to change the attending physician. Changes are detailed in
a new section at §418.24(f). The statement, developed by the hospice, should include information as follows:

- Physician’s full name
- Office address
- NPI number
- Date change is to be effective (Effective date can be no earlier than the date the statement is signed)
- Date statement is signed
- Patient/representative’s signature
- Acknowledgement that this change in attending physician is the patient’s/representative’s choice

CMS states that more information on the role of the attending physician, as well as information regarding billing physician services, will be developed and shared with hospice providers.

**Quality Reporting**

1. **Quality Measures:** CMS reiterates that the 7 quality measures announced in the FY2014 final hospice wage index rule remain in place for FY2015. They are:

   - NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen
   - NQF #1634 Pain Screening
   - NQF #1637 Pain Assessment
   - NQF #1638 Dyspnea Treatment
   - NQF #1639 Dyspnea Screening
   - NQF #1641 Treatment Preferences
   - NQF #1647 Beliefs/Values Addressed (if desired by the patient) (modified)

2. **Hospice Item Set:** Hospices are required to complete and electronically submit an admission HIS and a discharge HIS for each patient admission and discharge, regardless of payer or patient age. Hospice programs will be evaluated for purposes of the quality reporting program based on whether or not they submit data, not on their substantive performance level with respect to the required measures. Failure to report quality data via HIS in 2014 will result in a market basket update reduced by 2% in FY 2016.

3. **Hospices certified before November 1:** Hospices that receive their certification before November 1 of the calendar year before the fiscal year for which a payment determination will be made must submit data for the calendar year. This provision is codified in the Hospice Conditions of Participation at §418.312.

4. **Extraordinary Circumstances and Quality Reporting:** Hospices could request extensions/exceptions for extraordinary circumstances beyond the control of the provider. When an extension/exception is granted, a hospice will not incur payment reduction penalties.

5. **New Measures:** CMS confirms that no new measures are being proposed at this time. Future measures should expand measures already in use in other quality reporting programs that could apply or develop new measures if no suitable measures are ready for implementation or expansion.
6. **Public Reporting:** Data collected by hospices during Q1-3 CY 2015 will be analyzed starting in CY 2015 and decisions about reporting will be based on findings and analysis of CY2015 data. CMS also states that public reporting may occur during FY2017.

7. **CAHPS® Hospice Survey:** The CAHPS® Hospice Survey is a component of CMS’ quality reporting program which emphasizes the experiences of hospice patients and their primary caregivers listed in the hospice patients’ records. Measures from the survey will be submitted to the National Quality Forum (NQF) for approval as hospice quality measures.

<table>
<thead>
<tr>
<th>Deaths in Previous Calendar Year</th>
<th>Survey and Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 50 deaths</td>
<td>Exempt from CAHPS data collection and reporting</td>
</tr>
<tr>
<td>50 to 699 deaths n = 2,326 hospices</td>
<td>Survey and report all cases</td>
</tr>
<tr>
<td>&gt;= 700 deaths n = 274 hospices</td>
<td>Sample of 700 will be drawn under equal probability design</td>
</tr>
</tbody>
</table>

8. **CAHPS Survey Vendors:** Hospices are required to contract with a third-party vendor that is CMS-trained and approved, which ensures that the data are unbiased and collected by an organization that is trained to collect this type of data. A list of approved vendors will be provided on the CAHPS® Hospice Survey website closer to national implementation. Applications for survey vendors are available at [www.hospicecahpssurvey.org](http://www.hospicecahpssurvey.org). Vendor applications are due by August 7, 2014. No information is yet available on the list of approved vendors.

9. **Start date for CAHPS:** Every hospice must conduct a one month “dry run” during the first three months of CY2015. Beginning April 1, 2015, all hospices are required to participate in the survey on an ongoing monthly basis. This means hospices need to contract with a survey vendor to conduct the survey monthly on their behalf.

10. **Meeting Quality Reporting Requirement for Payment Update:** Participation for at least 1 month during the dry run, plus monthly participation for the 9 months between April 2015 and December 2015 (inclusive) is required to meet the pay for reporting requirement of the Hospice Quality Reporting Program (HQR) for the FY 2017 APU.

**Cap Report and Overpayments**

1. **Using the PS&R:** CMS has made efforts in the last two years to update the Provider Statistical and Reimbursement (PS&R) system, where the inpatient and aggregate caps could be managed. The updated PS&R enables hospices to calculate estimated caps and to monitor their cap status at different points during the cap year. The PS&R also allows hospices to calculate their cap liability after the cap year ends. CMS requires hospices to “wait at least 3 months after the end of the cap year, or January 31 or later, to calculate the self-determined aggregate cap, including a reasonable number of claims.”
2. **Due date for aggregate cap report**: CMS is requiring hospices complete and self report their aggregate cap determination within 5 months after the cap year ends on October 31 of each year, due by March 31 of each year. The MAC would reconcile all payments at the final cap determination, but would not initiate the cap report.

3. **Due date for cap overpayment**: CMS states that any cap overpayments would be remitted at the time that the aggregate cap determination is filed. As CMS states: “The requirement that hospices pay the overpayment when they file their cap determination is similar to the requirement for other provider types that final payment reconciliation are completed on the Medicare cost report.

4. **Extended repayment schedule**: Providers that have overpayments as a result of the self-determined cap calculation will follow the same overpayment processes that were in effect prior to this requirement.

5. **Inpatient cap calculation**: The Medicare Administrative Contractors (MAC) will continue to calculate the inpatient cap for providers.

6. **Fail to file cap report**: If a provider fails to file the cap report, that payments to the provider would be suspended in whole or in part until the self-determined cap is filed with the Medicare contractor.

**FY2015 Rates (Final)**

1. **Payment increase changes**: In the FY2015 Hospice Wage Index final rule, the hospital marketbasket increase is slightly higher than in the proposed rule – 2.1% in the final rule compared to 2.0% in the proposed rule. Please note the rates below in calculations for FY2015. NHPCO State/County charts and the Medicare Rate Calculator will be updated in coming days.

2. **Wage index changes**: CMS released updated tables with all wage index values, representing a change from the tables released for the proposed FY2015 wage index. Please note those changes when calculating rates for FY2015. The wage index tables are on the CMS website.

**For hospices submitting required hospice quality data**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY2014 Payment Rates</th>
<th>Increase by the FY2015 Final hospice payment update of 2.1%</th>
<th>FY 2015 Final Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care</td>
<td>$156.06</td>
<td>X 1.021</td>
<td>$159.34</td>
</tr>
<tr>
<td>652</td>
<td>Continuous Home Care</td>
<td>$910.78</td>
<td>X 1.021</td>
<td>$929.91</td>
</tr>
<tr>
<td></td>
<td>Full Rate applies to 24 hours of care, Hourly rate = $38.75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$161.42</td>
<td>X 1.021</td>
<td>$164.81</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$694.19</td>
<td>X 1.021</td>
<td>$708.77</td>
</tr>
</tbody>
</table>
If a hospice does not submit the required hospice quality data, the regulations require that the hospice payment update (marketbasket) percentage be reduced by 2.0%. For FY2015, as an example, the rates would increase by 0.1% if the hospice did not submit the required hospice quality data. See the chart below.

**For hospices who DO NOT submit the required hospice quality data**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY2014 Payment Rates</th>
<th>Increase by the FY2015 hospice payment update percentage of 2.1% minus 2% = 0.1% increase</th>
<th>FY2015 Hospice Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care</td>
<td>$156.06</td>
<td>X 1.001</td>
<td>$156.22</td>
</tr>
<tr>
<td>652</td>
<td>Continuous Home Care</td>
<td>$910.78</td>
<td>X 1.001</td>
<td>$911.69</td>
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<td>Full Rate applies to 24 hours of care,</td>
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<td>655</td>
<td>Inpatient Respite Care</td>
<td>$161.42</td>
<td>X 1.001</td>
<td>$161.58</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$694.19</td>
<td>X 1.001</td>
<td>$694.88</td>
</tr>
</tbody>
</table>

**Cap Amount:** The hospice aggregate cap amount for the 2014 cap year will be $26,725.79.

**Definitions of “terminal illness” and “related conditions”**

CMS requested feedback on proposed definitions of “terminal illness” and “related conditions.” No definitions were in the final rule, but CMS may consider definitions for possible future rulemaking.

For questions or more information, please contact regulatory@nhpco.org