Proposed FY 2017 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

To: **NHPCO Provider Members**
From: **Health Policy Team**
Date: **April 25, 2016**

On April 21, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a *proposed* rule (CMS-1652-P) that would update fiscal year (FY) 2017 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Comments on the proposed rule are due no later than **June 20, 2016.**

Summary at a Glance

The FY2017 proposed hospice wage index rule includes:

- Analysis of data trends in hospice utilization
- A projected 2% hospital market basket increase (subject to adjustment in the final rule)
- a projected cap amount of $28,377.17 (subject to adjustment in the final rule)
- a change in the cap year to October 1, 2016 through September 30, 2017
- 2 new quality measures; data collection to start April 1, 2017
- Development of a data collection instrument which would serve as a comprehensive patient assessment instrument, rather than the current chart abstraction.

Trends in Hospice Utilization

1. Five Most Common Diagnoses 2015

Hospice has grown from 513,000 patients in 2000 to nearly 1.4 million patients in FY2015, with a corresponding rise in expenditures, from $2.8 billion in 2000 to $15.5 billion in FY2015. CMS posted the top 5 diagnoses for 2015, as seen below:

Rank	ICD-9 Code	Diagnosis	Number of Hospice Patients	Percentage
1	331.0	Alzheimer's disease	195,469	13%
2	428.0	Congestive heart failure, unspecified	114,240	8%
3	162.9	Lung Cancer	87,661	6%
4	496	COPD	80,081	5%
5	331.2	Senile degeneration of the brain	46,610	3%

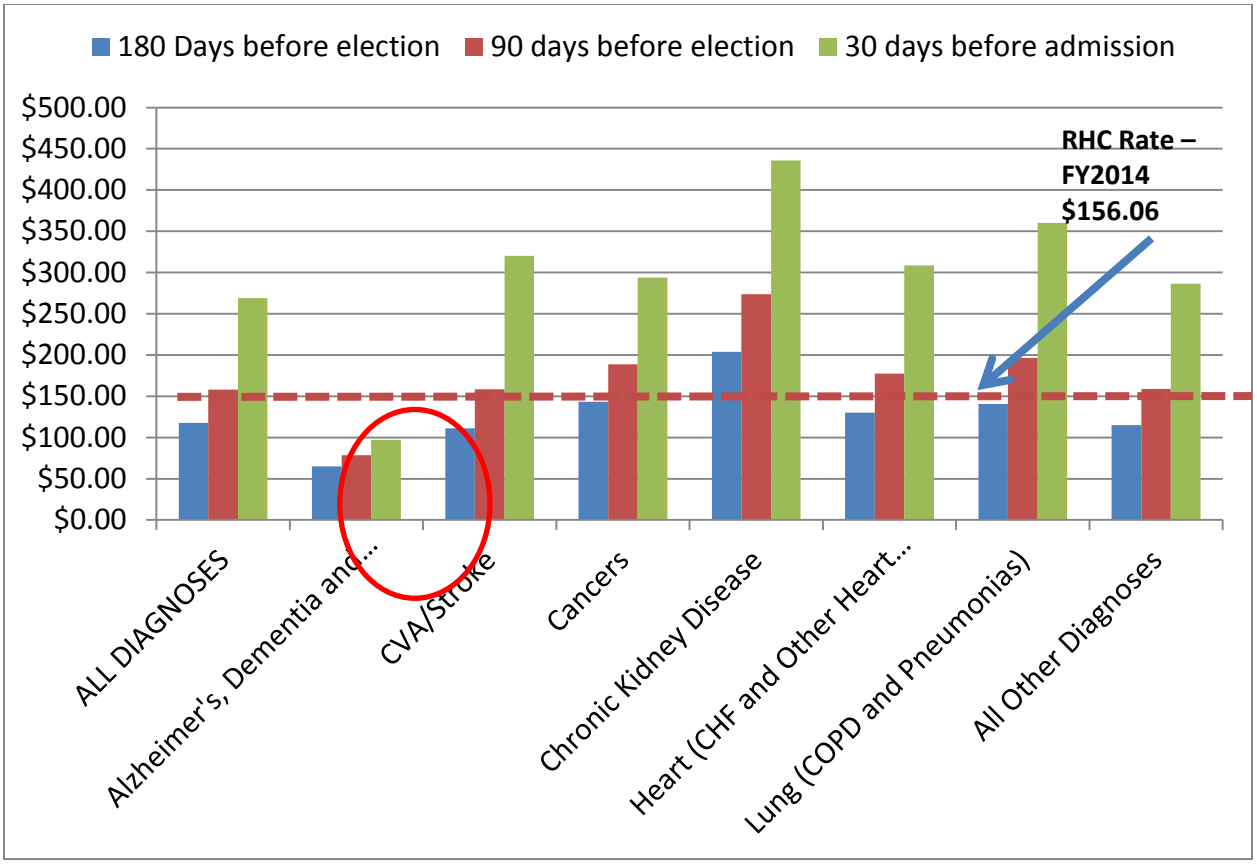
2. **Reporting All Diagnoses on Claim Form**
CMS reminds providers to include ALL diagnoses on the claim form, whether related or unrelated. CMS continues to monitor compliance with this requirement, and provided the number of claims that are filed with only one diagnosis on the claim form for 2014 and 2015.

Year	% of Claims with only one diagnosis
2014	49%
FY2015	37%
2 diagnoses	63%
3 or more diagnoses	46%

Monitoring for Potential Impacts Afforrdable Care Act Hospice Reform

1. **Pre-Hospice Spending**
A review of pre-hospice spending for five broad categories of hospice patients found that median Medicare spending before hospice election for a beneficiary with a diagnosis of Alzheimer's disease, non-Alzheimer's dementia or Parkinson's disease (about 20% of hospice patients) was significantly lower than the daily RHC rate, even as the beneficiary grew closer to the hospice election. Analysis also revealed that the average length of stay for this diagnosis grouping in FY2014 was greater than patients with other diagnoses, 119 days compared to 47 days for patients with cancer. Analysis of pre-hospice spending is viewed by CMS as being an initial step in determining whether a case-mix adjustment could be created in the future.

Diagnosis	Mean Lifetime Length of Stay
ALL DIAGNOSES	73.9
Alzheimer's, Dementia and Parkinson's	118.8
CVA/Stroke	55.6
Cancers	47.3
Chronic Kidney Disease	29.8
Heart (CHF and Other Heart Disease)	78.8
Lung (COPD and Pneumonias	69.4
All Other Diagnoses	78.2

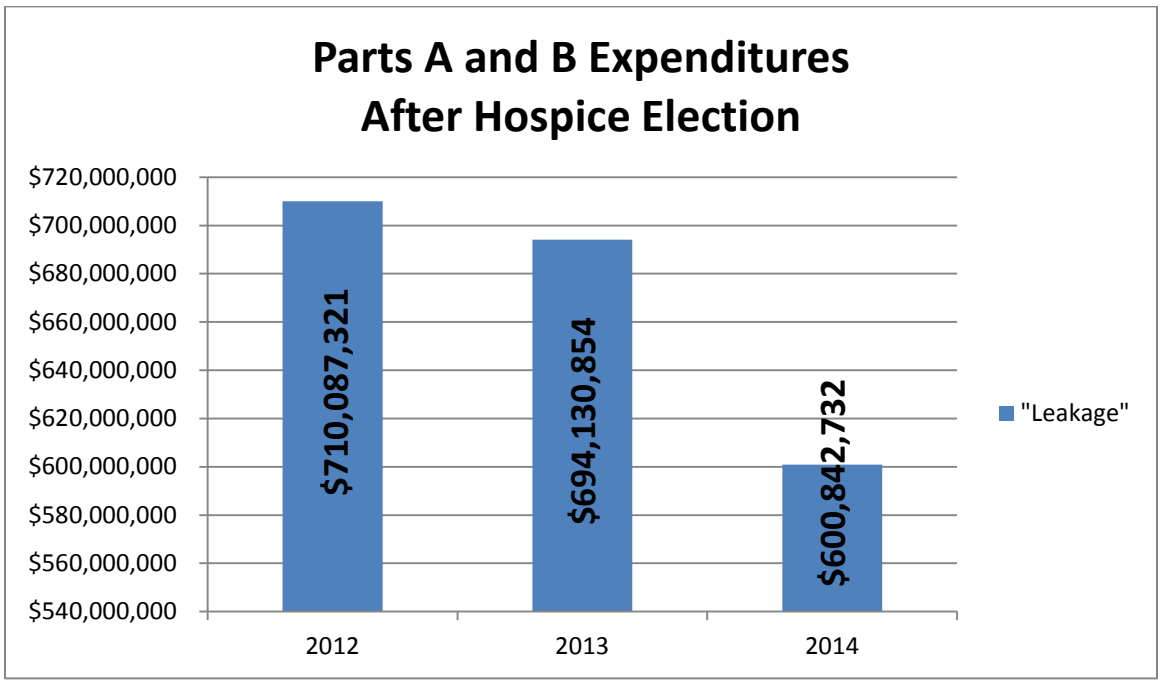


2. Non-Hospice Spending ("Leakage")

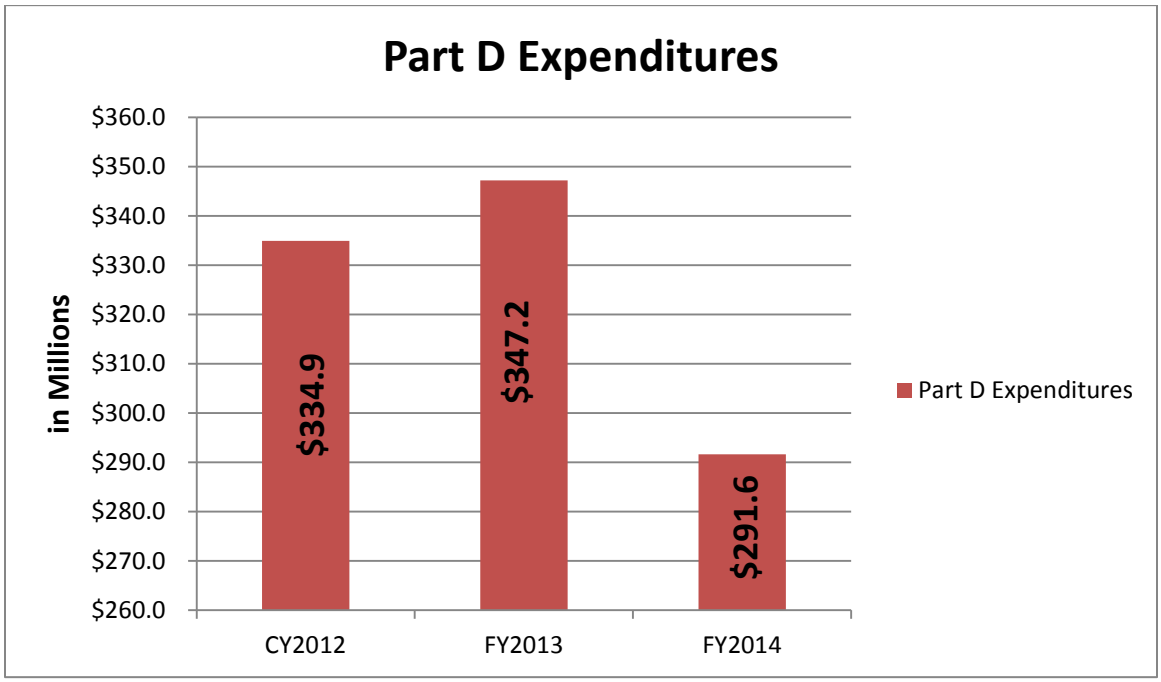
CMS reminds providers that they "believe that it would be **unusual and exceptional** to see services provided outside of hospice for those individuals who are approaching the end of life." CMS has been analyzing annual trends in spending outside the Medicare hospice benefit after the patient elects hospice. NHPCO has provided CMS with an extensive list of recommendations that are intended to address many of these issues, such as a hospice election alert in the claims submissions systems for other Medicare providers, but to date, CMS has not acted upon the suggestions.

Parts A and B: In the CMS analysis, non-hospice Part A and Part B spending has decreased over the three years 2012 through 2014 from $710,087,321 to $600,842,732, a decline of 15.4%. Beneficiary cost sharing for these expenditures totaled $122.5 million in FY2014, down from $132.5 in FY2013.

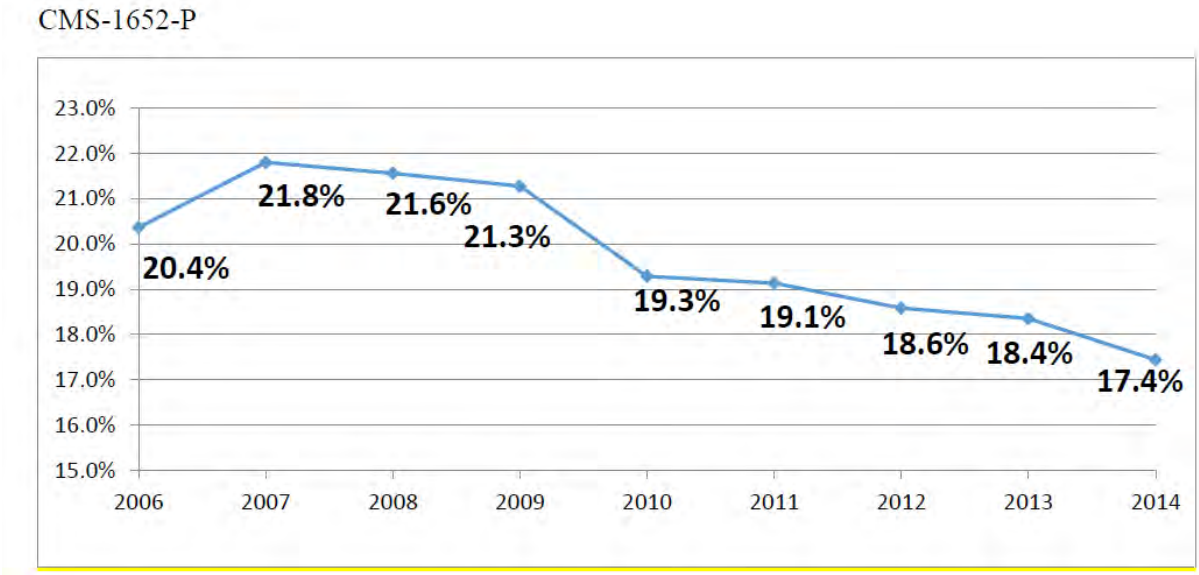
Total non-hospice spending for Medicare Parts A, B and D after the patient elects hospices is approximately $1.1 billion total in FY 2014.



Part D: CMS analysis of Part D expenditures over the same period also saw a decline from $334.9 million to $291.6 million in 2014.The patient pay amount in 2014 was $41.7 million, compared to $50.9 million in FY2013. A significant analysis of the Part D expenditures by diagnosis and drugs was presented in this proposed rule, to further understand the areas where Part D may be inappropriately paying for drugs that the hospice could be responsible for.



3. **Live Discharge Rates**
CMS reports a decline in the average live discharge rate for the years 2006 to 2014 as shown below, with a leveling off of the live discharge rate (all types of live discharges, including revocations) at about 18% over the last several years.



In this proposed rule, CMS has published significant analysis on the relationship between a hospice's live discharge rate, the amount of non-hospice spending, the average length of stay and the incidence of cap overpayments. They suggest that "some hospices may be using the Medicare Hospice program inappropriately as a long-term care ("custodial") benefit rather than an end of life benefit for terminal beneficiaries… and expect to analyze more recent hospice claims and cost report data as they become available to determine whether additional regulatory proposals to reform and strengthen the Medicare hospice benefit are warranted."

4. **Skilled Visits in the Last Days of Life**
CMS has analyzed FY 2014 claims data, which shows that on any given day during the last 7 days of a hospice election, "nearly 47 percent of the time the patient has not received a skilled visit (skilled nursing or social worker visit)… on the day of death nearly 26 percent of beneficiaries did not receive a skilled visit (skilled nursing or social work visit)."

CMS goes on to say that they "believe that the implementation of the Service Intensity Add-on (SIA) payment, finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47164 through 47177), represents an incremental step toward encouraging higher frequency of much-needed end of life care by encouraging visits during beneficiaries' most intensive time of need for skilled care –the last 7 days of life."

5. **Hospice Payment Reform Monitoring**
CMS announces that they will monitor the impact of hospice payment reform changes and general hospice trends in real time to identify program vulnerabilities and potential areas for fraud and abuse. Monitoring will include real time analysis of hospice claims as well as the use of the PEPPER process to assist providers in understanding areas of vulnerability and opportunities for improvement.

Monitoring will include:

- hospice diagnosis reporting
- length of stay
- live discharge patterns and their relationship to the provision of services and the aggregate cap
- non-hospice spending for Parts A, B and D during a hospice election
- trends of live discharge at or around day 61 of hospice care, and readmissions after a 60 day lapse since live discharge

FY2017 Wage Index

Beginning October 1, 2016, the wage index for all hospice payments would be fully based on the new OMB delineations for CBSAs and rural areas, in line with the 2010 US Census. While the wage index is no longer published in the Federal Register, the proposed wage index applicable for FY 2017 is available on the CMS Web site at https://www.cms.gov/Center/Provider-Type/Hospice-Center.html

NHPCO will publish a state-county chart with wage index values and rates in the coming days. Both wage index values and rates are subject to adjustment when the final rule publishes in late July or early August.

1. Proposed FY2017 Rates

Hospital Marketbasket Increase: CMS proposes a net 2.0% increase in hospice rates. The rate increase is based on the inpatient hospital market basket update of 2.8%, with a 0.5% reduction due to the productivity adjustment and an extra 0.3% adjustment specific to hospice. The final amount of the market basket increase may slightly increase or decrease when the final rule is issued.

Two Levels of Routine Home Care for Hospices that DO Submit Quality Data

Code	Description	FY2016 Payment Rates	Service Intensity BNF	Proposed Wage Index Standardization Factor	FY 2017 Proposed Hospice Payment Update %	FY2017 Proposed Payment Rates
651	Routine Home Care (days 1-60)	$186.84	X 1.0001	X 0.9990	X 1.020	$190.41
651	Routine Home care (days 61+)	$146.83	X 0.9999	X 0.9995	X 1.020	$149.68

Other Levels of Care

Code	Description	FY2016 Payment Rates	Proposed Wage Index Standardization Factor	FY 2017 Proposed Hospice Payment Update %	FY2017 Proposed Payment Rates
652	Continuous \\Home Care Full Rate = 24 hours of care $40.16 = FY 2017 hourly rate	944.79	X 1.000	X 1.020	$963.69
655	Inpatient Respite Care	$167.45	X 1.000	X 1.020	$170.80
656	General Inpatient Care	$720.11	X 0.9996	X 1.020	$734.22

2. Proposed FY 2017 Hospice RHC Payment Rates for Hospices That <u>DO NOT</u> Submit the Required Quality Data

Other Levels of Care

Code	Description	FY2016 Payment Rates	Proposed Wage Index Standardization Factor	FY 2017 Proposed Hospice Payment Update %	FY2017 Proposed Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care $39.37 = FY 2017 hourly rate	$944.79	X 1.000	X 1.000	$944.79
655	Inpatient Respite Care	$167.45	X 1.000	X 1.000	$167.45
656	General Inpatient Care	$720.11	X 0.9996	X 1.000	$719.82

3. Hospice Cap Amount for FY 2017

(a) Aggregate Cap Amount: The IMPACT Act of 2014 changed the cap calculation formula for each year that ends after September 30, 2016 and before October 1, 2025. The cap will be annually adjusted using the same hospice payment update percentage that is applied to the rates. For the 2017 cap year, the cap amount is projected to be **$28,377.17** and may change slightly when the final rule is issued.

(b) Change in Cap Year: Beginning in FY2017, the cap year for both the inpatient cap and the aggregate cap will be aligned with the federal fiscal year of October 1, 2016 to September 30, 2017. 2017 is considered the transition year so the following table will outline the timeframes for this year.

Hospice Aggregate Cap Timeframes for Counting Beneficiaries and Payments for the Alignment of the Cap Accounting Year with the Federal Fiscal Year

Cap Year	Beneficiaries		Payments	
	Streamlined Method	Patient-by-Patient Proportional Method	Streamlined Method	Patient-by-Patient Proportional Method
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 (Transition Year)	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

Source: Table 26, FY2016 Hospice Wage Index Final Rule.

Quality Reporting Requirements

1. Summary

- **All current measures continue:** CMS is not proposing to remove any of the current HQRP measures.

- **Two new quality measures proposed:** CMS is proposing changes to the hospice quality reporting program, including 2 new quality measures.

- **Public display and reporting:** CMS plans to display quality measures and other hospice data in a way similar to other Medicare provider types in a publicly available Hospice Compare website. CMS anticipates that "public reporting of the eligible HIS quality measures on the CMS Compare Web site for hospice agencies will begin sometime in the **spring/summer of CY 2017."**

2. New Quality Measures for the FY 2019 Payment Determination and Subsequent Years

CMS is proposing 2 new measures in the FY2017 proposed rule, for data collection beginning April 1, 2017. Data collected in 2017 will apply to the Annual Payment Update (APU) in FY2019.

The proposed new measures are:

(a) Hospice Visits When Death is Imminent Measure Pair

- Two measures that assess hospice staff visits to patients and caregivers in the last week of life
- The paired measures are:
  - **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** (Measure 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.**
    (Measure 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 wellbeing of the individual and others important in their life.)
- **New Items on HIS Discharge Record:** Data for the proposed measures will be collected via 4 new items to be added to the HIS Discharge record to collect the necessary data
- **Start date for data collection:** Data collection for these quality measures via the 4 new HIS items would begin no earlier than April, 2017.

(b) Hospice and Palliative Care Composite Process Measure Comprehensive Assessment at Admission

- **Makeup of the composite process measure:** The Composite Process quality measure will use the current HQRP quality measures as its components. (Pain Screening, Pain Assessment, Dyspnea Treatment, Patients Treated with an Opioid who are given a Bowel Regimen, and Treatment Preferences & Beliefs/Values Addressed if desired by patient).
- **Calculation:** The measure calculates the percentage of patients for whom HIS Admission records contain data on all seven current HQRP quality measures. The individual component of the composite measure are assessed separately for each patient and then aggregated into one score for each hospice.

Proposed Quality Measures and Data Collection Period Affecting the FY 2019 Payment Determination and Subsequent Years (Table 16 of FY2017 Proposed Rule)

Quality Measures	NQF ID#	Type	Submission Method	Data Collection to Begin
Hospice Visits when Death is Imminent	TBD	Process Measure	Hospice Item Set	04/01/2017
Hospice and Palliative Care Composite Process Measure	TBD			

3. New Data Collection and Submission Mechanisms under Consideration for Future Years

Enhanced data collection instrument: CMS is proposing to create an **enhanced data collection instrument** that would modify the current Hospice Item Set (HIS) data collection instrument to be more in line with other post acute care settings. This new data collection instrument would be a comprehensive patient assessment instrument, rather than the current chart abstraction.

This new data collection mechanism would serve 2 primary objectives:

(a) to provide the quality data necessary for HQRP requirements and the current function of the HIS; and
(b) provide additional clinical data that could inform future payment refinements.

4. Public Display of Quality Measures and other Hospice Data for the HQRPs

Quarters of Data Used for Determining Measures for Public Reporting: CMS realizes that the first 1-2 quarters of data reflect the "learning curve of the facilities" as the provider gets accustomed to data collection and reporting. Hospices began HIS reporting on July 1, 2014. CMS is using data collected by hospices during Quarter 4 (Q4) CY 2014 and Q1–Q3 CY 2015. CMS has determined that all 7 HIS measures are eligible for public reporting, and plan to publicly report all 7 HIS measures on a CMS Compare Web site for hospice agencies. CMS expects that public reporting will begin in the spring/summer of CY2017.

Data review before public reporting: The Affordable Care Act requires that agencies have the opportunity to review data for their agency before public reporting. "Preview" reports will be available in CASPER before public reporting and will give providers the opportunity to review their quality measure data.

Hospice Compare Web site: CMS is proposing a Hospice Compare Web site, which will "provide valuable information regarding the quality of care provided by Medicare-certified hospice agencies throughout the nation. Consumers would be able to search for all Medicare approved hospice providers that serve their city or zip code (which would include the quality measures and CAHPS® Hospice Survey results) and then find the agencies offering the types of services they need, along with provider quality information." CMS expects that public reporting will begin in the spring/summer of CY2017.

NHPCO will host two listening sessions on the proposed rule, dates to be determined. Watch *NewsBriefs* and My.NHPCO.org for the announcement of dates and times. Please contact regulatory@nhpco.org if you have questions.

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