National Hospice and Palliative Care Organization

Hospice Policy Compendium

The Medicare Hospice Benefit, Regulations, Quality Reporting, and Public Policy.

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Hospice Overview

Hospice is a patient-centered, cost-effective philosophy of care that utilizes an interdisciplinary team of healthcare professionals and trained volunteers to provide compassionate care for people facing a life-limiting illness or injury, including expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. At the center of hospice and palliative care is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so.

Hospice cares for people where they live. In most cases, care is provided in the patient's home. Hospice care is also provided in freestanding hospice centers, hospitals, and nursing homes and other long-term care facilities. Hospice services are available to patients of any age, religion, race, or illness. Hospice care is covered under Medicare, Medicaid, and most private health insurance plans, including HMOs and other managed care organizations.

Hospices now care for almost half of all Americans who die from cancer and a growing number of patients with other chronic, life-threatening illnesses, such as end-stage heart or lung disease. Hospice care is not limited to cancer patients.

Hospice care continues to grow. In 2014, an estimated 1.6-1.7 million patients received services from hospice.[1] The Medicare Payment Advisory Commission (MedPAC) estimates that 47.3 percent of Medicare decedents in the United States in 2013 received hospice care.[2]

Note: Statistics taken from the National Hospice and Palliative Care Organization's Facts and Figures 2012 may not match similar statistics provided by the Medicare Payment Advisory Commission (MedPAC) or the Centers for Medicare and Medicaid Services due to differences in the data analyzed. Information on the accuracy of the data presented in Facts and Figures can be found in "Appendix 2: How Accurate are the NHPCO Estimates?" in Facts and Figures 2012, 2013, 2014, and 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf.

[1] National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.

[2] Medicare Payment Advisory Commission. Chapter 12, Report to Congress: Medicare Payment Policy. March 2015. http://medpac.gov/documents/reports/chapter-12-hospice-services-(march-2015-report).pdf.

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Chapter 1: The Medicare Hospice Benefit

History of Hospice[3]

The term "hospice" can be traced back to medieval times when it referred to a place of shelter and rest for weary or ill travelers on a long journey. The name was first applied to specialized care for dying patients by physician Dame Cicely Saunders, who began her work with the terminally ill in 1948 and eventually went on to create the first modern hospice—St. Christopher's Hospice—in a residential suburb of London.

Saunders introduced the idea of specialized care for the dying to the United States during a 1963 visit to Yale University. Her lecture, given to medical students, nurses, social workers, and chaplains about the concept of holistic hospice care, included photos of terminally ill cancer patients and their families, showing the dramatic differences before and after the symptom control care.

In 1976, a U.S. Department of Health, Education, and Welfare task force reported that "the hospice movement as a concept for the care of the terminally ill and their families is a viable concept and one which holds out a means of providing more humane care for Americans dying of terminal illness while possibly reducing costs. As such, it is the proper subject of federal support." As a result, the Health Care Financing Administration (HCFA) initiated demonstration programs at 26 hospices across the country in 1979 to assess the cost effectiveness of hospice care and to better determine what exactly a hospice is and what types of care it should provide.

Congress subsequently included a provision to create a Medicare hospice benefit within the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), with a 1986 sunset provision. The Medicare Hospice Benefit was made permanent by Congressional action in 1986, and hospices were given a 10% increase in reimbursement rates. In that same year, states were given the option of including hospice in their Medicaid programs.

The Medicare Hospice Benefit

Considered the model for quality care for people facing a life-limiting illness, hospice provides expert medical care, pain management, personal care, and emotional and spiritual support individually tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well. Hospice focuses on caring, not curing. An interdisciplinary team of professionals is responsible for the care of each hospice patient. NHPCO estimates that approximately 1.6-1.7 million deaths in the United States in 2014 were under the care of a hospice program.[4]

[3] "History of Hospice Care." National Hospice and Palliative Care Organization. http://www.nhpco.org/i4a/pages/index.cfm?pageid=3285.
[4] 2015, NHPCO Facts and Figures on Hospice Care.

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Medicare pays hospice at one of four levels of care – (1) routine home care, (2) continuous home care, (3) general inpatient care, and (4) inpatient respite. The payment covers all aspects of the patient's care related to the terminal prognosis, including all services delivered by the Interdisciplinary team, medication, medical equipment and supplies. In 2014, 85.5% of hospice patients were covered by the Medicare Hospice Benefit, versus other payment sources.[5]

Medicaid Hospice Benefit

In 1986, hospice was added as an optional benefit under Medicaid. In 2014, 6.9% of hospice patients were covered by the Medicaid Hospice Benefit, versus other payment sources.[6] States offer the hospice benefit as an optional benefit through their Medicaid programs. The structure of the hospice benefit offered by traditional state Medicaid programs and the Medicaid hospice reimbursement rates, by statute, are tied to the federal Medicare Hospice Benefit. States with Medicaid Managed Care may allow Medicaid Managed Care Organizations to reimburse hospice providers at rates that do not mirror the Medicare rates as long as they are actuarially sound. Medicaid is often the second largest expense in most states' budgets (after education). In the current fiscal environment, states are under pressure to reduce spending levels further, and are therefore scrutinizing the benefits available to Medicaid recipients. In recent years several states have proposed, or are currently considering, cuts in their optional Medicaid benefits, including hospice benefits. However, currently 49 states continue to offer a Medicaid hospice benefit to eligible beneficiaries.

For more information about the Medicaid Hospice benefit, click here:
Medicaid Issue Brief:
http://www.nhpco.org/sites/default/files/public/regulatory/Medicaid_Issue_Brief.pdf.

Medicaid Managed Care Issue Brief:
http://www.nhpco.org/sites/default/files/public/regulatory/MedicaidManagedCare-Issue-Brief.pdf.

Eligibility for Hospice Care

Certification and Recertification for Hospice Care

A patient is eligible for the Medicare Hospice Benefit if (a) the patient is eligible for Part A of Medicare and (b) two physicians determine that the patient has six months or less to live if the disease runs its normal course.

[5] 2014, NHPCO National Data Set and/or NHPCO Member Database.
[6] 2014, NHPCO National Data Set and/or NHPCO Member Database.

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For the first 90-day period of care, the attending physician (if any) **and** the hospice medical director/ hospice physician are required to certify terminal illness. For subsequent certification periods, only the hospice medical director/ hospice physician is required to certify terminal prognosis, unless otherwise specified by state hospice regulations.

The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms. A face-to-face encounter is required for patients entering the third benefit period recertification (at 180 days) and every subsequent benefit period. Documentation from the face-to-face encounter must be used as the physician completes the brief physician narrative and must include an explanation of why the clinical findings of the face-to-face encounter continue to support a life expectancy of 6 months or less.

For more information about certification and recertification for hospice care, visit: http://www.nhpco.org/admission-certification-and-recertification.

Face-to-Face Guidelines[7]
See Face-to-Face Guidelines.

Benefit periods[8]
An individual may elect to receive hospice care during one or more of the following election periods:

(1) An initial 90-day period;
(2) A subsequent 90-day period; followed by
(3) An unlimited number of subsequent 60-day periods, if needed.

As long as the patient meets the certification criteria, there is no limit on the amount of time a patient can then spend under hospice care, although the hospice must continue to monitor continued eligibility as a part of the recertification process every 90 days for the first 180 days, and when the 90-day periods are complete, prior to every 60-day benefit period. This monitoring function takes place through the face-to-face encounter, as well as ongoing interdisciplinary team review.

If the patient is a nursing home resident and chooses to elect hospice care, the Medicare Hospice Benefit covers all care and services related to the terminal prognosis. However, the patient may not, except in unusual circumstances, receive their Medicare Skilled Nursing Home benefit at the same time as their hospice benefits. For those eligible for both Medicare and Medicaid, the nursing home's room and board is paid by the state Medicaid program to the

[7] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.22.
[8] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.21.

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hospice and paid to the nursing home under a contractual arrangement between the nursing home and the hospice.

Filing an election statement[9]

An individual who meets the eligibility requirements for hospice must file an election statement (Notice of Election or NOE) with a particular hospice. If the individual is physically or mentally incapacitated, his or her representative (as defined in §418.3)[10] may file the election statement on the patient's behalf.

The election statement must include:

- Identification of the particular hospice and of the attending physician that will provide care to the individual. The individual or representative must acknowledge that the identified attending physician was his or her choice.
- Identification of the particular hospice that will provide care to the individual.
- The individual's or representative's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal prognosis.
- Acknowledgement that certain Medicare services, such as any Medicare services that are related to the treatment of the terminal condition or related conditions for which hospice care was elected, are waived by the election.
- The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement.
- The signature of the individual or representative.

Notice of Election (NOE)

Once the patient or their representative signs the election statement, the hospice submits a Notice of Election (NOE) to the Medicare Administrative Contractor (MAC). Effective October 1, 2014, every hospice NOE must be submitted with the MAC electronically within five days after the effective date of the election statement. If a hospice does not submit the NOE timely, Medicare will not reimburse for days of hospice care from the effective date of election to the date of filing the notice of election (NOE). These days will be a provider liability, meaning that the provider will not be paid, although the services have been provided. In addition, the provider may not bill the beneficiary for them.

The hospice may file an exception request with the MAC to request consideration for payment of days of care if the NOE is not submitted timely. Each MAC has its own process for the consideration of exception requests. There are four reasons that an exception request may be granted:

1. Natural disasters or unusual events that may inflict extensive damage to the hospice's ability to operate;

[9] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.24.
[10] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.3.

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2. A CMS or Medicare contractor systems issue beyond the control of the hospice;
3. A newly Medicare-certified hospice notified of their certification after the Medicare certification date or awaiting its user ID from the Medicare contractor; or
4. Other situations determined by CMS to be beyond the control of the hospice.

Waiver of other benefits[11]

For the duration of an election of hospice care, an individual waives all rights to Medicare payments for any Medicare services that are related to the treatment of the terminal prognosis for which hospice care was elected. Exceptions include: services provided by the designated hospice, another hospice under special arrangements, or the individual's attending physician (if the physician is not an employee of the designated hospice or receiving compensation from the hospice for his or her services).

Delivery of Care – the Interdisciplinary Team (IDT)[12]

Typically, a family member serves as the primary caregiver and, when appropriate, helps make decisions for the terminally ill individual. The hospice team develops a care plan with the patient and the patient's family to meet the patient's individual needs and goals of care for pain management and symptom control. This interdisciplinary team usually consists of the hospice physician or medical director, nurses, hospice aides, social workers, bereavement counselors, clergy or other spiritual counselors, trained volunteers, and, if necessary, speech, physical, and occupational therapists. Members of the IDT make regular visits to assess the patient and provide additional care or other services. Hospice staff is on-call 24 hours a day, seven days a week.

Figure 1. Interdisciplinary Team

Attending Physician

Each hospice patient has the right to choose an attending physician who will provide care to the patient. Because the attending physician is typically someone with whom the patient had a relationship before electing to receive hospice care, the role of the attending physician is to provide a long-term perspective on the patient and family that takes into account their medical and personal history.

The choice of an attending physician belongs solely to the patient (or representative), and it is CMS' intent to safeguard and protect that beneficiary choice. A patient cannot be required or coerced to change his or her attending physician. No change in attending physician is necessary when a patient transitions to general inpatient care or other inpatient care for a short period of time. If a patient's attending physician does not have privileges at the hospital or other

[11] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.24
[12] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.78

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inpatient setting, the hospital may designate a hospitalist to provide "attending physician" services, but this designation does not meet the requirements for a hospice patient's attending physician and no change in attending is needed. If no hospitalist is designated, then, according to the Medicare hospice CoPs at §418.64(a)(3), the hospice physician or NP must provide any needed physician's services. However, while the hospice can bill Medicare Part A for its employed or contracted physicians providing needed physician services, it can only do so for its NPs if the NP is the designated attending physician. The hospice may not change the patient's attending physician to a hospice NP unless the patient or their representative chooses that person to be the attending.

Effective October 1, 2014, if a patient (representative) chooses to change attending physicians, the patient (or representative) must file a signed statement with the hospice, a "change of attending physician" form.[13] This form identifies the new attending physician in enough detail so that it is clear which physician or NP is designated as the new attending physician.

This information should include, but is not limited to:

- Physician's full name
- Office address
- Physician NPI number or any other detailed information to clearly identify the attending physician
- Date that the statement is signed, along with the patient's or representative's signature;
- Date the change is to be effective
- Acknowledgement that the change in attending physician is the patient (or representative) choice.

Volunteers

The Medicare Conditions of Participation for hospice requires that volunteers provide at least 5% of total patient care hours. Hospice volunteers provide service in three general areas: [14]

- direct support: spending time with patients and families,
- clinical support: providing clerical and other services that support patient care and clinical services
- general support: helping with fundraising efforts and/or the board of directors

Direct support and clinical support activities can be applied to the required 5% of total patient care hours for a hospice.

Volunteer hours related to board and committee service, as well as fundraising activities **do not qualify** to be included in the required 5% of total patient care hours.

[13] Centers for Medicare and Medicaid Services. Change Request (CR) 9114. May 8, 2015.
[14] National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.

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NHPCO estimates that 430,000 hospice volunteers provided 19 million hours of service in 2014. The majority of volunteers (60.8%) assisted with direct support in 2014, while 20.2% provided clinical care support and 19.1% provided general support.[15]

Bereavement[16]

For a minimum of one year following the death of hospice patients, grieving families and friends of hospice patients can access bereavement education and support. In 2014, for each patient death, an average of 2 family members received bereavement support from their hospice. This support included follow-up phone calls, visits, support groups and mailings throughout the post-death year.

Levels of Care

Because patients require differing intensities of care during the course of their disease, the Medicare Hospice Benefit affords patients four levels of care to meet their needs: routine home care, continuous home care, inpatient respite care, and General Inpatient Care. Ninety-four percent of hospice care is provided at the routine home care level.[17]

- **Routine Hospice Care** is the most common level of hospice care. With this type of care, an individual has elected to receive hospice care is at their residence, which includes a private residence, Assisted Living Facility or Skilled Nursing Facility.
- **Continuous Home Care** is care provided for between 8 and 24 hours a day to manage pain and other acute medical symptoms. Continuous home care services must be predominately nursing care, supplemented with homemaker and hospice aide services and are intended to maintain the terminally ill patient at home during a pain or symptom crisis.
- **General Inpatient Care** is provided for pain control or other acute symptom management that cannot feasibly be provided in any other setting. General inpatient care begins when other efforts to manage symptoms have been ineffective. General inpatient care cannot be provided in a private residence, an assisted living facility, or a hospice residential facility. However, general inpatient care can be provided in a Medicare certified hospital, hospice inpatient facility, or nursing facility that has a registered nursing available 24 hours a day to provide direct patient care.
- **Inpatient Respite Care** is available to provide temporary relief to the patient's primary caregiver. Respite care can be provided in a hospital, hospice facility, or a long term care facility that has sufficient 24 hour nursing personnel present on all shifts to

[15] National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.
[16] National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.
[17] National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.

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guarantee that patient's needs are met. Respite care is provided for a maximum of 5 consecutive days.

Locations of Care[18]

Patients may receive care at their place of residence, a hospice inpatient facility or an acute care hospital. Two-thirds of patients choose hospice care at home (Table 2).

Location of Death	2014	2013
Patient's Place of Residence	58.9%	66.6%
Private Residence	35.7%	41.7%
Nursing Home	14.5%	17.9%
Residential Facility	8.7%	7.0%
Hospice Inpatient Facility	31.8%	26.4%
Acute Care Hospital	9.3%	7.0%

Table 1. Location of Death

Hospice in the Nursing Home

As prescribed by statute, at least 80 percent of hospice services must be provided in a residential setting. For some Medicare recipients, the nursing home is their residence. As the American population lives longer, with more chronic conditions, more individuals will spend their final days in the nursing home. Hospice patients in nursing homes differ from hospice patients at home; nursing home residents are a very vulnerable, older population. The average age of nursing home patients is 76.6 years compared to 70.3 years for home patients. Nursing home patients are more often female (55.3% vs. 47.4%), unmarried, including widowed and divorced, (68.5%vs. 44.6%), and dually eligible for both Medicare and Medicaid. They also have higher rates of dementia and other non-cancer diseases as primary diagnoses.[19]

Nursing home residents who enroll in hospice continue to receive all of the services they are entitled to from the nursing home, much like the primary caregiver/supportive services provided by family and friends that the patient receives if he or she were at home. At the same time, these patients receive supplemental support and professional care for their terminal condition from the hospice agency. Additional benefits of hospice care delivered in the nursing home include enhanced pain management and increased family satisfaction with end-of-life care.

A 2010 study by Miller et al., examined the growth of Medicare-certified hospices providing hospice in the nursing home from 1999 to 2006. Using Medicare's minimum data set (MDS), the study found that the proportion of nursing home decedents who received hospice care rose from 14.0% in 1999 to 33.1% in 2006, a growth rate that closely paralleled the increase in

[18] 2015, NHPCO National Data Set and/or NHPCO Member Database.
[19] Stevenson DG, Huskamp HA, Grabowski DC, Keating NL. 2007. Differences in Hospice Care between Home and Institutional Settings. *Journal of Palliative Medicine*, 10(5):1040-1047.

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Medicare-certified hospice programs. The demographic characteristics of hospice patients in the nursing home changed little during that time and are very similar to the overall characteristics of hospice patients.[20] Even though a large majority (87%) of nursing homes hold nominal contracts with hospice agencies, only 30% actually have any hospice enrollees and most of these have only one or two at a time.[21]

Today, it is increasingly common for dying nursing home residents to be admitted under the Medicare Skilled Nursing Facility (SNF) benefit for "end of life" care. Medicare beneficiaries who elect hospice care must waive their right to other Medicare Part-A payments for services related to their terminal prognosis, including the SNF benefit. The SNF benefit allows Medicare to pay for room and board services for a set number of days, unlike the hospice benefit, creating a financial incentive for families to choose the SNF benefit so that nursing home room and board is covered, even when hospice care is desired. The time spent deciding among care options contributes to later hospice referrals and an increased likelihood that residents will have hospital deaths and aggressive care at the end of life.[22]

A 2012 MedPAC report found that rehospitalizations from SNFs accounted for more than $700 million in hospital stays in 2005, with hospitalizations originating from a nursing home stay contributing an additional $1.9 billion.[23] These and other statistics have fueled development of programs to ease transitions of care and thereby reduce rehospitalizations.

For a fact sheet on hospice in the nursing home, click here: http://hospiceactionnetwork.org/linked_documents/get_informed/issues/nursing_home/NH_Fact_Sheet.pdf.

For regulatory resources on hospice in the nursing home, visit: http://www.nhpco.org/regulatory-locations-and-levels-care/hospice-nursing-facility.

For a process map for dually eligible Medicaid beneficiaries electing the Medicare Hospice Benefit while residing in a nursing home, click here: http://hospiceactionnetwork.org/linked_documents/get_informed/issues/nursing_home/MHB_NH_Map.pdf.

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[20] Miller SC, Lima J, Gozalo P, Mor V. 2010. The Growth of Hospice Care in U.S. Nursing Homes, *Journal of American Geriatrics Society*, 58:1481-88.
[21] Stevenson DG and Bramson JS. 2009. Hospice Care in the Nursing Home Setting: A Review of the Literature. *J Pain Symptom Manage*, 2009;38:440-451.
[22] Miller SC, Lima JC, Looze J, Mitchell SL. 2012. Dying in US Nursing Homes with Advanced Dementia: How Does Health Care Use Differ for Residents with, versus without, End-of-Life Medicare SNF Care? *Journal of Palliative Medicine*, 15(1):43-50.
[23] Medicare Payment Advisory Commission. Chapter 8, Report to Congress: Medicare Payment Policy. March 2015. http://medpac.gov/documents/reports/chapter-8-skilled-nursing-facility-services-(march-2015-report).pdf.

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Length of Service[24]

The total number of days that a hospice patient receives care is referred to as the length of service (or length of stay). Length of service can be influenced by a number of factors including disease course, timing of referral, and access to care. The median (50th percentile) length of service in 2014 was 17.4 days and has remained between 17 and 18 days since 2000. This means that half of hospice patients receive care for less than three weeks and half receive care for more than three weeks. The average service is 72.6 days.

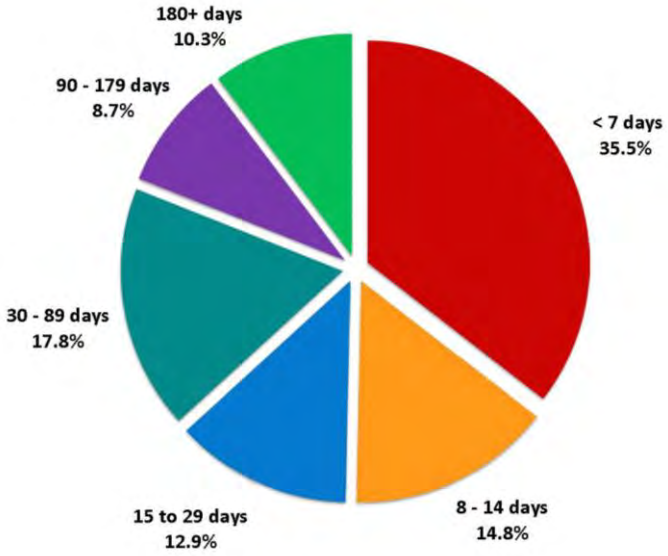

Figure 2. Proportion of Patients by Length of Service in 2014

Approximately 35.5% of hospice patients receive care for just seven days or less. In 2014, 50.3% of patients died or were discharged within 14 days of admission. Only 10.3% of patients remain under hospice care for longer than 180 days (Figure 2).

Discharge/Revocation/Transfer of Hospice Services

Discharge from Hospice Services[25]

The hospice benefit is available only to individuals who can be certified as terminally ill with a prognosis of 6 months or less to live if the disease runs its natural course; therefore, a hospice may discharge a patient if it discovers that the patient no longer fits these criteria. Discharge may also be necessary when the patient moves out of the service area of the hospice or there is a cause for discharge.

Effective October 1, 2014, when the hospice election is ended by discharge, the hospice must file a notice of termination/revocation of election (NOTR) with the Medicare contractor within 5 calendar days after the effective date of the discharge or revocation, unless the hospice has already filed a final claim for the beneficiary.[26] General coverage under Medicare Part A is reinstated on the date that the patient is discharged or revokes their hospice election. Reasons for hospice discharge:

- The beneficiary dies;
- The patient moves out of the hospice's service area or transfers to another hospice.

[24] 2014, NHPCO National Data Set and/or NHPCO Member Database.
[25] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.26.
[26] Centers for Medicare and Medicaid Services. Change Request (CR) 8877. August 22, 2014.

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- The hospice determines that the patient is no longer terminally ill.
- Discharge for cause: The hospice discharges the patient under a policy set by the hospice for the purpose of addressing discharge for cause, citing that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. The hospice must do the following before it seeks to discharge a patient for cause:
    i. Advise the patient that a discharge for cause is being considered;
    ii. Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation;
    iii. Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and
    iv. Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.

The hospice must make every effort to resolve these problems satisfactorily before it considers discharge an option. All efforts by the hospice to resolve the problem(s) must be documented in detail in the patient's clinical record and the hospice must follow the rules of the Medicare contractor and State Survey Agency regarding notification of the discharge.

Discharge order

If the hospice is initiating the live discharge, the hospice must obtain a written physician's discharge order from the hospice physician. If a patient has an attending physician involved in his or her care, documentation should appear in the clinical record that this physician was consulted prior to the discharge.

Effect of discharge

An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice—

1. Is no longer covered under Medicare for hospice care;
2. Resumes Medicare coverage of the benefits waived under § 418.24(d); and
3. May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

Discharge planning

1. The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.
2. The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

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Revocation of Hospice Care[27]

CMS allows an individual or representative to revoke the election of hospice care at any time in writing. To revoke the election of hospice care, the individual must file a document with the hospice that includes a signed statement that the individual revokes the election for Medicare coverage of hospice care for the remainder of that election period and the effective date of that revocation.

Effective October 1, 2014, when the hospice election is ended by revocation, the hospice must file a notice of termination/revocation of election (NOTR) with the Medicare contractor within 5 calendar days after the effective date of the discharge or revocation, unless the hospice has already filed a final claim for the beneficiary.[28]

An individual, upon revocation of the election of Medicare coverage of hospice care for a particular election period:

- Is no longer covered under Medicare for hospice care;
- Resumes Medicare Part A, B and D coverage of the benefits waived under § 418.24(e)(2); and
- May at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive.

Change/Transfer of Designated Hospice Provider[29]

An individual may change, **once** in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. The change of the designated hospice is not considered a revocation of the election, but is considered a transfer.

To change the designation of hospice programs, the individual must file a "Change of Hospice Providers" form (likely developed and available from either hospice) with the newly designated hospice and a signed statement that includes the following information:

- The name of the hospice from which the individual has received care;
- The name of the hospice from which they plan to receive care; and
- The date the change is to be effective.

If the patient chooses to transfer in the third or subsequent benefit periods, the transferring hospice must provide the receiving hospice with evidence that the face-to-face encounter was completed.

[27] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.28.
[28] Centers for Medicare and Medicaid Services. Change Request (CR) 8877. August 22, 2014.
[29] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.30.

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Hospice and Medicare Part D

When a patient elects hospice, the hospice provides all of the care related to the terminal prognosis, that constellation of diagnoses that contribute to the patient's terminal condition. Patients at the end of life may also have medical conditions with which they have struggled for years but do not contribute to the patient's terminal prognosis. In these cases, the other medical conditions may not be the responsibility of the hospice; they are the responsibility of the patient's primary insurer, which is usually Medicare, and Medicare Part D for medications. However, the hospice should ensure that the patient's medical conditions are clearly NOT related to the terminal prognosis and ensure that hospice does cover what is related to the prognosis. The hospice physician should document the reasons that the medical conditions are unrelated in the patient's medical record.

In June of 2012, the Department of Health and Human Services's Office of the Inspector General (OIG) released a report, "Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice" regarding the intersection of Hospice and Medicare Part D. Since 2010, NHPCO had been in active conversations with the OIG and with CMS about this issue, beginning when the OIG was researching the data for the 2012 report. The issuance of the OIG report increased the dialogue between CMS and NHPCO. Findings in the report showed that during calendar year 2009, Medicare Part D paid $33,638,137 for drugs for patients enrolled in the Medicare Hospice Benefit, specifically for drugs in the following categories:

- Analgesics,
- Antinauseants,
- Laxatives, and
- Anti-anxiety drugs.

In December 2013, CMS issued draft guidance noting that hospices were required to provide drugs used primarily for the relief of pain and symptom management related to the terminal illness and related conditions and that these drugs are NOT covered by Part D. CMS also indicated that some hospice providers were uncertain about the circumstances when Part D would cover drugs and that additional guidance was needed. Part D plan sponsors were encouraged to place beneficiary-specific prior authorization ("PA") edits in place for at least the four classes of drugs listed above. CMS stated in the December 6th draft guidance that "beneficiaries should only very rarely be taking drugs that are not covered under the hospice per diem."

NHPCO submitted a comment letter to CMS regarding this draft guidance in January 2014. In this letter, NHPCO addressed concerns about the proposed policy, including the blanket changes to all hospice providers rather than an identified subset of providers, timely updates of the notice of election and common working file, and prior authorization, among others.

On March 10, 2014 CMS issued final interim guidance to Part D Plan Sponsors and Medicare Hospice Providers detailing the clarification of policy regarding the use of Part D with hospice

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patients. CMS stated that in order for a drug to be covered by Part D after a beneficiary has elected the hospice benefit, the drug must be for "treatment of a condition that is completely unrelated to the terminal illness or related conditions; in other words, the drug is unrelated to the terminal prognosis of the individual." CMS expected that drugs covered under Part D for hospice patients would be under "unusual and exceptional circumstances."

The guidance also directed the Part D plan sponsors to place a beneficiary-level prior authorization (PA) process on ALL drugs for beneficiaries who have elected the Medicare Hospice Benefit to "determine whether the drugs are coverable under Part D." This means that the sponsor would "reject" all claims for drugs to be paid for under Part D, unless or until they have notification from the hospice, either prospectively or after a claim has been rejected through the PA process, of the drugs that are deemed unrelated to the terminal illness or related conditions. Once the hospice or other prescriber has provided information on medications unrelated to the terminal illness and related conditions to the sponsor, the sponsor would then direct the pharmacy to pay the claim under Part D.

After months of advocacy from NHPCO, the Hospice Action Network, hospice providers, and stakeholder groups, and letters from MedPAC, 86 U.S. Senators, and 202 U.S. Representatives, CMS issued revised interim guidance on July 18, 2014, to replace the March 10, 2014, guidance to hospices and Part D plan sponsors regarding payments for medications.

The revised guidance changes the prior authorization (PA) requirement to ONLY the four classes of drugs referenced in the OIG 2012 Report – analgesics, anti-emetics, laxatives, and anti-anxiety medications. **This guidance does not change the responsibility of the hospice to pay for all medications related to the terminal illness and related conditions, whether or not they are included in the four classes identified above**. That responsibility remains. However, if the hospice physician believes a medication in one of the four classes of drugs is being prescribed for a condition unrelated to the terminal illness, the hospice can file a "Hospice Information for Medicare Part D" form with the Part D sponsor. The guidance states that Part D sponsors should "accept the prescriber's or hospice provider's statement and retain the documentation." At that point, the Part D plan then assumes financial responsibility for that medication. No clinical documentation is required on the form, although clinical documentation should be available in the patient's clinical record.

For more information on the history of the hospice and Medicare Part D issue, as well as the Part D Compliance Guide, sample patient letters, other resources and NHPCO's comment letters on CMS guidance, visit:
http://www.nhpco.org/regulatory-compliance-hospices/new-interim-part-d-and-hospice-guidance.

"Hospice Information for Medicare Part D" form can be found here:
http://www.nhpco.org/sites/default/files/public/regulatory/HospicePA-andPlan-of-Care-file.pdf.

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For information on determining relatedness to the terminal condition, including NHPCO's algorithm, visit: http://www.nhpco.org/regulatory-compliance-hospices/determining-terminal-prognosis.

For links to Congressional sign-on letters to CMS Administrator Tavenner on Part D, and other Congressional actions on this topic, visit: http://hospiceactionnetwork.org/get-informed/issues/part-d/.

Additional resources

Hospice Action Network. 2014. The Medicare Hospice Benefit. http://hospiceactionnetwork.org/linked_documents/get_informed/policy_resources/Medicare_Hospice_Benefit_print.pdf

National Hospice and Palliative Care Organization. Hospice: A Historical Perspective. http://www.nhpco.org/history-hospice-care.

National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.

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Chapter 2: The Hospice Community

The number of hospice programs nationwide continues to increase — from the first program that opened in 1974 to over 6,100 locations (primary and secondary locations) today.[30] Hospices are located in all 50 states, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands.

The majority of hospices are independent, freestanding agencies (Table 3). The remaining agencies are either part of a hospital system, home health agency, or nursing home.

Agency Type	2014	2013
Freestanding/Independent Hospice	59.1%	58.3%
Part of a Hospital System	19.6%	19.8%
Part of a Home Health Agency	16.3%	16.7%
Part of a Nursing Home	5.0%	5.1%

Table 2. Agency Type

Hospice Reimbursement

Each hospice is reimbursed at a daily rate for each patient, depending on the patient's level of care. The daily rate is separated into two parts: labor and non-labor. The labor portion of the daily rate is adjusted based on geographic differences in wage rates.[31] The non-labor portion is a rate based on level of care. The Hospice Wage Index is updated annually. In the wage index for FY2016, changes in urban and rural areas were made, based on population changes in the 2010 US Census. In August 2015, the CMS services published the FY2016 hospice payment rates, effective October 1, 2015.[32]

[30] This estimate includes both primary locations and satellite offices of multi-site providers.
[31] Medicare Payment Advisory Commission. Chapter 11, Report to Congress: Medicare Payment Policy. March 2012. http://www.medpac.gov/documents/reports/mar12_ch11.pdf.
[32] Centers for Medicare and Medicaid Services, CMS-1629-F. "Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements." Display date July 31, 2015; Publication date August 6, 2015.

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Description	Rate	Wage Component Subject to Index	Non-Weighted Amount	Rate after Sequestration Reduction
Routine Home Care (October 1 – December 31, 2015)	$161.89	$111.23	$50.66	$158.65
Continuous Home Care Full Rate = 24 hours of care $39.37 hourly rate	$944.79	$649.17	$295.62	$925.89
Inpatient Respite Care	$167.45	$90.64	$76.81	$164.10
General Inpatient Care	$720.11	$460.94	$259.17	$705.71

Table 3. Hospice Reimbursement Rates Fiscal Year 2016[33]

Hospice Payment Reform

In its "FY 2016 Hospice Wage Index and Payment Rate Update," CMS established a two-tiered payment system for patients receiving routine home care (RHC).[34] Beginning on January 1, 2016, hospices will be reimbursed a higher per diem RHC rate for the first 60 days of a patient's care, and a lower rate for days 61 and after. The Medicaid hospice benefit is required to be the same in amount and method as the Medicare hospice benefit, although there are slight variations because there is no co-pay requirement for drugs and respite in the Medicaid hospice benefit.

Description	Rate	Wage Component Subject to Index	Non-Weighted Amount	Rate after Sequestration Reduction
Routine Home Care Patient Days 1-60	$186.84	$186.84	$58.46	$183.10
Routine Home Care Patient Days 61+	$146.83	$146.83	$45.94	$143.89

Table 4. Routine Home Care Rates: Two-Tiered Method (January 1 – September 30, 2016)

[33] Centers for Medicare and Medicaid Services, CMS-1629-F. "Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements." Display date July 31, 2015; Publication date August 6, 2015.

[34] Centers for Medicare and Medicaid Services, CMS-1629-F. "Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements." Display date July 31, 2015; Publication date August 6, 2015. http://www.regulations.gov/#!documentDetail;D=CMS_FRDOC_0001-1752.

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Service Intensity Add-On
Beginning January 1, 2016, a service intensity add-on (SIA) payment will be made for visits conducted by an registered nurse (RN) and/or social worker up to 4 hours a day (combined) during the last seven days of a hospice patient's life. The patient must be receiving routine home care and direct care is provided by the RN and/or social worker. The amount of time spent on eligible visits, entered on the claim form in quarter hour increments, will be multiplied by the continuous home care rate. This SIA payment is disbursed to the hospice in addition to the RHC rate for the days the RN and/or social worker visits are made. Example: A nurse and/or social worker spent a combined 5.5 SIA-eligible hours visiting a patient in last 7 days of the patient's life.

5.5 hours x $39.37 (CHC hourly rate) = $216.34, in addition to RHC per diem for last 7 days of life.

Reimbursement Rate Cuts

BNAF
A 2009 CMS rule implemented a seven-year phase out of the Budget Neutrality Adjustment Factor (BNAF), a key element in the calculation of the Medicare hospice wage index. Elimination of the BNAF will ultimately result in a permanent reduction in hospice reimbursement rates of approximately 4.2 percent. The last year of BNAF reductions is FY2016. The reduction is figured into the wage index value, and is invisible in the rate setting process. The Patient Protection and Affordable Care Act further altered the Medicare hospice rate formula through the introduction of a "productivity adjustment factor," that will reduce annual hospice payments each year. The productivity adjustment is in two parts – one for all Medicare providers (at 0.4% for FY2015) and an additional adjustment for hospice providers of 0.3% each year.

Sequestration
Sequestration reductions affect several areas of federal spending, including cuts to Medicare. Sequestration took effect on March 1, 2013. However, it first affected the hospice community in April 2013 for claims filed for care provided beginning March 1, 2013.

- Reductions of 2.0% each year in most Medicare spending, including hospice (total Medicare savings: $123 billion over 10 years)
- Reductions in premium support (resulting in increased beneficiary costs) for Medicare Part B and other spending changes (Medicare savings: $31 billion)
- The 2% sequestration reduction is likely to continue until 2025. Sequestration cuts are calculated by the Medicare Administrative Contractor and subtracted from reimbursement for claims submitted.

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Medicare Hospice Payment Limits ("Caps")[35]

The inclusion of the Medicare Hospice Benefit in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) was based in large part on the premise that the new benefit would be a less costly alternative to conventional end-of-life care (Government Accountability Office 2004, Hoyer 2007). To achieve this outcome, when the Congress established the hospice benefit it included two limitations, or "caps," on payments to hospices. The June 2006 MedPAC Report to Congress's chapter on hospice care provides the following description of the two cap limits:

> "One cap limits the share of inpatient care days (either inpatient respite care or general inpatient care). An agency may provide up to 20% of its total patient care days each year. This cap [is] also intended to prevent hospice care from becoming a predominantly inpatient benefit and to preserve the delivery of hospice care in the patient's home.[36] If an agency exceeds the 20% inpatient cap, Medicare pays the routine home care rate for the days above the threshold.
>
> The second cap limits the average annual payment per patient a hospice can receive from the program.[38] The average annual payment cap is calculated for the period November 1 through October 31 each year. … If an agency's total payments divided by its total number of beneficiaries exceeds the cap amount, then the agency must repay the excess to the program. As with the 20% inpatient day cap, this cap is not a spending limit on each individual beneficiary, but is applied at the agency level. The average aggregate payment cap is adjusted annually by the medical expenditure category of the consumer price index for all urban consumers. Unlike the daily payment rates, the average aggregate payment cap is not adjusted for geographic differences in cost. As a result, an agency serving a lower wage area can provide more days of the same category of care per beneficiary before reaching the cap than an agency serving a higher wage area."

Medicare Hospice Cap Amounts (Actual Cap)	
Year	**Cap Amount**
1984	*$6,500.00*
2010	$23,874.98
2011	$24,527.69
2012	$25,377.01
2013	$26,157.50
2014	$26,725.79
2015	$27,382.63[37]

Table 7. Medicare Hospice Cap Amounts

[35] Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy (March 2010). http://www.medpac.gov/documents/reports/Mar10_EntireReport.pdf.
[36] Gage, B., C. Miller, K. Copolla, et al. 2000. Important questions for hospice in the next century. In *Synthesis and Analysis of Medicare's Hospice Benefit*. Washington, DC: Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy.
[37] Centers for Medicare and Medicaid Services, CMS-1629-F. "Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements." Display date July 31, 2015; Publication date August 6, 2015.
[38] This cap was originally conceived to be an amount that reflected the cost to the Medicare program for patients with cancer in the last six months of life. However, the average annual payment cap was ultimately set at an amount that was not based on this calculation (GAO 2004).

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To read the hospice chapter of the June 2006 MedPAC Report to Congress, click here: http://www.medpac.gov/documents/reports/Jun06_Ch03.pdf.

To read more about the Medicare Hospice Caps, click here: http://www.nhpco.org/regulatory/hospice-caps.

Margins and Medicare Expenditures

According to MedPAC data, the aggregate Medicare hospice margin was 10.1% in 2012. Yet the projected margin for 2015 was 6.6% and included effects of the sequester.[39] However, margins vary widely across hospice providers (see table 6).

Category	Percent of Hospices in 2012	2007	2008	2009	2010	2011	2012
All	**100%**	**5.8%**	**5.5%**	**7.4%**	**7.4%**	**8.7%**	**10.1%**
Freestanding	71%	8.7%	8.3%	10.2%	10.7%	11.8%	13.3%
Home health based	13%	2.3%	3.4%	5.9%	3.2%	5.0%	5.5%
Hospital based	15%	-10.9%	-11.3%	-12.2%	-16.6%	-15.9%	-16.8%
For profit (all)	59%	10.4%	10.3%	11.7%	12.3%	14.5%	15.4%
Nonprofit (all)	35%	1.6%	0.7%	3.8%	3.0%	2.5%	3.7%
Urban	73%	6.3%	5.9%	7.9%	7.7%	9.0%	10.3%
Rural	27%	1.4%	2.1%	3.7%	5.2%	6.2%	7.8%

Table 8. Hospice Medicare margins by selected characteristics, 2007–2012[40]

[39] Medicare Payment Advisory Commission. Chapter 12, Report to Congress: Medicare Payment Policy. March 2015. http://medpac.gov/documents/reports/chapter-12-hospice-services-(march-2015-report).pdf.

[40] Medicare Payment Advisory Commission. Executive Summary, Report to Congress: Medicare Payment Policy. March 2015. http://medpac.gov/documents/reports/chapter-12-hospice-services-(march-2015-report).pdf.

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Medicare spending on hospice has risen to $15.1 billion in calendar year 2013, which still comprises only about 2% of Medicare expenditures.[41] This growth in spending on hospice reflects several important factors, including greater awareness of hospice care, which has led to increased utilization of the Medicare Hospice Benefit. [42] Additionally, hospices continue to grow as they serve more patients with non-cancer terminal diagnoses such as heart disease, lung disease, and dementia.[43]

Organizational Tax Status

Hospice agencies are organized into three tax status categories:

1. Not-for-profit [charitable organization subject to 501(c)3 tax provisions]
2. For-profit (privately owned or publicly held entities)
3. Government (owned and operated by federal, state, or local municipality)

Based on analysis of CMS's Provider of Service (POS) file, 27.9% of active Medicare Provider Numbers are assigned to providers that held not-for-profit tax status and 67.8% held for-profit status in 2014. Government-owned programs comprise the smallest percentage of hospice providers (4.3% in 2014).[44]

Historical charts of the growth in number of patients served by hospice and the growth in number of hospice programs in the U.S. can be found in Appendix A.

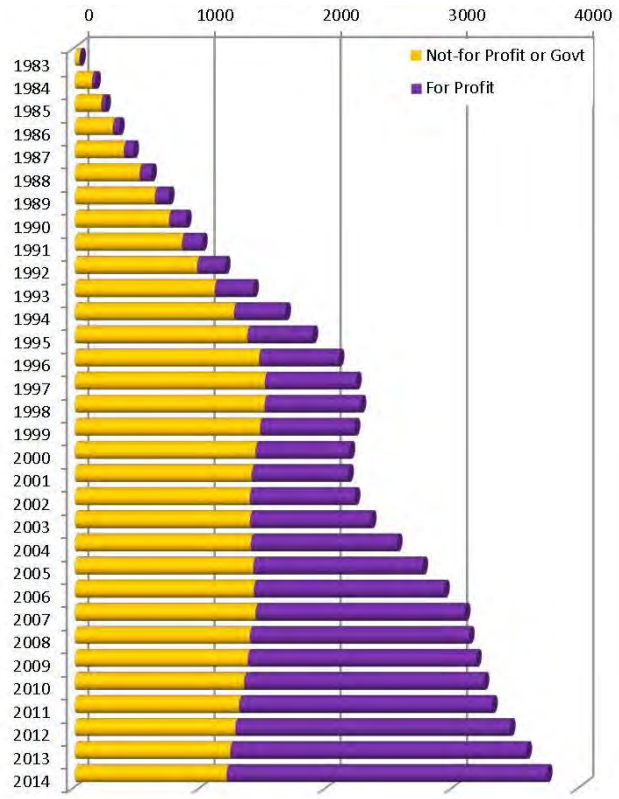

Figure 4. Number of Not-for-Profit and For Profit Hospices

Hospice and Managed Care

Medicare Advantage

Beginning in the 1970s, Medicare beneficiaries have been able to choose to receive their Medicare benefits through a private health plan instead of through the federally-managed fee-for-service program. In 2003, the Medicare Modernization Act termed this option "Medicare

[41] Medicare Payment Advisory Commission. Executive Summary, Report to Congress: Medicare Payment Policy. March 2015. http://medpac.gov/documents/reports/chapter-12-hospice-services-(march-2015-report).pdf.
[42] Medicare Payment Advisory Commission. Chapter 11, Report to Congress: Medicare Payment Policy. March 2012. http://www.medpac.gov/documents/reports/chapter-11-hospice-services-(march-2012-report).pdf.
[43] National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.
[44] 1st Quarter 2015, Centers for Medicare and Medicaid Services (CMS) Provider of Service File (POS).

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Advantage."[45] In 2015, 31% of Medicare beneficiaries were enrolled in a Medicare Advantage Plan, although enrollment rates vary greatly by state and locale.[46]

Medicare Advantage plans cover all services that traditional Medicare covers except for hospice and End-Stage Renal Disease (ESRD). When an individual with Medicare Advantage elects the Medicare Hospice Benefit, all Medicare-covered services they receive while in hospice care are covered by Original Medicare. This includes any Medicare-covered services for conditions unrelated to the terminal prognosis or provided by the attending physician.[47] If the Medicare Advantage Plan includes additional services not covered under Original Medicare (such as dental benefits) and the patient does not disenroll from the Medicare Advantage Plan, the Medicare Advantage Plan will continue to cover those additional services.[48]

Medicaid Managed Care (for patients not eligible for Medicare)
States have traditionally provided Medicaid benefits using a fee-for-service system. In the past 15 years, however, states have more frequently implemented a managed care delivery system for Medicaid benefits. In a managed care delivery system, beneficiaries get most or all of their Medicaid services from an organization under contract with the state. Based on 2014 data, over 43.5 million people received benefits through some form of managed care, either on a voluntary or mandatory basis.[49]

States can allow people to voluntarily enroll in a managed care program, but more frequently, states *require* residents to enroll in a managed care program. Increasing numbers of states are using Managed Long Term Services and Supports as a strategy for expanding home and community-based services, promoting community inclusion, ensuring quality and increasing efficiency.

Hospices, unlike most other providers, receive the same payment for the traditional Medicaid Hospice Benefit that they receive for the Medicare Hospice Benefit due to a provision in the Social Security Act. For states that cover the hospice benefit under their Medicaid Managed Care Plan, the Medicaid statute may not apply. Instead, states have the flexibility to require payment rates that mirror the Medicare rate or they may choose to allow Medicaid Managed Care Organizations to reimburse hospice providers at rates that are deemed by CMS as actuarially sound.

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[45] "Medicare Advantage." The Henry J. Kaiser Family Foundation. http://kff.org/medicare/fact-sheet/medicare-advantage/. June 2015.
[46] "Medicare Advantage 2015 Spotlight: Enrollment Market Update." The Henry J. Kaiser Family Foundation. http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/. June 30, 2015.
[47] Centers for Medicare and Medicaid Services. "Medicare Hospice Benefits." CMS Product No. 02154. http://www.medicare.gov/Pubs/pdf/02154.pdf. Revised August 2012.
[48] *Code of Federal Regulations*, Medicare Advantage Program, title 42, sec. 422.320; The Social Security Act, section 1853(h)(2)(B)
[49] The Expanded State of Medicaid in the United States, PwC, January 2015

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Health Insurance Plans for the Commercially Insured

Commercial payers constitute a relatively small proportion of hospice caseloads. Contractual relationships between hospice providers and health insurance plans often follow the lead of Medicare, both in form (all-inclusive, per-diem rates) and level of payment. Industry research indicates that the vast majority of health plans contract with hospices as ancillary providers. Other plans offer hospices per visit coverage for their services, following the model used with home health agencies. Some benefits may be written with low lifetime maximums for hospice care. In cases where there is no defined hospice benefit, health insurance plan case managers may be able to arrange coverage on an individualized basis or substitute other listed benefits to pay for hospice care. Decisions on how to cover hospice care are made individually by each health insurance plan, and a single plan could have dozens of coverage approaches for its different sponsoring employer groups or product lines.[50]

Accountable Care Organizations (ACOs)

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

Medicare offers several ACO programs:

- Medicare Shared Savings Program—a program that helps Medicare fee-for-service program providers becomes an ACO.
- Advance Payment ACO Model—a supplementary incentive program for selected participants in the Shared Savings Program.
- Pioneer ACO Model—a program designed for early adopters of coordinated care. (No longer accepting applications.) [51]

On October 20, 2011, CMS finalized rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through ACOs. ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program (Shared Savings Program) will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Provider participation in an ACO is purely voluntary.

The Affordable Care Act specifies that an ACO may include the following types of groups of providers and suppliers of Medicare covered services:

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[50] NHPCO Issue Brief: Managed Care and Hospice: Strengthening the Bonds, Building for the Future July 2005, Reissued December 2014.

[51] "Accountable Care Organizations" http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/.

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- ACO professionals (i.e., practitioners meeting the statutory definition) in group practice arrangements
- Networks of individual practices of professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals, or
- Other Medicare providers and suppliers as determined by the Secretary.

The ACO must have at least 5,000 beneficiaries enrolled for a period of three years.[52]

Hospice providers are now beginning to contract with ACOs to identify and provide care to terminally ill patients. With the expertise from hospice providers, ACOs should be able to identify patients earlier that are eligible for the Medicare Hospice Benefit.

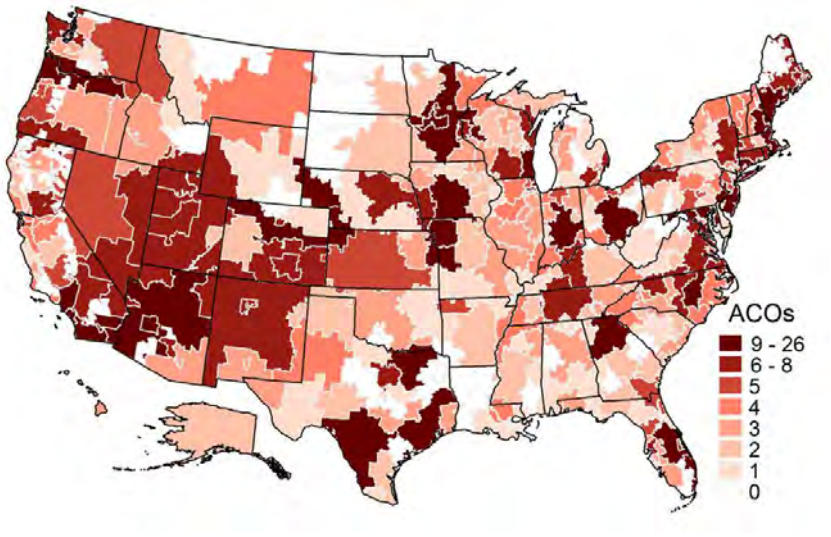

Figure 5. Number of ACOs by Hospital Referral Region, January 2015; Leavitt Partners Center for Accountable Care Intelligence, as reported in "Growth And Dispersion Of Accountable Care Organizations In 2015," Health Affairs Blog, David Muhlestein, March 31, 2015.

Care Transitions and the Continuum of Care

Hospice focuses on relieving symptoms and supporting patients with a life expectancy of months, not years. However, palliative care may be given at any time during a person's illness, and can be coupled with curative treatment. Most hospices have a set of defined services, team members, and rules and regulations. Hospice and palliative care both focus on helping a person be comfortable by addressing issues or symptoms causing physical or emotional pain or

[52] Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program, The Medicare Learning Network® (MLN), ICN 907404 November 2012.

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suffering. The goals of palliative care are to improve the quality of a seriously ill person's life, and to support that person and their family during and after treatment.[53]

Cost Effectiveness of Hospice Care

Research conducted at Mount Sinai's Icahn School of Medicine, published in the March 2013 issue of *Health Affairs*, found that hospice enrollment saves money for Medicare and improves care quality for Medicare beneficiaries across a number of different lengths of services. Among the key findings are:[54]

- Medicare costs for hospice patients were lower than non-hospice Medicare beneficiaries with similar diagnoses and patient profiles,
- Hospice enrollment is associated with fewer 30-day hospital readmissions and in-hospital deaths, and
- Hospice enrollment is associated with significantly fewer hospital and ICU days.

Likewise, a 2007 study out of Duke University concluded that during the last year of life, hospice saves the Medicare program an average of $2,309 for each beneficiary served.[55] Moreover, for nursing home residents receiving the hospice care benefit, the probability of end of life hospitalization(s) is reduced.[56,57] Therefore, transitions that adversely affect residents' quality of life are reduced. The resulting improved quality of life coupled with potential Medicare savings powerfully supports the benefit's value in the nursing home setting.

Continuum of Care

When there is a seamless care continuum, providers work together to develop a coordinated plan that addresses physical, emotional, social, caregiving, spiritual, nutritional and other needs. In some communities multiple agencies work together to offer a range of services along the continuum to ensure that needs are met. The common theme throughout all models is deciding when about when and how to infuse palliative care throughout the disease trajectory.

In addition to hospice care, some programs that fall along the care continuum include:

- **Adult day programs.** Adult day service centers provide a coordinated program of professional and compassionate services for adults in a community-based group setting. Designed to provide social and some health services to adults who need supervised care

[53] The National Consensus Project for Quality Palliative Care *Clinical Practice Guidelines for Quality Palliative Care,* 3rd ed. 2013.
[54] Kelley AS, Deb P, et al., "Hospice Enrollment Saves Money For Medicare and Improves Care Quality Across A Number of Different Lengths-Of-Stay." Health Affairs 2013; 32(3): 552-561.
[55] Taylor DH et al. 2007. What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program? *Social Science & Medicine*, 65: 1466-1478.
[56] Miller SC, Gozalo P, Mor V. 2001. Hospice Enrollment and Hospitalization of Dying Nursing Home Patients. *The American Journal of Medicine*, 111: 38-44.
[57] Miller SC, Lima JC, Looze J, Mitchell SL. 2012. Dying in US Nursing Homes with Advanced Dementia: How Does Health Care Use Differ for Residents with, versus without, End-of-Life Medicare SNF Care? *Journal of Palliative Medicine*, 15(1):43-50.

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in a safe place outside the home, adult day programs also afford caregivers respite from the demanding responsibilities of their job.[58]

- **Program of All-Inclusive Care for the Elderly (PACE).** Delivering all needed medical and supportive services, a PACE program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their home for as long as possible. Services include the following:
    - adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care;
    - medical care provided by a PACE physician familiar with the history, needs and preferences of each participant;
    - home health care and personal care;
    - all necessary prescription drugs;
    - social services;
    - medical specialties, such as audiology, dentistry, optometry, podiatry and speech therapy;
    - respite care; and
    - hospital and nursing home care when necessary.[59]

Advance Care Planning

Advance care planning consists of making decisions about the care one would want to receive if one happens to become unable to speak for one's self. Advance care planning enables the individual to make and document their decisions about end of life care based on personal values, preferences, and discussions with loved ones.

Advance care planning includes:

- Collecting information on the types of life-sustaining treatments that are available,
- Deciding what types of treatment one would or would not want should they be diagnosed with a life-limiting illness,
- Sharing personal values with loved ones, and
- Completing advance directives, POLST forms, or other appropriate documents to put into writing what types of treatment one would or would not want should he be unable to speak for them.

In 2015, CMS established Medicare coverage for two Current Procedural Terminology (CPT) codes for advance care planning, effective for use for services provided on or after January 1, 2016. These codes are billable under Medicare Part B. The advance care planning codes can be used by any physician or non-physician practitioner who is entitled to bill Part B independently, provided the services are within their scope of practice where they are licensed.

[58] National Adult Day Services Association. About Adult Day Services. http://www.nadsa.org/learn-more/about-adult-day-services/.
[59] National PACE Association. http://www.npaonline.org/policy-advocacy/value-pace#services.

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- **99497:** Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- **99498**: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

Read more about the CPT codes for Advance Care Planning at: http://www.nhpco.org/alerts/physician-fee-schedule-final-rule-covers-acp.

Advance Directives[60]

Advance directives are legal documents that allow an individual to plan and make their end-of-life wishes known in the event that they are unable to communicate. Advance directives consist of (1) a living will and (2) a medical (healthcare) power of attorney. A living will describes the person's wishes regarding medical care. A medical power of attorney is appointed by an individual and can make healthcare decisions for that person in case the individual is no long able to make such decisions.

To learn more about advance directives, visit: http://www.caringinfo.org/files/public/brochures/Understanding_Advance_Directives.pdf.

Caring Connections provides free advance directives and instructions for each state[61] at: http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289.

POLST

Physician Orders for Life Sustaining Treatment (POLST) is a set of medical orders based on a seriously ill individual's treatment wishes. Programs are now developing in 23 states, and may have different names. This set of documents follows a patient across sites of service and provides protection for healthcare workers (e.g. EMS). It may be labeled differently in different states.

To learn more about POLST visit: http://www.polst.org.

[60] National Hospice and Palliative Care Organization and Caring Connections. "Understanding Advance Directives" http://www.caringinfo.org/files/public/brochures/What_is_Palliative_Care_Brochure.pdf. 2005.

[61] These materials are copyrighted by Caring Connections. Permission is granted to download a single copy of any portion of these texts. Use by individuals for personal and family benefit is specifically authorized and encouraged. Further copies or publication are prohibited without express written permission.

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State Demonstrations to Integrate Care for Dual Eligible Individuals

As of August 2015 and under the State Demonstrations to Integrate Care for Dual Eligible Individuals, CMS had finalized memoranda of understanding with 13 states to implement demonstrations to better coordinate care for dual eligible individuals. Designed as three year programs, they allow states to change the care delivery systems through which beneficiaries receive their medical and long-term care services. In July 2015, CMS announced that states may extend their demonstrations for an additional two years.[62]

A longstanding barrier to coordinating care for Medicare-Medicaid enrollees has been the financial misalignment between Medicare and Medicaid. To begin to address this issue, CMS is testing two models for states to better align the financing of these two programs and integrate primary, acute, behavioral health and long term services and supports for their Medicare-Medicaid enrollees.

These two models include:

- Capitated Model: A State, CMS, and a health plan enter into a contract in which the health plan receives a prospective blended payment to provide comprehensive, coordinated care.
- Managed Fee-for-Service Model: A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

CMS is interested in testing these models across the country in programs that collectively serve up to 2 million Medicare-Medicaid enrollees. All programs will be rigorously evaluated as to their ability to improve quality and reduce costs.[63]

[62] Mesumeci, MaryBeth. "Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS", The Henry J. Kaiser Family Foundation. http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/. September 8, 2015.

[63] "Financial Alignment Initiative" https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html

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Chapter 3: Hospice Regulations and Compliance

Medicare Hospice Regulations, including the Hospice Conditions of Participation

Section 1861(dd) of the Social Security Act provides coverage for hospice care to terminally ill Medicare beneficiaries who elect to receive care from a Medicare-participating hospice. Under this section, the Secretary of the Department of Health and Human Services (HHS) established the regulations and Conditions of Participation (CoPs) that a hospice must meet to participate in Medicare and/or Medicaid, and are set forth at 42 CFR 418. The CoPs apply to a hospice as an entity as well as to the services furnished to each individual under hospice care. The Secretary is responsible for ensuring that the regulations and CoPs, and their enforcement, are adequate to protect the health and safety of individuals under hospice care. To implement this requirement, state survey agencies, or accreditation organizations that have been approved to substitute for the state survey, conduct surveys of hospices to assess their compliance with the CoPs. The hospice CoPs were originally published on December 16, 1983 (48 FR 56008) and were updated in December 2008. Each year when CMS publishes the Medicare Hospice Wage Index final rule, CMS also unveils changes to the Medicare hospice regulations. NHPCO offers members an easy-to-read version of the most updated regulations.

Patient Protection and Affordable Care Act (ACA)

In March 2010, Congress passed the Patient Protection and Affordable Care Act (ACA), which the President subsequently signed into law. The detailed chart in Appendix B outlines the provisions of the ACA that affect hospice.

Face-to-Face Requirements

The ACA requires that a hospice physician or nurse practitioner must have a face-to-face encounter with every hospice patient whose total stay across all hospices is anticipated to reach the third benefit period. The face-to-face encounter must occur prior to, but no more than 30 days prior to, the third benefit period recertification, and every benefit period (every 60 days) reconciliation thereafter, in order to gather clinical findings to determine continued eligibility for hospice care. The practitioner who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter. This policy was recommended by the Medicare Payment Advisory Commission (MedPAC) to ensure proper utilization of the benefit for long-stay patients; the provision took effect on January 1, 2011, and enforcement began April 1, 2011.

For answers to frequently asked questions about the face-to-face requirement, click here: http://www.nhpco.org/sites/default/files/public/regulatory/FAQs_Face-to-Face_v2.pdf.

Medical Review

The ACA incorporated a 2009 MedPAC recommendation that hospice programs with a high percentage of patients qualifying as long lengths of stay (more than 180 days) should have

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additional oversight through medical review. The IMPACT Act of 2014 provided technical fixes to the ACA language and the provision is now ready for CMS to set the threshold, or percentage, which will trigger medical review.

Quality Reporting

Section 3004 of the ACA directs the Secretary to establish quality reporting requirements for Hospice Programs. Section 3004 requires the Secretary to publish, no later than October 1, 2012 ,the selected quality measures that must be reported by Hospice Programs. The ACA requires that CMS use measures that have been endorsed by the National Quality Forum (NQF), but also allows CMS to specify measures that are not already endorsed if a feasible and practical measure in the area determined appropriate by the Secretary has not been endorsed.

Consequently, CMS developed the Hospice Quality Reporting Program (HQRP). For initial HQRP implementation hospice providers were required to collect data on two quality measures through December 31, 2013: the structural measure, which requires participation in a quality assessment and performance improvement (QAPI) program, and NQF #0209 (the "Comfortable Dying" measure). Hospices that failed to submit data on these measures by April 1, 2014, will have their market basket update reduced by 2% in FY 2015.

Effective January 1, 2014, the structural measure and NQF #0209 data collection was discontinued. Instead, data collection related to seven other NQF endorsed quality measures was initiated on July 1, 2014 using a standardized data collection instrument (the Hospice Item Set/HIS). The current measures required for quality reporting are:

- NQF #1634: Pain Screening;
- NQF #1637: Pain Assessment;
- NQF #1638: Dyspnea Treatment;
- NQF #1639: Dyspnea Screening;
- NQF #1617: Patients Treated with an Opioid who are Given a Bowel Regimen;
- NQF #1641: Treatment Preferences;
- modified NQF #1647: Beliefs/Values Addressed.

Hospice Item Set

For all patients admitted on or after July 1, 2014, completion of a standardized Hospice Item Set (HIS) is required regardless of payer or patient age. Hospices submit HIS data online on a rolling basis within 30 days of each patient's admission and discharge. The HIS includes a set of data elements that CMS will use to calculate scores for the seven NQF endorsed quality measures described above. The HIS is not a patient assessment tool and is not intended to replace a hospice's current initial and comprehensive patient assessment. Hospices failing to report quality data via the HIS in 2014 will see their market basket reduced by 2% in FY 2016 (October 1, 2015 – September 30, 2016).[64]

[64] Centers for Medicare & Medicaid Services. FY2014 Hospice Wage Index. http://www.gpo.gov/fdsys/pkg/FR-2013-08-07/pdf/2013-18838.pdf

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Hospice programs are evaluated for purposes of the quality reporting program based on data submission, not on their performance on the required measures.

For more information on the Hospice Items Set, click here: http://www.nhpco.org/quality/hospice-item-set-his.

CAHPS® Hospice Survey

The CAHPS® Hospice Survey is a component of CMS' Hospice Quality Reporting Program that emphasizes the experiences of hospice patients and their primary caregivers listed in the hospice patients' records. The survey follows the principles used in the development of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys and joins the CAHPS® family of surveys. The CAHPS Hospice survey is administered by vendors on behalf of hospices. Hospices are required to contract with an approved survey vendor and to provide family caregiver contact information to the vendor on a monthly basis. Hospices do not provide contact information for caregivers of patients who were discharged alive or decedents who were under the age of 18; who died within 48 hours of admission to hospice care; for whom no caregiver was listed or available; for whom caregiver is a non-familial legal guardian; for whom the caregiver has a foreign (non-US or US Territory) home address; or whose caregiver requested that they not be contacted.

Hospices participated in a "dry run" of the CAHPS® Hospice survey for at least one month in the first quarter of 2015 (January 1 - March 31, 2015). Ongoing data collection began April 1, 2015 and continues through the end of 2015. Hospices that fail to report survey data will incur a 2% market basket reduction for FY 2017 (beginning October 1, 2016).

Hospices that have fewer than 50 deceased survey eligible patients in the period from January 1, 2014 through December 31, 2014 will be exempt from the CAHPS® Hospice survey data collection and reporting requirements for the FY 2017 payment determination. The hospices will be required to submit their patient counts for the period of January 1, 2014 through December 31, 2014 to CMS online via a Participation Exemption for Size Form.

New Quality Measures and Payment Penalties

Beginning with the FY 2018 payment determination, measures adopted for the HQRP beginning with a payment determination year will be automatically adopted for all subsequent years' payment determinations, unless removed, suspended, or replaced by CMS. No measures were removed or added for the FY 2017 reporting cycle.

The CAHPS® Hospice Survey continues to be a component of the CMS Hospice Quality Reporting Requirements for the FY 2018 APU and subsequent years. CMS plans to submit measures from the CAHPS® Hospice Survey to the National Quality Forum (NQF) for endorsement as hospice quality measures. The measures derived from the CAHPS® Hospice Survey include five composite measures, three single item measures, and two global measures.

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CMS has imposed data submission timeliness threshold requirements 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.

For more information on the CAHPS® Hospice survey, click here:
http://www.nhpco.org/quality/cahps%C2%AE-hospice-survey .

For more information on the HIS Quality Reporting requirements, click here:
http://www.nhpco.org/quality/hospice-item-set-his

To view the Quality Reporting Timeline CY2013-2016, click here:
http://www.nhpco.org/sites/default/files/public/quality/QualityReportingTimeline.pdf

Accreditation Organizations

CMS permits Medicare-certified hospice providers to become "accredited" by an approved national accreditation organization and to be exempt from routine surveys by state survey agencies to determine compliance with Medicare Conditions of Participation. Three national accreditation organizations are approved to accredit hospice organizations: the Joint Commission, Community Health Accreditation Partners (CHAP), and the Accreditation Commission for Health Care, Inc. (ACHC).

Office of the Inspector General (OIG)

Office of Inspector General's (OIG) mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries. The Office of Audit Services (OAS) conducts independent audits of HHS programs and/or HHS grantees and contractors. These audits examine the performance of HHS programs and/or grantees in carrying out their responsibilities and provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement, and promote economy and efficiency throughout HHS. OAS conducts audits using its own

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resources and oversees audit work performed by others. OAS is the largest civilian audit agency in the Federal Government.

A summary of OIG reports on hospice care from 1995 to the present can be found here: http://www.nhpco.org/sites/default/files/public/regulatory/Summary_OIG_Reports1995-date.pdf.

OIG Workplan

The OIG Workplan for each Fiscal Year provides brief descriptions of activities that the OIG plans to initiate or continue with respect to HHS programs and operations in that fiscal year. When reports are issued, they are posted to OIG's website.

A summary of hospice issues in each OIG Workplan can be found here: http://www.nhpco.org/office-inspector-general-oig.

Compliance Programs

The OIG voluntarily promotes development and implementation of compliance programs for the health care industry. The adoption and implementation of voluntary compliance programs can significantly reduce fraud, abuse, and waste, while at the same time furthering the fundamental mission of provision of quality care to patients. Moreover, the ACA mandates that a broad range of providers, suppliers, and physicians adopt a compliance and ethics program. Congress delegated the development of the core requirements and implementation deadlines to the discretion of HHS, but dates for hospice providers have not yet been set.

In September 1999, the OIG issued guidance to assist hospices in developing effective internal controls that promote adherence to applicable Federal and State law, as well as the program requirements of Federal, State, and private health plans. In the OIG guidance, seven elements fundamental to an effective compliance program were listed:

- Implementation of written policies, procedures and standards of conduct;
- Designation of a compliance officer and compliance committee;
- Conduction of effective training and education;
- Development of effective lines of communication;
- Enforcement of standards through well-publicized disciplinary guidelines;
- Conduction of internal monitoring and auditing; and
- Prompt response to detected offenses and development of corrective action.

The OIG Compliance Guidance for Hospice Providers also listed 28 risk areas for hospice compliance. These risk areas are still valid today and should be a guide for hospices in their compliance activities. The list of risk areas can be found here: http://oig.hhs.gov/authorities/docs/hospicx.pdf.

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Regulatory and Compliance Oversight

Hospice Survey Requirement

Effective April 6, 2015, Medicare certified hospices will have mandatory surveys every 36 months, through 2025. CMS will contract with the appropriate state survey agency in each state. Surveys may also be performed by accrediting agencies with deemed status, such as the Joint Commission, CHAP, and ACHC.

CMS Medicare Administrative Contractors (MACs)

The CMS Medicare Administrative Contractors (MACs) serve as the primary point of contact for provider enrollment, Medicare coverage and billing requirements, and processing and payment of Medicare fee-for-service claims for Medicare providers. Medicare providers are assigned to the MAC based on their geographic location.

The three regional MACs for home health and hospice are CGS Administrators; National Government Services (NGS); and Palmetto, GBA. For more information about these MACs, visit: http://www.nhpco.org/billing-and-reimbursement/medicare-administrative-contractor-mac-information.

Each MAC has jurisdiction in the following states:

CGS Administrators: Colorado; Delaware; Washington, DC; Iowa; Kansas; Maryland; Missouri; Montana; Nebraska; North Dakota; Pennsylvania; South Dakota; Utah; Virginia; West Virginia; and Wyoming

National Government Services: Alaska, Arizona, California, Connecticut, Hawaii, Idaho, Maine, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, New York, Oregon, Puerto Rico, Rhode Island, Vermont Virgin Islands, Washington, Wisconsin

Palmetto, GBA: Alabama, Arkansas, Florida, Georgia, Indiana, Illinois, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas

MAC Audit Types

MACs can perform several types of audits, described below. More information about any of these types of audits can be found at http://www.nhpco.org/regulatory/fraud-and-abuse.

- Additional Documentation Request (ADR): When a Medicare Administrative Contractor (MAC) cannot make a coverage or coding determination from the information that has been provided on a claim and its attachments, they may ask for additional documentation by issuing an Additional Documentation Request (ADR). The MAC must request records related to the claim(s) being reviewed.

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- Comprehensive Error Rate Testing (CERT): The CMS CERT program measures improper payments in the Medicare fee-for-service program. The CERT program is not a measure of fraud. Since the CERT program uses random samples to select claims, reviewers are often unable to see provider billing patterns that indicate potential fraud when making payment determinations. The CERT program does not, and cannot, label a claim fraudulent.
- Payment Error Rate Measurement (PERM): The PERM measures improper payments in Medicaid and the Children's Health Insurance Program and produces error rates for each program. The error rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory, or administrative requirements.

Other Audit Types

- Medicaid Integrity Contractors (MIC): The Deficit Reduction Act of 2005 established the Medicaid Integrity Program (MIP) and MICs. A MIC ensures that paid claims were:
    - For services provided and properly documented;
    - For services billed properly, using correct and appropriate procedure codes;
    - For covered services; and
    - Paid according to Federal and State laws, regulations, and policies.
- Qualified Independent Contractors (QIC): Qualified Independent Contractors utilize a comprehensive data system to collect and share information about appeals decisions, give weight to carrier and fiscal intermediary local coverage determinations, and conduct a panel review of all medical necessity denials. A party to the redetermination may request a reconsideration if dissatisfied with the redetermination decision. A Qualified Independent Contractor (QIC) will conduct the reconsideration.
- Quality Improvement Organizations [QIO): CMS recently restructured the Quality Improvement Organization (QIO) Program to improve patient care, health outcomes, and save taxpayer resources. This restructuring included the award of contracts for two Beneficiary and Family-Centered Care (BFCC) QIO contractors who will support the program's case review and monitoring activities separate from the traditional quality improvement activities of the QIOs. These new contract awards will change the QIOs of some hospice providers and those providers will need to update the QIO information on their UPDATED - Notice of Medicare Non-Coverage (NOMNC) form. The NONMC is issued to a patient when the hospice determines the patient is no longer terminally ill. The patient has the right to appeal the decision to their QIO. The newly formed BFCC will serve that function.

For more information on the QIO restructuring and contact information for Livanta and Kepro, see the NHPCO Information Guide on "Transition of Medicare Quality Improvement Program" (July 2014) at http://www.nhpco.org/sites/default/files/public/regulatory/QIO_transition.pdf.

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Figure 5. Map of QIO Regions

- Recovery Audit Contractors (RAC): CMS has proposed the establishment of a fifth RAC contractor focused solely on DME, home health and hospice for the country. As of September 2014, all RAC contracts are on hold and there is limited new RAC activity.
- Zone Program Integrity Contractors (ZPIC): ZPICs are part of the Medicare Integrity Program and replace the former Program Safeguard Contractors. ZPICs are responsible for preventing, detecting, and deterring Medicare fraud. ZPICs complete the following functions for Medicare:
    - Prevents fraud by identifying program vulnerabilities.
    - Proactively identifies incidents of potential fraud that exist within its service area and takes appropriate action on each case.
    - Investigates (determines the factual basis of) allegations of fraud made by beneficiaries, providers, CMS, OIG, and other sources.
    - Explores all available sources of fraud leads in its jurisdiction, including the MFCU and its corporate anti-fraud unit.
    - Initiates appropriate administrative actions to deny or to suspend payments that should not be made to providers where there is reliable evidence of fraud.
    - Refers cases to the Office of the Inspector General/Office of Investigations for consideration of civil and criminal prosecution and/or application of administrative sanctions.
    - Refer any necessary provider and beneficiary outreach to the Provider Outreach and Education staff at the MAC.

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State-specific Regulatory and Compliance Information

CMS provides funding to surveyors in state agencies to inspect hospices for their compliance with the Medicare hospice Conditions of Participation. The State may also have surveyors who provide oversight for state hospice licensure regulations, in collaboration with State surveyors. Information on state-specific regulatory and compliance topics, including licensing boards, state regulations, and survey agencies, among others, can be found here: http://www.nhpco.org/regulatory/state-specific-resources.

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Chapter 4: Hospice Public Policy and Advocacy

Congressional Jurisdiction

When legislation is introduced in Congress, it is assigned to a committee that oversees legislation on a specific set of issues, including the topic of the assigned legislation. These committees are referred to as the committees of jurisdiction over the set of issues. The committees that oversee Medicare legislation, including the Medicare Hospice Benefit, are the Senate Finance Committee and the House Ways and Means Committee. Each chamber will only consider the legislation once it is passed in its Committee of Jurisdiction. However, the process by which a bill becomes law is rarely predictable and can vary significantly from bill to bill.

To learn more about the legislative process, visit: http://beta.congress.gov/legislative-process.

Senate Finance Committee website: http://www.finance.senate.gov/.
House Ways and Means Committee website: http://waysandmeans.house.gov/.

Medicare Payment Advisory Commission (MedPAC)

MedPAC is an independent Congressional agency tasked with advising Congress on issues affecting the Medicare program. The Commission's statutory mandate is broad: in addition to advising Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare. From time to time, MedPAC studies aspects of the Medicare Hospice Benefit, formulates recommended changes, and reports to Congress.

For more information on MedPAC's studies and reports on the Medicare Hospice Benefit, visit: http://www.hospiceactionnetwork.org/issues/medpac.html.

Medicare Payment Advisory Commission website: http://medpac.gov/.

Current Supported Legislation Regarding Hospice

Medicare Patient Access to Hospice Act (H.R. 1202/S.1354)
In rural and other medically under-served communities, a physician assistant (PA) may be the only primary care professionals in the community. Current Medicare rules hamper beneficiaries' access to care because the rules do not authorize PAs to provide primary care for hospice patients. This legislation fixes Medicare regulations so physician assistants can provide primary care to hospice patients. Sponsors: Representatives Lynn Jenkins (R-KS) and Mike Thompson (D-CA); Senators Michael Enzi (R-WY) and Thomas Carper (D-DE).

NHPCO Letter of Support: House/Senate

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Hospice CARE Act (H.R. 2208)
This bill will expand the types of hospice-employed professionals who can have a face-to-face encounter. Currently, a face-to-face visit can be done only by a physician employed by, or under contract with, the hospice or an NP who is employed by the hospice. This bill proposes also allowing hospice employed physician assistants or clinical nurse specialists to provide these visits. These changes will facilitate timely provision of face-to-face visits.

This bill also changes the reference to "the 180th day recertification" to "the first 60 day period" in order to make the statute consistent with CMS's interpretation. This change is simply an effort to make the statute consistent with CMS's interpretation. In the limited circumstances of a hospice newly admitting a patient who requires a face-to face encounter because of past hospice experience with a different hospice, this legislation will allow that hospices have up to 7 days after the patient elects hospice to provide a face-to-face encounter, so that admission isn't delayed. Sponsors: Representatives Tom Reed (R-NY) and Mike Thompson (D-CA).

Background
NHPCO Letter of Support

Care Planning Act (S. 1549)
The Care Planning Act is designed to give people with serious illness the freedom to make more informed choices about their care, and the power to have those choices honored. Specifically, *the Care Planning Act* (1) establishes a new Medicare benefit called Planning Services for those with advanced illness, allowing for a team-based approach of care planning discussions with doctors, nurses, and other healthcare professionals; (2) creates a pilot program for Advanced Illness Coordination Services to allow for home-based support of patients with multiple and complex chronic conditions; and (3) directs the Secretary of HHS to develop quality metrics, public educational efforts, and resource development on advance care planning. Sponsors: Senators Mark Warner (D-VA) and Johnny Isakson (R-GA).

Background
NHPCO Letter of Support

Hospice Care Access and Improvement Act (H.R. 3037)
This legislation also contains a number of program integrity provisions long-supported by the hospice community, including:

- Expanding CMS focused medical review to identify providers who have concerning results on multiple data points.
- Requiring programs to establish interventions to reduce likelihood of ER visits and hospital admissions for patients identified to be at high risk for readmissions, particularly in the first week of hospice service.
- Expanding the pre-hospice evaluation code to include additional clinical staff from the hospice interdisciplinary team.

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- Requiring, as part of a hospital discharge planning process, that any patient referred for possible admission to hospice be informed of all Medicare certified hospice programs in the service area who ask to be included, as well as noting those with whom the hospital has an ownership relationship.

Sponsors: Representatives Tom Reed (R-NY) and Mike Thompson (D-CA)

Background

Palliative Care and Hospice Education and Training Act (H.R. 3119)
This legislation will expand opportunities for interdisciplinary education and training in palliative care, inform patients and health professionals about the benefits of palliative care and the services available to support patients with serious or life-threatening illness, and direct funding toward palliative care research to strengthen clinical practice and health care delivery.
Sponsors: Representatives Eliot Engel (D-NY) and Tom Reed (R-NY).

Background
NHPCO Letter of Support

Recent Legislation Regarding Hospice

NHPCO affiliate the Hospice Action Network actively educates Congress on hospice care and advocates for legislation to address challenges hospices around the country currently face.

IMPACT Act of 2014
Hospice program integrity provisions, initially introduced in the HOSPICE Act (H.R. 5393), were passed by Congress as part of the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014* (H.R. 4994) in September 2014, and signed by President Obama on October 6, 2014. Under the new law, Medicare certified hospices will now have mandatory surveys every 36 months, through 2025. This provision builds on the provision from the HELP Hospice Act (H.R. 2302/S. 1053) that addresses mandating hospice surveys as a critically important program integrity provision. The law also makes a technical correction to allow the implementation of existing law requiring CMS to conduct a medical review of hospice programs that reach to be determined threshold of patients under care for more than 180 days. The threshold would be established by CMS. NHPCO has supported this provision since it was originally recommended by MedPAC in 2009. Finally, the IMPACT Act aligns the inflation of the hospice aggregate cap with hospice reimbursement for the 10 years, for the cap year beginning November 1, 2016/FY2017 (through the cap year ending October 31, 2025).

For more information on the IMPACT Act, click here:
http://hospiceactionnetwork.org/linked_documents/get_informed/legislation/IMPACT_Act_FAQ.pdf.

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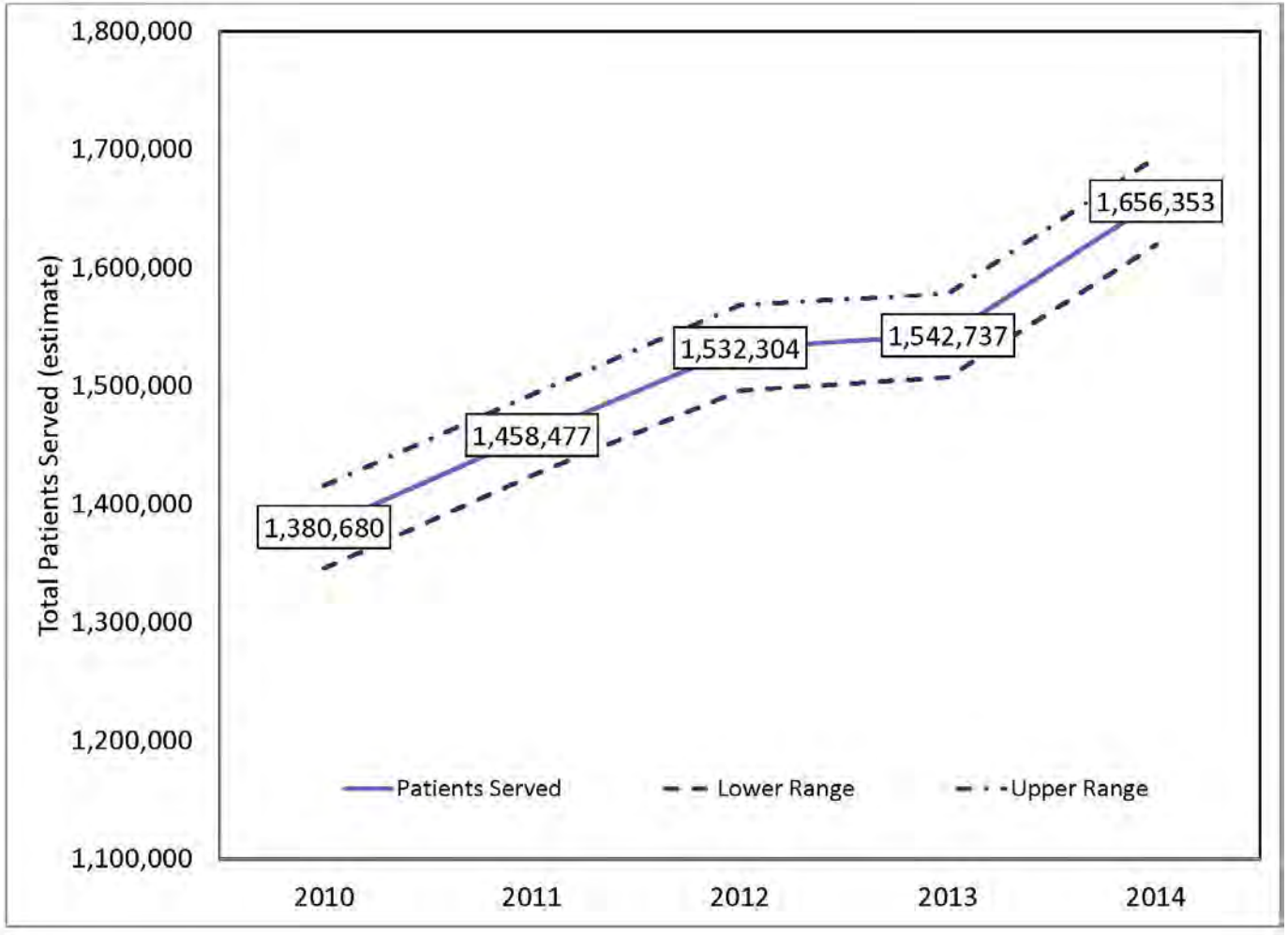
Appendix A: Growth in Patients Served by Hospice and Growth of Hospice Programs[65]



[65] 2014, NHPCO National Data Set and/or NHPCO Member Database.

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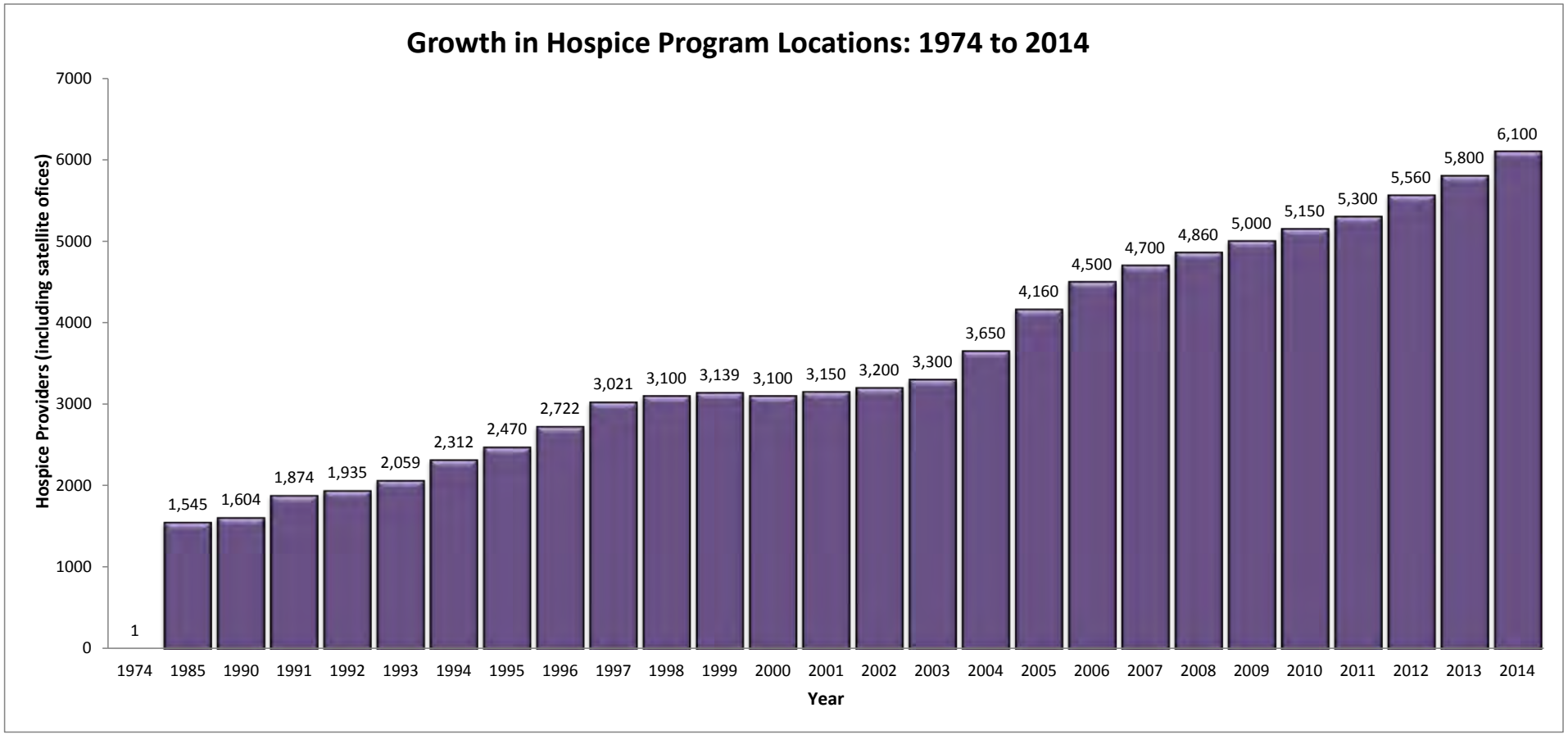

Source: National Hospice and Palliative Care Organization.
www.nhpco.org/research.

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Appendix B: Hospice Provisions in the Patient Protection and Affordable Care Act

Provision	Title	Section Number	Effective Date
Concurrent Care for Children in Medicaid and CHIP Programs	Title II – Role of Public Programs Subtitle D – Improvements to Medicaid Services	**2302**	**Immediately upon enactment – March 23, 2010.** **Action So Far:** • CMS issued a State Medicaid Director Letter on September 9, 2010 -- SMD # 10-018. • Two sets of Q&As have been posted on the NHPCO website with information from CMS, in February 2011 and again in May 2011. • States in various stages of implementation

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Quality Reporting for Hospice Programs In the Hospice Wage Index for Fiscal Year 2012 Final Rule (76 FR 47302, 47320 (August 4, 2011)), to meet the quality reporting requirements for hospices for the FY 2014 payment determination	Title III – Improving the Quality and Efficiency of Health Care Subtitle A – Transforming the Health Care Delivery System Part I – I	**3004**	10/1/2013 (FY 2014) (required that quality measures be published by 10/1/2012) Action So Far: • FY2012 Hospice Wage Index final rule confirms two measures for FY2014, with indications that the number of quality measures will increase in FY2015 and beyond • This includes data submission requirements for payment year 2014, quality measures required for hospice quality reporting for payment year FY2015 and beyond, data submission requirements for payment year FY2015, consideration of an expanded number of required measures to include additional measures endorsed by NQF for annual payment determinations beyond FY2015, and the possible implementation of a standardized data collection instrument to support quality measures.

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Hospice Reform • **Payment Reform**	Title III; Subtitle B - Improving Medicare for Patients and Providers; Part III – Improving Payment Accuracy	**3132**	**Additional data collection - 1/1/2011** **Payment reform no earlier than 10/1/2013 (FY 2014)** **Action So Far:** • In the FY2016 Hospice Wage Index Final Rule, CMS finalized the implementation of hospice payment reform effective January 1, 2016. At that time, routine home care will be billed at two separate amounts: a higher amount for patient days 1-60, and a lower amount for days 61+. • Face-to-face encounter requirements began January 1, 2011 for patients entering their third benefit period and each subsequent period of 60 days. Regulations published as a part of the Home Health Prospective Payment Rate Change Update on November 17, 2010. • CMS granted a three month delay in enforcement so that the effective date for enforcement was April 1, 2011. • No regulatory requirements released Return to Table of Contents
• **Adoption of MedPAC recommendations for:**			

Concurrent Care Demonstration Program (3 year program)	Title III(B)(III)	**3140**	**Not specified** **Action So Far:** • Demonstration project moved to the CMS Office of Innovations. Awaiting funding, based on CMS priorities.
Market Basket Updates and Productivity Adjustment	Title III, Subtitle E - Ensuring Medicare Sustainability	**3401(g)**	Effective 10/1/2012 (FY2013) for hospice. Amount of productivity adjustment (0.7% + 0.3% hospice specific) for hospice in FY2013 published in CR7857 on July 20, 2012.
Selected All Provider Provisions			
Background Check Requirement for Employees of LTC Facilities and Programs with Direct Patient Access	Title VI – Transparency and Program Integrity; Subtitle C – Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers;	**6201**	**Varies from State to State**

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Nursing facilities to have an effective compliance and ethics program in operation by March 23, 2013.	Title VI – Transparency and Program Integrity; Part III – Improving Staff Training; Subtitle E – Medicare, Medicaid and CHIP Program Integrity Provisions	**6401**	HHS to determine timelines for other entities at their discretion
Pilot Testing Pay-for-Performance Programs	Title X – Strengthening Quality, Affordable Health Care for All Americans; Subtitle C – Provisions Relating to Title III	**10326**	1/1/2016. A pilot for hospice providers is expected to be developed.

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