How to Deal with Current and Future Changes: Medicare Hospice Policy Roundup
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Presenters

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Healthcare Initiatives

- Improving patient experience of care
- Improving the health of populations
- Reducing per capita cost of health care

Healthcare Initiatives

- Shift from acute, institutional based care to primary care and care management
- Payment
  - Bundled payment
  - Medicaid expansion
  - Hospice payment reform
- Quality of Care
  - New quality programs/improved outcomes
  - Pay for performance
- Program Integrity
Patient Experience of Care

Quality of Care and Patient Satisfaction
Hospice Quality Reporting Program (HQRP)

Hospice Item Set (HIS)
Admission (14 days from admission)
Discharge (7 days from admission)
* Implement: admissions on/after July 1, 2014
* Payment Years: beginning 2016

Hospice CAHPS (formerly Hospice Experience of Care Survey)
* Implement: CY2015 (trial in Q1; full implementation Q2)
* Payment Years: beginning 2017
* Submission within 30 days of admission/discharge

HQRCP

Hospice Quality Reporting Program (HQRCP)
* Implementation of 2% payment reduction for not participating
* Public reporting could occur as soon as FY2017
* Jan. 2016 – ACA requires Pay-for-Performance pilot program
HQR P – Future Measures/Public Reporting

* Expand measures to address gaps – especially:
  * Symptom management (special focus on pain)
  * Patient-reported outcomes

* Public reporting – Reliability and validity of measures must be established – at least four quarters of data; first two quarters are not considered

* Data from 2014 quarters 3, 4 will NOT be used

* 2015 quarters 1 – 3 will be first data analyzed

* Public reporting MAY occur during FY2017

QIO Changes

Quality Improvement Organization Program Changes - Effective August 1, 2014

- Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs)
  - Manage beneficiary appeals
  - manage all beneficiary complaints
  - Memorandum of Agreement (MOA) signed by August 31.

- Quality Innovation Network - Quality Improvement Organizations (QIN-QIOs)
Notice of Election/Notice of Termination or Revocation

CR8877 – effective October 1 2014

REGULATORY CHANGE – timely filing to address errors related to patient status and appropriate attribution of costs to hospice/other areas of Medicare (Part D)

NOE – submitted and accepted within 5 calendar days of election

NOTR – submitted and accepted within 5 calendar days of live discharge unless final claim is filed

NOE

Consequence: provider liable days

What does “accepted” mean?

If not filed timely:

* Must report days between date of admission, and the date NOE accepted) as non-covered days.

* Noncovered days reported with OSC 77
NOE

Four exception circumstances for timely filing

1. Fire, flood, earthquake, or other unusual event that inflicts extensive damage to the hospice's ability to operate.

2. Event that produces a data filing problem due to a CMS or Medicare contractor systems issue that is beyond the control of the hospice.

3. Newly Medicare-certified hospice that is notified of Medicare certification after their Medicare effective date, or who is waiting on a user ID from its Medicare contractor.

4. Other circumstances determined by the MAC or CMS to be beyond the control of the hospice.

NOE

Waiver of timely filing requirement must be requested

- OSC 77 and noncovered dates
- 'KX' modifier on the first level of care revenue code line
- Submit documentation within 30 days
  
  MAC will override noncovered charges
  
  OR

  Process payment with noncovered charges
Consequence: none for provider at this time

Claim type 8xB

Live discharges only

Designation of/Change of Attending Physician

CR8877 – effective October 1 2014

REGULATORY CHANGE – concerns that hospices are assigning/changing attending or Medicare receives charges from multiple attending physicians

- Hospice election statement must include the patient’s choice of attending physician
- Information identifying the attending physician recorded in enough detail to be clear which physician or NP was designated as the attending physician
- Hospices have flexibility to include information on election statement in whatever format works best for them, provided the content requirements in §418.24(b) are met.

Language on election form should include acknowledgement by patient (or representative) that the designated attending physician was the patient’s (or representative’s) choice.
Designation of/Change of Attending Physician

CR8877 – October 1 2014

Change of Attending Physician

- Patient/rep. must file a signed statement with the hospice
- Statement must identify new attending in enough detail to be clear which physician/NP is being designated as the new attending
- Statement must include
  - date the change is to be effective,
  - date the statement is signed, and
  - the patient’s (or representative’s) signature, along with an acknowledgement that this change in the attending physician is the patient’s (or representative’s) choice.

The effective date of the change in attending physician cannot be earlier than the date the statement is signed

Concerns

- Changing a patient’s attending physician when the patient moves to an inpatient setting, often to an NP
- Assigning an attending based on whoever is available
Clarification of Q5003 and Q5004

CR8877

Q5004 - patients in a skilled nursing facility (SNF), or hospice patients in the SNF portion of a dually-certified nursing facility.

4 situations in which Q5004 should be reported.

* The beneficiary is receiving hospice care in a solely-certified SNF.
* The beneficiary is receiving general inpatient care in the SNF.
* The beneficiary is in a SNF receiving SNF care under the Medicare SNF benefit for a condition that is unrelated to the terminal illness, and is under routine home care.
* The beneficiary is receiving inpatient respite care in a SNF.

If the beneficiary is in a nursing facility, but does not meet one of the four situations above, report the place of service as Q5003.

CR8877 TIPS

* Verify eligibility
* Make every effort to submit the NOE as soon as possible after admission
* Make every effort to file a final claim or submit the NOTR as soon as possible after a live discharge/revocation
* Ensure ability to submit NOE/NOTR timely and with a back up plan
* Modify policies and procedures to reflect the new requirements, exceptions, and the hospice’s modified processes
CR8877 TIPS

* Educate all staff regarding the definition of attending physician for hospice care, the patient’s right to choose the attending physician, and what process to follow and documentation necessary in instances where the attending physician is unable or unwilling to fulfill the role.

* Modify the election statement to include
  * Patient’s choice of attending physician
  * Acknowledgement by the patient (or representative) that the designated attending physician was the patient’s (or representative’s) choice.

CR8877 TIPS

* Develop and implement a change in designated attending physician form to include
  * Identification of the new attending physician in enough detail to be clear which physician or NP was designated as the new attending physician
  * the date the change is to be effective,
  * the date that the statement is signed, and
  * the patient’s (or representative’s) signature, along with an acknowledgement that this change in the attending physician is the patient’s (or representative’s) choice.

Note: The effective date of the change in attending physician cannot be earlier than the date the statement is signed.
Program Integrity

Protecting the integrity of the Medicare hospice benefit

State Operations Manual

* Updates and clarification to the hospice policy chapter of the Medicare benefit manual
  * CR 8727
OIG Reports

* OIG reports
  * CMS's Reliance on Ohio Licensure Requirements Did Not Always Ensure the Quality of Care Provided to Medicaid Hospice Beneficiaries
  * Ohio Did Not Always Properly Claim Medicaid Reimbursement for Hospice Claims

Medical Review/Widespread Edits

* NGS: ACTIVATION FOR HOSPICE CLAIMS BILLED WITH OCCURRENCE CODE 32 AND MODIFIER GA
* Demand Bill Edit: 5AGIP
* On 08/01/14, Medical Review implemented a demand bill edit for hospice claims (bill type 81X or 82X) submitted with covered charges that contain revenue code 0656 for GIP care. The claim must contain the occurrence code of 32; with the date that the ABN was provided to the beneficiary; and at least one line with modifier GA on the claim. This is based on the demand billing of GIP level of care guidelines. Since this is a demand bill, all claims submitted are reviewed.
  * Hospice claims may be paid the RHC rate in lieu of the denied GIP service.
Medical Review/Widespread Edits

NGS

- Hospice (Edit Reason Code 5A699)
  - States: CT, MA, ME, NH, RI, VT
  - Condition Code :20

- Hospice Length of Stay (greater than 365 days) (Edit Reason Code 5AH01)
  - States: CT, MA, ME, NH, RI, VT

Medical Review/Widespread Edits

Palmetto

- Diagnosis Codes - NCLOS Rates
- HCPCS Code Q5004 - Hospice Services in SNF

October 30, 2013 - Palmetto service-specific prepay probe review on hospice claims with non-cancer diagnoses, billed with place of service Skilled Nursing Facility, HCPCS code Q5004.

- Patient is receiving skilled care from the SNF staff (i.e. hospice GIP level of care)
- 13 providers; 100 claims
Hospice Reviews

CONNOLLY RAC approved issue - Hospice documentation will be reviewed to determine the appropriateness of payments for hospice care services for Medicare beneficiaries.

Regulations Impacting Hospice

* Emergency Preparedness
  * S&C 14-12 ALL

* Infection control breaches which warrant reporting to public health authorities
  * S&C 14-36 ALL

* Disposal of controlled substances – final rule
Hospice Covered Services

Hospice Coverage

* The hospice is responsible for providing any and all services indicated in the plan of care as necessary for the palliation and management of the terminal illness and related conditions.

* Services must be consistent with the plan of care and reasonable and necessary for the palliation or management of the terminal illness and related conditions.

Medicare Claims Processing Manual, Chapter 9, Sections 40 (Benefit Coverage) and 40.1.9 (Other Items and Services)
Relatedness

A condition must be completely unrelated to the terminal illness/related conditions in order for Medicare to cover it outside of the Hospice Benefit.

Relatedness

* Is the [insert medication/item/service] related to the principal diagnosis or related conditions?
  * YES
    * Is it reasonable and necessary
  * YES
    * Covered by hospice
Relatedness

★ Is the [insert medication/item/service] related to the principal diagnosis or related conditions?
★ YES
   ★ Is it reasonable and necessary
★ NO
   ★ Should it be continued
   ★ Covered by beneficiary (or their non-Medicare insurance)
Hospice Risk Areas

* Eligibility
  * Not terminally ill
  * Not eligible for the level of care billed
  * Documentation supports *prognosis*
  * Technical components of election statements, CTIs, and Plans of Care
  * Live discharges
* Length of stay
* Site of service

Hospice Risk Areas

* Diagnosis coding
* Services/treatments outside of the hospice benefit
Strategies

* Adequate cash flow/line of credit
* Adequate staffing
* Must increase efficiencies
* Decrease expenses
* Partnerships, networking, etc.
* Compliance programs

Innovation and Opportunities
The Result for Hospice - Opportunities

- Medicare Care Choices Model (MCCM)
- Nursing facility F-tag - 155 Advance Directives
  - Survey and Certification Letter 13-16-NH
- Partnership to Improve Dementia Care in NH
  - S&C Letter 13-35-NH
- Physician payment for chronic care management/new CCM physician billing codes
- Payment for end-of-life discussions?
  - Yes from some commercial insurance companies

Money, Money, Money

Payment, Payment Reform Research, CMS response, and Future Concerns and Considerations
The Result for Hospice

★ Payment
★ Payment trends
★ Payment reform
★ Data – Cost Report
★ Payment reform findings, response
★ Hospice aggregate cap issues – self calculation / revision to cap
  update factor / impact of sequester
★ Future considerations and concerns

<table>
<thead>
<tr>
<th></th>
<th>FY2015 Medicare</th>
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<tr>
<td>Routine Home Care</td>
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<td>$173.48</td>
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<td>General Inpatient Care</td>
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NOTE: Hospice providers failing to submit required data by April 2014 will be subject to 2% reduction
Rates DO NOT reflect impact of 2% sequester
**Hospice Payment Trends**

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<tr>
<th></th>
<th>FY2013</th>
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<th>FY2015</th>
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<tr>
<td>Hospital MB</td>
<td>2.6%</td>
<td>2.5%</td>
<td>2.9%</td>
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<td>MINUS ACA Productivity</td>
<td>0.7 ppt</td>
<td>0.5 ppt</td>
<td>0.5 ppt</td>
</tr>
<tr>
<td>MINUS ACA MB reduction</td>
<td>0.3 ppt</td>
<td>0.3 ppt</td>
<td>0.3 ppt</td>
</tr>
<tr>
<td>MINUS BNAF 4th/5th/6th</td>
<td>0.6 ppt</td>
<td>0.6 ppt</td>
<td>0.6 ppt</td>
</tr>
<tr>
<td>Minus Addl Wage Changes</td>
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<td>0.1 ppt</td>
<td>0.1 ppt</td>
</tr>
<tr>
<td>NET IMPACT on Rates</td>
<td>0.9%</td>
<td>1.0%</td>
<td>1.4%</td>
</tr>
<tr>
<td>LESS SEQUESTER</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>FINAL IMPACT on Rates</td>
<td>MINUS 1.1</td>
<td>MINUS 1.0</td>
<td>MINUS 0.6</td>
</tr>
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</table>

**Payment Reform – CMS’ Charge**

The Affordable Care Act – Section 3132
The Secretary shall collect additional data and information…to revise payments for hospice care

* Not earlier than 10/2013, the Secretary shall implement revisions to the methodology for determining the payment rates for routine home care and other services...as the Secretary determines appropriate

* Revisions may include adjustments to per diem payments reflecting changes in resource intensity during the course of the entire episode of hospice care

* In first year, revisions must result in same estimated amount of aggregate expenditures as would have been made if the revisions had not been implemented (budget neutrality)
Payment Reform

- FY2014 proposed/final payment rule – first insights into CMS’ thoughts on payment changes

- FY2015 proposed/final payment rule – data behind CMS’ direction on payment reform – the WHY of payment changes CMS is contemplating and regulatory initiatives

Payment Reform

TIMING for payment reform – unclear

CMS has renewed contract with Abt Associates

Continuing work on payment reform will utilize data from following sources:

- Additional data on claims (CR 8358)
- New Cost Report data (first avail. April 2016)
- Extension of existing analyses
**TIERED PAYMENT MODEL**

<table>
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<tr>
<th>Payment model</th>
<th>Group 1: days 1 through 5 -- implied weight: 2.30</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Group 2: days 6 through 10 -- implied weight: 1.11</td>
</tr>
<tr>
<td></td>
<td>Group 3: days 11 through 30 -- implied weight: 0.97</td>
</tr>
<tr>
<td></td>
<td>Group 4: day 31 or later -- implied weight: 0.86</td>
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</tbody>
</table>

Group 5: last 7 days of a beneficiary’s lifetime length of stay. Beneficiary receives visiting service - nursing, aide, MSS, therapy - during the last 2 days of life if the last 2 days of life are RHC or the last 2 days of life are not RHC. Implied weight: 2.44

Group 6: last 7 days of a beneficiary’s lifetime length of stay. Beneficiary does NOT receive visiting service - nursing, aide, MSS, therapy - during the last 2 days of life. Last 2 days of life are RHC. Implied weight: 0.91

Group 7: RHC care when the beneficiary’s lifetime length of hospice is 5 days or less, each day of hospice is RHC. Implied weight: 3.64

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**Rebasing of RHC**

- 10% reduction ($1.6 B.); budget neutral in first year

**Site of service adjustment for hospice care provided in nursing facilities (NFs)**

Reduction in payment for hospice care provided in NFs; presumably in same range as MedPAC has suggested (3-5%)

**Inpatient respite**

Use of SNF Resource Utilization Groups (RUGs) – correspond/account for more than 72% of hospice SNF/NF days; two potential routes – would increase IRC rate by factor of 1.2 – 2.9 or 1.3 – 1.9

**Future activity**

- MORE tiers?
- Episodic-based model?
- Other levels of care?
Payment Reform – Data Sources

Additional Data on Claims – CR8358/April 1, 2014

☆ Key areas of concern (particularly under GIP):
  ☆ Injectable prescription drugs
  ☆ Non-injectable prescription drugs
  ☆ Infusion pumps and medication refills

MAC guidance/Q & A, tables for drug and pump reporting

Payment reform – CHARGES!

Payment Reform – Data Sources

Cost Report Overhaul
• CMS 1984-14 effective for cost reporting years beginning on/after Oct. 1, 2014
• Freestanding hospices; others to come
• Direct patient care costs by LEVEL OF CARE
• New General Cost centers

Need to:
☆ Expand Chart of Accounts
☆ Educate and enlist staff
☆ Assess and assess/utilize IT capabilities
Payment Reform FY2015

“An initial step of hospice payment reform in this proposed rule is to clarify and enforce hospice payment policy, when necessary, in order to safeguard beneficiaries and the Medicare hospice benefit.”

Payment Reform: Research Findings

VISITS AT THE END OF LIFE

* 28.9% of patients received no skilled visit on day of death
* 14.4% received no skilled visit last 2 day of life
* 6.2% received no skilled visits in last 4 days of life
* Short stay (5 days or less) – 10.3% received no visits on last 2 days of life
* Long stay (181 days or longer) – 15.9% received no visits on last 2 days of life
* 34 hospices – provided NO skilled visits during last 2 days of life for any decedents

IMPLICATIONS: Payment reform (tiers), S & C
Payment Reform: Research Findings

LEVELS OF CARE: Are all levels of care being provided when warranted?

GIP:
- 22.7% hospice beneficiaries had at least 1 GIP day in 2012
- 77.3% of beneficiaries had no GIP in 2012
- 21.1% hospices provided NO GIP to anyone

CHC:
- 0.42% of hospice days are CHC
- 42% of hospices billed at least 1 day of CHC
- 46% of ALL CHC days were delivered by 40 hospices

IRC:
- 3.4% of beneficiaries receive IRC
- 26 hospices provided NO respite at all

IMPLICATIONS: Referrals to S & C, Program Integrity

Payment Reform: Research Findings

LIVE DISCHARGES

- From 2000 to 2012, live discharges increased from 13.2% to 18.1%
- 71 hospices had live discharges on 100% of patients (ALOS 193 day)
- Troubling patterns of hospice discharge/hospital admission/immediate readmission to hospice

IMPLICATIONS: Referrals to Office of Financial Management and Program Integrity
SPENDING OUTSIDE OF HOSPICE: More than $1 billion in CY2012 for “non-hospice” care delivered to beneficiaries

- Part D: $340 M.
- Inpatient: 224 M.
- Physician/supplier: 202 M.
- Outpatient: 122 M.
- DME: 48 M.
- SNF: 41 M.
- Home Health: 32 M.

(MedPAC data; comparable findings by CMS)

SPENDING OUTSIDE OF HOSPICE: Additional issues

- During CY2010 and 2011-- $268.4 M spent for ER/Observation stays for 8.8% of beneficiaries; some with multiple admissions
- Part D – CMS notes that hospice costs for prescriptions (from cost report) trend downward from $20/patient day in 2004 to $11/patient day in 2011
- ABT reported $99 M of $350 M drugs covered under Part D strong likelihood of hospice responsibility
Addressing Non-hospice Spending: Part D

* Fall 2013 – recoupment for 2011/2012 analgesics
* Dec. 2013/March 2014 -- Preliminary and “Final” Guidance on prior authorization for all drugs processed through Part D for patient on hospice care
* July 2014 Revised Final Guidance (effective Oct. 1, 2014); prior authorization for:
  * Anti-inflammatory
  * Anti-emetic
  * Anti-anxiety
  * Laxatives

Addressing Non-Hospice Spending: Part D

* Oct. 3 -- Prior authorization form in PRA process (60 day comment period)
* CMS Action – NOE/NOTR
Addressing Non-Hospice Spending: Hospital Inpatient

- CR 8273/ Nov. 7, 2013-- Informational Unsolicited Response (IUR) or Denial of Inpatient Services Related to a Hospice Terminal Diagnosis (April effective date)

- If principal diagnosis on hospital claim is a hospice diagnosis, hospital payment will be denied/recouped (three year lookback)

- Rescinded but will be reissued

- MAC reviews of hospital care for “relatedness/unrelatedness”

Addressing Non-Hospice Spending: Physician Services

- CMS Concerns:
  - Hospices assigning or changing attending;
  - CY2010/2011 data – 35% of hospice beneficiaries had claims submitted by more than one physician acting as “attending”;
  - Insufficient understanding of meaning of “attending” for hospice purposes

- CMS action – Attending Physician requirement

- Potential conflict between physician payment policies re hospice attending and hospice CoPs

- Patient not required to change attending when entering GIP – if attending does not have privileges or is not available, CoPs require that medical director takes on role of attending

- Physician, hospital education needed
Hospice Diagnosis Coding

- CMS Correct Coding Initiative
- Hospice responsible for all care/treatment that is reasonable and necessary for the palliation and management of the terminal condition and any related conditions
- CMS data: Use of single diagnosis -- CY2012 – 72% of claims; FY2013 – 67% of hospices; CMS will continue to monitor
- July 2012 per CMS – nature of hospice indicates that terminal/related conditions should be specified

Hospice Diagnosis Coding

CR 8877

For services delivered on/after Oct. 1, 2014, hospices may not use following as principal diagnosis on hospice claim:

- Debility (799.3 and 780.79)
- Adult failure to thrive (783.7)
- Codes listed in Attachment A of CR8877
- Codes classified in the Medicare Code Editor as “manifestation” codes (latest version is v. 31-0, Oct. 2013)
Diagnosis Coding Tips

* Physician provides diagnoses, but OK for coders/billers to establish appropriate codes
* Add a compliance audit(s) for the ICD-9/ICD-10 CM coding guidelines
* Dementia a PARTICULAR challenge

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Diagnosis Coding Tips

- Are you providing multiple diagnoses on claims? Include ALL appropriate diagnoses that describe a patient’s terminal condition and related conditions on claims
- Abandon “cheat sheets”/reliance on “hospice diagnoses”
- Identify instances of use of manifestation codes as principal diagnosis/find alternatives
- **Ensure ongoing adherence to coding guidelines/rules; if complexities are not understood, staff should have training**
- Rely on assessing combined impact of existing related diagnoses to establish prognosis – physician education
Hospice Aggregate Cap

* MedPAC/CMS have tracked data on hospices that exceed aggregate cap. CMS found:
  
  - 2006 – 9.1%
  - 2009 – 12.8%
  - 2011 – 10.5%
  - 2012 – 11.6%

* Percent of over cap hospices trending upward; so is percent of hospices approaching cap

* Characteristics of over cap hospices: Predominantly for-profit; VERY long length of stay; VERY high profit margin (before repayment)

Hospice Aggregate Cap

* Historically MACs alert hospices of cap liability between 16-24 months after close of cap year

* Congressional, other concerns that overpayments are significantly delayed or go unrecouped

* CMS FY2015 Hospice Wage Index/Payment Rule:
  
  - Effective for the 2014 and subsequent cap years, each hospice must calculate its aggregate cap
  - Calculation made NO SOONER than 3 months following close of cap year (Jan. 31)
  - Cap calculation must be provided NO LATER than 5 months following the close of the cap year (March 31)
  - Use pro forma spreadsheet supplied by CMS
Hospice Aggregate Cap

* MACs will issue final cap determination at later date

* Cap/Sequester interface – 2013 Cap year – some determinations may be recalculated!!

* Cap historically has been updated annually by the BLS medical expenditure category of the Consumer Price Index for all Urban Consumers (CPI-U)

* Beginning with accounting years starting on or after Sept. 30, 2016 (until Oct. 1, 2025) the aggregate cap will be updated by the net hospice market basket index (result of IMPACT Act of 2014)

<table>
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<th>Year</th>
<th>Cap Value</th>
<th>CPI-M(U)</th>
<th>Net MB</th>
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<tr>
<td>2011</td>
<td>$24,527.69</td>
<td>2.73%</td>
<td>2.60%</td>
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<tr>
<td>2012</td>
<td>$25,377.01</td>
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<td>3.00%</td>
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<td>2013</td>
<td>$26,157.50</td>
<td>3.08%</td>
<td>1.60%</td>
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<tr>
<td>2014</td>
<td>$26,725.79</td>
<td>2.17%</td>
<td>1.70%</td>
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</table>
IMPACT Act – HR 4994

Uniform assessment instrument for post-acute care providers; data for future payment changes; signed by President on Monday, Oct. 6

HOSPICE PROVISIONS:
* Frequency of hospice surveys
  * At least every 36 months for the next 10 years (Sept. 30, 2025)
* Correction to ACA medical review provision targeting hospices with high proportion of long stay (180+ days) patients
* Changes to the hospice aggregate cap calculation methodology (10 years)
  * Annual update tied to the market basket
  * Slower growth rate

Hospice: Future Considerations/Concerns

What is the hospice bundle? CMS: “It is our general view that hospices are required to provide virtually all the care that is needed by terminally ill patients. Therefore, unless there is clear evidence that a condition is unrelated to the terminal prognosis, all services would be considered related. It is also the responsibility of the hospice physician to document why a patient’s medical needs would be unrelated to the terminal prognosis.”

DEFINITIONS:
- Terminal Illness
- Related Conditions
MedPAC 2014 Report

2014 Recommendations – Require Congressional action
* FY2015 payment – flat update
* Eliminate carve-out for hospice under Medicare Advantage beginning 2016

Continues to look at:
* Hospice in NF
* Length of Stay
  * ALF patients – highest average LOS
  * In 2011 – Medicare spent $7.9 B. on hospice care for beneficiaries whose lengths of stay exceeded 180 days
    * $2.7 B. on days 1-180
    * $5.2 B. on days 181 and over

CMMI RFI Private Plans

* RFI issued on Oct. 2 seeking input on initiatives to test innovative Medicare/Medicaid private plan models
  http://innovation.cms.gov/initiatives/HPI/
* Medicare: Includes request for input on MA and MA-PD plans that incorporate hospice and curative care
  * What factors should CMS consider in developing model that includes hospice/curative care (quality, outcomes metrics, beneficiary protections, etc.)?
  * How much lead time do plans need to prepare bids?
* Medicaid –
  * Would you recommend that CMS implement a Medicaid managed care model test in any of the areas listed below?
    Hospice, LTSS, ACOs
Office of the Inspector General

OIG Work Plan 2014

* General Inpatient Care – (Ongoing) Assess appropriateness of hospice general inpatient care use

* Hospices in ALFs – (New) Analyze length of stay, levels of care received, and common terminal illnesses of beneficiaries who receive hospice care in ALFs

Resources/Links


* CR 8877 -- NAHC Resources http://www.nahc.org/advocacy-policy/hospice-regulatory-issues/

Resources/Links


Resources/Links

* Hospice quality reporting program web
  * www.hospicecahpsurvey.org
Resources/Links

- FY2015 Hospice Final Rule

- FY2014 Hospice Final Rule

Resources/Links

- Abt May 2014 Technical Report

- Abt April 2012 Technical Report
Resources/Links

★ S&C Letter 13-23 ALL (Sequestration)

★ S&C Letter 13-27 Deemed providers (complaints)

Resources/Links

★ S&C Letter 14-02 ALL (government shutdown)

★ S&C Letter 14-04 ALL (government shutdown)
Resources/Links

* S&C Letter 14-12 ALL (emergency preparedness)

* S&C Letter 14-36 ALL (infection control)

Resources/Links

* Chronic Care Management codes – Physician Fee Schedule 2015
  * [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-P.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-P.html)

OIG Reports (Ohio) -
  * [https://oig.hhs.gov/oas/reports/region5/51200086.pdf](https://oig.hhs.gov/oas/reports/region5/51200086.pdf)
Resources/Links


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Resources/Links

- Hospice quality reporting program
  - [www.hospicecahpsurvey.org](http://www.hospicecahpsurvey.org)