FREE WEBINAR - *Hospice*

The 2018 Hospice Proposed Rule

Understand and comment on the regulations that affect your agency

with

Beth Noyce,

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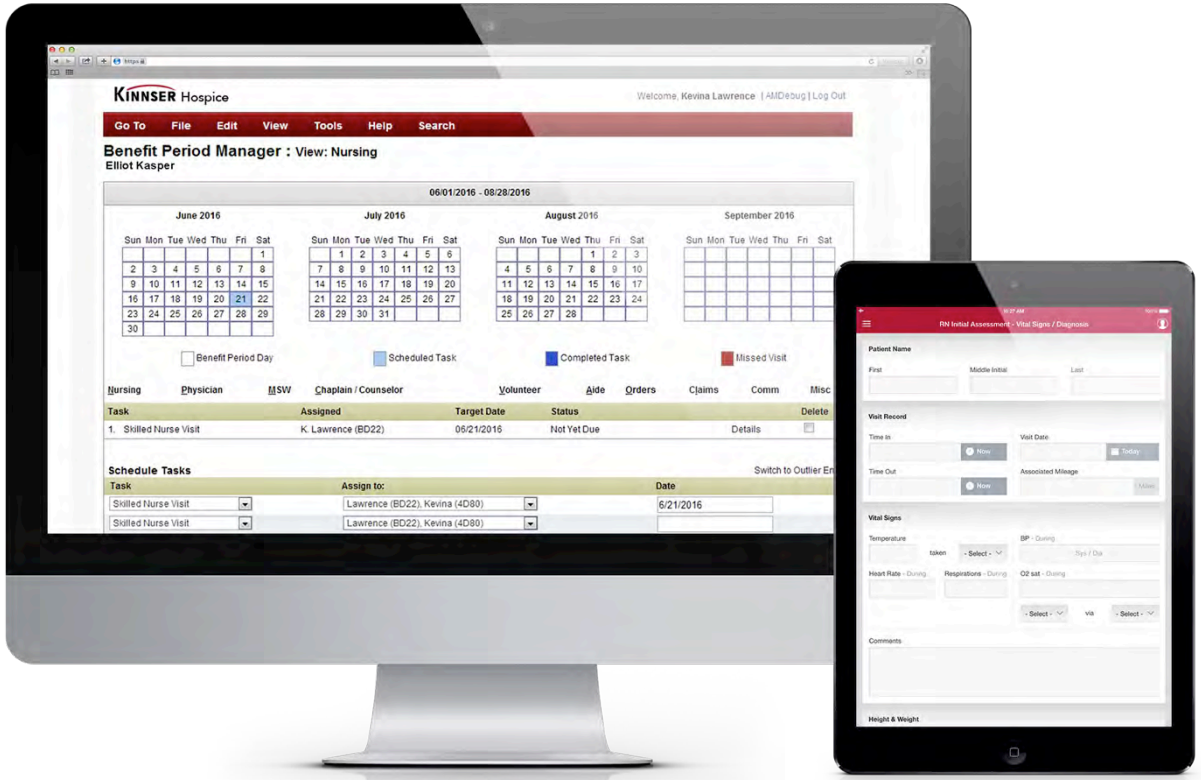

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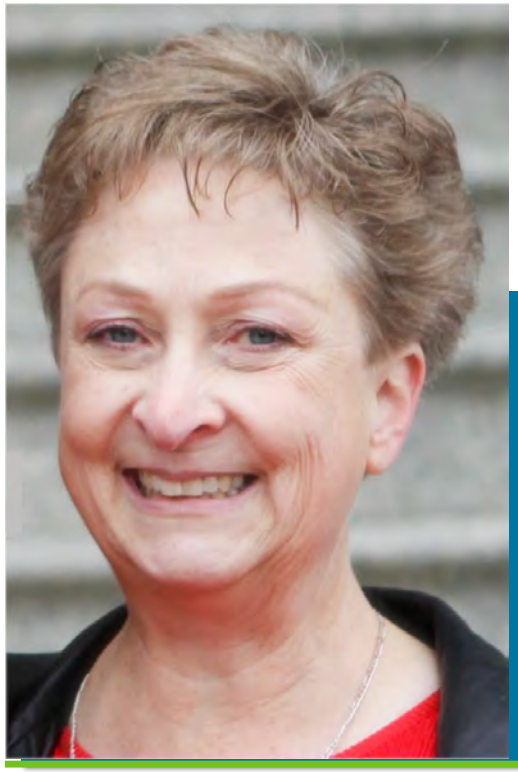

About the presenter

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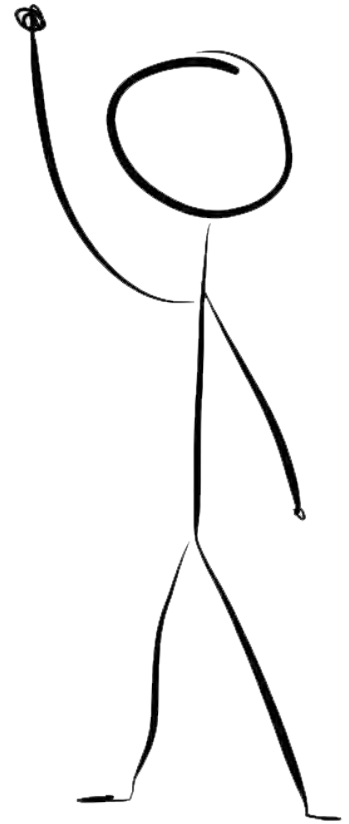
Your Chance to Be Heard

WHAT IS A PROPOSED RULE?

CMS Wants Your Opinion

The FY 2018 Hospice Proposed Rule seeks feedback/comments on proposed:

- Updates to the hospice wage index, payment rates, and cap amount for fiscal year (FY) 2018
- New quality measures for the hospice quality reporting program
- Enhanced data collection instrument
- Plans to publicly display quality measures and other hospice data



CMS Wants Your Opinion

FY 2018 Hospice Proposed Rule comments are due June 26, 2017.

- Time to tell CMS what hospices need.
- Comments can sway CMS's plans for final rule.

CMS Wants Your Opinion

Comments must be **received** by 5 p.m. on June 26, 2017, the close of the comment period.

- **Electronically**
  http://www.regulations.gov. Follow the "Submit a comment" instructions.
- **Regular postal mail**
  Centers for Medicare & Medicaid Services
  Department of Health and Human Services, Attention: CMS-1675-P
  P.O. Box 8010
  Baltimore, MD 21244-1850
- **Express or overnight mail**
  Centers for Medicare & Medicaid Services
  Department of Health and Human Services, Attention: CMS-1675-P, Mail Stop C4-26-05
  7500 Security Boulevard
  Baltimore, MD 21244-1850
- **By hand or courier**

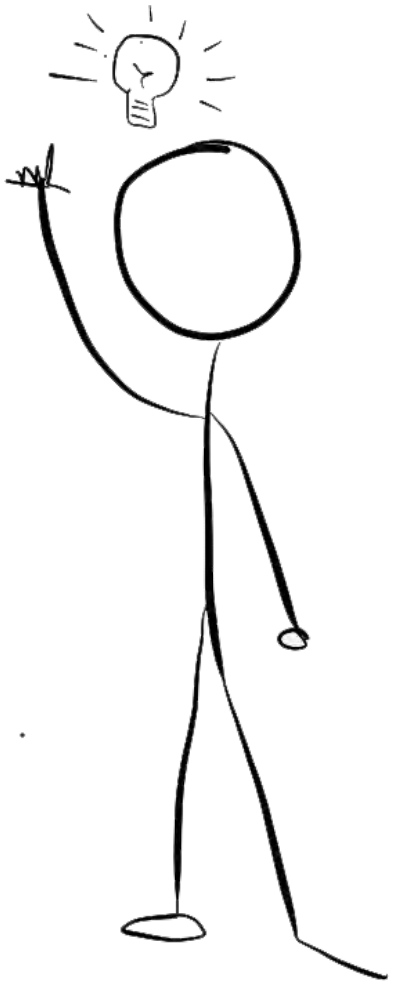
Join the Conversation

HOW TO ACHIEVE CMS TRANSPARENCY, FLEXIBILITY, SIMPLIFICATION & INNOVATION

Fishing for Feedback

To inform future hospice regulatory action, CMS wants ideas to better achieve:

- Transparency
- Flexibility
- Program simplification
- Innovation



Fishing for Feedback

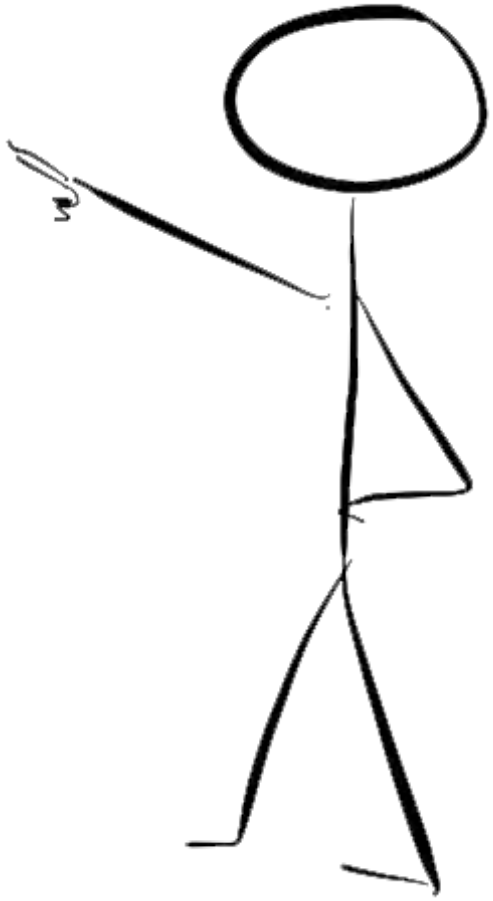
How can Medicare:

- Improve the health care delivery system?
- Decrease health care's bureaucracy and complexity?
- Reduce burden for clinicians, providers and patients?

Fishing for Feedback

CMS wants to:

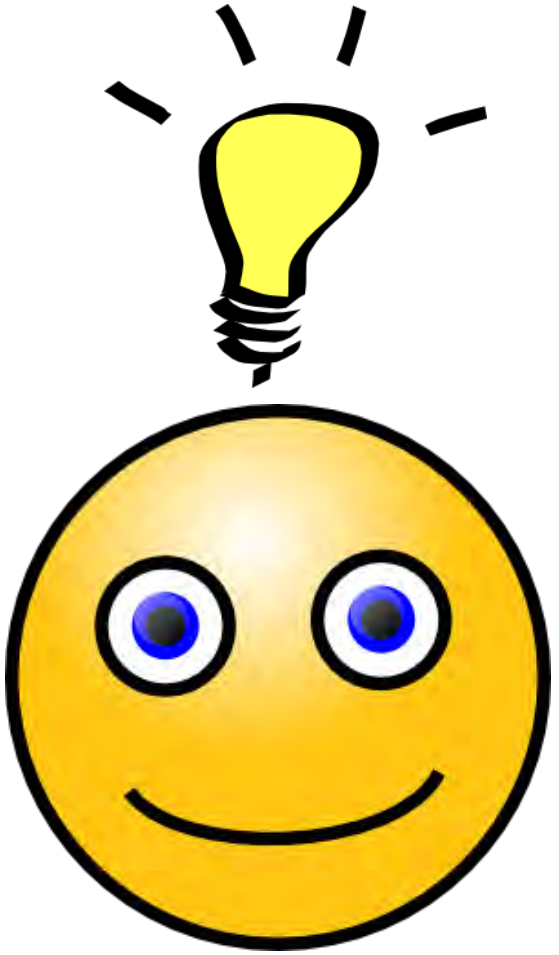
- Increase care quality and decrease costs
- Making the health care system more effective, simple, and accessible
- Maintain program integrity and prevent fraud



Fishing for Feedback

CMS wants regulatory, sub-regulatory, policy, practice and procedural ideas to better accomplish these goals, such as re-designing, eliminating, or stream-lining requirements for hospices'

- Payment system
- Reporting
- Monitoring
- Documentation



Fishing for Feedback

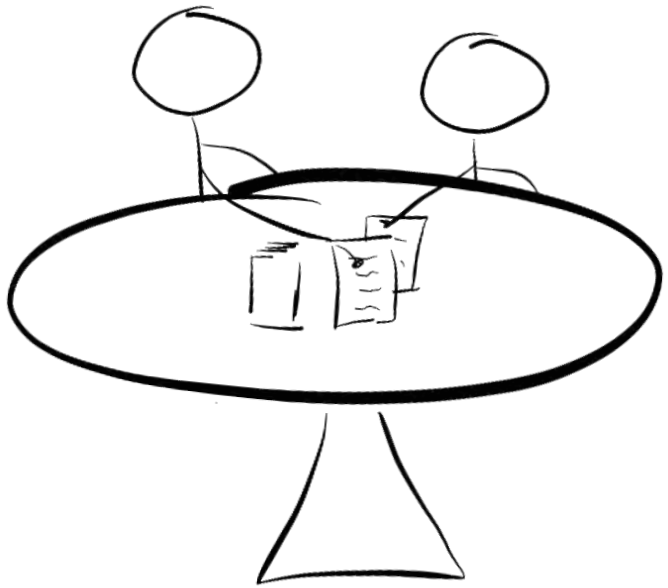
Medicare also solicits ideas to support the doctor-patient relationship in care delivery and facilitate patient-centered care within hospices through:

- Operational flexibility
- Feedback mechanism(s)
- Data sharing

Fishing for Feedback

Recommend to CMS:

- When and how to issue regulations and policies
- How to simplify rules and policies for beneficiaries, clinicians, providers and suppliers



Fishing for Feedback

- ✓ Proposals should be clear and concise and include data and specific examples.
- ✓ Analysis regarding CMS' authority is welcome if a proposal involves novel legal questions.
- ✓ CMS will actively consider all input in developing future regulatory proposals or future sub-regulatory guidance.

$180 Million More for Hospice

ROUTINE ANNUAL RATE SETTING CHANGES

1% Raise for Hospice

The Hospice market basket percentage increase for FY 2018 is 1%.

- About a $180 million increase

1% Raise for Hospice

1% maximum increase in rates as a part of MACRA for other Medicare providers, as well.

- In future years, absent congressional action, the hospice market basket increase will revert back to the market basket formula.

1% 2018 only

1% Raise for Hospice

The aggregate cap limits the overall payments made to a hospice annually, updated by the hospice payment update percentage.

- Cap amount for FY 2018 will be $28,689.04.
- Cap accounting year aligned with Federal Fiscal Year (10/1-9/30) for inpatient cap and hospice aggregate cap.

FY 2018 Proposed Rates

For Providers Submitting Quality Data:

Level of Care	FY2017 Payment Rates	FY2018 Proposed Payment Rates
Routine Home Care (Days 1-60)	$190.55	$192.80
Routine Home Care (Days 61+)	$149.82	$151.41
Continuous Home Care (Hourly rate)	$40.19	$40.68
Inpatient Respite Care	$170.97	$172.78
General Inpatient Care	$734.94	$743.55

For Providers that DO NOT Submit Required Quality Data:

Level of Care	FY2017 Payment Rates	FY2018 Proposed Payment Rates
Routine Home Care (Days 1-60)	$190.55	$188.98
Routine Home Care (Days 61+)	$149.82	$148.41
Continuous Home Care (Hourly rate)	$40.19	$39.88
Inpatient Respite Care	$170.97	$169.36
General Inpatient Care	$734.94	$728.83

SIA Budget Neutrality Factor (SBNF)

- CMS used data from FY2016 to adjust the FY 2018 rates, based on the utilization of SIA
- Adjustment is to comply with budget neutrality
- Two offsets applied to the routine home care rate:
  - Days 1-60: 1.0018
  - Days 61+: 1.0005

Hospice percentage of days by level of care (FY 2016):

RHC	98.02%
GIP	1.40%
CHC	0.27%
IRC	0.10%

Live Discharges and Length of Stay

- Average lifetime length of stay was 113.5 days in FY 2015 when level of care at admission is RHC
- Median total live discharge rate remains around 17%
- Of that number:
  - 38% were beneficiary revocations
  - 51% were discharged because the beneficiary was considered no longer terminally ill
  - 11% were discharged due to a beneficiary transfer to another hospice
- CMS states: "Overall, our analyses do not reveal any anomalies in lengths of stay and rates of live discharges at this time."

Skilled Visits at End of Life

FY2016 patients when death was imminent:

- 43.6% received a skilled visit (RN or MSW) on any given day in the last 7 days of life
- 21% received no skilled visit on day of death
- Insignificant change from before SIA and two-level routing home care rates

Costs Hospices Didn't Cover

Parts A and B: FY 2012 to FY 2016, non-hospice spending declined 25%.

- FY2012: $748 million
- FY2016: $534 million

CMS states monitoring continues on still-too-high amount.

Costs Hospices Didn't Cover

Part D: FY 2012 to FY 2016, non-hospice spending increased.

- FY2012: $331.3 million
- FY2016: $347.5 million

Costs Hospices Didn't Cover

CMS is concerned about:

- Hospices not covering common palliative and other disease-specific drugs for hospice
  - Though CMS is pleased with decreased Part D spending on analgesics, anti-nauseants, anti-anxiety, laxatives.
  - Prior authorization has kept this in check.
- Increased Part D spending for maintenance drugs

Costs Hospices Didn't Cover

Drugs for maintenance/to treat or cure a condition:

- Typically discontinued as care shifts to palliation and comfort measures
- Appropriate to **continue for symptom relief for palliation and management of the terminal illness and related conditions**

Costs Hospices Didn't Cover

Maintenance drugs that are continued are:

- **Covered under the hospice benefit, not Part D**
- For example, to treat:

  High blood pressure | Heart disease

  Asthma | Diabetes
- Examples include:

  Beta blockers | Calcium channel blockers

  Corticosteroids | Insulin

Certificate of Terminal Illness (CTI) Documentation Changes

FACE-TO-FACE ENCOUNTERS AT ADMISSION/
REFERRAL SOURCE TO VERIFY CTI?

CTI Changes

Proposed:

- Specify that the referring physician's and/or the acute/post-acute care facility's medical record would serve as the basis for initial hospice eligibility determinations.
  - Obtained by the hospice **prior to election of the benefi**t, when determining certification and subsequent eligibility.

CTI Changes

CMS:

- 2006 Hospice Wage Index final rule (70 FR 70538), we received comments stating that it is common practice for hospices to obtain clinical information from the referring physician, which is then documented in the patient's hospice medical record.
  - (No additional burden?)

CTI Changes

CMS:

- "Longstanding expectation" that the referring physician/acute/post-acute care facility's clinical documentation serves as the basis of the certification of terminal illness.
- Such records would be obtained **prior to election of the benefi**t, when determining certification and subsequent eligibility.
  - Patient admission would wait.

CTI Changes

This potential clarifying regulatory text change would be in alignment with benefit eligibility criteria that the individual **must be certified as terminally ill prior to receiving hospice services, and fundamentally could not be determined by hospice documentation obtained after admission**.

CTI Changes

CMS:

"Any information regarding the patient's health status from hospice staff (for example, registered nurses) should not be the sole documentation used to support the initial certification requirement as the patient has yet to meet the eligibility requirement."

CTI Changes

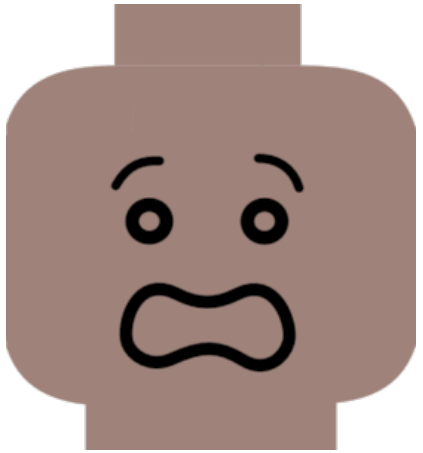
Proposed:

- Documentation of an in-person visit (Face-to-Face encounter) from the hospice Medical Director or the hospice physician member of IDG could be used as documentation to support initial hospice eligibility determinations, **only if needed to augment the clinical information from the referring physician/ facility's medical records.**

CTI Changes

CMS:

"Face-to-Face encounter with a hospice physician or allowed non-physician practitioner is not required until the third election period and each subsequent recertification thereafter. Consequently, a patient may never be seen by the hospice physician who is certifying that he or she is terminally ill."



CTI Changes

Comments on **current processes** used by hospices to ensure comprehensive clinical review to support certification and **any alternate suggestion**s for supporting clinical documentation sources are also encouraged.

Reviewing Family Satisfaction

8 NEW CAHPS® MEASURES

CAHPS®

- Proposed:
  - Measure calculations based on the survey data for display on Hospice Compare.
- Find more about the CAHPS® at the survey website, **www.hospicecahpssurvey.org**
  - **C**onsumer **A**ssessment of **H**ealthcare **P**roviders & **S**ystems

CAHPS®

- Hospice CAHPS® survey will compare hospices nationally, once publicly reported.
- CMS believes:
  - The data will help beneficiaries and their families to select a hospice program.
  - Public reporting of survey results will encourage hospices to improve quality.

Medicare.gov | Hospice compare
The Official U.S. Government Site for Medicare

CAHPS®

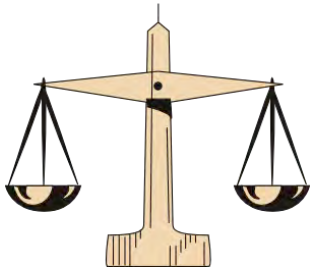
CAHPS risk-adjusted for:

- **Decedent and caregiver characteristics** known as systematic differences in survey responses, not directly related to hospice performance.
- **Patient Mix/Mode Adjustment:** CMS also plans to adjust CAHPS survey responses for differences in patient mix and the mode that is used to survey caregivers (mail, phone, or mix).

CAHPS®

Risk Adjustment for elements out of the hospice's control:

- Lag time between patient death and survey response
- Decedent's age
- Payer for hospice care
- Decedent's primary diagnosis
- Decedent's length of final episode of hospice care
- Caregiver's education
- Decedent's relationship to a caregiver
- Caregiver's preferred language and language in which the survey was completed
- Caregiver's age



CAHPS®

Proposed:

- Penalties for the Hospice CAHPS Survey for the FY 2020, FY 2021, and FY 2022 annual payment updates
- The Hospice CAHPS® Survey is a component of the Hospice Quality Reporting Program

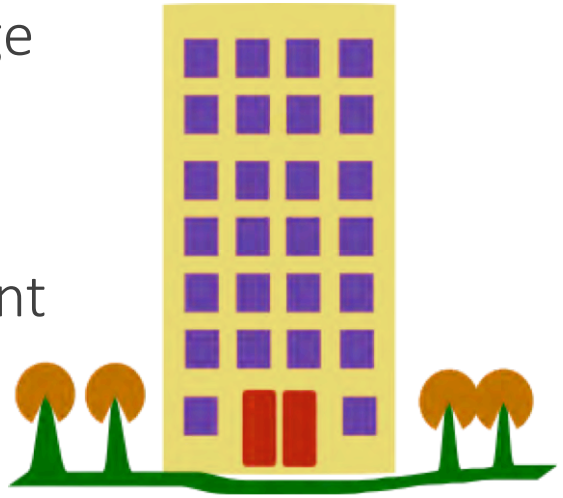
New Targeted Study Areas

CLAIMS-BASED MEASURES UNDER CONSIDERATION AND DEVELOPMENT

New Hospice Priority Areas

CMS is developing claims-based measures to study and address two high-priority issues:

- **Potentially avoidable hospice care transitions**
  - Encourage hospice providers to assess and manage patients' risk of care transitions.
- **Access to levels of hospice care**
  - Assess the rates at which hospices provide different levels of hospice care.



Potentially Avoidable Transitions

Reduce potentially avoidable transitions at the end of life:

- Burdensome to patients, families and the health care system
- Associated with:
  - Adverse outcomes
  - Lower patient and family satisfaction
  - Higher costs
  - Fragmentation of care delivery

Access to Hospice Care Levels

Focus on the provision of Continuous Home Care (CHC) and General Inpatient (GIP) levels of care.

- Measuring use of levels of care will incentivize hospice providers to continuously assess patient and caregiver needs and provide the appropriate level of care to meet these needs.

Access to Hospice Care Levels

- Average lifetime length of stay when the level of care at admission was routine home care (RHC):
  - FY 2015 – 113.5 days
  - FY 2016 – 114 days
- Patients admitted to hospice at other levels of care have overall shorter lengths of stay, an indication of greater acuity overall.

HEART
Patient-Assessment Tool

QUALITY MEASURE CONCEPTS UNDER CONSIDERATION FOR FUTURE YEARS

HEART Patient-Assessment Tool

Proposal:

- HEART patient-assessment tool to evolve from HIS
  - **H**ospice
  - **E**valuation &
  - **A**ssessment
  - **R**eporting
  - **T**ool
- More in line with other post-acute care settings

HEART Patient-Assessment Tool

HEART would capture valid and reliable information for:

- Patient assessment
- Care planning
- Service delivery

HEART Patient-Assessment Tool

Hospice clinicians will gather data at:

- Admission
- Discharge
- Potentially at other time points

HEART Patient-Assessment Tool

CMS:

- Will report progress in developing HEART
- **Wants to hear input from hospice community**

HEART Patient-Assessment Tool

CMS's measure development contractor, **RTI International**, has begun preliminary HEART development activities to determine what to capture in a hospice patient assessment.

- Conducting environmental scans
- Engaging clinical experts

HEART Patient-Assessment Tool

RTI International is also:

- Posting a national provider call
- Forming a Clinical Committee comprised of hospice organizations from across the U.S. to participate in the early development of an assessment

HEART Patient-Assessment Tool

RTI International is also:

- Collaborating within CMS to assess various stakeholder needs and encourage collaboration within CMS and across other HHS agencies

HEART Patient-Assessment Tool

To learn more about HEART, please contact:

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ibroyles@rti.org

RTI International
3040 E. Cornwallis Road
PO Box 12194
Research Triangle Park, NC 27709-2194
USA

HEART Patient-Assessment Tool

- Provide the quality data necessary for HQRP requirements and the current function of the Hospice Item Set (HIS).
- Enable greater accuracy in quality reporting.

Medicare.gov | Hospice compare
The Official U.S. Government Site for Medicare

HEART Patient-Assessment Tool

Provide additional clinical data that could inform future payment refinements.

HEART Patient-Assessment Tool

Decrease provider burden.

HEART Patient-Assessment Tool

Help surveyors ensure hospices are meeting the Conditions of Participation and are providing high quality patient care.

HEART Patient-Assessment Tool

Would:

- Complement data collected as part of high-quality clinical care.
- Replace the current HIS.
  - Integrate elements into clinical assessment

HEART Patient-Assessment Tool

Would not replace:

- Existing Medicare Hospice CoP requirements
  - Such as initial and comprehensive assessment
- Other HQRP data collection efforts (that is, the CAHPS® Hospice Survey)
- Regular claims data submission

Hospice Compare

IMMINENT PUBLIC HOSPICE REPORTING.

Hospice Compare

CMS:

- Hospice Compare site to launch late summer 2017 to inform customer choice
- CAHPS Survey data to display on Hospice Compare in 2018

Medicare.gov | Hospice compare

The Official U.S. Government Site for Medicare

Hospice Compare

CASPER system allows provider preview of data prior to public display.

- Certification And Survey Provider Enhanced Reports
- On-demand: Providers can compare their performance to the national average for a reporting period of their choice.

Hospice Compare

HIS measures to display for 2017 Hospice Compare launch:

- Treatment Preferences
- Beliefs/Values
- Pain Screening
- Pain Assessment
- Dyspnea Screening
- Dyspnea Treatment
- Bowel Regimen

DATA FROM HOSPICE DISCHARGES
OCT 1 2015 – MARCH 31 2016

Hospice Compare

Providers can preview their confidential CASPER QM reports:

- Separate from public reporting, for provider quality improvement
  - Hospice-Level Quality Measure Report
  - Patient Stay-Level Quality Measure Report

References

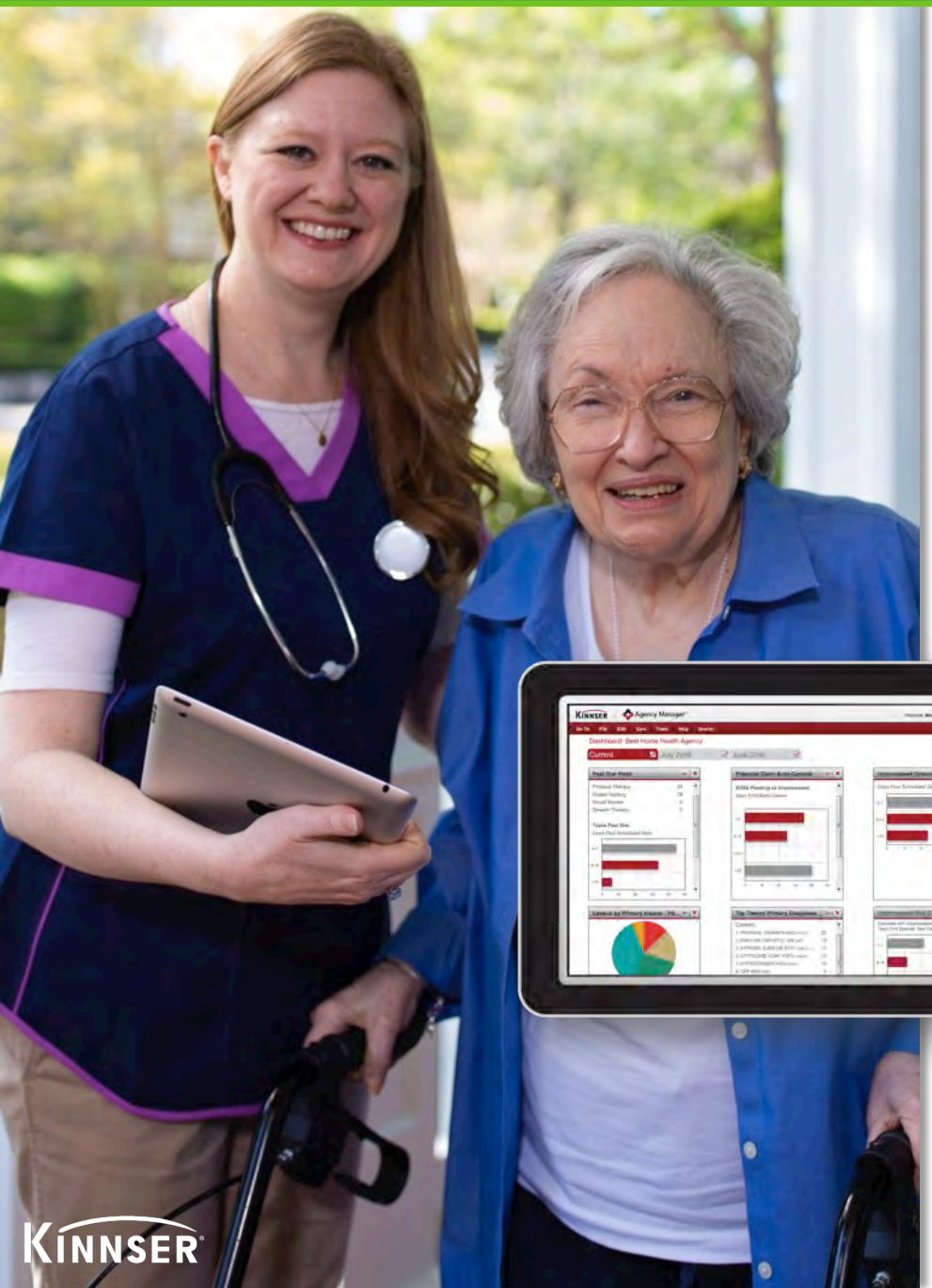
2018 Hospice Proposed Rule - https://www.gpo.gov/fdsys/pkg/FR-2017-05-03/pdf/2017-08563.pdf

CMS Proposes Updates to the Wage Index and Payment Rates for the Medicare Hospice Benefit for FY 2018, and Releases Request for Information - https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-04-27.html

CMS Hospice Center - https://www.cms.gov/Center/Provider-Type/Hospice-Center.html

NAHC *"CMS Posts FY2018 Hospice Payment and Quality Reporting Requirements Rule"* - http://www.nahc.org/NAHCReport/nr170427_1/

NHPCO Regulatory Alert - *"Details on the FY2018 Hospice Wage Index Proposed Rule"* NHPCO Health Policy Team, April 28, 2017



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