FREE WEBINAR SERIES
Hospice

The 2019 Hospice Proposed Rule:

Understanding Its Potential Impact on the Future of Hospice Care

with hospice clinical consultant and educator

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About the presenter

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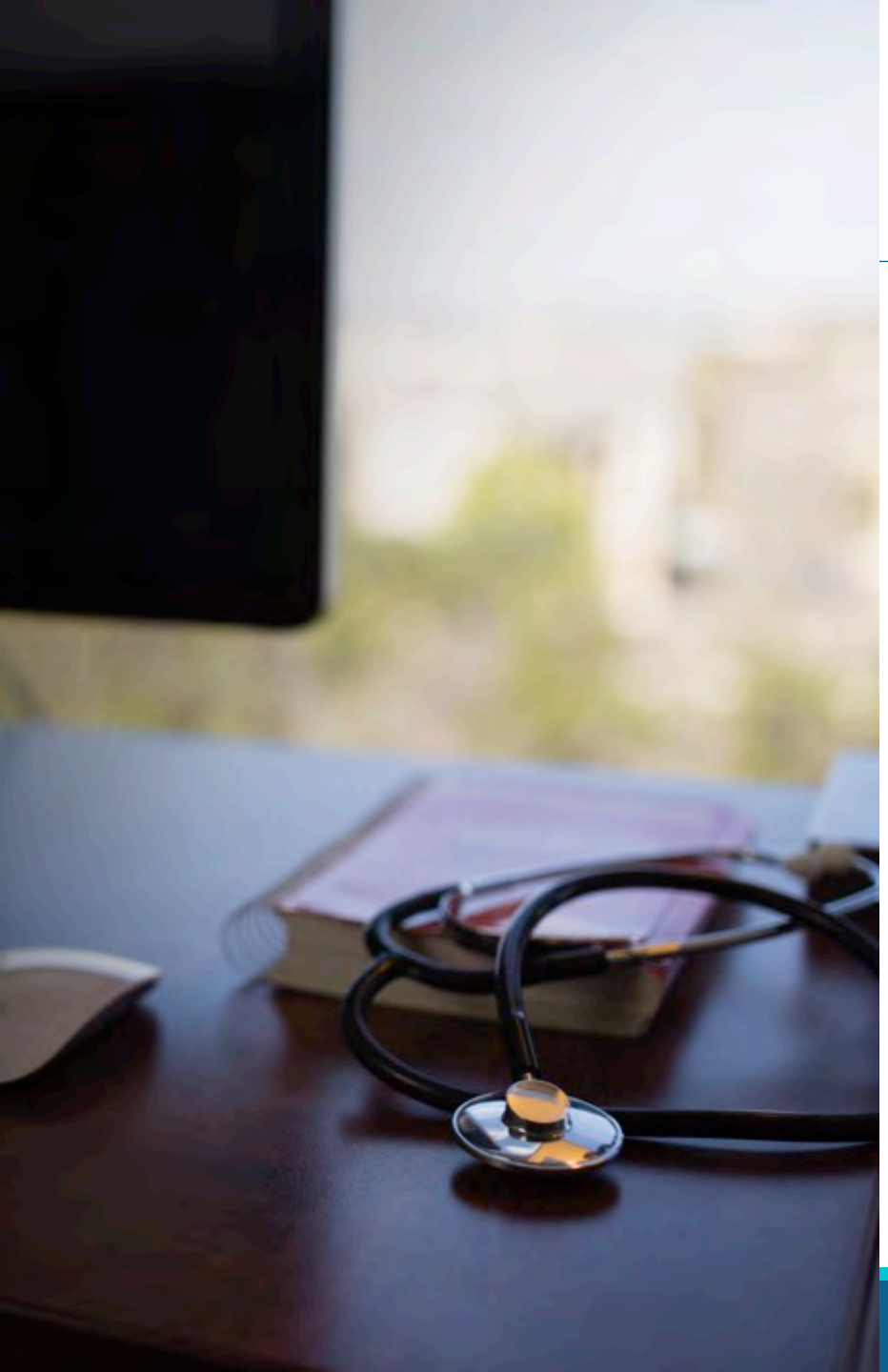

Objectives

1. Review of major changes to the hospice wage index
2. Identify updates to the HQRP to include data submission, CAHPS, and proposed changes in reporting outcomes
3. How using a physician assistant can impact hospice care
4. Updates to the HEART tool
5. Importance of giving feedback on the rule to affect positive change

Impact of the Proposed Rule

Breaks down into an estimated **$340 million** increase in payments to hospice during FY 2019

Cost Reports

Noted discrepancies in the submitted cost reports – about **66%** of submitted 2016 cost reports were missing at least one line of data that CMS considers **essential**.

Levels of Care Cost for All Hospice Days (based on 2017 claims)

- **RHC** - Makes up 98%. Medial cost was $125 with the per diem rate for FY 2016 at $161.89
- **CHC** - Makes up 0.28%. Medial cost was around $52/hr, but CHC payment in FY 2016 was $39.37/hr
- **GIP** - Makes up 1.38%. Medial cost was mid $800. The FY 2016 was $720.11
- **Respite** - Makes up 0.30%. Medial was about $300. The FY 2015 was $167.45

Wage Index Changes

Wage index is based on area wage levels of the closest hospital (hospital wage index) to the area. Based on urban or metro, the cost of services would be slightly different.

Proposed increases per LOC and cap for FY2019
100118-093019 will increase payment by 1.8%

RHC Day 1-60 = $196.25 (↑$3.47)
RHC Day 61+ = $154.21 (↑$2.80)
CHC = $998.77 (↑$22.35 for 24 hrs period) $40.68/hr to $41.62/hr

Inpatient = $176.01 (↑$3.23)
GIP = $758.07 (↑$14.52)
Cap = $29,205.44 (↑$516.40)
*****Oct 1 to Sept 30 cap year*****

Non-Compliant Agencies

Remember…

Agencies that do not comply with the submission requirements of quality data will be subject to a 2% reduction in payment, which means payment adjustments will be 1.8% minus 2% (-0.2% of 2018 rates).

Physician Assistants (PA)

No changes to §418.22

- Effective January 1, 2019, Medicare **will pay** for services provided by a Physician Assistant (PA) to patients who elect the hospice benefit and select a PA as their attending.

- PAs **cannot**:
  - Act as medical directors
  - Replace physicians of a hospice
  - Certify terminal illness
  - Perform Face-to-Face encounters

Length of Stay Stats - Year by Year

2017

Average Length of Stay (ALOS): **79.7 days**

2017 Lifetime Length of Stay: 96.2 days

2016

Average Length of Stay (ALOS): **79.2 days**

2015

Average Length of Stay (ALOS): **78.1 days**

More Hospice Facts and Figures

- Top neurological diagnosis was Alzheimer's/related dementias
- Longest average lifetime length of stay (LOS) by diagnosis was Parkinson's disease for 177 days
- Shortest average LOS by diagnosis was chronic kidney disease (CKD) and cancer (56.8-63 days)
- Average lifetime LOS across all levels of care was 96.2 days

Live Discharge
2017 Stats

16.7% of beneficiaries were live discharges

- 44% of those were revocations
- 45% were "no longer terminally ill"
- 9% were transfers

There has been a steady decrease from 2007 (22%) to 2017 (16.7%), but CMS will continue to monitor.

Service Intensity Add-on (SIA) Stats

Slight improvement from years past (but only slight)

- **42%** continue to not receive skilled visits (SN/SW) in last 7 days before death
- **20%** did not receive a skilled visit (SN/SW) on day of death
- More skilled visits on last day of death were performed by SN

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Medications and Medicare D

- The 2019 proposed rule has rehashed the old 1983 final rule saying that "virtually all" care would be provided by hospice.
- Analysis on Medicare D revealed that costs steadily increased from **$325 million in 2011** to **$380 million in 2017.**
- Increase Medicare D costs for "maintenance" drugs including: BP, heart disease, asthma and DM

Refer to the Hospice Conditions of Participation §418.25, 418.54, 418.56

Mandatory Reporting Requirements on Hospice Claims

CR8358 - *Hospice agencies shall report injectable and non-injectable prescription drugs on their claims. Both injectable and non-injectable prescription drugs should be reported on claims on a line-item basis per fill. Over-the-counter drugs are not to be reported at this time.*

- This is NO LONGER mandatory per CR10573 released April 27, 2018.
- Hospices have two choices now beginning **Oct 1, 2018:**
  1. Continue to report line item for medications
  2. Total aggregate drug and DME charges

The Hospice Quality Reporting Program (HQRP)

Intended to improve beneficiary outcomes by incentivizing providers to focus on care issues and make public data relate to these issues

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Meaningful Measures Initiative

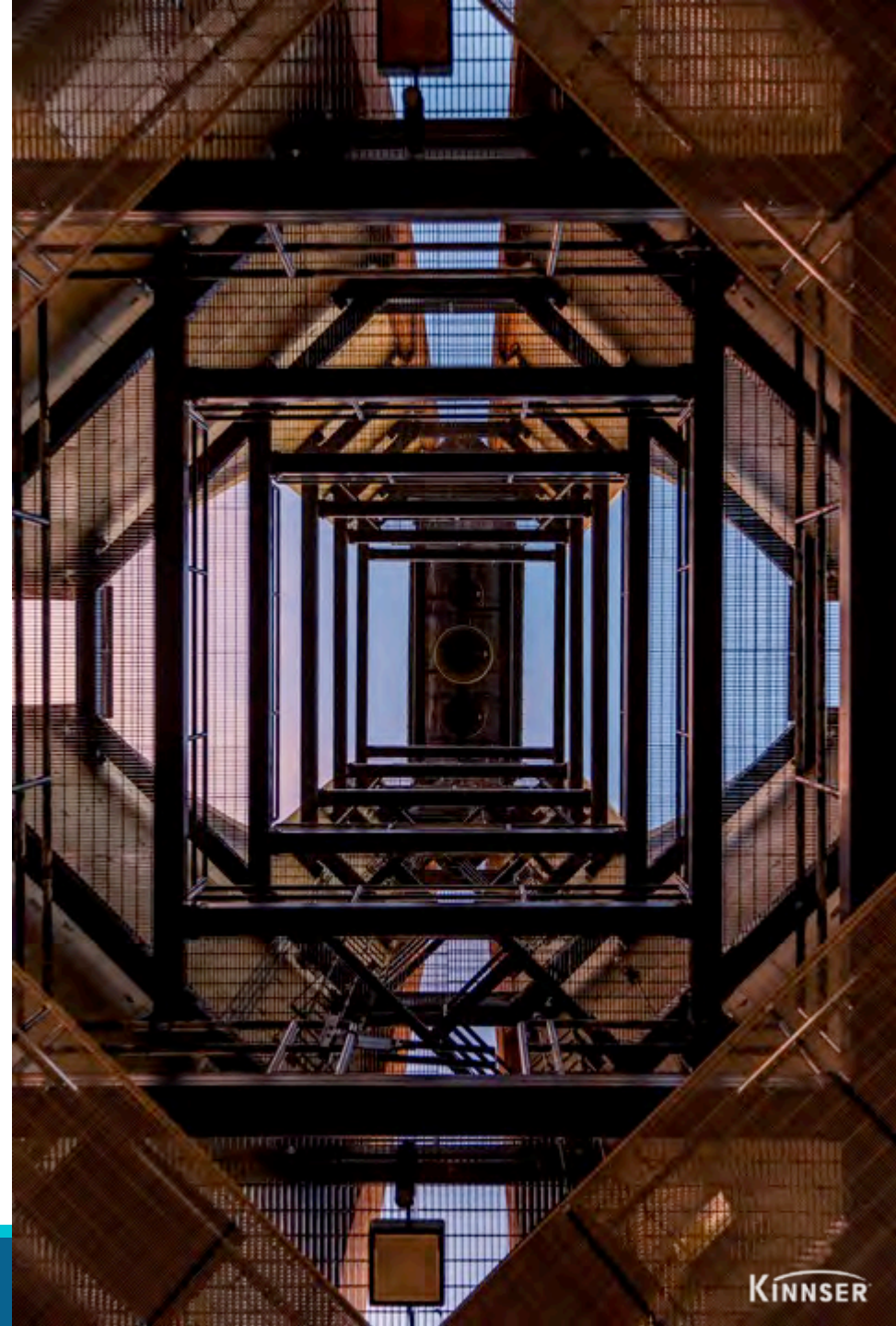
October 2017: CMS's aim is to evaluate and streamline regulation to decrease cost and burden, increase efficiency, and encourage beneficiaries' positive experiences by identifying quality measures to improve outcomes.

6 Quality Priorities

- Communication and coordination of care
- Treatment and prevention of chronic disease
- Use of best practice for healthy living
- Affordable care
- Prevent harm with delivery of care
- Increase the patient/family involvement in care

Framework of the Meaningful Measures Initiative

- Contains 19 meaningful measures areas
- Patient is at the center of all measures
- This framework connects all the goals that CMS feels are high priorities.



HQRP Overview

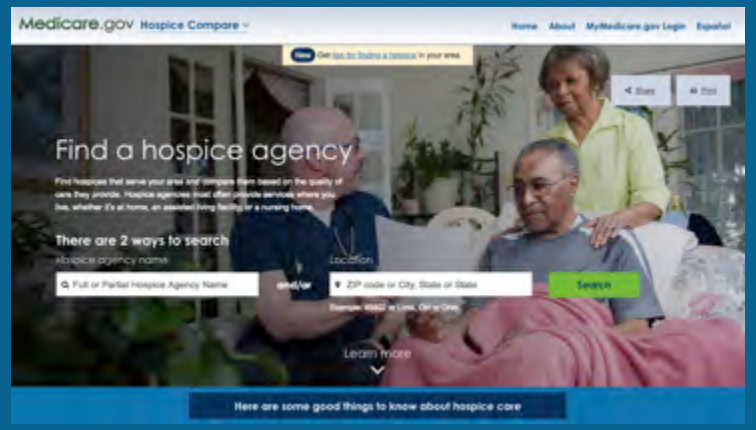
- Data was intended to be easily interpreted by beneficiary and assist in choice of provider
- Provide data in the least burdensome manner
- Incentivize improvement in care

Changes/Clarifications of HQRP

- Continue capturing the seven NQF endorsed measures along with the two new ones from 2017 (no new measures)
- The timeframe of HIS **corrections** (not submissions) will change from 36 months to 4.5 months from end of each quarter. This means HIS data submitted in Q1 2019 will be able to be changed/modified until August 15, 2019 for accurate public reporting.
- Last two endorsed measures regarding death and number of visits at end of life will be publicly reported in 2019

Format changes on **Hospice Compare**

Beginning Fall 2019



- Component measures will now be viewable in expandable format
- Composite measure will only show up above the new format (NQF# 3235)
- Addition of the Public Use File (PUF) information (Ex: # days hospice provided RHC, % of primary dx, etc)
- Any agency with 20 or more HIS submissions will be reported publicly

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Requirements for **CAHPS®** 2023-2025

- Submission on monthly basis from Jan 2021 through December 2021 to receive full payment for FY2023 and then every year after
- Exemption for newness still applies

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Your input matters

CMS wants your feedback on this proposed rule no later than 5:00PM **EDT June 26, 2018.**

Electronic submissions
http://www.regulations.gov)

Regular mail
Centers for Medicare & Medicaid Services,
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Attention: CMS-1692-P, P.O. Box 8010
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