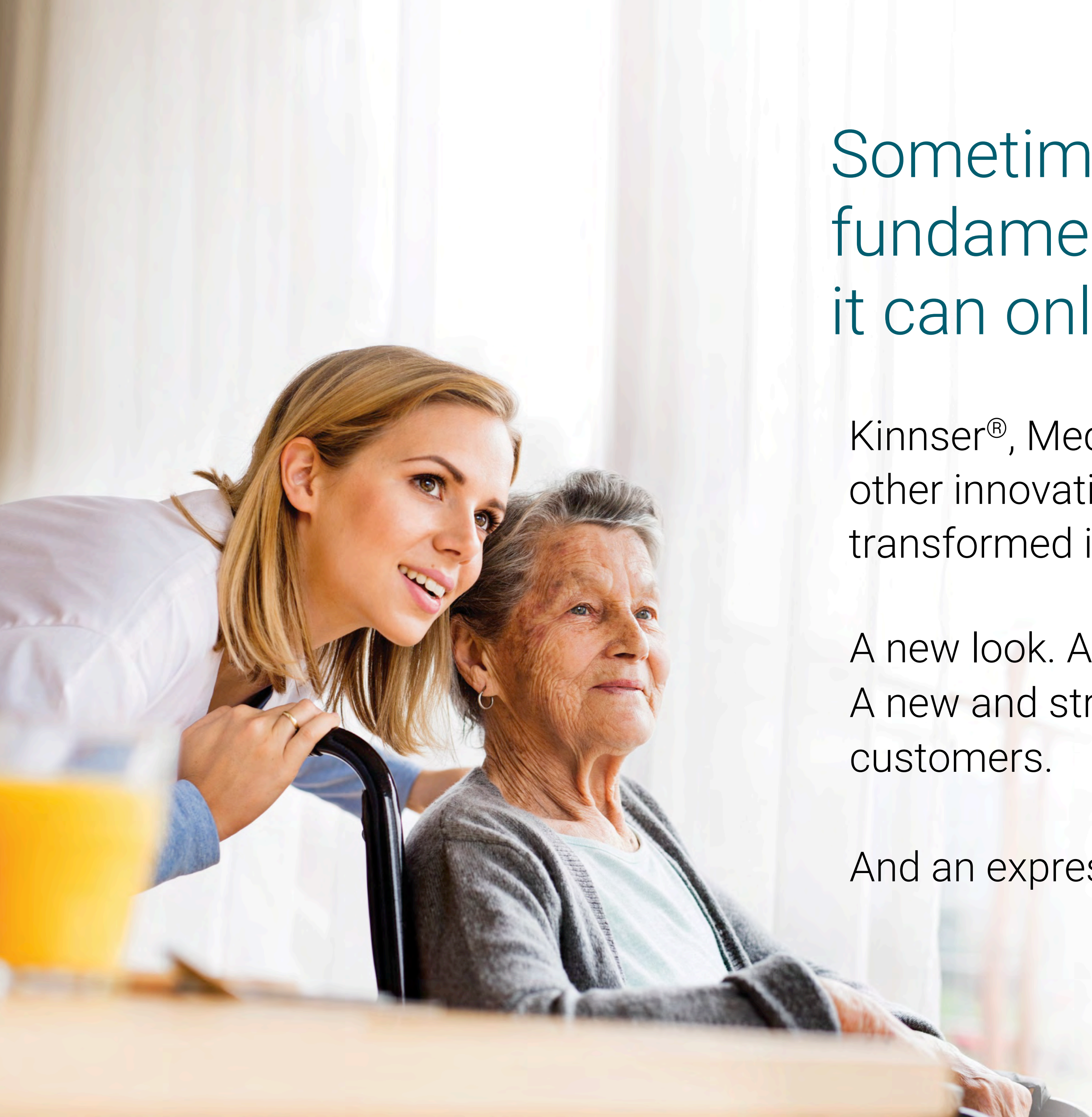
Webinar: Hospice

The 2019 Hospice Final Rule:

How to prepare now

with **Beth Noyce, RN, BSJMC**
Executive Director, Utah Hospice & Palliative Care Organization
and Utah Association for Home Care



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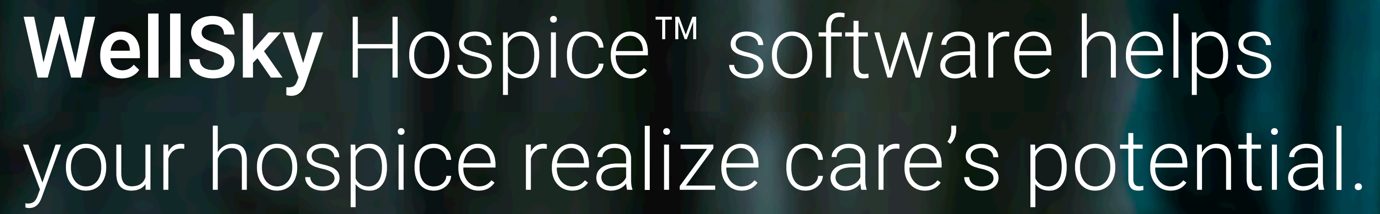

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About the presenter

Beth Noyce, RN, BSJMC

Hospice & Home Health Consultant
COS-C AHCC Advising Board Member
Executive Director for UHPCO & UAHC

FY 2019 Hospice Final Rule
Overview

- AKA (also known as):
  - FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

FY 2019 Hospice Final Rule
Overview

- Financial:
  - Raises hospice funding by 1.8% ($340 million)
  - Clarifies "cap period" language
  - OKs physician assistants to bill Medicare as hospice attending physicians (1.1.2019)

FY 2019 Hospice Final Rule
Overview

- Quality Hospice Reporting Program updates.
  - HIS data review and correction
  - Extends life of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey guidelines
  - Public reporting updates affecting the Hospice Compare website

FY 2019 Hospice Final Rule

Overview

- Other important stuff.
  - Summary of trend analysis from proposed rule
  - Quality priorities ➔ Meaningful Measures
  - Advancing Health Information Exchange
  - CMS' plan to continue reviewing hospice cost report data – though seen as of poor quality – to determine whether to adjust future hospice payments

$340 million more for hospice

Routine annual rate setting changes

1.8 % Raise for Hospice

- Hospice market basket percentage increase for FY 2019 is 1.8%.
  - About $340 million increase
  - FY 2018 only increased by 1%

Hospice Aggregate Cap

- The aggregate cap limits the overall payments made to a hospice annually, updated by the hospice payment update percentage (1.8).
  - Cap amount for FY 2019 is $29,205.44.
  - Cap amount for FY 2018 was $28,689.04.
  - Cap year matches fiscal year Oct. 1 – Sept. 30.

Cap rules

- If a hospice's total Medicare payments for the cap year exceed the hospice aggregate cap, then the hospice must repay the excess back to Medicare.
  - Since FY 2012, calculated using the patient-by- patient proportional methodology, within certain limits.
  - Providers must complete their aggregate cap determinations not sooner than 3 months and not later than 5 months after the end of the cap year, and remit any overpayments.
  - Payment suspended for hospices that fail to timely submit their aggregate cap determinations.

FY 2019 Payment Rates for RHC

for hospices that submit required quality data

Table 1: FY 2019 Hospice Payment Rates for RHC for Hospices that Submit the Required Quality Data

Code	Description	FY 2019 Payment Rate	Labor Share	Non-Labor Share
651	Routine Home Care (days 1-60)	$196.25	$134.84	$61.41
651	Routine Home Care (days 61+)	$154.21	$105.96	$48.25
652	Continuous Home Care Full Rate = 24 hours of care Hourly rate=$41.56	$997.38	$685.30	$312.08
655	Inpatient Respite Care	$176.01	$95.27	$80.74
656	General Inpatient Care	$758.07	$485.24	$272.83

FY 2019 Payment Rates for RHC

for hospices that do not submit required quality data

Table 2: FY 2019 Hospice Payment Rates for Hospices that DO NOT Submit the Required Quality Data

Code	Description	FY 2019 Payment Rate	Labor Share	Non-Labor Share
651	Routine Home Care (days 1-60)	$192.39	$132.19	$60.20
651	Routine Home Care (days 61+)	$151.18	$103.88	$47.30
652	Continuous Home Care Full Rate = 24 hours of care Hourly rate=$40.74	$977.78	$671.83	$305.95
655	Inpatient Respite Care	$172.56	$93.41	$79.15
656	General Inpatient Care	$743.18	$475.71	$267.47

Table 4—FY 2019 Hospice CHC, IRC, and GIP Payment Rates

Code	Description	FY 2018 payment rates	Wage index standardization factor	FY 2019 hospice payment update	FY 2019 payment rates
652	Continuous Home Care; Full Rate = 24 hours of care; $41.56 = FY 2019 hourly rate	$976.42	× 1.0034	× 1.018	$997.38
655	Inpatient Respite Care	172.78	× 1.0007	× 1.018	176.01
656	General Inpatient Care	743.55	× 1.0015	× 1.018	758.07

Table 3. Share of Hospice Days by Level of Care and Site of Service, for Beneficiaries Discharged Alive or Deceased in FY 2017

Level of Care	Site of Service	# of Hospice Days	% of All Hospice Days
RHC	Home + Hospice Residential Facility	66,320,796	55.75%
	SNF/NF	28,656,850	24.09%
	Assisted Living Facility	20,299,401	17.06%
	Other	1,351,575	1.14%
	Total	**116,628,622**	**98.04%**
GIP	Inpatient Hospital	409,123	0.34%
	Inpatient Hospice Facility	1,158,985	0.97%
	Skilled Nursing Facility	64,349	0.05%
	Other	5,571	0.01%
	Total	**1,638,028**	**1.38%**

CHC	Home + Hospice Residential Facility	199,595	0.17%
	SNF/NF	47,098	0.04%
	Assisted Living Facility	78,927	0.07%
	Other	3,758	0.00%
	Total	**329,378**	**0.28%**
IRC	Inpatient Hospital	32,397	0.03%
	Inpatient Hospice Facility	121,597	0.10%
	SNF/NF	206,983	0.17%
	Other	1,558	0.00%
	Total	**362,535**	**0.30%**
Total		**118,958,563**	**100%**

Source: Common Working File (CWF) All hospice claims from 2006 to 2017 were included, for beneficiaries whose final claim in FY 2017, according to through date, for a hospice discharge (excluded status code "30", indicating a continuing patient). Hospice days with invalid or missing site of service HCPCS code are excluded.

Table 5—FY 2019 Hospice RHC Payment Rates for Hospices That Do Not Submit the Required Quality Data

Code	Description	FY 2018 payment rates	SIA budget neutrality factor	Wage index standardization factor	FY 2019 hospice payment update of 1.8% minus 2 percentage points = −0.2%	FY 2019 payment rates
651	Routine Home Care (days 1-60)	$192.78	× 0.9991	× 1.0009	× 0.998	$192.39
651	Routine Home Care (days 61+)	151.41	× 0.9998	× 1.0007	× 0.998	151.18

Table 6—FY 2019 Hospice CHC, IRC, and GIP Payment Rates for Hospices That Do Not Submit the Required Quality Data

Code	Description	FY 2018 payment rates	Wage index standardization factor	FY 2019 hospice payment update of 1.8% minus 2 percentage points = −0.2%	FY 2019 payment rates
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655	Inpatient Respite Care	172.78	× 1.0007	× 0.998	172.56
656	General Inpatient Care	743.55	× 1.0015	× 0.998	743.18

The following table provides the breakdown of the labor and non-labor adjusted portions of the payment rates (these have remained the same for a number of years):

	LABOR	NON-LABOR
RHC	68.71	31.29
CHC	68.71	31.29
GIP	64.01	35.99
IRC (Respite)	54.13	45.87

HOSPICE CAP

https://report.nahc.org/cms-finalizes-fy2019-hospice-payment-quality-updates/

Reporting Drugs and DME on Claims

- Hospice providers may choose to report DME, drugs, and infusion pumps as line items or as aggregate monthly charges.
  - CMS prefers hospices to choose which method and use it consistently, though no penalty is mentioned.
  - Change Request 10573 provides details.

Physician Assistant as Attending

- Attending physician definition at §418.3 to include physician assistants (PA) as of 1.1.2019.
  - Physician assistants (PAs) will be recognized as designated hospice attending physicians, in addition to physicians and nurse practitioners.

Physician Assistant as Attending

- When a beneficiary prefers a PA, he or she may identify the PA as attending physician at the time he or she elects to receive hospice care.
  - The attending physician is the provider who has the most significant role in the determination and delivery of the individual's medical care.

Physician Assistant as Attending

- § 418.304 updated to allow Medicare payment for designated hospice attending physician services provided by physician assistants.
  - 85% of physician rate.

Physician Assistant as Attending

- PA services are billable to Medicare only if:
  - Performed by the beneficiary's designated attending physician/PA.
  - Medically reasonable and necessary.
  - A physician would normally perform them.
  - Not related to the certification of terminal illness.

Physician Assistant as Attending

- PAs may **not**:
  - Conduct Face-to-Face encounters,
  - Act as medical directors or physicians of the hospice.
  - Certify the beneficiary's terminal illness.
  - Work under contracts with hospices for attending physician services.

Hospice Reporting Tweaks

Hospice quality reporting program updates

Penalties for Not Reporting

- FY 2019 2% payment penalty for agencies that didn't report, for 2017:
  - Hospice Visits when Death is Imminent.
  - Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission.

2 % CUT

Penalties for Not Reporting

Hospice item set quality measure	Year the measure was first adopted for use in APU determination
Treatment Preferences	FY 2016
Beliefs/Values Addressed (if desired by the patient)	FY 2016
Pain Screening	FY 2016
Pain Assessment	FY 2016
Dyspnea Screening	FY 2016
Dyspnea Treatment	FY 2016
Patients Treated with an Opioid Who are Given a Bowel Regimen	FY 2016
The Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission	FY 2019
Hospice Visits when Death is Imminent	FY 2019

Quality Data Correction Process

- Hospices currently have 36 months to modify HIS records submitted to CMS.
  - As of “freeze date” no further modifications are possible before the respective CMS Hospice Compare website refresh.

Hospice Compare Data Preview CASPER

- QM Reports are for internal provider quality improvement.
  - Hospice-Level Quality Measure Report
    - Contains the numerator, denominator, hospice-level QM score, and national average.
  - The CASPER patient stay-level QM Reports
    - Show whether each patient stay is counted toward each quality measure.

CASPER

Quality Data Correction Process

- **New** data-correction deadline is 11:59:59 p.m. ET on the 15th of the month that is about 4.5 months after the end of the CY quarter from which the data were drawn.

NAHC's CAHPS Change Summary

CAHPS Issues: As part of the final rule, CMS is finalizing:

- The proposal to continue treating the preferred language of the caregiver as a recommended variable
- The proposal to continue requiring hospices to use CMS-approved vendors to conduct the CAHPS survey using one of the three approved modes
- The proposal to continue to report eight quarters of CAHPS data on Hospice Compare
- The proposal to exempt small hospices from CAHPS data collection
- The proposal to continue offering the "newness" exemption in future years

Quality Measure Handling

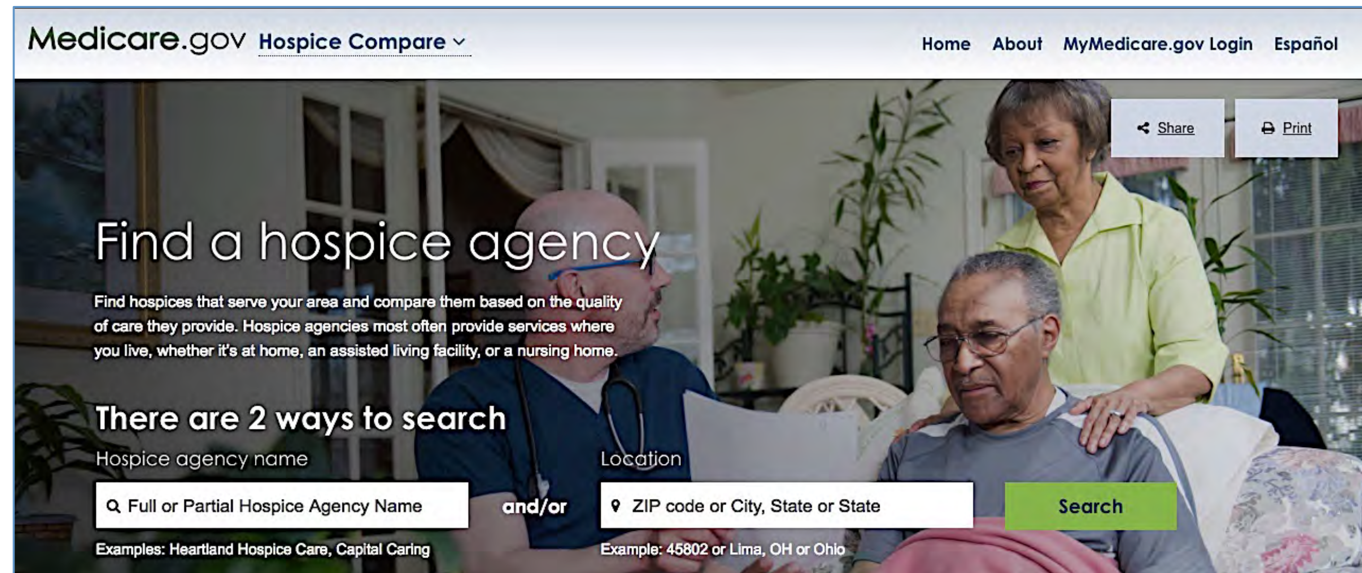
- CMS will announce to providers any future intent to publicly report a quality measure on Hospice Compare, including timing, through sub-regulatory means.
  - Not part of final rule.
  - Transmittals.
  - MLM articles

Hospice Compare

Recently updated – never complete

Hospice Compare Tweaks

- Hospice Comprehensive Assessment Measure to appear Fall 2018.
  - HIS-based.
  - Composite of the 7 original HIS Measures.
  - Will replace those 7 original HIS Measures.



Hospice Comprehensive Assessment Measure

- 12- rolling month data selection period.
- Minimum denominator size = 20 patient stays.

Medicare.gov Hospice Compare
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Find hospices that serve your area and compare them based on the quality of care they provide. Hospice agencies most often provide services where you live, whether it's at home, an assisted living facility, or a nursing home.
There are 2 ways to search
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and/or
Location
ZIP code or City, State or State
Search
Examples: Heartland Hospice Care, Capital Caring
Example: 45802 or Lima, OH or Ohio

What Stays the Same?

- HIS data collection process is unchanged.
- The seven component measures will still appear on CASPER QM reports and HIS provider preview reports.

Data Newly Available to Public

- Hospice Visits when Death is Imminent Measure Pair to appear sometime in FY 2019.
  - The exact timeline announced through regular sub-regulatory channels once necessary analyses and measure specifications are finalized.

Hospice Public Use Files

- CMS to post information from the Hospice Public Use File (PUF) and other data on the Hospice Compare site.
  - CMS to seek input from providers, key stakeholders, and the public concerning addition of PUF and/or other publicly available data and making any refinements to Hospice Compare.

Hospice Public Use Files

- PUF data will appear in a separate section of Hospice Compare from the HIS and CAHPS quality data.
- CMS plan is to average PUF and other data over multiple years and include text explaining the purpose of the data points and how consumers can use them.
- CMS will suppress PUF data for
  - Small providers (< or = 10 patients)
  - Small count data points.

Cost Report Analysis

Worries about poor quality

> ½ Cost Reports Missing Data

- Level I edits that would reject a submitted cost report if it did not contain data on specified lines that should, based on appropriate cost reporting practices, include a value greater than zero.
  - Some have suggested Level 1 edits be implemented.

66% Reject Rate

- Nearly 66% would reject with this standard.
- NAHC states this underscores widespread concerns:
  - Current quality of cost report submissions.
  - That the data that is being drawn from them is being used to make policy decisions

ONC and CMS Priority

Advancing health information exchange

Interoperable Data

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires assessment data to be standardized and interoperable to allow for exchange of the data among post-acute providers and other providers.

Interoperable Data

- The Office of the National Coordinator for Health Information Technology Data Element Library to serve as a publically available centralized, authoritative resource for standardized data elements and their associated mappings to health IT standards.

Reducing Provider Burden

- These interoperable data elements can reduce provider burden by:
  - Allowing the use and reuse of healthcare data.
  - Supporting provider electronic health information sharing for:
    - Care coordination.
    - Person-centered care.
    - Real-time, data driven, clinical decision making.

Data Element Library

- Once available, standards in the Data Element Library can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA).

Trusted Exchange Framework

- 2016: 21st Century Cures Act
  - Congress directed ONC to "develop or support a trusted exchange framework, including a common agreement among health information networks nationally."
- Still no help for hospices to finance IT advancements within agencies.

Hospice Industry Trends

CMS is always watching

More Hospice Beneficiaries

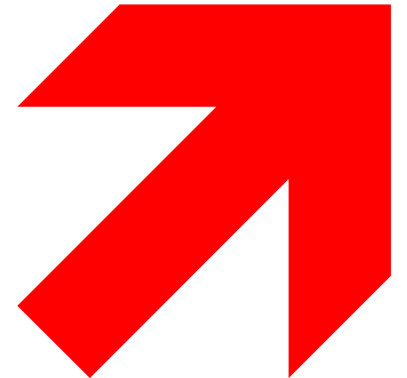
- Medicare beneficiaries receiving hospice services:
  - 513,000 in FY 2000
  - Up to nearly 1.5 million in FY 2017

More Costs

- Medicare hospice expenditures:
  - $2.8 billion in FY 2000
  - Up to about $17.7 billion in FY 2017

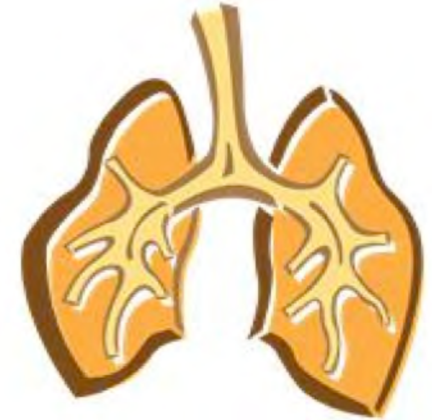
Higher Spending

- CMS' Office of the Actuary projects that hospice expenditures continue to increase by approximately 8% annually due to more:
  - Medicare beneficiaries.
  - Beneficiary awareness of the Medicare hospice benefit for end-of-life care.
  - Preference for care provided in home and community-based settings.



Diagnosis Trends

- Principal diagnosis = Hospice Terminal Illness
  - 2002 – lung cancer.
  - 2013 – 2017 – neurologically based diagnoses
  - FY 2013 – "debility"
    - Debility and Failure to Thrive accounted for about 14% of all diagnoses.



Never-primary ICD-10 diagnoses

- As of Oct. 1, 2014, CMS, **excluded** as hospice principal diagnoses:
  - Debility
    - ICD-10 R53.81 or R54
  - Adult Failure to Thrive
    - ICD-10 R62.7

FY 2019 Hospice Final Rule Dx. Trends

- CMS: "As a result of [excluding "debility" and "failure to thrive"], the most common hospice claims-reported diagnoses have changed from primarily cancer diagnoses to neurological and organ-based failure diagnoses."

Shifting from Non-Specific Dx.

- NAHC recommended in 2014:
  - ✓ Review cases with ‘debility’ or ‘adult failure to thrive’ as the principal diagnosis.
  - ✓ Check for another qualifying principal diagnosis.
  - ✓ Change principal diagnosis to a new qualifying diagnosis for all future claims.

Shifting from Non-Specific Dx.

- CMS recommended:
  - ✓ Consult the pre-terminal medical record.
  - ✓ Add all contributing diagnoses to the claim.
  - ✓ Consult with physician to determine which is contributing most to terminal prognosis.
  - ✓ Awareness of all conditions will ensure expert care for patients at end-of-life.

Comply with ICD-10 Coding Rules

- CMS: Don't list etiology dementia diagnoses as principal diagnosis.
  - Follow etiology/manifestation rules.
  - Coding manuals specify manifestations.
    - "Code first the underlying condition."
    - "In diseases classified elsewhere."
    - Other indicators differ by publisher.

Alternatives to Non-Specific Dx

- Example: Alzheimer's Dementia
  - ICD-10
    - G30.1 Alzheimer's Disease with late onset
    - F02.80 Dementia in other diseases classified elsewhere, without behavioral disturbance

Alternatives to Non-Specific Dx

- CMS: Don’t list etiology dementia diagnoses as principal diagnosis.
  - Instead, seek out the cause.
  - Dementias result from various issues:
    - ✓ 290.X = neurological
    - ✓ 290.4X = vascular
    - ✓ 291.X = alcohol-induced
    - ✓ 294.1 = in conditions classified elsewhere

When Nobody Knows Why

- When dementia's cause is unknown:
  - Study pre-hospice medical records
  - Ask the physician if unclear
  - Default for ICD-10, though not recommended as primary Dx/terminal illness:
    - F03.9- Unspecified dementia

Top 10 Terminal Illnesses FY 2017

Rank	ICD-10/reported principal diagnosis	Count	Percentage
1	G30.9 Alzheimer's disease, unspecified	155,066	10
2	J44.9 Chronic obstructive pulmonary disease	77,758	5
3	I50.9 Heart failure, unspecified	69,216	4
4	G31.1 Senile degeneration of brain, not elsewhere classified	66,309	4
5	C34.90 Malignant Neoplasm Of Unsp Part Of Unsp Bronchus Or Lung	53,137	3
6	G20 Parkinson's disease	40,186	3
7	G30.1 Alzheimer's disease with late onset	38,710	2
8	I25.10 Atherosclerotic heart disease of native coronary art without angina pectoris	34,761	2
9	J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation	33,547	2
10	I67.2 Cerebral atherosclerosis	30,146	2

Improvement Noted

- FY 2017 hospice claims:
  - 100 % hospices reported more than one diagnosis.
  - 89 % submitted at least two diagnoses.
  - 81 % included at least three diagnoses.

CMS Hospice Industry Analysis

Final Rule refers back to concerns in Proposed Rule

Hospice Trends from Proposed Rule

- CMS analyzed current trends in hospice utilization and provider behavior, such as lengths of stay, live discharge rates, skilled visits during the last days of life, and non-hospice spending.
  - To find, if any, potential impacts related to hospice reform policies in the FY 2016 Final Hospice Wage Index and Rate Update.

Hospice Trends from Proposed Rule

- CMS continues to monitor non-hospice spending during a hospice election:
  - Drugs paid for by Part D and provided to beneficiaries during GIP stays, in response to March 2016 Office of Inspector General (OIG) report.
  - Non-hospice spending during a hospice stay.

Hospice Spending from Cost Report

- Included information on the costs of hospice care using data from the new hospice Medicare cost report, effective for cost reporting periods that began on or after October 1, 2014 (FY 2015).

Data May Inform Future Pay

- Affordable Care Act authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes, including such data sources as the Medicare cost reports.
- Analyses may inform future work that could include change hospice payment rates.

End-Of-Life Skilled Visits Up Only 2%

- Analysis of FY 2017 claims data
  - 10/1/2016 – 9/30/2017
  - **Nearly 42%** of patients did not receive a skilled visit (From a skilled nurse or social worker) on any given day during the last 7 days of life.
  - Better than FY 2016 when **44%** of patients did not receive a skilled visit on any given day during the last 7 days of life.
  - But not good enough for CMS.

CMS Dissatisfied with Small Increase

CMS: "Beneficiaries appear to be receiving similar levels of care when compared to time periods prior to the implementation of the payment policy reforms, which may indicate that **hospices are not providing additional resources to patients during a time of increased need**. **We expect that hospices would be increasing visit frequency at the end of life**, as the SIA payment serves to compensate providers for the cost of providing additional, more intensive care at the end of life, in addition to the payment already made for those RHC level of care days that qualify for the SIA."

Beneficiary Eligibility Suspect

Length of stay and live discharges

Hospice Eligibility Requirements

- Hospice-eligible individuals have a medical prognosis 6 months or less life expectancy if the illness runs its normal course.
- A beneficiary may be under a hospice election longer than 6 months as long as a reasonable expectation persists of a life expectancy of 6 months or less.

The Long and Short of It

- Hospice Lengths of Stay are variable.
- Longer hospice lengths of stay may reflect, for example:
  - Admission to hospice earlier in the disease trajectory.
  - Miscalculation of prognosis.

The Long and Short of It

- Shorter hospice lengths of stay may reflect:
  - Hospice election late in the disease trajectory or a rapidly progressing acute condition.
  - Individual reluctance to accept that his or her condition is terminal and choose the hospice benefit.

The Long and Short of It

- Shorter hospice lengths of stay may reflect:
  - Inadequate knowledge regarding the breadth of services available under hospice care,
  - Cultural, ethnic, and/or religious backgrounds inhibiting or even precluding the use of hospice services, etc.

Length of Stay Shifts

- FY 2015, average LOS 8.1 days.
- FY 2016 average LOS 79.2 days.
- FY 2017, average length of stay in hospice was 79.7 days and the average lifetime length of stay in hospice was 96.2 days.
- The average lifetime length of stay similarly remained virtually the same between FY 2016 and FY 2017, 96.1 and 96.2 days, respectively.

Lengths of Stay

- The median (50th percentile) length of stay in FY 2017 was 18 days.
  - Half of hospice beneficiaries received care for fewer than 18 days and half received care for more than 18 days.

18

Hospice Patient Waives Non-Hospice Coverage

- When a beneficiary elects the Medicare hospice benefit, he or she waives the right to Medicare payment for services related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made, except for services provided by the designated hospice and the attending physician.

Unbundling Is Not Allowed

- However, we continue to conduct ongoing analysis of non-hospice spending during a hospice election and the results of our analysis seems to suggest the unbundling of items and services that perhaps should have been provided and covered under the Medicare hospice benefit.

Hospice Covers Virtually Everything

- Hospice services are comprehensive and we have reiterated since 1983 that "virtually all" care needed by the terminally ill individual would be provided by hospice.
- We believe that it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life.

References

- FY2019 Hospice Final Rule
- FY2019 Hospice Proposed Rule
- OIG report: “Hospice Inappropriately Billed Medicare Over $250 Million for General Inpatient Care” (OEI-02-10-00491), 3/2016

Thank you!

Remember and apply

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