Hospice Regulatory Review
September 2015
Presented by:
Deanna Loftus
Director of Regulatory Compliance

Webinar Agenda

- CY 2016 Final Rule
  - New Payment Rates
  - New Service Intensity Add-On
  - HQRP Updates
  - CAHPS Oversight Activities
  - Diagnosis Coding
- ICD-10 Are you Ready?
- Important Reminders/Upcoming Changes and Mandates
- Medicare Administrative Contractors

Hospice Regulatory Review

CY 2016 Hospice Final Rule

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-
Regulations-and-Laws/Hospice-Regulations-and-Notices-items/CMS-1629-
F.html
https://www.cms.gov/Regulations-and-
Guidance/Guidance/Transmittals/Downloads/R3326CP.pdf
Fiscal Year 2016 Rate Increase

- Hospital market basket update: 2.4%
- ACA productivity reduction: minus 0.5% points
- Additional ACA mandated reduction: minus 0.3% points
- Net Market Basket update: 1.6%

Wage Index files: [http://www.cms.gov/Center/Provider-Type/Hospice-Center.html](http://www.cms.gov/Center/Provider-Type/Hospice-Center.html)

CBSA/Wage Transition Period: One year period

Wage Index Changes

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>CBSA Based on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>2000 Census CBSAs</td>
</tr>
<tr>
<td>2016</td>
<td>Transition to 50/50 blend of 2000 and 2010 CBSAs</td>
</tr>
<tr>
<td>2017</td>
<td>2010 Census CBSAs</td>
</tr>
</tbody>
</table>

FY2016 RHC Payment Rate for 10/1/2015–12/31/2015

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2015 Payment Rate</th>
<th>Hospice Pmt Update %</th>
<th>Final FY 2016 Pmt Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Days</td>
<td>$159.34</td>
<td>X1.016</td>
<td>$161.89</td>
</tr>
</tbody>
</table>

**NOTE:** Temp rate for October through December to allow industry preparation for new dual rate as of January 1, 2016
### FY2016 RHC Payment Rates for 1/1/16–9/30/16

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rates</th>
<th>SIA BNAF</th>
<th>Hospice Pmt Update %</th>
<th>Proposed FY 2016 Pmt Rate</th>
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</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Days 1-60</td>
<td>$187.54</td>
<td>0.9806</td>
<td>X1.018</td>
<td>$186.84</td>
</tr>
<tr>
<td>651</td>
<td>Routine Days 61+</td>
<td>$145.14</td>
<td>0.9957</td>
<td>X1.018</td>
<td>$146.83</td>
</tr>
</tbody>
</table>

### What is an "Episode of Care"

A hospice election period or series of election periods separated by no more than a 60-day gap.

The "count of hospice days" will follow the patient (count the days relative to the patient’s lifetime length of stay):

- Hospice patients discharged and readmitted to hospice within 60 days of that discharge, will have their prior hospice days continue to follow them and count toward their patient days for the receiving hospice upon hospice election.
- Applies to patients who transfer from one hospice to another

### Hospice Payment Count Day

- How do I determine the hospice payment count day / know if a gap of more than 60 days exists between "episodes of care"?
  - Request Eligibility Information to review historical election period/benefit period information:
    - CMS Direct Data Entry HQA screens (currently available, CMS planning to sunset in the future)
    - CMS HITTS (HIPAA Eligibility Transaction System)
Examples of “Episode of Care”

Day 1 Patient Elects Hospice
Day 75 Patient terminated due to no longer meeting requirements or electing to be terminated
Day 126 Patient re-elects hospice
(51 days in between elections – Patient would continue on with day 76 ‘payment day count’ / Day 60+ rate amount)

Day 1 Patient Elects Hospice
Day 75 Patient terminated due to no longer meeting requirements or electing to be terminated
Day 155 Patient re-elects hospice
(80 days in between elections – Patient would start “payment day count” back at 1 due to more than 60 days in between elections)

Service Intensity Add-On

Service Intensity Add-on applies when:

- Patient is in their last 7 days of care
- Patient is discharged due to Death
- Direct/in person patient care is provided by an RN or social worker on the day being billed as RHC
  - Additional rate equivalent to the continuous care rate may be billed up to 4 hours
  - CMS will create two separate G-codes to differentiate nursing visits by RNs vs. LPNs

FY2016 Payment Rates (GHC, IRC, GIP)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Labor</th>
<th>Non-Labor</th>
<th>2015 Pmt Rate</th>
<th>Proposed Hospital Prem Update %</th>
<th>Proposed FY 2016 Pmt Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>652</td>
<td>Continuous Home Care</td>
<td>68.71</td>
<td>31.29</td>
<td>$999.90</td>
<td>X 1.016</td>
<td>$1,016.16</td>
</tr>
<tr>
<td></td>
<td>Full Rate=24 hours of Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$=33.33/hourly rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>54.13</td>
<td>45.87</td>
<td>$164.81</td>
<td>X 1.016</td>
<td>$167.45</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>64.01</td>
<td>35.99</td>
<td>$708.77</td>
<td>X 1.016</td>
<td>$720.11</td>
</tr>
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</table>
Changes to Hospice Cap

- Modify the cap updated beginning with the 2016 cap year to reflect recent changes included to the IMPACT Act
  - Aggregate Cap amount for accounting years that end after September 30th, 2016 and before October 1st, 2025, will be updated by the hospice payment update rather than the CPI-U for medical care
- Align the Inpatient and Aggregate Cap accounting years with the federal fiscal year (Oct. 1 through Sept. 30) beginning in federal fiscal year 2017 and thereafter

Hospice Cap Timeframes

<table>
<thead>
<tr>
<th>Cap Year</th>
<th>Beneficiaries</th>
<th>Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>10/1/16 - 9/30/16</td>
<td>10/1/16 - 9/30/16</td>
</tr>
<tr>
<td>2017 (Transitional Year)</td>
<td>11/1/16 - 9/30/17</td>
<td>11/1/16 - 9/30/17</td>
</tr>
<tr>
<td>2018</td>
<td>10/1/17 - 9/30/18</td>
<td>10/1/17 - 9/30/18</td>
</tr>
</tbody>
</table>

Hospice Inpatient Cap and Dual RHC Rate

- When a hospice exceeds the inpatient cap that limits the total number of Medicare inpatient days (GIP and IRC) to no more than 20% of a hospice’s total Medicare hospice days, CMS will use the 61+ RHC rate for payment reconciliation.
- CMS noted using the lower of the two RHC rates is appropriate as the higher rate exceeds the IRC payment rate.
Future CMS CAP Considerations

- Adjust aggregate CAP by wage index
- Rebase aggregate CAP
- Use cost report data to establish average episode cost for use as CAP value

Aggregate Cap Amounts Since 1984

<table>
<thead>
<tr>
<th>Year</th>
<th>Cap Amount</th>
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<tbody>
<tr>
<td>1984</td>
<td>$6,500.00</td>
</tr>
<tr>
<td>1985</td>
<td>$6,884.00</td>
</tr>
<tr>
<td>1986</td>
<td>$7,391.00</td>
</tr>
<tr>
<td>1987</td>
<td>$7,898.00</td>
</tr>
<tr>
<td>1988</td>
<td>$8,406.00</td>
</tr>
<tr>
<td>1989</td>
<td>$9,010.00</td>
</tr>
<tr>
<td>1990</td>
<td>$9,787.00</td>
</tr>
<tr>
<td>1991</td>
<td>$10,712.00</td>
</tr>
<tr>
<td>1992</td>
<td>$11,551.00</td>
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<tr>
<td>1993</td>
<td>$12,448.00</td>
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<tr>
<td>1994</td>
<td>$12,846.00</td>
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<td>1995</td>
<td>$13,489.00</td>
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<tr>
<td>1996</td>
<td>$13,974.00</td>
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<tr>
<td>1997</td>
<td>$14,394.00</td>
</tr>
<tr>
<td>1998</td>
<td>$14,788.00</td>
</tr>
<tr>
<td>1999</td>
<td>$15,313.00</td>
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<tr>
<td>2000</td>
<td>$15,916.98</td>
</tr>
<tr>
<td>2001</td>
<td>$16,650.85</td>
</tr>
<tr>
<td>2002</td>
<td>$17,390.89</td>
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<tr>
<td>2003</td>
<td>$18,143.26</td>
</tr>
<tr>
<td>2004</td>
<td>$18,963.47</td>
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<tr>
<td>2005</td>
<td>$19,777.51</td>
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<tr>
<td>2006</td>
<td>$20,585.39</td>
</tr>
<tr>
<td>2007</td>
<td>$21,420.04</td>
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<tr>
<td>2008</td>
<td>$22,386.15</td>
</tr>
<tr>
<td>2009</td>
<td>$23,104.50</td>
</tr>
<tr>
<td>2010</td>
<td>$23,874.38</td>
</tr>
<tr>
<td>2011</td>
<td>$24,527.35</td>
</tr>
<tr>
<td>2012</td>
<td>$25,377.01</td>
</tr>
<tr>
<td>2013</td>
<td>$26,157.50</td>
</tr>
<tr>
<td>2014</td>
<td>$26,725.79</td>
</tr>
<tr>
<td>2015</td>
<td>$27,135.96</td>
</tr>
</tbody>
</table>

Diagnosis Coding

- Hospices must report **ALL** diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual.
  - CMS is not instituting any requirements to differentiate between related and unrelated on claims
- This is the 3rd year CMS has made mention of/stressed information about diagnosis reporting in the proposed or final rules
  - A high percentage of hospice claims are still only including one diagnosis
Diagnosis Coding Cont.

- In reaching a decision to certify the patient, the hospice medical director must consider at least the following:
  - Diagnosis of the terminal condition of the patient.
  - Other health conditions, whether related or unrelated to the terminal condition.
  - Current clinically relevant information supporting all diagnoses.
- Verify your clinicians are conducting a comprehensive assessment as required
- Verify your patient plans of care are being updated as required

Diagnosis Coding Cont.

- What can you do to determine if any of your patients are not being fully coded per coding guidelines
  - Run reports in your software to list all diagnoses per patient
  - Conduct a clinical review on a sampling of patients that have only one diagnosis listed in their medical chart.
    - Was the patient’s physical, emotional, spiritual and psychosocial well-being assessed?

HQRProposed Changes Beginning FY 2018

New providers will be required to begin reporting on the date they receive their CCN/Medicare Provider

Hospices must submit all HIS records within 30 days of the Event Date beginning

Incremental HIS submission threshold beginning with all HIS Adm. and DC records that occur on or after:

- Jan 1, 2016 – Dec 31, 2016 = 70% (FY 2018)
- Jan 1, 2017 – Dec 31, 2017 = 80% (FY 2019)
- Jan 1, 2018 – Dec 31, 2018 = 90% (FY 2020)
No New Measures

No firm date on “Hospice Compare”

Adopted quality measures will be retained for use in the subsequent FY payment determination unless otherwise stated.

Future Measure Development

CMS is looking at the following high priority concept areas for future HIS measures:

1. Patient-reported pain outcome measure that incorporates patient and/or proxy report regarding pain management;
2. Claims-based measures focused on care practice patterns including skilled visits in the last days of life, burdensome transitions of care for patients in and out of the hospice benefit, and rates of live discharges from hospice;
3. Responsiveness of hospice to patient and family care needs;
4. Hospice team communication and care coordination.

Hospice Experience of Care Survey

“CAHPS” for Hospice

• Participation will continue and be required to meet FY 2018 and 2019 APUs
• Hospices with fewer than 50 deaths from will continue to be exempt from requirements for payment determination
• Hospices who fail to participate in the Hospice CAHPS survey will have a 2% market basket reduction in each Fiscal Year

http://www.hospicecahpsurvey.org
Hospice Experience of Care Survey

<table>
<thead>
<tr>
<th>APU</th>
<th>Sample Months (Death Month)</th>
<th>Quarterly Submission Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>dry run Jan-March 2015 (Q2)</td>
<td>August 12, 2015</td>
</tr>
<tr>
<td>2017</td>
<td>April – June 2015 (Q2)</td>
<td>November 11, 2015</td>
</tr>
<tr>
<td>2018</td>
<td>Jan-March 2016 (Q1)</td>
<td>August 10, 2016</td>
</tr>
<tr>
<td>2018</td>
<td>April – June 2016 (Q2)</td>
<td>November 9, 2016</td>
</tr>
<tr>
<td>2018</td>
<td>July – Sept 2016 (Q3)</td>
<td>February 8, 2017</td>
</tr>
<tr>
<td>2018</td>
<td>Oct – Dec 2016 (Q4)</td>
<td>May 10, 2017</td>
</tr>
<tr>
<td>2019</td>
<td>Jan-March 2017 (Q1)</td>
<td>August 9, 2017</td>
</tr>
<tr>
<td>2019</td>
<td>April – June 2017 (Q2)</td>
<td>November 8, 2017</td>
</tr>
<tr>
<td>2019</td>
<td>July – Sept 2017 (Q3)</td>
<td>February 14, 2018</td>
</tr>
<tr>
<td>2019</td>
<td>Oct – Dec 2017 (Q4)</td>
<td>May 9, 2018</td>
</tr>
</tbody>
</table>

CAHPS Oversight Activities

- Continue the requirement that vendors/providers participate in oversight activities to ensure compliance.
- Reconsiderations/Appeals process for hospices failing to meet CAHPS® data collection requirements will be part of the Reconsideration and Appeals process already developed for the Hospice Quality Reporting Program.
- Use QIES and CASPER in addition to mail to notify providers of compliance with reporting requirements.
- Use several communication channels including memos, emails, MLNs, etc. to notify providers of report availability in CASPER.
- Publish list of hospices successfully meeting requirements.

Hospice Regulatory Review

ICD-10
It’s Getting Close!!!!

COUNTDOWN TO ICD-10

DAYS HOURS MINS SECS
27 10 30 30

ICD-10 HEALTHCARE first will Change Everything

Regulatory Documentation / Links

CMS ICD-10 Website

Federal Register Final Rule for ICD-10

FAQs: ICD-10 Transition Basics

Additional ICD-10 Information
http://www.cgsmedicare.com/hhh/claims/5010.html

What is Dual Coding and Why is it Necessary?

• Including both an ICD-9 and the associated ICD-10 in your patient’s chart.

• Hospice claims must be split for based on dates of service:
  • All ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015
  • All ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.

• Most software programs have built in the ability to allow two diagnosis versions in a patient chart. This allows software systems to automatically pull in the appropriate version to claims based on DOS.
When Do I Begin Dual Coding, What if I Don’t?

- What happens if patients are not dual coded:
  - Claims beginning with October dates of service will be rejected for not having the correct diagnosis version, which could impact agency cash flow.
  - Most agencies began dual coding upon release of ICD-10 functionality to take advantage of lead time for training and preparation purposes.
  - Agencies can choose to wait billing of October Dates of service to dual code/add ICD-10 codes to a patients chart, but depending on agency size, this could impact cash flow and/or cause employee frustration.

Where Do I Start?

Questions to ask within your agency:

- Which positions/people in your agency currently have any relationship with ICD-9 coding?
- Is your agency’s current ICD-9 coding process effective?
- Who is responsible for preparing you agency for and leading it through the ICD-10 transition?
- What is your agency’s current competency level of clinicians regarding completion of the OASIS C-1 and ICD-9 coding?

Where Do I Start? cont.

- Get to know your top 25 diagnoses in your agency.
- Learn the documentation requirements for these diagnoses first.
Hospice Regulatory Review

Important Reminders/Upcoming Changes

PECOS for Part D Changes

Now effective Jan 1, 2016

Originally stated Part D plans could no longer cover drugs that were prescribed by physicians or other eligible professionals who are:

• neither enrolled in Medicare
• not have validly opted out of Medicare

Now revised to include others that are permitted by state or other applicable law to prescribe medications

https://www.federalregister.gov/articles/2015/05/06/2015-10545/medicare-program-changes-to-the-requirements-for-part-d-prescribers

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html

Reminder: Sequestration Still in Effect

• The 2011 Budget Control Act mandates cuts equally over nine years (2013 – 2021).
• Does not apply to Medicaid.
CMS Transitioning Eligibility Systems

CMS is in the process of terminating all Eligibility systems other than the HETS 270/271

- PPTN and VPIQ
  - Multi Carrier System (MSC) – Discontinued April 2013
  - VIPS Medicare System (VMS) - Discontinued April 2013
- FISS/DDE
  - HIQA/HiQH – Currently still active
  - ELGH/ELGA – Currently still active


Hospice CAHPS

- Upcoming CMS Hospice CAHPS Training Session for:
  - Hospices that participate in the CAHPS
  - Hospice survey vendors that administer CAHPS
  - Other interested individuals and organizations
- Wednesday, Sept 30th from 11:30am to 4:30pm EST
  - http://www.hospicecahpsurvey.org/Content/TrainingForm.aspx
- Registration will close September 17, 2015.

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Medicare Administrative Contractors
Home Health & Hospice Jurisdictions

Medicare currently has four Jurisdictions assigned for Home Health and Hospice Administrative Contractors. Jurisdictions A – D are reserved from the HH & Hospice workloads. A map of the regions can be found at:


It is important for your agency to be up to date with the instructions from your contractor. Make sure you are signed up for their newsletters and alerts.

Palmetto GBA

Jurisdiction 11 Home Health and Hospice

http://www.palmettogba.com/Palmetto/Providers/nfs/PalmettoGBAHomeHealthAndHospiceJurisdiction11

National Government Services (NGS)

NEWS AND ALERTS

http://www.ngsmedicare.com

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