# PUBLICATION

## Proposed Regulation - Medicare Program: Hospice FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements [Ober|Kaler]

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On May 5, 2015, the Centers for Medicare and Medicaid Services (CMS) published its proposed payment rate and wage index regulation, also containing language on hospice quality reporting requirements (the "Proposed Regulation"). While the Proposed Regulation is chiefly focused on reimbursement, it is also a useful tool for compliance purposes, since is evident that a number of the proposed reimbursements are, at their heart, efforts to address areas of interest and concern to CMS about the manner in which the Medicare hospice benefit has been used. It is noteworthy that the Proposed Regulation cites not only typical sources such as CMS' own internal data and research contractor findings, MedPAC and Office of Inspector General (OIG) reports and recommendations, but also quotes from Securities and Exchange Commission filings by publicly traded hospices and from articles about hospices in the media.

The Proposed Regulation has several components, including:

1. Updating the hospice payment rates and wage index for FY 2016, including incorporating the last year of the seven year phase-out of the wage index budget neutrality adjustment factor (BNAF). The BNAF phase-out, per CMS, is not a reduction in the hospice wage index or hospice payment rates, but is a reduction in the BNAF increase. The Proposed regulation proposes an increase to hospice rates for FY 2016. CMS is also proposing a change to the wage index by incorporating new Office of Management and Budget core-based statistical area (CBSA) definitions using a 50/50 blend of existing and new CBSA designations but with specific provisions relating to certain hospice locations.
2. Changing the manner in which routine home care (RHC) by a hospice is reimbursed to place a financial emphasis on the first 60 days of RHC services. CMS plans to have a higher RHC rate for the first sixty days of home hospice care and a lower RHC rate for RHC days beginning at day 61. CMS wishes to avoid situations where hospice care is most profitable during long, low-cost "middle portions" of a stay, since that creates an incentive to admit hospice patients who are seeking hospice to augment custodial care. The 60 days would "follow the patient" who is discharged and readmitted to hospice for RHC, subject to whether there is a gap in election periods of 60 days or more. This change is an outgrowth of a larger discussion, addressed below, about CMS concerns with respect to hospices that focus on low intensity, longer stay residents with more chronic conditions, with the result that hospice augments custodial care versus being mainly a shorter stay benefit.
3. Creating a service intensity add-on (SIA) applicable to RHC services during the last seven days before death, but only if identified criteria are met. The SIA would provide an add-on equal to the Continuous Home Care hourly payment rate multiplied by the amount of direct patient care provided by a registered nurse or social worker during those seven days, but only if the required criteria are met. CMS prefers that reimbursement reflect a "U Shaped" curve in which resource use is greatest during the first part and last part of a RHC hospice stay. CMS is concerned that the data show that

hospice patients are not receiving skilled visits during the last days of life. To qualify for the SIA, the hospice must provide RHC, the patient is discharged as deceased and the day of care is within 7 days of death, an RN or social worker provides direct, in person care, and the service and less complex and costly care is NOT provided in a skilled nursing facility or nursing facility (even though home hospice care can be provided in those settings, because the OIG believes hospice patients in those settings receive longer and less complex and costly care). There is also a special discussion about when the SIA is available where the RHC is longer than 7 days, so that an SIA may be available for all days where the total RHC stay before death is 7 days or less.

4. Implementing changes to the aggregate hospice cap mandated by the Improving Medicare Post-Acute Transformation Act of 2014 (IMPACT) and making certain fiscal year alignments of the cap, *i.e.* by aligning the inpatient hospice cap and aggregate cap with the federal fiscal year starting in FY 2017. This addresses IMPACT requirements for the aggregate cap for accounting years ending after September 30, 2016 and before October 1, 2025 to use the hospice payment update versus the CPI-U;
5. Addressing the hospice quality reporting program by imposing a 2 percent reduction in their payment update percentage for hospices failing to make required quality reports and offering other guidance. The Proposed Regulation addresses participation requirements for current year 2015 regarding the Consumer Assessment of Healthcare Providers and Systems Hospice Survey, and reminds hospices that last year CMS set the July 1, 2014 implementation date for the Hospice Item Survey. More than seven new quality measures will be derived from these so that no new measures are proposed this year. The Proposed Regulation makes changes to the reconsideration process, extraordinary circumstance exceptions and hospice quality reporting program eligibility requirements for newly certified hospices, as well as new data timeliness requirements and compliance thresholds.
6. Changing the regulation on diagnosis reporting to require hospices to report all diagnoses of the hospice beneficiary on the hospice claim, using reporting that comply with current coding guidelines and admission requirements for hospice certifications. This includes reporting mental health disorders.

There is important commentary in the Proposed Regulation. CMS analyzed data that looks at pre-hospice spending in relation to types of diagnoses, such as comparing cancer patients to those with Alzheimer's Disease or Parkinson's Disease, and tying those data to length of hospice stay. CMS identifies that hospice patients with the longest length of stay tended to have lower pre-hospice spending versus hospice patients with shorter lengths of stay. It suggests CMS has a question about whether hospice is a cost-savings solution for certain kinds of patients with lower pre-hospice spending. This leads to a discussion about potential future changes and an evident CMS concern that, for some kinds of patients, hospice not evolve into a longer term benefit for chronic conditions, versus a benefit focused on terminal patients with a shorter length of stay.

CMS went on to discuss its findings about the incentives created by a system that pays the same RHC rate across a hospice stay, leading to greater profitability for longer lengths of stay. This supported CMS' decision to pay more for RHC during the first 60 days.

CMS also detailed the basis for its concern that some hospices engage in practices that result in a "systematic unbundling" of services that should be covered under the hospice rate. It cites examples of hospices classifying conditions as unrelated to the terminal illness resulting in referrals to non-hospice providers and a failure to properly coordinate and manage care to avoid costs. CMS specifically discussed Malignant Neoplasm of the Trachea, Bronchus and Lung, Chronic Airway Obstruction, Cerebral Degeneration and Congestive Heart Failure.

Another example of a compliance-focused discussion in the Proposed Regulation relates to Live Discharge Rates. CMS discusses the important distinction between a patient decision to revoke a hospice election versus

a hospice discharge of a patient. CMS analyzed hospice aggregate cap status to determine whether there is a relationship between live discharge rates and aggregate cap status, finding that hospices with higher live discharge rates are also above the cap. Plus, those hospices provide fewer visits per week. CMS also identified a nexus to those same hospices with higher non-hospice spending causing CMS to believe it is paying twice for the same service. Hospices with those patterns are advised to review this policy discussion closely.