Hot Off the Press!
The FY2017 Final Rule & Its Implications for Hospices

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Presenter

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Objectives

• Describe two areas of data analysis addressed by CMS in the FY2017 Wage Index Final Rule.
• Identify two actions needed to comply with quality reporting requirements in 2017.
• Discuss the implications of the FY2017 Wage Index Final Rule.
Main Points

FY 2017 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (CMS-1652-F)
• Updates the hospice wage index, payment rates, and cap amount for fiscal year FY 2017
• Outlines changes to the HQRP including implementation of 2 new quality measures
• Provides an update on plans for an enhanced data collection instrument
• Updates plans for public reporting of hospice data
• Provides discussion about ongoing data monitoring efforts

HOSPICE QUALITY REPORTING

Overview
• Two new measures will impact payments in FY2019
• Future changes to measures by NQF that are only “non-substantive” will be implemented without rulemaking
• CMS will pursue developing live discharge measures
• Eliminating the 7-day exclusion once the NQF endorsement process is complete
  – More hospices can participate as they will have enough qualifying stays to be included in quality measure score calculations
New Measure – Hospice Visits When Death is Imminent Measure Pair

• To assess hospice staff visits to patients in last week of life

• **Measure 1** – Assess the percentage of patients receiving at least 1 visit from RNs, MDs, NPs or PAs in the last 3 days of life.

• **Measure 2** – Assess the percentage of patients receiving at least 2 visits from MSWs, Chaplains, LPNs, or Hospice Aides in the last 7 days of life (includes the 3 days prior to death)
  – Excludes patients with LOS ≤ 1 day (i.e., died day of admission)

Hospice Visits When Death is Imminent Measure Pair

• Only for patients at the Routine Home Care level
• Effective April 1, 2017
• Including short stay patients as CMS expects them to benefit from more visits due to “high symptom burden”
• Phone calls NOT included in the definition
• Focus on these measures may motivate providers to be “more proactive” in addressing symptoms to enhance quality of life

Hospice Visits When Death is Imminent Measure Pair

• Adds new items on the HIS Discharge Record:
  – Section O – Service Utilization – New section
  – O5000 – Level of care in final 3 days – New item
  – O5010 – # visits in final 3 days by discipline – New item
  – O5020 – Level of care in final 7 days – New item
  – O5030 – # visits in 3-6 days prior to death by discipline – New item

• Few changes to HIS-Admission form for other reasons:
  – Patient A0550 Patient ZIP code – New item
  – A1400 Payor information – New item
  – J0900 Pain Screening – Change to the skip pattern
  – J0905 Pain Active Problem – New item to refine NQF #1637 Pain Assessment
Points to Consider

• With the elimination of the 7-day exclusion, what steps do you need to take to ensure all HIS items are addressed at admission?
• Does your agency consistently submit HIS data within the 30 day timeframe?
• Have you reviewed the new HIS items to be added?
• Will your vendor be prepared to extract the new data points in advance of the April 2017 implementation date?

New Measure – Hospice and Palliative Care

Composite Process Measure – Comprehensive Assessment at Admission

Composite Process quality measure will use the current HQRP quality measures as its components:

– Pain Screening
– Pain Assessment
– Dyspnea Screening
– Dyspnea Treatment
– Patients Treated with an Opioid who are given a Bowel Regimen
– Treatment Preferences
– Beliefs/Values Addressed, if desired by patient

Composite Process Measure

• Captures 4 domains
  – Structure and Processes of Care
  – Physical Aspects of Care
  – Existential Aspects of Care
  – Ethical and Legal Aspects of Care Domains
• Calculation: % of patients with data on all 7 measures on HIS-Admission
• Assesses individual components separately for each patient and then aggregates into one score
Composite Process Measure

- No new data collection is needed
- Measure testing and reportability analysis needed before deciding if appropriate for public reporting
- To give consumers a single measure regarding care provision and the completeness of the admission assessment

HIS Areas for Improvement

- Currently, hospices score 90% or higher on 6 of 7 measures
- But Pain Assessment is 65.7% when viewed individually
- Only 68.9% of patients had all processes completed at admission
- What percentage of HIS records have all 7 elements captured?

Current Compliance Requirements

- Applies to HIS-Admission and HIS-Discharge and CAHPS Hospice Survey
  - 70% threshold for CY 2016 to avoid payment impact for FY 2018
  - 80% threshold for CY 2017 to avoid payment impact for FY 2019
  - 90% threshold for CY 2018 to avoid payment impact for FY 2020
  - Threshold continues unless changed in the future
- Applies only to submission deadline (30 days after admission or discharge) and not to completion dates
Monitor Current Compliance

- Review Hospice Timeliness Compliance Threshold Report in CASPER (Certification and Survey Provider Enhanced Reports)
  - Number submitted, number submitted on time and % submitted on time
- Monitor other reports to ensure successful submission with no fatal errors
- Do you consistently submit 80% of HIS records timely? (Threshold for CY 2017)
- Who in your agency monitors quality reports in CASPER?

Hospice CAHPS® Experience of Care Survey

- No changes in processes, exemptions, exceptions, reconsideration requests, or timelines
- Must collect and report data on an ongoing basis
- Data collection begins 2 months after month of death
- Vendors must report data quarterly – 2nd Wednesday of Feb, May, Aug, and Nov
- Do you monitor vendor timeliness?
- Are reports from CAHPS vendors used in QAPI program?
- Do you know who doesn’t respond? Are there any trends?

Hospice CAHPS® Experience of Care Survey

- Exemption based on size is available – fewer than 50 survey-eligible decedents/caregivers from January 1 – December 1 each year
  - Participation Exemption for Size Form must be submitted by August 10, 2017 for the 2016 calendar year
- New hospices that receive their CCN after 1/01/17 are exempt from the FY 2019 requirements
  - CMS makes the final determination – No form needed
Public Reporting

• Public reporting via Hospice Compare site planned in CY 2017
• CMS is building infrastructure for the website and determining how best to include HIS measures and results of Hospice CAHPS Survey
• Hospice Item Set – All 7 measures are eligible for public reporting

Public Reporting

• CAHPS – Will report an 8-quarter rolling average
  – This number will address concerns about variability of data
• Will conduct additional analysis of how non-responders differ from responders to see if they need to control for non-response bias
• Plan to include both the hospice rating questions and the willingness to recommend question
  – Using any number from 0 to 10, where 0 is the worst hospice care possible and 10 is the best hospice care possible, what number would you use to rate your family member’s hospice care?
  – Would you recommend this hospice to your friends and family?

Public Reporting

• CMS plans to release Quality Measure (QM) Reports in December 2016 to give provider-specific scores on HIS-based quality measures
  – Will allow tracking of performance over time to inform internal QAPI efforts
• Will provide Preview reports in CASPER for hospices to review before made public
  – Will have 30 days to preview before posted publicly
  – No corrections to underlying data will be permitted
  – Can ask for a correction to the measure calculations & if wrong, the data will be suppressed, recalculated and published with the next scheduled posting
CASPER Reports

1. HIS Record Error Detail By Provider
2. HIS Record Errors By Field By Provider
3. HIS Records With Error Number Xxxxx
4. Hospice Admissions
5. Hospice Discharges
6. Hospice Error Number Summary By Provider By Vendor
7. Hospice Final Validation
8. Hospice Item Set Print
9. Hospice Item Set Submission Statistics By Provider
10. Hospice Item Sets Submitted
11. Hospice Roster
12. Hospice Submitter Final Validation
13. Hospice Timeliness Compliance Threshold Report

• Is someone in your agency reviewing reports regularly?

CASPER Reports

• Public reporting will eventually include the 5-star rating system
• Public data set posted – https://data.medicare.gov
• High-level demographic data of hospice agencies that have been registered with Medicare
  – Source: CMS Automated Survey Processing Environment (ASPEN)
  – Provider name, address, phone #, CMS Certification Number (CCN), ownership type, profit status, and date of original CMS certification
• Report future changes via PECOS
• Have you verified your agency’s data?
• Do you regularly update provider enrollment information?

Data Collection Tool

• Considering implementation of patient assessment instrument
  – Collect more data for quality reporting
  – Provide clinical data to inform future payment changes, i.e., feasibility of case mix system
• Would capture information on symptom burden, functional status, patient and family preferences
• Would replace HIS, but not the comprehensive assessment forms
• Data would be collected at admission and at discharge
FY 2017 Hospice Payment Update

- Average 2.1% increase in payment rates – Overall $350 million increase in payments for FY 2017
  - 2.7% inpatient hospital market basket update minus 0.3 percentage point multifactor productivity (MFP) adjustment minus 0.3 percentage point adjustment set by the ACA
- Does not factor in 2% sequestration reduction or 2% reduction for not meeting quality reporting requirements

FY 2017 Hospice Payment Update

- SBNF – SIA budget neutrality factor (SBNF) applied to RHC rates
  - For FY2017, days 1-60 is 1.0000 and days 61+ is calculated at 0.9999
- Wage index standardization factor to mitigate fluctuations in the wage index and retain budget neutrality
- Effective 10/01/16, transition to full adoption of new OMB delineations for Metropolitan Statistical Areas (MSAs) – Revert to former CBSA codes
**FY 2017 Hospice RHC Payment Rates**

*(From Table 11 in Final Rule)*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rates</th>
<th>SBNF</th>
<th>Wage Index Standardization Factor</th>
<th>FY 2017 Hospice Payment Update Percentage</th>
<th>FY 2017 Payment Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care (days 1-60)</td>
<td>$186.84 X 1.0000 X 0.9989 X 1.021</td>
<td></td>
<td></td>
<td></td>
<td>$190.55</td>
</tr>
<tr>
<td>651</td>
<td>Routine Home Care (days 61+)</td>
<td>$146.83 X 0.9999 X 0.9995 X 1.021</td>
<td></td>
<td></td>
<td></td>
<td>$149.82</td>
</tr>
</tbody>
</table>

**FY 2017 Hospice CHC, IRC, and GIP Payment Rates**

*(From Table 12 in Final Rule)*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rates</th>
<th>Wage Index Standardization Factor</th>
<th>FY 2017 Hospice Payment Update Percentage</th>
<th>FY 2017 Payment Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>652</td>
<td>Continuous Home Care Full Rate = 24 hrs. $40.19 = FY 2017 hourly rate</td>
<td>$944.79 X 1.0000</td>
<td></td>
<td></td>
<td>$964.63</td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$167.45 X 1.0000</td>
<td>X 1.021</td>
<td></td>
<td>$170.97</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$720.11 X 0.9996 X 1.021</td>
<td></td>
<td></td>
<td>$734.94</td>
</tr>
</tbody>
</table>

**Aggregate Cap**

- Average amount of reimbursement allowed per patient per year
- For accounting years that end after September 30, 2016 and before October 1, 2025, cap is updated by the hospice payment update percentage (had used consumer price index for urban consumers – CPI–U)
- FY2017 – $28,404.99
- Cap accounting year now aligned with federal fiscal year – 2017 cap year is October 1, 2016 – September 30, 2017
DATA ANALYSIS
Source: FY 2015 claims data

Monitoring for Potential Impacts of Hospice Payment Reform

• CMS has ongoing analysis of many data points – provider level and patient level
• Want to assess the effects of payment changes
• Will continue to monitor hospice trends and “vulnerabilities” within the hospice benefit & explore strategies to address and respond to “concerning behavior” in the industry
• May have targeted program integrity efforts
• Acumen, a CMS contractor, will track numerous metrics monthly and annually

Diagnosis Reporting

• Change in top diagnoses with more neurologically-based diagnoses
• Top 5 – Alzheimer’s disease, CHF, Lung cancer, COPD and Senile degeneration of brain.
• Less hospices with only 1 diagnosis on claim
  – 37% of claims have 1 diagnosis
  – 63% have 2 or more
  – 46% have at least 3 diagnoses
• Is your agency consistently reporting more than one diagnosis per claim?
Pre-hospice Spending

• Daily pre-hospice spending analysis of FY2014 data for patients with Alzheimer’s disease, non-Alzheimer’s dementia or Parkinson’s (about 20% of patients)
  – $64.87 per day in the 180 days prior to admission to hospice
  – $96.99 per day in the 30 days prior to hospice election
  – Both are less than the RHC rate
  – Average LOS in hospice was 119 days (compared to 47 days for cancer)

Non-Hospice Spending

• For Part A and Part B, non-hospice spending is down 15.4% but almost $601 million was spent in FY2014
• Part D spending was down by 12.9% - spent $291.6 million in FY2014
  – Many common disease-specific and palliative drugs paid for by Part D – Medicare could be paying twice for hospice patients
• CMS believes it would be “unusual and exceptional” for services to be provided outside of hospice
• Do you have a defined process for the hospice MD to document why services are unrelated?

Non-Hospice Spending

• CMS is going to investigate ways to educate other providers about billing regulations
• How many medications are billed to Part D?
• Do all consulting physicians know to bill your agency instead of Medicare?
• Do you monitor all invoices to be sure you are paying for all items and services that are related?
• Do staff ask on every visit if the patient has new medications or received care outside the home?
Live Discharge Rates

- CMS analyzes characteristics of hospices with higher live discharge rates
  - Provide fewer visits per week and fewer skilled visits
  - Correlation between high live discharge hospices and spending outside of hospice and overall lengths of stay
- CMS concerned with number of live discharges
- Provider community asking for more analysis comparing patient-initiated discharges separately from hospice-initiated discharges

Live Discharge Rates

- Do you track live discharge reasons?
- Are discharge-readmit cases reviewed to ensure discharge was the best course?
- What are the reasons your agency has live discharges?
- How does your agency compare to peers on the PEPPER?
- Why do patients revoke their benefit?
- Do you have GIP contracts with local facilities so that you do not have to discharge for leaving the service area?

Skilled Visits in the Last Days of Life

- In last 7 days, 47% of the time patients did not receive skilled visit from RN or SW
  - 49% did not receive skilled nursing visit
  - 91% did not receive SW visit
- On day of death, nearly 26% did not have a skilled visit
- What are the visit statistics for patients in your agency?
- Do you routinely provide more than one nursing visit per week? If not, why not?
- How many patients receive a SW and chaplain visit in the last week?
- Does visit frequency vary by setting?
Data Points

- Percentage of Medicare beneficiaries electing hospice
- Total number of Medicare hospice patients
- Demographic and geographic location characteristics among Medicare hospice patients
- Number and share of Medicare hospice patients presenting with various terminal conditions, aggregated by broader clinical categories
- Total payment for hospice care and by level of care

Data Points

- Number and share of live discharges
- Number and rate of readmissions
- Average length of episodes
- Proportion of days by level of care
- Volume and payments for non-hospice services used during hospice stays

Data Points (cont.)

Will monitor the following to assess effects of the recent changes in the RHC payment rate:
- Average length of hospice stays
- Total number and share of live discharges
- Average readmissions rates within or after 60 days
Data Points (cont.)

Will monitor the following metrics to determine effects of the SIA payments on incentivizing care at the RHC level:

- Total number of nursing visits – aggregate and separately for RNs and LPNs
- Total number of visits by social workers
- Average number of services billed per discharge
- Average number of hours billed per discharge and per hospice day
- Average number of services billed during the first 7 days, middle of a stay, and last 7 days of a hospice stay
- Intensity of services billed during the first 7 days, middle of a stay, and last 7 days of a hospice stay

Internal Data Analysis

- What are your top diagnoses and how has that changed over the past 2 years?
- What is the length of stay by diagnosis?
- What is your agency’s readmission rate? Does it vary by length of stay?
- What percent of patients receive at least 2 visits by non-nursing staff in the last week of life?
- How many visits does a patient receive during the first week of admission? During the last week?

Resources

Resources

• HIS Hospice User Guides & Training –
  https://www.qtso.com/hospicetrain.html
• HIS Technical Information Webpage –
  https://www.cms.gov/Medicare/Quality-Initiatives-
  Patient-Assessment-Instruments/Hospice-Quality-
  Reporting/HIS-Technical-Information.html
• HIS Education & Resources (QTSO webpage) –

The Carolinas Center is the leading voice for quality end of life care in the Carolinas, representing an extensive number of hospice and palliative care providers in North and South Carolina. Since 1977, TCC has provided visionary leadership, pertinent education, technical assistance, advocacy, and resources to end of life care providers across the two states.

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