On Thursday, May 1, 2015, the Centers for Medicare and Medicaid Services (CMS) issued the Fiscal Year 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements proposed rule. The rule proposes a number of changes to the way in which hospice payment rates are calculated and updated. The most significant change is to propose two routine home care day rates to account for more costly days at the beginning of a hospice stay and a supplemental payment at the end of the stay. It also proposes changes to the Hospice Quality Reporting Program (HQR) and would implement new coding requirements to better enable CMS to track and monitor Medicare spending outside of the hospice benefit for individuals enrolled in hospice.

The overall economic impact of this proposed rule is estimated to be $200 million. This represents a 1.3% payment increase to hospices in FY 2016. Payment to non-profit hospices in the aggregate is expected to increase by 2.7%. In comparison, payment to for-profit hospices is anticipated to increase by .3%. The difference between aggregate payments to non-profit and for-profit hospices is due to the proposed change to the routine home care rate.

In the rule CMS provides select findings from analyses conducted by CMS, the Medicare Payment Advisory Commission (MedPAC), and other organizations. The findings presented in the rule provide context for proposed changes or policy discussions. In this year’s rule, CMS presents data on hospice utilization trends, impact of certain patient characteristics on cost, spending on services outside of the hospice benefit, and live discharge rates. A summary of the findings presented in this year’s rule can be found at Appendix A.
Proposed Hospice Payment Rates for FY 2016

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2015 Rate</th>
<th>Proposed FY 2016 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care(Days 1-60)</td>
<td>$159.34</td>
<td>$188.20</td>
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<tr>
<td>651</td>
<td>Routine Home Care(Days 61+)</td>
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<td>652</td>
<td>Continuous Home Care</td>
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<td></td>
<td>Hourly Rate: $38.75</td>
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<td>Inpatient Respite Care</td>
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<td>656</td>
<td>General Inpatient Care</td>
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</table>

Major Provisions of the Proposed Rule

CMS proposes to:

1. Revise the current routine home care rate to differentiate between days 1-60 and days 60+.
   Hospices would receive a higher rate for the first 60 days to reflect the intensity of service delivery at the beginning of a hospice stay.

2. Create a Service Intensity Add-On (SIA) payment to reimburse providers for higher intensity of services within the last week of a patient’s life if certain conditions are met.

3. Implement the most recent Office of Management and Budget (OMB) labor market area delineations for purposes of determining the wage index for each hospice.

4. Implement a payment update based on the hospital market basket update, the economy-wide productivity adjustment, and a .3% cut to the hospice payment update required by the Affordable Care Act (ACA).

5. Align the accounting year for the aggregate cap with the federal fiscal year.

6. Clarify that hospices must report all diagnoses – not just principle – on hospice claims.

Proposed Routine Home Care Rates and Service Intensity Add-On (SIA) Payment

Section 3132(a) of the ACA directed the Secretary to implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care as determined appropriate by the Secretary. The legislation was motivated by concerns raised by MedPAC that the existing per diem payment model may incentivize inappropriate longer lengths of stay. CMS noted that “the percentage of episodes that are more than 6 months in length has nearly doubled from about 7 percent in 1999 to 13 percent in 2013.” CMS also acknowledged industry concerns about inadequate reimbursement for short hospice stays.

CMS, MedPAC, and others have studied the impact of the current payment model on length of stay and possible payment alternatives. In the rule, CMS considers several models, including MedPAC’s
“U-Shared Payment Model,” and Abt Associates’ “Tiered Payment Model.” The research consistently demonstrates that costs are unevenly distributed through a hospice stay. In general, the very early and final days of hospice are the most resource intensive. Visit intensity is the greatest on days 1-7, after which intensity declines rapidly through approximately day 60. After day 60, the intensity level essentially flattens until the 7 days prior to death. While generally of greater intensity, there is variation in hospice resource use at the very end of life. Costs vary significantly based on how much care an individual receives in his or her final days.

Based on this research, CMS proposed two modifications to the existing hospice payment model: 1) create two routine home care rates, a higher one for the first 60 days of a stay and a lower one for day 61 and beyond; and 2) create a supplemental Service Intensity Add-On (SIA) payment to account for higher intensity services in the last seven of an individual’s life when certain criteria are met.

### Routine Home Care

The proposed routine home care rates for days 1-60 and 61+ are based on two components: a labor portion of the rate and a non-labor portion of the rate. The non-labor portion of the rate is the same for both the 1-60 day rate and the 60+ day rate. The labor component of the rate differs and has been calculated by CMS based on the average wage-weighted minutes per day for the 1-60 day period and the 61+ day period.

In order to mitigate inappropriate discharges and readmissions, CMS proposes to have the “days follow the patient.” In other words, if a patient changes hospices or is discharged and readmitted to the same hospice, the total count of days in hospice will continue and not start from 1. The only exception is for patients who experience a gap of 60 days or more between hospice episodes.

### Service Intensity Add-On Payment

CMS proposes to pay hospices an additional amount for high intensity days near the end of life. To qualify for a SIA payment, CMS proposes the following criteria:

1) the day is billed as a routine home care level of care day;
2) the day occurs during the last 7 days of life (and the beneficiary is discharged dead);
3) direct patient care is provided by a RN or a social worker that day; and
4) the service is not provided in a skilled nursing facility/nursing facility.

The SIA payment (currently $38.75/hr) would be calculated by multiplying the continuous home care hourly payment rate by the amount of direct patient care provided by a registered nurse or social worker up to 4 total hours per day. The SIA payment would be added to the routine home care per diem rate. In other words, the SIA payment would not be the hospice agency’s only payment for that day.
CMS notes that the proposed changes described above would “advance hospice payment reform incrementally... while simultaneously maintaining flexibility for future refinements” (emphasis added). In other words, CMS may seek to further refine the hospice payment methodology in the future. The changes in the proposed rule would be made in a budget neutral manner and would not require major revisions to the claims processing system or process.

2. Proposed FY Hospice Wage Index and Rates Update

The proposed rule would implement three additional provisions that impact hospice payment rates: (a) the final installment of the Wage Index Budget Neutrality Factor (BNAF) phase out, (b) new geographic delineations for purposes of the wage index, and (c) the annual payment update. The payment update would reflect the estimated FY 2016 market basket update and productivity adjustment and the additional .3% reduction in hospice payments required by the ACA. While not a new provision, CMS reminds hospices that they are also subject to a 2 percent decrease in payments if they fail to comply with CMS’ quality reporting requirements.

a. Elimination of the Wage Index Budget Neutrality Factor (BNAF)

The FY 2010 Hospice Wage Index rule finalized a provision to phase out the BNAF over 7 years. This proposed rule incorporates the final installment of the BNAF phase out. For FY 2016, the BANF is reduced by an additional and final 15 percent. In other words, as of FY 2016, the BNAF is eliminated. The overall economic impact of this provision is a -.7 percent (or $120 million) payment reduction.

b. Proposed Implementation of New Labor Market Delineations

In 2013, the Office of Management and Budget (OMB) announced revisions to the delineation of geographic areas (e.g., Metropolitan Statistical Areas, Micropolitan Statistical Areas, Combined Statistical Areas, etc.). These revisions result in the creation of new Core Based Statistical Areas (CBSAs), some urban counties becoming rural, some rural counties becoming urban, and the division of certain existing CBSAs. CMS proposes to implement the most recent OMB delineations to better reflect geographic variation in wage levels in the hospice payment rate. Hospices in impacted areas may see the labor portion of their rate change. CMS proposes to implement the new labor market areas through a one-year transition period during which the wage index for affected hospices would be a blended rate between the old delineations and the new. In year two, the new delineations would be fully used to determine a hospice’s wage index. The overall economic impact of this provision is a .2 percent (or $30 million) payment increase. CMS has published the 2016 proposed wage index tables including the new area designations at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html
c. Proposed Hospice Payment Update Percentage

The hospice payment rate is updated annually based on inflation using the market basket update. The ACA required two other hospice payment reductions that impact the FY 2016 update rate. These include the productivity adjustment, which takes into account economy-wide productivity levels, and an additional .3 percent reduction. For FY 2016, the market based update is estimated to be 2.7 percent and the productivity adjustment is anticipated to be -.6 percent. In total, CMS proposes to update hospice payments by 1.8 percent (2.7 percent minus .6 percent minus .3 percent). CMS proposes to update these numbers if more current data becomes available. The overall economic impact of this provision is a 1.8 percent (or $290 million) payment increase.

3. Proposed Alignment of the Inpatient Aggregate Cap Accounting Year with the Federal Fiscal Year

Hospices are subject to two payment caps: the aggregate cap and the inpatient cap. The aggregate cap limits the total aggregate payment any individual hospice may receive in a year. The inpatient cap limits the total number of Medicare inpatient days a hospice may be reimbursed for in a year. The proposed rule includes several provisions related to caps, including a change to the calculation of the aggregate cap and alignment of the aggregate cap accounting year with the federal fiscal year.

The ACA required that, effective for the FY 2016 cap year, the aggregate cap amount be calculated by applying the hospice payment update to the prior year’s cap amount. This replaces the current methodology of adjusting the original cap amount by the annual change in the consumer price index (CPI-U) for medical expenditures. As a result, the aggregate cap will change from $27,135.96 in FY 2015 to $27,624.41 in FY 2016.

CMS also proposes to align the accounting year for the aggregate cap with the federal fiscal year. Today, hospices have two options for tallying patients for purposes of calculating both the aggregate and the inpatient caps: the “streamlined method” and the “patient-by-patient proportional method.” Under the streamlined method, a different timeframe from the cap year is used to count the number of beneficiaries because this model allows hospices to assign beneficiaries to the year in which they received the majority of their care. In the proportional method, the actual portion of the patients’ time receiving hospice services in a year is assigned to that year. In other words, if a patient only received hospice services in 2013, the entire patient (1) is assigned to 2013. However, if hospice services were provided evenly across 2012 and 2013, 50% (or .5) of the patient is assigned to each of the years.

CMS has previously refrained from aligning the cap accounting year and the federal fiscal year due to concerns about how to count patients in hospices using the streamlined method. However, as of FY 2013, only 486 hospices continued to use that method to count patients. Therefore, CMS proposes in the rule to align the cap accounting year for both the inpatient cap and the hospice
aggregate cap with the federal fiscal year for FY 2017 and later. In addition to aligning the cap accounting year with the federal fiscal year, CMS would also align the timeframe for counting the number of beneficiaries with the federal fiscal year. Through this change, CMS intends to eliminate the complexity of using different timeframes for counting payments and beneficiaries from the federal fiscal year.

4. **Proposed Updates to the Hospice Quality Reporting Program**

CMS implemented the HQRP in 2014. The proposed rule would implement several modifications to the program for FY 2018. CMS proposes that any measures that are adopted in a given year continue in the program indefinitely until action is taken by CMS. The intent of this provision is to streamline the rulemaking process for the program. However, CMS would still be required to use the rulemaking process to propose new measures or to remove, suspend, or replace existing measures. CMS also proposes to require that new hospices begin quality reporting on the date they receive their Medicare Certification Number (CCN) and that all hospices must submit HIS records within 30 days of the Event Date (admission or discharge). CMS proposes compliance thresholds for timeliness of reporting. CMS proposes that hospices be required to submit 70% of all records within the 30 day timeframe in FY 2018, which would increase to 80% and 90% in FYs 2019 and 2020 and beyond, respectively. For FY 2018, the timeliness threshold would be calculated for admission and discharge records that occur on or after January 1, 2016.

CMS does not propose any new quality measures for FY 2017. However, CMS is working with the National Quality Forum (NQF) to identify measure concepts for future implementation. CMS identifies the following areas as high priority for future measure development:

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; and

4) Hospice team communication and care coordination.

The proposed rule would implement several changes to the CAHPS Hospice Survey protocols. Consistent with current policy, CMS proposes to continue to exempt hospices with fewer than 50 eligible decedents/caregivers from participating in the data collection and reporting requirements. The rule provides guidance to hospices that seek an exemption. CMS also proposes to continue a requirement that vendors and hospice providers participate in CAHPS hospice survey oversight activities and that the reconsiderations and appeals process for hospices failing to meet the CAHPS data collection process be part of the existing reconsiderations and appeals processes. The rule includes guidance on how to submit a reconsideration request.
CMS also proposes changes to its communications processes with respect to hospice compliance with the HQRP. In addition to traditional mail, CMS proposes to issue electronic compliance notices via the QIES and CASPER systems in FY 2017. CMS also proposes to publish a list of hospices that successfully meet the reporting requirements on the program’s website.

Finally, CMS discusses plans to ultimately make hospice quality data public, including via a Hospice Compare website that includes star ratings. They note that they are analyzing FY 2014 data to assess the reliability and validity of the current quality measures. CMS will continue their analyses with FY 2015 data before making decisions related to public reporting.

5. **Clarification Regarding Diagnosis Reporting on Hospice Claims**

Based on analyses of spending on Medicare Part A, B, and D services for beneficiaries enrolled in hospice, CMS expresses concerns about potential “unbundling” of services that are included in the hospice benefit. CMS has identified $1.3 billion in spending annually outside of the hospice benefit for individuals who are enrolled in hospice. CMS reiterated Congressional intent of the hospice benefit as providing “comprehensive care aimed at addressing (patients’) physical, emotional, psychosocial and spiritual needs as they approached the end of life.” In addition to questionable levels of spending outside of the hospice benefit, CMS has also received complaints from non-hospice providers that they have been inappropriately denied reimbursement from hospices for services that should have been covered through the hospice benefit.

In the rule, CMS clarifies that 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. This includes reporting any mental health disorders and conditions that would affect the plan of care. CMS will use this data to “inform thoughtful, appropriate, and clinically relevant policy for future rulemaking.” Implications may include program integrity oversight actions. CMS notes that hospices are not fully coding both principle and other diagnoses. In 2014, 49% of hospice claims had only one diagnosis. During that same period, 50% of beneficiaries in hospice had eight or more chronic conditions and 75 percent had five or more chronic conditions.
Appendix A: Significant Research Findings

In the rule, CMS provides select findings from analyses conducted by CMS, the Medicare Payment Advisory Commissioner (MedPAC), and other organizations. The majority of the analyses were conducted by Abt Associates under contract to CMS using FY 2013 claims data. The findings presented in the rule provide context for proposed changes or policy discussions. Below are several of the highlights from this year’s rule:

- **Hospice Utilization Trends**
  - CMS projects that hospice expenditures will continue to increase by approximately eight percent annually. CMS cites three reasons for this growth: increased beneficiary awareness of the benefit, increased patient preference for care provided in home and community based settings, and increased hospice lengths of stay.
  - Average lifetime hospice lengths of stay have increased from 54 days in FY 2000 to 98.5 days in FY 2013.
  - Diagnoses of those using the benefit have changed since implementation of the benefit. Whereas cancer was the predominant diagnosis when the benefit was originally implemented, the two most common diagnoses in FY 2014 were Alzheimer’s disease and Congestive Heart Failure.

- **Impact of Patient Characteristics on Cost and Length of Stay**
  - Lengths of stay are longer for individuals with a primary diagnosis of Alzheimer’s disease, non-Alzheimer’s dementia, or Parkinson’s disease. Individuals with those diagnoses had an average lifetime length of stay of 119 days in FY 2013 compared to 47 days for patients with a principle diagnosis of cancer.
  - Spending in the pre-hospice period for individuals with the same grouping of diagnoses above is lower than for patients with other diagnoses, including cancer. For example, average daily spending for an individual with Alzheimer’s disease, non-Alzheimer’s dementia, or Parkinson’s disease was $66.84 in the 180 days prior to hospice admission. Spending increased to $105.24 in the 30 days prior to hospice admission. In contrast, patients with cancer diagnoses cost on average $145.56 per day in the 180 days prior to hospice admission and $289.85 in the 30 days prior to admission.

- **Non-Hospice Spending During Hospice Stays**
  - In FY 2013, Medicare paid $694.1 million in Part A and B services and $347.1 million in Part D benefits for individuals enrolled in hospice. Of the Part A and B spending, 38.8% was spent on physician, labs, ambulance transport, and physician office visit claims; 28.6% was spent on inpatient care; 16.6% was spent on outpatient Part B services; and the rest was split among durable medical equipment, skilled nursing facility care, and home health care.
- As a result, hospice beneficiaries incurred $132.5 million in cost sharing for items and services through Parts A and B and $50.9 million in cost sharing for Part D drugs while they were in hospice.

- **Live Discharge Rate**
  - Between 2000 and 2013, the overall rate of live discharge increased from 13.2% to 18.3%.
  - There is significant variation in the rate of live discharges. Hospices in the 5th percentile have a live discharge rate of 8.1%. Hospices in the 90th percentile have a live discharge rate of 50%.
  - 40.3% of hospices above the 90th percentile for live discharges were also above the aggregate cap for FY 2013.
  - Hospices with high live discharge rates provide on average fewer visits per week. Hospices at or above the 90th percentile for live discharge rates provide 3.97 visits per week on average, compared to all other hospices at 4.48 visits per week.
  - There is a relationship between high live discharge rates, long lengths of stay, and spending outside of the hospice benefit. Hospices with patients that on average accounted for $30 per day in non-hospice spending while in hospice had live discharge rates that were 33.8% on average and had an average lifetime length of stay of 156 days. In comparison, hospices with patients who had on average $4 per day in non-hospice spending had live discharge rates that were on average 19.2% and an average lifetime length of stay of 103 days.

- **Absence of Skilled Nursing Visits During Last Days of Life**
  - Nearly 5 percent of hospices did not provide any skilled visits in the last 2 days of life to more than 50 percent of their decedents receiving routine home care on those last 2 days.
  - 34 hospices did not make any skilled visits in the last 2 days of life to any of their decedents who died while receiving routine home care.