Details on the FY2018 Hospice Wage Index Proposed Rule

To: NHPCO Provider Members
From: NHPCO Health Policy Team
Date: April 28, 2017

Summary at a Glance

On April 27, 2017, the Federal Register posted the FY2018 Hospice Wage Index proposed rule for public inspection. Download the proposed rule, public inspection version (PDF). The rule includes a 1% rate increase for FY2018, additional information about quality reporting and Hospice Compare, and a request for information on easing regulatory burden. Details of the proposed rule and the proposed FY2018 wage index values are below. Comments are due to CMS no later than June 26, 2017.

NHPCO will be discussing this proposed rule at the upcoming NHPCO Management and Leadership Conference and it will be featured in an upcoming podcast. In addition, NHPCO will schedule listening sessions to listen to provider suggestions and feedback in the coming weeks. Watch for options to contribute your thoughts and opinions.

Rate Increase

- 1% for FY2018 ONLY. An additional $180 million in spending.
- 1% maximum increase in rates as a part of MACRA. Other Medicare providers, such as nursing homes and inpatient rehab facilities, also have a 1% maximum increase.
- Future years, absent Congressional action, the hospice marketbasket increase will revert back to market basket formula.

Wage Index

- CMS has posted the proposed FY2018 Hospice Wage Index charts for rural areas and CBSAs on the CMS website. Download the proposed FY2018 wage index from CMS. Please note that the wage index values could change when the FY2018 rule is final, but this can be used for budget planning for the coming year.

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Cap

- Cap amount: **$ 28,689.04**
- Cap accounting year aligned with Federal Fiscal Year (10/1-9/30) for inpatient cap and hospice aggregate cap

FY 2018 Proposed Rates

For Providers Submitting Quality Data:

Level of Care	FY2017 Payment Rates	FY2018 Proposed Payment Rates
Routine Home Care (Days 1-60)	$190.55	$192.80
Routine Home Care (Days 61+)	$149.82	$151.41
Continuous Home Care (Hourly rate)	$40.19	$40.68
Inpatient Respite Care	$170.97	$172.78
General Inpatient Care	$734.94	$743.55

For Providers that DO NOT Submit Required Quality Data:

Level of Care	FY2017 Payment Rates	FY2018 Proposed Payment Rates
Routine Home Care (Days 1-60)	$190.55	$188.98
Routine Home Care (Days 61+)	$149.82	$148.41
Continuous Home Care (Hourly rate)	$40.19	$39.88
Inpatient Respite Care	$170.97	$169.36
General Inpatient Care	$734.94	$728.83

SIA Budget Neutrality Factor (SBNF)

- CMS used data from FY2016 to adjust the FY 2018 rates, based on the utilization of SIA
- Adjustment is to comply with budget neutrality
- Two offsets applied to the routine home care rate:
  - Days 1-60: 1.0018
  - Days 61+: 1.0005

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Hospice percentage of days by level of care (FY 2016):

RHC	98.02%
GIP	1.40%
CHC	0.27%
IRC	0.10%

Live Discharges and Length of Stay

- Average lifetime length of stay was 113.5 days in FY 2015 when level of care at admission is RHC
- Median total live discharge rate remains around 17%
- Of that number:
  - 38% were beneficiary revocations
  - 51% were discharged because the beneficiary was considered no longer terminally ill
  - 11% were discharged due to a beneficiary transfer to another hospice
- CMS states: "Overall, our analyses do not reveal any anomalies in lengths of stay and rates of live discharges at this time."

Skilled Visits Prior to Death (FY 2016)

- In FY2016, on any given day in the last 7 days of life, 43.6% of patients didn't receive a skilled visit (registered nurse or social worker). 21% of patients did not receive a skilled visit on day of death. Comparing FY 2015 and FY 2016 data, there were relatively the same amounts of nursing and medical social service visits (1.6 hours per day) provided at RHC level.
- CMS states, "…we do not believe that the results highlight any immediate concerns regarding behavior changes among hospices, and it appears that beneficiaries are receiving similar levels of care when compared to time periods prior to the implementation of the policy reforms."

Spending Outside the Hospice Benefit After Hospice Election

- **Parts A and B:** Non-hospice spending after the hospice election has consistently declined since first reported in the FY 2015 NPRM.
  - From FY 2012 to FY 2016, non-hospice spending in these areas have declined 25%
  - CMS states: Amounts are not trivial and monitoring will continue:
    - In FY2012: $748 million
    - In FY2016: $534 million

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- **Part D**: Spending outside the hospice benefit, unlike Parts A and B, increased in FY 2016 as compared to FY 2012.
    - In FY2012: $331.3 million
    - In FY2016: $347.5 million
    - CMS states: Concern that common palliative and other disease-specific drugs for hospice beneficiaries that should be covered under the Part A hospice benefit are instead being covered and paid for through Part D. Also raises issue of maintenance drugs.

Data for Certifying Terminal Illness

- Questions raised about the source of clinical information for the hospice medical director to use in making certification decisions.

- Question about Local Coverage Determination (LCD) indicators and whether the "long term monitoring and evaluation by a physician separate from the hospice medical director is necessary.

- CMS concerns:
    - "face-to-face encounter with a hospice physician or allowed non-physician practitioner is not required until the third election period and each subsequent recertification thereafter. Consequently, a patient may never be seen by the hospice physician who is certifying that he or she is terminally ill."
    - "any information regarding the patient's health status from hospice staff (for example, registered nurses) should not be the sole documentation used to support the initial certification requirement as the patient has yet to meet the eligibility requirement."

- Soliciting comments:
    - Specify that the referring physician's and/or the acute/post-acute care facility's medical record would serve as basis for initial hospice eligibility determinations.
    - Would be obtained prior to election of the benefit, when determining certification and subsequent eligibility.
    - Individual must be certified as terminally ill prior to receiving hospice services; could not be determined by the hospice after admission.
    - Documentation of an in-person visit from the hospice Medical Director or hospice physician member of the interdisciplinary group could be used as documentation to support initial hospice eligibility determinations, only if needed to augment the clinical information from the referring physician/facility's medical records.

- Comments on current processes used by hospices to ensure comprehensive clinical review to support certification and any alternate suggestions for supporting clinical documentation sources are also encouraged.

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New Priority Areas for Claims-based Measures under Consideration and Development

1) **Potentially avoidable hospice care transitions**
    - Reduce potentially avoidable transitions at the end of life which are burdensome to patients, families and the health care system, because they are associated with adverse outcomes, lower patient and family satisfaction, higher costs and fragmentation of care delivery.
2) **Access to levels of hospice care**
    - Focus on the provision of CHC and GIP. Measuring use of levels of care will incentivize hospice providers to continuously assess patient and caregiver needs and provide the appropriate level of care to meet these needs.

New Data Collection and Submission Mechanisms Under Consideration: Hospice Evaluation & Assessment Reporting Tool (HEART)

- Under development.
- This new data collection mechanism would be a hospice patient assessment tool
- Two primary objectives:
    - To provide the quality data necessary for HQRP requirements and the current function of the HIS
    - provide additional clinical data that could inform future payment refinements

Hospice Compare (targeted for late summer 2017)

- CMS is developing a Hospice Compare web site which will allow consumers, providers and stakeholders to search for all Medicare-certified hospice providers and view their information and quality measure scores.
- June 1, 2016: Hospice will have chance to review and challenge results, prior to posting on Hospice Compare.
- Only the 7 HIS measures will be in Hospice Compare in 2017. The Hospice CAHPS measures will be added in the "winter of 2018."

Star Ratings (coming, but not definite time period)

- Like other CMS Compare sites, the Hospice site will, in time feature a quality rating system that gives each hospice a rating of between 1 and 5 stars.
- Hospices will have pre-publication access to their own quality data.

Reducing Regulatory Burden

- Request for Information issued
- Asking for ideas, suggestions on payment system redesign, elimination or streamlining of reporting, monitoring and documentation requirements

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- Provide operational flexibility, feedback mechanisms, and data sharing that would enhance patient care, support of physician-patient relationship in care delivery, and facilitation of individual preferences.
- Responses to this Request for Information could also include recommendations regarding when and how CMS issues regulations and policies and how CMS can simplify rules and policies for beneficiaries, clinicians, physicians, providers, and suppliers.

Questions should be directed to regulatory@nhpco.org.

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NHPCO • 1731 King Street • Alexandria, VA 22314
703/837-1500 • 703/837-1233 (fax) • www.nhpco.org

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