DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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FACT SHEET

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CMS proposes updates to the wage index and payment rates for the Medicare Hospice Benefit

Overview

On May 2, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule [CMS-1609-P] that would update fiscal year (FY) 2015 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries.

The proposed hospice payment rule reflects the ongoing efforts of CMS to protect beneficiary access to patient-centered hospice care. As proposed, hospices would see an estimated 1.3 percent ($230 million) increase in their payments for FY 2015. The hospice payment increase would be the net result of a proposed hospice payment update to the hospice per diem rates of 2 percent (a "hospital market basket" increase of 2.7 percent minus 0.7 percentage point for reductions mandated by law), and a 0.7 percent decrease in payments to hospices due to updated wage data and the sixth year of CMS' seven-year phase-out of its wage index budget neutrality adjustment factor (BNAF).

Proposed Rule Details

BNAF phase-out

This proposed rule would implement the sixth year of the seven-year BNAF phase-out, reducing the BNAF by 15 percent, for a total reduction of 85 percent since FY 2010. The BNAF was implemented in 1997, when the former Health Care Financing Administration (HCFA), now CMS, moved from an outdated wage index to a more current and accurate method for determining hospice payments. In the FY 2010 Hospice Wage Index final rule, CMS finalized a schedule to phase-out the BNAF over seven years, reducing it by 10 percent in FY 2010 and by 15 percent reductions each year from FY 2011 through FY 2016.

Terminal illness and related conditions

Under the Medicare hospice benefit, the hospice is responsible for providing any and all services necessary for the palliation and management of the terminal illness and related conditions. The Medicare hospice benefit requires that the hospice physician and the patient's attending physician (if any) certify that the patient has a medical prognosis with a life expectancy of six-months or less if the terminal illness runs its normal course. In previous rules, we have reiterated that all diagnosis codes contributing to the prognosis of the beneficiary should be reported on the hospice claim. However, coding practices continue to show that hospices are primarily focused on one diagnosis code on the hospice claim. We have also received numerous inquiries that indicate providers need

formal definitions for the terms “terminal illness” and “related conditions.” Therefore, we are soliciting comments on possible definitions of “terminal illness” and “related conditions”.

Notice of Election and Termination/Revocation Notice

When electing hospice, a beneficiary waives Medicare coverage for any care for the terminal illness and related conditions except for services provided by the designated hospice and attending physician. A hospice is to file a Notice of Election (NOE) as soon as possible to set up the hospice election within the claims processing system. Late filing of the NOE can result in inaccurate benefit period data and leaves Medicare vulnerable to paying non-hospice claims related to the terminal illness and related conditions and beneficiaries liable for cost sharing associated costs. We are proposing to revise the regulations to require that the NOE be filed within three calendar days after the effective date of hospice election. We are proposing that when the NOE is filed beyond this three day period, the hospice providers would be liable for the services furnished during the days from the effective date of hospice election to the date of NOE filing.

Similar to the NOE, the claims processing system must be notified of a beneficiary’s discharge from hospice or hospice benefit revocation. This update to the beneficiary’s status allows claims from non-hospice providers to process and be paid. Upon discharge or revocation, the beneficiary immediately resumes the Medicare coverage that had been waived when he/she elected hospice. We are proposing new regulations to require hospices to file a notice of termination/revocation within three calendar days of a beneficiary’s discharge or revocation, unless the hospices have already filed a final claim. The proposed requirement would protect beneficiaries from delays in accessing needed care.

Including the attending physician on the Hospice Election form

A hospice “attending physician” is described by the statutory and regulatory definitions as a medical doctor, osteopath, or nurse practitioner whom the patient identifies, at the time of hospice election, as having the most significant role in the determination and delivery of his or her medical care. We have received reports of problems with the identification of the patient’s designated attending physician. Over a third of hospice patients had multiple providers submit Part B claims as the “attending physician” using a modifier. We propose revising the regulations to require the hospice to identify the attending physician on the election form signed by the beneficiary.

Part D and Hospice

When a Part D sponsor receives a daily transaction reply report (DTRR) from CMS indicating a beneficiary has elected hospice, we require that the sponsor have controls in place to ensure that Part D does not pay for drugs and biologicals that are included in the hospice payment rates and therefore are the hospice’s responsibility. In December 2013, we published guidance with request for comments entitled “Part D Payment for Drugs for Beneficiaries Enrolled in Hospice”. Commenters requested that CMS establish and require a standardized process for determining payment responsibility for prescription drugs. In this proposed rule, we are soliciting comments on Part D and hospice coordination and appeals processes that we are considering proposing in the future.

Hospice Experience of Care Survey

Hospice providers are required to begin using a Hospice Experience of Care Survey for informal caregivers of hospice patients surveyed in 2015. This proposed rule provides background and a

description of the development of the Hospice Experience of Care Survey, including the model of survey implementation, the survey respondents, eligibility criteria for the sample, and the languages in which the survey is offered. The proposed rule also outlines participation requirements for calendar year (CY) 2015. We also discuss vendor oversight activities and the reconsideration and appeals process. We are planning to launch a website for the hospice survey in the summer of 2014 (http://www.hospicecahpssurvey.org).

Expedited Hospice cap overpayment recovery

Our current practice is for the Medicare contractors to complete the hospice cap determinations about 16 to 24 months after the cap year in order to demand any overpayment. To better safeguard the Medicare Trust Fund, we believe that demands for cap overpayments should occur sooner. We propose to require providers to complete their cap determination within 150 days after the cap period and remit any overpayments. If a hospice does not complete its cap determination timely, its Medicare payments would be suspended until the cap determination is complete and received by the contractor. This proposal is similar to the current practice by all other provider types that file cost reports with Medicare.

Eligibility requirements for new hospices

We are proposing to permit newly certified hospices receiving notice of their CMS certification number on or after November 1, 2014 to be excluded from the quality reporting requirements for the FY 2016 payment determination. Data submission and analysis would not be possible for a hospice receiving notification of their certification this late in the reporting time period. For future years, we propose that for hospices that receive notification of certification on or after November 1, of the preceding year involved, to be excluded from any payment penalty for quality reporting purposes for the following fiscal year.

The proposed rule went on display on May 2, 2014 at the *Federal Register's* Public Inspection Desk and will be available under "Special Filings," at https://www.federalregister.gov/public-inspection.

For further information, see http://www.cms.gov/Center/Provider-Type/Hospice-Center.html. Public comments on the proposal will be accepted until July 1, 2014.