HOSPICE COMPLIANCE/REGULATORY REQUIREMENTS, WITH MEDICARE REIMBURSEMENT CHANGES

2009 - 2015
Hospices are facing a perfect storm
- multiple Medicare reimbursement reductions, a series of costly regulatory changes, and hospice payment reform looming.

With the confluence of reimbursement cuts, increased regulatory and administrative burdens, and the prospect of significant additional changes to the Medicare Hospice Benefit in the near future, the health of the hospice community, and access to it, is in danger.

Hospice care relies far more heavily on Medicare and Medicaid reimbursements (92.3% of patients) compared to other types of providers. This poses a challenge for hospice providers, allowing little room for shifting costs in response to the financial, administrative, and regulatory challenges.

According to recent MedPAC data...
the projected hospice margin for 2014 is 7.8%. Once other mandatory but non-reimbursable costs are included (bereavement services and volunteer programs), the aggregate margin drops to 6.1%, and that is before taking into account the effects of sequestration.
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Budget Neutrality Adjustment Factor (BNAF) (October 1, 2009)
Since 1997, use of the BNAF ensured that aggregate Medicare payments for hospice services would remain at the same level as they would have under the previous wage index. In 2008, elimination of the BNAF was proposed. The American Reinvestment and Recovery Act (“ARRA”) included a provision to delay the BNAF phase-out until October 2009. After a gradual seven year phase out process ending in FY2016, the BNAF will no longer be used in the hospice wage index calculation. The reduction in hospice reimbursement is estimated at -4.2 percent when the phase out is complete.

Brief Physician Narratives (October 1, 2010)
This hospice physician narrative requirement was a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addition to the certification and recertification forms.

CR4644: Reporting Visit Intensity on Claim Form (January 1, 2011)
CMS requires hospices to provide time data for visits by adding visit length in 15-minute increments for nurses, social workers, and hospice aides. CR4644 adds physical therapists, occupational therapists, and speech language therapists to the reporting requirement.

Concurrent Care for Children (March 20, 2011)
Section 2302 of the Patient Protection and Affordable Care Act (ACA) requires that terminally ill children enrolled in Medicaid or CHIP programs and eligible for hospice services are now allowed to receive hospice services without foregoing curative treatment.

CR1242: Report Revocations as Separate Code on Claim Form (July 1, 2012)
Hospices must code a patient revocation separately on the claim form for CMS tracking of revocations separately from hospice-initiated discharges.

Productivity Adjustment (July 1, 2012)
The ACA imposed an additional change to the Medicare hospice formula that will further reduce hospice payments by approximately 11.8 percent over the next ten years through the introduction of a “productivity adjustment” on the calculation of annual payment updates forable 10.1%.

Quality Reporting for Hospice Programs (October 1, 2012)
Section 3102 of the ACA adds a new requirement to report on two measures: a structural measure on patient-focused performance improvements and a pain score which measures pain on admission and pain after 48 hours.

CR3311: Demand Billing of hospice General Inpatient Level of Care (July 1, 2013)
CMS requires the hospice provider to issue an advance beneficiary notice (ABN) if the beneficiary wants to continue receiving general inpatient (GP) level of care that likely won’t be covered by Medicare when the hospice determines that continued hospice GP care is not reasonable and medically necessary.

Deadline for CY2013 Quality Reporting (April 1, 2014)
HCFA 355:Mandatory Data Collection Form (April 1, 2014)
Hospices must report each GP visit to hospice staff in a contract facility, facility name, and provider identifier (NPI) as well as visit type, performance (Inpatient and non-inpatient), and insurance information.

CMS Guidance on Hospices and Part D (July 1, 2014)
All prescription drugs for a patient in hospice will be reported in hospice will be reported for payment by Part D and will require the hospice to submit a prior authorization form to justify why a drug is unsuitable to the terminal illness and should be covered by the Part D plan.

Hospice Skilled Staff (July 1, 2014)
The implementation data of seven new quality measures begins July 1, 2014. Data is collected throughout a patient’s enrollment period (P0). The data is divided into two parts: HIS-Admission and HIS-Discharge. The data is collected from hospice records and can be used to calculate 6 National Quality Forum (NQF) measures and 1 modified NQF measure.

Sequestration (July 1, 2013)
As part of deficit reduction efforts, Medicare providers, including hospices, will experience a non-compensating 2% reduction in payments each year until 2021. Since sequestration was first introduced in 1997, it has been extended to 2024 as a method to offset the costs of other legislation.

Long Term Care Facilities: Hospice Services Final Rule (August 23, 2013)
The final rule on “face-to-face” encounters as a secondary/other diagnosis.

ACA Productivity Adjustment (July 1, 2013)
The ACA imposes an additional productivity adjustment on top of the productivity adjustment applied to all Medicare providers. The FY2015 Medicare-wide productivity adjustment percentage will be set in mid-summer 2014.

Reporting on Structural Measure and NQF 0209 data due to CMS.

Hospice Care as a Medicare benefit.

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The HIPAA Omnibus Rule (September 22, 2014)
CMS made this change to improve the rules for business associates, require HIPAA policies and procedures to address possible breaches of unsecured PHI, update notification procedures, and train employees on updated obligations.

Penalties for Failure to Participate in CY2013 Quality Reporting (October 1, 2014)
If data not submitted by the hospice by the April 1, 2014, deadline, the hospice will have a 2% hospital market-based reduction in payment year FY2015.

Hospice Claims To Be Readied (October 1, 2014)
CMS (FY2014 Wages Index Final Rule) has directed that all claims that use a manifestation code as a primary diagnosis (including both initial and subsequent) will not be paid for services provided on and after October 1, 2014. However, these codes may be used as a secondary code.

Hospice Cost Report (October 1, 2014)
CMS will implement a new cost report for free-standing hospice providers for cost reporting periods beginning October 1, 2014. The hospice cost report will be required to overwhelm their charts of accounts in order to collect data on expenses based on level of care. Other changes in forms and data requirements also exist.

ACA Productivity Adjustment (October 1, 2014)
In FY2015, hospices will continue to receive a -0.3 productivity adjustment on top of the productivity adjustment applied to all Medicare providers. The FY2015 Medicare-wide productivity adjustment percentage will be set in mid-summer 2014.

Since sequestration went into effect, it has been extended to 2024 as a method to offset the costs of other legislation.

Hospice CAHPS Survey (formerly known as the Hospice CAHPS Survey), which is sent out to family caregivers of deceased patients.

A post-death family caregiver survey, developed by CMS for the assessment of patient and family experiences with hospice care will be administered by survey vendors on behalf of hospice. A different version of the survey will be administered based upon the patient’s site of death: home, nursing home, or inpatient unit.

Hospice CAHPS Survey Mandate: Implementation April 1, 2015
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