HOSPICE COMPLIANCE/REGULATORY REQUIREMENTS, WITH MEDICARE REIMBURSEMENT CHANGES

2009 - 2016
Budget Neutrality Adjustment Factor (BNAF) (October 1, 2010)
BNAF to adjust hospice payments for the length of stay, starting in 2011.

MedPAC that hospice programs with a high

Hospices do not identify which diagnoses they have determined to be related versus unrelated. The list of diagnoses includes any mental health disorders or conditions that affect the plan of care.

Sequestration (January 2013)
An across-the-board reduction to all Medicare programs, including hospice, experience a non-compounding two percent reduction in payments for services provided to 2012.

Long-Term Care Facilities: Hospice Services
Final Rule August 25, 2012
Long-term care facilities and skilled nursing facilities arrange for hospice care through an agreement with one or more Medicare-certified hospices. The hospice must maintain written agreements specifying the roles and responsibilities of all parties involved.

ACA Productivity Adjustment (July 1, 2011)
In FY2011, Medicare providers receive a productivity adjustment of -0.3 percent, for a total payment reduction of 0.8 percent.

Hospice Self-Reporting to the Aggregate Cap
March 20, 2013
CMS requires hospices to complete hospice cap determination within 5 months after the cap year ends. It provides the hospice with the opportunity to dispute the cap until April 15, 2013.

Hospice Case Management
March 20, 2013
MedPAC recommends hospice case management for patients with severe comorbidities or when the patient's life expectancy is less than 90 days.

Quality Reporting for Hospice Programs
October 1, 2012
CMS requires hospices to report on two measures: a structural measure on patient-focused performance and a process measure.

ICD – 10 Implementation
October 1, 2012
ICD-10 codes replace ICD-9 codes used by medical coders and billers to report hospice care diagnoses and procedures.

Implementation of 2013 Claims CBSA or State Designations
October 1, 2013
FY2013 is the first period using the new ICD-10-CM code set. Hospice providers can use the new codes to report hospice care diagnoses and procedures.

Reimbursement rate equals the continuous home care hourly wage index (which has been revised to the national 85th percentile) plus post-mortem visits; and

CR8371: Demand Billing of Hospice General Inpatient Level of Care
October 1, 2014
CMS implements Hospice CAHPS, a post-death family caregiver survey designed to assess patient and family experiences with hospice. The survey includes 12 questions that assess the quality of care.

CR541: Rule-Making
October 1, 2014
CMS issues revised guidance regarding the prior authorization (PA) requirement for medications unrelated to the terminal prognosis. The PA now applies only to medications unrelated to the terminal illness and submitted for payment under a patient’s Part D plan. The PA now applies only to medications that are considered to have a high potential for misuse or abuse.

CR542: Final Rule
October 1, 2014
CMS requires hospices to submit the NOE and/or NOTR, and have the form(s) accepted by their Medicare contractor. Hospices must submit their NOE and/or NOTR within 30 days of the end of the benefit period.

CR543: Final Rule
October 1, 2014
In FY2016, hospices must provide a signed document designating a new attending physician. CMS intends that this new attending physician will be the new primary physician of the patient.

CR544: Final Rule
October 1, 2014
The SIA payment equals the continuous home care hourly wage index (which has been revised to the national 85th percentile) plus the estimated amount of aggregate expenditures for hospice care. The estimated amount is considered a reimbursement rate and is used to calculate the payment for hospice services.

CR545: Final Rule
October 1, 2014
The Service Intensity Add-On is a productivity adjustment of -0.3 percent applied to the total productivity adjustment applied to all Medicare providers.

### Sequestration

In 2013, the across-the-board reduction to all Medicare programs, including hospice, experience a non-compounding two percent reduction in payments for services provided in 2012.

Long-term care facilities and skilled nursing facilities arrange for hospice care through an agreement with one or more Medicare-certified hospices. The hospice must maintain written agreements specifying the roles and responsibilities of all parties involved.

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Medicare providers receive a productivity adjustment of -0.4 percent. Hospices experience an additional 0.7 percent productivity adjustment, for a total payment reduction of 1.1 percent.

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

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 more heavily on Medicare and Medicaid reimbursements (91% of patients) than 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 2016 is 7.7%. Once other mandatory but non-reimbursable costs are included (bereavement services and volunteer programs), the aggregate margin drops to 6.0%.