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

FOR IMMEDIATE RELEASE
August 4, 2014

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CMS finalizes updates to the wage index and payment rates for the Medicare Hospice benefit for fiscal year 2015

Overview

On August 4, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a final rule [CMS-1609-F] to update the Medicare hospice payment rates and the wage index for fiscal year (FY) 2015.

The final rule reflects the ongoing efforts of CMS to protect beneficiary access to patient-centered hospice care. Hospices will see an estimated 1.4 percent ($230 million) increase in their payments for FY 2015. The hospice payment increase would be the net result of a hospice payment update to the hospice per diem rates of 2.1 percent (a "hospital market basket" increase of 2.9 percent minus 0.8 percentage point for reductions required 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).

Final Rule Details

BNAF phase-out

This final rule continues with 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 earlier wage index to a new 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. Ongoing data analysis and anecdotal reports indicate that there is some possible confusion and misinterpretation by hospices as to the

meanings of "terminal illness" and "related conditions." As such, the proposed rule solicited comments on possible definitions of "terminal illness" and "related conditions." We appreciate the comments received in response to this solicitation and will consider those comments for possible future rulemaking.

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 record the hospice election within the claims processing system. Late filing of the NOE can result in inaccurate benefit period data, leaving Medicare vulnerable to paying non-hospice claims related to the terminal illness and related conditions, and beneficiaries potentially liable for sharing associated costs. In this rule, we are finalizing a requirement that the NOE be filed within five calendar days after the effective date of hospice election. When the NOE is filed more than five calendar days after the effective date of election, the hospice would be financially liable for the cost of the beneficiary's care on days between the effective date of hospice election to the date of NOE filing. In response to comments, the final rule provides for an exceptional circumstance policy, which would waive the consequences of filing a late NOE when certain circumstances beyond a hospice's control prevent timely 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 be processed and paid. Upon discharge or revocation, the beneficiary immediately resumes the Medicare coverage that had been waived when he/she elected hospice. This rule puts in place a policy to require hospices to file a notice of termination/revocation (NOTR) within five calendar days after a beneficiary's discharge or revocation, unless the hospice has already filed a final claim. This final policy helps protect beneficiaries from unnecessary delays in accessing necessary non-hospice 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. This rule finalizes a requirement that the election form include the beneficiary's choice of attending physician. We also finalized a requirement that the beneficiary provide the hospice with a signed document when he or she chooses to change attending physicians. We will also provide information to providers and physicians about the role of the attending physician, as well as information related to billing of physician services provided to beneficiaries under the Medicare hospice benefit.

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 July 2014, we published guidance with a 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 the proposed rule, we solicited comments on Part D and hospice coordination, and the appeals processes that we are considering proposing in the future. We appreciate the comments received in response to our solicitation and will consider those comments in possible future rulemaking.

CAHPS® Hospice Survey

National implementation of the CAHPS® Hospice Survey will begin January 1, 2015, with a dry run, followed by monthly participation. Hospices must conduct the survey for at least one month during the dry run, which will occur between January and March of 2015. Monthly participation starts April 1, 2015. Hospices must contract with a CMS-approved vendor to conduct the survey on their behalf. Participation for calendar year 2015 will impact hospices' Annual Payment Update (APU) in FY 2017. The final rule provides background and a description of the development of the CAHPS® Hospice Survey, including the modes of survey implementation, the survey respondents, eligibility criteria for the sample, and the languages in which the survey is offered. The rule also describes vendor oversight activities and the reconsideration and appeals process. The website for the survey is 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. This rule finalizes a policy requiring providers to complete their aggregate cap determination within five months after the cap year, but not sooner than three months after the end of the cap year, and remit any overpayments. It also finalizes our proposal to suspend payments for hospices that did not file their aggregate cap report. We did not finalize any policies related to the completion of the inpatient cap.

Eligibility requirements for new hospices

The final rule permits 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 are finalizing our proposal that hospices which receive notification of certification on or after November 1, of the preceding year involved, be excluded from any payment penalty for quality reporting purposes for the following fiscal year.

The final rule went on display on August 4, 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.

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