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May 26, 2011

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Proposed Hospice Rule Tackles Aggregate Cap Calculation, Face-to-Face Encounter Rule and Quality Reporting

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After substantial litigation over CMS's method for counting Medicare beneficiaries in its hospice aggregate cap calculation, CMS has now proposed to revise the hospice cap regulation to include proportional counting methodology.

On April 28, 2011, CMS proposed changes to hospice cap calculations for FY 2012 and beyond, as well as changes to the hospice face-to-face encounter requirements. The proposed rule also sets forth how CMS proposes to implement a hospice quality reporting program. The proposed rule was published in the Federal Register on Monday May 9 and can be found here [PDF]. Although the May 9 Federal Register indicated that CMS would accept comments on the proposed rule until July 8, 2011, CMS later published a correction [PDF] indicating the comment period expires on June 27, 2011.

Aggregate Cap Calculation

As discussed in previous Payment Matters articles ("Two More Courts Invalidate CMS's Regulations for Calculating Hospice Cap" and "CMS Capitulates, Issues Ruling Granting Relief in Hospice Cap Challenges"), Medicare pays a hospice provider a predetermined fee for each day that an eligible patient receives hospice services. The hospice benefit includes an annual per-beneficiary cap, applied retrospectively and in the aggregate, to limit the total amount that can be paid to a hospice each year. A number of district courts and two appellate courts have held that CMS's counting methodology, which counts a beneficiary only in a single year, is invalid because it is contrary to the express direction in the enabling statute to allocate a patient's stay across multiple fiscal years "to reflect the proportion of hospice care that each such individual was provided in a previous or subsequent

accounting year" (42 U.S.C. § 1395f(i)(2)(C)). Throwing in the towel, CMS issued a Ruling on April 14, 2011 granting relief to any hospice provider that has a properly pending administrative appeal on this issue. In order to avoid further litigation, CMS has now proposed to change its hospice cap regulation to include a proportional counting methodology.

Beginning with the 2012 cap year, the proposed rule would change the current hospice aggregate cap methodology, which CMS calls the "streamlined method," and adopt a patient-by-patient proportional methodology. The proposed rule explains that:

> under the proposed patient-by-patient proportional methodology a hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in that cap year, using the best data available at the time of the calculation. We propose that the whole and fractional shares of Medicare beneficiaries' time in a given cap year would then be summed to compute the total number of Medicare beneficiaries served by that hospice in that cap year.

Under the proposed rule, any hospice provider that has had its cap calculated under the proportional method for any year prior to FY 2012, as a result of judicial action or application of the Ruling, would have to continue using the proportional method. Hospices that have not had their hospice caps calculated by the proportional method may make a one-time election to continue to have their caps determined under the "streamlined method." This election must be made within 60 days following the receipt of the 2012 cap determination.

Hospice providers that elect to have their cap determinations calculated using the streamlined methodology may later elect to have their cap determinations calculated pursuant to the patient-by-patient proportional methodology by either electing to change to the patient-by-patient proportional methodology or by appealing a cap determination calculated using the streamlined methodology to determine the number of Medicare beneficiaries. However, once a hospice has had

its cap determination calculated using the patient-by-patient proportional methodology for any cap year it must continue to have its cap calculated using this methodology.

According to CMS, contractors will provide hospices with instructions regarding the cap determination methodology election process.

Face-to-Face Encounter

In the final hospice rule issued in November 2011, CMS implemented the provision of the Affordable Care Act that requires that a physician have a face-to-face encounter with a hospice patient before the 180th-day recertification . In that final rule, CMS required that the face-to-face encounter be performed by the same hospice physician who certified the terminal illness, and that this encounter take place “no more than 30 calendar days prior to the 3rd benefit period recertification” and “no more than 30 calendar days prior to every recertification thereafter.”

Many hospices and physicians objected to the requirement that the same physician perform both the face-to-face encounter and the recertification of terminal illness, asserting that it would limit access to hospice care, especially in rural areas. In response, CMS has now proposed to ease the requirement. Under the proposed rule, any hospice physician can perform the face-to-face encounter and provide the clinical findings to the hospice physician who then can recertify the terminal illness, a requirement for continued eligibility for hospice services.

CMS also clarified in the proposed rule that the face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the third benefit period recertification, and every benefit period recertification thereafter. CMS was concerned that hospices may have interpreted the current regulatory language to mean that the encounter could occur no earlier than 30 days prior to the recertification period but could take place after the beginning of the recertification period.

Quality Reporting

The Affordable Care Act provides that, beginning with FY 2014, CMS shall reduce the annual market basket update by 2 percentage points for any hospice that does

not comply with quality data submission requirements. To implement this provision, CMS proposes that hospices submit the following data:

- Data on the National Quality Forum (NQF) measure on pain management (NQF #0209), by April 2013;
- Data on a structural measure related to Participation in a Quality Assessment and Performance Improvement (QAPI) Program that Includes at Least Three Quality Indicators Related to Patient Care, by January 31, 2013; and
- A voluntary submission of the proposed structural measure, including a description of each of the patient-care focused quality indicators.

Ober|Kaler's Comments

Hospices that haven't already obtained the use of the proportional method for the hospice cap will need to assess the calculations of their caps under both the streamlined method and the new proportional method, to determine which is more advantageous to them. In addition, hospices now will face the same kind of quality reporting as other providers, and should take every opportunity to comment on the appropriateness of the quality measures. Down the road, their annual payment will depend heavily on their submission of these quality data, so care must be taken to ensure they are in a position to comply with the reporting requirements.