Hospice Proposed Rule:

How to Prepare for 2022

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Lindsay Cobb
Product Marketing Director
WAYSTAR

Melinda Gaboury
COS-C, CEO

Greg Lotz
Director of Partner, Contract & EVV Mgmt
KanTime Healthcare Software

Kristen Duell
Executive Vice President
KanTime Healthcare Software

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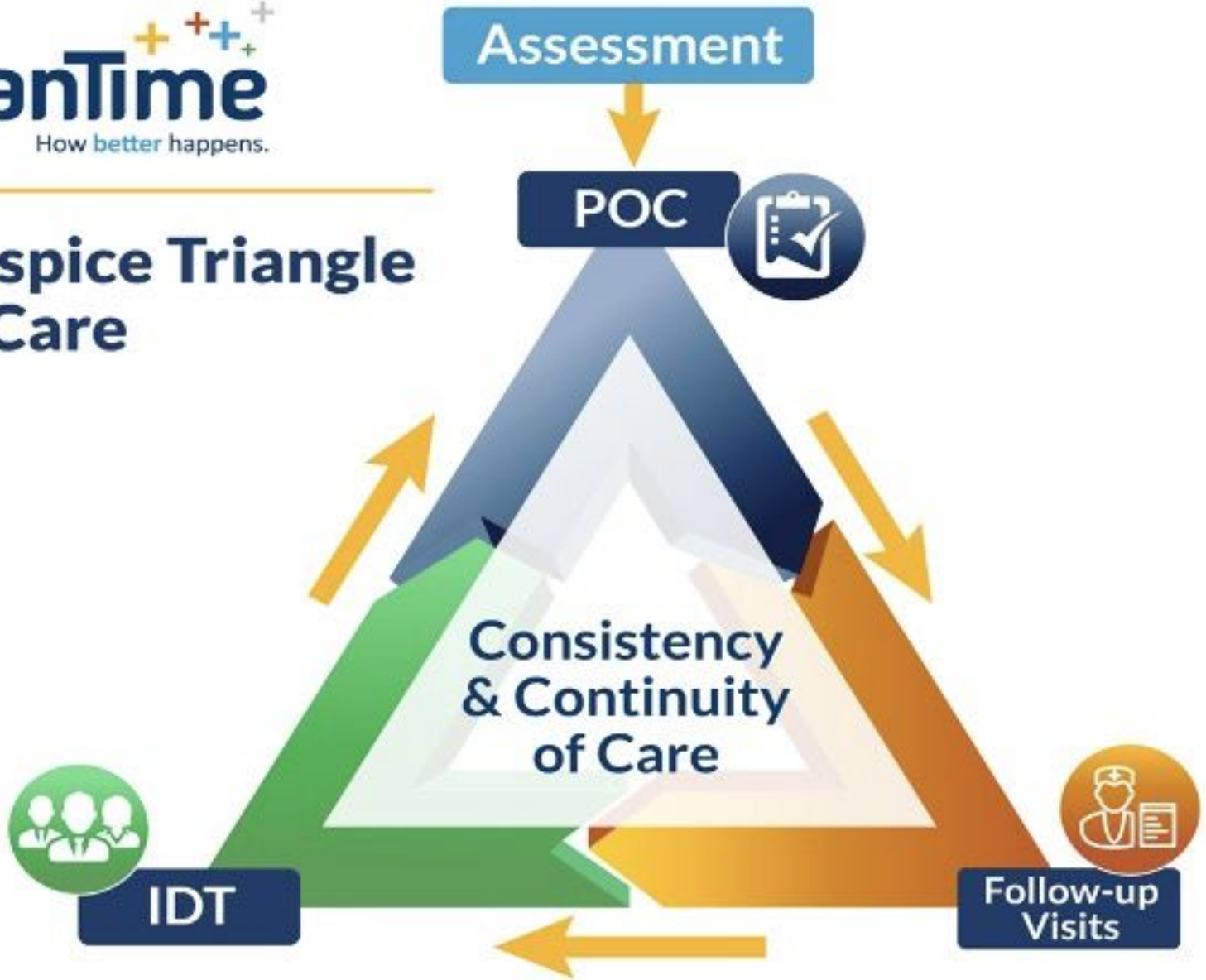
Hospice Triangle of Care



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COS-C, CEO

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The Hospice FY2022 Proposed Payment Rule

April 8, 2021 CMS issued the Proposed Payment Rule for the FY202 Hospice Wage Index and Payment Rate Update

- **This rule proposes:**
  - Updates to the hospice wage index, payment rates, and aggregate cap amount for Fiscal Year 2022
  - Changes to the labor shares of the hospice payment rates
  - Clarifying regulations text changes to the election statement addendum that was implemented on October 1, 2020
  - Includes information on hospice utilization trends and solicits comments regarding hospice utilization and spending patterns
  - To make permanent selected regulatory blanket waivers that were issued to Medicare-participating hospice agencies during the COVID-19 public health emergency and updates the hospice conditions of participation
  - Updates to the Hospice Quality Reporting Program
  - Changes beginning with the January 2022 public reporting for the Home Health Quality Reporting Program to address exceptions related to the COVID-19 public health emergency

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Proposed Updates - Hospice Wage Index

- The overall economic impact of this proposed rule is estimated to be **$530 million** in increased payments to hospices for FY 2022.
- The Rule Proposes Updates:
  - To the hospice wage index and makes the application of the updated wage data budget neutral for all four levels of hospice care.
  - FY 2022 hospice payment update percentage of **2.3 percent**
  - To the hospice payment rates
  - To the hospice cap amount for FY 2022 by the hospice payment update percentage of 2.3 percent.

Proposed Updates - Hospice Wage Index

- The proposed FY 2022 hospice wage index ***would not*** include a cap on wage index decreases and ***would not*** take into account any geographic reclassification of hospitals.
  - The appropriate wage index value is applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC.
  - The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

Proposed FY 2022 Hospice Payment Rates

For agencies that ***DO*** submit the required quality data

Code	Description	FY 2021 Payment Rates	FY 2022 Payment Rates
651	Routine Home Care (days 1-60)	$199.25	$203.81
651	Routine Home Care (days 61 +)	$157.49	$161.02
652	Continuous Home Care Full Rate = 24 hours of care	$1432.41 ($59.68 per hour)	$1465.79 ($61.07 per hour)
655	Inpatient Respite Care	$461.09	$474.43
656	General Inpatient Care	$1045.66	$1070.35

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Proposed FY 2022 Hospice Payment Rates

For agencies that ***DO NOT*** submit the required quality data

Code	Description	FY 2021 Payment Rates	FY 2022 Payment Rates
651	Routine Home Care (days 1-60)	$199.25	$199.83
651	Routine Home Care (days 61 +)	$157.49	$157.81
652	Continuous Home Care Full Rate = 24 hours of care	$1432.41 ($59.68 per hour)	$1437.14 ($59.88 per hour)
655	Inpatient Respite Care	$461.09	$465.16
656	General Inpatient Care	$1045.66	$1049.43

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Proposed Hospice Cap Amount

- The proposed hospice cap amount for the FY 2022 cap year will be **$31,389.66**
  - This is equal to the FY 2021 cap amount ($30,683.93) updated by the proposed FY 2022 hospice payment update percentage of 2.3 percent.

Rebase and Revise Labor Shares

- **CMS is proposing to:**
  - Rebase and revise the labor shares for CHC, RHC, IRC and GIP using MCR data for freestanding hospices.
  - Establish separate labor shares for each level of care and base those on the calculated compensation cost weights for each level of care from the 2018 MCR data.
- The labor shares for CHC and RHC are 68.71 percent were established with the FY 1984 Hospice benefit implementation based on the wage/nonwage proportions specified in Medicare's limit on home health agency costs.
- The labor shares for IRC and GIP are currently 54.13 percent and 64.01 percent, respectively, and were based on skilled nursing facility wage and nonwage cost limits and skilled nursing facility costs per day.

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Rebase and Revise Labor Shares

- CMS is proposing to derive a compensation cost weight for each level of care based on five major components:
  1. Direct patient care salaries and contract labor costs – costs associated with medical services provided by medical personnel including physicians, RNs, and hospice aides
  2. Direct patient care benefits costs
  3. Other patient care salaries – salaries attributable to patient transportation, labs, imaging services, and other services
  4. Overhead salaries
  5. Overhead benefits costs
- The total compensation costs for each hospice provider would then be calculated by summing costs of the five components for each level of care.

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Proposed Labor Share By Level of Care

TABLE 11: Proposed and Current Labor shares by Level of Care

	Proposed Labor shares	Current Labor shares
Continuous Home Care	74.6%	68.71%
Routine Home Care	64.7%	68.71%
Inpatient Respite Care	60.1%	54.13%
General Inpatient Care	62.8%	64.01%

Hospice Utilization Trends

- The analysis includes data on the number of beneficiaries using the hospice benefit, live discharges, reported diagnoses on hospice claims, Medicare hospice spending, and Parts A, B and D non-hospice spending during a hospice election.
- This analysis showed:
  - Changes in the pattern of diagnoses from primarily cancer diagnoses to neurological diagnoses and organ-based failure conditions.
  - Continued increase in the average length of stay for hospice patients
  - Increasing Medicare non-hospice spending with over $1 billion spent under Medicare Parts A, B and D during hospice elections in FY2019
  - An increase in non-hospice Medicare spending of 18.7% between FY2016 and FY 2019

Hospice Utilization Trends – Diagnoses Change From Primarily Cancer to Neurological

TABLE 2: Top Twenty Principal Hospice Diagnoses, FY 2019

Rank	ICD-10/Reported Principal Diagnosis	Number of Beneficiaries	Percentage of all Reported Principal Diagnoses
1	G30.9-Alzheimer's disease, unspecified	148,890	9.2%
2	G31.1-Senile degeneration of brain, not elsewhere classified	92,931	5.8%
3	J44.9-Chronic obstructive pulmonary disease, unspecified	84,926	5.3%
4	I50.9-Heart failure, unspecified	60,383	3.7%
5	C34.90-Malignant neoplasm of unspecified part of unspecified bronchus or lung	51,927	3.2%
6	G30.1-Alzheimer's disease with late onset	47,817	3.0%
7	G20-Parkinson's disease	46,781	2.9%
8	I25.10-Atherosclerotic heart disease of native coronary artery without angina pectoris	43,186	2.7%
9	I67.2-Cerebral atherosclerosis	35,355	2.2%
10	I11.0-Hypertensive heart disease with heart failure	28,657	1.8%
11	J44.1-Chronic obstructive pulmonary disease with (acute) exacerbation	28,333	1.8%
12	I63.9-Cerebral infarction, unspecified	27,405	1.7%
13	C61-Malignant neoplasm of prostate	26,652	1.7%
14	I13.0-Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	25,818	1.6%
15	I67.9-Cerebrovascular disease, unspecified	24,467	1.5%
16	N18.6-End stage renal disease	22,727	1.4%
17	C25.9-Malignant neoplasm of pancreas, unspecified	21,700	1.3%
18	C18.9-Malignant neoplasm of colon, unspecified	21,111	1.3%
19	E43-Unspecified severe protein-calorie malnutrition	20,741	1.3%
20	I51.9-Heart disease, unspecified	17,428	1.1%

Source: Analysis of data for FY 2019 accessed from the CCW on January 15, 2021.
Notes: The frequencies shown represent beneficiaries that had a least one claim with the specific ICD–10 code reported as the principal diagnosis. Beneficiaries could be represented multiple times in the results if they had multiple claims during FY 2019 with different principal diagnoses. The percentage column represents the percentage of beneficiary/diagnosis pairs in FY 2019 with a specific ICD-10 code.

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Hospice Utilization Trends – Length of Stay

TABLE 5: Hospice Length of Stay FYs 2016 - 2019

	FY 2016	FY 2017	FY 2018	FY 2019
Average Length of Election	74 Days	74 Days	75 Days	77 Days
Median Lifetime Length of Stay	19 Days	19 Days	19 Days	20 Days
Average Lifetime Length of Stay	95 Days	95 Days	96 Days	99 Days

Source: Hospice claims data accessed from CCW on January 15, 2021.

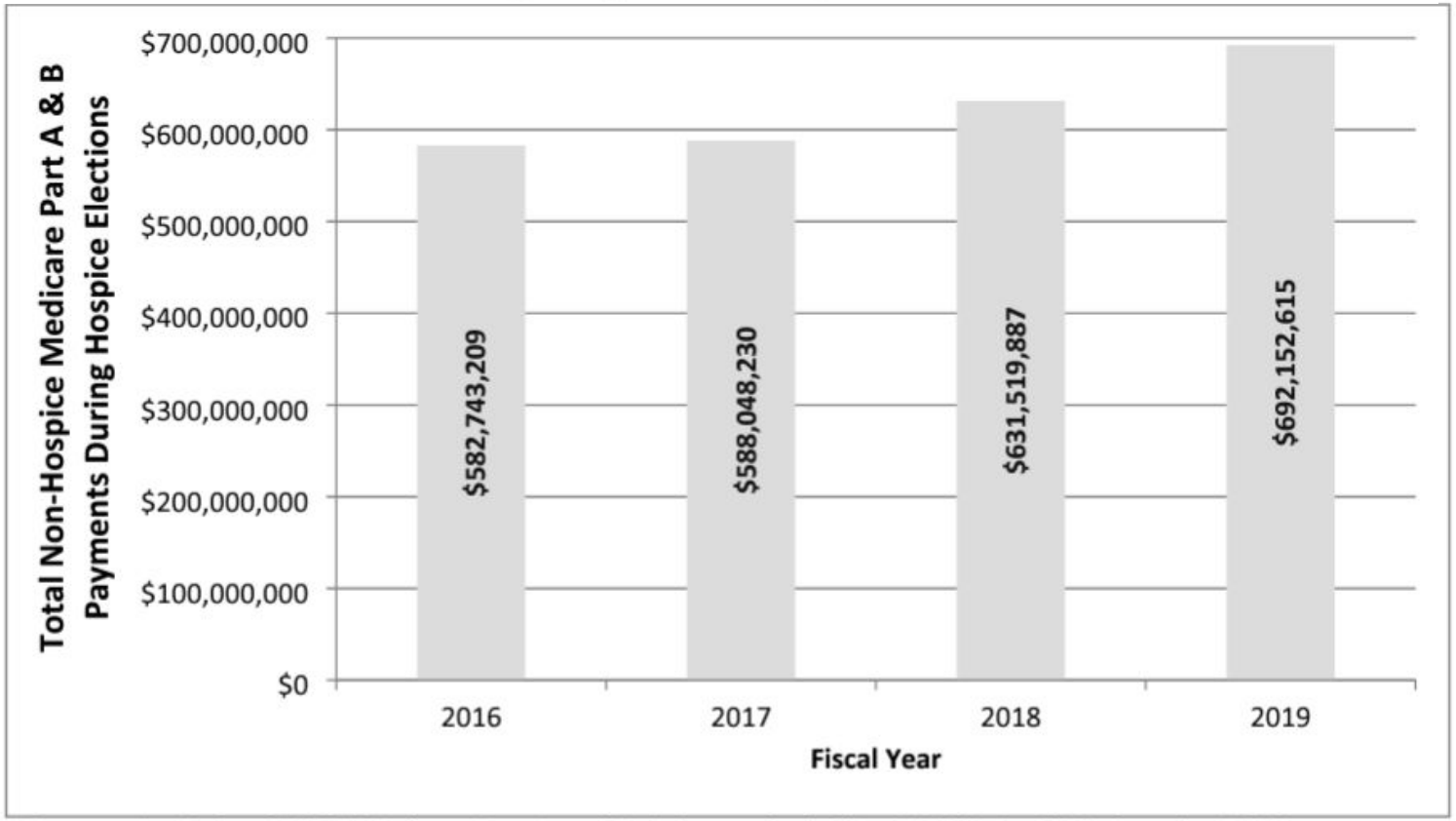
Hospice Utilization Trends – Length of Stay 2019

TABLE 6: Average Length of Stay in Days for Hospice Users in FY 2019

Category	Number of Hospice Users Discharged at the End of FY 2019	Average Length of Election	Median Lifetime Length of Stay	Average Lifetime Length of Stay
Alzheimer's, Dementia, and Parkinson's	210,944	126.9	52	169.0
CVA/Stroke	57,100	114.7	34	148.3
Cancers	290,868	45.7	17	53.5
Chronic Kidney Disease/Kidney Failure	28,130	35.6	8	44.3
Heart (CHF and Other Heart Disease)	210,087	85.4	24	107.6
Lung (COPD and Pneumonias)	112,852	82.2	20	108.0
Other	351,977	64.2	14	82.1
All Diagnoses	1,261,958	77.3	20	98.8

Hospice Utilization Trends – Medicare Payments for Non-Hospice Items and Services

Figure 4: Medicare Payments for Non-Hospice Medicare Part A and Part B Items and Services During Hospice Elections, FY 2016 – FY 2019



Source: Analysis of 100% Medicare Part A and B claims analytic files, FY 2016 – 2019, from the CCW, accessed January 15, 2021.

Notes: Payments are based on estimated total non-hospice Medicare utilization ($) per hospice service day, excluding utilization on hospice admission or live discharge days. Only Medicare paid amounts are included. The Medicare paid amounts were equally apportioned across the length of each claim and only the days that overlapped a hospice election (not including hospice admission or live discharge days) were counted.

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Hospice Utilization Trends

- CMS is seeking comments from hospice providers, patients, and advocates on **Hospice Utilization and Spending Patterns** to help inform potential future policy development regarding:
  - Skilled visits in the last week of life, particularly, what factors determine how and when visits are made as an individual approaches the end of life.
  - How changes in patient characteristics may have influenced any changes in the provision of hospice services.
  - Information surrounding hospices' determinations as to what items, services, and drugs are related versus unrelated to the terminal illness and related conditions, and on what other factors may influence whether/how certain services are furnished under hospice.
  - Whether the hospice election statement addendum has changed the way hospices make care decisions and how the addendum is used to prompt discussions with beneficiaries and non-hospice providers to ensure beneficiary care needs are met.

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Regulation Text Changes - Election Statement Addendum

- Currently regulations at require that if a beneficiary or his or her representative requests the addendum at the time of the initial hospice election the hospice must provide this information, in writing, to the individual (or representative) within 5 days from the date of the election.
- In the situation where a beneficiary or representative does not request the addendum at the time of election, but rather within the 5 days after the effective date of the election, the regulations require the hospice to provide the addendum within 3 days.
- This could mean that the hospice must furnish the addendum prior to completion of the comprehensive assessment.
- If the addendum is completed prior to the comprehensive assessment, the hospice may not have a complete patient profile, which could potentially result in the hospice incorrectly anticipating the extent of covered and non-covered services and lead to an inaccurate election statement addendum.
- Hospice providers are only able to discern what items, services, and drugs they will not cover once they have a beneficiary's comprehensive assessment.

Regulation Text Changes - Election Statement Addendum

- CMS is proposing to allow the hospice to furnish the addendum within 5 days from the date of a beneficiary or representative request, if the request is within 5 days from the date of a hospice election.
- **Example:**
  - The patient elects hospice on December 1st and request the addendum on December 3rd. The hospice would have until Dec 8th to furnish the addendum.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1 – Hospice Election	2	3 - Addendum Request	4	5
6	7	8 – Addendum furnished within 5 days				

Regulation Text Changes - Election Statement Addendum

- Currently there is not a timeframe in regulations regarding the patient signature on the addendum. The regulations require the beneficiary's signature (or his/her representative's signature) as well as the date the document was signed.
  - There are situations where the beneficiary or representative may request an emailed addendum or request more time to review the addendum before signing, in which case the date the hospice furnished the addendum may be different from the signature date.
  - This means the hospice may furnish the addendum within the required timeframe, but the signature date may be beyond the required timeframe.
- CMS is proposing to clarify in regulation that the "date furnished" must be within the required timeframe rather than the signature date, and that the hospice would include the "date furnished" in the patient's medical record and on the addendum itself.

Regulation Text Changes - Election Statement Addendum

- For instances in which the beneficiary (or representative) refuses to sign the addendum.
- In this proposed rule, CMS is clarifying that if a patient or representative refuses to sign the addendum, the hospice must document clearly in the medical record, and on the addendum itself, the reason the addendum is not signed in order to mitigate a claims denial for this condition for payment.
- In such a case, although the beneficiary has refused to sign the addendum, the "date furnished" must still be within the required timeframe, within 3 or 5 days depending on when the request was made, and noted in the chart and on the addendum itself.

Regulation Text Changes - Election Statement Addendum

- If a non-hospice provider or Medicare contractor requests the addendum (not the beneficiary or representative) there is no expectation of a signed copy in the patient's medical record.
- Hospices can develop processes (including how to document such requests from non-hospice providers and Medicare contractors) to address circumstances in which the non-hospice provider or Medicare contractor requests the addendum, and the beneficiary or representative does not.
- CMS is proposing to clarify in regulation that if a non-hospice provider requests the addendum, rather than the beneficiary or representative, the non-hospice provider ***is not required*** to sign the addendum.

Regulation Text Changes - Election Statement Addendum

- There may be instances in which the beneficiary or representative requests the addendum and the beneficiary dies, revokes, or is discharged prior to signing the addendum.
- In the FY 2020 Hospice final rule, CMS stated that if the beneficiary requests the election statement addendum at the time of hospice election but dies within 5 days, the hospice would not be required to furnish the addendum as the requirement would be deemed as being met in this circumstance, this policy was not codified in regulation.
- CMS is proposing conforming regulations text changes at § 418.24(c) to reflect this policy.

Regulation Text Changes - Election Statement Addendum

- CMS is also proposing the following related to instances in which the beneficiary or representative requests the addendum and the beneficiary dies, revokes, or is discharged prior to signing the addendum:
  - Clarification that if the patient revokes or is discharged within the required timeframe 3 or 5 days, depending upon when the request was made, but the hospice has not yet furnished the addendum, the hospice is not required to furnish the addendum.
  - Clarification that in the event that a beneficiary requests the addendum, and the hospice furnishes the addendum within 3 or 5 days depending upon when the request for the addendum was made, but the beneficiary dies, revokes, or is discharged prior to signing the addendum, a signature from the individual (or representative) is no longer required.
  - The hospice should note the date furnished in the patient's medical record and on the addendum, if the hospice has already completed the addendum, as well as an explanation in the patient's medical record noting that the patient died, revoked, or was discharged prior to signing the addendum.

Regulation Text Changes - Election Statement Addendum

- CMS is proposing conforming regulations text changes indicating that hospices have "3 days," rather than "72 hours" to meet the requirement when a patient requests the addendum during the course of a hospice election.
  - Hospices must furnish the addendum ***no later than 3 calendar days*** after a beneficiary's (or representative's) request during the course of a hospice election.
  - This means that hospice providers must furnish the addendum to the beneficiary or representative ***on or before*** the third day after the date of the request.
  - **Example:** If a beneficiary (or representative) requests the addendum of Feb 22nd, then the hospice will have until Feb 25th to furnish the addendum, regardless of what time the addendum was requested on Feb 22nd.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
21	22 – Addendum requested	23	24	25 - Addendum furnished within 3 days	26	27

Selected COVID-19 Waivers Made Permanent CoPs

- **Changes to the Hospice Conditions of Participation**
- CMS Proposed changes to the **hospice aide competency evaluation** standards making certain flexibilities that are allowed during the COVID-19 Public Health emergency (PHE) permanent.
  - To allow for hospice aide competency testing for those tasks that must be observed being performed on a patient to be assessed by observing the hospice aide with a pseudo-patient, such as a person trained to participate in a role-play situation or a computer-based mannequin device, instead of actual patients.
  - To amend the requirement that the hospice aide must complete a full competency evaluation when an area of concern if identified during an RN on-site supervisory visit and instead will only need to complete a competency evaluation of the deficient skill and all related skill(s).

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Selected COVID-19 Waivers Made Permanent CoPs

- **Proposed Definitions:**
  - **Pseudo-patient:** A person trained to participate in a role-play situation, or a computer-based mannequin device. A pseudo-patient must be capable of responding to and interacting with the hospice aide trainee, and must demonstrate the general characteristics of the primary patient population served by the hospice in key areas such as age, frailty, functional status, cognitive status and care goals.
  - **Simulation:** A training and assessment technique that mimics the reality of the homecare environment, including environmental distractions and constraints that evoke or replicate substantial aspects of the real world in a fully interactive fashion, in order to teach and assess proficiency in performing skills, and to promote decision making and critical thinking.

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HQRP - Transition to iQIES

- Hospices are currently required to submit HIS data to CMS using the Quality Improvement and Evaluation System (QIES) Assessment and the Submission Processing (ASAP) system.
- The FY 2020 Hospice final rule finalized the proposal to migrate to a new internet Quality Improvement and Evaluation System (iQIES) for submitting and processing assessment data.
- iQIES allows for real-time upgrades, greater security.
- Similar change made for Home Health in 2020.
- No date announced yet for the migration.

HQRP – Removal of the Seven Hospice Item Set Process Measures

- CMS is Proposing:
  - To remove the seven individual Hospice Item Set (HIS) measures from HQRP beginning FY 2022 and also to remove the "7 measures that make up the HIS Comprehensive Assessment Measure" section of Care Compare, but continue to have it publicly available in the data catalogue
  - To make these changes removing the seven HIS process measures as individual measures from HQRP no earlier than May 2022.
- The proposal is to remove the 7 individual HIS process measures, but it does not propose any changes to the requirement to submit the HIS admission assessment.
- Hospices that do not report HIS data used for the HIS Comprehensive Assessment Measure will not meet the requirements for compliance with the HQRP.

HQRP – HCI Measure

- CMS is proposing A new measure to the HQRP called the ***Hospice Care Index*.**
- This single measure includes ***10 indicators*** of quality that are calculated from claims data.

1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided
2. Gaps in Nursing Visits
3. Early Live Discharges
4. Late Live Discharges
5. Burdensome Transitions (Type 1) - Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission
6. Burdensome Transitions (Type 2) - Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital
7. Per-beneficiary Medicare Spending
8. Nurse Care Minutes per Routine Home Care (RHC) Day
9. Skilled Nursing Minutes on Weekends
10. Visits Near Death

HQRP - HCI Measure

- Each indicator equally affects the HCI score, reflecting the equal importance of each aspect of care delivered from admission to discharge.
- A hospice is awarded a point for meeting each criterion for each of the 10 indicators.
- The sum of the points earned from meeting the criterion of each indictor results in the hospice's HCI score, with 10 as the highest hospice score.
- The indicators represent different aspects of hospice care and aim to convey a comprehensive characterization of the quality of care furnished by a hospice.
- The HCI will help to identify whether hospices have aggregate performance trends that indicate higher or lower quality of care relative to other hospices.
- CMS will revise the QM report to include claims-based measure scores, including agency and national rates through the Certification and Survey Provider Enhanced Reports (CASPER) or replacement system.
- The QM report will also include results of the individual indicators used to calculate the single HCI score and provide details on the indicators and HCI overall score.
- If finalized, this measure would be publicly reported no earlier than May 2023.

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Hospice Care Index Indicator Scoring Example

Name (Hospice Score Units)	Numerator	Denominator	Hospice Observed Score	National Average Score	Percentile Rank Among Hospices Nationally	Index Earned Point Criteria	Points Earned?	Points Awarded
Provided CHC/GIP (% days)	48	3,904	1.2%	0.9%	83	Hospice Score Above 0%	Yes	+1
Gaps in nursing visits (% elections)	12	104	11.5%	5.9%	92	Below 90 Percentile Rank	No	0
Early live discharges (% live discharges)	3	27	11.1%	7.7%	75	Below 90 Percentile Rank	Yes	+1
Late live discharges (% live discharges)	14	27	51.9%	37.3%	84	Below 90 Percentile Rank	Yes	+1
Burdensome transitions, Type 1 (% live discharges)	4	27	14.8%	8.7%	77	Below 90 Percentile Rank	Yes	+1
Burdensome transitions, Type 2 (% live discharges)	0	27	0.0%	2.7%	1	Below 90 Percentile Rank	Yes	+1
Per-beneficiary Medicare spending (U.S. dollars $)	$2,322,657	256	$9,073	$12,959	22	Below 90 Percentile Rank	Yes	+1
Nurse care minutes per routine home care day (minutes)	44,100	6,985	6.3	16.0	2	Above 10 Percentile Rank	No	0
Skilled nursing minutes on weekends (% minutes)	9,090	157,230	5.8%	9.4%	17	Above 10 Percentile Rank	Yes	+1
Visits near death (% decedents)	147	151	97.4%	94.5%	46	Above 10 Percentile Rank	Yes	+1
						Hospice Care Index Total Score		**8**

HQRP – HVLDL

- The Addition of the claims-based Hospice Visits in the Last Days of Life (HVLDL) measure for public reporting.
  - OMB approved the proposal to replace the HVWDII measure with the HVLDL measure and remove Section O from the discharge assessment on February 16, 2021.
  - The HIS V3.00 became effective on February 16, 2021 and expires on February 29, 2024
  - CMS will no longer report HVWDII with patient discharges and will start publicly reporting HVLDL no earlier than May 2022

HQRP –Submission of Hospice Quality Reporting Program Data

- To address the inclusion of administrative data and correct technical errors identified in the FY 2016 and 2019 Hospice Wage Index and Payment Rate Update final rules, CMS proposes to revise the regulation at § 418.312(b) by adding paragraphs (b)(1) through (3).
- Proposed paragraph (b)(1) would now include the existing language on the standardized set of admission and discharge items.
- Paragraph (b)(2) would require collection of Administrative Data, such as Medicare claims data, used for hospice quality measures to capture services throughout the hospice stay. These Data automatically meet the HQRP requirements for § 418.306(b)(2).

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HQRP –Submission of Hospice Quality Reporting Program Data

- Paragraph (b)(3) would be a technical correction to address errors identified in the FY 2016 and FY 2019 Hospice Wage Index and Payment Rate Update final rules.
- CMS may remove a quality measure from the Hospice QRP based on one or more of the following factors:
  (1) Measure performance among hospices is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.
  (2) Performance or improvement on a measure does not result in better patient outcomes.
  (3) A measure does not align with current clinical guidelines or practice.
  (4) The availability of a more broadly applicable (across settings, populations, or conditions) measure for the particular topic.
  (5) The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic.
  (6) The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.
  (7) Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.
  (8) The costs associated with a measure outweigh the benefit of its continued use in the program.

HOPE Update

- Is a tool intended to help hospices better understand care needs throughout the patient's dying process and contribute to the patient's plan of care.
- It assesses patients in real-time, based on interactions with the patient.
- The HOPE will support quality improvement activities and calculate outcome and other types of quality measures in a way that mitigates burden on hospice providers and patients.
- CMS anticipates that the HOPE will replace the HIS.
- The draft HOPE has undergone cognitive and pilot testing, and will undergo field testing to establish reliability, validity and feasibility of the assessment instrument.
- CMS anticipates proposing the HOPE in future rulemaking after testing is complete.

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Proposal to add CAHPS Star Ratings to Public Reporting

- CMS proposes to introduce Star Ratings for public reporting of CAHPS Hospice Survey results on the Care Compare or successor websites no sooner than FY 2022.
  - The calculation and display of the CAHPS Hospice Survey Star Ratings be similar to other CAHPS Star Ratings such as Hospital and Home Health CAHPS.
  - The stars would range from one star (worst) to five stars (best).
  - The stars be calculated based on “top-box” scores for each of the eight CAHPS Hospice Survey measures.
    - Individual-level responses to survey items would be scored such that the most favorable response is scored as 100 and all other responses are scored as 0.

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Proposal to add CAHPS Star Ratings to Public Reporting

- CMS proposes:
  - To calculate a summary or overall CAHPS Hospice Survey Star Rating by averaging the Star Ratings across the 8 measures with a weight of ½ for Rating of the Hospice and Willingness to Recommend the Hospice, and a weight of 1 for each of the other measures, then rounding to a whole number.
  - Only the overall Star Rating be publicly reported.
  - That hospices must have a minimum of 75 completed surveys in order to be assigned a Star Rating.
  - To publish the details of the Star Ratings methodology on the CAHPS Hospice Survey website.
  - To introduce Star Ratings for public reporting of CAHPS Hospice Survey results on Care Compare no sooner than FY 2022.

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Quality Data Submission Reporting Requirements

- FY 2014 through FY 2023, a reduction in the market basket update by 2 percentage points and beginning in FY 2024 and for each subsequent year, a reduction the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.

TABLE 21: HQRP Reporting Requirements and Corresponding Annual Payment Updates

Reporting Year for HIS and Data Collection Year for CAHPS data (Calendar year)	Annual Payment Update Impacts Payments for the FY	Reference Year for CAHPS Size Exemption (CAHPS only)
CY 2020	FY 2022 APU	CY 2019
CY 2021	FY 2023 APU	CY 2020
CY 2022	FY 2024 APU*	CY 2021
CY 2023	FY 2025 APU	CY 2022

* Beginning in FY 2024 and all subsequent years, the payment penalty is 4 percent. Prior to FY 2024, the payment penalty is 2 percent.

Quality Data Submission Reporting Requirements

- **Compliance:**
  - HQRP Compliance requires understanding three timeframes for both HIS and CAHPS.

    (1) The relevant Reporting Year, payment FY and the Reference Year.
    - The “Reporting Year” (HIS)/“Data Collection Year” (CAHPS).
    - This timeframe is based on the CY.
    - It is the same CY for both HIS and CAHPS.
    - If the CAHPS Data Collection year is CY 2022, then the HIS reporting year is also CY 2022.

    (2) The APU is subsequently applied to FY payments based on compliance in the corresponding Reporting Year/Data Collection Year.

    (3) For the CAHPS Hospice Survey, the Reference Year is the CY prior to the Data Collection Year.
    - The Reference Year applies to hospices submitting a size exemption from the CAHPS survey (there is no similar exemption for HIS).

Quality Data Submission Reporting Requirements

- **Submission Data and Requirements:**
  - Ninety percent of all required HIS records (admission or discharge) must be submitted and accepted within the 30-day submission deadline to avoid the statutorily-mandated payment penalty.
  - To comply with CMS' quality reporting requirements for CAHPS, hospices are required to collect data monthly using the CAHPS Hospice Survey.
  - Hospices comply by utilizing a CMS-approved third-party vendor.
  - Most hospices that fail to meet HQRP requirements do so because they miss the 90 percent threshold.

Public Reporting - HIS-based Measures With Fewer Quarters Due to PHE

- CMS proposes that, in the COVID-19 PHE, they would use 3 quarters of HIS data for the final affected refresh, the February 2022 public reporting refresh of Care Compare for the Hospice setting.
- Using 3 quarters of data for the February 2022 refresh would allow for displaying Q3 2020, Q4 2020, and Q1 2021 data beginning in February 2022, rather than continuing to display November 2020 data (Q1 2019 through Q4 2019).
- Updating the data in February 2022 by more than a year relative to the November 2020 freeze data would assist consumers by providing more relevant quality data and allow hospices to demonstrate more recent performance.

Public Reporting -HIS-based Measures With Fewer Quarters Due to PHE

TABLE 27: Original, Revised, and Proposed Schedule for Refreshes Affected by COVID-19 PHE Exemptions

Quarter Refresh	HIS Quarters in Original Schedule for Care Compare (number of quarters)	HIS Quarters in revised/proposed Schedule for Care Compare (number of quarters)
November 2020	Q1 2019- Q4 2019 (4)	Q1 2019- Q4 2019 (4)
February 2021	Q2 2019- Q1 2020 (4)	Q1 2019- Q4 2019 (4)
May 2021	Q3 2019-Q2 2020 (4)	Q1 2019- Q4 2019 (4)
August 2021	Q4 2019- Q3 2020 (4)	Q1 2019- Q4 2019 (4)
November 2021	Q1 2020- Q4 2020 (4)	Q1 2019- Q4 2019 (4)
February 2022	Q2 2020-Q1 2021 (4)	Q3 2020-Q1 2021 (3)

Note: The shaded cells represent data frozen due to COVID-19 PHE.

Public Reporting of CAHPS due to PHE Exemption

- Prior to COVID-19 PHE, the CAHPS Hospice Survey publicly reported the most recent eight rolling quarters of data.
- CMS froze CAHPS data starting with the November 2020 refresh and concluding with the November 2021 refresh.
- **CMS proposes:**
  - Starting with the February 2022 refresh, to display the most recent 8 quarters of CAHPS Hospice Survey data, excluding Q1 and Q2 2020.
  - To resume public reporting by displaying 3 quarters of post-exemption data, plus five quarters of pre-exemption data.
  - In each refresh subsequent to February 2022, to report one more post-exemption quarter of data and one fewer pre-exemption quarter of data until reaching eight quarters of post-exemption data in May of 2023.
  - As of August 2023, to resume reporting a rolling average of the most recent 8 quarters of data.
  - This will allow reporting the maximum amount of new data, maintaining reliability of the data, and permitting the maximum number of hospices to receive scores.

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Public Reporting of CAHPS due to PHE Exemption

TABLE 28: Proposed CAHPS Hospice Survey Public Reporting Quarters During and After the Freeze

Refresh	Publicly Reported Quarters
Freeze:	*Q1 2018-Q4 2019*
*November 2020-November 2021**	
February 2022	Q4 2018 – Q4 2019, Q3 2020 – Q1 2021
May 2022	Q1 2019-Q4 2019, Q3 2020-Q2 2021
August 2022	Q2 2019-Q4 2019, Q3 2020-Q3 2021
November 2022	Q3 2019-Q4 2019, Q3 2020-Q4 2021
February 2023	Q4 2019, Q3 2020-Q1 2022
May 2023	Q3 2020-Q2 2022
*The grey shading refers to the frozen quarters.	

Proposals for Calculating & Publicly Reporting Claim-based Measure as part of HQRP

- **CMS Proposes:**
  - To adopt the HCI into the HQRP for FY2022
  - To extract claims data to calculate claims-based measures at least 90 days after the last discharge date in the applicable period, which we will use for quality measure calculations and public reporting on Care Compare.
    - **Example:**
      - If the last discharge date in the applicable period for a measure is December 31, 2022, for data collection January 1, 2022, through December 31, 2022, we would create the data extract on approximately March 31, 2023, at the earliest. Those data would be used to calculate and publicly report the claims-based measures for the CY2022 reporting period.

Proposals for Calculating & Publicly Reporting Claim-based Measure as part of HQRP

- The proposed approximately 90-day “run-out” period is shorter than the Medicare program’s current timely claims filing policy under which providers have up to 1 year from the date of discharge to submit claims.
- However, several months lead-time is necessary after acquiring the data to conduct the claims-based calculations.
- If we were to delay our data extraction point to 12 months after the last date of the last discharge in the applicable period, we would not be able to deliver the calculations to hospices sooner than 18 to 24 months after the last discharge.

Proposals for Calculating & Publicly Reporting Claim-based Measure as part of HQRP

- To implement this process, hospices would not be able to submit corrections to the underlying claims snapshot or add claims (for those claims-based measures) to this data set at the conclusion of the 90-day period following the last date of discharge used in the applicable period.
- CMS would consider the hospice claims data to be complete for purposes of calculating the claims-based measures at this point.
- It is important that hospices ensure the completeness and correctness of their claims prior to the claims “snapshot.”

Proposals for Calculating & Publicly Reporting Claim-based Measure as part of HQRP

- **CMS Proposes:**
  - To update the claims-based measures used for the HQRP annually.
  - Specifically, to refresh claims-based measure scores on Care Compare, in preview reports, and in the confidential CASPER QM preview reports annually.
    - Using only 1 year (4 quarters) of data, as is currently done for HIS-based quality measures reported on Care Compare, allows us to share with the public only the most up-to-date information and best reflects current realities.
    - Having only the most recent data can also help incentivize hospices with lower scores to make changes and have the results of their effort be reflected in better scores.
  - Using 2 years of data to publicly report HCI and HVLDL in 2022.

Public Reporting of the Hospice Care Index and HVLDL Measures

- **CMS is proposing to:**
  - Publicly report the HCI and HVLDL using 2 years, which is 8 quarters of Medicare claims data.
  - To publicly report the HCI and HVLDL beginning no earlier than May 2022 using FY2021 Medicare hospice claims data, and to include it in the Preview Reports no sooner than the May 2022 refresh.
  - The publicly-reported version of HCI on Care Compare will only include the final HCI score, and not the component indicators.
  - The Preview Reports will reflect the HCI as publicly reported.

Closing the Health Equity Gap

- Significant and persistent inequities in health outcomes exist in the United States.
- In recognition of persistent health disparities and the importance of closing the health equity gap, CMS is requesting information on expanding several related programs to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable for providers and patients.
- See the proposed rule for list of specific topics for which CMS is seeking comments.
- CMS intends to use this input to inform future policy development.

Conclusion

- In comparison to prior years, there are many changes in this proposed rule including a proposal for HHQRP.
- Updates to –
  - Wage Index/Payment Rates
  - Labor Shares
  - Hospice Cap Amounts
  - Rebase and Revise Labor Shares
- Comment Solicitation for Hospice Utilization Trends
- Hospice Conditions of Participation - Hospice aide
  - Competency Testing - pseudo-patient
  - Competency Evaluation - only need to complete a competency evaluation of the deficient skill
- Hospice Quality Reporting Program
  - Removal of the Seven Hospice Item Set Process Measures
  - HCI Measure
  - Proposal to add CAHPS Star Ratings to Public Reporting
- Begin preparation for the many proposed changes!

Waystar + KanTime Partnership Overview

Kantime | Waystar Partnership

PARTNERSHIP BY THE NUMBERS

5K+
payer connections

98.5%
first-pass clean claim rate

300
agencies

2B
transactions annually

2014
year our partnership with KanTIme was established

20+
years in the industry

Breadth of revenue cycle – end to end coverage

Financial Clearance

Claim Management

Payment Management

Denial Prevention + Recovery

Analytics + Reporting

SINGLE-INSTANCE PLATFORM	INTUITIVE UI WORKFLOW	24/7, REAL-TIME PROCESSING	SEAMLESS INTEGRATION	TRUE PREDICTIVE ANALYTICS

KanTime | Waystar Solutions + Integration

Eligibility*

Coverage Detection

Claims*

Claim Monitoring

Claims Attachments

Medicare Enterprise

Remits*

Patient Statements

Patient Payments

Denials Management

Appeals Management

Analytics Pro | Peak

Medicare Analytics

Quality + Compliance Reporting

***Integrated Solution**

SINGLE-INSTANCE PLATFORM	INTUITIVE UI WORKFLOW	24/7, REAL-TIME PROCESSING	SEAMLESS INTEGRATION	TRUE PREDICTIVE ANALYTICS

HPS | WAYSTAR | KanTime Healthcare Software | How better happens.

6 key pillars that help us deliver value differently

Our Values
Who we are and how it guides us

Client Experience and Accolades
Net Promoter Score and KLAS

Single Platform
Commercial & Government

Depth & Breadth of Solutions
End-to-end Revenue Cycle coverage with rich solutions

Intelligent Automation
Robotic Process Automation and Artificial Intelligence

Seamless Integration
Delivering value in a client's practice management workflow

Have questions?

Melinda Gaboury
COS-C, CEO

Lindsay Cobb
Product Marketing Director

WAYSTAR

Kristen Duell
Executive Vice President

KanTime Healthcare Software

Kristen@Kanrad.com

Greg Lotz
Director of Marketing & Sales Technology

KanTime Healthcare Software

Greg@Kanrad.com