CMS Hospice Quality Reporting Program- Master Guidance on Item A1400

Item A1400 reports the patient's payor information at the time of admission. Identify all payors that the patient has, regardless of whether or not that payor is expected/likely to provide reimbursement. A1400 should reflect all payors available for healthcare expenses. Healthcare expenses may include services, medications, supplies, and room and board. Page 2A-13 and 2A-14 in the HIS Manual provide guidance on how to complete Item A1400. Beyond the guidance provided in the HIS manual, below is additional guidance from CMS on how to classify common payor categories:

- **Response option "A. Medicare (traditional fee-for-service)":** Select response option A if the patient is a traditional fee-for-service Medicare patient.
    - If the patient has Medicare Part D, select response option "A. Medicare (traditional fee-for-service)".

- **Response Option "B. Medicare (managed care/Part C/Medicare Advantage)":** Select response option B if the patient has Medicare HMO/managed care, another Medicare Advantage Plan, or Medicare Part C.
    - If the patient was a Medicare Advantage patient prior to enrolling in hospice, select "B. Medicare (managed care/Part C/Medicare Advantage)" even though Medicare Advantage may not reimburse the hospice directly for any services.
    - If the patient was Part C/Medicare Advantage prior to enrolling in hospice, select the response options for BOTH part C and traditional fee-for-service, as applicable.

- **Response Option "C. Medicaid (traditional fee-for-service)":** Select response option C if the patient has traditional fee-for-service Medicaid.

- **Response Option "D. Medicaid (managed care)":** Select response option D if the patient has Medicaid managed care.

- **Response option "G. Other government (e.g., TRICARE, VA, etc.)"**: Select response option G if the patient has a government plan besides Medicare and/or Medicaid. This would include TRICARE, VA, etc.

- **Response option "H. Private Insurance/Medigap":** Select response option H if the patient has available any private insurance. This would include commercial plans irrespective of how they were purchased (i.e., regardless of whether they are provided through an employer or purchased individually by the patient or through a health insurance exchange, etc.).
    - This response option should also be used for prescription drug coverage from a private insurer in addition to/other than Medicare Part D coverage.

- **Response option "I. Private Managed Care":** Select response option I if the patient has available any private insurance that is a managed care plan. This would include commercial or privately purchased managed care plans (e.g., commercial HMO or PPO plans) irrespective of how they were purchased (i.e., regardless of whether they are provided through an employer or purchased individually by the patient or through a health insurance exchange, etc.).

- **Response option "J. Self-pay":** For purposes of completing Item A1400, the minimum threshold for a "self-pay" patient would be ability to pay for any low-cost medication, supply or service (e.g., medication co-pay or over-the-counter medication). Based on this definition of self-pay, for certain providers, a large majority of patients may be identified as self-pay; this is acceptable.
    - Select response option J if the patient has any amount of personal funds available to contribute to healthcare expenses during the hospice episode of care. CMS recommends selecting this response option if the patient is paying for or able to pay for any of their own medications, supplies, services, room and board, etc.
    - Self-Pay should be chosen even if the patient is not actively paying for anything, but could pay for something or has the funds if needed. Additionally, the intent of the self-pay response option is not to assess patients' *ability* to self-pay, but rather to determine *availability* of funds to cover costs of care. Selecting the self-pay response option obligates neither the hospice nor the patient to use those funds to pay for care, should a need to self-pay arise. In this sense, collection of data to complete Item A1400 should not influence the delivery of hospice services based on the patient's ability to self-pay for care, or based on availability of other pay sources the patient may have. This HIS item is not used for quality measure calculation.
    - For the purposes of completing Item A1400, existence of pay sources can be based on patient/caregiver report, and gathering additional supplementary financial information is not likely to be necessary. It is possible to collect the information during the referral/intake/admission process when verifying insurance sources, or during preadmission/admission discussions of what the hospice benefit will cover and what the patient may be responsible for. CMS understands that these conversations may take place as part of an overall assessment of the patient's ability to pay for such items that may not traditionally be paid for by the Hospice Benefit.

- **Response option "K. No payor source":** Select response option K if the patient does not have any of the payor sources in response options A-I available, nor do they have any personal funds available (response option J, Self-pay) to contribute to healthcare expenses (services, supplies, medications, room and board, etc.) during the hospice episode of care.

- **Response option "X. Unknown":** select response option X if the patient is not confirmed to have any of the above payor sources in response options A-K available to contribute to healthcare expenses (services, supplies, medications, room and board, etc.) during the hospice episode of care.

- **Response option "Y. Other":** select response option Y if the patient has available one or more payor sources that is not listed in responses options A-K above to contribute to healthcare expenses (services, supplies, medications, room and board, etc.) during the hospice episode of care.

- **For charity patients:** For the purposes of completing the HIS, there are two types of charity care patients: patients that will receive funds from a funded charity care program and patients that have available no other pay source and are not part of a funded charity care program. Select response option "Y. Other" if the patient has available as a pay source a *funded* charity program.

Select response option “K. No payor source” if a patient does not have available any of the pay sources listed in A-J, nor will they be part of a *funded* charity program.

Beyond the guidance provided above and the guidance provided in the HIS Manual, CMS recommends the following:

- For classifying individual commercial plans, CMS recommends providers use their best judgement or follow-up with the appropriate commercial or private contact to classify individual commercial plans. For state-specific plans (other than traditional Medicaid) or other government plans (e.g., Tricare or other VA plans), CMS recommends providers follow-up with the appropriate state or government contacts for advice on classifying these plans.