
Welcome to the Centers for Medicare & Medicaid Services training presentation, “Updates to the Hospice Item Set Manual Version 1.02”.

This is the second of four modules. This module covers updates made to Chapter 1 of V1.02 of the HIS Manual.

# Objectives

- Cover updates and changes to the Hospice Item Set (HIS) Manual made from V1.01 to V1.02
  - Download a copy of V1.02 of the HIS manual here: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html
- For a comprehensive overview of data collection instructions for each HIS item, providers should view the "Data Collection Training for the Hospice Item Set (HIS)"
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html


Our objectives for today's presentation are intended to cover updates that were made to the Hospice Item Set Manual from V1.01 to V1.02. This presentation will provide clarifications of HIS definitions and expectations for use. Updates to the HIS Manual were made based on frequently asked questions received on the Quality Help Desk. Since the focus of this presentation is on highlighting the changes made to the Hospice Item Set manual, providers may find it helpful to have a copy of V1.02 of the HIS Manual available to review during the presentation. Providers can download the updated HIS manual from the "Hospice Item Set " portion of the CMS website available at the web address listed on the slide.

Since this presentation includes only updates that were made to the HIS Manual from V1.01 to V1.02, this presentation is not intended to provide a comprehensive overview of HIS reporting. For a comprehensive training on HIS reporting, providers should review the "Data Collection Training for the Hospice Item Set" on the "Hospice Item Set" portion of the CMS website at the web address listed on this slide.

All content from the National Provider Call presentation today will be recorded and posted for provider viewing at a later date. Along with the content presented on this call, an additional module that was previously recorded will be made available at a later date. This previously recorded module provides a more in-depth overview and background of the Hospice Item Set and the Hospice Quality Reporting Program.

At this time, I will turn the presentation over to Alexis Kirk from RTI International.

# Chapter 1: Background and Overview of the Hospice Item Set Manual

Alexis Kirk, RTI International

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Thank you. My name is Alexis Kirk and I'll be presenting this portion of the National Provider Call. In this section of the presentation, we will review information found in Chapter 1 of the Hospice Item Set (or "HIS") Manual. Chapter 1 provides an introduction of contextual information, timing and sequence policies, and general guidance related to implementation and use of the HIS.

Chapter 1 begins on Page 1-1 of V1.02 of the HIS Manual.

Since this presentation covers updates made to V1.02 of the HIS Manual, throughout the slides in this presentation, we have included relevant HIS Manual page numbers in the blue and yellow box at the bottom right-hand corner of the slide.

# Background

- Hospice Quality Reporting Program (HQRP) requirement established by Section 3004 of the Affordable Care Act
- Hospice Item Set is a patient-level data collection tool that all Medicare-certified hospice providers are required to use as part of current HQRP requirements
- Providers began using the HIS on all patient admissions on July 1, 2014. Providers must submit 2 HIS records for each patient admission: HIS-Admission & HIS-Discharge
- HIS data can be used to calculate 7 quality measures

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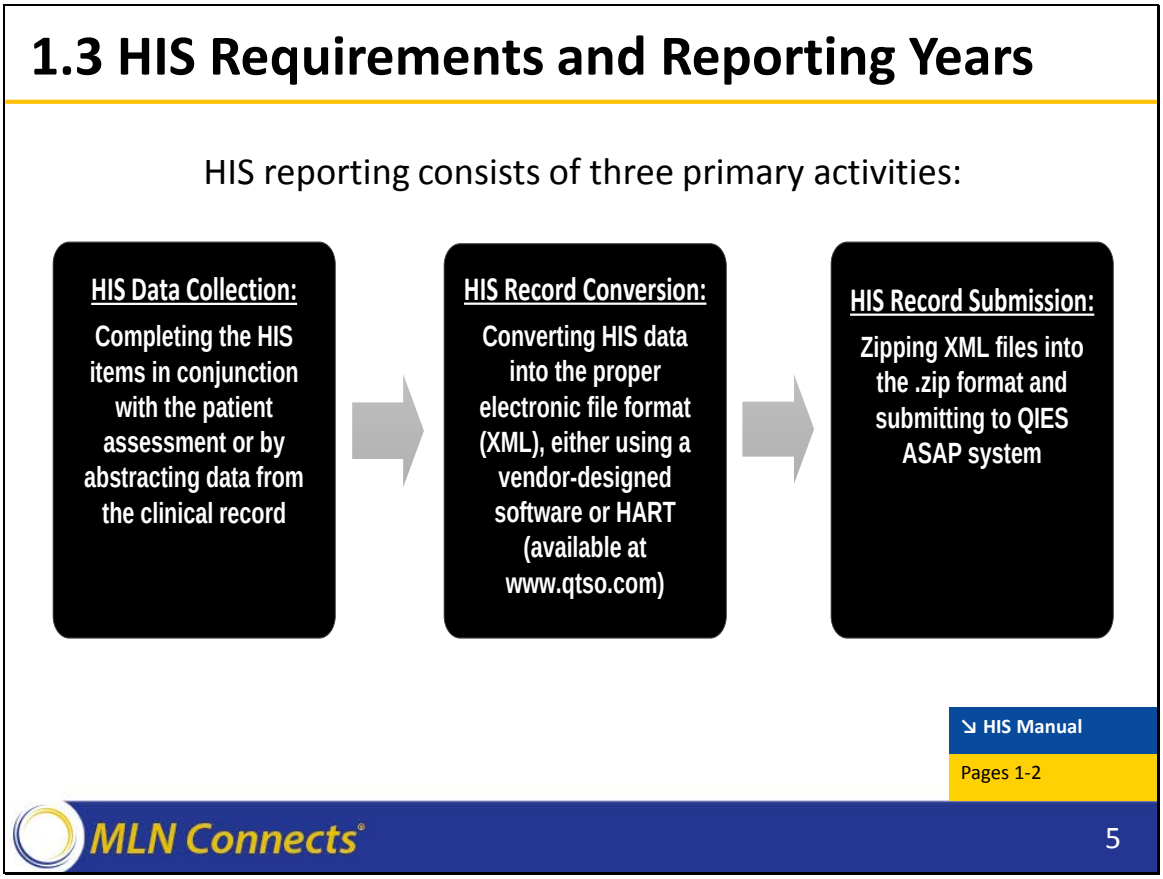
The Hospice Quality Reporting Program, or "HQRP" was established by Section 3004(c) of the Affordable Care Act.

The HIS is a patient-level data collection tool that all Medicare-certified hospice providers were required to begin using on July 1, 2014.

Hospice providers must submit two HIS records for each patient admission to their hospice: an HIS-Admission record and an HIS-Discharge record.

Hospice providers submit HIS records to CMS, and CMS uses HIS data to calculate facility-level scores on 7 quality measures.




Section 1.3 of the HIS Manual, which begins on Page 1-2, outlines HIS requirements and reporting years. Figure 1 on page 1-2 of the Manual outlines the three primary phases of HIS reporting.

As shown in Figure 1 on this slide, the process of collecting and reporting HIS data can be broken down into three primary steps: HIS Data Collection, HIS Record Conversion, and HIS Record Submission.

The first step, HIS Data Collection, consists of selecting responses to HIS items in conjunction with patient assessment activities, or through a process of abstracting information from the patient's clinical record. Responses to HIS items may be collected on a paper form, or electronically using an electronic medical record.

The second step is HIS Record conversion, where HIS data is converted into the proper electronic file format necessary for successful submission to CMS. XML is the required file format. To convert HIS records into XML, providers can use either a vendor designed software, or providers can use the Hospice Abstraction Reporting Tool (or "HART") software. HART software is free to use and can be downloaded from the QIES Technical Support Office website at www.qtso.com. Additional information about installing the HART software and a related user guide are also available at the qtso.com website.

The third and final step is HIS Record Submission. Once HIS records are converted, the files can be submitted to CMS using the Quality Improvement and Evaluation System Assessment Submission and Processing (or QIES ASAP) system. All hospice providers must use the QIES ASAP system to submit HIS data to CMS.

Additional information related to HIS record conversion and submission are available in Chapter 3 of the HIS manual.

# 1.3 HIS Requirements and Reporting Years

**Figure 2. FY 2017 Reporting Year Activities**

| First Year: HIS Data Collection and Submission | Second Year: Compliance Determinations | Third Year: Payment Impact |
|---|---|---|
| **CY 2015**: Collect and submit HIS data for all patient admissions occurring during CY 2015 (January 1, 2015 – December 31, 2015). | **CY 2016:** CMS makes compliance determinations based on HIS submissions for patient admissions occurring in 2015. | **FY 2017:** Determinations of noncompliance made in 2016 will go into effect in FY 2017 (10/1/2016), reducing the FY 2017 APU by two percentage points. |

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It is helpful to understand the "cycle" or timing of HIS data reporting and corresponding payment impacts. The relationship between HIS reporting and reimbursement currently spans a three year cycle. In the first year of the cycle, the provider collects and submits HIS data; in the second year of the cycle, the provider's compliance is determined based on the first year's HIS submissions. If it is determined that the provider was noncompliant with HIS requirements, then the two percentage point APU payment reduction would occur in third year of the cycle.

Let's review that cycle again  using an example. Suppose Hospice A does not report HIS data during January through December of 2015 – the first year in the cycle. In 2016 -- the second year in the cycle -- Hospice A's reporting status would be evaluated and a determination of noncompliance would be made. If upheld, this finding of noncompliance would reduce Hospice A's APU in Fiscal Year (FY) 2017 – the third year of the cycle.

As you can see based on this example, by the time the determination of noncompliance is made and a hospice's APU is reduced, the opportunity to collect HIS data for that reporting period is over.

HIS reporting year cycles are referenced by the payment year they impact. So the three year cycle outlined on this slide is referred to as the FY 2017 Reporting Year.

# 1.4 Applicable Facilities and Requirements for New Facilities

- Hospices receiving CMS Certification Number (CCN) notification letter on or after November 1 of the preceding year involved are excluded from any payment penalty for that FY.
- **Example:** Hospice receives CCN notification letter on 11/2/15. This hospice:
  - is not required to submit HIS data on patient admissions occurring in CY 2015
  - is not subject to the payment reduction for FY 2017 APU
  - should begin submitting HIS data 1/1/16 (or before)
  - will be subject to FY 2018 APU payment reduction, if noncompliant
  - https://www.federalregister.gov

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Section 1.4 in V1.02 of the HIS Manual provides information about requirements for new facilities.

All Medicare-certified hospice providers are required to submit HIS data on all patient admissions on or after July 1, 2014.

Reporting eligibility and requirements for new hospice providers is addressed by CMS through rulemaking. In the Fiscal Year 2015 Hospice Wage Index and Payment Rate Update final rule, CMS finalized that any hospice that receives its CMS Certification Number (or CCN) notification letter on or after November 1 is excluded from any payment penalty for quality reporting purposes for the APU determinations for that particular reporting year cycle.

Under current requirements, a new hospice that received their CCN notification letter on November 2, 2015 would not be required to submit HIS data on patient admissions occurring during Calendar year 2015 (which would affect the Fiscal Year 2017 APU).

In this instance, at the latest, the hospice would begin HIS data collection and submission on patient admissions occurring on or after January 1, 2016, and for all subsequent years. HIS data submitted on patient admissions for Calendar Year 2016 would affect the Fiscal Year 2018 APU.

For more details on requirements for new facilities, see Proposed and Final Rules published by CMS in the Federal Register, at the web address listed on the slide.

# 1.6 Record Types and Definitions

- Hospices are required to submit a HIS-Admission and a HIS-Discharge record for each patient admission.
- HIS-Admission and HIS-Discharge completion is triggered by the patient's admission or discharge to a Medicare-certified hospice.
  - Definitions for "admission" and "discharge," along with special circumstances, are presented in Section 1.6 of HIS Manual V1.02

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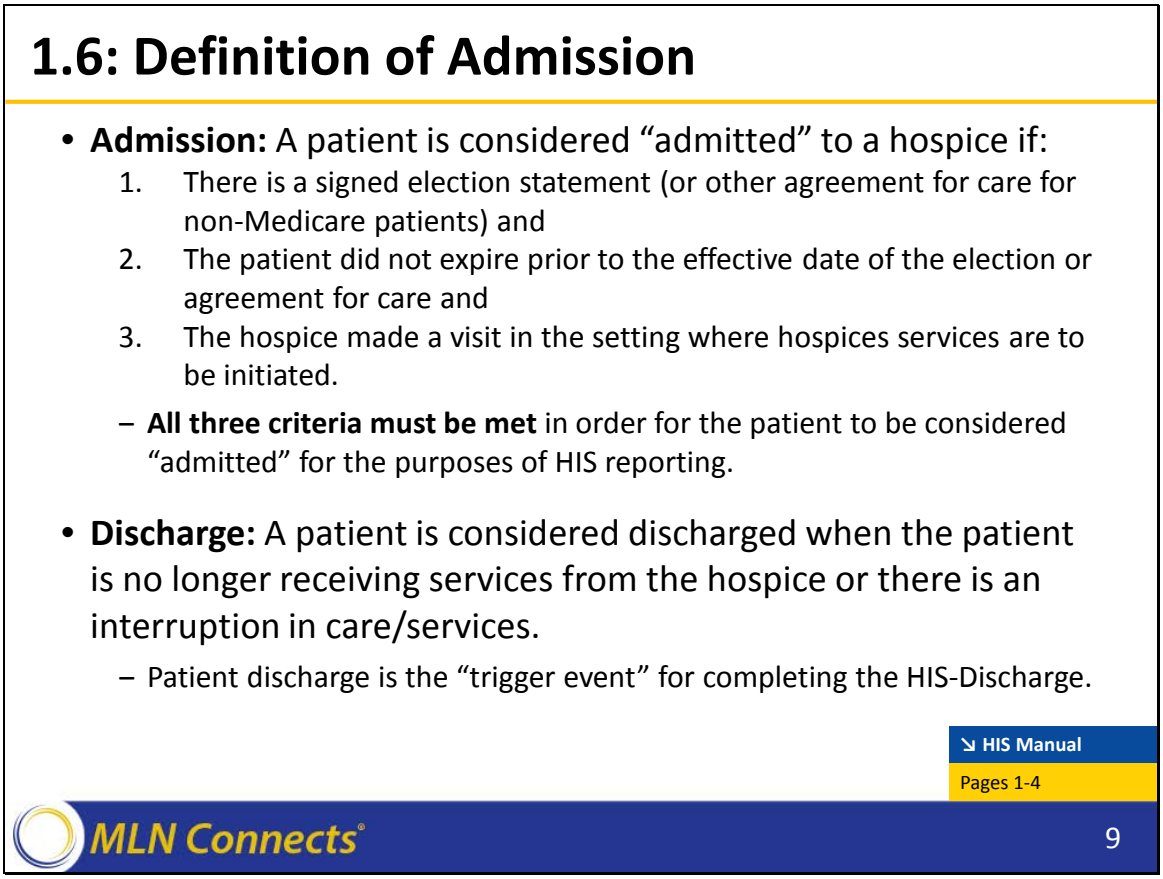
Section 1.6 "Record Types and Definitions" is a new section in V1.02 of the HIS Manual. This section provides information on the two record types (HIS-Admission and HIS-Discharge), along with relevant definitions for each record type.

Section 1.6 begins on Page 1-4 of V1.02 of the HIS Manual.

Hospices are required to submit two HIS records for each patient admission to their organization: an HIS-Admission and an HIS-Discharge record. HIS-Admission and HIS-Discharge completion is generally triggered by the patient's admission or discharge to a Medicare-certified hospice.




For the purposes of completing the HIS-Admission, a patient is considered "admitted" to a hospice if the following three conditions have been met.

First, there must be a signed election statement (or other agreement for care for non-Medicare patients).

Second, the patient must **not** have expired prior to the effective date of the election or agreement for care.

Third, the hospice must make a visit in the setting where hospice services are to be initiated.

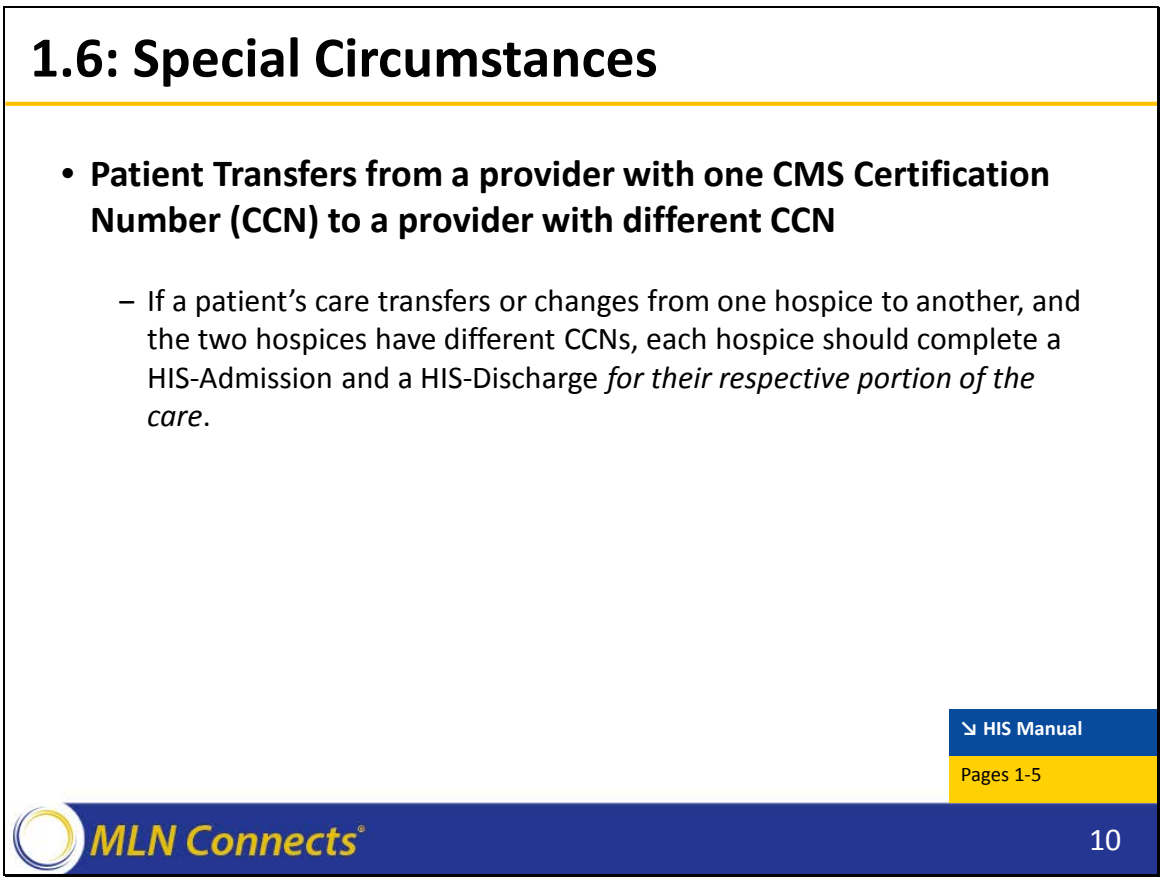
Once **all three** of these criteria are met, the patient is considered admitted to the hospice, and HIS reporting is required.

The criteria outlined on this slide are for determining admission status for HIS reporting purposes only. A**dmission" status may be different for billing purposes, depending on payer.**

A flow chart, which is presented as Figure 3 in Section 1.6 of the HIS Manual is particularly helpful in determining whether or not a patient should be considered "admitted" to Hospice for purposes of determining if HIS reporting is required.

For the purposes of completing the HIS, a patient is considered discharged when the patient is no longer receiving services from the hospice or there is an interruption in care or services. The reasons why a patient might be discharged from hospice are reported in A2115 and include: a patient expiring; a patient revoking the election of hospice care; determination that the patient is no longer terminally ill; a patient moving out of the hospice's service area; a patient transferring to another hospice provider; or a hospice discharging a patient for cause.

Patient discharge is the "trigger event" for completing the HIS-Discharge. Meaning, hospices should complete an HIS-Discharge record once the patient is no longer receiving services from the hospice or there is an interruption in care or services.




The next several slides cover special circumstances for defining "admission" and "discharge" for the purposes of HIS reporting. These special circumstances are new to V1.02 of the HIS Manual and begin on Page 1-5.

The first special circumstance we'll cover are patient transfers. Sometimes, due to patient preference or patient re-location, a patient will change hospice providers. These situations can involve two related hospices under common ownership who have the same CMS Certification (or CCN) Number, or these situations can involve two unrelated hospices, each with their own CCN.

In general, HIS reporting occurs at the CCN level. Thus, when a patient transfers from a provider with one CCN, to a provider with different CCN, each provider is independently responsible for compliance with HIS reporting. In the situation where a patient transfers from one hospice to another, and the two hospices have different CCNs, each hospice should complete an HIS-Admission and an HIS-Discharge record for the care provided to the patient by their organization. When the **transferring** hospice completes their HIS-Discharge record, response 05 'transferred to another hospice' should be selected for Item A2115. Reason for Discharge. Completing HIS records according to these guidelines allows for HIS quality data to be captured and attributed to the portion of the care that each hospice provided.

When a patient transfers between two providers with one common CCN, there is no need for the **transferring** hospice to complete an HIS-Discharge, or for the **receiving** hospice to complete an HIS-Admission. In this situation, the **transferring** hospice would complete the HIS-Admission and the **receiving** hospice would complete the HIS-Discharge, both under the came CCN.

Let's go over an example. In this example, a patient initially receives hospice care from Hospice A. Hospice A completes an HIS-Admission record for that patient. Sometime later, the patient decides to change hospice providers to receive care from Hospice B. The patient is discharged from Hospice A, and Hospice A completes the HIS-Discharge record, listing "transfer" as the Reason for Discharge in Item A2115. Hospice B then admits the patient, completing an HIS-Admission record. Hospice B would complete an HIS-Discharge record once the patient is no longer receiving services from Hospice B, or there is an interruption in services or care.

# 1.6: Special Circumstances, Continued

- **HIS-Discharge is not required in the case of administrative discharges with no interruption in care**, such as:
  - Change in patient's payer source – e.g., patient changes from a private pay patient to Medicare patient
  - Hospice fails to meet the face-to-face requirement, patient remains on service
- In these two situations, the hospice would submit HIS-Discharge once the patient is no longer receiving hospice service or there is an interruption in care related to one of the reasons for discharge listed in Item A2115.

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Let's look at another special circumstance, which begins on Page 1-6 of the HIS Manual. This special circumstance covers administrative discharges with no interruption in care. There may be circumstances where it is a hospice's policy to administratively discharge a patient and re-admit them, without an interruption in care. In general, as long as there is no interruption in hospice care, completion of an HIS-Discharge is not required.

This slide lists two examples of situations where the hospice may administratively discharge the patient, but there is no interruption in care.

One such circumstance is when a patient has a change in payer source – for example, a private pay patient might become eligible for the Medicare benefit during the course of hospice care. In this situation, it might be the hospice's policy to complete an "administrative" or "paper" discharge and immediate re-admission to meet billing purposes.

Another situation might occur when a hospice fails to meet the face-to-face requirement. In this circumstance, the hospice must administratively discharge the patient, but there is no interruption in care, so no HIS-Discharge would be required.

In the case of administrative discharges with no interruption in care – such as the two examples listed on this slide, the hospice would submit an HIS-Discharge once the patient is no longer receiving hospice service or there is an interruption in care related to one of the reasons for discharge listed in Item A2115.

# 1.6: Special Circumstances, Continued

- **Traveling patients: patient moves out of the service area or transfers to another hospice**
  - If **home hospice** discharged patient and **host hospice** admitted patient and filed a Notice of Election (NOE) in claims processing system:
    - **Home hospice** must submit HIS-Discharge and
    - **Host hospice** must submit HIS-Admission and HIS-Discharge.
  - If no NOE is filed, no action is required.
    - **Home hospice** submits HIS-Discharge once patient is no longer receiving services or there is an interruption in services.

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According to CMS regulations at 418.26, a hospice may discharge a patient if the patient moves out of the service area or transfers to another hospice.

However, per the hospice regulations, a hospice may also enter into a written agreement with another Medicare-certified hospice program for the provision of core services to supplement hospice employee or staff to meet the needs of the patient.

In the case of a traveling patient, whether or not a hospice should submit an HIS-Discharge and new HIS-Admission depends on whether the home hospice discharged the patient and whether the host hospice admitted the patient to hospice care and filed a notice of election (NOE) within the claims processing system.

If there is no discharge by the home hospice, then the home hospice is not required to submit an HIS-Discharge when the patient travels out of the home hospice's service area. Relatedly, the host hospice would not need to submit an HIS-Admission or HIS-Discharge for a traveling patient that they are providing services for under a written agreement with the home hospice. This is because the host hospice is providing services as an agent of the home hospice. Thus, the home hospice would be responsible for submitting the HIS-Discharge, once they discontinued providing hospice services, either directly, or under arrangement.

# 1.7 Timing and Sequence Policies

- If a hospice realizes that it will not meet the timeliness criteria for any given record, it should still complete and submit that record.
- Late completion and submission of HIS records will result in a non-fatal (warning) error.
- Records with non-fatal errors can still be accepted by the QIES ASAP system.

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Section 1.7 of V1.02 of the HIS Manual discusses policies related to the timing and sequence of HIS record completion and submission.

In situations where a hospice realizes that it will not meet the timeliness criteria for any given record, it should still complete and submit that record, even if that means the record would be “late.” Late completion and submission of HIS records will result in a non-fatal (warning) error. Records containing non-fatal errors can still be accepted by the QIES ASAP system.

## 1.9 Compliance with HQRP Requirements and APU Determinations

- "Pay-for-reporting" program → submitting the required HIS records determines compliance.
  - https://www.federalregister.gov
- Beginning in the FY 2017 Reporting Year, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey will be considered part of general HQRP requirements.
  - CAHPS is part of the HQRP, but is separate from the HIS requirement
  - http://www.hospicecahpssurvey.org/Content/HomePage.aspx

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Failure to comply with HQRP requirements can result in a 2 percentage point reduction in a hospice's APU for the relevant Fiscal Year.

The HQRP is currently a "pay–for-reporting" program, meaning it is the act of submitting required HIS records that determines compliance with program requirements. This means that quality measure scores or performance are not a factor in determining compliance with HQRP requirements at this time.

Beginning with the FY 2017 Reporting Year, in order to avoid the two percentage-point reduction in their APU, hospices will also be required to meet requirements for the Consumer Assessment of Healthcare Providers and Systems (or "CAHPS") Hospice Survey as part of general HQRP requirements. The CAHPS survey is part of the HQRP, but is separate from the HIS requirement. For more information on CAHPS Hospice Survey requirements, please visit the CAHPS website at the web address listed on the slide.

This concludes updates made to Chapter 1 of V1.02 of the HIS Manual.