Hospice Regulatory & Quality Reporting Update

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Bipartisan Budget Act

- Medicare Patient Access to Hospice Act - passed 2/9/18
  - PAs will be allowed to serve as the attending physician to hospice patients and perform other functions that are otherwise consistent with their scope of practice, beginning January 1, 2019.
  - CMS will issue additional guidance or rulemaking which will provide additional information on changes in the Medicare Hospice Conditions of Participation and other parameters for their practice in the Medicare Hospice Benefit.
Bipartisan Budget Act

- Hospital payment policy for early discharge to hospice care - passed 2/9/18
  - Payment reduction in the DRG payment for hospitals for early discharges to hospice, effective October 1, 2018.
  - Early discharge is defined as “more than 1 day earlier than the Medicare mean length of stay for an applicable DRG.”
  - Change is based on the 2013 OIG Report “MEDICARE COULD SAVE MILLIONS BY IMPLEMENTING A HOSPITAL TRANSFER PAYMENT POLICY FOR EARLY DISCHARGES TO HOSPICE CARE.”
  - Payment will impact hospitals who discharge patients to hospice early.
  - Accompanying regulations will be published in hospital inpatient proposed rule.

Medicare Advantage and Hospice

- Senate Chronic Care Working Group has proposed that Medicare Advantage plans (MA) assume both the clinical management and financial responsibility of the hospice benefit, essentially “carving-in” hospice under Medicare Advantage
- NHPCO opposes this proposal based on hospices’ experience with private commercial insurance and Medicaid managed care
- We are gravely concerned that the proposal would negatively impact beneficiaries, hospices, and the Medicare program

NHPCO concerns:
- Limiting beneficiary access to the hospice of their choice
- Diluting the quality and integrity of the hospice benefit
- Undermining the autonomy of the hospice Medical Director
- Increasing the administrative burden for hospice providers
- Threatening the financial stability of hospice programs

We are monitoring this issue, and continue to meet with Congressional staff regarding our concerns on this proposal
**Opioid Disposal Act**

- On February 15th, H.R. 5041, the Safe Disposal of Unused Medication Act was introduced in response to America's opioid crisis.
- This legislation would help prevent the misuse or diversion of unused medications by equipping hospice professionals with the legal authority to safely dispose of unused drugs after a hospice patient’s death.

**NHPCO Responds to Opioid Crisis**

- The Senate Finance Committee recently solicited input from NHPCO and other stakeholders on ways to address the opioid epidemic as it relates to Medicare, Medicaid, and Human Services programs.
- NHPCO outlined important details regarding opioids’ role in end-of-life care, how the hospice community is actively working toward avoiding drug diversion and how hospice and palliative care providers can play an even greater role in helping with the treatment of serious pain.

- We also highlighted how many hospices offer grief and bereavement support to communities that are experiencing loss as a result of the opioid epidemic.
- We will continue to work closely with policymakers state and federal policy changes do not unintentionally impair the hospice and palliative care community’s ability to effectively manage their patient’s pain and symptoms.
Innovation Considerations

Key Reflections

• Any payment reform changes to the current hospice benefit could be accomplished through the existing statute, with limitation
• Demonstrations/models to test care delivery and payment structures
• The data tells a story
  – To implement or not to implement, that is the question.

What’s on the table?

• Payment Model Technical Advisory Committee
  – Advanced Care Model
  – Patient and Caregiver Support for Serious Illness
  – Hospital at Home Plus
  – Home Hospitalization (Acute care in the home)
• Medicare Care Choices
• Independence at Home Demonstration
• Bundled Payments for Care Improvement - Advanced (BPCI Advanced)
What could be on the table?

- Alzheimer’s and Related Dementia Care Delivery and Payment Model
  - Large sample size and a fast growing population
  - Known concerns from policymakers
  - Bipartisan interest in modernizing Medicare to adapt to the growing population
  - Public acceptance

Pre-Hospice Spending

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Mean Lifetime Length of Stay</th>
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<tbody>
<tr>
<td>ALL DIAGNOSES</td>
<td>73.9</td>
</tr>
<tr>
<td>Alzheimer’s, Dementia and Parkinson’s</td>
<td>118.8</td>
</tr>
<tr>
<td>CVA/Stroke</td>
<td>55.6</td>
</tr>
<tr>
<td>Cancers</td>
<td>47.3</td>
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<tr>
<td>Chronic Kidney Disease</td>
<td>29.8</td>
</tr>
<tr>
<td>Heart (CHF and Other Heart Disease)</td>
<td>78.8</td>
</tr>
<tr>
<td>Lung (COPD and Pneumonias)</td>
<td>69.4</td>
</tr>
<tr>
<td>All Other Diagnoses</td>
<td>78.2</td>
</tr>
</tbody>
</table>

Pre-Hospice Spending Analysis

- 180 Days before election
- 90 days before election
- 30 days before admission

RHC Rate
- FY2014
- $556.68
MA Carve-in

- Not openly considered or widely studied, but believed to be inevitable, recommended by MedPAC since 2014
- Including hospice in MA plans enables greater hospice use, innovation, and creates more continuous care for patients
- Despite possible benefits and interest from MA plans, significant concerns remain about preserving integrity of the benefit and impact on the financial health of hospices

Concept Model Design and Beyond

- Payment Model Design
  - Developing the base rate or bundled payment
  - Adjustment considerations
    - Geographic
    - Outliers
    - Social Determinants of Health
    - Risk Adjustment
- Quality Measures and Data Collection
- Program Integrity
- Sustainability

Hospice Data Trends as a Predictor
Data Sources

- CMS Proposed Rules
- MedPAC – Medicare Payment Advisory Commission
- Surveys
- Abt Associates claims analysis
- PEPPER Reports
- OIG Work Plan

Data Focused on....

- Growth in # of hospices and # of beneficiaries
- Spending
  - Medicare Hospice Benefit
  - After enrollment, spending outside the hospice benefit
    - Parts A and B
    - Part D
- Cost of care compared to reimbursement
  - By level of care
  - Margins
- Specific red flag indicators
Hospice use continues to grow

<table>
<thead>
<tr>
<th>Percent of Medicare decedents using hospice</th>
<th>Average annual percentage point change</th>
<th>Percentage point change</th>
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</thead>
<tbody>
<tr>
<td>2000</td>
<td>2015</td>
<td>2016</td>
</tr>
<tr>
<td>All decedents</td>
<td>23.2%</td>
<td>22.8%</td>
</tr>
<tr>
<td>Age 65+</td>
<td>29.7%</td>
<td>29.3%</td>
</tr>
<tr>
<td>White</td>
<td>26.9%</td>
<td>26.5%</td>
</tr>
<tr>
<td>Urban</td>
<td>26.2%</td>
<td>25.9%</td>
</tr>
<tr>
<td>Rural</td>
<td>17.6%</td>
<td>17.4%</td>
</tr>
<tr>
<td>Median age</td>
<td>79.1</td>
<td>79.0</td>
</tr>
</tbody>
</table>


Hospice use and expenditures increased in 2016

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<tr>
<th></th>
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<tbody>
<tr>
<td>Number of hospice users</td>
<td>134,000</td>
<td>1,314,000</td>
<td>1,390,000</td>
<td>1,427,000</td>
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<tr>
<td>Total hospice days among beneficiaries (mil)</td>
<td>26,000</td>
<td>29,000</td>
<td>30,000</td>
<td>31,000</td>
</tr>
<tr>
<td>Length of stay among decedents (days)</td>
<td>53.5</td>
<td>56.3</td>
<td>57.6</td>
<td>58.5</td>
</tr>
</tbody>
</table>

Estimated cost by level of care for freestanding providers, 2015

<table>
<thead>
<tr>
<th>Level of care</th>
<th>Average cost per day</th>
<th>Median cost per day</th>
<th>Medicare payment per day</th>
<th>Share of hospice days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine home care</td>
<td>$124</td>
<td>$128</td>
<td>$109</td>
<td>97.5%</td>
</tr>
<tr>
<td>General inpatient care</td>
<td>$710</td>
<td>$682</td>
<td>$709</td>
<td>1.6</td>
</tr>
<tr>
<td>Inpatient respite care</td>
<td>$489</td>
<td>$343</td>
<td>$165</td>
<td>0.3</td>
</tr>
<tr>
<td>Continuous home care</td>
<td>$48/ per hour</td>
<td>$51/ per hour</td>
<td>$39/ per hour</td>
<td>0.3</td>
</tr>
</tbody>
</table>
Investor Public Comments

- Home Health Care News, December 6, 2017
  - "Looking ahead, hospice will likely continue to be a hot sector, with higher valuations and less regulation compared to home health care."
  - "Hospice has recently seen an uptick in interest, as its higher margins and fewer regulatory pressures have made it an increasingly attractive sector. ..."
  - "Because of the reimbursement problems in home health, I think organizations are looking more to hospice as an investment opportunity, especially as some other non-strategic buyers will want to get into that space as they see more consolidation opportunities there," Blessing said."
HOSPICE QUALITY REPORTING

New in 2018

 HIS User’s Manual Version 2.00
  • Use as THE reference for calculating HIS measure scores
  • Quick Reference: Current Measures pdf (12/11/17)

HIS User’s Manual Version 2.0

• HIS is a data collection tool
• Measure specifications (numerator and denominator) and HIS data elements may not be the same
• Do not confuse instructions for completing the HIS record with how the measure is calculated
HIS User’s Manual Version 2.0

- More data are collected in HIS than are used in calculating the measures.
- More requirements for compliance with measures than indicated in data collection instructions
  - Example: Pain items

HQRP COMPLIANCE

**HIS Submission Timeliness**

\[
\text{% of HIS Records Submitted on Time} = \left( \frac{\text{number of HIS records in the numerator}}{\text{number of HIS records in the denominator}} \right) \times 100 \text{ rounded to the nearest whole number.}
\]

- **90% for 2018** (FY 2020 penalty)

HQRP COMPLIANCE

**Hospice CAHPS Survey**

- Survey vendor to collect and submit data on an ongoing monthly basis
- Hospice responsible to see that vendor is in compliance
HQRp - Extensions/Exemptions

• Extraordinary or extenuating circumstance beyond the hospice’s control (e.g., natural disasters)
• Request must be initiated within 90 days of the extraordinary circumstance event
• Instructions on HQRp website

WHAT IS IN THE QUALITY PIPELINE?

HEART
Hospice Evaluation & Assessment Reporting Tool ❤️

Standardized Assessment
– Admission
– Interim
– Discharge
HEART

Pilot Testing

- Two phases:
  - A: 1/2018 – 3/2018
  - B: 6/2018 - 9/2018

- Analysis: 9/2018

- Implementation: ???

New Measures for Hospice Compare

Specifications Known

- HIS Composite
- Hospice Visits When Death Is Imminent
  - RN, etc. last 3 days of life
  - SW, etc. last 7 days of life
  - Data collection started 4/2017
  - NQF endorsement before inclusion in HC

Potential Measures

Measure Concepts/Specifications Not Known

1. Potentially avoidable hospice care transitions
   - Live Discharges (followed by death or acute care in short period of time)
2. Access to levels of hospice care
   - Utilization of GIP and CHC

Data Source = Hospice Claims
Draft Measure Comment Period

- Transitions from Hospice Care, Followed by Death or Acute Care, Draft Measure Development for Hospice QRP
- Public Comment Period Ends **April 25, 2018**
- Transitions from Hospice Care, Followed by Death or Acute Care will estimate the risk adjusted rate of transitions from hospice care, followed by death within **30 days** or acute care use within **7 days**
  - Outcome measure

Measure Numerator

- Number of live discharges that are followed by death within 30 days or a hospitalization/emergency room visit/observation stay within 7 days of hospice discharge (unadjusted)

Measure Denominator

- The eligible stays for this measure are discharged hospice stays among all Medicare FFS patients that do not meet exclusions for the measure
Measure Exclusions

• Patients not continuously enrolled in Part A Medicare FFS in the 12 months prior to the hospice admission date, during the hospice stay, or at least 7 days following the hospice discharge date

• Patients enrolled in Medicare Advantage in the 12 months prior to the hospice admission date, during the hospice stay, or in the 7 days following the hospice discharge date

• Patients who are under 18 years old at hospice admission

Future Measures

Sources:
• HEART
• Hospice Claims
• Other Providers

TBD

Hospice Compare STAR ratings – Normative or Criterion based?

Value Based Purchasing
Training from CMS

• CMS posted new two educational series in March 2018.

• The first series, focuses on helping providers navigate the websites pertinent to the Hospice Quality Reporting Program (HQRP)
  – newly designed CMS HQRP website along with the CAHPS® survey website and the QIES Technical Support Office (QTSO) website to improve the user experience.

Training from CMS

• The second series focuses on refined coding guidance for the HIS

• Based on questions frequently asked on the Hospice Quality Help Desk, CMS has produced refined coding guidance for select Hospice Item Set (HIS) items

• Refined coding guidance includes additional clarification on clinical examples, tips, and item-level HIS coding guidance

Training from CMS

• Both series are available on CMS’s YouTube channels as short, self-directed segments (or modules)

• Slides and speaker notes for each series are also available on the “Hospice Quality Reporting Training: Training and Education Library” webpage
**Federal Scrutiny**

- Department of Justice (DOJ)
  - False Claims Act violation
  - Medicare fraud and abuse
- Office of the Inspector General (OIG)
  - Hospice in a nursing facility
  - Hospice in an assisted living facility
  - Hospice and Part D drugs
  - Hospice general inpatient level of care

**Federal Scrutiny**

- Zone Program Integrity Contractor (ZPIC)
  - Not a random audit
  - Audit issues vary
- Recovery Auditor (RA)
  - Inappropriate payment/reimbursement
- Comprehensive Error Rate Testing (CERT)
  - Inappropriate payment/reimbursement
Federal Scrutiny – In Transition

Unified Program Integrity Contractor (UPIC)
- The UPIC will combine and integrate existing CMS program integrity functions carried out by multiple contractors and contracts into a single contract to improve its capacity to swiftly anticipate and adapt to the ever changing and dynamic nature of those involved in health care fraud, waste, and abuse across the Medicare and Medicaid program integrity continuum.

Know Your Auditor
- Zone Program Integrity Contractor (ZPIC)
  - AdvanceMed
- Recovery Auditor
  - Performant
    - https://performantrac.com/
Expansion of Targeted Probe and Educate

- CMS is expanding the existing Targeted Probe and Educate (TPE) pilot, which included hospitals and home health, to include all Medicare Administrative Contractors (MACs), effective October 1, 2017
- The purpose of this expansion is to reduce appeals, decrease provider burden, and improve the medical review and education process
- The goal of TPE is to reduce/prevent improper payments

Pre-Pay and Post Pay Audits

- Aberrant data as a trigger
- Sustained high levels of denials (≥15%) may trigger referral to UPIC/ZPIC
  - Targeted education (one-on-one) by phone or video
  - Improve on “education letters” that offer very little educational value
CMS Proposed Rule FY2018
Part A and B Spending Outside Hospice Benefit

In millions

Part A and B Spending

Source: FY2018 Hospice Wage Index Proposed Rule, April 27, 2017

CMS Comments

- 25% drop in Part A and B spending since 2012.
- **Not a trivial amount**
- CMS will continue to monitor data regarding this issue

Part D Spending

In millions

Source: FY2018 Hospice Wage Index Proposed Rule, April 27, 2017
CMS Concerns

- Current prior authorization process has lowered Part D expenditures for 4 classes
- Increase in beneficiaries filling “maintenance” medications through Part D
- Hospices are responsible for covering drugs and biologicals related to the palliation and management of the terminal illness and while the patient is under hospice care
- Part D coverage: treatment unrelated to the terminal illness or related conditions

Source: FY2018 Hospice Wage Index Proposed Rule, April 27, 2017

COPD

Overlapping Drugs – Part D Expenditures
Total Spend Outside Hospice Benefit: $11,194,870

- Common Palliative Drugs
- Antiasthmatic and Bronchodilator Agents
- Respiratory Agents - Misc.
- Corticosteroids

Source: FY2017 Hospice Wage Index Proposed Rule – FY2014 Data

OIG Focus Areas

- OIG and CMS to monitor hospices that have a high census of nursing facility residents on hospice care
- OIG asked CMS to reduce hospice payments when the patient resides in a SNF
- If your hospice has a high percentage of patients in SNFs, plan internal auditing of those claims
  - OIG defines high percentage as two-thirds or more
OIG Focus Areas

- In a study, OIG alleged that 82% of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements.
- OIG alleged inappropriate uses of inpatient respite care for nursing home patients.
- Failure to discharge when no longer terminally ill.
- Overuse of GIP level of care.

OIG Focus Areas

- OIG plans to audit duplicate drug payments (hospice and Part D). Key drugs: analgesics, anti-nausea, laxatives, anti-anxiety.
- Pharmacy audits (e.g., Rawlings); legal sources recommend cooperating with these reviews but always try to settle at a discount.

OIG Adds Hospice Topic to FY2017-2018 OIG Work Plan

- Medicare Payments for Unallowable Overlapping Hospice Claims and Part B Claims.
- The OIG has identified this area for noncompliance with Medicare billing requirements.
- They will review Medicare Part A payments to hospices to determine whether claims billed to Medicare Part B for items and services were allowable under current Federal regulations.
- The report is expected to be released in FY2018.
2018 Hospice PEPPER Report Review

- An online review of the new release of the Hospice PEPPER (version Q4FY17, scheduled for release by April 16, 2018) will occur on Thursday, April 26, 1:00 – 2:00 p.m., CST
- The updated report will be available to hospice providers by April 16, 2018. PEPPER reports are a valuable resource for providers; those wishing to learn more should participate in the review
- **Registration is required**
Hospice Target Areas – 2017 PEPPER

- Live discharges – not terminally ill
- Live discharges – revocations
- Live discharges – 61-179 days
- Long length of stay
- CHC in assisted living facility
- RHC in assisted living facility
- RHC in nursing facility
- RHC in skilled nursing facility
- Episodes with no CHC or GIP
- Long General Inpatient Care Stays (> 5 days)

2017 Survey Deficiencies - #1-5

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<th>L Tag</th>
<th>Survey Deficiency</th>
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<tr>
<td>#1</td>
<td>L0543 Plan of care</td>
</tr>
<tr>
<td>#2</td>
<td>L0530 Content of comprehensive assessment</td>
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<tr>
<td>#3</td>
<td>L0629 Supervision of hospice aides</td>
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<td>#4</td>
<td>L0523 Timeframe from the completion of the assessment</td>
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<td>#5</td>
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2017 Survey Deficiencies - #6-10

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<td>L0579 Prevention</td>
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<td>#9</td>
<td>L0531 Content of the comprehensive assessment</td>
</tr>
<tr>
<td>#10</td>
<td>L0596 Counseling services</td>
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Why Do We Care?

• Every hospice will receive a Medicare compliance survey every 3 years
• Every hospice is potentially at risk for a federal or state audit
• Every hospice is at risk for medical review form their MAC
• More hospice providers are being audited

Why Do We Care?

• The quality of a hospice’s documentation will determine:
  – Payment retention (post payment review)
  – Payment receipt (prepayment review)
  – Ability to maintain Medicare certification and/or state hospice licensure

What does all of this mean?

• Higher margins is cause for additional scrutiny
• Cost of RHC – differential of $35 in cost/reimbursement
  – LARGE difference
  – Already raises questions about rate adjustment
• Higher or no GIP/Respite utilization may draw attention to some providers
• Providers with high percentages of ALF or NH patients
• Staff visits – few visits? No visits?
• Identification of providers who have 3 or more negative indicators...
What's a Hospice to Do?

• Use the data points
• Plot your own hospice's data
• Identify areas of risk
• Identify areas for improvement
• Review regularly

OTHER 'STUFF'

CMS Issues Clarification on Responsibilities of Hospice Medical Director

• NHPCO has been in conversation with CMS Region V (Chicago) over some interpretations of the responsibilities of the hospice medical director
• CMS confirms that:
  – There can be only one hospice medical director per hospice provider number
  – Either the medical director or a physician member of the IDT may certify or recertify patients for terminal illness and eligibility for the Medicare Hospice Benefit
CMS Issues Clarification on Responsibilities of Hospice Medical Director

• Organization chart should show hospice physicians reporting to the one medical director

• Evidence of supervision by the one medical director of other staff physicians
  – Established in program polices/procedures
  – Should be more frequently than annual evaluation

CMS Issues Clarification on Responsibilities of Hospice Medical Director

• Providers should review their policies, job descriptions, and organizational charts to ensure that these two issues are covered. Read NHPCO’s Regulatory Alert (03/27/18) for more details

Calculating Hospice Routine Home Care Payments After Transfer

• CMS recently issued Change Request (CR) 10180, “Identifying Prior Hospice Days When Calculating Hospice Routine Home Care Payments after a Transfer”

• This CR corrects the number of days used to determine the 60 days of high Routine Home Care payments on hospice claims
Calculating Hospice Routine Home Care Payments After Transfer

- Currently, Medicare has instructed hospices to account for this by reporting the benefit period start date as the admission date on their claim in the case of transfers.
- While this workaround results in correct payments, it requires the hospice to submit misleading information and cannot serve as a permanent solution.
- The requirements instruct CWF to identify prior days correctly in transfer situations, so hospices no longer need to use this workaround.

Transition to New Medicare Numbers and Cards

- CMS is removing Social Security Numbers from Medicare cards to prevent fraud, fight identity theft, and keep taxpayer dollars safe
- New Medicare cards will be mailed beginning in April 2018
- Planning in place to test systems before implementation
- Transition period
  - Can use either the HICN or the MBI to exchange data
  - The transition period will begin no earlier than April 1, 2018 and run through December 31, 2019

Medicare Card New Look

- 11-characters in length
- Made up only of numbers and uppercase letters (no special characters)
Alert Your Patients

CMS encourages Medicare providers to help alert your patients by displaying a **poster** in your office and giving your patients **tear-off sheets** or **fliers**.

Alert Your Patients

- CMS has created an **educational website** for Medicare providers, external partners and people with Medicare to use to find the most recent information regarding the NMC project.
- Visit the website frequently to check for updates.

NHPCO members enjoy unlimited access to Regulatory Assistance. Feel free to email questions to regulatory@nhpco.org.
Regulatory & Quality at NHPCO

Regulatory Questions
• Email us at: regulatory@nhpco.org

Quality Reporting Questions
• Email us at: quality@nhpco.org

How to keep up...
• NHPCO provider members have access to:
  – NHPCO News Briefs
    • Every Thursday
    • Regulatory and compliance updates every week
  – NHPCO Podcasts
    • Every 1st and 3rd Tuesday of each month
    • Specific regulatory and policy content
  – Regulatory Alerts
    • For time sensitive and important regulatory issues
    • Sign up to receive email regulatory alerts
  – Regulatory Round Ups
    • Once a month, all regulatory issues summarized
  – My.NHPCO – regulatory entries for specific groups