HOSPICE REGULATORY UPDATE: What Now???
PRESENTER

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OBJECTIVES

• Describe how the federal government plans on increasing its scrutiny

• Name three regulatory changes that went into effect in 2014

• Identify the regulatory challenges that are in the works for the hospice industry
SESSION GOALS

• Provide insight into current & potential government scrutiny

• Provide an update on 2014 regulatory changes, their potential financial impact

• Provide insight into future regulatory & payment changes
DATA MINING
TRENDS IN HEALTHCARE FRAUD

• $4.3 billion recovered in health care fraud in 2013

• 66% increase in new health care fraud cases since 2009

• The government budget for health care fraud & abuse is $2 billion for 2015 - nearly $700 million more than in 2014

• Sources -
  • The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program
  • U.S. Dept. of Justice, Fraud Statistics - Health and Human Services, October 1, 1987 - September 30, 2013
MEDICARE HOSPICE STATISTICS FOR 2012

- Increasing for-profit hospices with higher margins
- Longer LOS (ALF & SNF!)
- High % LTC hospices have higher margins
- More than half of Medicare hospice spending was for patients exceeding 180 days

Source - MedPAC June 2014, A Data Book: Health Care Spending & the Medicare Program
2012 STATE STATISTICS

- CA #1 for the number of hospice admissions
- NV #35 for rank in number of hospice admissions
- CA $1.5 billion in total hospice Medicare expenditures
- NV $157 Million in Medicare expenditures
- CA average of $13,972 per beneficiary
- NV average of $15,703 per beneficiary
- National average of $11,833 per beneficiary

www.HospiceAnalytics.com
CURRENT SCRUTINY FOR HOSPICES

• Increasing ADRs, Audits & 100% pre-payment reviews
• Frequent whistleblower lawsuits
• Numerous fines and settlements have been paid back to the government
• Many have had to entered into Corporate Integrity Agreements (CIAs)
• Hospice professionals have been convicted of fraud
• Several hospices have closed
HAS THERE BEEN FRAUD IN HOSPICE?

• Intentional marketing & admission of ineligible patients

• Intentional recertification of patients who are no longer eligible

• Intentional growth of programs through kickbacks with physicians, nursing homes & assisted living facilities
OFTEN IT IS NOT FRAUD BUT...

• No compliance program or policies to educate and enforce right practices

• Lack of knowledge of the regulations and changing requirements

• Neglected to educate staff, including physicians

• Neglected to update forms to meet regulatory requirements
UNDERSTANDING ERRORS, WASTE, FRAUD & ABUSE

Mistakes  Inefficiencies  Bending the rules  Intentional deception

Error  Waste  Abuse  Fraud

Incorrect coding  Medically unnecessary service  Improper billing practices (e.g., up-coding)  Billing for services that were not provided
FULL STEAM AHEAD FOR CMS AUDITORS!
PAYMENT RELATED
SCRUTINY

WHO IS LOOKING?
MEDICARE CONTRACTORS – CA/NV

• Medicare Administrative Contractor (MAC)
  • National Government Services

• Comprehensive Error Rate Testing (CERT) Review Contractor (RC)
  • AdvanceMed Corp.

• Medicare Recovery Auditor (RA or RAC)
  • HealthDataInsights – HDI

• Zone Program Integrity Contractor (ZPIC)
  • Safeguard Services, LLC
MEDICAID CONTRACTORS – CA/NV (CONT’D)

• State Medicaid Auditors
  • Medi-Cal/

• Payment Error Rate Measurement (PERM) Review Contractor
  • A+ Government Solutions

• Medicaid Integrity Contractor (MIC) Audit MIC
  • Health Management Systems (HMS)

• Medi-Cal RAC Auditor
  • Health Management Systems (HMS)
UNIFIED PROGRAM INTEGRITY CONTRACTOR (UPIC)

- ZPIC & MAC to merge
- Focus will be on both Medicare & Medicaid integrity issues
- MAC would take on a broader role in program integrity activities
- Medicaid Integrity Contractors will be phased out
- Recovery Auditors will remain in place
- Medicare & Medicaid data will be a unified database
PAYMENT RELATED RISK

What Are They Looking For?
OIG’S FOCUS ON HOSPICE

• Coverage requirements for hospice patients residing in nursing homes
• Medicare hospices that focus on nursing facility residents ("high percentage hospices")
• Marketing practices with nursing facilities
• GIP appropriateness & Hospital-to-GIP transfers
• Duplicate drug claims (including non-covered but hospice-related medications)
• Compliance with Medicaid reimbursement requirements (Patient Liability/Share of Cost)
2014 & 2015 OIG WORK PLAN - HOSPICE

Hospice Provision of GIP

• Review claims and patient records
• Evaluate for eligibility for this higher level of care

Hospice in Assisted Living Facilities (ALF)

• Have the longest LOS in hospice.
• Review the numbers of hospice beneficiaries in ALFs, their LOS & common diagnoses
• Utilize this information for payment reform
• Develop quality measures

Expected issue date for both evaluations in FY 2015
ZPIC/MIC AUDITS
ZPIC AUDIT FOCUS IN HOSPICE

• ↑ Length of Stay (LOS)
• ↑ Non-CA diagnosis
• ↑ SNF care
• ↑ Readmits after discharge
• ↑ Higher levels of care – GIP & Continuous Care
• Technical and clinical compliance
• Medical necessity
ZPIC/MIC AUDITS

- They act as if one didn’t know the other was coming
- Record volume submission can be a tremendous burden
  - Medicare and Medicaid separate requests with immediate deadlines
  - “It took 16 people working FT”
- One request was for 200 records
- Can take 1 – 2 years to hear results
- Sample review can lead to 100% pre-payment review prior to audit results
- Extrapolation can be deadly
- Frequently the statistical sampling and extrapolation is incorrect
MAJOR RISK AREAS

Technical Risks

Clinical Risks
<table>
<thead>
<tr>
<th><strong>MAJOR TECHNICAL RISKS</strong></th>
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<tbody>
<tr>
<td>Election Statement</td>
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<td>Certification &amp; Recertification</td>
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<td>Plan of Care</td>
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MAJOR CLINICAL RISKS

Eligibility for Hospice & General Inpatient/Continuous Care

Discharges & Revocations

Related vs. Not Related to the terminal illness
NGS TOP REASONS FOR DENIAL

• Not following LCDs for dementia, cardiac, nutritional/metabolic disorders

• Long lengths of stay

• Continuous Care

• Technical reasons –
  • 55H1B – untimely cert/recertification
  • 55H1F – lack of valid physician certification
  • 55H1G – beneficiary NOE did not meet the statutory/regulatory requirement
PHYSICIANS ROLE IN ELIGIBILITY

• MHB requires hospice to cover all palliative care related to the terminal illness and related conditions

• Physicians must help the IDG in identifying related, secondary, contributing and unrelated diagnoses

• All services are considered related unless the hospice physician documents why a patient’s medical needs are unrelated to the terminal illness

• Appropriate ICD-10 coding will only occur with sufficient information from your Attending Physician
PHYSICIANS ROLE IN ELIGIBILITY

• Physician narrative can make or break reimbursement

  • Detailed description of clinical findings to support the limited prognosis – comparative metrics for evidence of decline

  • Keep unrelated diagnoses and medications out of the narrative
MEDICAL NECESSITY
A GROWING PROBLEM FOR HOSPICE ELIGIBILITY
MEDICAL NECESSITY IN HOSPICE

- IDT documentation is essential in demonstrating medical necessity
- Meet LCDs at admission and ongoing
- Documentation demonstrates decline over time
  - Intake, Mid arm circumference, weights
  - Dependency in ADLs
  - Burden of illness on caregivers
- Changes in the POC demonstrate need
  - Higher level of care
  - Medication & treatment changes
  - Increase in visit frequency & type of hospice support
- Each claim’s documentation must stand on its own merit
WHAT TO AVOID

• Bonuses tied to new admissions or ADC for clinical and admissions staff
• Any bonus tied to average length of stay
• Undue pressure on hospice staff to increase census
• Marketing staff overruling/pressuring on admissions
• Undue delays in live discharges
• Allowing Medical Director to over-rely on hospice staff for clinical assessments; make sure IDG meetings are robust!
• Frequent discharges for hospitalizations and readmissions
• Numerous “unrelated” medications
2014 REGULATORY UPDATE
CR 8371 - DEMAND BILLING OF GIP

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• Implementation January 6, 2014
• Patient no longer requiring GIP, yet patient wants to appeal
  • ABN must be provided
  • If GIP is not considered necessary by the QIO, the MAC can process the days as RHC without the need for the hospice to re-bill for RHC days
• Billing instructions for demand bills associated with ABN issuance are provided in CMS Publication 100-4 Claims Processing Manual, Chapter 1 General Billing Requirements, section 60.4.1 Outpatient Billing with an ABN (Occurrence Code 32)
CR 8358 - ADDITIONAL DATA REPORTING

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- Reissued 1/31/14 – Mandatory reporting effective April 1, 2014
  - Hospice staff visits for GIP in contracted SNF/hospital
  - NPI, facility name & address of any facility-based care
  - Visits after death of patient on same calendar day
    - Nurses, aides, SWs, & therapists
    - PM modifier used to identify post-death visits
  - Injectable & non-injectable prescription drugs
    - For the terminal & related conditions
    - NDC number of the drug, NDC qualifier (drug quantity), charge for each fill
  - Infusion pumps, medications & refills
CR 8620 - VACCINES

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- CR 8620, issued April 28th, removes the changes made to Medicare systems in CR 8098, in order to allow any provider to furnish vaccines to hospice beneficiaries.

- Your MAC will allow professional claims for vaccines (Influenza, PPV, and Hepatitis B) and vaccine administration containing modifier GW when the date of service falls within a hospice election.

- Your MAC will adjust vaccine claims with dates of service on or after October 1, 2013, which were previously rejected due to a hospice election, if you bring such claims to your MAC’s attention.
PEPPER REPORT

• Summarizes Medicare claims data statistics for one hospice in “target areas” that may be at risk for improper Medicare payments
• Compares a hospice’s Medicare claims data with aggregate Medicare data for the nation, MAC jurisdiction and state
• PEPPER is an educational tool that is intended to help providers assess their risk for improper Medicare payments
• Target areas have been length of stay and live discharges
• PEPPER cannot identify improper Medicare payments!
PEPPER REPORT

• TMF Health Quality Institute developed a secure web portal through which certain providers can access their Program for Evaluating Payment Patterns Electronic Report (PEPPER)
• Reports can be downloaded
• They will remain accessible for 1 year
• To receive notification when the PEPPER is available & guidance on accessing it, join the email list at –

PEPPERresources.org
http://pepperresources.org/TrainingResources/Hospice/HospicePEPPERTrainingSession1.aspx
QUALITY REPORTING
QUALITY REPORTING

• NQF 0209 & QAPI Structural Measure phased out April 1, 2014
  • Failure to report will impact FY2015 payments (-2%)

• Hospice Item Set (HIS) mandatory reporting began July 1, 2014
  • Affordable Care Act (ACA) required to implement a quality reporting program for hospice
  • Purpose is to create a standardized mechanism or tool for the extraction of data from the medical record, which CMS will use to calculate 7 specific measures
  • Must be submitted electronically at admission and discharge
HOSPICE ITEM SET (HIS) MEASURES

- NQF #1617 – Patients Treated with an Opioid who are Given a Bowel Regime
- NQF #1634 – Pain Screening
- NQF #1637 – Pain Assessment
- NQF #1638 – Dyspnea Treatment
- NQF #1639 – Dyspnea Screening
- NQF #1641 – Treatment Preferences
- Modified NQF #1647 – Beliefs/Values Addressed (if desired by the patient)

HIS REPORTING TIMEFRAMES

• HIS-Admission to be completed within 14 days of admission date

• HIS-Discharge to be completed within 7 days of discharge date

• Hospices will electronically submit HIS records to CMS within 30 days from a patient admission or discharge to submit the appropriate HIS record for that patient

• Failure to report will impact FY2016 payments (-2%)

• Public Reporting of Hospice Quality Measures not prior to 2017
HOSPICE MANUAL UPDATES
CR 8727 & CR 8877
HOSPICE MANUAL UPDATES

CR 8727 - Updates and Clarifications to the Hospice Policy Chapter of the Benefit Policy Manual from previous CRs
Effective: August 8, 2014

CR 8877 - Hospice Manual Update for Diagnosis Reporting and Filing Hospice Notice of Election (NOE) and Termination or Revocation of Election. This CR rescinds and fully replaces CR 8777
Effective: October 1, 2014
ELECTION OF BENEFIT - CR 8727

Each patient must have a signed EOB and the form must contain all 6 required elements:

- Hospice provider’s name
- **Name of the attending physician** & acknowledgement that is was the patient’s/representative’s choice (10/1/14)
- Palliative vs. curative care
- Waiver language
- Start of care (SOC) or effective date - not retroactive
- Patient’s or representative’s signature prior to SOC
CR 8727 (CONT)

- Effective 10/1/14 providers have 5 calendar days to submit the NOE & have it accepted by the MAC via DDE

- Day 1 = first day after the hospice election date

- NOEs can only be submitted by direct data entry (DDE) using the Fiscal Intermediary Standard System (FISS), or via a paper UB-04; they cannot be submitted electronically

- Source - Update to the FY2015 Hospice Wage Index Final Rule (CMS-1609-F) and updated in the Federal Register - August 22, 2014
CR 8727 (CONT)

- To be accepted, the NOE must be free of billing or keying errors that would cause the NOE to be returned or rejected.

- The first hospice claim for a beneficiary may be submitted only after the NOE has processed.
CR 8727 (CONT)

- If you are unable to file due to a recognized exception, document the circumstances to support a request for an exception.

- The Medicare Administrative Contractor (MAC) will use the documentation to determine whether the delay in filing qualifies as an exception.
CR 8727 (CONT)

Exceptions for timely filing:

- Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice’s ability to operate
- Data filing problem due to CMS or the MAC
- New Medicare-certified hospice that is notified of its certification after the Medicare certification date
- New hospice that has not received their user ID from the MAC
- Other circumstances, determined by CMS, to be beyond control of the hospice
CR 8727 (CONT)

Exceptions NOT allowed for timely filing:

- Hospice personnel issues
- Failure to have back up staff
- Internal hospice IT issues
- Ignorance
CR 8727 (CONT)

• If the NOE is not filed within the time limit, the first day of care until the timely filing occurs, will be billed with occurrence span code 77 to identify the provider liable days.

• CMS will monitor the timely filing and may shorten the timeframe in the future!
CHANGE IN ATTENDING PHYSICIAN

• Patient must sign a Change of Attending document
• The statement needs to include:
  • Physician’s full name, NPI number & office address
  • Effective date of the change (no earlier than the date signed)
  • Patient’s (or representative’s) signature, along with an acknowledgement that this change in the attending physician is the patient’s (or representative’s) choice
  • Date that the statement is signed
• If attending is unable or unwilling, document in record
FINAL RULE REGARDING OVERPAYMENTS

FINAL RULE REGARDING OVERPAYOUTS

- ACA Section 6402 – Most issues in final rule effective May 23, 2014

- Changes to requirements for Medicare Advantage ("MA") and prescription drug benefit ("Part D") programs for contract year 2015

- Requires physicians who order durable medical equipment, prosthetics, orthotics and supplies ("DMEPOS"), medications or **certify** all other categories of Medicare items or services, including covered Part D drugs to be enrolled in the Medicare program
FINAL RULE REGARDING OVERPAYMENTS (CONT.)

• Outlines physician involuntary disenrollment from Medicare if CMS determines that there is a pattern or practice of prescribing Part D drugs that —
  • Is abusive and represents a threat to the health and safety of Medicare beneficiaries; or
  • Fails to meet Medicare requirements

• “Necessary evaluation” of the patient was not defined in the final rule and has some hospice physicians nervous

• Declined to establish a specific exception for hospice or palliative physicians or services, “for this would eliminate our ability to take action against truly egregious and dangerous prescribing practices that may occur in such settings”.

FINAL RULE REGARDING OVERPAYMENTS (CONT.)

• If problems are identified, they must be voluntarily reported and refunded within 60 days of identifying an overpayment

• If significant refund potential or inducements – involve counsel

• Only audit pre-billed clinical records
  • You can adjust billing prior to submission if documentation is missing or does not support billing
ABN / NOMNC / DENC
A Growing Risk Area for Hospice
SITES FOR INFORMATION

• **NOMNC** – Notice of Medicare Non Coverage

• **ABN** – Advance Beneficiary Notice of Non-coverage

• **DENC** – Detailed Explanation of Non Coverage

CMS Beneficiary Notice Website

http://www.cms.gov/Medicare/Medicare-General-Information/BNI
NEW QIO

• Effective August 1, 2014 - CMS restructured the Quality Improvement (QIO) Program to improve patient care, health outcomes, and save taxpayer resources
• The new Beneficiary and Family-Centered Care QIO for CA & NV is:
  
  **Livanta, LLC**

  **877-588-1123**


• Hospices need to change the name of the QIO on your **Notice of Medicare Non-Coverage** form (**CMS 10123**) that is issued to patients discharged because they are no longer terminally ill
CODING CHANGES
All Diagnoses

Primary Diagnosis or Co-Morbid Conditions that Influence Prognosis
- Listed on Claim
  - Pay

Co-Morbid Conditions that Do Not Influence Prognosis
- Not Listed on Claim
  - Don't Pay
• Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under HIPAA.
ICD-9-CM CODING CONVENTIONS

• Certain conditions have both an underlying etiology (cause) and potential body system manifestations (complications) that are due to the underlying etiology.

• ICD-9 requires that the underlying condition (the etiology or cause) must be sequenced first followed by the manifestation(s).

• Manifestations should never be listed as primary diagnoses.

• Example –
  • diabetic end stage renal disease:
  • 250.40 [585.6]
CODING FOR ALZHEIMER’S & OTHER DEMENTIAS

• To assign a dementia code, there must be a specific diagnosis documented in the clinical record with physician confirmation as to the specific type of dementia that the patient has.

• **Vague** dementia codes cannot be used, such as:
  • 290.0 Senile dementia uncomplicated
  • 294.8 Other persistent mental disorder due to conditions classified elsewhere
INAPPROPRIATE PRIMARY CODES

• On October 1, 2014, certain primary diagnoses will cause claims to be denied \textbf{Any} Signs, Symptoms & Ill-defined (SSI) codes, such as:

783.41 (R62.51) Failure to thrive
783.7 (R62.7) Adult failure to thrive
799.3 (R53.81) Debility Unspecified

• Source - Final FY 2014 Wage Index
CODING FOR ALZHEIMER’S & OTHER DEMENTIAS

• Avoid using the coding classification “Mental, Behavioral, and Neurodevelopmental Disorders”
  • Not allowable as a principal diagnosis per ICD-9-CM coding guidelines

• Select from diagnoses in ICD-9-CM coding classification “Diseases of the Nervous System and Sense Organs”
  • Can be used as principal diagnoses per ICD-9-CM coding guidelines
WHICH PATIENT ICD-9 CODING LOOKS MORE HOSPICE APPROPRIATE?

Primary Code: 332.0, Parkinson’s disease

OR

Primary Code: 332.0, Parkinson’s disease
• Other (secondary) codes:
  • 787.20, dysphagia
  • 783.21, weight loss
  • 458.0, orthostatic hypotension
  • V12.61, history of pneumonia
  • V85.0, adult BMI below 19
PART D & HOSPICE
• During CY09 Medicare Part D paid over $33 Million for drugs of hospice patients
• 14.9% of hospice patients enrolled in Part D had $12.9 million in analgesics paid by Part D
• 10% of hospices accounted for 51% of Part D analgesic claims
• 50.3% of these claims were for SNF-based hospice patients
PART D GUIDANCE 3/11/14

• “We expect drugs covered under Part D for hospice beneficiaries will be unusual and exceptional circumstances” – CMS

• Part D Final Guidance 3/11/14 - Part D plans were instructed to establish a prior authorization (PA) process on **ALL** drugs of Medicare Hospice Benefit patients
• If hospice is providing a drug in one of these 4 categories that is “clearly & unequivocally unrelated” to the terminal prognosis, a PA is required by the Part D Plan
  
  • Analgesics
  • Anti-emetics
  • Anti-anxiety
  • Laxatives

PART D FINAL GUIDANCE – 7/18/14

• Hospices are still required to “provide virtually all the care” needed by their patients

• “Beneficiaries should only very rarely be taking drugs that are not covered under the hospice per diem”

• “Unless there is clear evidence that a condition is unrelated to the terminal illness, all service would be considered related”
PART D FINAL GUIDANCE – 7/18/14

• Using the **standardized PA form** fulfills the PA requirement if initiated prior to submission of a claim for Part D payment

  [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Hospice-Info-PartD.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Hospice-Info-PartD.pdf)

• Does not require any supporting documentation on the form other than the designation of “U” for unrelatedness

• Physician **must** still document rationale for unrelatedness for each medication in the patient’s clinical record
Hospice reports patient election to Part D sponsor
- Use standardized form to notify Part D sponsor; check the box on the first page indicating the hospice election
- 2nd page is not mandatory, but helps in Part D care coordination
- Fax or mail form to the Part D sponsor, depending on the Part D sponsor’s direction and guidance to the hospice provider
- This communication can be used by the Part D sponsor to override the beneficiary-level hospice PA at point-of-sale (POS)
- This is completed for every patient that has Part D drug coverage
PART D FINAL GUIDANCE – 7/18/14

- Report **revocations and discharges** to Part D sponsor as soon they occur
- Use standardized form to notify Part D sponsor; check box on the first page indicating the hospice revocation or discharge
- Fax or mail the form to the Part D sponsor, depending on the Part D sponsor
- Other documentation can be sent to Part D sponsor as evidence of revocation or discharge
  - Revocation form
  - NOMNC
  - Discharge Summary
DRUG PAYMENT RESPONSIBILITY

- **Hospice** – Drugs related to the palliation and management of the patient’s terminal illness or related conditions

- **Medicare Part D** – Drugs for the treatment of a condition that is completely unrelated to the patient’s terminal illness or related conditions

- **Beneficiary** – 1) Related drugs not reasonable or necessary to palliation or symptom management; or

  2) Patient wants a specific drug instead of its equivalent on the hospice’s formulary
ISSUANCE OF AN ABN

Issue the ABN:

• If the hospice provider provides the medication even though it is not reasonable and necessary, the hospice must issue an ABN in order to charge the patient or their representative for the medication.

Do not issue the ABN:

• If a hospice provider does not provide the medication, an Advance Beneficiary Notice of Non-coverage or ABN) does not need to be issued to the patient/representative.
BENEFICIARY APPEAL RIGHTS

• Hospice **must** inform patients of their appeal rights if they desire to continue to take drugs not covered by Part A (hospice) or Part D

• Patients may submit to Medicare and appeal on Form CMS-1490S

• Beneficiaries may also submit quality of care complaints to a QIO when the beneficiary prefers a non-formulary drug that the hospice will not provide
PART D OPERATIONAL CHANGES

• Proactively identify Part D sponsor and initiate prior authorization as soon as patient elects

• Adjust admission process to:
  • Collect patient’s Part D information
  • Describe the possibility that the patient may be liable for some drugs
  • Contact any prescribers to initiate care coordination

• Adjust medication management process
  • Have physician determine unrelated medications
  • Have physician document reasons for un-relatedness for submission in prior authorization
NEW CA PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

POLST
POLST 2014

• New CA Physician Orders for Life-Sustaining Treatment (POLST) went into effect October 1, 2014
• POLST is a physician order signed by both the doctor and patient
• Specifies the types of medical treatment a patient wishes to receive toward the end-of-life
• Most changes in Sections B & C
• Previous versions of POLST will still be honored
• Void older versions of POLST when a patient’s POLST is updated

http://caPOLST.org/2014polst
NEW RULES FOR SAFE AND SECURE PRESCRIPTION DRUG DISPOSAL
DRUG DISPOSAL

- Final rule effective October 9, 2014 on disposal of controlled substances

- Don’t flush medications!

- Possible options encouraged to be used include:
  - Drug take-back programs
  - Mail-back programs
  - Collection receptacles for drug disposal
HOSPICE SPECIFIC DRUG DISPOSAL RULES

• Hospice staff are not authorized to receive pharmaceutical controlled substances from patients/families for disposal

• Patient/family/representative may dispose of the patient’s drugs

• Hospices are encouraged to assist patients/families in accordance with the CSA and its implementing regulations
HOSPICE SPECIFIC DRUG DISPOSAL RULES

• Hospices cannot utilize the LTC facility's (LTCF) collection receptacle for LTC-based hospice patients

• Are hospice IPUs LTCFs?

  • LTCF is defined at § 1300.01(b) and “means a nursing home, retirement care, mental care or other facility or institution which provides extended health care to resident patients.” DPHS will need to clarify whether Hospice Inpatient Facilities are an LTCF
HOSPICE COST REPORT
COST REPORT

- Published in CMS Pub. 15-2, Chapter 43 accessible on CMS website

- New cost report will be **only** for **free-standing** hospices for periods beginning on or after October 1, 2014

- Updated new Chart of Accounts
  [http://www.hhfma.org/Accounts.htm](http://www.hhfma.org/Accounts.htm)
COST REPORT

• Highlights of the Form CMS 1984-14 include:
  • Reporting by Level of Care
  • New General Service Cost Centers
  • Expanded Direct Patient Care Cost Centers
  • Expanded Non-Reimbursable Cost Centers
  • Different/Revised Worksheets

• Cost report information needs to be accurate in able
to assure appropriate information for payment reform
HOSPICE EXTRAORDINARY CIRCUMSTANCE EXEMPTION
EXTENDED
EXTRAORDINARY CIRCUMSTANCE EXEMPTION

- Extended until September 30, 2016 due to the continued nursing shortage
- Hospice must notify the State Survey Agency that it intends to elect an exception under the “extraordinary circumstance” authority
- Can be utilized when the hospice has been unable to hire enough nurses
- Must submit justifying documentation of good faith efforts to hire
- Contracted nurses should not be used solely to provide the continuous nursing level of care or on call service
- Recruitment efforts must continue

CA REGULATORY ISSUES
MEDI-CAL

• Medi-Cal Fingerprinting & Criminal Background checks of “high risk” applicants
  • Any person with ≥5% direct or indirect ownership interest in a provider or applicant - W&I Code §14340.38

• Hospice same day reimbursement clarified
  • When one hospice discharges a Medi-Cal hospice patient the same day as another hospice admits them
  • Retroactive to July 1, 2013 – An Erroneous Payment Correction (EPC) will reprocess the claims

• Co-existing or additional diagnoses should be included on Medi-Cal Hospice claims effective August 1, 2014
HOSPICE INPATIENT FACILITY

- Statutory language, COP §418.110, & LSC 2000 serve as the current regulations

- Hospice work group and DPHS developing a survey tool

- Current issues regarding some of the statutory references

- State regulations are to be completed by DPHS in the future
WHAT ELSE DOES THE FUTURE HOLD?
CMS HOSPICE CONCURRENT CARE DEMONSTRATION

HTTP://INNOVATION.CMS.GOV/INITIATIVES/MEDICARE-CARE-CHOICES/
MEDICARE CARE CHOICES MODEL

• Allows the hospice to provide specific palliative care services and care coordination while the patient is still receiving curative services
• Specific criteria for patient eligibility
• Hospice applications were due in June
• Hospices must implement within 180 days of acceptance
• Selection should be forthcoming
QUESTIONS CMS HOPES TO ANSWER

• Will access to such services result in:
  • Improved quality of care
  • Patient and family satisfaction

• Are there any effects on use of curative services and the Medicare hospice benefit?
IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION ACT OF 2014

IMPACT ACT
IMPACT ACT

• Mandated Medicare hospice surveys of Medicare certified hospice providers at least every three years for the next ten years at the minimum.

• Medical reviews for hospice programs with a soon to be determined percentage/number of patients receiving care for more than 180 days. The specific patient load that would trigger this medical review will be set by CMS.

• Hospice aggregate financial cap will be aligned with hospice reimbursement using a common inflationary index that will not change hospice reimbursement for providers.
MEDICARE HOSPICE REGULATIONS

- **Subpart A** - § 418.1 - § 418.3  General Provisions and Definitions
- **Subpart B** - § 418.20 - § 418.30  Eligibility, Election, Duration of Benefits
- **Subpart C** – § 418.52 - § 418.78  Conditions of Participation: Patient Care
- **Subpart D** – § 418.100 - § 418.116  Conditions of Participation - Organizational Environment
- Subpart E - Reserved
- **Subpart F** – § 418.200 - § 418.205  Covered Services
- **Subpart G** – § 418.301 - § 418.311  Payment for Hospice Care
- **Subpart H** - § 418.400 - § 418.405  Coinsurance
INTERPRETIVE GUIDELINES

• State Operations Manual - Appendix M – Guidance to Surveyors: Hospice


• Develop audit tools & perform mock surveys
• Identify areas of non-compliance and a plan of correction
SURVEY STATS FOR CY 2013

- 3,970 active hospice providers
- 1,301 number of surveys of hospice providers

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<tr>
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<th>Tag Description</th>
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<tr>
<td>L0543</td>
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<td>Updates of Comprehensive Assessment</td>
</tr>
<tr>
<td>L0671</td>
<td>Clinical Records</td>
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PAYMENT REFORM
HOSPICE PAYMENT REFORM

• ACA authorized CMS to revise the methodology for payments for hospice no earlier than FY2014 (10/1/13)

• Current models being studied by Abt Associates:
  • MedPAC recommended U-shaped model
  • Tiered model – payments based on length of stay
  • Short stay add-on, similar to Home Health Low Utilization Payment Amount (LUPA)
  • Case-mix model
  • Rebasing the Routine HC rate
  • Site of service adjustment for hospice patients in nursing facilities
PAY-FOR-PERFORMANCE

- HHS Secretary is required to establish a pilot program to test value-based purchasing under hospice.

- Pilot testing for Pay-for-performance to occur no later than January 1, 2016
MEDPAC RECOMMENDS “CARVE-IN”

• In its March 2014 report to Congress, MedPAC recommended that Medicare Advantage plans assume both the clinical management and financial responsibility of the hospice benefit

• A new study commissioned by NHPCO projects that the “carve-in” would create an additional cost to Medicare of $1.3 Billion over a 10-year budget window
MEDPAC “CARVE-IN” CONCERNS

• It would remove “choice” for the beneficiary

• Hospices would not be assured the baseline reimbursement rates

• Administrative coordination, billing and data reporting would increase for hospice
OIG RECOMMENDATIONS

• Establish a hospital transfer payment policy for early hospital discharges to hospice care

• Monitor Hospices that depend heavily on SNF residents & modify the payment system for hospice care in SNFs

• Seek legislation or promulgate regulation to set specific timeframes for the frequency of hospice surveys
HOSPICE EXPERIENCE OF CARE SURVEY

http://www.hospicecahpssurvey.org
HOSPICE EXPERIENCE OF CARE SURVEY (HECS)

- Consumer Assessment of Healthcare Providers and Systems (CAHPS)

- RAND was contracted to design and field test the Hospice CAPHS survey to measure the patients and caregivers experiences with hospice care
HOSPICE EXPERIENCE OF CARE SURVEY (HECS)

- Purpose –
  - Public reporting for patient/family hospice selection
  - Aid hospices with internal quality improvement efforts and external benchmarking
  - Provide CMS with information for monitoring the care provided
HECS (CONT.)

47 standardized questions composed of the following measures:

- Hospice Team Communication
- Getting Timely Care
- Treating Family Member with Respect
- Providing Emotional Support
- Getting Help for Symptoms
- Information Continuity
- Understanding the Side Effects of Pain Medication
- Getting Hospice Care Training
HECS (CONT.)

• Administered 2-3 months after the patient’s death

• Hospices must participate in a “dry run” for at least one month in the first quarter of 2015 (Jan-Mar)

• Continuous mandatory participation is April 1, 2015

• For 2015, providers will submit a minimum of 10 months of data to the CAHPS Hospice Survey Data Warehouse
HECS (CONT.)

• Continuous monthly participation is required in subsequent years

• Hospices that fail to meet the CAHPS requirements will receive -2%

• Failure in 2015 reporting will impact reimbursement in FY2017

• Public reporting currently planned for FY2017
HECS (CONT.)

• Hospices must contract with a CMS approved survey vendor who will collect and submit the data on the provider's behalf

• CMS approved vendors are available at:
  http://hospicecahpssurvey.org/Content/ApprovedSurvey.aspx
HECS (CONT.)

• The survey will be administered to the caregivers of the patients who died while receiving hospice care as long as:
  
  • The patient was 18+ at the time of death
  • The patient lived over 48 hours after admission to hospice care
  • The patient had a primary care giver listed
  • The patient’s primary care giver had a non-foreign address The patient or primary care giver were not on a “no publicity” list
HECS (CONT.)

- CMS set goals for annual return of surveys:
  - <50 annual decedents – can apply for an exemption
  - 50 – 699 decedents – 100% of census
  - 700 + decedents – Random sample of 700 decedents
ICD-10-CM

- The US is the only country still using ICD-9 codes
- ICD-9 is 30 yrs. Old
- Outdated terminology, lacks specificity & has run out of room for new diagnoses
- ICD-10 is mandatory October 1, 2015
ICD-10-CM

• ICD–10 will replace the ICD–9 on October 1, 2015
• A critical issue associated with the transition to ICD–10 involves the matter of cross-walking between ICD–9 and ICD–10 code sets
• Obtain a 2014 coding book with the conversion tables
• Send someone from your agency to training. Many of the rules will be different
ICD-10-CM

• Even veteran coders will need to start from scratch
• Coders need to brush up on anatomy & physiology as diagnosis coding will require more specificity of site of disease processes, including site and side of body for wound and fracture codes
• It may be time to consider an external contracted coding company to assist in coding and billing
CR 8620 - EMERGENCY PREPAREDNESS PROPOSED RULE

- Federal Register on December 27, 2013 with comments due March 31, 2014
- Would establish mandatory national emergency preparedness requirements for all Medicare & Medicaid participating providers
  - Man-made & natural disasters
  - Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach
  - Coordinate with federal, state, tribal, regional & local emergency preparedness systems
  - Ensure that providers are adequately prepared to meet the needs of patients, residents, clients & participants during disasters or emergency situations
EMERGENCY PREPAREDNESS PROPOSED RULE (CONT.)

• Four core elements –
  • Risk Assessment and Planning
  • Policies and Procedures
  • Emergency Preparedness Communication Plan
  • Training and Testing

• Requirements for both home hospice and inpatient hospice providers
EMERGENCY PREPAREDNESS PROPOSED RULE (CONT.)

PART 418-- HOSPICE CARE

• § 418.110 [Amended]
  • 8. Amend § 418.110 by removing paragraph (c)(1)(ii) and by removing the paragraph designation (i) from paragraph (c)(1)(i)

• New COP in Subpart D
  § 418.113 Condition of participation: Emergency preparedness.
  • Sections include the Emergency Plan, Policies & Procedures, Communication Plan & active Training & Testing

COMPLIANCE PROGRAM
REGULATIONS
ARE YOU PREPARING?
COMPLIANCE PROGRAMS

- Compliance Guidance for Hospice Providers in 1999
  https://oig.hhs.gov/authorities/docs/hospicx.pdf

- Patient Protection and Affordable Care Act of 2010 mandated compliance and ethic programs
  - Congress delegated the development of the core requirements and implementation deadlines to the discretion of HHS – no dates for hospice yet
  - OIG promotes the voluntary development of compliance programs for the health care industry

- Protects an organization by detecting and preventing improper conduct and promoting adherence to the organization's legal and ethical obligations
QUESTIONS