Hot Regulatory Topics

Judi Lund Person, MPH
National Hospice and Palliative Care Organization
Session Objectives

• Describe the current regulatory environment and the issues driving change.
• Discuss the concept of prognosis, determination of relatedness, and diagnoses on the claim form.
• Describe FY2016 Hospice Wage Index final rule and the changes in reimbursement.
• Discuss OIG and Department of Justice activity for hospice.
FY2016 Final Wage Index Rule

Posted July 31, 2015
Published in Federal Register
August 6, 2015
Rate Update

• 1.6%

• Net effect: 1.1%
  – Adjustments for the final year of BNAF
  – Adjustments for wage index variations

• Effective October 1, 2015

• Standard rate increase in effect for period October 1, 2015 through December 31, 2015
## FY2016 Hospice Rates to December 31, 2015

<table>
<thead>
<tr>
<th>Description</th>
<th>10/1/2015 through 12/31/2015 Rates</th>
<th>2015 Rate</th>
<th>Difference</th>
<th>% Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Home Care</td>
<td>$161.89</td>
<td>$159.34</td>
<td>$2.55</td>
<td>1.6%</td>
</tr>
<tr>
<td>Continuous Home Care Full Rate = 24 hours of care</td>
<td>$944.79</td>
<td>$929.92</td>
<td>$14.87</td>
<td>1.6%</td>
</tr>
<tr>
<td>Hourly Rate</td>
<td>$39.37</td>
<td>$38.75</td>
<td>$0.62</td>
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<tr>
<td>Inpatient Respite Care</td>
<td>$167.45</td>
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<tr>
<td>General Inpatient Care</td>
<td>$720.11</td>
<td>$708.77</td>
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<td>1.6%</td>
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Hospice payment reform

• Implemented January 1, 2016
• Two tiered routine home care rate
  – Based on length of stay
  – 1-60 days – 15% more than current rate
  – 61+ days -- -8% less than current rate
• Service Intensity Add-on
  – Last seven days of life
  – RN or social worker
### Final FY2016 Rates – Effective January 1, 2016

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<th>Difference</th>
<th>% Increase</th>
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<tr>
<td>Routine Home Care</td>
<td></td>
<td>$159.34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-60 days</td>
<td>$186.84</td>
<td>$27.50</td>
<td>17.26%</td>
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<tr>
<td>61+ days</td>
<td>$146.83</td>
<td>$(12.51)</td>
<td>-7.85%</td>
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<td>Continuous Home Care Full Rate = 24 hours of care</td>
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Count of days follows the patient

• For patients who revoke their hospice benefit or are discharged and readmitted to hospice care within 60 days of their discharge, the patient’s prior days in hospice care will “continue to follow the patient and will count toward his or her patient days for the new hospice election.”
Count of days example
1-60 days

• Patients elects Medicare hospice benefit
• Day 3 – revoke for additional curative treatment
• Day 10 – re-elect Medicare hospice benefit

• Count of days
  At re-election, the day count is 4
Count of days example
61+ days

• Patient elects Medicare hospice benefit with hospice #1
• Day 55 – discharged by hospice for “no longer terminally ill”
• Day 56 – patient re-elects their Medicare hospice benefit with hospice #2
• How does the day count work?
  – First hospice – 55 days at higher RHC rate
  – Second hospice – 5 days at higher RHC rate, remaining days at lower RHC rate
Day count and levels of care

• Day count includes all hospice days of care
• All levels of care
• Regardless of whether days of care were billable or not
  – Days not billable because of a late face to face
  – Days not billable because of a NOE that RTPs
Breaks in Service

• If a hospice patient revokes or is discharged from hospice care and the break in service is 61 days or more, then the patient qualifies for the higher RHC rate.

• If the break in service is 60 days or less, the day count resumes and the patient’s RHC rate drops to the 61+ rate when the total days of care total 61 days or more.
Existing patients on January 1, 2016

• The calculation of days of care will start with the patient’s hospice election, even if that election started before January 1, 2016.

• Example
  
  – Patient elects Medicare hospice benefit on December 1, 2015
  
  – New hospice payment rates begin January 1, 2016
    
    • Day count for higher RHC rate is day 32 on 1/1/2016
Transfer Day

• If a patient transfers from one hospice to another and there is no gap in care, the transfer day will be counted as 1 day, and both hospices will include the same date on their claim.
Episodes of care

• 2 counts of days will need to be tracked
  – Benefit (election) periods – 90/90/60s
  – Episode of care – Benefit period or series of benefit periods applicable to a single patient, with no more than a 60 day gap in hospice care
Service Intensity Add-on

• For visits conducted by an RN or social worker
• Any time in the last seven days of a hospice patient’s life,
• If the following criteria are met:
  – The day of care is a RHC day
  – The day occurs during the last 7 days of life
  – The patient’s discharge is due to death
  – Direct care is provided by an RN or social worker
  – Only in person visits count toward the payment; no social worker phone calls
• The total hours paid at the SIA cannot exceed 4 hours in a day for the RN and social worker combined
SIA Payments

• The SIA payment equals the CHC hourly rate of $39.37, regionally adjusted
• Multiplied by the number of hours of RN and social worker direct patient care visit time, listed on the claim form in 15 minute increments.
• Minimum of 15 minutes, maximum of 4 hours per day
# Service Intensity Add-on Payment

<table>
<thead>
<tr>
<th>Discipline</th>
<th>National Rate, regionally adjusted</th>
<th>Minimum per day</th>
<th>Maximum per day</th>
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</thead>
<tbody>
<tr>
<td>RN</td>
<td>$39.37</td>
<td>15 minutes, combined RN and social worker</td>
<td>4 hours, combined RN and social worker</td>
</tr>
<tr>
<td>Social Worker</td>
<td>$39.37</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RN Visits

• Current visit reporting (G-codes) includes both RN and LPN/LVN
• CMS will create two separate G-codes to track RN and LPN visits separately to allow for SIA payments for RN visits
• Watch for a CMS transmittal and implementation date
Two-tiered RHC with SIA
100 day length of stay

FY2015
Two-Tiered Rate
Two-tiered RHC with SIA
30 day length of stay

![Graph showing two-tiered reimbursement rates over 30 days of care. The blue line represents FY2015, while the red line represents the Two-Tiered Rate. The graph shows a flat rate of reimbursement up to 22 days, followed by a step increase at 23 days and a continued flat rate for the remainder of the 30-day period.]
Claims processing

• **RHC:** Hospice will file claim for a routine home care day
  – CMS claims processing will determine 60 day or 61+ day payment rate

• **SIA:** Hospice will report visits and visit times as usual
  – CMS claims processing will determine which days and visits will qualify for SIA payment
Medicaid Implementation

• The Social Security Act requires that Medicaid “payment for hospice care be in amounts no lower than the amounts, using the same methodology,” used under Medicare

• CMS confirms that:
  – two-tiered RHC rate
  – SIA payments
  – Rate reduction when no quality reporting

• apply to both Medicare and Medicaid
NHPCO Meets with CMS

• Three discussion topics:
  – Implementation of two tiered RHC payment and SIA
  – Hospice Medicaid for states with Medicaid managed care
  – Nursing home room and board when state has Medicaid managed care
• No states have reported issues with implementation
NHPCO Survey of States

• Responses from 38 state Medicaid agencies
• 3 states report that they will “make every effort to be ready on January 1, 2016”
• Other states report:
  – Not be ready, some for several years
  – Does the statute really apply?
  – Questions about room and board payments
Quality Reporting Provisions
Proposed quality measures for future years

- No new measures are proposed for payment year FY2017
- High priority concept areas are being considered, including:
  - Patient reported pain outcome measure
  - Claims-based measures focused on care practice patterns
    - skilled visits in the last days of life
    - burdensome transitions of care for patients in and out of the hospice benefit
    - rates of live discharge from hospice
  - Responsiveness of hospice to patient and family care needs
  - Hospice team communication and care coordination
CAHPS participation for 2018 Annual Payment Update

• Required to collect data using the CAHPS® Hospice Survey
• Must use CMS-approved third party vendors
• Ongoing monthly participation is required January 1, 2016 through December 31, 2106
• Compliance will dictate the payment amounts for FY2018
• Deadlines for data submission occur quarterly
• Due second Wednesday of the submission months
  – August
  – November
  – February
  – May
Quality Reporting Thresholds

• Data submission deadlines for HIS records thresholds:
  – January 1 – December 31, 2016: 70% of all related HIS records will be submitted within the 30 day submission timeframe for the year or face the 2% reduction in the marketbasket update for 2018.
  – January 1 – December 31, 2017: 80% of all related HIS records will be submitted within the 30 day submission timeframe or face the 2% reduction in the marketbasket update for 2019.
  – January 1 – December 31, 2018: 90% of all related HIS records will be submitted within the 30 day submission timeframe for the year or face the 2% reduction in the marketbasket update for 2020.
Fewer than 50 survey-eligible caregivers for CAHPS survey

• If a hospice has fewer than 50 survey-eligible decedents/caregivers in the period January 1, 2016 to December 31, 2016, are exempt from the CAHPS ® Hospice Survey.

• To qualify a hospice MUST submit an exemption request form, available in the first quarter of 2017.
Notification of non-compliance

- CMS will begin using the QIES National System for Certification and Survey Provider Enhanced Reports (CASPER) system
- Can be accessed using the CASPER reporting application
- Letters will also be sent via regular USPS mail, beginning with the FY2017 payment determination
Public display of quality measures

• CMS will develop “the infrastructure for public reporting and method for hospices to preview their quality data prior to publicly reporting any such information”

• A timeframe for public reporting of quality measure data in hospice will be announced in future rulemaking
Quality Reporting Impact on Payments

• Beginning in FY 2014, hospices which fail to report quality data will have their market basket update reduced by 2 percentage points.

• For FY2016, the percentage increase is -0.4%
Diagnosis Reporting on Claim Form
Diagnosis Reporting on Hospice Claims

• **Clarification:** Hospices will report ALL diagnoses identified in the initial and comprehensive assessments on the hospice, whether related or unrelated to the terminal prognosis, **effective October 1, 2015.**

• **Mental health conditions:** This will include any mental health disorders or conditions that would affect the plan of care.

• **“Virtually all”:** CMS states that “hospices are required to provide virtually all the care that is needed by terminally ill individuals and we [CMS] would expect to see little being provided outside the benefit**
% of Claims with One Diagnosis

Source: CMS FY2016 Hospice Wage Index Final Rule
CMS Concern

• Anecdotal reports from hospices, hospice beneficiaries, and non hospice providers

• Hospices may not be:
  – conducting a comprehensive assessment or
  – updating the plan of care
NOE/NOTR Submissions
NOE Issues

• Time for MAC acceptance of submitted NOE
• MAC denial of exception requests
• MACs report no decrease in the number of exception requests
• Provider liable days
• Difficult to gather adequate data for advocacy
NHPCO/NAHC Survey

- ~400 hospices participating
- 186,000 NOEs submitted – 1/1/15 to 6/30/15
- 7,500 RTP from MAC – 4%
- Unpaid days
<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospices participating</td>
<td>400</td>
</tr>
<tr>
<td>NOEs submitted January – June 2015</td>
<td>186,000</td>
</tr>
<tr>
<td>RTP from MAC</td>
<td>7,500 or 4%</td>
</tr>
<tr>
<td>Unpaid days of care</td>
<td>89,211</td>
</tr>
<tr>
<td>$$ value of unpaid days @ RHC rate of $159.34</td>
<td>$14,214,880</td>
</tr>
</tbody>
</table>
Advocacy

- Meetings with Congressional and committee staff
- Meetings with MACs
- Meetings with CMS Claims Processing
- Meetings with HHS and OMB

Single biggest question: **What is the size of the problem?**
Determining Relatedness
The Regulation

§ 418.3 Definitions

“Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.”
Why all the Fuss?

- CMS discussion about relatedness
- Virtually all care at EOL is related
- Diagnoses on claim form

**FY 2014 Hospice Wage Index Rule**

**FY 2015 Hospice Wage Index Rule**

- Abt data related to $ leakage in to Medicare Parts A, B, D
- Proposed definitions for terminally ill and related conditions
- Virtually all care at EOL is related
- Diagnoses on claim form

**FY 2016 Hospice Wage Index Rule**

- $ leakage in to Medicare Parts A, B, D
- Virtually all care at EOL is related
- Co-morbidities
- Diagnoses on claim form
NHPCO Relatedness Workgroup

• A subcommittee of the NHPCO Regulatory Committee.
• Formed in 2013 in response to FY 2014 proposed Hospice Wage Index Rule.
• The group’s mission was to develop resources for the NHPCO membership that will assist in determining related diagnoses, treatments, medications, supplies, and equipment for a patient.
Physician Determines Relatedness

- Relatedness is not determined by the CFO based on cost to hospice provider
- It is determined patient by patient, case by case, related to the palliative plan of care
Documenting “Un-relatedness”

• It is the hospice physician’s responsibility to document what is unrelated

• Where should that occur?
  – In the certification narrative? *Not the best place*
  – In a progress note? *May be hard to locate*
  – In the med profile? *Include non-med treatments*
  – Stand-alone document?

• EMR vs. Paper documentation concerns
Documenting “Unrelatedness” cont...

• What does the hospice physician document?
• CMS has providing varying guidance on this
  – Recent CMS Open Door Forum call: should be a brief narrative that is reasonable in explaining why the condition is unrelated
Discontinuation

• When is the right time to discuss discontinuation?
• What drives the determination of discontinuation?
• Who determines discontinuation?
• Does the patient have a choice?
Medications
Buckets of “Relatedness”

- RELATED and HELPFUL
- RELATED BUT NOT HELPFUL
- RELATED BUT NOT ON FORMULARY
- UNRELATED & HELPFUL—PART D ELIGIBLE
- UNRELATED, BUT NO LONGER HELPFUL
If medication is deemed related...

• Hospice covers the cost
  – Care (services, treatment, etc. ...)
  – Medications
  – DME & supplies

• Documentation should appear in the clinical record that it is related
  – Physician narrative
  – Plan of care
  – Medication profile
Related and NOT in Plan of Care

• Not effective
  – not “supported by the evidence” or “truly necessary”
• May be harmful for reasons not usually thought of by patients and families
  – “not free from harm”
• Duplicate medications
• Not on hospice formulary or preferred med list
  – And pt/family decline an equivalent medication that would be covered

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If medication is deemed unrelated...

• CMS expects that another health care professional would come to the same conclusion after reviewing the same data
  – Subject to MAC and auditor review
  – Subject to Part D plan sponsor review
    • Audits directed to start again with 2014 Part D claims
• Documentation should appear in the clinical record that it is NOT related
  – Consistent, accessible location
• “We expect drugs covered under Part D for hospice beneficiaries will be extremely rare.”
Hospice Risk Areas

- Failure to identify and claim responsibility for a diagnosis and condition that contributes to the terminal prognosis
- Increases risk for audit and financial penalty
- Increases risk for Medicare decertification
ICD-10 Implementation
ICD-10 Ombudsman for Transition

• **CMS ICD-10 Transition Work Group**
  – NHPCO appointed to CMS ICD-10 transition team to provide support to hospices as they implement ICD-10
  – Will meet regularly for next 18-24 months

• **General ICD-10 information**
  – CMS ICD-10 webpage
  – CMS Road to 10 webpage

• **Claims questions**
  – Contact Medicare Administrative Contractor (MAC)
  – State Medicaid agency
  – Commercial health plan
OFFICE OF INSPECTOR GENERAL
ACTIVITIES
Mid 2015 OIG Work Plan Update

• Hospice general inpatient care
  – Assess the appropriateness of hospices’ general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care.
  – Review hospice medical records to address concerns that this level of hospice care is being misused.
  – OEI; 02-10-00491; 02-10-00492; expected issue date: FY 2015
Hospice care in assisted living

• Report released January 2015
• Payments in ALFs more than doubled in 5 years, totaling $2.1 billion in 2012.
• Hospice beneficiaries in ALFs often had diagnoses that usually require less complex care.
• Hospices typically provided fewer than 5 hours of visits per week
• Visit mix was heavily hospice aides
Median Days in Hospice Care by Beneficiary, by Setting

<table>
<thead>
<tr>
<th>Primary Setting of Hospice Care</th>
<th>Median Days in Hospice Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALF</td>
<td>98</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>50</td>
</tr>
<tr>
<td>Home</td>
<td>45</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>30</td>
</tr>
</tbody>
</table>
Percentage of Beneficiaries with Long Lengths of Stay, by Setting

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<tr>
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<th>181-365 days</th>
<th>&gt; 365 days</th>
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<tbody>
<tr>
<td>ALF</td>
<td>36%</td>
<td>18%</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>28%</td>
<td>14%</td>
</tr>
<tr>
<td>Home</td>
<td>22%</td>
<td>10%</td>
</tr>
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Primary Setting of Hospice Care
Visits per Week, 2012

- Hospice Aide Visits, 2.4
- Nursing Visits, 1.7
- Medical Social Service Visits, 0.3
Percentage of Visit-Hours Provided to Beneficiaries Receiving Routine Home Care in ALFs by Day of the Week, 2012

- Monday: 20%
- Tuesday: 19%
- Wednesday: 18%
- Thursday: 18%
- Friday: 19%
- Saturday: 4%
- Sunday: 3%
OIG Areas of Concern

• 25 hospices reported no visits to their patients in ALFs in 2012 -- $2.3 million in Medicare $$

• 97 hospices relied on ALFs for most of their Medicare patients. More than ½ of Medicare payments they received in 2012
Other Proposed Rules of Interest
Physician Fee Schedule (PFS) Proposed Rule
CY2016 Medicare Physician Fee Schedule

• Posted July 8, 2015
• Two codes for Advance Care Planning “activated” for 2016
  – CPT code 99497: 1st 30 minutes
  – CPT code 99498: each additional 30 minutes
• Comment letter submitted: September 8, 2015
• Final rule to be published by November 1, 2015
ACP Code Payments

• CPT code 99497: 1st 30 minutes

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<tr>
<td>Non-facility payment</td>
<td>$86.66</td>
</tr>
<tr>
<td>Facility payment</td>
<td>$80.16</td>
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• CPT code 99498: each additional 30 minutes

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Physician Fee Schedule Opportunity

• New funding for advance care planning conversations
• Opportunities for hospice to be a leader in helping physicians learn how to successfully have ACP conversations
• Broader than end of life
• Broader than serious illness
Nursing Home Reform Proposed Rule
Reform of Requirements for Long-Term Care Facilities

• Complete rewrite of nursing home Requirements for Participation (RoPs)
• Similar to Medicare hospice CoPs
• More than 200 comment letters received
NHPCO Submits Comments

• Includes:
  – Comments on including POLST in requirements for nursing home advance care planning
  – Hospice provisions for nursing homes
    • Nursing home cannot charge extra for hospice services
    • Information provided from transferring to receiving provider
  – Pharmacist role and conflict with Medicare hospice Conditions of Participation
  – Psychotropic medications
Pharmacy Services

• Role of nursing home pharmacist does not consider hospice responsibility for:
  – Professional management of resident’s hospice services
  – Contractual requirement for determination of “drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions” when hospice services delivered in nursing facility
Definition of Psychotropic Drug

• A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior

• NHPCO concerns
  – overly and unintentionally broad
  – Could also include non-steroidal anti-inflammatory drugs (NSAIDs), antihistamines, anticonvulsants
Proposed List of Not Allowed Meds

• Anti-psychotic
• Anti-depressant
• Anti-anxiety
• Hypnotic
• Opioid
• Any other drug that results in effects similar to the drugs listed above
How to keep up...

• NHPCO News Briefs
  – Every Thursday
  – Regulatory and compliance updates every week
• 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
NHPCO Regulatory Resources

• NHPCO website
  – Regulatory – check Hot Topics for latest issues
  – Compliance guides, tip sheets, wage index rate charts and detailed regulatory/compliance information

• Regulatory technical assistance
  – Contact regulatory@nhpco.org
Always remember who we serve ---
Hard to keep going?