Recent Regulatory Developments

- Almost half of Medicare beneficiaries (46.7%) use the hospice benefit before death
- From 2003 to 2011, the number of Medicare beneficiaries electing hospice increased from 729,000 to 1.2 million
- From 2003 to 2011, Medicare spending increased from $5.9 billion to $13.7 billion; $15 billion in 2012

Recent Regulatory Developments

- Average length of stay for 2012 is 88 days (up from 86 in 2011) – average length of stay longer at for-profits (105 v. 69 days)
- Median length of stay remains very low at 17 days
- Length of stay at the 90th percentile is 246 days
- According to MedPac’s December 2013 meeting, profit margins averaged 8.7%, with higher margins in the for-profit sector
Recent Regulatory Developments

- New Cost Reporting requirements
- Will require significant changes to hospices in reporting statistical and financial information on the four levels of service: routine in-home, inpatient, continuous care and inpatient respite
- Effective for free-standing hospices October 2014
- Will need to track and report all direct patient care costs for each type of care

Hospice Cost & Data Report (CMS Form 1984-14)

- Substantially expanded from current form (1984-99)
- CMS estimated changes will require additional 188 hours of time to complete at $20/hour = $3,760
- Some instructions are vague, leaving them open to interpretation
- Providers will have to institute additional significant recordkeeping
Hospice Cost & Data Report (CMS Form 1984-14)

General service cost centers have been expanded and now include:

- Laundry and linen service
- Housekeeping
- Dietary
- Nursing Administration
- Routine medical supplies
- Medical records
- Medical social service
- Spiritual counseling
- Pharmacy

Providers must be accurate in every aspect of reporting hospice claims
- Must accurately prepare cost reports
- Failure to do so places hospice at increased risk of scrutiny
Hospice Patients in Nursing Homes

- New regulation for nursing homes that complements the hospice regulations for coordination of care (42 CFR §483.75(t))
- LTC facilities must have written agreements with each hospice providing care in facility
- Services provided by each entity must be clearly delineated
- Regulation requires notification to hospice for any transfer of the patient

Hospice Patients in Nursing Homes

- LTC care facility staff must provide orientation to hospice staff
- LTC person with a clinical background must be designated to coordinate care with hospice staff
- Too many hospice patients in an LTC can raise a regulatory issue
- Why this regulation?
Miscellaneous Items

- Good site for assessment tools
  - [http://www.victoriahospice.org/health-professionals/clinical-tools](http://www.victoriahospice.org/health-professionals/clinical-tools)
- For certification, CMS is looking at terminal “prognosis” versus terminal “diagnosis” – see 42 CFR §419.25(b)
- CMS pilot project to cover hospice and curative care simultaneously – Providers can apply through June 19, 2014
  - [http://innovation.cms.gov/initiatives/Medicare-Care-Choices/](http://innovation.cms.gov/initiatives/Medicare-Care-Choices/)

“Related To” Definition

- Statute
  - Hospice is responsible for services “related to the treatment of the individual’s condition with respect to which a diagnosis of terminal illness has been made.” Social Security Act § 1812(d)(2)
- Regulations
  - Hospice must provide services “related to the treatment of the terminal condition for which hospice care was elected or a related condition.” 42 C.F.R. § 418.24(d)(2)
  - “Relatedness” determination made on a case by case basis by the hospice physician based upon the beneficiary’s medical condition
“Related To” Definition

- CMS clarified its view of when a condition is “related to” the patient’s terminal condition in August 7, 2013 commentary on the hospice benefit
- Referred to preamble to the 1983 hospice rule
- “[H]ospices are required to provide virtually all care that is needed by terminally ill patients.”
- There must be clear evidence that a condition is unrelated to the terminal prognosis. Otherwise, all services are considered related.

“Related To” and Drug Coverage

- Hospice plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions
- CMS December 6, 2013 Memo
  – Hospices are required to provide virtually all the care that is needed by terminally ill individuals
- CMS March 10, 2014 Memo
  – Omits “virtually all”
  – Reverts back to “all services necessary”
Part D Payment Final Guidance

- Part D covers prescription drugs for conditions that are completely unrelated to the terminal prognosis
- Only for “unusual and exceptional circumstances”
- Sponsors advised to:
  - place prior authorization requirements on all drugs for hospice patients to determine whether they are covered under Part D
  - conduct retrospective determinations of payment responsibility
  - recover payments that were improperly paid

Part D Payment Final Guidance

- Beneficiary liability for drugs not covered by Part A hospice benefit or Part D
  - Hospice may charge beneficiaries for medications that are not covered by Part A if the hospice provides the medication and has issued an Advance Beneficiary Notice of Non-coverage (“ABN”)
General Inpatient Care (GIP)

- Second most expensive level of hospice care after continuous care
- May be provided in one of three settings:
  - Medicare-certified hospice inpatient unit
  - Hospital
  - SNF
- Should be utilized for pain control and symptom management that cannot be managed in other settings
- Intended to be short-term

General Inpatient Care

- OIG May 3, 2013 Memo
  - Based upon general inpatient care provided in 2011
- Concerns
  - Inappropriate use by some hospices
    - Long lengths of stay
    - Use of GIP in inpatient units
  - No provision of GIP by some hospices
General Inpatient Care

- Moving forward
  - Further review of long lengths of stay (greater than 5 days) and appropriateness of care
  - CMS to focus on hospices that do not provide general inpatient care and ensure that these hospices are providing beneficiaries access to needed levels of care at the end of their lives

Recoupment Efforts by CMS to Address Fraud and Possible Disclosure Issues

- The Government has many ways to recoup amounts overpaid to providers
- Overpayments may be considered merely an overpayment or false or fraudulent claims
Data Mining

- Involves CMS or contractor reviewing data submitted
- Looking for pattern of claims substantially different from peers
- "Outliers" may be subject to increased scrutiny

CMS Use of Data

- Pick a statistically valid sample
- Request documentation in sample
- Conduct a Probe audit
Zone Program Integrity Contractor (ZPIC) Audits

- May be Pre- or Post-Payment audit
- Will use a small sample
- Will extrapolate error percentage to entire population

Issues for Possible Overbilling/Fraud

- Long length of stay
- Medical necessity/terminal illness
- Certifications
- Technical Violations
- Level of Service
- Receipt of Duplicate Services
- Recipient not entitled to benefit
CMS Common Working File System

- Used by Medicare Administrative Contractors (MACs)
- Automatically flags certain claims for recoupment
- Appeals are through normal Departmental Appeals process

Repayment Demands

- Failure to timely conduct face-to-face visit
- Certification not timely signed
- Improper certifications
- Lack of proper documentation to support certification/LCD guidelines
- Improper primary diagnoses
Other Auditors

- Recovery Auditor Contractors (RAC)
- New RAC dedicated to only hospice and home health
- Medicaid Fraud Control Units
- What do you get when you cross a ZPIC & a MAC? A UPIC – Unified Program Integrity Contractor
- UPIC will deal with integrity issues but does not replace the MAC

Data Reporting

Hospice Quality Reporting Program

- AKA HQRP
- Mandated by §3004 of the Affordable Care Act of 2010
- Directs the Secretary to establish quality reporting requirements for Hospice Programs

Public Availability of Reported Data

- Section 3004 requires making data available to the public
- No date has been specified to begin public reporting of quality data.
Failure to submit required quality data results in a 2% reduction to the market basket percentage increase (aka “Annual Payment Update”) for that fiscal year.

HQRP FY 2015:
- Reporting was due April 1, 2014
- Two measures
  - Structural measure
  - National Quality Forum (NQF) #0209 pain measure collected during CY 2013

HQRP FY 2016: The Hospice Information Set (“HIS”)
Collects standardized, patient-level data to calculate seven National Quality Forum (NQF) endorsed quality measures under the HQRP

- NQF #1634 Hospice and Palliative Care – Pain Screening
- NQF #1637 Hospice and Palliative Care – Pain Assessment
- NQF #1639 Hospice and Palliative Care – Dyspnea Screening
- NQF #1638 Hospice and Palliative Care – Dyspnea Treatment
- NQF #1617 Patients Treated With an Opioid who are Given a Bowel Regimen
- NQF #1641 Hospice and Palliative Care – Treatment Preferences
- NQF #1647 Beliefs/values addressed
Download:

HIS Manual: Guidance Manual for Completion of the Hospice Item Set (HIS)

WARNING: “HIS is not an assessment instrument and does not replace a thorough and ongoing assessment of each patient as required by the Medicare Hospice Conditions of Participation, nor does it replace standard clinical practice and judgment”.

General Conventions for Completing the HIS

1. A HIS (HIS-Admission and HIS-Discharge) should be fully and accurately completed on all patient admissions on or after July 1, 2014.
2. The HIS may be completed by any hospice staff member.
3. To complete each HIS accurately and fully, hospice staff should understand what information and data each item requires, and complete the item based only on what is being requested.
4. All completed HIS records must be electronically submitted through CMS’s Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.
5. HIS record submission: 30 days of Admission and Discharge
6. Policies outlined in the Manual describe how to correct errors in a HIS record that has already been accepted.
7. A HIS-Admission and HIS-Discharge should be submitted even if the patient revokes the hospice benefit or is discharged from hospice before all HIS-related care processes are complete.
Documentation

Eligibility

To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual’s life expectancy is six months or less if the illness runs its normal course.

Physician Certification of Terminal Illness

Written certification must be on file in the hospice patient’s record prior to submission of a claim to the fiscal intermediary

- States that the patient is terminally ill, with a prognosis of 6 months or less if the illness runs its normal course;
- Includes a written narrative either immediately prior to the physician’s signature, or as a signed addendum. The narrative includes a statement under the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient’s medical record or, if applicable, his or her examination of the patient; and
- Is accompanied by clinical information or other documentation supporting the diagnosis.
Physician Certification of Terminal Illness

For patients entering the 3rd or subsequent benefit period on or after Jan. 1, 2011, must also include documentation –

- ensuring that a face-to-face encounter (and attestation of that encounter) for the purpose of gathering clinical evidence that supports continuing hospice eligibility is conducted by a hospice physician or hospice NP within the 30 calendar days prior to new benefit period.

The face-to-face attestation and signature must be either a separate and distinct area on the recertification form, or a separate and distinct addendum to the recertification form, that is easily identifiable and clearly titled.

If the hospice physician conducts the encounter, he/she must attest that
- the face-to-face encounter took place,
- the date on which it took place, and
- sign and date the attestation;
- the hospice physician conducting the encounter must also compose the narrative (using clinical findings from the face-to-face encounter to help determine continuing eligibility for hospice) and sign the CTI.

If the face-to-face encounter is conducted by a hospice NP, the NP must attest that
- the encounter took place,
- the date on which it took place, and
- sign and date the attestation.

The hospice NP’s attestation must include an affirmation that he/she provided the clinical findings to the physician who will be certifying terminal illness for use in determining continued eligibility for hospice care.
Possible Liability Issues for ALFs

- Increasingly a target of plaintiff’s attorneys
  - Hospice facilitates Aging in Place

- State Regulators
  - “she shouldn’t be in here”
  - Coordinated care

- Anti-Kickback

Questions?