Hospice Regulatory & Quality Update

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National Hospice and Palliative Care Organization
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FY2018 HOSPICE WAGE INDEX FINAL RULE

HOSPICE RATES AND CAP
Rate Increase

• 1% -- FY2018 ONLY
• Reduced rate is part of MACRA physician payment agreement
• Other Medicare providers, such as nursing homes, home health, and inpatient rehab facilities, also have a one year 1% maximum increase
• Future years – back to marketbasket formula

FY2018 Final Payment Rates

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>FY2017 Payment Rates</th>
<th>FY2018 Final Payment Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Home Care (Days 1-60)</td>
<td>$190.55</td>
<td>$192.78</td>
</tr>
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<td>Routine Home Care (Days 61+)</td>
<td>$149.82</td>
<td>$151.41</td>
</tr>
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<td>Continuous Home Care (Hourly rate)</td>
<td>$40.19</td>
<td>$40.68</td>
</tr>
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<td>Inpatient Respite Care</td>
<td>$170.97</td>
<td>$172.78</td>
</tr>
<tr>
<td>General Inpatient Care</td>
<td>$734.94</td>
<td>$743.55</td>
</tr>
</tbody>
</table>

FY2018 Final Payment HQRP Non Compliance Penalty

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>FY2017 Payment Rates</th>
<th>FY2018 Proposed Payment Rates</th>
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<td>General Inpatient Care</td>
<td>$734.94</td>
<td>$728.83</td>
</tr>
</tbody>
</table>
Hospice Cap Details

- Cap amount: $28,689.04
- Cap accounting year for:
  - inpatient cap
  - Hospice aggregate cap
- Aligned with Federal Fiscal Year (October 1 – September 30) for fiscal year for FY 2017 and later
- Cap report due: February 28, 2018

FY2018 Discussion on Relatedness

- In 1983 CMS says:
  - "...we believe that the unique physical condition of each terminally ill individual makes it necessary for these decisions to be made on a case by case basis.
  - It is our general view that hospices are required to provide virtually all the care that is needed by terminally ill patients."
- Unless there is clear evidence that a condition is unrelated to the terminal prognosis, all conditions are considered to be related to the terminal prognosis and the responsibility of the hospice to address and treat.
- Physician should document if a diagnosis, medication or treatment is not related to the terminal prognosis.
Top 5 Diagnoses in FY2016

<table>
<thead>
<tr>
<th>Disease</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s disease, unspecified</td>
<td>162,845</td>
<td>11%</td>
</tr>
<tr>
<td>Heart Failure, unspecified</td>
<td>84,088</td>
<td>6%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease, unspecified</td>
<td>74,131</td>
<td>5%</td>
</tr>
<tr>
<td>Malignant Neoplasms of Bronchus or Lung</td>
<td>57,077</td>
<td>4%</td>
</tr>
<tr>
<td>Senile Degeneration of the Brain</td>
<td>55,305</td>
<td>4%</td>
</tr>
</tbody>
</table>

Approximately 30% of all claims-reported principal diagnosis codes reported in FY 2016

Key Live Discharge Data

- Of the 17% live discharge rate in 2016:
  - Patient initiated:
    - Revocations: 38%
  - Hospice initiated:
    - No longer terminally ill: 51%
    - Hospice transfers: 11%
Live Discharge Rates for Hospices With 50 or More Live Discharges, FY 2014 to FY 2016

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>5th Percentile</td>
<td>7.5%</td>
<td>6.9%</td>
<td>6.8%</td>
</tr>
<tr>
<td>10th Percentile</td>
<td>9.0%</td>
<td>8.5%</td>
<td>8.4%</td>
</tr>
<tr>
<td>25th Percentile</td>
<td>12.4%</td>
<td>11.6%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Median</td>
<td>17.6%</td>
<td>16.8%</td>
<td>16.9%</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>26.3%</td>
<td>24.6%</td>
<td>25.4%</td>
</tr>
<tr>
<td>90th Percentile</td>
<td>39.4%</td>
<td>35.9%</td>
<td>37.2%</td>
</tr>
<tr>
<td>95th Percentile</td>
<td>50.0%</td>
<td>45.6%</td>
<td>49.1%</td>
</tr>
<tr>
<td># of Providers</td>
<td>3,160</td>
<td>3,215</td>
<td>3,232</td>
</tr>
</tbody>
</table>

Source: FY2014, FY2015, and FY2016 hospice claims from Common Working File that list a discharge status code. Live discharges were defined as hospice claims with a status code of “01.” Published in FY2018 Hospice Wage Index Proposed Rule, April 27, 2017

Visits in last days of life

- Analysis of FY 2016 claims data
- October 1, 2015 - September 30, 2016
- On any given day during the last 7 days of a hospice election, nearly 44% of the time the patient has not received a skilled visit (skilled nursing or social worker visit)
- 21% did not receive any visits on the day of death

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

Part A and B Spending Outside Hospice Benefit

<table>
<thead>
<tr>
<th>Year</th>
<th>Part A and B Spending in millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$748</td>
</tr>
<tr>
<td>2013</td>
<td>$712</td>
</tr>
<tr>
<td>2014</td>
<td>$625</td>
</tr>
<tr>
<td>2015</td>
<td>$593</td>
</tr>
<tr>
<td>2016</td>
<td>$594</td>
</tr>
</tbody>
</table>

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

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

Part D Spending

<table>
<thead>
<tr>
<th>Year</th>
<th>Spent (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$311,000,000</td>
</tr>
<tr>
<td>2013</td>
<td>$294,000,000</td>
</tr>
<tr>
<td>2014</td>
<td>$280,000,000</td>
</tr>
<tr>
<td>2015</td>
<td>$290,000,000</td>
</tr>
<tr>
<td>2016</td>
<td>$300,000,000</td>
</tr>
</tbody>
</table>

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
There are ongoing CMS concerns that some hospice patients may be inappropriately certified as terminally ill.

CMS Current Certification Concerns
- Patient is not required to choose an attending physician.
- Hospice medical director/hospice physician is not required to have face-to-face encounter with the patient when initially certifying the patient as terminally ill.
- A patient may never be seen by the hospice physician who is certifying that he or she is terminally ill.

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

• CMS received many comments on this issue
• Not proposing a change in regulations “at this time”
• CMS will work with the Medicare Administrative Contractors (MACs) to ensure that they are requesting clinical documentation used for eligibility when claims are selected for medical review

Role of Initial Assessment

• CMS reminds providers that the hospice admission assessment can accompany the initial written certification; however, “this information should further substantiate rather than provide the basis for certification”
No new quality measures for 2018

Measure Concepts Under Consideration for Future Years

Priority Area 1: Potentially avoidable hospice care transitions
- Claims-based measure focusing on transitions of care
- Potentially avoidable hospice care transitions at end of life are burdensome to patients, families, and the health care system at large

Measure Concepts Under Consideration for Future Years

Priority Area 2: Access to levels of hospice care
- Claims based measure
- Appropriate use of CHC and GIP
- Measuring use of levels of care will incentivize hospice providers to continuously assess patient and caregiver needs and provide the appropriate level of care to meet these needs
HEART

- Hospice Evaluation & Assessment Reporting Tool (HEART)
- Hospice patient assessment
- Two primary objectives:
  1. Provide the quality data necessary for current and future quality measures
  2. Provide additional clinical data that could inform future payment refinements

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HEART

- In the development of the HEART tool, CMS states that they will address “the holistic nature of hospice”
  - Medical
  - Psychosocial
  - Spiritual
  - Other aspects of care that are important for patients and their caregivers

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HEART

When ready, HEART
- **Would** replace the current HIS; but HIS measures would be incorporated
- **Would not** replace other HQRP data collection efforts (that is, the CAHPS® Hospice Survey)
- **Would not** replace regular submission of claims data
- **Would not** replace current CoP requirements for the initial and comprehensive assessments

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HEART

• In early stages of development
  – Working on content and feasibility

• Once development has progressed, CMS will announce:
  – Timeline, testing and implementation
  – Communicated in future rulemaking cycles

Extraordinary Circumstances Exemption and Extension

Qualifying Event:
• Acts of nature; systemic issues with CMS data systems, issues outside the control of the hospice

Deadline for submitting exemption or extension request:
• 90 calendar days from the qualifying event (new)

Applies to:
• HIS data submission, submission of the CAHPS® Hospice Survey data and HQRP data submissions

Public Reporting

CMS Hospice Compare website
• Released **August 16th**

• All 7 HIS quality measures adopted for the FY 2016 and beyond
• Based on a rolling **12 month** data selection period
• Minimum denominator size of 20 patient stays
Hospice Compare

• Hospice Compare is a result of a provision in the Affordable Care Act that required established procedures for making hospice quality data available to the public
• Consumers are able to search for all Medicare-approved hospice providers that serve their city or ZIP Code and then find agencies, along with provider quality information

What Data are Displayed in Hospice Compare Now?

• The initial launch of Hospice Compare includes individual scores for each of the HIS seven quality measure (QM) scores
  – Patient Treated with an Opioid who are Given a Bowel Regimen (NQF #1617)
  – Pain Screening (NQF #1634)
  – Pain Assessment (NQF #1637)
  – Dyspnea Treatment (NQF #1638)
  – Dyspnea Screening (NQF #1639)
  – Treatment Preferences (NQF #1641)
  – Beliefs/Values Addressed (If Desired by the Patient) (NQF #1647)
Why is My Hospice Not Displayed?

- Hospices with a QM denominator size of fewer than 20 patient stays (based on 12 rolling months of data) will not have the QM score publicly displayed since a score on the basis of small denominator size may not be reliable.

Hospice Compare Datasets

- These official datasets allow a consumer to compare the quality of care provided by Medicare-certified hospice agencies throughout the nation.

https://data.medicare.gov/Hospice-Compare/Hospice-CASPER-ASPEN-Contacts/qx7x-wipa/data
Future Information for Hospice Compare

Immediate future
• The 8 CAHPS® Hospice Survey measures
  – Included in winter of CY 2018
  – Eight rolling quarters of data
  – Starting with patients who died between April 1, 2015 and March 31, 2017
  – Scored displayed only if 30 or more completed questionnaires in reporting period

CAHPS Reported Measures
• Hospice Team Communication
• Getting Timely Care
• Treating Family Member with Respect
• Getting Emotional and Religious Support
• Getting Help for Symptoms
• Getting Hospice Care Training

In addition, there are two other measures, also called “global ratings”:
• Rating of Hospice
• Willingness to Recommend

Future Information for Hospice Compare
• Composite measure - 2018
• Visits at the end of life – currently under NQF review
  – Need 4 quarters of data for the review
  – Earliest would be 2019
Star Rating System

- Quality rating system that gives each hospice a rating of between 1 and 5 stars
- Timeline to be announced for development and implementation in future rulemaking
- CMS solicit input from the public regarding star rating methodology
- CMS has stated “we will benefit from lessons learned from the development and implementation of the star ratings in other quality reporting programs to help guide development of star ratings for hospice.”

Problems with Hospice Compare

- System issues
- Demographic data issues

Data Errors in Hospice Compare

- Providers should review their demographic information on Hospice Compare to ensure it is correct
- In the event that your demographic data is not correct in Hospice Compare, contact your CASPER/ASPEN and Regional Office coordinator with updated information
Provider Preview Reports – Quality Data

• If errors in measure results are found:
  – Hospices have 30 days to request review beginning from the date the reports are ready for review
  – CMS will review. If confirms errors CMS will:
    • Suppress the measure on the Hospice Compare website for one time only
    • Display the corrected measure during the subsequent quarterly refresh of the Compare website

National Percentile

• The Comparison Group National Percentile is provided for your information to let you know where you stand when compared to all other hospices in the Nation
  – i.e. if your report shows that your Comparison Group National Percentile for a measure is 90, you know that 90 percent of all hospices performed the same as or worse than your hospice on this measure for the same period

Provider Preview Reports

• Accessed through CASPER
• Automatically generated and saved
• Available approximately 8 months after the end of each data collection period
• First reports available June 1, 2017
• Second reports available August 29, 2017
Hospice Compare

Results suppressed for:
• Hospices with a QM denominator size of fewer than 20 patient stays (based on 12 rolling months of data)
• Data not available (Medicare certified < 6mos or not submitted)
• Provider request (circumstances beyond control)

Hospice Compare Refresh

• Quarterly
• Rolling 12 months of data
  – Discharges Q4 2015 through Q3 2016
  – Discharges Q1 2016 through Q4 2016
  – Discharges Q2 2016 through Q1 2017
• First refresh November 2017

Provider Preview Reports

• Can still submit HIS modification and inactivation records up to 36 months after the target date
  – (Target dates: Admission Record = admit date
    Discharge Record = discharge date)
• Corrected data will be reflected in future Preview reports and Hospice Compare refreshes
CMS Review Request

• Submit request via email
• Subject line: “[Provider/Facility Name] Hospice Public Reporting Request for Review of Data” followed by CCN
• Send to: HospicePRquestions@cms.hhs.gov

CMS Review Request

Requirements for submitting request
• HQRP web site
• Hospice Quality Reporting section (left menu)

CAHPS® Hospice Measure Results; Improving Performance
CAHPS® Hospice Measures

✓ Become familiar with all of the questions on the survey
✓ Consider what aspect of care and hospice practice each question reflects

CAHPS® Hospice Measures

• Look for opportunities for improvement using unadjusted results
• CMS applies survey mode adjustment to adjust responses for the effect of mode of survey administration
  • The unadjusted “top-box” score for each hospice is calculated as follows:
    - the numerator is the number of respondents who selected the most positive response category(ies) for that question and the denominator is the number of total respondents to that question
• CAHPS vendor should provide unadjusted data upon request

CAHPS® Hospice Measures

• Determine which opportunities for improvement should be your focus based on your hospice’s standard of care
CAHPS® Hospice Measures

If 3 in 10 persons responded with the less than best response for a question, is that the goal that you want to set for your hospice program?

<table>
<thead>
<tr>
<th>Q 16</th>
<th>Yes Definitely</th>
<th>Yes Somewhat</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>As much help with pain as needed</td>
<td>70</td>
<td>70%</td>
<td>20</td>
</tr>
</tbody>
</table>

CAHPS® Hospice Measures

- Examine your respondent population
- Compare respondent population to total population served

Don’t

Do not make evaluations based on too little data
- Results from a small number of surveys may not accurately reflect performance
- Use a timeframe (e.g., calendar quarters) that will allow meaningful evaluation of trends in scores
Don’t

Do not assume your vendor’s comparison data are the same as national data

• Check CMS national results against vendor’s

Stay In Touch With CAHPS® Vendor

• Remember, CAHPS® requirements are to submit data quarterly: Each quarterly submission must be complete (have 3 months or 1 quarter’s worth of data)
• Each quarterly submission must be submitted and accepted by the quarterly data submission deadline
• Each hospice must use an approved vendor for CAHPS®, and your CAHPS® vendor’s actions can influence whether you are in compliance
• CAHPS® vendor failure can cost you money

Stay In Touch With CAHPS® Vendor

• Find out when your CAHPS® vendor is going to submit your data
• Sign up for data submission reports on the Information for Hospices section of the CAHPS® survey website
• Monitor your CAHPS® vendor’s actions
CMS Support

- Web site: www.hospicecahppssurvey.org
- Email: hospicecahppssurvey@HCQIS.org
- Telephone: 1-844-472-4621

Quality Compliance

HQRP Requirements

Two current requirements for HQRP:
- Hospice Item Set (HIS).
- CAHPS® Hospice Survey.

All Medicare-certified hospice providers must comply with these two reporting requirements.
Pay for Participation

- Submitting data determines compliance with HQRP requirements
- Failure to comply = market basket update (also known as the Annual Payment Update, or APU) reduced by 2 percentage points.

How the Annual Payment Update determination works

- HQRP runs on a 3 year cycle of data collection, compliance determinations, and payment impact

Timeline for FY 2019 APU Reporting Year

HIS Submission

- Through QIES ASAP system
- Must be successfully accepted by system within **30 calendar days** of the event date
  - 30 calendar days from the Admission Date (A0220)
  - No later than 30 calendar days from the Discharge Date (A0270)
HIS Submission

- SUBMITTED does not mean that the HIS Records are ACCEPTED
- Need to check – final validation reports in CASPER

Final Validation Reports

Review each one to determine the status of each submitted record.
- Fatal Error = Rejected status:
  - Not saved into the system.
  - Correct and resubmit
- Records with Warning messages are accepted and saved are saved into the QIES ASAP system, even if there are Warning messages associated with them.

Final Validation Reports

- Evaluate warnings and take necessary corrective actions!
- An error identified in an accepted HIS record must be corrected.
  - Modification Request
  - Inactivation Request
Hospice User Guides and Training
https://www.qtso.com/hospicetrain.html

Hospice Quality Reporting Training – Downloads
April 2017 Data Submission and Reporting Webinar pdf

Technical Help Desk
help@qtso.com or 1-877-201-4721

Hospice CAHPS Survey

• Contract with an approved survey vendor to collect and submit data using the CAHPS Hospice Survey on an ongoing monthly basis

• Hospice responsible to see that vendor is in compliance

CASPER Reports

WHAT WENT WRONG?
• Were best practice processes followed?
• Is practice accurately documented?
• Did data extraction capture everything needed?
• Were data submitted correctly to CMS?
Hospice Timeliness Compliance Threshold Report

- Check regularly
- Key to avoiding Annual Payment Update (APU) penalty

HOSPICE ROSTER REPORT

Lists all patients on record for your hospice for whom the most recent accepted HIS record is not a discharge record (all active patients).
Verify:
- All current patients have had HIS Admission record accepted
- All discharged patients no longer display Admission record (to verify that their discharge record has been submitted).

RESOURCES

- QIES Technical Support Office (QTSO) Help Desk: help@qtso.com 1-877-201-4721
Other Reports

• Hospice Directory
  – Demographic information on all Medicare certified hospices
  – Posted June, 2016
  https://data.medicare.gov/data/hospice-directory

Other Reports

• National Level Aggregate Results
  – 7 HIS measures
  – Hospice CAHPS measures
  – Posted December, 2016
  – One time release
  https://data.medicare.gov/data/hospice-directory

Hospice QRP: Q+A Document for the Second Quarter of 2017 Now Available

• A new Question and Answer (Q+A) document is now available in the “Downloads” section of the Hospice Item Set (HIS) webpage. The Q+A document reflects frequently asked Hospice Item Set (HIS) related questions that were received by the Quality Help Desk during the second quarter (April-June) of 2017.
• This document also contains quarterly updates and events from the second quarter as well what’s coming up in the third quarter.
OTHER ITEMS IN PROPOSED RULE

Reducing Regulatory Burden

• NHPCO Robust Suggestion list
• Examples:
  – CMS should explore options to eliminate sequential billing for hospice
  – Eliminate provider liable days for hospice when there are claims processing issues outside the hospice’s control
  – Allow hospice to contract with nurses for the provision of continuous home care (CHC) and require hospice training as a part of the contractual obligation

More Stuff
NURSING HOME INTERPRETIVE GUIDELINES RELEASED

Nursing Home Interpretive Guidelines Released

- The original NH Requirements for Participation were published in August 2013
- Interpretive Guidelines published in July 2017
- Most difficult compliance issues concern coordination of services through the care plan
- Take effect November 28, 2017
- Advance copy of the Guidance to Surveyors for LTC is located at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html Scroll down to “Advance Appendix PP including Phase 2

F684 – Quality of Care

F684
§ 483.25 Quality of care
- Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents.
- Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices...
F684 – Quality of Care

• Review of a Resident at or Approaching End of Life and/or Receiving Hospice Care and Services Assessment
• The resident must receive a comprehensive assessment to provide direction for the development of the resident’s care plan to address the choices and preferences of the resident who is nearing the end of life.
• The facility and the resident’s attending physician/practitioner, should, to the extent possible:
  – Identify the resident’s prognosis and the basis for that prognosis

F684 – Quality of Care

• The facility and the resident’s attending physician/practitioner, should, to the extent possible:
  – Initiate discussions/considerations regarding advance care planning and resident choices to clarify goals and preferences regarding treatment
  – Consider:
    • Pain management and symptom control
    • Treatment of acute illness
    • Choices regarding hospitalization

Guidance: §483.70(o) Provision Of Hospice Services In A Nursing Home

• As described in §§483.70(o)(1)(i),(ii), there is no requirement that a nursing home allow a hospice to provide hospice care and services in the facility.
Guidance: §483.70(o) Provision Of Hospice Services In A Nursing Home

- If a nursing home has made arrangements with one or more hospices to provide services in the nursing home, there must be a written agreement describing the responsibilities between each hospice and the nursing home prior to the hospice initiating care for a resident who has elected the hospice benefit.

- The written agreement applies to the provision of all hospice services for any nursing home resident receiving services from the specific hospice and does not need to be rewritten for each resident.

F849 – Hospice Services

- §483.70(o) Hospice services.

- §483.70(o)(1) A long-term care (LTC) facility may do either of the following:
  i. Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
  ii. Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

Hospice Plan of Care in Nursing Home

- Hospice Plan of Care

- As described in §483.70(o)(2)(ii)(B), when a hospice patient is a resident of a nursing home, the hospice must establish the hospice plan of care in coordination with the nursing home, the resident’s nursing home attending physician/practitioner, and to the extent possible, the resident/designated representative.
Hospice Plan of Care in Nursing Home

• In order to provide continuity of care:
  – **Collaboration**: Hospice and the nursing home must collaborate in the development of a coordinated plan of care for each resident receiving hospice services.
  – **Structure**: Is established by the nursing home and the hospice.

Hospice Plan of Care in Nursing Home

• In order to provide continuity of care:
  – **Responsibility**: must identify the provider responsible for performing each or any specific services/functions that have been agreed upon.
  – **Maintaining the plan of care**: The plan of care may be divided into two portions, **one maintained by the nursing home and the other maintained by the hospice**.

Nursing Home Designee(s) Responsibilities

• §483.70(a)(3)(i)-(v)
  • Nursing home must identify and designate, in writing, an **employee of the nursing home** to assume the responsibilities for **collaborating and coordinating activities between the nursing home and the hospice**.
  • Nursing home employee must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
**Communication Process Between Nursing Home and Hospice**

- §483.70(o)(2)(iii)(D)
- Written agreement must specify a process for communicating necessary information regarding the resident’s care between the nursing home and the hospice
- 24-hours a day, 7-days a week
- Includes how these communications will be documented

**Responsibilities for Bereavement Services for Nursing Home Staff**

- The death of the resident may have a direct impact on identified nursing home staff
- The written agreement should specify when the nursing home should provide information to the hospice regarding nursing home staff that may benefit from bereavement services

**ANYONE HAS ACCESS TO YOUR HOSPICE DATA NOW!**
Sources of Hospice Data

- CY2014 and CY2015 Hospice PUF Data
- PEPPER Reports
- Claims

CMS Hospice Public Data Set

- CY 2014 released on October 6, 2016
- CY 2015 released on August 8, 2017
- Hospice Utilization and Payment Public Use File (referred to as “Hospice PUF”)
- Calendar year 2014 and Calendar year 2015
- Source: Medicare hospice claims data
- Contains information on:
  - Utilization
  - Payment
  - Primary diagnoses
  - Sites of service
  - Hospice beneficiary demographics
- 100% final-action hospice claims for the Medicare population
  - Includes beneficiaries enrolled in a Medicare Advantage plan

Data Elements Available

**CY2014**

**Hospice Demographics**
- Name, address, city, state/zip, provider number

**Services Summary**
- Total patients served
- Total days of care
- Total reimbursement
- Total physician services
- Discipline hours per day
- Live discharges
- Short stay < 7 days
- Medium stay > 60 days
- Long stay > 180 days
- Visit hours/day in last week of life

**Patient Demographics**
- Average age
- # male/female patients
- Race/ethnic origin
- Medicare Advantage status
- Medicaid eligible
- Diagnoses – broad categories
- Site of service, based on Q code
  - Home
  - ALF
  - Non-skilled LTC facility
  - SNF
  - Inpatient hospital
  - Inpatient hospice
  - Other
Hospice Aide Hours Per Day

Source: CMS CY2014 Hospice PUF Data

Level of Detail for Data

- Data elements are available for
  - State level data
  - Provider level data for each provider – includes provider number and all hospice provider details

- State level data
  - compare states and aggregate nationally

- Provider level data
  - compare providers with each other
  - referral sources compare hospices

% of Medicare Beneficiaries in MA

Source: Hospice Public Use File, CY2014
Who would use this data?

- Hospitals in area
- Commercial insurance plans
- Other provider types looking for contracts
- Other hospice competitors
NHPCO members enjoy unlimited access to Regulatory Assistance. Feel free to email questions to regulatory@nhpco.org.