Hospice Regulatory & Quality Reporting Update

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National Hospice and Palliative Care Organization
October 2018

Summary of FY2019 Hospice Wage Index Final Rule

August 6, 2018


TRENDS IN HOSPICE UTILIZATION
Number of Medicare Patients in Hospice

Total Medicare Spending in Hospice

Top 20 Hospice Diagnoses - 2017

© National Hospice and Palliative Care Organization, 2018
Top 20 Hospice Diagnoses - 2017

<table>
<thead>
<tr>
<th>Rank</th>
<th>ICD-10</th>
<th>Reported Principal Diagnosis</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>C61</td>
<td>Malignant neoplasm of prostate</td>
<td>25,215</td>
<td>2%</td>
</tr>
<tr>
<td>12</td>
<td>H5.9</td>
<td>Cerebral infarction, unspecified</td>
<td>22,825</td>
<td>1%</td>
</tr>
<tr>
<td>13</td>
<td>N18.6</td>
<td>End stage renal disease</td>
<td>21,543</td>
<td>1%</td>
</tr>
<tr>
<td>14</td>
<td>C18.9</td>
<td>Malignant neoplasm of colon, unspecified</td>
<td>21,543</td>
<td>1%</td>
</tr>
<tr>
<td>15</td>
<td>C25.9</td>
<td>Malignant neoplasm of pancreas, unspecified</td>
<td>20,851</td>
<td>1%</td>
</tr>
<tr>
<td>16</td>
<td>I51.9</td>
<td>Heart disease, unspecified</td>
<td>18,794</td>
<td>1%</td>
</tr>
<tr>
<td>17</td>
<td>I11.0</td>
<td>Hypertensive heart disease with heart failure</td>
<td>18,345</td>
<td>1%</td>
</tr>
<tr>
<td>18</td>
<td>I13.0</td>
<td>Hypertensive heart disease and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease</td>
<td>15,632</td>
<td>1%</td>
</tr>
<tr>
<td>19</td>
<td>I13.0</td>
<td>Hypertensive heart disease and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease</td>
<td>18,234</td>
<td>1%</td>
</tr>
<tr>
<td>20</td>
<td>A41.9</td>
<td>Sepsis, unspecified organism</td>
<td>14,012</td>
<td>1%</td>
</tr>
</tbody>
</table>

Length of Stay in Hospice

Source: National Hospice and Palliative Care Organization, 2018

Percentage of Hospice Days by Level of Care and Site of Service

Source: National Hospice and Palliative Care Organization, 2018
### Percentage of Hospice Days by Level of Care and Site of Service

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Site of Service</th>
<th># of Hospice Days</th>
<th>% of All Hospice Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHC</td>
<td>Home and Hospice Residential Facility</td>
<td>199,595</td>
<td>0.17%</td>
</tr>
<tr>
<td></td>
<td>SNF/NF</td>
<td>47,068</td>
<td>0.04%</td>
</tr>
<tr>
<td></td>
<td>Assisted Living Facility</td>
<td>78,927</td>
<td>0.07%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1,758</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>329,378</td>
<td>0.28%</td>
</tr>
<tr>
<td>IRC</td>
<td>Inpatient Hospital</td>
<td>32,207</td>
<td>0.03%</td>
</tr>
<tr>
<td></td>
<td>Inpatient Hospice Facility</td>
<td>121,597</td>
<td>0.10%</td>
</tr>
<tr>
<td></td>
<td>SNF/NF</td>
<td>206,983</td>
<td>0.17%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1,558</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>362,535</td>
<td>0.30%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>118,958,563</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Annual Live Discharge Rates

**Figure 1:** Annual Live Discharge Rates for FY 2007 to FY 2017

Source: FY 2007 through FY 2017: based on data from the Federal下班系统 Login (FHL). All records were assumed that if a discharge date code was missing, it was excluded if the record code was 79, indicating a continuing patient. Live discharges were defined as the record code in a record code of "10".

Source: FY2019 Hospice Wage Index Final Rule, Aug 8, 2018

### Live Discharge by Length of Stay

- **Within 30 days:** 22%
- **31-60 days:** 10%
- **61-90 days:** 14%
- **91-180 days:** 20%
- **> 180 days:** 35%

Source: FY2019 Hospice Wage Index Final Rule, Aug 8, 2018
Skilled Visits in Last Days of Life

- FY2017
  - On any given day in the last 7 days of life
    - 42% of patients received NO skilled visits – RN or SW
  - RN visits on any given day
    - 45% did not receive a visit
  - SW visits on any given day
    - 89% did not receive a visit

CMS Concerns

- We are concerned about the lack of increase in visits to hospice patients at the end of life. Beneficiaries appear to be receiving similar levels of care when compared to time periods prior to the implementation of payment policy reforms
- ... may indicate that hospices are not providing additional resources to patients during a time of increased need.
- Data collection on Hospice Visits When Death Is Imminent in 2017 will inform quality reporting for the FY2019 annual payment update.

CMS Final Rule FY2019 Part A and B Spending Outside Hospice Benefit

<table>
<thead>
<tr>
<th>Year</th>
<th>Part A Spending</th>
<th>Part B Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$748</td>
<td>$712</td>
</tr>
<tr>
<td>2013</td>
<td>$625</td>
<td>$591</td>
</tr>
<tr>
<td>2014</td>
<td>$586</td>
<td>$566</td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CMS Concerns

• Current prior authorization process for 4 classes of drugs (analgesics, antiemetics, laxatives and anti-anxiety) working
• Increase in fills for “maintenance medications”
  – Some are discontinued after hospice election
  – Some may still have symptom relief value
• Examples of maintenance meds used to treat:
  – High blood pressure
  – Heart disease
  – Asthma
  – Diabetes

CMS Concerns

• Medicare may be paying twice for some of these drugs
• CMS remains concerned about the high volume of drugs being paid for by Part D
• CMS encourages hospices to educate beneficiaries about the comprehensive nature of the hospice benefit, including medications
Quality Improvement Organization (QIO)

• Providers must inform Medicare beneficiaries at the time of admission, in writing, that the care for which Medicare payment is sought will be subject to Quality Improvement Organization review.
  • Beneficiary disagreement about what conditions are unrelated
    – we [CMS] strongly encourages hospices to work to resolve the disagreement with the beneficiary (or representative)
    – taking into consideration his or her wishes, treatment preferences and goals.
  • Immediate advocacy process led by the QIO

CMS Concerns

• We will continue to monitor non-hospice spending during a hospice election
• Will consider ways to address the issue through future
  – Regulatory and/or
  – Program integrity efforts

Analysis of RHC Costs and Payments
FY2019 HOSPICE RATES

Rates

FY 2019 Rate Calculation

<table>
<thead>
<tr>
<th>Hospital marketbasket</th>
<th>2.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>less productivity adjustment</td>
<td>0.8%</td>
</tr>
<tr>
<td>less additional hospice reduction (last year)</td>
<td>0.3%</td>
</tr>
<tr>
<td>FY2019 Hospice Rate Increase</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

FY2019 Proposed Payment Rates

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>FY2018 Payment Rates</th>
<th>FY2019 Proposed Payment Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Home Care (Days 1-60)</td>
<td>$192.78</td>
<td>$196.25</td>
</tr>
<tr>
<td>Routine Home Care (Days 61+)</td>
<td>$151.41</td>
<td>$154.21</td>
</tr>
<tr>
<td>Continuous Home Care (Hourly rate)</td>
<td>$40.68</td>
<td>$41.62</td>
</tr>
<tr>
<td>Inpatient Respite Care</td>
<td>$172.78</td>
<td>$176.01</td>
</tr>
<tr>
<td>General Inpatient Care</td>
<td>$743.55</td>
<td>$758.07</td>
</tr>
</tbody>
</table>
Wage Index Values

• Comments received:
  – Several commenters expressed concerns about the volatility of the wage index values for their area.
  – Several commenters expressed concern that an adjacent CBSA had a higher wage index value.

• CMS response:
  – CMS responded with a reference to the calculation for the wage index and explained that the “annual changes in the wage index reflect real variations in costs of providing care in various geographic locations.
  – The hospice wage index is derived from the pre-floor, pre-reclassified wage index for hospitals, which is which is calculated based on cost report data from hospitals.”

FY2019 Rates

• Even though the published rate increase is 1.8%, the wage index for an area will dictate what the rate increase will be in a metropolitan or rural area.

• Sequestration remains in place at a 2% deduction.

• NHPCO state/county wage index charts with final FY2019 rates for all levels of care for provider use

FY2019 Cap Amount

• Cap year: October 1 – September 30

• Cap amount: $29,205.44
Reporting Hospice Drug Information

- Effective October 1, 2018
- A hospice “can submit total, aggregate DME and drug charges on the claim.
- At this time, claims processing edit prohibiting providers to submit both separate line item drug data and aggregate drug data on the claim.
- CMS encourages providers to select one consistent mechanism for reporting this data.”
- NHPCO will continue to work with CMS and with Medicare Administrative Contractors (MACs) to further clarify this sub-regulatory policy.

PHYSICIAN ASSISTANTS

Physician Assistants as Attending Physician for Hospice Patients

- Effective January 1, 2019
- Recognized as designated hospice attending physician
- Join nurse practitioners and physicians in this role
- Must function within the scope of practice per state law
PAs Cannot

- Physician assistants cannot:
  - Certify or recertify terminal illness.
    - No one other than an MD or DO can perform that function.
  - Conduct face-to-face encounters.
    - The face-to-face encounter statutory language was not changed when PAs were added as an attending physician
  - Replace the hospice physician in the IDT.

HOSPICE QUALITY REPORTING PROGRAM

No Changes

- No new quality reporting measures for FY 2019.
- Failure to comply with HIS and CAHPS submission requirements will result in a 2% reduction in a provider’s reimbursement rate.
Patients Over Paperwork Initiative

• Regulatory reform and reducing regulatory burden are high priorities for CMS.

• Patients Over Paperwork Initiative was launched in October 2017 and is aimed at evaluating and streamlining regulations.

Meaningful Measures

• The Meaningful Measures initiative is one component of the Patients Over Paperwork Initiative.

• Goals of the Meaningful Measures initiative include:
  – Reduction of regulatory burden on the healthcare industry
  – Lowering of health care costs
  – Enhancement of patient experience

• This initiative applies to all provider types under Medicare.

• Several of the meaningful measures apply to hospice services.

Social Risk Factors

• CMS plans to continue working on this important issue to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences.
New Measure Removal Factor

• In the FY 2016 Hospice Final Rule (80 FR 47186), CMS adopted seven factors for measure removal.
• CMS is adopting an eighth factor to consider when evaluating measures for removal from the HQRP measure set:
  – The costs associated with a measure outweighs the benefit of its continued use in the program.

New Measure Removal Factor

• Measures based on this factor on a case-by-case basis.
• CMS may decide to retain a measure that is burdensome for health care providers to report if they conclude that the benefit to beneficiaries justifies the reporting burden.

Composite Measure

• The Hospice and Palliative Care Composite Process Measure was approved by NQF in July 2017 and will be reported in Hospice Compare in November 2018 refresh.
• Measure is calculated based on a 12-rolling month data selection period, to be eligible for public reporting with a minimum denominator size of 20 patient stays.
Visits when Death is Imminent Measures

- Will be reviewed by NQF for approval when 4 quarters of acceptable data are determined by CMS.
- After receiving NQF approval, the measure pair will be eligible to be reported on Hospice Compare.
- Exact timeline for public reporting of this measure pair will be announced through regular sub-regulatory channels once necessary analyses and measure specifications are finalized but will be reported sometime in 2019.

Change to HIS Measure Display

- CMS will no longer directly display the 7 component measures as individual measures on Hospice Compare, once the Composite measure is displayed.
- They will still provide the ability to view these component measures by reformatting the display of the component measures allowing users the opportunity to view the component measure scores that were used to calculate the main composite measure score.

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>Measure Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission (NQF #1225)</td>
<td>71.3%</td>
</tr>
<tr>
<td>Component Measure: Tumor Staging (NQF #1044)</td>
<td>98.0%</td>
</tr>
<tr>
<td>Component Measure: Vitals (NQF #1167)</td>
<td>95.9%</td>
</tr>
<tr>
<td>Component Measure: CT Scan (NQF #1154)</td>
<td>93.2%</td>
</tr>
<tr>
<td>Component Measure: MRI (NQF #1155)</td>
<td>92.8%</td>
</tr>
<tr>
<td>Component Measure: Outcome Measure: Death Prediction (NQF #1158)</td>
<td>80.3%</td>
</tr>
<tr>
<td>Component Measure: Hospice Compare (NQF #1167)</td>
<td>95.5%</td>
</tr>
</tbody>
</table>
### Time period for HIS Data Review

- CMS proposes there be a specified time period (4.5 months) for HIS data review and a correlating data correction deadline for public reporting at which point the data is frozen for the associated quarter.

- Any record-level data correction after the data frozen date will not be incorporated into measure calculation for public reporting on the CMS Hospice Compare Web site.

### CASPER Reports Reminder

- Providers should review their measures using CASPER Reports.

- Two provider feedback reports are available to providers:
  - the Hospice-Level Quality Measure Report
  - the Patient Stay-Level Quality Measure Report

- These reports are for the purposes of internal provider quality improvement and are available to hospices on-demand.

### Future Measures

- CMS will announce to providers any future intent to publicly report a quality measure on Hospice Compare or other CMS website, including timing, through **sub-regulatory means**.

- Announced on
  - HQRP website
  - MLN e news
  - national provider association calls
  - Open Door Forums
Hospice Public Use File (PUF) Data

- PUF data will be added to Hospice Compare as a separate “information” section of website
- Hospice PUF contains information on utilization, payment, submitted charges, primary diagnoses, sites of service, and hospice beneficiary demographics organized by CMS Certification Number and state.
- Could add other publicly available CMS data to Hospice Compare through sub-regulatory guidance

HOSPICE CAHPS UPDATE

Extending CAHPS Requirements to Future Years (FY2023 and every year thereafter)

- Hospices must:
  - Contract with a CMS-approved vendor to collect survey data
  - Provide a list of patients who died under their care along with associated primary caregiver information to vendor
  - Ensure that vendor has submitted timely
- The vendor must:
  - Collect survey data on a monthly basis
  - Report to CMS on quarterly basis by deadlines established for each reporting period
CAHPS Reporting in Hospice Compare

- Data timeframe
  - Most recent 8 quarters of data (rolling quarters)
- No data reported on hospice compare if fewer than 30 completed surveys in designated reporting period
- To meet participation requirements for the FY 2025 APU, Medicare-certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from January 2023 through December 2023 (all 12 months) to receive their full payment for the FY 2025 APU.

Size Exemption

- Fewer than 50 survey eligible decedents/caregivers in the reference year (January 1 – December 31)
- Can request an exemption from CAHPS Hospice Survey data collection and reporting requirements
- Application for exemption good for one year only

Newness Exemption

- No changes to policy
- One time exemption only
- Hospice providers should keep the letter they receive providing them with their CCN.
  - The letter can be used to show when you received your number.
CAHPS Study

• The CAHPS Hospice Survey team has recently decided to launch a study of the cover letter and phone script to determine how it can be made more readable to all members of the public.

• This research will include a review of the grade level of each item and feedback from respondents.

Updates to Provider Demographic Information

• If inaccurate or outdated demographic data are included on the Preview Report or on Hospice Compare, hospice providers should follow guidance in the How to Update Demographic Data document in the downloads section of the Public Reporting: Background and Announcements page on the CMS HQRP Website.
HEART Update

• CMS convened a Technical Expert Panel meeting in Fall 2017 and, after further analysis, CMS began pilot testing (Pilot A) an early version of the HEART.
• concerns were raised during Pilot A testing, and further testing phases are being delayed at this time.
• CMS is working diligently to retool the HEART following the lessons learned from Pilot A.
• There will be significant interaction between CMS and stakeholders via Special Open Door Forums (SODF).

Draft Measure Comment Period

• Transitions from Hospice Care, Followed by Death or Acute Care, Draft Measure Development for Hospice QRP
• Public Comment Period: April 25, 2018
• Transitions from Hospice Care, Followed by Death or Acute Care will estimate the risk adjusted rate of transitions from hospice care, followed by death within 30 days or acute care use within 7 days
  – Outcome measure
OIG REPORT ON HOSPICE CARE

OIG Portfolio on Hospice

• “Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio (OEI-02-16-00570)
  – Posted on 7/30/18
  – https://oig.hhs.gov/oei/reports/oei-02-16-00570.asp
• The portfolio synthesizes OIG’s body of work on the Medicare hospice benefit.
• It covers hospice care since 2005 and describes the growth in hospice utilization and reimbursement.
• The portfolio also summarizes key vulnerabilities that OIG has identified and continues to monitor.

What the OIG Found

• The OIG identified vulnerabilities in the program.
  – Hospices do not always provide needed services to beneficiaries and sometimes provide poor quality care.
  – In some cases, hospices were not able to effectively manage symptoms or medications, leaving beneficiaries in unnecessary pain for many days.
  – Found that beneficiaries and their families and caregivers do not receive crucial information to make informed decisions about their care.
What the OIG Found

• Hospice billing concerns
  – Hospices' inappropriate billing costs Medicare hundreds of millions of dollars billing for an expensive level of care when the beneficiary did not need it.
  – Fraud Schemes - Some fraud schemes involved enrolling beneficiaries who are not eligible for hospice care, while other schemes involve billing for services never provided.

What the OIG Found

• Payment system concerns
  – the current payment system creates incentives for hospices to minimize their services and seek beneficiaries who have uncomplicated needs.
  – A hospice is paid for every day a beneficiary is in its care, regardless of the quantity or quality of services provided on that day.
  – While CMS made some changes to payments, the underlying structure of the payment system remains unchanged.

OIG Recommendations to CMS

• Recommend that CMS implement 15 specific actions that relate to 7 areas for improvement.
  – CMS should strengthen the survey process to better ensure that hospices provide beneficiaries with needed services and quality care.
  – CMS should also seek statutory authority to establish additional remedies for hospices with poor performance.
  – CMS should develop and disseminate additional information on hospices, including complaint investigations, to help beneficiaries and their families and caregivers make informed choices about hospice care.
OIG Recommendations to CMS

- CMS should educate beneficiaries and their families and caregivers about the hospice benefit, working with its partners to make available consumer-friendly information.
- CMS should promote physician involvement and accountability to ensure that beneficiaries get appropriate care.

• CMS should strengthen oversight of hospices
  - Analyze claims data to identify hospices that engage in practices that raise concerns.
  - Take steps to tie payment to beneficiary care needs and quality of care to ensure that services rendered adequately serve beneficiaries’ needs, seeking statutory authority if necessary.

NHPCO’s Response to OIG Report

• NHPCO recognizes the value of some of the OIG recommendations and we welcome measures that will help hospices focus on value over volume and patients over paperwork.
• However, NHPCO continues to stress that outliers cited in the report do not adequately reflect the context of hospice care provision in the U.S.
• Importantly, CMS rejects over half of the OIG’s hospice recommendations, and we generally agree.

NHPCO’s Response to OIG Report

• We believe that incidents of deliberate fraud and abuse in the hospice field, though rare and isolated, are indefensible.
• It is necessary to understand that rare incidents of deliberate fraud and abuse should be viewed separately from unintentional documentation or mathematical errors in an extraordinarily burdensome and complicated regulatory environment.
NHPCO’s Response to OIG Report

• We look forward to working with the Administration to simplify and streamline the hospice benefit and compliance process and to ease the governmental red tape in order to encourage honest and law-abiding hospice providers while protecting the public from unacceptable intentional abuse.
• NHPCO encourages the OIG and CMS to examine ways in which the current structure of the benefit can prevent patients and families from accessing medically necessary care and subject them instead to more costly and less beneficiary-friendly environments.


Medicare Card Update

Transition to New Medicare Numbers and Cards

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

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

Mailing Waves

<table>
<thead>
<tr>
<th>Wave 1 State(s)</th>
<th>Wave 2 State(s)</th>
<th>Wave 3 State(s)</th>
<th>Wave 4 State(s)</th>
<th>Wave 5 State(s)</th>
<th>Wave 6 State(s)</th>
<th>Wave 7 State(s)</th>
<th>Wave 8 State(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York, Texas</td>
<td>North Carolina</td>
<td>South Carolina</td>
<td>Nevada, Hawaii</td>
<td>Wisconsin, Iowa</td>
<td>Iowa, Minnesota</td>
<td>North Dakota, South Dakota, Utah, Montana</td>
<td>Arizona, New Mexico</td>
</tr>
</tbody>
</table>

Alert Your Patients

CMS encourages Medicare providers to help alert your patients by displaying a poster in your office and giving your patients tear-off sheets or fliers.
NHPCO members enjoy unlimited access to regulatory and quality reporting assistance.
Feel free to email questions to regulatory@nhpco.org or quality@nhpco.org.

NEW
episodes released the 1st and 3rd Tuesday of every month
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