Medicare Hospice Policy Roundup

Theresa M. Forster  
VP for Hospice Policy & Programs  
NAHC

Katie Wehri, CHC CHPC  
Hospice Operations Expert  
NAHC

March 26, 2014

Agenda

Concurrent Care Demo
Hospice Payment Issues
Hospice Payment Reform
Hospice Cost Report Revisions
MedPAC – 2014
Related? Unrelated?
Part D Drugs and Hospice Dx Coding

Additional Data Reporting on Claims
Audits and Edits
Additional Issues
Hospice Quality Reporting Program (HQRP)
Vaccines
Emergency Preparedness
Compliance Issues
Concurrent Care Demonstration

- CMS released plans March 18 for 3-year, 30-site demo
- Medicare-certified hospices to provide RHC and INPT respite, coordination of care, counseling and other services for $400 PBPM
  - All other services covered under Parts A, B, and/or D
- Patients must be hospice eligible
- Advanced cancers, COPD, CHF and HIV/AIDS
- [http://innovation.cms.gov/initiatives/Medicare-Care-Choices/](http://innovation.cms.gov/initiatives/Medicare-Care-Choices/)

Hospice Payment Updates

<table>
<thead>
<tr>
<th></th>
<th>FY2013</th>
<th>FY2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital MB</td>
<td>2.6 percent</td>
<td>2.5 percent</td>
</tr>
<tr>
<td>LESS</td>
<td>0.7 ppt</td>
<td>0.5 ppt</td>
</tr>
<tr>
<td>ACA productivity (varies annually)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACA MB reduction</td>
<td>0.3 ppt</td>
<td>0.3 ppt</td>
</tr>
<tr>
<td>4th/5th year BNAF</td>
<td>0.6 ppt</td>
<td>0.6 ppt</td>
</tr>
<tr>
<td>Wage index changes (vary)</td>
<td>0.1 ppt</td>
<td>0.1 ppt</td>
</tr>
<tr>
<td>NET</td>
<td>0.9 percent update</td>
<td>1.0 percent update</td>
</tr>
<tr>
<td>Less: 2 ppt sequester</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FINAL OUTCOME OVER FY2012 payments</td>
<td>MINUS 1.1 ppt</td>
<td>MINUS 1.0 ppt</td>
</tr>
</tbody>
</table>
# Update on Payment Reform

Our most recent information on payment reform came from CMS in April 2013; we may see additional information later in April 2014:

- New “tiered” payment model for RHC Payment based on “lifetime length of stay” – if readmission, not eligible for increased payment for start of care
  - 7 payment groups or “tiers” with associated “implied weights” that vary based on timing during episode and service inputs; CMS may build more tiers and address live discharge

<table>
<thead>
<tr>
<th>MedPAC</th>
<th>CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment model</strong></td>
<td><strong>Payment model</strong></td>
</tr>
<tr>
<td>Tiered payment model</td>
<td>Tiered payment model</td>
</tr>
<tr>
<td><strong>Tier (days)</strong></td>
<td><strong>Tier (days)</strong></td>
</tr>
<tr>
<td>1-7</td>
<td>1.97</td>
</tr>
<tr>
<td>8-14</td>
<td>1.01</td>
</tr>
<tr>
<td>15-30</td>
<td>0.95</td>
</tr>
<tr>
<td>31+</td>
<td>0.86</td>
</tr>
<tr>
<td>Last 7 days before death add on 1.15</td>
<td>Last 7 days before death WITH visit</td>
</tr>
<tr>
<td>Take action as quickly as possible to address incentives to maintain patients on hospice benefit for longer periods of time</td>
<td>Last 7 days before death W/O visit</td>
</tr>
<tr>
<td></td>
<td>LOS ≤ 5 days w/death</td>
</tr>
</tbody>
</table>

**Other options**

Case-mix adjusted system (don’t have enough data at present)
<table>
<thead>
<tr>
<th>MedPAC</th>
<th>CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebasing of RHC</td>
<td>Addressing aggregate payments based on level of care could be addressed at some future time</td>
</tr>
<tr>
<td>Site of service adjustment for hospice care provided in nursing facilities (NFs)</td>
<td>“Suggested” 3 – 5% reduction in payment for hospice care in NFs (not included in annual payment policy recommendations to Congress)</td>
</tr>
<tr>
<td></td>
<td>In future will examine whether this reduction should be imposed in a non-budget neutral manner</td>
</tr>
</tbody>
</table>

**Hospice Cost Report**

- CMS has undertaken major revisions -- lengthy process – includes 2 public comment periods
- Changes significantly expand detail on costs by level of care
- First version 4/13 – eff. for cost reporting years on/after 1/14
- Additional revisions issued 11/13 – eff. for cost reporting years beginning on or after 10/14
- Awaiting final version
- Changes require more detail and significant adjustment in how hospices are reporting costs
- Applicable for FREESTANDING hospices only, but facility-based hospice change will come soon; ALL MUST PREPARE
- NAHC’s HHFMA has created a chart of accounts with input from CMS; free access is available at: http://www.hhfma.org/Accounts.htm
MedPAC 2014 Report

2014 Recommendations
- FY2015 payment – flat update
- Eliminate carve-out for hospice under Medicare Advantage
  - Effective 2016
  - Hospice Benefit, in its entirety, included
    - Preauthorization possible, not likely
    - Beneficiary cost sharing could apply
    - Beneficiary may only choose among MA plan-contracted hospices
  - Requires Congressional action

MedPAC: Areas of Inquiry

- Hospice in NF
- Length of Stay – varies by Dx, location of care, provider type
- In 2011 – Medicare spent $7.9 B. on hospice care for beneficiaries whose lengths of stay exceeded 180 days
  - $2.7 B. on days 1-180
  - $5.2 B. on days 181 and over
Related? Unrelated?

2012 Medicare spending for hospice patients outside of hospice -- $1B. TOTAL

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part D</td>
<td>$340 M.</td>
</tr>
<tr>
<td>Inpatient</td>
<td>224 M.</td>
</tr>
<tr>
<td>Phys./supplier</td>
<td>202 M.</td>
</tr>
<tr>
<td>Outpatient</td>
<td>122 M.</td>
</tr>
<tr>
<td>DME</td>
<td>48 M.</td>
</tr>
<tr>
<td>SNF</td>
<td>41 M.</td>
</tr>
<tr>
<td>Home Health</td>
<td>32 M.</td>
</tr>
</tbody>
</table>

Part D Drugs and Hospice

- Dec. 6 CMS Memo to Plans: institute PA for all drugs for hospice patients; seeking comments
- Significant response from hospice community
- March 10 CMS issued new guidance effective May 1
- CMS – This guidance is designed to address “how Part D should treat drugs for patients on hospice”
- Additional issue to be addressed “What is part of the hospice bundle?” Later, through regulation
Part D Drugs and Hospice

• Under new guidance – prior authorization process for all drugs for hospice patients at the beneficiary level
  – Complex but uniform
  – Directs Part D plans to accept hospice explanation as to why drug is “unrelated”
  – Part D plans may continue other PA processes they have in place (categories of drugs)
  – Independent Review Body to be established through regulation

Part D Drugs and Hospice

• Guidance to hospice providers:
  – Confirm terminal and related Dx
  – Find out if patients are on Part D, if so, what plan
  – Communicate with patients about PA process, payment responsibility (Hospice, Part D, patient)
  – Reach out to Part D plan to coordinate, advance PA process
  – Ensure documentation of why drugs are unrelated

NAHC/HAA TOOLKIT FORTHCOMING
Dx Coding

July 2012 -- Diagnosis Coding on Claims – nature of hospice indicates that terminal/related conditions should be specified

- **CMS continues to track provider behavior**
- Concerns about adherence to ICD-9-CM guidelines, proper use and sequencing of codes
Dx Coding

Manifestation codes
- Describe symptoms rather than etiology
- Should never be used as principal Dx; some clues in ICD-9-CM denote manifestation, e.g.:
  - “In diseases classified elsewhere”
  - “code first”
  - “not first listed Dx”
- Of particular concern relative to hospice:
  - Debility and Adult failure to thrive (20% of hospice patients)
  - SOME dementia codes (both Alzheimer's or dementia w/Lewey Bodies can be principal Dx)

Dx Coding

RTP claims beginning Oct. 1, 2014

Debility
AFTT
Non-specified dementia

*Anticipated* - ANY manifestation code as principal Dx
Dx Coding

• Guidance
  – Are you providing multiple diagnoses on claims?
  – Ensure ongoing adherence to coding guidelines/rules; if complexities are not understood, staff should have training
  – Abandon “cheat sheets”/reliance on “hospice diagnoses”
  – Identify instances of use of manifestation codes as principal diagnosis/find alternatives
  – CMS says physician provides diagnoses, but OK for coders/billers to establish appropriate codes
  – Rely on assessing combined impact of existing diagnoses to establish prognosis – physician education

CR8358 Additional Claims Data

Re-issued January 31, 2014

Additional Data on Claims

- Line item visit data for hospice staff provided under general inpatient care (GIP) in skilled nursing facilities (SNF) or hospitals
- National Provider Identifier (NPI) of nursing facility, hospital, or hospice inpatient facility where patient receives services (if not billing hospice)
- Post-mortem visits (occurring on date of death) for hospice employed nurses, aides, social workers and therapist
- Injectable prescription drugs
- Non-injectable prescription drugs
- Infusion pumps and medication refills

Additional Data on Claims

- Voluntary January 2014
- Mandatory April 1, 2014
- Numerous questions
## Additional Data on Claims

<table>
<thead>
<tr>
<th>Additional Data</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line item visit data for hospice staff provided under general inpatient care (GIP) in skilled nursing facilities (SNF) or hospitals</td>
<td>No changes to visit reporting for a hospice inpatient unit</td>
</tr>
</tbody>
</table>
| National Provider Identifier (NPI) of nursing facility, hospital, or hospice inpatient facility where patient receives services (if not billing hospice) | Claims RTP’d if NPI not provided for these settings  
Applies to all levels of care  
Hospice inpatient facility – only need NPI if it is different than the hospice submitting the claim |

### Additional Data on Claims

<table>
<thead>
<tr>
<th>Additional Data</th>
<th>Notes</th>
</tr>
</thead>
</table>
| 450 line limit                                                                | Monthly billing cycle, sequential  
Verify visits are being recorded properly                                              |
| Post-mortem visits (on date of death) for hospice employed nurses, aides, social workers and therapist | Based on date of death  
Body does not need to be present  
Includes all billable visits and calls  
Cannot use a PM modifier for visits during GIP  
Split visit if death occurs during visit |

**Post-mortem visits (on date of death)** for hospice employed nurses, aides, social workers and therapist:

- Based on date of death
- Body does not need to be present
- Includes all billable visits and calls
- Cannot use a PM modifier for visits during GIP
- Split visit if death occurs during visit
Additional Data on Claims

<table>
<thead>
<tr>
<th>Additional Data</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injectable prescription drugs</td>
<td>Only drugs related to the principal dx/related conditions</td>
</tr>
<tr>
<td>Non-injectable prescription drugs</td>
<td>Applies to all levels of care in all settings</td>
</tr>
<tr>
<td>Infusion pumps and medication refills</td>
<td>Hospices are working with their pharmacies to obtain the required data and electronic record vendors to transfer the data to the claim</td>
</tr>
<tr>
<td></td>
<td>Requires line-item reporting on claim per fill based on amount dispensed</td>
</tr>
<tr>
<td></td>
<td><strong>Exception:</strong> Medication management systems summarize “fills” per drug</td>
</tr>
<tr>
<td></td>
<td>Requires CHARGE</td>
</tr>
</tbody>
</table>

Single MAC Q & A document issued March 14:
http://www.ngsmedicare.com/ngs/wcm/connec
t/295b3338-c5b6-42fd-bd63-9d26bb13c8de/1530_0314_CR_8358_QA_Sum
mary_Final_508.pdf?MOD=AJPERES&useDefault
Text=0&useDefaultDesc=0

Additional answers to come --
Medical Review/Widespread Edits

• October 30, 2013 - Palmetto service-specific prepay probe review on hospice claims with non-cancer diagnoses, billed with place of service Skilled Nursing Facility, HCPCS code Q5004.
  – Patient is receiving skilled care from the SNF staff (i.e. hospice GIP level of care)
  – 13 providers; 100 claims

Medical Review/Widespread Edits

• October 30 2013 CGS expands widespread hospice edits
  – Implement a new widespread edit, 5118T, that will select claims with a length of stay between 150 days and 365 days for providers that bill to CGS within the states of NH, ID, GA, UT, CO, DE, MO, AL, AR, KS, TS, and WV.
  – Discontinue widespread edit 5048T (selects hospice claims with a length of stay of 999 days or more) once the new edit 5118T is implemented.
  – Expand parameters for edit 5091T to include any non-oncologic diagnosis code. Edit 5091T selects claims when the beneficiary resides in a nursing home, the hospice length of stay is greater than 180 days, and the principal diagnosis is debility, unspecified. The reason for expanding the diagnosis codes on this edit is the high denial rate of 61%.
CR 8425 – Removal of Prohibition

• CR 8425 “Removal of Prohibition”
• Being rescinded due to the need to clarify CMS’ policy and will not be replaced at this time.
• Allows contractors to make a determination or take action on claims not under review but related to claims submitted for review
• MAC, RAC and ZPIC contractors now have the discretion to automatically deny claims submitted that are related to other claims where non-coverage or non-payment decisions have been determined though medical record review.

Enforcement of Respite LOS

• CR 8569


July 7, 2014
HETS

- HETS
  - Eliminate access to HIQA/HIQH April 1, 2014
  - DELAYED
  - No implementation date but will have 90 days notice

Hospice Quality Reporting Program

ACA
Mandated reporting
ALL Patients – ALL Payors

Financial penalty for not participating

Public reporting as soon as FY2018
Hospice Quality Reporting Program

Pain Measure #209
   Report: April 1, 2014
   Impacts FY2015 payments

   Replaced by two new pain measures in 2014

Hospice Quality Reporting Program

Hospice Item Set (HIS)
   Admission
   Discharge
   Implement: July 1, 2014
   Payment Year: 2016

Hospice Experience of Care Survey
Hospice Quality Reporting Program - HIS

HIS Manual
- HEART – May 2014

Hospice Quality Reporting Program - HIS

- NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen
- NQF #1634 Pain Screening
- NQF #1637 Pain Assessment
- NQF #1638 Dyspnea Treatment
- NQF #1639 Dyspnea Screening
- NQF #1641 Treatment Preferences
- NQF #1647 Beliefs/Values Addressed (if desired by the patient)
Hospice Quality Reporting Program
Experience of Care Survey

- Pilot testing fall 2013
- Mandatory collection begins 2015
- Financial penalty for not *participating*
- Public reporting – TBD
- Exemption < 50 patients

Hospice Quality Reporting Program
Experience of Care Survey

- **Dry run**
  January, February and/or March 2015
  Data not publicly reported

- **Continuous monthly participation**
  April 1, 2015 – December 31, 2015
Vaccines

Claims for Hospice Patient Vaccines/CR 8098:

Additional Issues

OIG Work Plan 2014
Hospices in ALFs

• We will determine the length of stay, levels of care received, and common terminal illnesses of beneficiaries who receive hospice care in ALFs.

• Our work is intended to provide HHS with information relevant to these requirements
Additional Issues

Connolly – RAC

Hospice documentation will be reviewed to determine the appropriateness of payments for hospice care services for Medicare beneficiaries.

Additional Issues

OIG Work Plan 2014
• General Inpatient Care
We will review the use of hospice general inpatient care. We will assess the appropriateness of hospices’ general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care. We will also review hospice medical records to address concerns that this level of hospice care is being misused
Emergency Preparedness Proposal

• Would require hospices to inform officials of patients in need of evacuation
• Inform officials of inpatient occupancy (includes contracted inpatient locations)
• Inform officials of hospice inpatient unit ability to provide assistance
• Soliciting comments

Hospice Compliance
Areas of Action – Areas of Vulnerability

- **Payment Reform**
  - Anticipate and prepare for impact
  - Accurate data – accurate claims
- **Non compliance with coding requirements**
- **Patients not eligible**
  - Not terminally ill
  - Not eligible for the level of care billed
  - Documentation supports *prognosis*
  - Technical components of election statements, CTIs, and Plans of Care

Areas of Action – Areas of Vulnerability

- **Levels of care**
- **Length of stay**
- **Site of service**
- **Proper use and administration of Medicare/Medicaid benefits**

*Develop checks and balances*
Areas of Action – Areas of Vulnerability

• Payment for items/services, particularly medications, related to the terminal dx. and related conditions

Per CMS:
“It is our general view that hospices are required to provide virtually all the care that is needed by terminally ill patients. Therefore, unless there is clear evidence that a condition is unrelated to the terminal prognosis, all services would be considered related. It is also the responsibility of the hospice physician to document why a patient’s medical needs would be unrelated to the terminal prognosis “

Compliance Plans

• Voluntary at this time

• Guidance first published 1999

• Effectiveness

• Seven elements
<table>
<thead>
<tr>
<th>Theresa Forster</th>
<th>Katie Wehri, CHC, CHPC</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="mailto:TMF@nahc.org">TMF@nahc.org</a></td>
<td><a href="mailto:Katie@nahc.org">Katie@nahc.org</a></td>
</tr>
</tbody>
</table>