Hospice Regulatory & Quality Reporting Update

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National Hospice and Palliative Care Organization
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Conflict of Interest/Continuing Education

• I have no conflict of interest to report

Nurses: This session has been approved for 1.0 contact hours.

Hospice & Palliative Care Network of Maryland is an approved provider of continuing nursing education by the Maryland Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.

Social Workers: The Maryland Board of Social Work Examiners certifies that this program meets the criteria for 1.0 credit hours of Category I continuing education for social workers in Maryland.

MNA/ANCC does not endorse or approve any commercial products.
Summary of FY2019 Hospice Wage Index Final Rule

August 6, 2018


TRENDS IN HOSPICE UTILIZATION
Number of Medicare Patients in Hospice

Source: FY2019 Hospice Wage Index Proposed Rule, April 27, 2018
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Total Medicare Spending in Hospice

Source: FY2019 Hospice Wage Index Proposed Rule, April 27, 2018
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## 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>1</td>
<td>G30.9</td>
<td>Alzheimer’s disease, unspecified</td>
<td>155,066</td>
<td>10%</td>
</tr>
<tr>
<td>2</td>
<td>J44.9</td>
<td>Chronic obstructive pulmonary disease</td>
<td>77,758</td>
<td>5%</td>
</tr>
<tr>
<td>3</td>
<td>I50.9</td>
<td>Heart failure, unspecified</td>
<td>69,216</td>
<td>4%</td>
</tr>
<tr>
<td>4</td>
<td>G31.1</td>
<td>Senile degeneration of the brain, not elsewhere classified</td>
<td>66,309</td>
<td>4%</td>
</tr>
<tr>
<td>5</td>
<td>C34.90</td>
<td>Malignant Neoplasm of Unsp Part of Unsp Bronchus or Lung</td>
<td>53,137</td>
<td>3%</td>
</tr>
<tr>
<td>6</td>
<td>G20</td>
<td>Parkinson’s disease</td>
<td>40,186</td>
<td>3%</td>
</tr>
<tr>
<td>7</td>
<td>G30.1</td>
<td>Alzheimer’s disease with late onset</td>
<td>38,710</td>
<td>2%</td>
</tr>
<tr>
<td>8</td>
<td>I25.10</td>
<td>Atherosclerotic heart disease of native coronary art without angina pectoris</td>
<td>34,761</td>
<td>2%</td>
</tr>
<tr>
<td>9</td>
<td>J44.1</td>
<td>Chronic obstructive pulmonary disease with (acute) exacerbation</td>
<td>33,547</td>
<td>2%</td>
</tr>
<tr>
<td>10</td>
<td>I67.2</td>
<td>Cerebral atherosclerosis</td>
<td>30,146</td>
<td>2%</td>
</tr>
<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>I63.9</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>21,549</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>I67.9</td>
<td>Cerebrovascular disease, unspecified</td>
<td>18,234</td>
<td>1%</td>
</tr>
<tr>
<td>19</td>
<td>I13.0</td>
<td>Hypertensive hear 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>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

- Average Length of Stay
  - 2000: 54 days
  - 2013: 88 days
  - 2014: 88.7 days
  - 2015: 86.7 days
  - 2016: 79.2 days
  - 2017: 79.7 days

- Median Length of Stay
  - 2017: 18 days

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>RHC</td>
<td>Home and Hospice Residential Facility</td>
<td>66,320,796</td>
<td>55.75%</td>
</tr>
<tr>
<td></td>
<td>SNF/NF</td>
<td>28,656,850</td>
<td>24.09%</td>
</tr>
<tr>
<td></td>
<td>Assisted Living Facility</td>
<td>20,299,401</td>
<td>17.06%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1,351,575</td>
<td>1.14%</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>116,628,622</td>
<td>98.04%</td>
</tr>
<tr>
<td>GIP</td>
<td>Inpatient Hospital</td>
<td>409,123</td>
<td>0.34%</td>
</tr>
<tr>
<td></td>
<td>Inpatient Hospice Facility</td>
<td>1,158,985</td>
<td>0.97%</td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing Facility</td>
<td>64,349</td>
<td>0.05%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>5,571</td>
<td>0.01%</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td>1,638,028</td>
<td>1.38%</td>
</tr>
</tbody>
</table>
### 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>47,098</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>3,758</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>32,397</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>

Source: FY2019 Hospice Wage Index Proposed Rule, April 27, 2018

### Annual Live Discharge Rates

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

Source: FY 2007 through FY 2017 hospice claims data from Common Working File (CWF). All hospice claims were examined that had a discharge status code (meaning claims were excluded if they listed status code 00, indicating a continuing patient). Live discharges were defined as hospice claims with a status code of “01”.

Source: FY2019 Hospice Wage Index Proposed Rule, April 27, 2018
Live Discharges – FY2017

<table>
<thead>
<tr>
<th>Reason for Live Discharge</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revocation</td>
<td>44%</td>
</tr>
<tr>
<td>No longer terminally ill</td>
<td>45%</td>
</tr>
<tr>
<td>Transferred to another hospice</td>
<td>9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Providers by Percentile</th>
<th>Percentage of Live Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>5th percentile</td>
<td>6.9%</td>
</tr>
<tr>
<td>25th percentile</td>
<td>11.7%</td>
</tr>
<tr>
<td>Median</td>
<td>17.3%</td>
</tr>
<tr>
<td>75th percentile</td>
<td>25.4%</td>
</tr>
<tr>
<td>95th percentile</td>
<td>47.6%</td>
</tr>
</tbody>
</table>

Live Discharge by Length of Stay

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

In millions

Part A and B Spending

Source: FY2019 Hospice Wage Index Proposed Rule, April 27, 2018
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Part D Spending

In millions

Source: FY2019 Hospice Wage Index Proposed Rule, April 27, 2018
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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

![Bar chart showing weighted mean, median, and RHC FY2016 payment.]($126, $124, $161.89)

FY2019 HOSPICE RATES
Rates

FY 2019 Rate Calculation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital marketbasket</td>
<td>2.9%</td>
</tr>
<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 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
  - https://www.nhpco.org/billing-and-reimbursement/medicare-rates
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.
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.

Meaningful Measures Areas

<table>
<thead>
<tr>
<th>Quality Priority</th>
<th>Meaningful Measure Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making Care Safer by Reducing Harm Caused in the Delivery of Care</td>
<td>Healthcare-Associated Infections</td>
</tr>
<tr>
<td></td>
<td>Preventable Healthcare Harm</td>
</tr>
<tr>
<td>Strengthen Person and Family Engagement as Partners in Their Care</td>
<td>Care is Personalized and Aligned with Patient’s Goals</td>
</tr>
<tr>
<td></td>
<td>End of Life Care according to Preferences</td>
</tr>
<tr>
<td></td>
<td>Patient’s Experience of Care</td>
</tr>
<tr>
<td></td>
<td>Patient Reported Functional Outcomes</td>
</tr>
<tr>
<td>Promote Effective Communication and Coordination of Care</td>
<td>Medication Management</td>
</tr>
<tr>
<td></td>
<td>Admissions and Readmissions to Hospitals</td>
</tr>
<tr>
<td></td>
<td>Transfer of Health Information and Interoperability</td>
</tr>
</tbody>
</table>
Meaningful Measures Areas

<table>
<thead>
<tr>
<th>Quality Priority</th>
<th>Meaningful Measures Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote Effective Prevention and Treatment of Chronic Disease</td>
<td>Preventive Care</td>
</tr>
<tr>
<td></td>
<td>Management of Chronic Conditions</td>
</tr>
<tr>
<td></td>
<td>Prevention, Treatment and Management of Mental</td>
</tr>
<tr>
<td></td>
<td>Prevention and Treatment of Opioid and Substance Use Disorders</td>
</tr>
<tr>
<td></td>
<td>Risk Adjusted Mortality</td>
</tr>
<tr>
<td>Work with Communities to Promote Best Practices of Healthy Living</td>
<td>Equity of Care</td>
</tr>
<tr>
<td></td>
<td>Community Engagement</td>
</tr>
<tr>
<td>Make Care Affordable</td>
<td>Appropriate Use of Health Care</td>
</tr>
<tr>
<td></td>
<td>Patient-focused Episode of Care</td>
</tr>
<tr>
<td></td>
<td>Risk Adjusted Total Cost of Care</td>
</tr>
</tbody>
</table>

Social Risk Factors

- Studies show that social risk factors can be associated with poor health outcomes and how some of this disparity is related to the quality of health care.
- CMS aims to improve health outcomes, attain health equity for all beneficiaries, and ensure that complex patients as well as those with social risk factors receive excellent care.
- CMS may consider differences in patient backgrounds that might affect outcomes.
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.
Seven Factors For Measure Removal

1. Measure performance among hospices is so high and unvarying that meaningful distinctions in improvements in performance can be no longer be made
2. Performance or improvement on a measure does not result in better patient outcomes
3. A measure does not align with current clinical guidelines or practice

4. A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available
5. A measure that is more proximal in time to desired patient outcomes for the particular topic is available;
6. A measure that is more strongly associated with desired patient outcomes for the particular topic is available
7. Collection or public reporting of a measure leads to negative unintended consequences
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.
**Change to HIS Measure Display**

<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 #3235)</td>
<td>71.5%</td>
</tr>
<tr>
<td>Component Measure: Treatment Preferences (NQF #1641)</td>
<td>98.8%</td>
</tr>
<tr>
<td>Component Measure: Beliefs/Values (NQF #1647)</td>
<td>95.9%</td>
</tr>
<tr>
<td>Component Measure: Pain Screening (NQF #1634)</td>
<td>93.2%</td>
</tr>
<tr>
<td>Component Measure: Pain Assessment (NQF #1637)</td>
<td>87.5%</td>
</tr>
<tr>
<td>Component Measure: Dyspnea Screening (NQF #1639)</td>
<td>98.5%</td>
</tr>
<tr>
<td>Component Measure: Dyspnea Treatment (NQF #1638)</td>
<td>92.8%</td>
</tr>
<tr>
<td>Component Measure: Bowl Regimen (NQF #1617)</td>
<td>97.5%</td>
</tr>
</tbody>
</table>

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**Text Posted On Hospice Compare**

- CMS feels it is important for consumers to be able to distinguish between process, outcome, and consumer feedback measures.
- CMS has decided to separate the data into two sections on the Hospice Compare Web site:
  - 'Family experience of care' and 'Quality of patient care'.
  - Both sections have accompanying text explaining their data source.
Text Posted On Hospice Compare

- The website explains that the 'Family experience of care' data comes from a national survey that asks a family member or friend of a hospice patient about their hospice care experience.
- The 'Quality of patient care' section explains that this data is reported by hospices using the Hospice Item Set (HIS).
- CMS has included text explaining why these measures should be important to consumers.

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

Examples of PUF use by a consumer:
– patient has a specific need, like receiving hospice care in a nursing home, information from the PUF could help this patient or their loved ones determine if a provider in their service area has provided care in this setting
– conditions treated by the hospice could show a patient with dementia if a hospice specializes or is experienced in caring for patients with this condition
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
Draft Measure Comment Period

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August 2018 Hospice Compare Refresh - HIS

<table>
<thead>
<tr>
<th>Measure</th>
<th>August 2018</th>
<th>May 2018</th>
<th>February 2018</th>
<th>December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice and palliative care treatment preferences</td>
<td>98.7%</td>
<td>98.6%</td>
<td>98.5%</td>
<td>98.4%</td>
</tr>
<tr>
<td>Beliefs and values addressed (if desired by the patient)</td>
<td>94.9%</td>
<td>94.5%</td>
<td>94.2%</td>
<td>93.9%</td>
</tr>
<tr>
<td>Hospice and palliative care pain screening</td>
<td>95.3%</td>
<td>94.8%</td>
<td>94.4%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Hospice and palliative care pain assessment</td>
<td>83.4%</td>
<td>81.5%</td>
<td>79.7%</td>
<td>78.7%</td>
</tr>
<tr>
<td>Hospice and palliative care dyspnea screening</td>
<td>97.8%</td>
<td>97.6%</td>
<td>97.5%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Hospice and palliative care dyspnea treatment</td>
<td>95.3%</td>
<td>95.2%</td>
<td>95.1%</td>
<td>94.8%</td>
</tr>
<tr>
<td>Patients treated with an opioid who are given a bowel regimen</td>
<td>93.7%</td>
<td>93.6%</td>
<td>93.5%</td>
<td>93.5%</td>
</tr>
</tbody>
</table>

Source: CMS
Improving HIS Scores

• Know your numerator and denominator of each HIS measure.
  – Validate staff understanding related to HIS

• Determine if low scores are linked to:
  – Clinician practice
  – Documentation
  – EMR Extraction issues

• Use CASPER reports for self-assessment

August 2018 Hospice Compare Refresh - CAHPS

<table>
<thead>
<tr>
<th>Measure</th>
<th>August 2018 score</th>
<th>May 2018 score</th>
<th>February 2018 score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional and spiritual support</td>
<td>90%</td>
<td>89%</td>
<td>89%</td>
</tr>
<tr>
<td>Rating of this hospice</td>
<td>81%</td>
<td>81%</td>
<td>80%</td>
</tr>
<tr>
<td>Willing to recommend this hospice</td>
<td>85%</td>
<td>85%</td>
<td>84%</td>
</tr>
<tr>
<td>Treating patient with respect</td>
<td>91%</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>Help for pain and symptoms</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Communication with family</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Getting timely help</td>
<td>78%</td>
<td>78%</td>
<td>78%</td>
</tr>
<tr>
<td>Training family to care for patient</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>

*Source: Hospice Compare*
CAHPS® Hospice Measures

• Hospice staff should be 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
CAHPS® Hospice Measures

- Determine which opportunities for improvement should be a focus based on your hospice’s standard of care
  - Examples
    - Service after regular office hours
    - Communication
    - Education to patient/family

Caution

- 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
Caution

- Do not assume your vendor’s comparison data are the same as national data
- Check CMS national results against vendor’s

OIG REPORT ON HOSPICE CARE

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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

• Vulnerabilities in the program:
  – Needed services not always provided
  – Sometimes poor quality care
  – Hospices not able to effectively manage symptoms or medications, leaving beneficiaries in unnecessary pain for many days.
  – 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
  – Inappropriate billing for higher levels of care cost Medicare hundreds of millions of dollars
  – Fraud Schemes
    • Enrolling beneficiaries who are not eligible for hospice care
    • Billing for services never provided

What the OIG Found

• Payment system concerns
  – Incentives to minimize services and seek uncomplicated patients
  – Payment for every day of care, regardless of services provided
  – Payment system changes may not be enough
OIG Recommendations to CMS

• Recommend that CMS implement 15 specific actions
• CMS concurred with 6 recommendations

CMS Concurs with OIG

• Develop other claims-based information and include it on Hospice Compare
• Work with its partners, such as hospitals and caregiver groups, to make available consumer-friendly information explaining the hospice benefit to beneficiaries and their families and caregivers
• Analyze claims data to identify hospices that engage in practices or have characteristics that raise concerns
CMS Concurs with OIG

• Take appropriate actions to follow up with hospices that engage in practices or have characteristics that raise concerns
• Increase oversight of general inpatient care claims and focus particularly on general inpatient care provided in SNFs, given the higher rate at which these stays were inappropriate
• Implement a comprehensive prepayment review strategy to address lengthy general inpatient care stays so that beneficiaries do not have to endure unnecessarily long periods of time in which their pain and symptoms are not controlled

OPIOID ISSUES
Opioid Shortages

• Shortages
  – Injectables
  – Could have new supply later in 2018
  – Likely will be an ongoing issue
  – Pfizer manufacturing challenges an issue
  – Hurricane Maria a factor
  – DEA approved new manufacturing quotas to increase supply
• Could be months before available

Opioid Considerations

• Patient and Family Safety
  – Home assessment
  – Implement medication safety procedures
  – Report if family does not dispose medication
• Staff Safety
  – Is the patient care setting safe?
  – Can the hospice continue to serve patient? (Discharge for cause)
  – Options for nighttime on-call?
Opioid Considerations

• Alternatives to Opioids
  – Another drug?
  – Discontinued?
  – Other therapies?
  – Abuse deterrent formulations?

• Organizational Liability
  – Corporate officer liability related to employee opioid diversion
  – Other liabilities for organization

Opioid Considerations

• Inpatient facility safety
  – Medications safely stored and locked
  – Who has access?
  – Night time security in place

• Drug Disposal
  – Policy for disposal?
  – Special packaging?

• HR
  – Vigilance in evaluating drug seeking employees and applicants
  – Random drug testing?
Proper Disposal

• Drugs belong to the “ultimate user” after death
• The ultimate user controls the disposal
• Home hospice and homecare personnel are not authorized to receive pharmaceutical controlled substances from ultimate users for the purpose of disposal
• A member of the hospice patient’s household may dispose of the patient’s pharmaceutical controlled substances, but the home hospice or homecare provider cannot do so unless otherwise authorized by law (for example, under state law) to dispose of the decedent’s personal property

• TRANSLATION: The hospice staff may instruct or supervise the disposal, but may not “take possession” of the drug

• MAY BE DIFFERENT STATE RULES

Changes Coming…

• Omnibus opioid package includes changes in drug disposal for hospice employees
• Not signed into law yet, but getting close
• Stay tuned
OPIOID ISSUES

Hospice Medical Director

- Concern on surveys
- Only 1 hospice medical director per provider number
  - Even if multiple locations
  - Even if large census
- Can have a physician designee to serve in the absence of the medical director
- Other physicians employed by or under contract with the hospice – **CANNOT** be called medical director
- MUST have reporting relationship to medical director shown on the org chart
Hospice Medical Director – To Do

• Job titles
• Job description for medical director
  – Even if position is titled Chief Medical Officer, reference the ONE medical director language in the job description
  – Must state in the job description that this position is the ONE medical director for the hospice
• Organizational chart for reporting relationships
Hospice Medical Director – To Do

• Job titles and job descriptions for other physicians
  – Cannot be called medical director
  – Choose other job titles

• Update policies and procedures about how a physician designee is chosen when the hospice medical director is unavailable

• Staff training – language is important

https://pepperresources.org/
Hospice Target Areas – 2018 PEPPER

• Live discharges – not terminally ill
• Live discharges – revocations
• Live discharges – 61-179 days
• Long length of stay
• CHC in assisted living facility
• RHC in assisted living facility
• RHC in nursing facility
• RHC in skilled nursing facility
• Episodes with no CHC or GIP
• Long General Inpatient Care Stays (> 5 days)

Why It Matters

• Every hospice will receive a Medicare compliance survey every 3 years
• Every hospice is potentially at risk for a federal or state audit
• Every hospice is at risk for medical review form their MAC
• More hospice providers are being audited
Why It Matters

• The quality of a hospice’s documentation will determine:
  – Payment retention (post payment review)
  – Payment receipt (prepayment review)
  – Ability to maintain Medicare certification and/or state hospice licensure

What’s a Hospice to Do?

• Use the data points
• Plot your own hospice’s data
• Identify areas of risk
• Identify areas for improvement
• Review regularly
Scrutiny on Hospice

Who’s Auditing Hospice

Federal
- Department of Justice (DOJ)
- Office of the Inspector General (OIG)
- Zone Program Integrity Contractor (ZPIC)
- Medicare Recovery Auditor (RA) – Medicare
- Comprehensive Error Rate Testing (CERT)

State
- Medicaid Payment Error Rate Measurement (PERM)
- State Survey Agency
- Medicaid Integrity Contractor (MIC)

Third party payers
- Medicare Administrative Contractor (MAC)
Federal Scrutiny

- Department of Justice (DOJ)
  - False Claims Act violation
  - Medicare fraud and abuse
- Office of the Inspector General (OIG)
  - Hospice in a nursing facility
  - Hospice in an assisted living facility
  - Hospice and Part D drugs
  - Hospice general inpatient level of care

Federal Scrutiny – In Transition

Unified Program Integrity Contractor (UPIC)

- The UPIC will combine and integrate existing CMS program integrity functions carried out by multiple contractors and contracts into a single contract to improve its capacity to swiftly anticipate and adapt to the ever changing and dynamic nature of those involved in health care fraud, waste, and abuse across the Medicare and Medicaid program integrity continuum
Know Your Auditor

- Unified Program Integrity Contractor (UPIC)
  - Qlarent
  - [http://www.qlarant.com/about/contracts/](http://www.qlarant.com/about/contracts/)

- Recovery Auditor
  - Performant
  - [https://performantrac.com/](https://performantrac.com/)
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Why Do We Care?

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  – Ability to maintain Medicare certification and/or state hospice licensure
Hospice Documentation Risk Areas

• Sufficient evidence of hospice eligibility
  • Admission
  • Ongoing
• Hospice physician documentation of unrelatedness
  • Meds, diagnoses, etc...
• Insufficient evidence of meeting Medicare ‘Conditions of Coverage’
• Sufficient evidence for GIP and CHC days of care

Where Are Your Issues?

• Practice?
• Documentation?
Focused Quality Documentation

- Concentrated on a specific problem, symptom, issue related to the patient and family
- Drills down to detail
- Requires more than ‘point and click’ on electronic documentation or check boxes on a form
Focused Quality Documentation

• Examples:
  – Document limits to daily activities of living for a patient with end-stage heart disease.
  – Describe the extent of oxygen for a patient COPD and shortness of breath.
  – State facts with objective information:
    • “Clothing no longer fits due to weight loss”
    • “Sleeping XX number of hours of day”
    • “Pain is severely limiting activities of daily living”

Comparative Documentation

• Contrasts the patient’s present condition to his/her prior condition
• Individualizes patients by focusing on their trajectory of decline
  – Ie: weight loss on a graph
• Presents specific information, not generalizations
  – One week ago, patient was eating ½ - ¾ of 2 meals per day
    Now eating only ¼ of 1 meal each day
Insufficient Documentation

• Does not paint a complete picture of the patient

• Insufficient documentation uses words/ phrases like:
  – Slow, progressive decline
  – Appears to be losing weight
  – No change

• Lacks sufficient detail to support hospice eligibility and terminal prognosis

Insufficient documentation example

• “Patient losing weight” could mean:
  – Patient is eating less than before.
  – Patient is not eating at all.
  – Patient has lost two pounds.
  – Patient has lost twenty pounds.
  – Patient appears cachectic
Accurate & Consistent Documentation

• All IDG members need to be on the same page
• Use the IDG meeting to not only share information but to compare information that will affect care planning going forward
  – Functional status
  – Symptom status
  – Identified problems
  – Progress towards goals

Consistent & Accurate Documentation

• Accurate clinical documentation is a requirement for good communication
• Characteristics of accurate documentation:
  ✓ Reflects the scope of care and services provided
  ✓ Justifies hospice eligibility of the patient
  ✓ Records observations without conclusions
  ✓ Timely (point of care)
Ensuring Accuracy & Consistency

• Validate baseline knowledge of staff and ensure each IDG member is speaking the same language
  – Administration of functional scales, symptom management scales, etc...
  – Definitions (i.e.: ambulatory, falls, ...)

• Teach non-clinical staff to document related patient’s functional and symptom status
  – Document observations and subjective comments
  – Trigger questions to learn about functionality and symptom status

Inconsistent Documentation

• Inconsistent documentation
  – Nursing notes: non-ambulatory
  – Chaplain notes: walked in hall

• Pain assessment without documentation of interventions

• “First-line” documentation (nurse, aide, SW, volunteer) does not match “second-line” documentation (IDG notes, narratives, clinical summaries)
Electronic Health Records (EHR)

Benefits:
• Improves efficiency and quality of health care
• Storage capability
  – Time
  – Space
• Accessible from anywhere
• Allows for customized views of information

Issues with Electronic Documentation

• Not enough detail (appears standardized)
• Cut & paste option (duplicating information)
• Not timely (depending on accountability of staff)
• Inconsistent between disciplines (appears multidisciplinary vs. interdisciplinary)
EHR Documentation Improvement

- Increase detail in electronic documentation
  - Expand on “point and click” selections in a note
    - Record observations about details the “drop down” does describe
      - I.e.: state the number of feet a patient can ambulate
- Make it a requirement for IDG members

EHR Documentation Detail

- Document subjective comments from the patient and family to support continued eligibility
  - I.e.: “I sat outside last week, but this week I just don’t have the energy to go out”
  - I.e.: “He has been sleeping more during the day and is not interested in waking up to eat”
- Ensure authentication process is in place and outlined in policy/procedure (CoPs - §418.104)
Documentation Example #1

• Summary note
  – Alert w/confusion. Fair appetite with recent weight loss. Recent falls. Dyspnea at rest. Changes in activities.

• More detail
  – Alert. Confused, oriented to person only. Fair appetite. Recent wt. loss. Current wt. 104, previous wt. 110 one month ago. Recent falls due to unsteady gait and OOB w/o assist. Dyspnea at rest, 02 prn. Withdrawing from activities, refuses to go to dining room.

Documentation Example #2

• Plan of Care – IDT Review:

• Important Data Omitted:
  – PRN pain med increased recently. Had increased N/V necessitating change in diet and increased use of antiemetic. Decreased intake to less than 2 meals/day
"Fast is fine, but accuracy is everything."
Wyatt Earp

Documentation Example

• Chaplain note for patient with end stage dementia:
  “Patient sitting up in chair today and made eye contact during visit. Patient listened to prayers and hymn and appeared to enjoy the visit”

• Reality:
  – Patient was propped in chair with 3 pillows and displayed a vacant stare toward chaplain during visit. Chaplain prayed with patient and sang a hymn. Patient did not verbally or nonverbally interact with chaplain during visit
The Devil is in the Detail

- Each notes should provide enough information to clearly support the terminal prognosis
- Documentation must support eligibility by “painting the picture” of eligibility and decline
- Clear documentation includes subjective comments from patient and family that supports the staff observations and documentation
- All disciplines should be documenting eligibility

Establish Minimum Standard Requirements

- Telling staff they need to improve the quality of documentation does not guarantee better documentation
- Teach staff what needs to be minimally included in the documentation per discipline
  - Level of detail expected
  - Additional notes expected (EMR)
  - Timeframes for completion
  - Coordination of care documentation expectations
NHPCO members enjoy unlimited access to regulatory and quality reporting assistance

Feel free to email questions to regulatory@nhpco.org or quality@nhpco.org

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