Regulatory Updates for Hospice Physicians

Presenter
Annette Kiser, MSN, RN, NE-BC
Director of Quality & Compliance
The Carolinas Center for Hospice & End of Life Care
akiser@cchospice.org

Objectives
- Identify two current compliance issues of importance to hospice physicians
- Describe the data analysis of hospice care taking place
The Auditors & Scrutinizers

CMS Contractors – Federal

- Medicare Administrative Contractor (MAC) – Palmetto GBA
  - Audit areas of focus:
    - Ongoing audits based on NCLOS (Non-Cancer Length of Stay) scores
    - Planning an audit of GIP care in hospitals and hospice inpatient facilities
    - Looking at live discharges
    - May receive referral from another contractor

- Zone Program Integrity Contractor (ZPIC) – AdvanceMed
  - Audit for fraud and abuse and are active in NC and SC

- Medicaid Integrity Contractor (MIC) – Health Integrity
  - Active with audits in SC focusing on Medicaid

- Comprehensive Error Rate Testing (CERT) Contractor
  - Audit the MAC to ensure they are paying claims correctly

- Recovery Audit Contractor (RAC)
  - Conduct audits of other provider types – hospitals, physicians, etc.
Oversight Agencies

- US Department of Justice (DOJ)
  - Conducts investigations or joins audits conducted by OIG and others
- Office of Inspector General (OIG)
  - 2015 Work Plan Focus Areas:
    - Assisted living facility claims
    - General inpatient care claims

Hospice in Assisted Living Facilities

- OIG did an audit of claims from 2007-2012
- Average length of stay (ALOS) in ALF longer than other settings
- 18% had LOS > 365 days, 5% with LOS > 2 years
- 60% had ill-defined conditions
- Review noted that hospice makes very few visits on weekends
- Care should be similar for all patients regardless of setting

Recent Lawsuit Against a Hospice

- Whistleblower lawsuit against Alive Hospice – US Attorney investigated
- Alleged that claims to Medicare and TennCare were filed for patients who did not qualify for General Inpatient (GIP) care – 6/01/10-12/31/12
- Hospice disagreed but settled to avoid costly litigation
- Hospice repaid $1,548,220
- Former employee brought claims under whistleblower provisions of the False Claims Act (private citizens with knowledge of false claims can bring civil suits on behalf of the government and share in any recovery)
- Whistleblower will receive $263,197 as her share of the settlement
Current Regulatory Challenges

Diagnosis Reporting – CMS Speaks

- CMS has concerns that hospices are not doing a thorough comprehensive assessment or updating the plan of care as they should.
- As a result, hospices are not recognizing all conditions that affect prognosis and thus are related.
- Coding guidelines require reporting of all diagnoses affecting the management & treatment of patient.
- CMS has made it clear now that hospices must following all coding guidelines.

Determining the Principal Diagnosis

- For hospice, this is the diagnosis most contributory to the terminal prognosis of the individual.
- Do not use nonspecific codes such as debility and AFTT.
- Do not use dementia codes classified as unspecified or which have a "code first" sequencing convention.
- Must code the underlying conditions as the principal diagnosis when guidelines dictate.
  - Example: Code cerebral atherosclerosis and then vascular dementia.
Other Diagnoses
- Code additional diseases and conditions that affect patient care and require clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, or increased nursing care and/or monitoring
- Coding guidelines definition – all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay

Patients Have Many Other Diagnoses
- Per FY 2014 claims data, 49% of hospices list only one diagnosis
- But claims showed that patients have many diagnoses:
  - 50% of patients had 8+ chronic conditions
  - 75% had, on average, 5+ chronic conditions
- Common conditions: hypertension, anemia, CHF, COPD, ischemic heart disease, depression, diabetes and atrial fibrillation, etc.

Must Report ALL Diagnoses
- Effective October 1, 2015, report all diagnoses identified in the initial & comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis
- Must report any mental health disorders and conditions that would affect the plan of care
- Per §418.54(c), initial and comprehensive assessments should identify the diagnoses
- Extensive historical review of past medical records is not needed
- Ensure ongoing review throughout course of care
Decide What to Report

- Report diagnoses that require active intervention or active management of chronic disease, or if continued on chronic management.
- Code chronic diagnoses not under active management when they may have a bearing on the management of the patient.
- CMS wants more data to define hospice patient characteristics to help "inform thoughtful, appropriate, and clinically relevant policy for future rulemaking."
- This additional information can help CMS decide if a case mix payment system is feasible.

ICD-10 Implementation

- Effective October 1.
- Select the appropriate code with specificity – some allowance if in the correct code family.
- Non-specific codes and those in the dementia category should not be used (Refer to CR 8878).
- Requirement applies to dates of service so current patients will need new ICD-10 codes assigned.

Prognosis vs. Diagnosis

- CMS has changed the terminology.
- Must look at the big picture and consider what may affect symptoms and life expectancy.
- Begins at point of referral – must involve hospice medical director.
- Diagnosis, prognosis and relatedness are intertwined.
- Include all diagnoses that will affect the patient.
Relatedness Determinations

- "... since the implementation of the Medicare hospice benefit in 1983, we have stated that it is our general view that hospices are required to provide virtually all the care that is needed by terminally ill individuals and we would expect to see little being provided outside of the benefit."

Documenting Relatedness Decisions

- Define your process for deciding what is related
- Decisions need to be made by the medical director working with the clinical staff
- Management should not make decisions as the emphasis can shift to finances rather than medical necessity and relatedness
- Define the documentation process by the hospice physician

Spending Outside The Medicare Hospice Benefit
CMS Addresses the Spending

- Top diagnoses – Heart failure, COPD, Cerebral degenerations, Senile Conditions, Lung Ca
- “Services clinically indicated” for these conditions, but were billed to other parts of Medicare
- CMS notes this is a “violation of requirements” and they are concerned with “unbundling” of the Medicare hospice benefit
- Cite multiple reasons why this spending may take place: 1) incorrectly classifying conditions as unrelated, 2) Not communicating and coordinating care, 3) Deliberately to avoid costs

FY2013 Non-Hospice Spending

- While a patient was receiving hospice, Medicare made the following payments in addition to payments to hospice:
  - $694.1 million for Part A and Part B items and services
    - 56% of patients were at home
    - 25.7% of patients were in nursing facility
  - $347.1 million for Part D medications

Medicare Part A & B Spending – 2013

- DME – 6.4%
  - Wheelchairs - $2,295,038
  - Hospital Beds - $943,731
  - Oxygen & Supplies - $2,412,281
  - Med/Surgical Supplies - $7,467,616
  - Other Items - $13,985,356
    - Total - $27,104,022
- Inpatient Care – 28.6%
- Outpatient Part B – 16.6%
- Other Part B (MD, Lab, Diagnostics, EMS, etc.) – 38.8%
- Skilled Nursing Facility – 5.3%
- Home Health Care – 4.3%
Medicare Part D Payments

- Concern that hospices are not paying for medications as they should
- $116.48 per admission – national average billed to Part D for drugs which hospice likely should have covered
- NC ranked 20 – $121.53 billed per admission
- SC is ranked 4 – $173.54 billed per admission

Patients Bear the Cost As Well

- In addition to Medicare payments, patients had cost sharing liabilities:
  - $132.5 million for Part A & B
  - $50.9 million for Part D
  - $183.4 million Total
- Medicare + Patient Spending = $1.22 BILLION!
- Signals improper implementation of Medicare Hospice Benefit when patients are paying this much out of pocket

Actions to Address Non-Hospice Spending

- Review internal practices used to determine relatedness – ensure the hospice physician is documenting rationale for anything unrelated
- Review invoices and claims to ensure paying for related items
- Educate other providers on the hospice benefit and how payment works
- Ongoing education to patients and families is required
- Staff need to have ongoing dialogue with patients about medications, MD visits, labs, etc.
Other Areas of Data Analysis
Length of Stay, Live Discharges, Aggregate Cap, and More

Length of Stay – Short & Long
- LOS < 7 days
  - 32.7% National (2013)
  - 36.4% NC (FY2014)
  - 36% SC (CY2014)
- LOS > 180 days
  - 5.2% National (2013)
  - 8.5% NC (FY2014)
  - 8.6% SC (CY2014)

Live Discharges
- Overall rate up nearly 50% from 13.2% in 2000 to 18.3% in 2013
- CMS is concerned that some discharges are inappropriate
- Patterns of discharge, hospitalization, then hospice readmission cause concern – Is hospice trying to avoid paying for costly hospitalizations, procedures, drugs, or services?
  - South Carolina is in top 10 at 29.8%!
CMS Feedback on Live Discharges

- It is not appropriate for hospices to “encourage, request or demand” that the beneficiary revoke
- Discharge cannot occur because care is “costly or inconvenient”
- Revocation must be an informed choice based on patient’s “goals, values and preferences” for services they want

Additional CMS Comments

- CMS questions if revocation and then readmission is a sign that patients are admitted inappropriately or that hospices are not fully explaining the palliative versus curative nature of hospice care
- CMS plans to monitor claims data for “hospice trends and vulnerabilities” to determine if policy changes or additional program integrity measures are needed

Live DC Rates & Aggregate Cap

- Hospices are subject to an aggregate cap each year – $27,820.75 for 2016 – must repay any overpayment
- Higher live discharge rates correlate to the hospice being above the cap
- Hospices with higher live discharge rates make fewer visits per week (3.97 vs. 4.48)
- The case mix is important – must aim to balance short and long stay patients
### Aggregate Cap Overpayments 2013

<table>
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<th>State</th>
<th>Number of Providers</th>
<th>Number With Overpayment</th>
<th>% With Overpayment</th>
<th>Total Overpayment</th>
<th>Average Overpayment</th>
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<td>27</td>
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<td>$615,074</td>
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<td>29%</td>
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<tr>
<td>North Carolina</td>
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<td>2</td>
<td>3%</td>
<td>$45,441</td>
<td>$22,721</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>1,751</strong></td>
<td><strong>229</strong></td>
<td><strong>13%</strong></td>
<td><strong>$100,808,186</strong></td>
<td><strong>$440,210</strong></td>
</tr>
</tbody>
</table>

This data is for the 16 states in the Palmetto GBA region.

### Visits at End of Life – FY2013

- On the day of death, nearly 30% of patients had no skilled visit (nurse or social worker)
- On any given day in last 7 days of life, 46.3% of patients had no skilled visit
- 5% of hospices did not provide skilled visits in the last 2 days to 50+% of patients
- 34 hospices did not make any skilled visits in the last 2 days to any of their patients on RHC

### Service Intensity Add-On Payment

- Effective January 1, 2016, CMS will pay extra to hospices for visits in the last 7 days of life
- Patient must be at Routine Home Care level
- Only visits by a RN or SW are counted toward the SIA payment
- Will pay for up to 4 hours per day
- Reimbursement will be at the continuous home care hourly rate in addition to the RHC rate
Provision of All Levels of Care

- CMS is concerned that hospices are not providing all 4 levels of care
- Particular concerns with those not providing general inpatient care (GIP) or continuous home care (CHC), but also some are not providing inpatient respite care (IRC)
- Survey deficiencies can result as the CoPs address the need for contracts to meet patient needs

Hospices Not Providing GIP Care

- Per OIG study, 953 hospices (27%) did not provide any GIP in 2011
- Of those 953 hospices:
  - 12% provided only routine home care
  - 68% did not provide continuous care
  - 62% did not provide inpatient respite care
- OIG concerned that GIP was less likely to begin on the weekend
- Those using inpatient units were more likely to provide GIP to their patients

Ensure Provision of All Levels of Care

- Additional concerns with no provision of respite or continuous home care services
- If the problem is a lack of contracts for GIP or IRC, document efforts to obtain contracts
- Review eligibility criteria for GIP – want to ensure the patient’s needs warrant GIP but don’t be too restrictive
- Intravenous pain medication is not needed to justify GIP
- Focus on the needs and whether or not they can be managed by the caregivers in another setting or lower level of care
Other Topics

Public Reporting & Hospice Compare

- Hospice Item Set (HIS) data from July 2014 forward is being used to establish validity and reliability
- Plan to use CY 2015 data to decide on what measures to report publicly
- Will create a Hospice Compare web page in the future
- Need to use 2016 to get ready as public reporting is anticipated to begin in 2017

Choice of Attending Physician

- CMS noted concerns with hospices’ actions related to the designated attending physician as follows:
  - Assigning an attending physician based upon whichever hospice physician is available
  - Changing a patient’s attending physician when the patient moves to an inpatient setting for inpatient care, often to a nurse practitioner
  - Not having the attending sign the initial certification which is required for Medicare to cover and pay for hospice services (unless the attending is a nurse practitioner and then the hospice physician signs)
Patient Must Choose the Attending Physician

- The statute emphasizes that the attending physician must be chosen by the patient and not by the hospice.
- Per the CoPs the hospice MD has the responsibility of meeting the patient’s medical needs in the absence of the attending – no need to change the attending MD when the patient is admitted to the hospice facility.
- CMS is reviewing claims to determine if program integrity measures are needed.

Resources

CMS Resources

Data Analysis Resources


Data Analysis Resources

- An Update to Hospice Payment Reform Research (December 2014) – Abt Associates: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Hospice-Project-Background.pdf

The Carolinas Center

The Carolinas Center is the leading voice for quality end of life care in the Carolinas, representing an extensive number of hospice and palliative care providers in North and South Carolina. Since 1977, TCC has provided visionary leadership, pertinent education, technical assistance, advocacy, and resources to end of life care providers across the two states.

800.662.8859
www.cchospice.org