Hospice Regulatory and Quality Reporting Review

Alicia Sterritt, LBSW, MSW
Director of Quality & Compliance
The Carolinas Center

Annette Kiser, MSN, RN, NE-BC, CHC
Chief Compliance Officer
Teleios Collaborative Network

Innovation and Excellence in Advanced Illness at End of Life
43rd Annual Hospice & Palliative Care Conference – September 2019 – Greenville, SC
Focus Areas

• FY 2020 Hospice Final Rule
• Quality Reporting Updates
• OIG Reports
• Survey Areas of Focus
• Federal Audit Update
• Drug Disposal & Prescribing
FY 2020 Final Rule

• Hospice Wage Index Final Rule published 08.06.19 in Federal Register

• Payment Updates
  – Routine Home Care – 2.72% decrease
  – Continuous Home Care, General Inpatient Care, Inpatient Respite Care – 2.6% increase

• Aggregate Cap – $29,964.78
Non-Hospice Spending

- Hospices are not paying for all of the drugs, items and services that they should
- Must consider the cost to patients!
- Presents a financial burden for beneficiaries that is unnecessary in most cases
- Per CMS, “services unrelated to the terminal illness and related conditions should be exceptional, unusual and rare”
Non-Hospice Spending FY17

• Parts A & B
  – Medicare – $566 million
  – Beneficiary Cost-Sharing – $138 million

• Part D
  – Medicare – $380 million
  – Beneficiary Cost-Sharing – $68.6 million
New! OIG Report: Part D Issues

- Medicare paying twice for drugs – hospice per diem and Part D
- Reviewed 200 Part D records and contacted hospice to review payment decisions
- $422.7 million reviewed
  - Estimate that $160.8 million was paid by Part D that hospice should have paid for
  - Remaining $261.9 million reported as not hospice-liable but questionable per OIG
## Why Hospice Didn’t Provide Drugs

<table>
<thead>
<tr>
<th>Reason</th>
<th># of Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had no knowledge the medication was provided by outside MD, filled by outside pharmacy or both</td>
<td>36</td>
</tr>
<tr>
<td>Had no knowledge medication was ordered by nursing home staff and filled by outside pharmacy</td>
<td>13</td>
</tr>
<tr>
<td>Miscoded as non-covered</td>
<td>11</td>
</tr>
<tr>
<td>Dispensed close to admission so the election was not in Part D’s system</td>
<td>7</td>
</tr>
<tr>
<td>Pharmacy that dispensed the drug was aware of hospice but billed in error</td>
<td>6</td>
</tr>
<tr>
<td>Thought a third party was paying or they would have covered</td>
<td>1</td>
</tr>
</tbody>
</table>
Non-Hospice Spending Issues

• Patients not informed up front by hospice of noncovered items, drugs, or services
• Patients and families report items not covered that they think are related
• Non-hospice providers report lack of hospice response to questions on relatedness
Non-Hospice Spending Examples

• Diabetic test strips for CHF patient
• Seated walker for patient with lung cancer
• Benign prostatic hypertrophy (BPH) medication with diagnosis of sepsis due to UTI
• Palliative radiation or chemo for symptom management
• Palliative blood transfusions
Election Statement Revisions

• Must amend Election Statement effective October 1, 2020

• 418.24(b) Content of Election Statement
  – (2) The individual's or representative’s acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness and related conditions.
— (3) Acknowledgement that the individual has been provided information on the hospice’s coverage responsibility

— Includes providing the patient with information indicating that services unrelated to the terminal illness and related conditions are “exceptional and unusual” and hospice should be providing virtually all care needed by the individual who has elected hospice
Election Statement Changes

– (5) Information on individual cost-sharing
– (6) Notification of the patient’s right to receive an election statement addendum if there are items determined to be unrelated that would not be covered by hospice
– (7) Must provide information on the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), including the right to immediate advocacy and BFCC-QIO contact information
Addendum to Election Statement

• Effective October 1, 2020
• To be titled “Patient Notification of Hospice Non-Covered Items, Services, and Drugs”
• Is a condition of payment so this can have an impact during audits
• Not required to be given to all patients
• Provided upon request to patients or non-hospice providers
Providing Addendum

- If requested at admission – 5 days
- If requested after start of care – within 72 hrs.
- Acknowledgement – Must have signature of patient or representative
Items for the Addendum

• Diagnoses and conditions present on admission, or with plan of care update if later
• List of what is NOT covered by hospice because it is deemed unrelated to terminal illness and related conditions
• Written clinical explanation in simple language
  – Why unrelated?
  – Why not needed for pain or symptom management
More Items for Addendum

• Statement that
  – Relatedness decisions are made for each patient
  – The patient should share the clinical explanation with other health care providers for unrelated care
  – That signature does not equal agreement, only acknowledgement of receipt

• References to any relevant clinical practice, policy, or coverage guidelines

• Information on the purpose of the addendum and right to immediate advocacy
Addendum to Other Providers

• CoPs require sharing of information with other non-hospice healthcare providers and suppliers furnishing unrelated services [§418.56(e)(5)]

• Must be able to provide documentation listing the conditions (and thus items, drugs, and services) determined to be unrelated and documented as such on the hospice plan of care
QUALITY REPORTING UPDATES
Reminder

Hospice Quality Reporting =
1. Hospice Item Set, AND
2. CAHPS Survey (Consumer Assessment of Healthcare Providers and Systems)

Compliance with BOTH must be fully met to meet HQRP requirements and avoid payment penalty

*No new measures this year
Goal is to identify measures that

• Provide a window into Hospice care throughout the dying process
• Fit well with the Hospice business model
• Meet the objectives of the Meaningful Measures Initiative
CMS Meaningful Measures (MM) Initiative

• Framework with 19 Meaningful Measure areas organized into specific, overarching healthcare quality priorities
• Identifies high priority areas for quality measurement and improvement
• Not intended to replace existing quality measures
• Intended to increase measure alignment across the health care provider field
Claims Based Measures

• Acknowledge there are some limitations of using claims data

• Outline many advantages to using claims data for quality measurement
  – No additional data collection and data submission
  – The universe of claims creates an abundant and standardized source of patient information
  – Claims data is widely available, relatively inexpensive, and amenable to analysis due to the electronic format
Hospice Outcomes and Patient Evaluation (HOPE) Tool

CMS Goal: A hospice assessment tool that is more comprehensive than the HIS by capturing care needs in real-time and throughout the end of life; not just at admission and discharge. This includes flexibility to accommodate patients with varying lengths of stay.
• Comprehensive assessment instrument for hospice care to align with other post acute care settings, where feasible and practical.

• Objectives:
  – Establish goals of care that embrace the individual’s values and preferences, consistent with a person-centered approach
  – Values the person and caregiver
  – Emphasis on physical, psychosocial, spiritual, and emotional support
HOPE Tool Development

• CMS will continue to engage stakeholders through a variety of methods – calls, webinars, Open Door Forums, etc.

• SODF: Developing a Hospice Patient Assessment Tool, now called Hospice Outcomes & Patient Evaluation (HOPE) Tool - Status Update
  – Thursday, September 12, 2019 from 2:00pm – 3:00pm Eastern Time
  – To participate, dial: 1-888-455-1397 & Conference ID: 4676500
Review & Correct Reports

• New this year (April 2019)
• Provides hospice agencies an opportunity to ensure the accuracy of their data
• Allows providers to track quarterly data cumulatively
• Includes data from the most current quarter “open” for data correction
• Includes data from previous three quarters “closed” for data correction (frozen data)
SURVEYS, AUDITS, AND INVESTIGATIONS!
OIG Reports

• Hospice Deficiencies Pose Risks to Beneficiaries (OEI-02-17-00020) July 2019
• Safeguards Must Be Strengthened (OEI-02-17-00021) July 2019
• Medicare Part D is Still Paying Millions for Drugs (A-06-17-08004) August 2019
Deficiencies Pose Risks

• OIG reviewed survey deficiency and complaint data from 2012 – 2016
• Analyzed accreditation organizations and State agency reports
• Over 80% had at least 1 deficiency; 20% had a serious deficiency
• Most common – Poor care planning, mismanagement of aide services, inadequate assessments
Safeguards Must Be Strengthened

• Reviewed 50 serious survey deficiencies from 2016
• Focused on 12 with beneficiary harm
• These do not represent most hospices
• Major issues
  – Poor care by hospices
  – Inaction by hospice when caregiver/other abusing patients
Top Survey Deficiencies

• 418.56(b) Plan of Care – #1 for 4 of 5 years
• 418.54(c)(6) Drug Profile
• 418.76(h) Aide Supervision
• 418.56(c) Content of Plan of Care
• 418.56(c)(2) Content of Plan of Care
• Taking a “See one, cite one” approach
Plan of Care Issues

• **Lack of individualized** written plan of care
  – Generalized end of life goal without addressing the patient’s specific needs
  • Be careful with generic care plans that try to encompass all needs in one overarching goal statement
  • If using a single goal for short-stay patients, must have individualized interventions
Plan of Care Issues

– Visit frequencies too broad such as when written for full benefit period
  • If frequent PRN visits are needed, POC should be updated

– Need for information on grief support noted but no evidence of follow up
  • Ensure good communication of follow up
Drug Profile

• Deficiency examples
  – Patient reported using Maalox OTC – Not on profile
  – Hydrocodone/APAP ordered – Allergy to acetaminophen listed
  – Nurse didn’t have smooth system for reconciliation during home visit
  – Lack of evidence of education on side effects of new medication

• Medication reconciliation must occur each visit
• Document all teaching – dosage, side effects, interactions, when to call RN
Aide Supervision

• Supervisory visits were documented at greater intervals – 15 days, 18 days, or more
  – Require weekly supervision documentation

• LPN documented aide supervision
  – Ensure LPN scope of practice is clear

• No documented supervision of contract aides
  – Educate RNs that they are responsible for supervision of all staff – employed or contracted
Other Areas of Focus

- 418.60(a) Infection Control Prevention
- 418.78(e) Volunteer Level of Activity
- 418.54(c)(7) Bereavement Assessment
- 418.54(b) Timeframe for Completion of Comprehensive Assessment
- 418.56(e)(2) Coordination of Services
Survey – Discharge for Cause

• **New!** Medicare Surveys conducted in North Carolina on patients discharged for cause
• May happen in other states due to CMS triage criteria which includes instructions for frequency
• Managed and recorded as complaint surveys even though there was no complaint filed by the patient or family
• Survey agency can ask CMS permission to survey a deemed status agency
Survey – Discharge for Cause

• Review to determine if hospice is handling these correctly
  – Triage based on the information given by the hospice and look at the agency’s history
    • Any other complaints in this area?
    • What were the facts surrounding the discharge?
  – Survey for the following:
    • Regulatory compliance
    • Determine if patient rights are respected
    • Assess efforts to resolve problems
    • Ensure coordination with IDG

Innovation and Excellence in Advanced Illness at End of Life
SMRC Audits

• Supplemental Medical Review Contractor – Noridian Healthcare Solutions

• Have 2 current hospice projects posted
  – 01-009 General Inpatient Hospice Notification of Medical Review – GIP in Any Setting
  – 01-013 Hospice Portfolio Notification of Medical Review – Phase 1, GIP in SNF

• Audit 20 records – typically from 2018

• Must submit records within 45 days including those from outside providers such as SNF
Palmetto GBA issued a Comparative Billing Report (CBR) on General Inpatient Care

Focus: Hospices whose ALOS was greater than their peers

- NC State average = 5.4 days
- All Jurisdiction M = 4.9 days

Those greater than 8 days received direct education via phone call with Palmetto GBA

CBR is an educational tool that signifies the hospice needs to take action
Actions to Take for GIP

• Review agency LOS for GIP
  – Look at PEPPER for past few years
  – Run numbers by setting of care on regular basis

• Audit records in all settings
  – Does all documentation support GIP every day?
  – SNF – Is there a note every shift by an RN to show direct patient care?
  – Is there documentation of education, care coordination, discharge planning?
Actions to Take for Long LOS

• Run a report of average length of stay
  – Deaths and discharges
  – Living patients currently on census

• Audit records to ensure eligibility is supported
  – All disciplines’ notes need to align
  – Scoring tools need to be used consistently

• Educate staff on quality documentation to support the right care at the right time

• Require more than one MD or leader to review at recertification if any question
Audit Update: TPE

• Targeted Probe and Educate (TPE)
• TPE is the new medical review process now used by all Medicare Administrative Contractors (MACs) such as Palmetto GBA, the MAC for our region
• Will focus only on providers who have the highest claim error rates or billing practices that vary significantly from their peers
Audit Update: TPE

Current TPE medical reviews for Hospice:

• Inpatient Hospice (GIP) greater than 72 hours
  – Recently added

• Non-Cancer Diseases of the Nervous System
  – 400 Hospice providers that were outliers were identified early 2019 and moved into TPE during 2019 and early 2020.
# TPE Denials

April-June 2019 for 81X Bill Type Denials
Total Denials = 117

<table>
<thead>
<tr>
<th>Rank</th>
<th>Denial Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Not Hospice Appropriate</td>
</tr>
<tr>
<td>2</td>
<td>Physician Narrative Statement Not Present or Not Valid</td>
</tr>
<tr>
<td>3</td>
<td>Auto Denial – Requested Records Not Submitted</td>
</tr>
<tr>
<td>4</td>
<td>Notice of Election Is Invalid – Doesn’t meet statutory / regulatory requirement</td>
</tr>
<tr>
<td>5</td>
<td>Face to Face Encounter Requirements Not Met</td>
</tr>
</tbody>
</table>
DRUG DISPOSAL & PRESCRIBING — FEDERAL AND STATE
Establishment of Physician-Patient Relationship as Prerequisite to Prescribing Drugs

- A licensee may prescribe for a patient whom the licensee has not personally examined under certain circumstances including, but not limited to:
  - Writing admission orders for a newly hospitalized patient
  - Prescribing for a patient of another licensee for whom the prescriber is taking call
  - Prescribing for a patient examined by a licensed advanced practice registered nurse, a physician assistant, or other physician extender authorized by law and supervised by the physician
• Physician who is an employee of, or under contract with the hospice may prescribe up to a 14-day supply of medications for Hospice patient...
  – For the purpose of controlling symptoms prior to establishing a traditional patient-physician relationship by a direct physical examination.
  – Visit is then required
Quality Hospice Programs Act Drug Disposal Amendment, Section 44-71-85

• Upon patient’s death if receiving outpatient services, ownership of unused controlled substances transfers to the hospice for immediate disposal.
• Must have written procedure to ensure safe disposal
• Must dispose in the presence of a witness who shall sign a document indicating their witnessing of the disposal
• Nurse must document in the medical record the name and quantity of each unused controlled substance.

• Alternate Method: Immediate mail-back to a collector registered pursuant to 21 CFR Section 1317.40

• A hospice facility is a 'long-term care facility' as defined by 21 CFR Section 1300.01 for the purpose of disposal of unused medications
Prescription Monitoring Databases

- Most states have a statewide prescription monitoring program database
- Hospices need to be proactive and check the database to show due diligence
- Should always be reviewed when there is suspected misuse of opioids or benzodiazepines by the patient or family
- Most states allow a nurse to be delegated by the physician to do the checks
NC Prerequisite to Prescribing

Contact with Patients before Prescribing

• Prescribing drugs to an individual the prescriber has not examined to the extent necessary for an accurate diagnosis is inappropriate except as noted on next slide.

• Ordinarily, this will require an appropriate H&P and formulation of a therapeutic plan which must be documented appropriately.

• No time frame provided for visit
Contact with Patients before Prescribing (cont.)

• Prescribing for a patient whom the licensee has not personally examined may be suitable under certain circumstances:
  – Admission orders for a newly hospitalized patient
  – Interim orders or prescriptions, including pain management, from a hospice physician for a hospice patient
  – Prescribing for a patient of another licensee for whom the prescriber is taking call
  – Continuing medication on a short-term basis for a new patient prior to the patient’s first appointment
  – An appropriate prescription in a telemedicine encounter where the threshold information to make an accurate diagnosis has been obtained
NC STOP Act Review

- Electronic Prescribing is effective January 1, 2020
- Practitioners must electronically prescribe for all targeted controlled substances – Schedule II and III opioids and narcotics per the North Carolina Controlled Substances Act
- This provision does not apply to the following practitioners:
  - When dispensing directly to an ultimate user
  - When ordering for administration in facilities including a hospice facility
  - If experiencing temporary technological or electrical failure or other extenuating circumstances that prevent electronic transmission
- Must document the reason for this exception within a patient’s medical record
- When writing a prescription to be dispensed by a pharmacy located on federal property
NC Drug Disposal Review

- No state drug disposal rules for Hospices so defer to federal regs
- SUPPORT Act, major legislation aimed at addressing the opioid epidemic, became law in late 2018
- Includes a provision to amend the Controlled Substances Act (CSA) to permit, but not require, hospices to develop policies and procedures to allow certain hospice employees to assist with controlled substance disposal onsite under certain circumstances without being DEA registrants.
- Hospice employees – not subject to the rules applicable to DEA registrants
Federal Drug Disposal Review

• No specific guidance from DEA and CMS
• Hospices can decide to comply with SUPPORT Act provisions, or continue to instruct patients and families on methods of disposal
• If the employee is the patient’s physician and DEA registrant, may dispose of the drugs onsite when a controlled substance is no longer needed because the patient’s plan of care is modified
Federal Drug Disposal Review

• Allows physicians, PAs, NPs, and nurses who are employed by (or in the case of physicians, under contract with) the hospice to assist with disposal if:
  – Acting within the scope of their employment
  – Have completed hospice program training regarding disposal of controlled substances in a secure and responsible manner.

• Above employees may handle controlled substances for the purpose of onsite disposal after the death of a hospice patient, or if the drug has expired.
EPA New Rules

• Environmental Protection Agency “Standards for the Management of Specific Hazardous Wastes and Specific Types of Hazardous Waste Management Facilities”

• Applies to Long-Term Care Facilities and includes Hospice facilities

• Is not applicable to “in-home” care
EPA New Rules

• Prohibits all facilities (subject to the rule) from sewering hazardous waste pharmaceuticals

• “This action will help address the issue of pharmaceuticals in drinking and surface waters as well as their negative impacts to aquatic and riparian ecosystem.”

• Hospice facilities must ensure they have proper disposal methods.
EPA New Rules

• FDA-approved over-the-counter nicotine replacement therapies will no longer be included under the listing for hazardous waste
  – Nicotine patches, gums and lozenges can be discarded as nonhazardous waste
HQRPM Resources


Resources


• SMRC Auditor: https://www.noridiansmrc.com/current-projects/

• Palmetto GBA Medical Reviews: https://www.palmettogba.com/palmetto/providers.nsf/docscat/Providers~JM%20Home%20Health%20and%20Hospice~Medical%20Review~Medical%20Review%20Denials
Resources

• OIG Report – Hospice Deficiencies Pose Risks to Medicare Beneficiaries: [https://oig.hhs.gov/oei/reports/oei-02-17-00020.asp](https://oig.hhs.gov/oei/reports/oei-02-17-00020.asp)

• OIG Report – Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm: [https://oig.hhs.gov/oei/reports/oei-02-17-00021.asp](https://oig.hhs.gov/oei/reports/oei-02-17-00021.asp)

Medical Board Resources

• SC Medical Board Policies: https://llr.sc.gov/med/MDDOPolicies.aspx

• NC Medical Board Position Statements: https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements
State & Federal Resources

- SC Quality Hospice Programs Act: https://www.scstatehouse.gov/code/t44c071.php
Alicia Sterritt – asterritt@cchospice.org
www.cchospice.org