Federal Issues Update on Hospice and Palliative Care

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Payment Rates and Aggregate Cap

FY2018 Hospice Payment Update

Code/Description	FY2017 Rate	Final FY2018 Rate
651/Routine Home Care days 1 - 60	$ 190.55	$192.78
651/Routine Home Care days 61+	$ 149.82	$151.41
Rates NOT adjusted for wage index, sequester or failure to meet HQRP requirements		

FY2018 Hospice Payment Update

Code/Description	FY2017 Rate	FY2018 Rate
652 -- Continuous Home Care (hourly rate for SIA)	$964.63 ($40.19/hour)	$976.42 ($40.68/hr.)
655 -- Inpatient Respite	$170.97	$172.78
656 -- General Inpatient Care	$734.94	$743.55
Rates are not adjusted for wage index, sequester or failure to meet HQRP requirements		

Revised Cost Report Data

Freestanding hospices – cost reporting periods in FY 2015

Substantial variation in the reported cost per day

“Any interpretations regarding overall alignment between costs and payment would likely be premature”

Hospice Cost Report Data Analysis

Total Cost Per Day by Level of Care FY2015

	Median Cost	Weighted Mean Cost	Rate
Routine Home Care	$125	$123	$159.34
Continuous Home Care (hourly)	$51	$49	$38.75
Inpatient Respite	$343	$467	$164.81
General Inpatient Care	$879	$792	$708.77

Aggregate Cap

Aggregate Cap

- 2017 cap amount: $ 28,404.99
- 2018 cap amount: $ 28,689.04

Transition cap year to federal fiscal year effective with 2017 cap year*

- 2017 cap to be self- reported by **February 28, 2018**

*finalized in FY2016 Hospice Final Rule

Aggregate Cap Accounting Year Transition Time Frames

	Streamlined		Patient-by-patient (Proportional)	
	Patients	**Payments**	**Patients**	**Payments**
2016	9/28/15-9/27/16	11/1/15-10/31/16	11/1/15-10/31/16	11/1/15-10/31/16
2017	9/28/16-9/30/17	11/1/16-9/30/17	11/1/16-9/30/17	11/1/16-9/30/17
2018	10/1/17-9/30/18	10/1/17-9/30/18	10/1/17-9/30/18	10/1/17-9/30/18

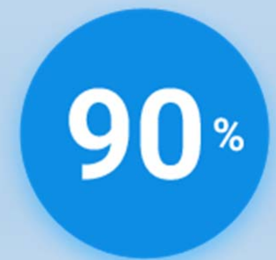
Hospice Quality Reporting Program

HQRP – HIS Submission Requirements

Third year of tiered submission requirements

January 1, 2018 – December 31, 2018

- HIS – Admission and HIS – Discharge must be submitted within 30 days of the applicable event
- Penalty – 2% APU reduction for FY2020
- Timeliness Compliance Threshold Report



HQRP - Measures

- Two new measures added FY2017
  - Hospice Visits When Death is Imminent (paired measure)
  - Composite Process Measure

- National Quality Forum (NQF) status
  - CMS has submitted the Composite Process Measure for approval
  - CMS will submit the Paired Measure after data analyses

HQRP - Measures

- No new measures
- No removed measures
- Measure concepts under consideration
  - **Potentially avoidable hospice care transitions**
  - **Access to levels of hospice care**

Would be claims based

CMS SOLICITED COMMENTS

HQRP – CAHPS Hospice Survey

PROPOSED and FINALIZED:

- Adopt eight survey-based measures for CY 2018
  - six composite measures
  - two global measures

    These measures have already been endorsed for rulemaking by the NQF

- A hospice's CAHPS Survey scores be displayed as "top box" scores
  - Proportion of respondents that endorse the most positive response(s) to the question

HQRP - CAHPS Hospice Survey PROPOSED and FINALIZED MEASURES

Six Composite Measures

- Hospice Team Communication
- Getting Timely Care
- Treating Family Member with Respect
- Getting Emotional and Religious Support
- Getting Help for Symptoms; and
- Getting Hospice Care Training

Two Global Measures

- Rating of Hospice
- Willingness to Recommend Hospice

HQRP – Comprehensive Patient Assessment Instrument

- HEART – Hospice Evaluation & Assessment Reporting Tool
- CMS currently in early stages of development of comprehensive patient assessment instrument tool
- Tool would serve two primary objectives
  - provide the quality data necessary for HQRP requirements and the current function of the HIS; and
  - provide additional clinical data that could inform future payment refinements

HQRP – Comprehensive Patient Assessment Instrument

- HEART
    - Would replace HIS
    - Would NOT replace current assessment requirements
    - Would be completed at
        - Admission
        - Discharge
        - Intervals in between, possibly

HQRP – Public Reporting

- Began August 2017
  - Includes all seven HIS measures
  - Does not include CAHPS Hospice Survey measures until 2018
    - Winter 2018
    - All eight measures
- HIS results based on rolling 12-month period
  - Will exclude data for measures with less than 20 eligible patient “stays”
- CAHPS Hospice Survey results will be based on 8 rolling quarters

HQRP – Public Reporting

Five Star Rating

- Will be part of the HQRP
- historically implemented approximately one year after Compare site
- hospice may take longer

CMS Concerns – Certification of Terminal Illness

Sources of Clinical Information

- The hospice is to admit a patient only upon the recommendation of the medical director in consultation, or with input from, the attending physician (if any)
- Current requirement is that medical director must consider at least the following
  - Diagnosis of the terminal condition
  - Other health conditions, related or unrelated
  - Current clinically relevant info supporting all diagnoses

Sources of Clinical Information

CMS SOUGHT COMMENT:

- Amending regulations at 418.25 to specify that the referring physician's and/or the acute/post acute care facility's medical record would serve as the basis for initial hospice eligibility determinations
- Amending the regulations text at §418.25 to specify that documentation of an in-person visit from the hospice Medical Director or the hospice physician member of the interdisciplinary group could be used as documentation to support initial hospice eligibility determinations, only if needed to augment the clinical information from the referring physician/facility's medical records
- Comments on current processes used by hospices to ensure comprehensive clinical review to support certification and any alternate suggestions for supporting clinical documentation sources

Sources of Clinical Information

- Physician or facility record for source of clinical information
  - Would be obtained prior to election and subsequent recertifications

"Fundamentally, could not be determined by hospice documentation obtained after admission"

Sources of Clinical Information

CMS will be working with MACs to confirm if they are requesting comprehensive clinical information as part of medical review

If not – should such information be included in the ADRs

Summary of CMS Monitoring

CMS Monitoring - Data

- Length of stay
- Days of hospice care by level of care and site of service
- Live discharges
- Skilled visits in last days of life
- Non-hospice spending
- Revised cost report data

Length of Stay

	Average LOS	Median LOS	Average Lifetime LOS
FY 2015 Chronic/progressive neurological disease – RHC Cancer	78 days	Not available	95.2 days 165.3 63.7
FY 2016	79 days	18 days	96.1 days

Days of Care by Level of Care/Site of Service

- No surprises
- Medicare days are 98% RHC
  - Patient's home: 56%
  - Nursing home or ALF: 41%

Live Discharges

Overall decreasing trend of 22.8% between FY2007 and FY2016

- Timing
  - 26% within 30 days of start of hospice care
  - 13% between 31-60 days
  - 14% between 61-90
  - 19% between 91-180
  - 28% after 180 days
- Seventeen percent of all discharges were live discharges
  - revocations 38%
  - discharges due to no longer terminally ill 51%
  - transfers 11%

Skilled Visits in Last Days of Life

- Monitoring especially since implementation of payment reforms and changes to the HQRP
- No immediate concerns – will continue to monitor
- Hours of care in final days of life stable at 1.6
- Incremental improvement in FY2016 compared to FY2014
  - 44% of patients did not receive RN or MSW visit during last seven days
  - 21% of patients did not receive RN or MSW visits on last day of life

Non- hospice Spending

- Analysis suggests unbundling of items and services that perhaps could have been provided and covered under the Medicare hospice benefit
- Decreases have occurred each year since reporting began
  - Overall decrease of 25% from FY2012 to FY2016
  - Will continue to monitor
  - *Increase in Part D spending*

Non-hospice Spending – Part D

- Increase of $33M between FY2015 and FY2016
- PA process has reduced payments in the four targeted categories

Analgesics	Anti-nauseants
Anti-anxiety	Laxatives

- BUT INCREASE in Part D spending on maintenance drugs
  - Medications for heart disease, high blood pressure, asthma, diabetes
  - Beta blockers, calcium channel blockers, corticosteroids and insulin

Regulatory Update

NOE Update

- Overall intent: beneficiary status information to CWF faster
- CMS updates NOE exceptions / MACs update NOE job aid
- CR 10064 – electronic submission

http://www.palmettogba.com/Palmetto/Providers.Nsf/files/Notice_of_Election_(NOE)_Timely_Filing_and_Exceptional_Circumstance_Guidelines.pdf/$File/Notice_of_Election_(NOE)_Timely_Filing_and_Exceptional_Circumstance_Guidelines.pdf

MedPAC

- Beneficiary participation growing
- Margins for 2017 estimated at 7.7%
- Live discharge rate dropped 1.7% between 2013 and 2015

Recommendations

- NO UPDATE for FY2018

Anticipate future discussion of hospice in <u>nursing</u> <u>facilities</u>

Hospice & Managed Care

- 2014 MedPAC recommendation – bring hospice under MA bundle of services
- Currently sets with Senate Finance Committee – Chronic Care Work Group
- Same benefit "bundle" as under FFS
- Potential impact:
  - Insufficient payment
  - Selective contracting (no consumer choice)
  - Copays for patients

Vulnerability
Just Ahead

OIG Reports/Activities

- Eligibility
- Election statements and CTIs
- GIP
- Qualified personnel requirements
  - Criminal background checks
  - Professional licensing
  - State required health assessments and testing

Technical Reports

- Live discharges
- Long lengths of stay
- Use (or lack thereof) of GIP, CC and respite
- Skilled visits in last days of life
- Spending outside of the hospice benefit

PEPPER - Target Areas

- Live Discharges Not Terminally Ill
- Live Discharges – Revocations
- Live Discharges LOS 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
- Claims with Single Diagnosis Coded
- Episodes with no GIP or CHC
- Long GIP Stays

MedPAC and MACs

- Medical review of long stay patients for hospices with a high proportion of long stay patients
- Long lengths of stay
- Hospice claims where an ABN was given
- GIP
- Previous denials for selected beneficiary
- Certain diagnoses codes
- New hospices

Key Vulnerabilities

- Eligibility and Technical Requirements
  - for the hospice benefit
  - levels of care
- Spending outside the hospice benefit
- Personnel requirements
- Site of Service/Marketing and relationships

*60 day return of self-identified overpayments

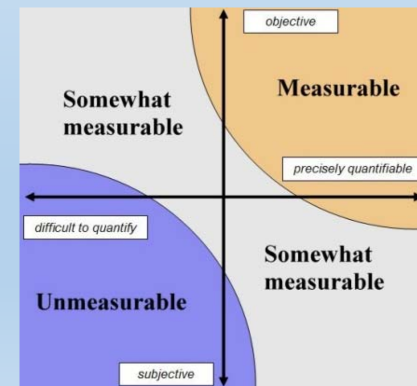
Eligibility

- LCD vs. prognosis

- Physician reviews clinical information and hospice assessments

Eligibility - Common Problems

- Terminal condition not supported
  - Lack of consistent, objective data
  - Lack of comparison
  - Karnofsky/PPS not supported by other documentation
  - Incorrect use of scales/screening tools
    - FAST
    - PPS, etc.



Site of Service/Marketing and Relationships

- Education
- Legal review of bonus structures and marketing practices
- Audits
  - Eligibility
  - Level of care
  - Marketer reports and activities
  - Contracts

Spending Outside the Hospice Benefit

- The hospice is responsible for providing any and all services indicated in the plan of care as necessary for the palliation and management of the terminal illness and related conditions.

- Services must be consistent with the plan of care and reasonable and necessary for the palliation or management of the terminal illness and related conditions

Relatedness

A condition must be completely unrelated to the terminal illness/related conditions in order for Medicare to cover it outside of the Hospice Benefit

Palliative Care

Business Perspective

- Diversification
- Alignment
- Continuity of care

Rules and Regulations

Not a Medicare or Medicaid defined benefit

No conditions of participation

Conditions for payment?

Rules and Regulations

- Medicare and Medicaid billing requirements
- Medicare Part B – Physician Fee Schedule
  - Coding
  - Documentation
  - Record keeping
- Federal False Claims Act

Rules and Regulations

- PQRS eligible professionals
  - Physicians
  - NP
  - PA

Rules and Regulations

- Anti-kickback
- Stark
- HIPAA Privacy and Security
- State-specific
  - POLST (P.L. 2011, c. 145)

Guidelines and Standards

- Accrediting organization certification standards
- OIG compliance guidance
- Advance care planning conversation model

Legislation

- New York-specific – Palliative Care Information Act
- Palliative Care and Hospice Education and Training Act (PCHETA)
  - **H.R.1676 — 115th Congress (2017-2018)**
  - Require the Department of Health and Human Services (HHS) to provide support for Palliative Care and Hospice Education Centers. These centers must improve the training of health professionals in palliative care and establish traineeships for individuals preparing for advanced education nursing degrees, social work degrees, or advanced degrees in physician assistant studies in palliative care.

Discussion of Various Models

- Inpatient - Outpatient
- Physician led – NP led – Other discipline
- Volunteer only
- Disease management
- Case management
- Hospice and home health

Next Steps

- Strategic assessment
- What type, if any, palliative care program meets
  - Patient/client needs
  - Goals of the organization
  - Resources of the organization

CONCLUSIONS
A.
B.
C.

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