Hot Regulatory Topics

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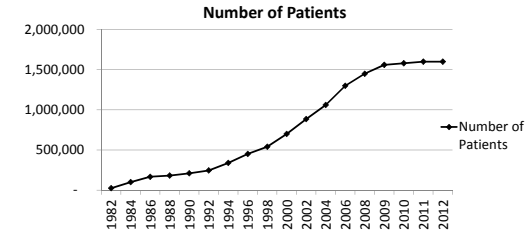
Session topics

- Hospice Data – shaping the discussion
- Compliance Deadlines in 2014
- Medicare Care Choices Model
- Pharmacy Issues
- OIG Work Plan
- Additional Data Collection – CR8358
- Cost Report
- Survey Deficiencies 2013
- New Proposed CoP: Emergency Preparedness
- Fraud and Abuse Activity
- Hospice Payment Reform
- Resources
- Questions and Answers

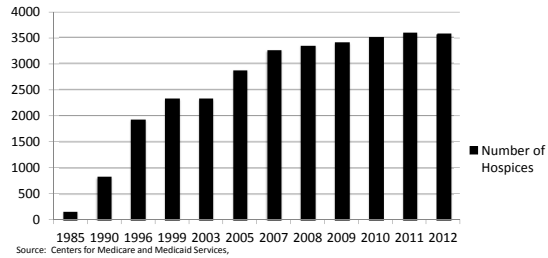
Hospice Data – Shaping the Discussion

Patients Served by Hospice in the US 1982-2012



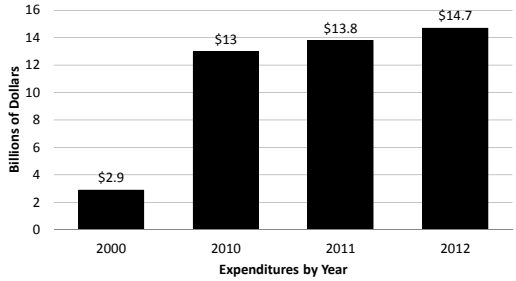
Source: National Hospice and Palliative Care Organization, 2013

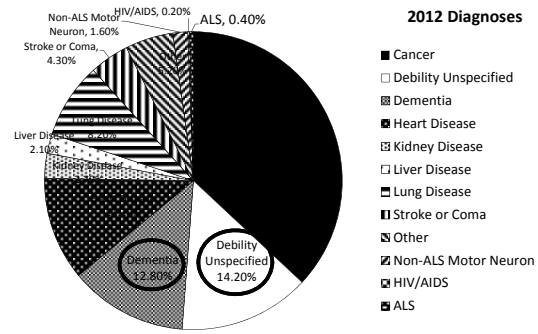
Number of Medicare Certified Hospices



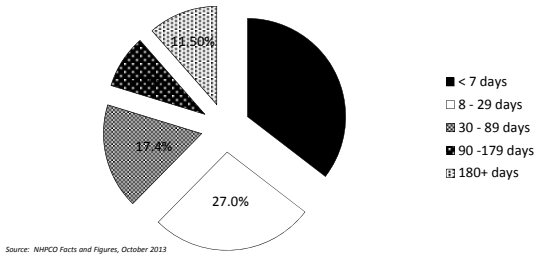
Source: Centers for Medicare and Medicaid Services,
2011 Data Compendium and CMS Final FY2014 Wage Index Rule

Total Medicare Spending on Hospice





Proportion of Patients by Length of Service - 2012

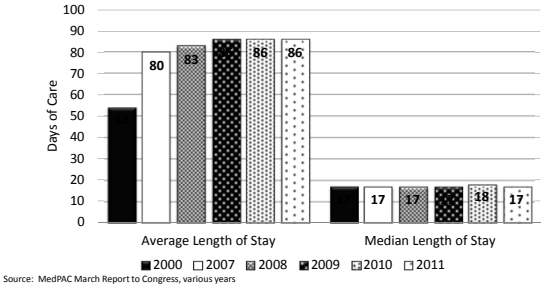


Source: NHPCO Facts and Figures, October 2013

Percentage of days by level of care

Level of Care	Percentage of total days
Routine Home Care	97.3%
General Inpatient	2.0%
Continuous Home Care	0.5%
Inpatient respite	0.2%

Length of Service in Hospice



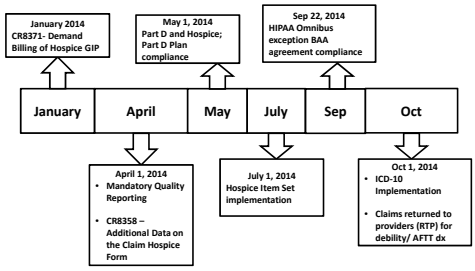
Source: MedPAC March Report to Congress, various years

Policy maker questions

- Are patients being admitted "too soon?"
- Data shows that there are more patients with much longer lengths of stay -- > 180 days.
- What about short stays? What are the reasons for a short stay?
- Why would some hospices have large numbers of live discharges? Does this indicate other problems?

Compliance Deadlines in 2014

Compliance Deadlines in 2014



Medicare Care Choices Model

ACA Provision: Concurrent Care Demonstration Project

Medicare Care Choices Model Background

- Will test whether Medicare beneficiaries who qualify for coverage under the Medicare hospice benefit would elect to receive the palliative and supportive care services typically provided by a hospice if they could continue to seek services from their curative care providers.

Questions CMS Hopes to Answer

- Will access to such services result in:
  - improved quality of care and
  - patient and family satisfaction
- Are there any effects on use of curative services and the Medicare hospice benefit?

Target Patient Population

- Medicare beneficiaries who are:
  - eligible for the Medicare Hospice Benefit
  - dual eligible beneficiaries who are enrolled in traditional Medicare and eligible for the Medicaid hospice benefit.
- Beneficiaries must not:
  - have elected the Medicare or Medicaid Hospice Benefit (or the Medicaid hospice benefit) within the last 30 days prior to participating in the model
- Beneficiaries must satisfy all the eligibility criteria listed in the Request for Applications

Diagnoses Included

- Participation limited to beneficiaries with:
  - advanced cancers
  - chronic obstructive pulmonary disease (COPD)
  - congestive heart failure
  - HIV/AIDS

Sites and Enrollment

- At least 30 rural and urban Medicare certified and enrolled hospices
- Sites must have demonstrated experience with an established network of providers for referrals to hospice
- Preference will be given to hospices that can demonstrate experience in developing, reporting, and analyzing quality assurance and performance improvement data
- Expected enrollment of 30,000 beneficiaries during 3-year period.

Payment Model

- Participating hospices will provide services available under the Medicare hospice benefit for routine home care and inpatient respite levels of care that cannot be separately billed under Medicare Parts A, B, and D
- Available 24/7, 365 calendar days per year
- CMS will pay a $400 per beneficiary per month fee for these services
- Providers and suppliers furnishing curative services to beneficiaries participating in Medicare Care Choices Model will be able to continue to bill Medicare for the reasonable and necessary services they furnish

Application Process

- Must be a Medicare certified and enrolled hospice
- CMS seeking diverse applicants representing
  - various geographic areas
  - urban and rural
  - varying sizes
- Experience providing coordination and/or case management services
- Experience assisting beneficiaries with shared decision-making prior to electing the Medicare hospice benefit in conjunction with their referring providers/suppliers

Due Date

- Applications due no later than:

June 19, 2014

Link for More Information and RFP

Medicare Care Choices Model

http://innovation.cms.gov/initiatives/Medicare-Care-Choices/

Pharmacy Issues

Part D and Hospice

- OIG report issued in 2012
- Ongoing and intense discussions about the "intersection between Part D and hospice" with CMS Part D and CMS Part A since summer 2013
- Draft guidance issued December 6 2013
- Final guidance issued by CMS on March 10 2014
- Implement by date:

May 1, 2014

Current Part D Activity

- **Recoupment**
  - Pharmacies instructed to recoup $$ spent on analgesics if the patient had elected hospice
  - No opportunity to submit information about relatedness
  - Applies to 2011 and 2012 only
  - Effective September 24 2013

Four Buckets of Relatedness

Part D and Hospice Final Guidance

- **Four Buckets**
  - **Related to terminal illness**
    - Hospice pays
  - **Related to terminal illness but no longer medically necessary**
    - Patient pays
  - **Unrelated to terminal illness and documented by hospice physician as unrelated**
    - Prior authorization submitted to Part D
    - Part D pays
  - **Unrelated but no longer medically necessary**
    - Not covered by hospice
    - Not covered by Part D
    - Could be paid for by the patient

Prior Authorization Process

- Part D sponsor receives a pharmacy claim for a beneficiary who has elected hospice
- Part D rejects the claim with standardized reject coding
- Code states “Hospice Provider- Request Prior Authorization for Part D Drug Unrelated to the Terminal Illness or Related Conditions”
- Pharmacy receives the rejection along with a **24-hour pharmacy help desk phone number to call with questions**

Prior Authorization

- Pharmacy contacts the beneficiary or the prescriber (who may or may not be affiliated with the hospice) to determine relatedness
- The prescriber may provide:
  - Verbal explanation of relatedness or
  - Written completion of the PA form and submit
- Recommend written completion for documentation of PA

Prior Authorization

- Pharmacy bills:
  - the hospice for related medications
    - The hospice may choose to provide them through its usual pharmacy source
  - Part D for unrelated medications
  - The patient for related medications that are deemed to no longer be effective or have additional negative symptoms

Actions for the Hospice

- Proactively identify Part D plan sponsor and initiate prior authorization as soon as patient elects
- Adjust admission process to:
  - Collect patient's Part D information
  - Describe the possibility that the patient may be liable for some drugs
  - Contact any prescribers to initiate care coordination
- Adjust medication management process
  - Determine unrelated medications
  - Document reasons for unrelatedness for submission in prior authorization

NHPCO Resources

- NHPCO website
  - Regulatory "Hot Topics"
  - All Part D relevant information on this page
- Compliance Guide
- Look for additional tools and resources to be developed in the coming weeks
- Interactive Forum at NHPCO Management and Leadership Conference on Part D and Hospice
- CMS Update concurrent session – Part D and hospice addressed

The bottom line

- Hospice providers are responsible for everything related (including drugs) to the terminal diagnosis and related conditions that contribute to the patient's terminal prognosis
- These diagnoses are recorded on the hospice claim form

OIG 2014 Work Plan

Office of Inspector General 2014 Work Plan

- Hospice in assisted living facilities
  - Length of stay, levels of care received, and common terminal illnesses of beneficiaries who receive hospice care in ALFs
- Hospice general inpatient care
  - Appropriateness of GIP claims, content of election statements, medical record review to assess GIP misuse

Office of Inspector General 2013 Work Plan Reports Pending

- **Acute-Care Inpatient Transfers to Inpatient Hospice Care**
  - Discharge from acute care hospital to hospice care – should the hospital receive the full PPS rate?
- **Marketing Practices and Financial Relationships with Nursing Facilities**
  - Review hospices' marketing materials and practices and their financial relationships with nursing facilities
- **Medicaid -- Compliance with Reimbursement Requirements**
  - Whether Medicaid payments by States for hospice services complied with Federal reimbursement requirements

Additional Data Collection – CR8358

Additional Data Collection on Claim Form (CR 8358)

- CR 8358 was reissued with clarifications on January 31, 2014
- Mandatory implementation remains April 1, 2014
- Many questions still unanswered or clarified by CMS

FAQs Issued by All MACs

- On each MAC's website
- Regulatory Alert published
- Categories of questions answered:
  - General
  - Visit reporting
  - NPI reporting
  - Drug and infusion pump reporting

Issues Pending

- Reporting drugs and NDC coding for patients in a contract acute care hospital
  - Contractual changes between hospice and hospitals
  - Hospital refusal to provide NDC coding
  - Hospital insistence on different contractual pricing if NDC codes are required to be provided
  - Discussions between NHPCO and CMS

Relatedness

Relatedness

- MHB requires hospice to cover all palliative care related to the terminal illness and related conditions
- **All services considered related** unless…
  - Hospice physician documents why a patient's medical needs would be unrelated to the terminal prognosis
- Determination of "relatedness"
  - Clinical expertise and judgment of the hospice medical director
  - Collaboration with the IDG

Cost Report

Cost Report

- New forms and instructions not yet final
- Projected start date for cost report periods beginning

October 1, 2014

Survey Deficiencies 2013

Survey Deficiencies from 2013

- Calendar year 2013
- Active hospice providers = 3,970
- Total number of surveys = 1301
- % of active providers surveyed = 33%

L Tag #	Tag Description	# of Citations	% Providers Cited	% Surveys Cited
L0543	Plan of Care	85	2.0%	6.5%
L0545	Content of Plan of Care	74	1.8%	5.7%
L0530	Content of Comprehensive Assessment	67	1.6%	5.1%
L0555	Coordination of Services	65	1.6%	5.0%
L0547	Content of Plan of Care	60	1.5%	4.6%
L0591	Nursing Services	47	1.1%	3.6%
L0629	Supervision of Hospice Aides	46	1.1%	3.5%
L0557	Coordination of Services	45	1.1%	3.5%
L0533	Update of Comprehensive Assessment	45	1.1%	3.5%
L0671	Clinical Records	43	1.0%	3.3%

New Proposed CoP: Emergency Preparedness

Proposed rule: Emergency Preparedness

- Posted in the Federal Register on December 27, 2013
- Will become a new CoP: § 418.113 under Subpart D, Administration
- Proposed regulations encourage coordination of preparedness efforts within provider communities and states as well as across state lines.
- Comments due to CMS on March 31, 2014

Proposed rule: Emergency Preparedness

- Four core elements:
  - Risk Assessment and Planning
  - Policies and Procedures
  - Emergency Preparedness Communication Plan
  - Training and Testing
- Requirements for both home hospice and inpatient providers

Fraud and Abuse Activity

The Big Fraud and Abuse Picture

- **Affordable Care Act**
  - Fraud in Medicare, Medicaid and private insurance – all provider types
  - $350 million budgeted over 10 years (FY 2011 - FY 2020) to fight fraud and abuse
  - "Integrated data repository" to incorporate data from all federally supported health care programs

Results – "Return on Investment"

- HHS report in Feb 2014 showed that for **every $1.00 spent** on health care-related fraud and abuse investigations in the last three years, the government **recovered $8.00**
- This is the highest three-year average return on investment in the 16-year history of the Health Care Fraud and Abuse Program

Types of Contractors

Contractors reviewing hospice claims:
(not all-inclusive)

- Medicare
  - Medicare Administrative Contractors (MAC)
  - Recovery Audit Contractors (RAC)
  - Zone Program Integrity Contractors (ZPIC)
  - Office of Inspector General (OIG)
  - Department of Justice (DOJ)
- Medicaid
  - State Medicaid agency audits
  - Medicaid Integrity Contractors (MIC)
  - Medicaid Recovery Audit Contractors (Medicaid RAC)

Contacts for Reporting Fraud

- **Beneficiaries:**
  - Call 1-800-MEDICARE or
  - DHHS OIG hotline at 1-800-HHS-TIPS (1-800-447-8477)
- **Providers:**
  - Call the DHHS Office of Inspector General hotline at 1-800-HHS-TIPS (1-800-447-8477).

Hospice Payment Reform

Payment Reform Options

- ACA authorizes CMS to revise the methodology for payments for hospice care **no earlier than FY2014 – or October 1, 2013**
- Options under consideration:
  - U-shaped model – higher payments at beginning and end of a hospice stay, lower payments in the middle
  - Tiered approach – payments based on length of stay
  - Short-stay add on payment
  - Case mix adjustment

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New Reform Options

- Rebase the routine home care rate
  - Data available for 3 of 9 components of rate
  - Figures presented in FY2014 Final Rule:
  - FY2011: $146.63
  - FY2011 rebased: $130.54
- Option under consideration
- No recommendation made this year

Site of Service Adjustment for Hospice Patients in Nursing Facilities

- Lower payments for hospice patients in nursing facilities based on:
  - Possible efficiencies in the nursing home setting –
    - multiple patients in a single setting
    - reduced driving time and mileage
    - to reduced workload due to an overlap in aide services
    - supplies provided by the nursing facility
- 2011 OIG report – 250+ hospices with 2/3 or more of patients in nursing homes
- Number and length of aide visits differ for hospice patients in nursing homes
- No recommendation made this year

Regulatory/ Compliance Team at NHPCO

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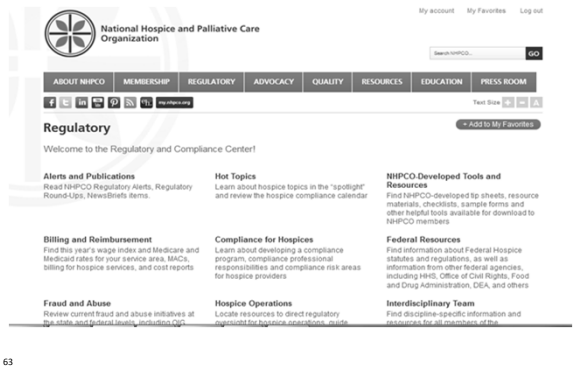
Resources

www.nhpco.org/regulatory



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