HOSPICE REGULATORY UPDATE

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Hot Topics

- Final FY2009 Hospice Wage Index
- New COPs
- Survey and Certification
- CR 5567
- ABN (updated)
- MACs
- ESRD
- Performance Measures
- Nursing homes
- Rural Health Clinics & CAH’s
- MedPAC
Atmosphere at CMS

- On a mission to scrutinize hospice industry
- 3 of 4 high level CMS administrators had “bad” hospice experiences with family members
- Why?
  - CMS goal to align hospice with other healthcare entities
    - Data collection
    - Reimbursement system
  - Hospice cap issues
  - Increased costs to Medicare for hospice overall
  - Suspect fraud & abuse in hospice industry

Atmosphere – Hospice Community

- Medicare Hospice Benefit is our life
- Nervous about coming changes
- New entrants
- Data collection coming – are we prepared?
  - Visit information
    - Collected?
    - Available for reporting on claim form?
  - Other data points?
  - Cost data – analysis of the cost report.
- Performance measures coming
President’s FY09 Budget Proposal

- February 4, 2008, President submitted the FY09 Budget to Congress.
- Three recommendations:
  - Hospital marketbasket updates frozen for FY2009 – FY2011 and reduced by 0.65% in FY2012 and FY2013
  - Adjust budget authority to facilitate hospice surveys:
    - FY07: Every 14 years
    - FY08: Every 10 years
    - FY09: Every 11.5 years
  - Eliminate budget neutrality factor for the hospice wage index. National average reduction of 4.6%

Final FY2009 Hospice Wage Index

- Phase-out the hospice-specific wage index adjustments over three years.
- Proposed rule published May 1, 2008
- Comments due June 27, 2008
- CMS published final rule on August 8, 2008
- Effective October 1, 2008
- NHPCO tools
  - Wage index calculator to assist providers in seeing impact
  - Wage index table to see impact by year
NHPCO Lawsuit

- NHPCO sued CMS over FY2009 Wage Index rule
- Trying to protect hospice services that are delivered to patients and families all across the country.
- Hospice programs cannot absorb cuts of 4% or more.
- Administrative costs can only be cut so much. Then, the only thing left to cut will be patient and family services.
- These cuts are particularly serious given that normal operating costs keeping going up -- and hospices feel even more cost pressures with the record setting gasoline prices.

Lawsuit Timeline

- The lawsuit was filed in U.S. District Court for the District of Columbia on Friday, September 5.
- The judge met with lawyers from both CMS and NHPCO September 9.
- The entire case is to be decided by the end of October.
- CMS agreed to pay hospices retroactively to October 1 if the judge rules in NHPCO’s favor.
Legislative Fix

- House bill introduced
- Senate bill introduced
- Action to date
- What you can do

Medicare Hospice
Conditions of Participation

- Implementation date: December 2, 2008
- Key changes
  - Patient rights
  - Comprehensive assessment
  - QAPI
  - Criminal background checks
  - Change in social work requirement
NHPCO Resources for Providers

• Helping providers with implementation
• Training available EOL Online
• Tip sheets for topics and for disciplines
• Resources at www.nhpco.org/regulatory

Survey and Certification

□ Hospice surveys – Tier 4
  ▪ Initial certification surveys – new requirement
  ▪ Accreditation organizations performing deem surveys

□ State reciprocity
  ▪ Hospices providing care across state lines
  ▪ Problems and proposed solutions

□ Multiple locations
  ▪ Approved by state survey agency
  ▪ Approved by CMS Regional Office

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Survey and Certification

- Companions to New Conditions of Participation
  - Interpretive Guidelines – in clearance
  - State Operations Manual (SOM)
  - Appendix M
  - State surveyor training – November 18-20, 2008

CMS – CR 5567

- July 1, 2008 mandatory implementation
- Visits for nurses, social workers, hospice aides, physicians
- No contract staff
- Charges per visit for each specified discipline
- Not all disciplines included
CR 5567 – Charges

- NHPCO recommends that hospice providers consult with a healthcare CPA or cost report preparer to assess costs for purposes of CR5567.
- Charges should be a % add-on once costs have been determined

Medicare Summary Notice
Post CR5567

- May have patient/family confusion over wording
- Watch for Medicare secondary payor or supplemental payments
- Train social work staff and billing staff to explain the visit reporting requirement
CMS Advanced Beneficiary Notice of Non-coverage

- Effective date: March 1, 2009
- Form to be used: CMS-R-131
- CMS resources:
  - Beneficiary Notice Initiative (BNI) web page: www.cms.hhs.gov\bni

Reasons a Hospice Uses ABN

- Four reasons for a hospice to use an ABN
  - Ineligibility because the beneficiary is not “terminally ill”.
  - Specific items or services that are billed separately from the hospice payment, such as physician services, are not reasonable and necessary.
  - The level of hospice care is determined to be not reasonable or medically necessary specifically for the management of the terminal illness and/or related conditions.
  - Services delivered by non-hospice providers
    - Example: non-contract facility
When are ABNs not required for hospice services?

- **Revocations:**
  - Revocations are not considered terminations since the beneficiary is choosing to discontinue hospice services.

- **Respite Care Beyond Five Consecutive Days:**
  - Respite care on the sixth consecutive day is considered outside the definition of the hospice benefit, and the hospice provider is not required to issue a mandatory ABN. However, CMS encourages hospice providers to give the ABN as a voluntary notice to inform patients of possible financial liability in such cases.

- **Transfers**
  - Beneficiaries are allowed one transfer to another hospice during a benefit period. An ABN is not required.

Electronic signatures on the CTI

- **CMS CR 5550 – Program Integrity**
  - Originally issued August 24, 2007

- **Clarifications issued in CR 5971 in March 2008**
  - *Signature(s) of the physician(s) must be handwritten on the certifications of terminal illness for hospice.*
  - *Faxed, handwritten and authenticated physician signatures acceptable.*
  - *Stamped physician signatures not acceptable.*
Discharge for Cause Data

- **Effective January 1, 2009**
- **Hospices required to identify patients who were discharged for cause**
- **FL 6: Patient Discharge Status**
  This code indicates the patient’s status as of the "Through" date (FL 6) of the billing period. The hospice enters the most appropriate NUBC approved code.
- **Condition code: H2**
  - To be used in addition to the discharge status code.
  - The hospice must have a policy addressing discharges for cause and the appropriate documentation. Discharge for cause identifies a discharge from the provider’s care, and based on the patient’s discharge status code, may not be discharge from the Medicare hospice benefit.

**CMS Resource: Transmittal CR6115**

Medicare Administrator Contractors (MACs)

- CMS must replace current FIs and carrier contracts with competitively procured contracts.
- CMS has from 2005 and 2011 to implement this mandate.
- Four DME and four Home Health/Hospice specialty MACs, and 15 primary A/B MACs.
- Specialty MAC claims workloads will be integrated into A/B MAC workloads.
- Where are we in the process?
  - A/B contract currently being awarded
  - Specialty MAC proposals submitted, awaiting awards.
ESRD and hospice

- Interpretive guidelines for conditions of coverage now available
- Hospices CAN care for patients with ESRD
- If kidney disease is terminal diagnosis or related, hospice is responsible for dialysis
- If terminal diagnosis is not kidney disease, Medicare ESRD benefit accessible
- NHPCO publication for providers about hospice and ESRD coming

CMS Performance Measures

- CMS contracted with the Carolinas Center for Medical Excellence (the NC/SC Quality Improvement Organization) on hospice and palliative care performance measures
- 131 assessment and data collection instruments reviewed
  - 39 recommended
- 102 quality measures reviewed
  - 34 recommended
- Recommended measures and assessment instruments now available on the www.medqic.org website
Performance Measures

- Apply to both hospice and palliative care
- Based on the National Consensus Project Guidelines
- Must be approved by NQF process before CMS can use them
- NHPCO measures already approved
  - FEHC
  - End Result Outcome Measures
    - Pain
    - Unwanted hospitalization

Samples of Performance Measures

- Physical symptoms
  - Pain on admission
  - Pain at 24/48 hours/regular intervals after
  - Dypsnea
  - Bowel protocol for narcotics
- Psychosocial
- Cultural competency
- Imminent death
Nursing Homes and OIG

- December 20, 2007 - (OIG) released a report (OEI-02-06-00220) “Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings.”
- September 30, 2008 - OIG Supplemental Compliance Program Guidance for Nursing Facilities

OIG Supplemental Guidance

- September 30, 2008
- OIG issues “OIG Supplemental Compliance Program Guidance for Nursing Facilities”
- Identifies fraud and abuse risk areas
  - Inducements for referrals:
    - Remuneration in the form of free nursing services for non-hospice patients;
    - Additional room and board payments;
    - Inflated payments for providing hospice services to the hospice’s patients.
Anti-Kickback Warnings

Some of the practices that are suspect under the anti-kickback statute include:

- Offering free goods or goods at below-fair-market value to induce a nursing facility to refer patients to the hospice;
- A hospice paying room and board payments to the nursing facility in excess of what the nursing facility would have received directly from Medicaid had the patient not been enrolled in hospice. Any additional payment must represent the fair-market value of additional services actually provided to that patient that are not included in the Medicaid daily rate;

A hospice paying amounts to the nursing facility for additional services that Medicaid considers to be included in its room and board payment to the hospice;

A hospice paying above fair-market value for additional services that Medicaid does not consider to be included in its room and board payment to the nursing facility;
Anti Kickback Warnings

- A hospice referring its patients to a nursing facility to induce the nursing facility to refer its patients to the hospice;
- A hospice providing free (or below fair-market value) care to nursing facility patients, for whom the nursing facility is receiving Medicare payment under the SNF benefit, with the expectation that after the patient exhausts the SNF benefit, the patient will receive hospice services from that hospice; and
- A hospice providing staff at its expense to the nursing facility.

Nursing Homes

- Companion COP for nursing homes expected as proposed rule in 2009
- State surveyors required to look at a hospice patient’s chart when surveying the nursing home
- Deficiencies could include the hospice: “Failure to coordinate care and services"
- Expect change
Rural Health Clinics

- Attending physician billing:
  - A rural health clinic physician may be a hospice patient’s attending physician, but the physician may only bill Part B for attending physician services. The clinic cannot bill for the services as "rural health clinic services."
  - Rural health clinic physicians may not separately bill Part B for services performed at the rural health clinic, during clinic hours. These are "RHC services” and are payable only to the clinic.
- CMS interpretation: RHC physicians may not see hospice patients for whom they serve as attending during business hours or on the premises of the RHC.
- May take a legislative fix

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Critical Access Hospitals

- Presently reimbursement for hospice inpatient days in a CAH are ½ of the CAH’s payment from Medicare for an inpatient day of care
- NHPCO and NRHA have worked to have hospice inpatient days excluded from the hospital’s cost report
- Progress being made

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**MedPAC update**

MedPAC – Medicare Payment Advisory Commission Commissioners appointed – high level economists and health policy experts of stature in the field
- Medicare Hospice Benefit is "ripe for a major overhaul"
- Analysis includes:
  - Cap
  - Hospice access
  - Changing demographics
  - Margins

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**MedPAC Update Hospice Expenditures**

- Spending for FY2008 is expected to top $10 billion.
- All beneficiaries groups – age, sex, race/ethnicity, Medicare eligibility and Medicare insurance type increased by 50% from 2000 to 2005.
- Hospice growth from 2000 to 2006 was mostly among for profit providers, with a 5% growth in for profits each year.

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**Hospice spending tripled between 2000 and 2007**

Source: CMS Office of the Actuary

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**MedPAC Report on Margins**

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<th>% of Providers (2005)</th>
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<th>2005</th>
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**ALL**

| 100 | 1.0 | **3.4** |

Source: MedPAC presentation March 2008

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MedPAC Update
Further Investigation

- Next detailed analysis in November 2008
- Does hospice care save money for the Medicare system?
- Overhaul to the hospice payment system?
  - Alternatives to the per diem payment system
  - Adjustments in eligibility
  - Case mix adjustment
  - Payment variations by diagnosis or length of stay

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Resources & References

☐ National Hospice and Palliative Care Organization
  ☐ www.nhpco.org/regulatory

☐ CMS website for the most updated resources
  ☐ www.cms.hhs.gov/center/hospice.asp

☐ Medicare Benefit Policy Manual

☐ Office of the Inspector General
  ☐ www.oig.hhs.gov

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NHPCO Information Resources

☐ NHPCO’s Issue Brief – Hospice General Inpatient Care: Its Proper Use And Supporting Processes
☐ Pathway For Patients & Families Facing Terminal Illness
☐ Compliance Program Toolkit
☐ Hospice Operations: Resources For Managing A Hospice Program
☐ Hospice Service Guidelines
☐ Hospice Volunteer Program Resources
☐ Operational Guidance: Hospice & Assisted Living
☐ Providing Direct, Billable Physician Services
☐ Providing Hospice And Palliative Care In Rural Areas
☐ The Discontinuation Of Hospice Care
☐ Traveling Patient Toolkit
☐ OIG Voluntary Compliance Guidance
☐ Guidelines for Bereavement Care in Hospice
☐ Guidelines for Spiritual Care
☐ Guidelines for Nursing Care
☐ Guidelines for Social Workers

Products will be updated to reflect language and requirements in the new Medicare hospice CoPs

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NHPCO Regulatory Resources

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Questions

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