2018 Regulatory Priorities

Judi Lund Person, MPH, CHC
Vice President, Regulatory and Compliance
National Hospice and Palliative Care Organization

Today’s Topics

• President’s budget and hospice provisions
• Opportunities for innovation
• Data trends that predict regulatory change
  – Abt data
  – PEPPER reports and their value
• Areas of scrutiny
  – GIP
  – Live discharges
• Fraud and abuse

ON THE HILL...
Bipartisan Budget Act

- Passed February 9, 2018
- Physician Assistants allowed to serve as the Hospice Attending Physician
  - The Medicare Patient Access to Hospice Act, which would allow physician assistants to serve as the attending physician to hospice patients and perform other functions that are otherwise consistent with their scope of practice.
  - PA role will be similar to that of a Nurse Practitioner
  - PA WILL NOT BE ABLE TO CERTIFY OR RECERTIFY
  - PA WILL NOT BE ABLE TO CONDUCT FACE TO FACE ENCOUNTERS

Bipartisan Budget Act

- Hospital payment policy for early discharge to hospice care
  - Payment reduction in the DRG payment for hospitals for early discharges to hospice, effective October 1, 2018
  - Follows same policy as for other post acute care providers
  - Early discharge is defined as “more than 1 day earlier than the Medicare mean length of stay for an applicable DRG.”
  - Change is based on the 2013 OIG Report: MEDICARE COULD SAVE MILLIONS BY IMPLEMENTING A HOSPITAL TRANSFER PAYMENT POLICY FOR EARLY DISCHARGES TO HOSPICE CARE
  - Payment will impact hospitals who discharge patients to hospice early—any setting
  - Accompanying regulations will be published in hospital inpatient proposed rule in April 2018

Rural Health Clinics and Federally Qualified Health Centers

- RHC/FQHC physicians cannot serve as a patient’s attending physician once they enroll in hospice
- 27 million Americans served by FQHCs and RHCs
- The Rural Access to Hospice Act (S. 980/H.R. 1828)
- Senate sponsors: Senators Capito and Shaheen
- House by Representatives by Congresswoman Jenkins and Congressman Kind
- Bill will allow RHCs and FQHCs to receive payment for serving as the hospice attending physician
- Currently actively working to get included in the Omnibus package or in the Farm bill
Opioid Disposal

- H.R. 5041, the Safe Disposal of Unused Medication Act
  - Will allow hospice employees to dispose of unused medications and after the death of a patient
- Senate companion being considered
- Will likely move as a part of a large package of opioid legislation

Other Opioid Issues

- Shortages
  - Injectables
  - Could have new supply in April
  - Likely will be an ongoing issue
  - Hurricane Maria a factor
- Attention on issue
  - Ongoing media and policymaker attention
  - Do our part
    - Look for alternative drugs
    - Assess for drug safety in home
    - Ensure proper disposal

OPPORTUNITIES FOR INNOVATION
Key Reflections

- Any payment reform changes to the current hospice benefit could be accomplished through the existing statute, with limitation
- Demonstrations/models to test care delivery and payment structures
- The data tells a story
  - To implement or not to implement, that is the question.

What's on the table?

- Payment Model Technical Advisory Committee
  - Advanced Care Model
  - Patient and Caregiver Support for Serious Illness
  - Hospital at Home Plus
  - Home Hospitalization (Acute care in the home)
- Medicare Care Choices Model (MCCM)
- Independence at Home Demonstration
- Bundled Payments for Care Improvement - Advanced (BPCI Advanced)

What could be on the table?

- Alzheimer's and Related Dementia Care Delivery and Payment Model
  - Large sample size and a fast growing population
  - Known concerns from policymakers
  - Bipartisan interest in modernizing Medicare to adapt to the growing population
  - Public acceptance
- Medicare Advantage plans offering supplemental services
Pre-Hospice Spending – Where is Our Risk?

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Mean Lifetime Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL DIAGNOSES</td>
<td>73.9</td>
</tr>
<tr>
<td>Alzheimer’s, Dementia and Parkinson’s</td>
<td>118.8</td>
</tr>
<tr>
<td>CVA/Stroke</td>
<td>55.6</td>
</tr>
<tr>
<td>Cancers</td>
<td>47.3</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>29.8</td>
</tr>
<tr>
<td>Heart (CHF and Other Heart Disease)</td>
<td>78.8</td>
</tr>
<tr>
<td>Lung (COPD and Pneumonias)</td>
<td>69.4</td>
</tr>
<tr>
<td>All Other Diagnoses</td>
<td>78.2</td>
</tr>
</tbody>
</table>

Pre-Hospice Spending Analysis

Challenges and Opportunities for Hospice

- New models borrow the best from hospice, but are not bound by hospice rules and regulations
- Could either divert patients from or drive them to hospice
- Can we innovate????
  - What do our patients and potential patients need?
  - How do we get there from where we are?
Hospice 2.0

• Reimagining Hospice to address current challenges, position us to compete:
  – Eligibility – lift the 6 month requirement?
  – More all-inclusive (Part D, Physician Services)?
  – Concurrent care?
  – Additional payment reforms?

MEDICARE ADVANTAGE
Medicare Advantage Basics

- Can be an HMO or some other private health plan contracting with Medicare to provide health services
- Huge growth in enrollees
- MedPAC: March 2017 – MA plan enrollment continued to grow faster than total Medicare beneficiary growth in 2016
- Medicare Extenders package, passed into law February 2018:
  - MA plans can provide supplemental services
  - Could be palliative care or supportive services
  - Hospices who can provide care “upstream” could engage in discussions with their local plans
  - Establish a relationship – palliative care and transition to hospice
Medicare Advantage Provider Networks

• MA plans are required to include:
  – a specified number of physicians for each of 26 medical specialties
  – chiropractic care
  – Hospitals
  – other providers
• Within a particular driving time and distance of enrollees in order to ensure that Medicare Advantage enrollees have access to the physicians that they may need
• MA plan networks have been found to include:
  – 51% of all hospitals in their county
  – 46% of the physicians in their county
• In 2015, 35% of MA enrollees (35%) were in plans with narrow physician networks

Why Do We Care About MA?

• Today:
  – Medicare hospice benefit is “carved out” of Medicare Advantage
  – If patient qualifies for hospice and elects, they leave MA and go back to fee for service Medicare
  – Hospice is the last “carved out” benefit for MA
• Future:
  – All Medicare services will be “inside the MA bundle” including hospice

MA Carve-in

• Not openly considered or widely studied, but believed to be inevitable, recommended by MedPAC since 2014
• Suggested by the Senate Finance Committee in 2016
• Including hospice in MA plans enables greater hospice use, innovation, and creates more continuous care for patients
• Despite possible benefits and interest from MA plans, significant concerns remain about preserving integrity of the benefit and impact on the financial health of hospices
What Would you Do?

- Table discussion on MA contracting
- Questions to be answered:
  - What MA plans are in my area?
  - Does your hospice contract with them now?
  - How would you prepare for a conversation, contract discussion?
- Services and data preparation
  - Hospice data
  - Palliative care
  - Examples of community collaborative relationships
  - Examples of care transitions handled well
- What’s next?

HOSPICE DATA TRENDS AS A PREDICTOR OF FUTURE REGULATORY CHANGES

Data Sources

- CMS Proposed Rules
- MedPAC – Medicare Payment Advisory Commission
- Surveys
- Abt Associates claims analysis
- PEPPER Reports
- OIG Work Plan
Hospice use and expenditures increased in 2016

- Number of hospice users: 534,000 in 2000, 1,324,000 in 2015, 1,427,000 in 2016.
- Total hospice days among all beneficiaries: 26,926,961 in 2016.
- Length of stay among decedents: Average 93.5 days in 2000, 88.2 days in 2015, 87.8 days in 2016.

CMS Proposed Rule FY2018
Part A and B Spending Outside Hospice Benefit

- In millions:
  - 2012: $748
  - 2013: $712
  - 2014: $625
  - 2015: $593
  - 2016: $534

Source: FY2018 Hospice Wage Index Proposed Rule, April 27, 2017
CMS Comments

- 25% drop in Part A and B spending since 2012.
- **Not a trivial amount**
- CMS will continue to monitor data regarding this issue

Source: FY2018 Hospice Wage Index Proposed Rule, April 27, 2017

Estimated cost by level of care for freestanding providers, 2015

Unpack this statistic

- Payment for 1 day of RHC: $159.00
- Average cost for 1 day of RHC: $124.00
- Difference: $35.00

What does this mean?
- CMS now looking at cost reports
- Significant difference in cost compared to payment
- Could signal a rate reduction for RHC if trend continues?
- Cost report preparation? Is yours high quality and accurate?
Abt Associates Contract

- CMS has contracted with Abt Associates Inc. to conduct comprehensive data analysis and monitoring of the hospice payment system
- As part of these analyses, we examine measures of utilization and determine how they vary across hospices
- For this presentation we will look at two key analyses:
  - Analysis 1: How hospice ownership, size, and age correlate with certain measures
  - Analysis 2: How certain measures vary across different deciles of hospices
- Presentation by Abt at MLC 2017
Background

• Medicare has implemented a hospice quality reporting program (HQRP) in FY2014
  – HQRP uses data from a patient assessment tool (Hospice Item Set) and survey of caregivers of patients who died while in hospice
• The measures reported in this presentation are separate from the HQRP
  – The measures in this presentation are used by CMS to understand patterns of care and to monitor how hospices provide services under the current hospice payment system

CMS Administrative Data

• 100% Medicare Hospice Claims
  – Analysis 1: FY2014 data
    • Hospices with at least 30 discharges
    • 3,453 hospices representing 1.3 million Medicare beneficiaries
  – Analysis 2: FY2015 data, All hospices
    • Provider of Services file
    • Medicare Enrollment Database

Analysis 1 – Research Question

• What are the characteristics of the hospices that exceed a particular threshold for multiple measures?
### Data – Hospice Level Indicators

<table>
<thead>
<tr>
<th>Measures</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Cutoff</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Hospice provided no CHC or GIP</td>
<td>GIP and CHC days</td>
<td>hospice days</td>
<td>Hospice did not provide this service</td>
</tr>
<tr>
<td>(2) Hospice’s days which are GIP (%)</td>
<td>GIP Days</td>
<td>hospice days</td>
<td>90th percentile and higher</td>
</tr>
<tr>
<td>(3) Hospice decedents without a professional staff visit (%)</td>
<td>Number of times there is no visit by nurse or medical social worker in the last 2 days of life while on RHC</td>
<td>Hospice patients with the last 2 days of life being RHC level of care</td>
<td>90th percentile and higher</td>
</tr>
<tr>
<td>(4) Lack of nursing visits for greater than 7 days</td>
<td>Number of times when there is a gap in nursing visits greater than 7 days</td>
<td>Number of patients with a length of stay of at least 30 days</td>
<td>90th percentile and higher</td>
</tr>
</tbody>
</table>

### Data – Hospice Level Measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Cutoff</th>
</tr>
</thead>
<tbody>
<tr>
<td>(5) Nurse minutes per RHC day</td>
<td>Total nurse minutes on RHC days</td>
<td>Number of RHC days</td>
<td>10th percentile and lower</td>
</tr>
<tr>
<td>(6) Live discharge in the first 7 days of hospice</td>
<td>Number of hospice live discharges within 7 days of hospice admission</td>
<td>Number of live discharges</td>
<td>90th percentile and higher</td>
</tr>
<tr>
<td>(7) Live discharge on or after the 180th day of hospice</td>
<td>Number of live discharges after 180 or more days on hospice services</td>
<td>Number of live discharges</td>
<td>90th percentile and higher</td>
</tr>
<tr>
<td>(8) Burdensome transition</td>
<td>Number of live discharges with hospice discharge, hospital admission, and hospice readmission</td>
<td>Number of live discharges</td>
<td>90th percentile and higher</td>
</tr>
</tbody>
</table>

### Data – Hospice Level Measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Cutoff</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9) Selective enrollment of ALF patients</td>
<td>Number of RHC days in ALF</td>
<td>Number of RHC hospice days</td>
<td>90th percentile and higher</td>
</tr>
<tr>
<td>(10) Selective enrollment of NH patients</td>
<td>Number of RHC days in NF/SNF</td>
<td>Number of RHC hospice days</td>
<td>Set based on MedPAC recommendation at 40% or higher</td>
</tr>
<tr>
<td>(11) Hospice length of stay greater than or equal to 180 days</td>
<td>Sum of the length of stay of decedents</td>
<td>Number of decedents</td>
<td>90th percentile and higher</td>
</tr>
</tbody>
</table>
### Percentiles

<table>
<thead>
<tr>
<th>Statistics</th>
<th>25&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
<th>75&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
<th>90&lt;sup&gt;th&lt;/sup&gt; Percentile (Threshold unless indicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hospice provided no CHC or GIP (Threshold = 0)</td>
<td>0.0</td>
<td>0.0</td>
<td>1.0</td>
</tr>
<tr>
<td>2. Hospice's days which are GIP (%)</td>
<td>0.0%</td>
<td>0.9%</td>
<td>3.7%</td>
</tr>
<tr>
<td>3. Hospice decedents without a professional staff visit (%)</td>
<td>3.2%</td>
<td>19.5%</td>
<td>33.3%</td>
</tr>
<tr>
<td>4. Lack of nursing visits for greater than 7 days</td>
<td>27.1%</td>
<td>66.3%</td>
<td>78.4%</td>
</tr>
<tr>
<td>5. Nurse minutes per RHC day</td>
<td>12.1</td>
<td>18.9</td>
<td>22.9</td>
</tr>
</tbody>
</table>

### Distribution of Hospices By Score

- Score = 0 (N = 1,042) 13.4%
- Score = 1 (N = 1,215) 30.2%
- Score = 2 (N = 732) 35.2%
- Score = 3 or more (N = 464) 21.2%

Source: Abt Associates presentation at NHPCO Management and Leadership Conference May 2017
Variation in the Average Score of Hospices in Each State

Results – Unadjusted

- A higher percentage of for-profit hospices had a score of 3 or more compared to non-profit hospices (17.2% versus 6.3%)
- Comparing across all for-profit hospices, the largest hospice category had a lower percentage of hospices with a score of 3 more compared to small and medium sized hospices (13.5% versus 18.8-20.1%)
- Comparing across all non-profit hospices, the largest hospice category had a lower percentage of hospices with a score of 3 more compared to small and medium sized hospices (2% versus 8.5 – 9.5%)

What does all of this mean?

- Higher margins is cause for additional scrutiny
- Higher or no GIP/CHC utilization may draw attention to some providers
- Providers with high percentages of ALF or NH patients may be under scrutiny
- Staff visits – few visits? No visits? > 2 weeks between visits?
- Identification of providers who have 3 or more negative indicators...
Take Home List

• Know your own hospice's:
  – Margins
  – % of GIP and CHC
  – Median and average length of stay
  – Percentage of ALF and NH patients
  – Any other data point

• Look for opportunities to
  – Begin a QAPI project
  – Analyze data for internal staff and board reporting
  – Identify areas for improvement
2017 National Hospice PEPPER Downloads

# PEPPERs Available: 4,081
# PEPPERs Retrieved: 2,477

Retrieval Rate: 60.7% as of February 20, 2018

Download your PEPPER: www.pepperresources.org

2017 Oregon Hospice PEPPER Downloads

# PEPPERs Available: 49
# PEPPERs Retrieved: 34

Retrieval Rate: 69.39% as of February 20, 2018

Download your PEPPER: www.pepperresources.org

2017 Washington Hospice PEPPER Downloads

# PEPPERs Available: 32
# PEPPERs Retrieved: 30

Retrieval Rate: 93.75% as of February 20, 2018

Download your PEPPER: www.pepperresources.org
Hospice Target Areas – 2017 PEPPER

- Live discharges – not terminally ill
- Live discharges – revocations
- Live discharges – 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
- Episodes with no CHC or GIP
- Long General Inpatient Care Stays (> 5 days)

What’s a Hospice to Do?

- Download your PEPPER Report and USE IT
- Use the data points
- Plot your own hospice’s data
- Identify areas of risk
- Identify areas for improvement
- Review regularly

Comparative Billing Reports

- Educational tools administered by the Centers for Medicare & Medicaid Services (CMS), disseminated by eGlobalTech.
- Insight into billing trends across regions and policy groups
- CMS has now formalized and expanded the program nationally
- Go to NGS website for more information
NHPCO members enjoy unlimited access to Regulatory Assistance
If you are a NHPCO member, feel free to email questions to
regulatory@nhpco.org