Regulatory and Audit Issues

The list is long...

• Sources of clinical information for certifying terminal illness
• Electronic filing of NOE through EDI
• Attending physician and hospice medical director issues
• 2017 survey deficiencies
• New nursing home interpretive guidelines
• Auditors and their focus
• OIG Work Plan target areas
• Update on AseraCare

REMINDER ABOUT CERTIFYING TERMINAL ILLNESS
Sources of clinical information for certifying terminal illness

- Ensure that clinical information is gathered from all sources
- **Document** in medical record
- Reference in eligibility determination
- Show involvement of other physicians in referral to hospice
- **Not just the hospice nurse’s decision**

Role of Initial Assessment

- CMS reminds providers that the hospice admission assessment can accompany the initial written certification; however, “this information should **further substantiate** rather than provide the basis for certification”

OTHER REGULATORY ISSUES
Electronic Filing of NOE

• Fix for system on 2/5/2018
• Hospices may be able to submit Notices of Election electronically from EMR software
• Hospices should:
  – Submit batch transmissions with groups of NOEs, separate from batch transmissions with groups of claims
  – Watch for a 999 acknowledgment within minutes of submission if accepted
  – Monitor their acceptance reports (277CA and 999) at regular intervals
  – Monitor the status of the NOE in DDE for corrections

Electronic Filing of NOE – Things to Do

• Pay attention to the day count for the NOE – if close to day 5, submit through DDE
• Watch for guidance from MAC
• Check with software vendor to assess implementation date
• Work with billing staff to set up processes for this change
• Keep DDE log in information as a back up

Hospice Medical Director

• Concern on surveys
• Only 1 hospice medical director per provider number
  – Even if multiple locations
  – Even if large census
• Can have a physician designee to serve in the absence of the medical director
• Other physicians employed by or under contract with the hospice – CANNOT be called medical director
• MUST have reporting relationship to medical director shown on the org chart
Hospice Medical Director – To Do

- Check job titles
- Check job description for medical director
  - Even if position is titled Chief Medical Officer, reference the ONE medical director language in the job description
  - Must state in the job description that this position is the ONE medical director for the hospice
- Check organizational chart for reporting relationships
- Check job titles and job descriptions for other physicians
  - Cannot be called medical director
  - Choose other job titles
- Check and update policies and procedures about how a physician designee is chosen when the hospice medical director is unavailable

Attending Physician Issues

- Complex issue
- Core question: when does an attending physician become the patient’s attending?
  - What if the chosen attending does not respond with verbal cert within 3 days?
  - What if chosen attending refuses?
- NHPCO working with 3 MACs
  - Soliciting information from providers
  - Clarifications from CMS requested by MACs
  - No resolution yet
- Eventually:
  - Resources for patients/families/referring physicians and hospices

2017 SURVEY DEFICIENCIES
### 2017 Survey Deficiencies - #1-2

<table>
<thead>
<tr>
<th>Ranking</th>
<th>L Tag</th>
<th>Survey Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>L0543</td>
<td>Plan of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient’s needs if any of them so desire.</td>
</tr>
<tr>
<td>#2</td>
<td>L0530</td>
<td>Content of comprehensive assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drug profile. A review of all of the patient’s prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy.</td>
</tr>
</tbody>
</table>

### 2017 Survey Deficiencies - #3-4

<table>
<thead>
<tr>
<th>Ranking</th>
<th>L Tag</th>
<th>Survey Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>#3</td>
<td>L0629</td>
<td>Supervision of hospice aides</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A registered nurse must make an on-site visit to the patient’s home:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient’s needs.</td>
</tr>
<tr>
<td>#4</td>
<td>L0523</td>
<td>Timeframe for the completion of the comprehensive assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.</td>
</tr>
</tbody>
</table>

### 2017 Survey Deficiencies - #5-6

<table>
<thead>
<tr>
<th>Ranking</th>
<th>L Tag</th>
<th>Survey Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>#5</td>
<td>L0545</td>
<td>Content of the plan of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments.</td>
</tr>
<tr>
<td>#6</td>
<td>L0547</td>
<td>Content of the plan of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.</td>
</tr>
</tbody>
</table>
### 2017 Survey Deficiencies - #7-8

<table>
<thead>
<tr>
<th>Ranking</th>
<th>L Tag</th>
<th>Survey Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>#7</td>
<td>L0647</td>
<td>Level of activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff.</td>
</tr>
<tr>
<td>#8</td>
<td>L0579</td>
<td>Prevention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.</td>
</tr>
</tbody>
</table>

### 2017 Survey Deficiencies - #9-10

<table>
<thead>
<tr>
<th>Ranking</th>
<th>L Tag</th>
<th>Survey Deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>#9</td>
<td>L0531</td>
<td>Content of the comprehensive assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bereavement. An initial bereavement assessment of the needs of the patient’s family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient’s death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.</td>
</tr>
<tr>
<td>#10</td>
<td>L0596</td>
<td>Counseling services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>§418.64(d) - Counseling services must include, but are not limited to, the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) Bereavement counseling. The hospice must:</td>
</tr>
</tbody>
</table>

### Nursing Home Interpretive Guidelines Released
Nursing Home Interpretive Guidelines Released

- The original NH Requirements for Participation were published in August 2013
- Interpretive Guidelines published in July 2017
- Most difficult compliance issues concern coordination of services through the care plan
- Take effect November 28, 2017
- Advance copy of the Guidance to Surveyors for LTC is located at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html Scroll down to “Advance Appendix PP including Phase 2

Key Provisions for Hospices

- New requirements for anti-psychotics in nursing homes
- Quality of care
- Nursing home-hospice relationship

Anti-Psychotic Drugs

§483.45(e) Psychotropic Drugs. [§483.45(e)(1)-(5) will be implemented beginning November 28, 2017 (Phase 2)]

Based on a comprehensive assessment of a resident, the facility must ensure that—

5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
Concerns about Anti-Psychotic Medications

- Appropriate use of anti-psychotic medications can be very beneficial in controlling symptoms at the end-of-life
- Not risk-adjusted for hospice
- Nursing home staff are extremely reluctant to administer the medications
- Question about the meaning of “evaluates the resident”
  - Actual personal visit?
  - Review of the resident’s response without a visit?
- No answers yet…

F684 – Quality of Care

F684
§ 483.25 Quality of care
- Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents.
- Based on the comprehensive assessment of a resident

F684 – Quality of Care

Review of a Resident at or Approaching End of Life and/or Receiving Hospice Care and Services Assessment
- The resident must receive a comprehensive assessment to provide direction for the development of the resident’s care plan to address the choices and preferences of the resident who is nearing the end of life.
- The facility and the resident’s attending physician/practitioner, should, to the extent possible:
  - Identify the resident’s prognosis and the basis for that prognosis
F684 – Quality of Care

• The facility and the resident’s attending physician/practitioner, should, to the extent possible:
  – Initiate discussions/considerations regarding advance care planning and resident choices to clarify goals and preferences regarding treatment
  – Consider:
    • Pain management and symptom control
    • Treatment of acute illness
    • Choices regarding hospitalization

Guidance: §483.70(o) Provision Of Hospice Services In A Nursing Home

• As described in §§483.70(o)(1)(i),(ii), there is no requirement that a nursing home allow a hospice to provide hospice care and services in the facility.

guidance: §483.70(o) Provision of Hospice Services In A Nursing Home

• If a nursing home has made arrangements with one or more hospices to provide services in the nursing home, there must be a written agreement describing the responsibilities between each hospice and the nursing home prior to the hospice initiating care for a resident who has elected the hospice benefit.

  • The written agreement applies to the provision of all hospice services for any nursing home resident receiving services from the specific hospice and does not need to be rewritten for each resident.
F849 – Hospice Services

• § 483.70(o) Hospice services.
• § 483.70(o)(1) A long-term care (LTC) facility may do either of the following:
  i. Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
  ii. Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

F849 – Hospice Services

Hospice Plan of Care

• As described in § 483.70(o)(2)(ii)(B), when a hospice patient is a resident of a nursing home, the hospice must establish the hospice plan of care in coordination with the nursing home, the resident’s nursing home attending physician/practitioner, and to the extent possible, the resident/designated representative.

F849 – Hospice Services

The 3 C’s of the Hospice/Nursing Home Plan of Care

• Communication
• Collaboration
• Coordination
F849 – Hospice Services

Hospice Plan of Care in Nursing Home
• In order to provide continuity of care:
  – Collaboration: Hospice and the nursing home must collaborate in the development of a coordinated plan of care for each resident receiving hospice services
  – Structure: Is established by the nursing home and the hospice

F849 – Hospice Services

Hospice Plan of Care in Nursing Home
• In order to provide continuity of care:
  – Responsibility: must identify the provider responsible for performing each or any specific services/functions that have been agreed upon
  – Maintaining the plan of care: The plan of care may be divided into two portions, one maintained by the nursing home and the other maintained by the hospice

F849 – Hospice Services

Nursing Home Designee(s) Responsibilities
• §483.70(o)(3)(i)-(v)
• Nursing home must identify and designate, in writing, an employee of the nursing home to assume the responsibilities for collaborating and coordinating activities between the nursing home and the hospice.
• Nursing home employee must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
F849 – Hospice Services

Communication Process Between Nursing Home and Hospice
- §483.70(o)(2)(ii)(D)
- Written agreement must specify a process for communicating necessary information regarding the resident’s care between the nursing home and the hospice
- 24-hours a day, 7-days a week
- Includes how these communications will be documented

Responsibilities for Bereavement Services for Nursing Home Staff
- The death of the resident may have a direct impact on identified nursing home staff
- The written agreement should specify when the nursing home should provide information to the hospice regarding nursing home staff that may benefit from bereavement services

AREAS OF SCRUTINY FOR HOSPICES
Focus Areas for Scrutiny

- Live discharges
- Visits in the last days of life
- Part D and Hospice

FOCUS ON LIVE DISCHARGES

Live Discharge Rates for Hospices With 50 or More Live Discharges, FY 2014 to FY 2016

<table>
<thead>
<tr>
<th>Percentile</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>5th Percentile</td>
<td>7.5%</td>
<td>6.9%</td>
<td>6.8%</td>
</tr>
<tr>
<td>10th Percentile</td>
<td>9.0%</td>
<td>8.5%</td>
<td>8.4%</td>
</tr>
<tr>
<td>25th Percentile</td>
<td>12.4%</td>
<td>11.6%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Median</td>
<td>17.6%</td>
<td>18.8%</td>
<td>18.9%</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>26.5%</td>
<td>24.6%</td>
<td>25.4%</td>
</tr>
<tr>
<td>90th Percentile</td>
<td>39.4%</td>
<td>35.9%</td>
<td>37.2%</td>
</tr>
<tr>
<td>95th Percentile</td>
<td>50.0%</td>
<td>45.6%</td>
<td>49.1%</td>
</tr>
<tr>
<td># of Providers</td>
<td>3,160</td>
<td>3,215</td>
<td>3,232</td>
</tr>
</tbody>
</table>

Source: FY2014, FY2015 and FY2016 hospice claims from Common Working File that list a discharge status code. Live discharges were defined as hospice claims with a status code of "01." Published in FY2018 Hospice Wage Index Proposed Rule, April 27, 2017.
Distinction between live discharge and revocation

• Separate codes
• Patient initiated - revocation
• Hospice initiated
  – Moved out of service area
  – No longer terminally ill
  – Discharged for cause
• Monitoring with PEPPER report

CMS Comments on Live Discharges

• As part of our ongoing monitoring efforts, we analyzed the distribution of live discharge rates among hospices with 50 or more discharges (discharged alive or deceased)
• **Significant variation** in the rate of live discharge between the 10th and 90th percentiles
• Hospices at the **95th percentile discharged** 49.1 percent of their patients alive in FY 2016

Concerns about Live Discharges

• Claims data tells the story

<table>
<thead>
<tr>
<th>Claims Indicator</th>
<th>Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live discharge in first 7 days of hospice care</td>
<td>14.6% of patients or more</td>
</tr>
<tr>
<td>Live discharge on or after 180 days</td>
<td>57.8% of patients or more</td>
</tr>
</tbody>
</table>

• Could be a concern for quality
Skilled Visits in the Last Days of Life

- On any given day during the last 7 days of a hospice election, "nearly 44% of the time the patient has not received a skilled nursing or social worker visit.
- On the day of death nearly 26% of beneficiaries did not receive a skilled nursing or social work visit.

CMS Comments on Visits in the Last Days of Life

- We believe it is important to ensure that beneficiaries and their families and caregivers are, in fact, receiving the level of care necessary during critical periods such as the very end of life.
Incentives for Skilled Visits

- Service Intensity Add-on
  - RN and social worker visits
  - Up to 4 hours per day combined disciplines
  - Paid at CHC hourly rate
- New quality measure measuring visits when death is imminent
- What is CMS telling us?

FOCUS ON PART D AND HOSPICE

Part D Spending

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

• Current prior authorization process has lowered Part D expenditures for 4 classes
• Increase in beneficiaries filling “maintenance” medications through Part D
• Hospices are responsible for covering drugs and biologicals related to the palliation and management of the terminal illness and while the patient is under hospice care
• Part D coverage: treatment unrelated to the terminal illness or related conditions

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

Common Palliative Drugs

• Analgesics
  – Anti-inflammatory
  – non-narcotic
  – Opioids
• Antianxiety agents
• Antiemetics
• Laxatives

Source: FY2017 Hospice Wage Index Proposed Rule

Cerebral Degeneration

Overlapping Drugs - Part D Expenditures - 2014
Total Spend OUTSIDE Hospice Benefits: $16,873,285

Source: FY2017 Hospice Wage Index Proposed Rule - FY2014 Data
Part D Recoupment Audits

- Seeing PDP audits (like Rawlings) that will try to recoup for drugs that were paid by Part D and should have been paid by the hospice
  - Check your records to see that you did not pay
  - Cooperate but negotiate for a discounted settlement
- Be in touch with health care legal counsel for additional information

What Should Your Hospice Do?

- Live discharges
  - Check your hospice’s rate of live discharge and revocation
  - Analyze reasons
    - Hospital contracts
    - Patient preferences
- Visits in last days of life
  - Identify patients at risk
  - Develop protocol for initiating visits
- Part D and hospice
  - Review your hospice’s prescribing practice, including formularies
  - Do your patients access Part D for some medications? Do you check?
  - Work closely with local pharmacies
  - Cooperate with Part D recoupment companies
HOSPICE AUDITS

Bevy of Medicare Audit Contractors

- CMS contractors
  - MAC
  - ZPIC/UPIC
  - SMRC
  - Recovery Audit Contractors (RAC)
- Audit parameters set by companies with some CMS oversight
- Incentive payments
  - RAC contractors have % of collections agreements
  - Other contractors incentivized to deliver results

Federal Scrutiny – In Transition

Unified Program Integrity Contractor (UPIC)
- The UPIC will combine and integrate existing CMS program integrity functions carried out by multiple contractors and contracts into a single contract to improve its capacity to swiftly anticipate and adapt to the ever changing and dynamic nature of those involved in health care fraud, waste, and abuse across the Medicare and Medicaid program integrity continuum
Know Your Auditor

- Zone Program Integrity Contractor (ZPIC)
  - AdvanceMed

- Recovery Auditor
  - Performant
    - https://performantrac.com/

Audit Company Tools

- Referrals from MAC or PEPPER contractor
- Strong data mining and analytics platforms
- Investigators (many former law enforcement), analysts
- Medical reviewers (often RNS)
- Statisticians
Pre-Pay and Post Pay Audits

- New audit process for MAC - Targeted Probe & Educate (TPE)
  - Replacing all medical reviews (ADRs subsumed)
  - Three rounds of prepayment probe reviews
  - 20 to 40 prepayment claims to start
  - Aberrant data as a trigger
  - Sustained high levels of denials (≥15%) may trigger referral to UPIC/ZPIC
    - Targeted education (one-on-one) by phone or video
    - MACs encourage provider calls and questions
    - Finding success in provider education after first or second round
- Topics for TPE identified by MAC and published on website

NGS TPE Focus Areas

- If GIP denied, then claim will automatically suspend
- Continue to check NGS website
OIG Focus Areas

- Medicare Hospice Benefit Vulnerabilities and Recommendations for Improvement: A Portfolio
- Review of Hospices’ Compliance with Medicare Requirements
- Hospice Home Care – Frequency of Nurse On-Site Visits to Assess Quality of Care and Services
- Trends in Hospice Deficiencies and Complaints
- Medicare Payments for Unallowable Overlapping Hospice Claims and Part B Claims
- Duplicate Drug Claims for Hospice Beneficiaries

AseraCare Update

- Government alleged that company defrauded Medicare by coercing employees to admit borderline patients
- Alleged that certifications of terminal illness for many patients were unsupported
- Federal Judge allowed case to go to trial but bifurcated the trial into two phases:
  - falsity element
  - other elements

AseraCare

- Jury found that 104 of 121 patient cases had been falsely certified
- $200 million in potential liability
- Jury sided with DOJ but judge tossed the verdict
- Then granted summary judgment for AseraCare
- Government has appealed – awaiting 11th Circuit ruling
AseraCare – Judge’s Ruling

• “[T]his case boils down to conflicting views of physicians about whether the medical records support AseraCare’s certifications that the patients at issue were eligible for hospice care.”
• “When hospice certifying physicians and medical experts look at the very same medical records and disagree about whether the medical records support hospice eligibility, the opinion of one medical expert alone cannot prove falsity without further evidence of an objective falsehood.”

Scrutiny…. summarized

• Here to stay
• Physician role vitally important – both hospice medical director and attending physician
• Proactive compliance team – with staff support throughout the organization
• Expert health care legal counsel as needed