



# Regulatory Update



**National Hospice and Palliative Care Organization**

**March 2010**

National Hospice and Palliative Care  
Organization



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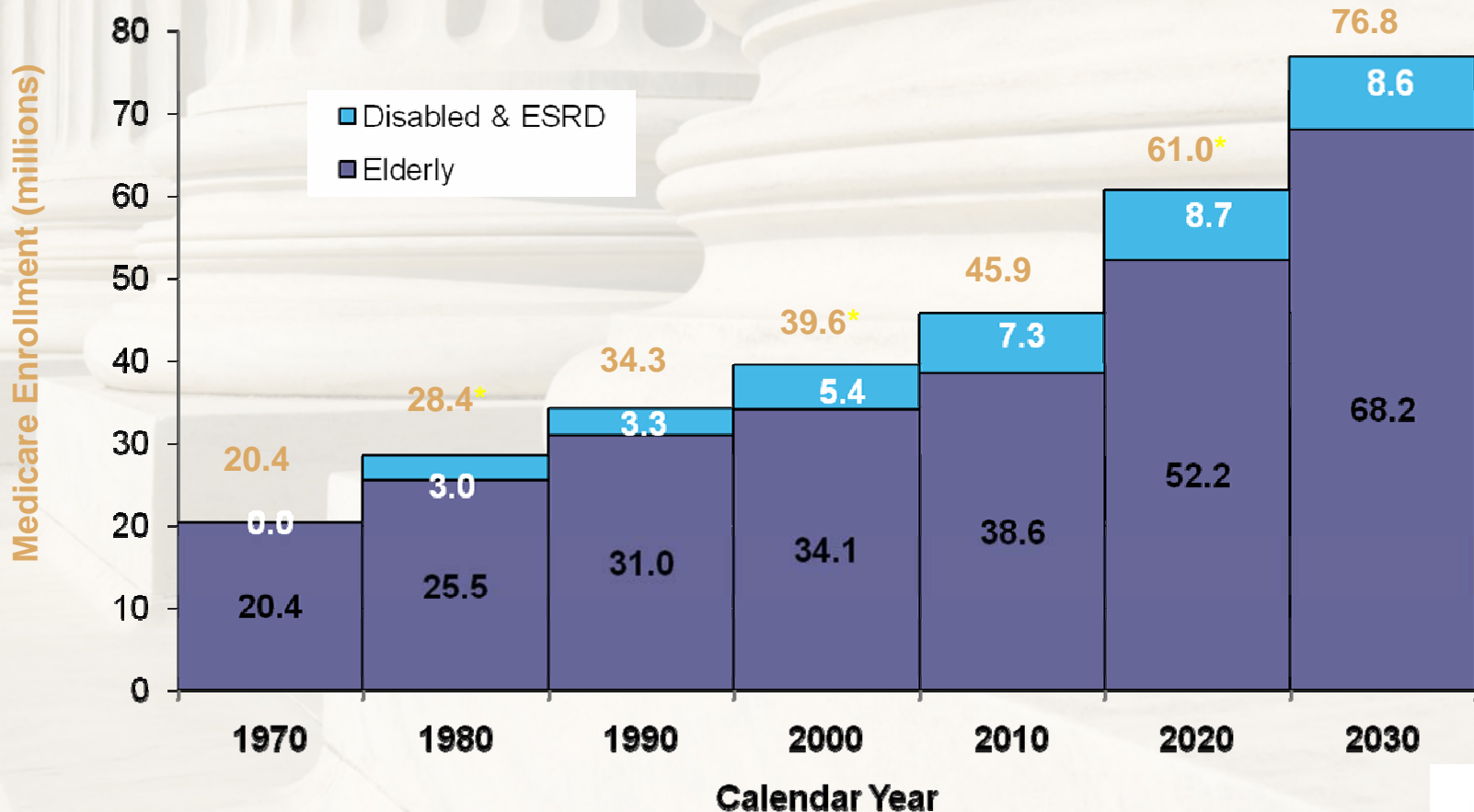
# Ever Growing List

- Hospice growth
- Change requests
  - CR 6440
  - CR 6540
  - CR 6791
  - CR 6778
- Recovery Audit Contractors (RACs)
- HITECH Act
- Hospice Cost Report
- Performance Measures
- Medicare Administrative Contractors (MACs)
- Nursing Homes
- Fraud and abuse
- FDA

# Medicare Beneficiaries to 2030

*The number of people Medicare serves will nearly double by 2030.*

## Number of Medicare Beneficiaries



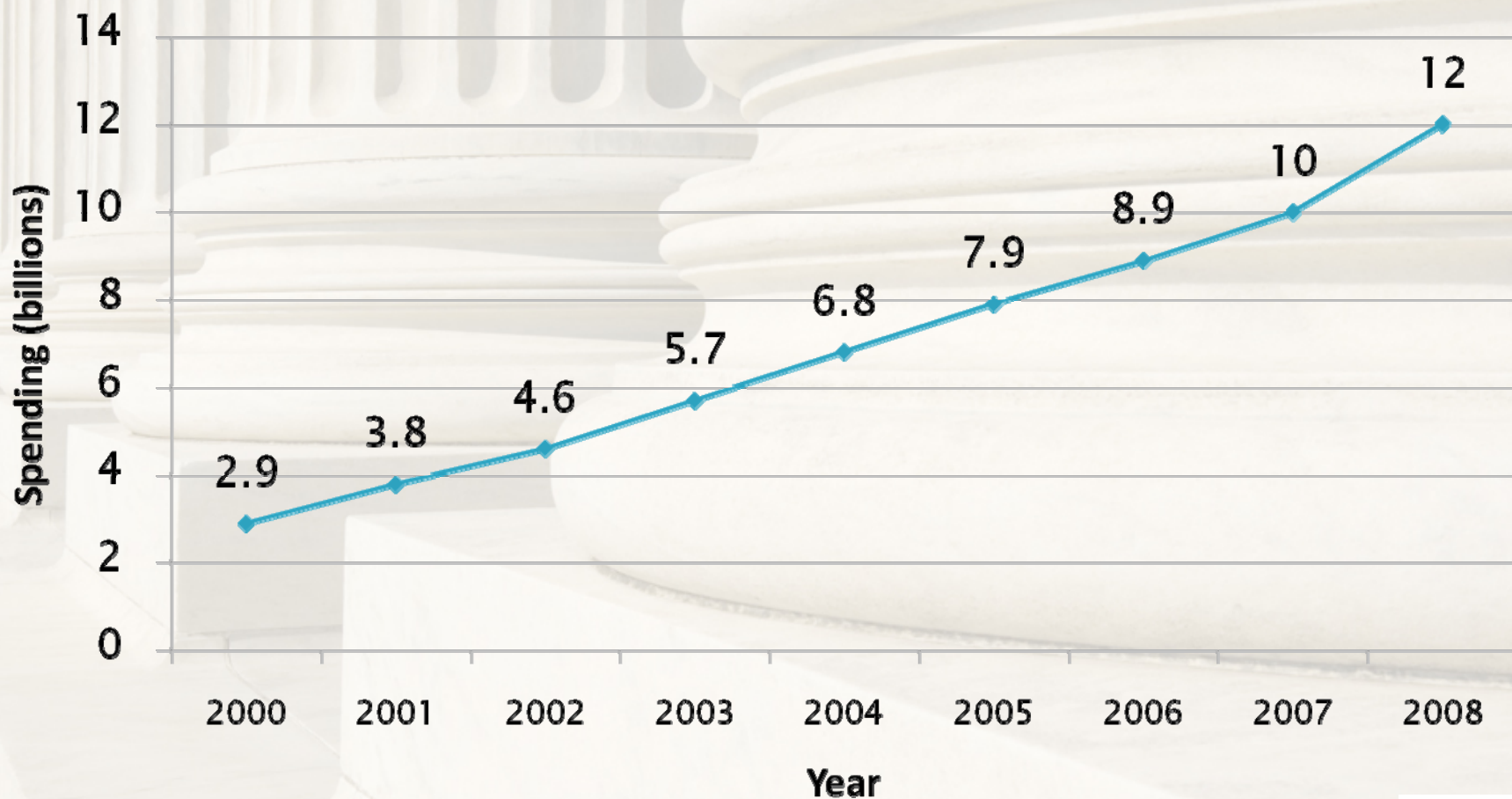
\* Numbers may not sum due to rounding

# Medicare

- Problems facing Medicare are even worse than those of Social Security
- The Medicare trust fund is projected to be depleted by **2017** or just 9 years from now.
- Average growth rate of 5.5%
- Medicare expenditures expected to increase at a faster pace than either workers' earnings or the economy overall.

Source: CMS Office of the Actuary  
Trustees Report  
May 2009

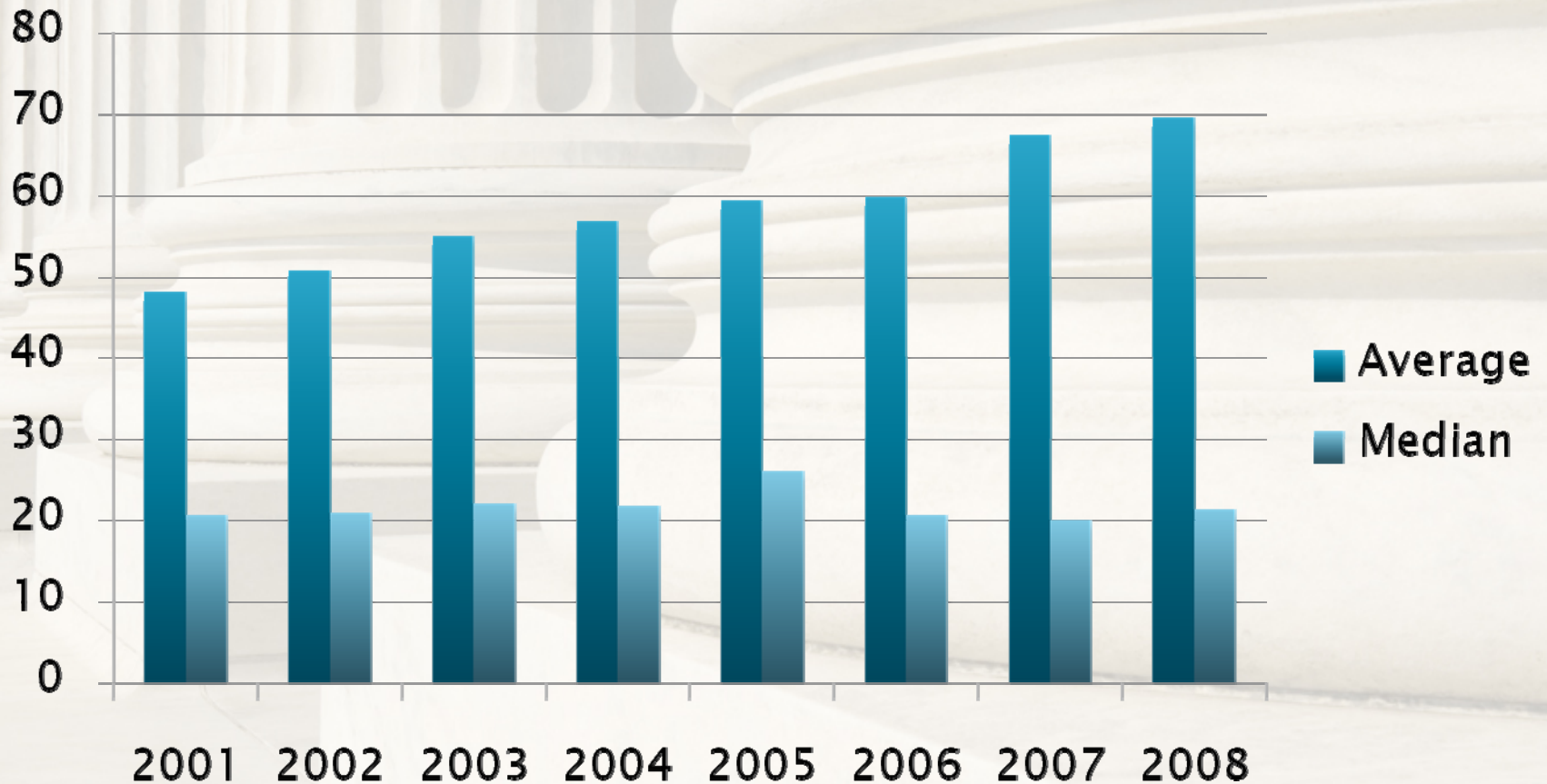
# Hospice Spending Tripled between 2000 and 2008



Source: CMS Office of the Actuary



# Average and Median Length of Stay



Source: NHPCO National Data Set 2001 – 2008

# Health Care Reform Passed

- **March 21, 2010 the House passed H.R. 3590, the Patient Protection and Affordable Care Act**
- **This version of the bill softens the productivity cuts to hospice from a proposed \$10 billion to \$7.8 billion**
- **Market Basket Cuts & Productivity**
  - productivity adjustment reduction into the market basket update beginning in fiscal year 2013, as well as a market basket reduction of .3 percent for hospice providers from fiscal years 2013-2019

# Hospice Payment Reform

1. Would require the Secretary to collect data and update Medicare hospice claims forms and cost reports by 2011
2. Secretary would be required “implement revisions to methodology for determining payment rates for RHC and other services included in hospice care” no earlier than FY 2013.
3. After January 1, 2011, a hospice MD or NP must have a face-to-face encounter with each hospice patient to determine continued eligibility for hospice care prior to the 180th-day recertification and each subsequent recertification, and attest that such visit took place.
  - **In addition, the Secretary will medically review certain patients in hospices with high percentages of long-stay patients.**

# Hospice Payment Reform

- **Medicare Hospice Concurrent Care Demonstration Program**
  - 3 year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare covered services while receiving hospice care
- **Curative and Palliative Care for Children in Medicaid and CHIP**
- **Independent Payment Advisory Board**
  - Tasked to present Congress comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries as well as the private health system

# Hospice Payment Reform

- **Hospice Value Based Purchasing/Promoting High Value Health Care**
  - Provides the Secretary of HHS authority to test value-based purchasing programs for long-term care providers, including hospice providers, no later than January 1, 2016
- **Quality Reporting**
  - Requires hospice report on quality measures determined by the Secretary or face a 2 percent reduction in their market basket update
    - Measures published in 2012 for reporting to begin in 2014

# We are still Fighting!

- **We can't afford to lose \$7.8 billion from the national investment in end-of-life care**
  - productivity cuts on top of more than 4 % regulatory reduction associated with the elimination of the budget neutrality adjustment factor (BNAF) we will absorb over the next 7 years, is more than the community can or should sustain
- NHPCO will continue to ensure that hospice is “at the table” after the political dust settles and before the community and the patients we serve feel the brunt of the cuts

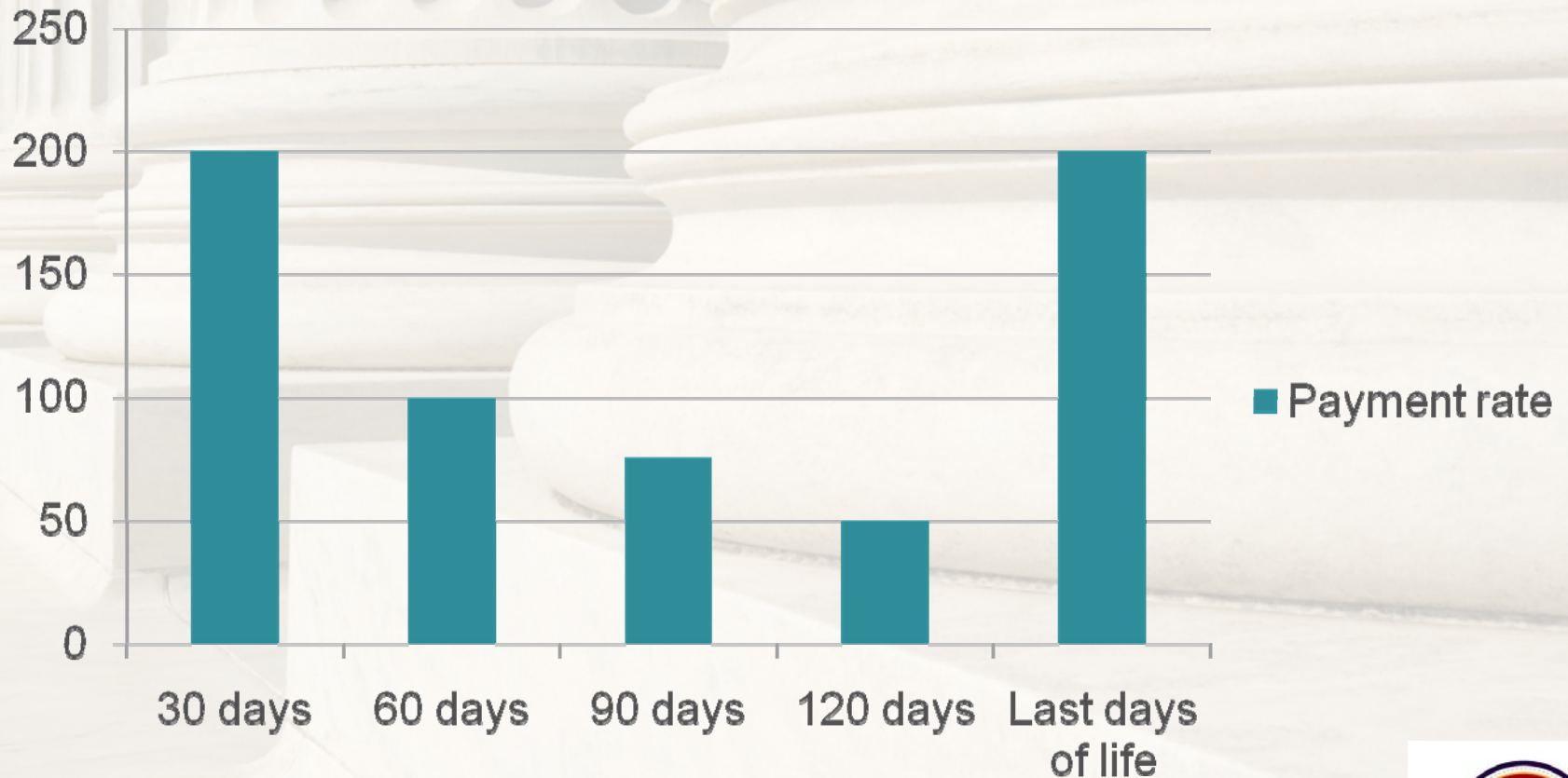
# MedPAC Recommendations to Congress – March 2009

## Change the Medicare payment system for hospice to a U-shaped payment curve:

- Relatively higher payments at the beginning of care and at the end
- Relatively lower payments in the middle
- Implement changes in 2013

# U-Shaped Payment Model

## Example of Payment Rate



# NHPCO Response: U- Shaped Payment Model

- Data-gathering
- The Moran Company working with software vendors and hospice providers to:
  - **Collect as much patient level data as possible**
  - **Tie data to cost**
  - **Model different payment models**
- Brown University will be conducting academic research on various payment models

# Regulatory Changes Keep Coming even if there is no health care reform

- **Data**
  - Visit time reporting requirements
  - Cost report changes
- **Payment reform**
  - MedPAC recommendations
  - Modeling for U-shaped curve
- **Performance measures**
- **Audits and medical review**
  - NGS – medical review and pre-pay audits
  - CERT audits
  - RACs (Recovery Audit Contractors)
  - ZPICs
- **OIG**
  - Nursing homes
  - Physician billing

**Data**

**Audits, Fraud  
and Abuse**



# CMS

- Following direction of MedPAC
  - **Patient level data – what do we have/what do we need?**
  - **Payment reform**
  - **Cost report**
- Pressure on growth and spending
- No administrator but major reorganization underway
- Focus on fraud and abuse
- Concern about beneficiary misinformation about hospice services

# Physician narrative

- Requires a physician to write a brief narrative to accompany the certification and recertification
- Implementation date = October 1, 2009
- Provider confusion about need to obtain a verbal narrative with a verbal certification of terminal illness from physician.
- CMS clarified in a Q&A:
  - **The oral certification/recertification should state that the patient is terminally ill with a life expectancy of 6 months or less, if the illness runs its normal course. Currently, we do not require the narrative to be provided orally at the same time as the oral certification/recertification.**
    - NHPCO Regulatory Alert:  
<http://www.nhpco.org/i4a/pages/index.cfm?pageID=6199>

# CR 6440

- Requires provider to submit time spent on visits in 15 minute increments on claim form
- Implementation date = January 1, 2010
- Provider questions received by NHPCO before and after implementation date:
  - **SW calls**
  - **Charges**
  - **Documentation**
- NHPCO has asked CMS for clarification.

# CR 6440 – Social Work calls update

Q&A ID#: 9970, Posted February 19, 2010

- CMS posted a new Q&A update related to the Social Worker (SW) phone call requirement in CR 6440 this afternoon. The language in the new Q&A states that CMS acknowledges that care coordination phone calls by a social workers to other than family members could be reportable on the claim form.
- This is a change from the January 27, 2010 CMS Q&A posting which stated that **only** calls to the patient and family should be recorded on the claim form.
- **CMS cautions that**, “it would be inappropriate to record every phone call that a social worker makes on behalf of a patient.”

# CR 6440 – Documentation

**Q&A ID#: 9916, Posted November 20, 2009**

- Documentation time (such as the updating of medical records) which occurs during, and as part of, an otherwise covered and billable visit to a patient can be included in the time reported for the visit.
- Documentation time which occurs outside the context of such a visit is not reportable.

# CR 6440 – Charges

**Q&A ID#: 9971, Posted January 27, 2010**

- The total charges should be the hospice provider's total charges for the service billed on that line of the claim based on the provider's charge structure.
- What is placed in the charges is completely dependent on the provider and their own charge structure. If a provider charges \$100 per visit regardless of the length of the visit, then the charge would be \$100 on the line for the visit regardless of the number of units for the length of the visit.
- If the provider has a timed charge structure then they would report the total charge after calculating their rate for the length of the visit being reported on the claim.

# CR 6440 – Charges

- Each hospice – choose a charge structure
- Complete the claim based on that charge structure.
- NHPCO strongly recommends a unit charge structure reflecting a 15 minute increment charge

Units of time x per unit charge = total charge

# CR 6540 – Reporting for Physician Certifying the Terminal Illness

- The hospice provider must report the National Provider Identifier (NPI) of the attending physician/NP in the attending physician field on the NOE and claim with effective dates or dates of service on or after April 1, 2010.
- **Original effective date: January 1, 2010**
- **NHPCO intervened with CMS to request a delay in implementation**
- **CMS Reissues CR6540 with a new Implementation Date: April 1, 2010**

# CR 6540 – Reporting for Physician Certifying the Terminal Illness

**ID#: 9955, Posted January 7, 2010**

- For mid-stream changes in the "attending physician" hospices should report the "attending physician" that exists at the end of the billing period of that particular claim. At this time, we are not requiring changes to the "attending physician" on the NOE.
- For mid-stream changes in the "certifying physician" hospice should report the physician who actually certified the beneficiary for the hospice benefit period reflected by the services on the claim.

# CR 6540 – Reporting for Physician Certifying the Terminal Illness

**ID#: 9955, Posted January 7, 2010**

- For mid-stream changes in the "certifying physician" hospice should report the physician who actually certified the beneficiary for the hospice benefit period reflected by the services on the claim.
- If the billing period spans more than one hospice benefit period, the hospice should report the physician who certified the beneficiary for the latest, most recent hospice benefit period reflected on the claim.
- At this time, we are not requiring changes to the "certifying physician" on the NOE.

# CR 6791 – Associating Hospice Visits to the Level of Care on the Claim Form

- Hospices should report separate line items for the level of care each time the level of care changes.
  - This includes revenue codes:
    - 0651 (Routine Home Care)
    - 0655 (Inpatient Respite Care)
    - 0656 (General Inpatient Care)
- **CMS Issues Caution:** Should providers not adhere to this policy CMS may consider implementing a **line item date of service billing requirement for hospice level of care revenue codes.** This would require reporting a separate line for the level of care for each day billed on the hospice claim.

# CR 6778 – Medicare Systems Edit Refinements Related to Hospice Services

- Describes system edits that will become effective for claims submitted on or after July 6, 2010.
- The two edits include:
  - Medicare Advantage and Medicare hospice services claims can both be processed on the date of hospice election.
  - CMS names the Q codes where a particular level of care can be provided.
- Technical correction on the calculation of continuous care hours stating “nursing care must be provided for ‘more than half’ of the period of care.”

# CR 6778 – Medicare Systems Edit Refinements Related to Hospice Services

NHPCO clarifications with CMS. Clarifying Q&A soon.

## Q Code clarification:

1. Hospices should use Q5003 for patients who reside in the nursing facility and are not receiving SNF level of care. Typically, it would be unusual for a hospice patient to be receiving SNF level of services at the routine home care level of care, and most often the site of service code would be Q5003.
2. For the Q5003 code, continuous home care CAN be provided. It will be incumbent on the hospice to determine whether the patient is in a NF bed or a SNF bed.

# CR 6778 – Medicare Systems Edit Refinements Related to Hospice Services

- **Continuous home care nursing hours:**
  - Language in the COPs is “predominantly” and the interpretation of that language is more than 50%.
  - *Example:* if the patient has 8 hours of continuous home care provided in a 24 hour period, that would be 32 15-minute increments to be billed. Nursing care must be at least 17 of the 32 increments in that 8 hour period. Correspondingly, if there is more than 8 hours of continuous care provided in a 24 hour period, the same “more than half” applies.

# Pending Q&A's from CMS

- Clarification about site of care codes (CR 6778)
- Clarification about counting visits in a hospice owned facility

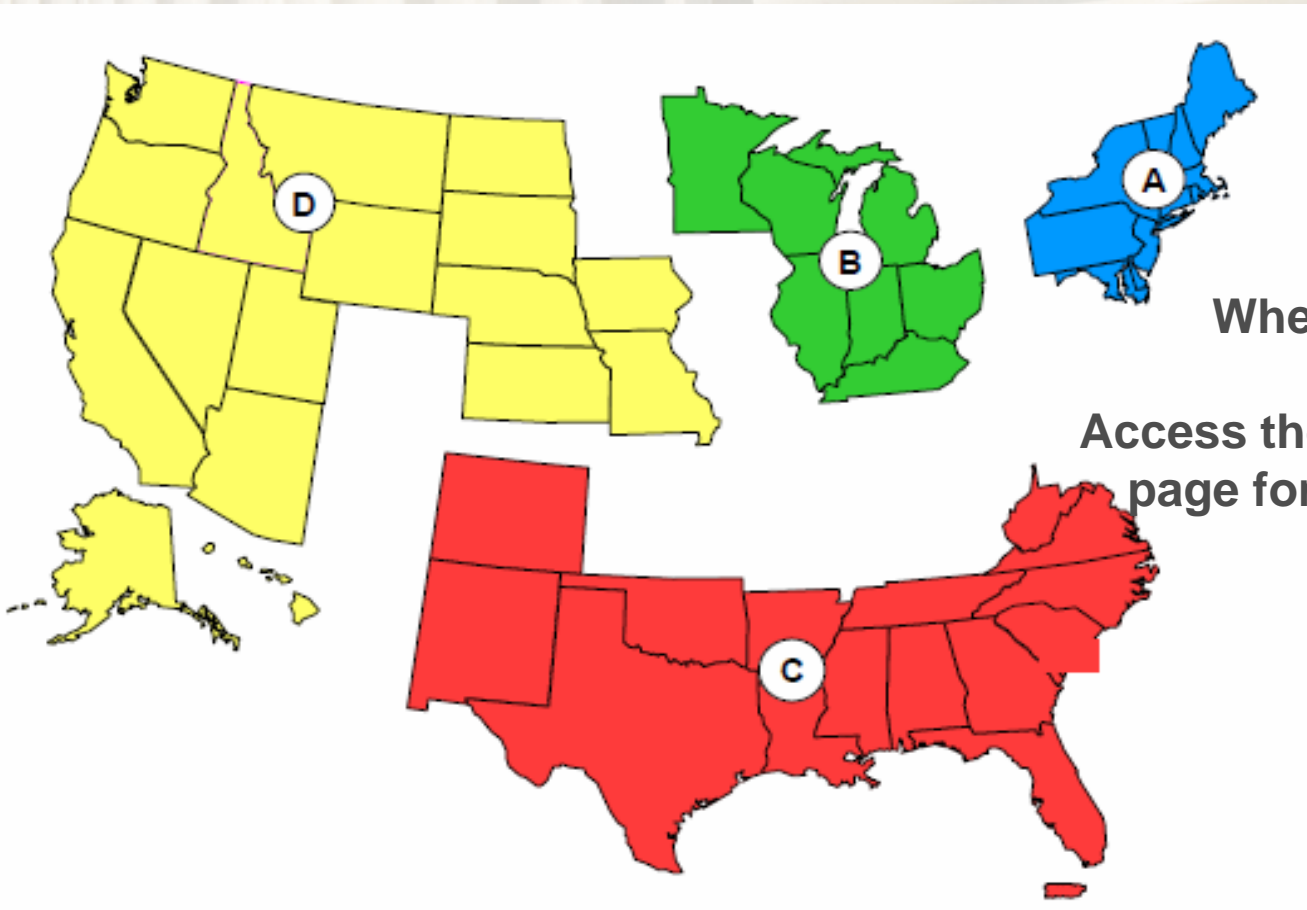
# Recovery Audit Contractor (RAC) Audits begin

- Health Data Insights, the Recovery Audit Contractor (RAC) for Region D, announced that they will be looking at two hospice-related issues beginning immediately.
  - **DME while in hospice – DME providers will be reviewed**
  - **Hospice Related Services – Medicare Parts A and B providers will be reviewed for services related to the patient's terminal illness.**
- For these two issues, hospice providers are not likely to be identified as a first-line recipients of a RAC audit, but the posting of these two issues confirms that RACs are looking at hospice providers.

# Recovery Audit Contractor (RAC) Audits begin

- The RAC program
  - mandated by Congress
  - aimed at detecting and correcting past improper payments
  - CMS and Medicare Administrative Contractors (MACs) can implement actions that will prevent future improper payments.
- There are 4 RAC contractors, each covering approximately  $\frac{1}{4}$  of the country

# Recovery Audit Contractor (RAC) Map



Where can I locate RAC information?  
Access the NHPCO RAC Web page for more information.

# Recovery Audit Contractor (RAC) Audits begin

- **What happens now?**

- For these two hospice audit issues, hospice claims will not be reviewed, but claims from other providers will be reviewed. NHPCO will continue to update the RAC webpage in the NHPCO Regulatory and Compliance Center with information on these audits and expansion to other RAC contractors.
- Hospice-specific audits are expected in FY2010

- **Be prepared!**

- Learn the RAC process now and get to know your RAC before a letter is ever received.
- Complete internal monitoring of areas for improvement.
- Review recent ADR's, RHHI/ MAC probe edits, and claims denials information.

# HIPAA HITECH compliance

- Effective **February 17, 2010**, the HITECH rule requires providers to update business associate (BA) contracts, breach notification, and other policies.
- HITECH makes business associates liable for civil and criminal sanctions for violating HIPAA in the same manner as covered entities by.
- Following HITECH, these penalties are enhanced for covered entities and business associates alike.
- HITECH imposes new data breach notification obligations on CEs and BAs and enhances enforcement authority with respect to HIPAA violations.

# HIPAA HITECH history

- HHS issued the HITECH Interim Final Rule in August 2009 which included new requirements for business associates and electronic access.
- The Health Information Technology for Economic and Clinical Health (“HITECH”) provisions are in the American Recovery and Reinvestment Act of 2009 (“ARRA”, also referred to as the “Stimulus Bill”)
- Provisions codify and expand on many of the requirements contained in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and its regulations to protect the privacy and security of protected health information (“ PHI”).

# Cost Report Additions and Adjustments

- Clarification of reporting of days
- Updated revenue categories for revenue by levels of care
- Revenue reported for freestanding hospices AND provider based hospices
- Eliminate confusion and create standard locations for responses
- Data on cost report contemplated as basis for payment reform

# Performance Measures

- Contract issued by CMS to IPRO – the NY State Quality improvement Organization
- 7 hospices in NY selected
- Use PEACE and CARE measures
- Determine hospice data collection process and use in improving quality
- Develop measures for NQF approval
- Develop a packet of materials that hospices can use outside New York

# Performance Measures Selected

## Structure and process

- % of patients admitted to hospice who had a screening for symptoms during the admission visit
- % of patients who had a comprehensive assessment completed within five days of admission

## Care for physical symptoms

- For patients who screened positive for pain, % whose pain was at a comfortable level within two days of screening
- For patients who screened positive for dyspnea, % who improved within one day of screening

# Performance Measures Selected

## Care for physical symptoms

- For patients who screened positive for nausea, % of patients who received treatment within one day of screening
- % of patients on opioids who have a bowel regimen initiated within one day of Opioid initiation

# Performance Measures Selected

## Care for psychosocial symptoms

- For patients who screened positive for anxiety, % who received treatment within two weeks of diagnosis

## Social aspects of care

- % of families reporting the hospice attended to family needs for information about medication, treatment and symptoms

## Cultural aspects of care

- Provision of interpreter or translator for non-English-speaking or deaf patients

# Performance Measures Selected

## Care of the imminently dying

- % of patients who had moderate to severe pain on a standard rating scale at any time in the last week of life

## Ethical and legal aspects of care

- % of patients with chart documentation of an advance directive or discussion that there is no advance directive

# Performance Measures Selected

## Adverse events

- Selected number of occurrences per 100 patient days
  - falls
  - medication errors
  - DME issues (complaint, malfunction or error),
  - patient/family complaints

# Medicare Administrator Contractors (MACs)

- Replaces the FIs
- All contracts awarded
- Contracts contested for:
  - **Noridian Administrative Services**
  - **Palmetto**
  - **Highmark Medicare Services (Cahaba)**
    - Contract is still in dispute under a “stay of performance”
    - Cahaba will continue “in a holding pattern”
- All transitions to the new MACs will stop until the contested contract awards are settled

# Nursing Homes and COPs

- Companion COP for nursing homes expected as proposed rule in 2010
- State surveyors required to look at a hospice patient's chart when surveying the nursing home
- Nursing facility deficiencies (F-tags) could include the hospice:
  - F-309: Failure to coordinate care and services”**

# Medicare Fraud and Abuse

- HHS and DOJ create a new interagency effort to combat Medicare fraud
- Goals
  - strengthen existing programs to combat fraud
  - invest new resources and technology to prevent fraud, waste and abuse before it happens
- OIG also looking at fraud and abuse in hospice

# Medicare Fraud and Abuse

- **Initiatives include:**

- Increased training for providers on Medicare compliance
- Improving data sharing between the Centers for Medicare & Medicaid Services and law enforcement
- Strengthening program integrity activities to monitor and ensure Medicare Parts C (Medicare Advantage plans) and D (prescription drug programs) compliance and enforcement

# Medicare Fraud and Abuse

## What You Can Do to Prepare

- Be compliant with all regulations
- Be aware of any practice in your daily business or operation that could possibly be viewed as a kickback or inducement
- Ensure that your hospice has a compliance program in place and that staff are trained when hired and in-services are offered regularly

# FDA

## – Opioid shortages

- Due to closure of ETHEX as manufacturer

## – Unapproved drugs initiative

- Morphine sulfate liquid concentrate in the 20 mg/mL concentration now approved for Roxanne

## – REMS

- Development of a Risk Evaluation and Mitigation Strategy for long-acting and extended release opioids

## – Emergency Prescribing

- Definition of emergency
- Work with DEA

# Questions



# NHPCO's Regulatory & Compliance Center



**Are You Compliant?**  
Visit the Regulatory page for helpful resources!

### Regulatory & Compliance Issues

- Hot regulatory topics
- NHPCO regulatory alerts
- CMS

### Hospice Wage Index

- Hospice reimbursement rates
- Wage index information

### Hospice Billing

- Billing guidance
- Fiscal intermediary information
- Revised ABN form (CMS-R-131)

### Hospice Operations

- Hospice care environments (nursing home, assisted living facility, etc...)
- Hospice administration

### Clinical Care

- Pain and symptom management
- Patient care

### Download a Web Page Tip Sheet

### NHPCO Resources

### Contact NHPCO's Regulatory & Compliance Team



# Resources & References

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- National Hospice and Palliative Care Organization
  - [www.nhpco.org/regulatory](http://www.nhpco.org/regulatory)
- CMS website for the most updated resources
  - [www.cms.hhs.gov/center/hospice.asp](http://www.cms.hhs.gov/center/hospice.asp)
- Medicare Benefit Policy Manual
  - [www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf](http://www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf)
- Office of the Inspector General
  - [www.oig.hhs.gov](http://www.oig.hhs.gov)

