Update from Washington – The Latest in Hospice Regulatory and Quality

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Learning Outcomes

1. Describe 3 data trends that are concerns for policymakers in hospice care
2. List changes in the survey process and enforcement implemented in 2022
3. Describe 2 new quality measures for hospices implemented in 2022

Hospice Data Trends - 2020

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Total Number of Hospices

TABLE 11–1

Increase in total number of hospices driven by growth in for-profit providers

Category	2010	2017	2018	2019	2020	Average annual percent change 2010–2019	Percent change 2019–2020
All hospices	3,498	4,488	4,639	4,840	5,058	3.7%	4.5%
For profit	1,958	3,101	3,234	3,436	3,680	6.4	7.1
Nonprofit	1,316	1,226	1,245	1,255	1,220	–0.5	–2.8
Government	224	161	159	148	147	–4.5	–0.7
Freestanding	2,401	3,525	3,701	3,936	4,178	5.6	6.1
Hospital based	609	470	453	429	415	–3.8	–3.3
Home health based	465	471	463	456	444	–0.2	–2.6
SNF based	23	22	22	19	19	–2.1	0.0
Urban	2,485	3,603	3,760	3,976	4,196	5.4	5.5
Rural	950	879	872	859	850	–1.1	–1.0

Note: SNF (skilled nursing facility). Some categories do not sum to total because of missing data for some providers. The rural and urban definitions used in this table are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census).

Source: MedPAC analysis of Medicare cost reports, Provider of Services file, and Medicare hospice claims data from CMS.

Share of Medicare Decedents Using Hospice

TABLE 11–2

Number of Medicare decedents and number of decedents using hospice grew substantially in 2020

	2010	2017	2018	2019	2020	Average annual percent change 2010–2019	Percent change 2019–2020
Number of Medicare decedents (millions)	1.99	2.28	2.31	2.32	2.73	1.7%	17.6%
Number of Medicare decedents who used hospice (millions)	0.87	1.14	1.17	1.20	1.31	3.6	9.0
Share of decedents who used hospice	43.8%	49.8%	50.6%	51.6%	47.8%		

Note: The number of decedents who used hospice reflects decedents who used hospice in the last calendar year of life. Analysis excludes beneficiaries without Medicare Part A because hospice is a Part A benefit. Yearly figures presented in the table are rounded, but figures in the percent change columns were calculated using unrounded data.

Source: MedPAC analysis of data from the Common Medicare Enrollment file and hospice claims data from CMS.

A Focus on Equity

	Share of Medicare decedents who used hospice					
	2010	2018	2019	2020	Average annual percentage point change 2010–2019	Percentage point change 2019–2020
Race/ethnicity						
White	45.5	52.7	53.8	50.8	0.9	–3.0
Black	34.2	39.7	40.8	35.5	0.7	–5.3
Hispanic	36.7	42.5	42.7	33.3	0.7	–9.4
Asian American	30.0	38.8	39.8	36.1	1.1	–3.7
North American Native	31.0	37.8	38.5	33.5	0.8	–5.0

Source: MedPAC March 2022 Report to Congress

Location of Care in 2020

TABLE 11–5

The location of hospice care shifted in 2020

Main location of hospice care	Number of Medicare decedents who received hospice (in thousands) 2019	2020	Percent change 2019–2020
Home	588	696	18%
Nursing facility	248	233	–6%
Assisted living facility	136	150	11%
Hospice facility	135	126	–7%
Hospital	87	96	10%

Note: "Main location of hospice care" reflects the setting in which the hospice patient received the most days of care.

Source: MedPAC analysis of data from the Common Medicare Enrollment file and hospice claims data from CMS.

Length of Stay

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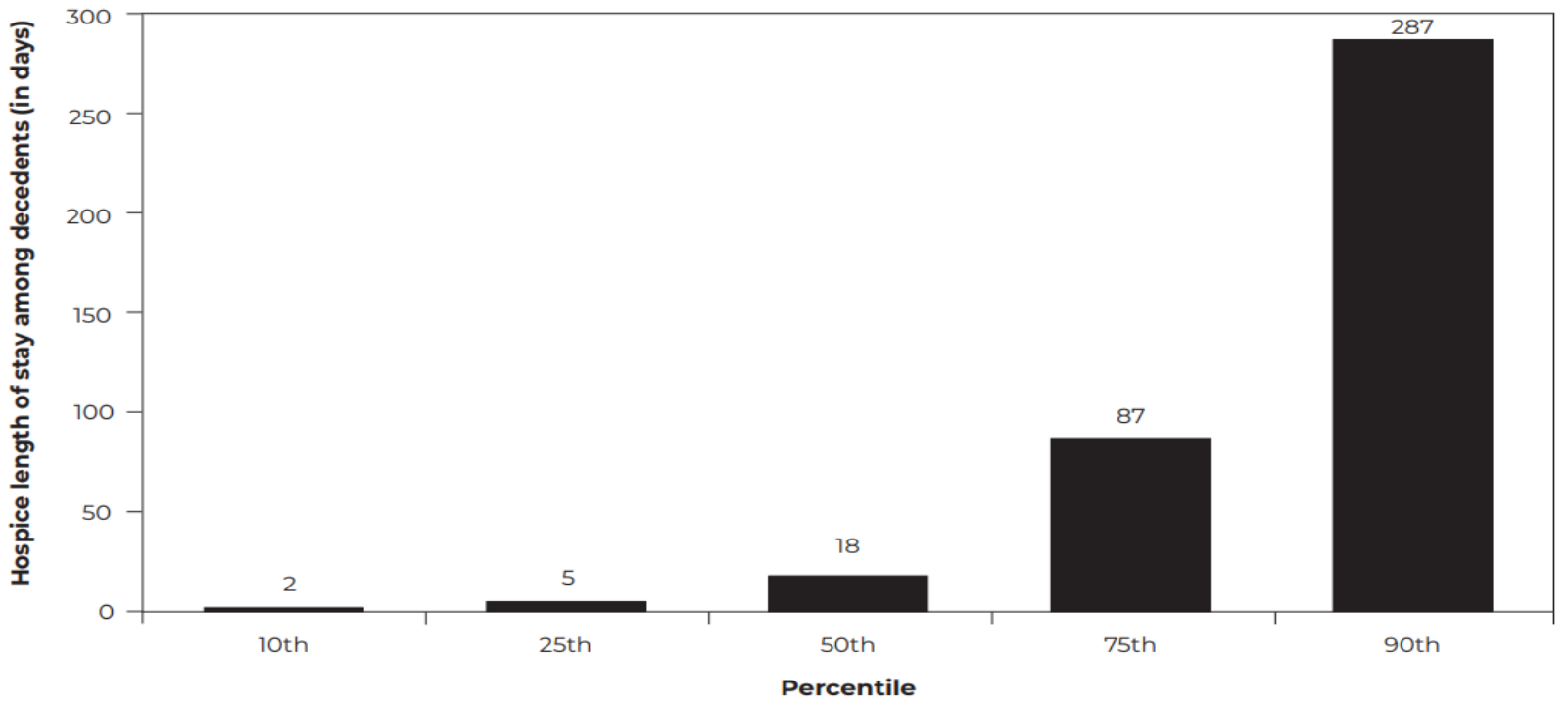
Hospice Length of Stay by Percentile

FIGURE 11–2

Most hospice decedents in 2020 had relatively short stays, but some had very long stays



Note: Lifetime length of stay is calculated for decedents who were using hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during their lifetime.

Source: MedPAC analysis of the Common Medicare Enrollment file and the Medicare Beneficiary Database from CMS.

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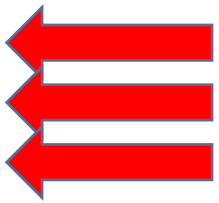
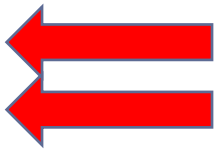
TABLE 11–7

Hospice length of stay among decedents by beneficiary and hospice characteristics, 2020

Characteristic	Average length of stay (in days)	Percentile of length of stay				
		10th	25th	50th	75th	90th
Beneficiary						
Diagnosis						
Cancer	53	3	6	16	50	129
Neurological conditions	161	4	9	40	191	483
Heart/circulatory	109	2	5	19	101	324
COPD	135	3	6	32	156	403
Other	54	2	3	7	31	149
Main location of care						
Home	90	3	7	23	82	244
Nursing facility	133	3	7	26	145	410
Assisted living facility	172	5	13	59	222	491





Source: MedPAC March 2022 Report to Congress

In Person Visits per Week

TABLE 11–11

Average number of in-person visits per week declined in 2020

	Average number of visits or calls per patient per week		
	2018	**2019**	**2020**
Total visits	4.4	4.3	3.5
Nurse visits	1.8	1.8	1.6
Aide visits	2.2	2.2	1.7
Social worker visits	0.3	0.3	0.2
Social worker calls and visits	0.4	0.4	0.3

Note: "Visits" refer to in-person visits only. "Nurse visits" include both registered nurse and licensed practical nurse visits. Number of visits by category may not sum to total due to rounding.

Source: MedPAC analysis of Medicare hospice claims data from CMS.

Live Discharges

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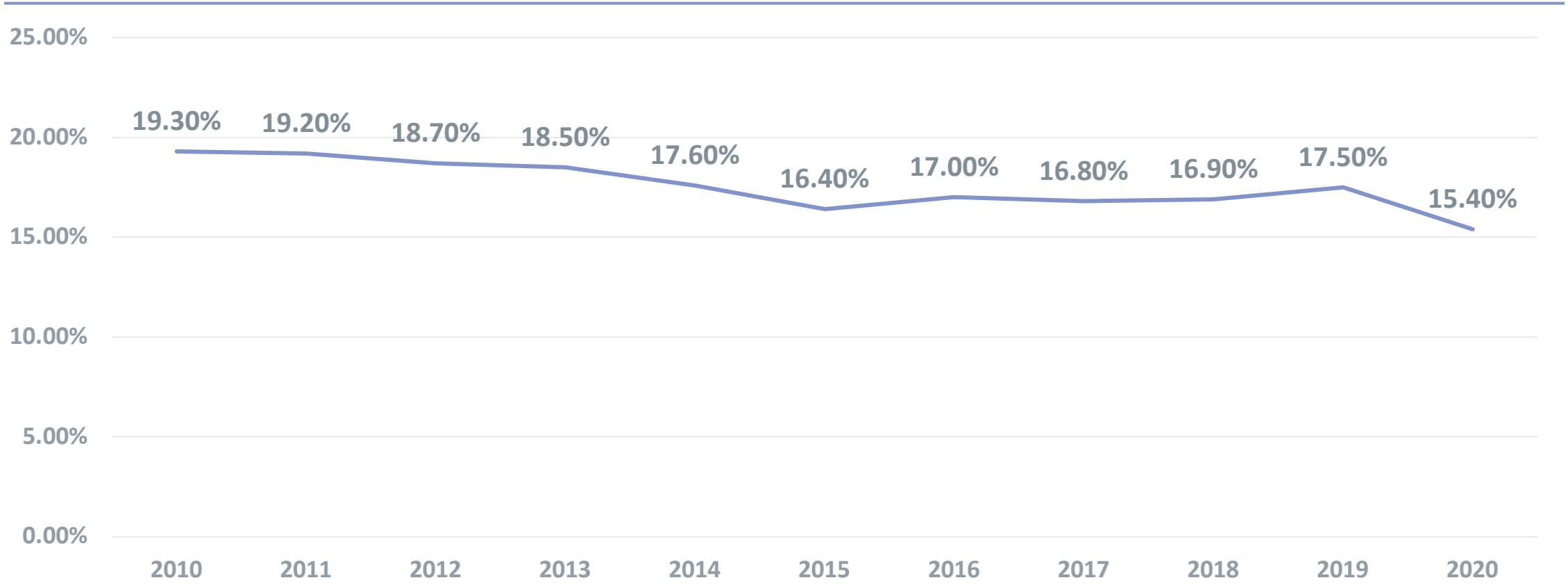
Live Discharges by Fiscal Year



Source: Analysis of FY 2010 through 2019 from CCW on January 15, 2021. Analysis of FY 2020 from MedPAC March 2022 Report to Congress.

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Reasons for Live Discharge 2018-2020

TABLE 11–13 **Rates of hospice live discharge and reported reason for discharge, 2018–2020**

Category	2018	2019	2020
Live discharges as a share of all discharges, by reason for live discharge			
All live discharges	17.0%	17.4%	15.4%
No longer terminally ill	6.3	6.5	5.6
Beneficiary revocation	6.6	6.5	5.7
Transferred hospice providers	2.2	2.3	2.2
Moved out of service area	1.6	1.7	1.6
Discharged for cause	0.3	0.3	0.3

Source: MedPAC March 2022 Report to Congress

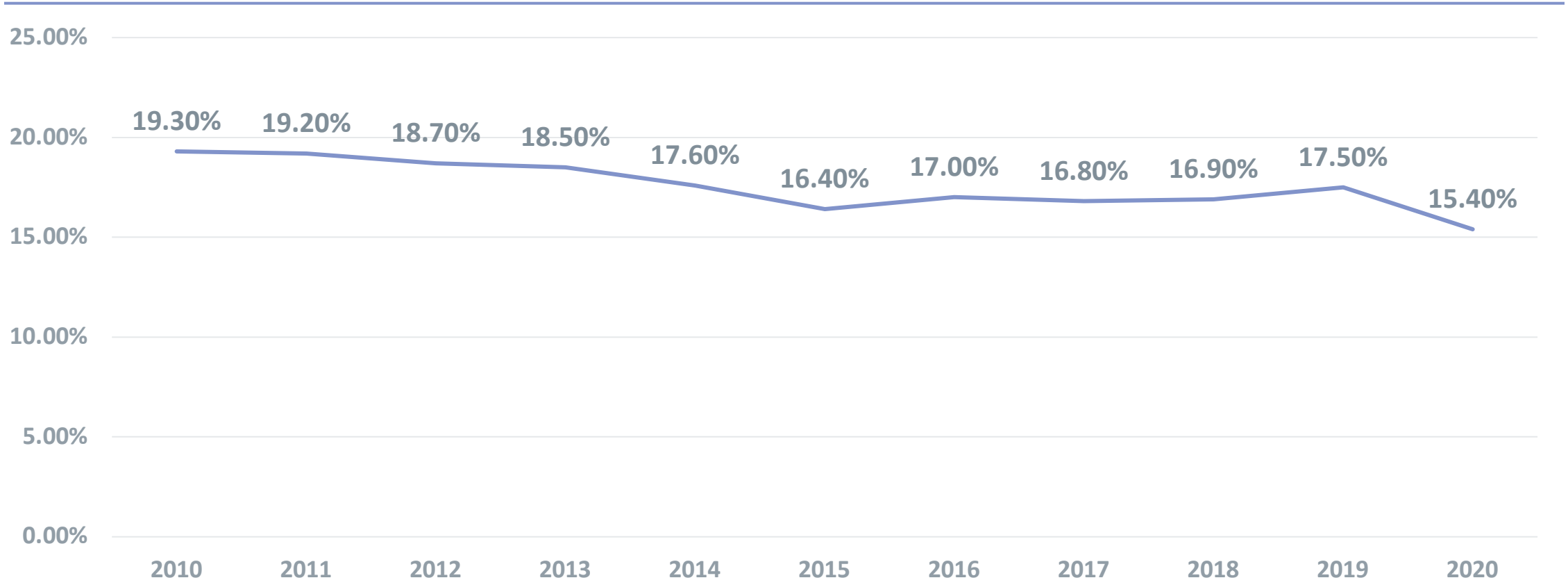
Live Discharges by Provider Percentile

Category	2018	2019	2020
Providers' overall rate of live discharge as a share of all discharges, by percentile (for providers with more than 30 discharges)			
10th percentile	8.5%	8.6%	7.5%
25th percentile	12.0	12.3	10.9
50th percentile	17.9	18.9	16.9
75th percentile	27.8	29.5	26.6
90th percentile	42.5	46.6	43.3

Note: Percentages may not sum to total due to rounding. "All discharges" includes patients discharged alive or deceased.

Source: MedPAC analysis of the 100 percent hospice claims standard analytical file, Medicare hospice cost reports, and Medicare Provider of Services file from CMS.

Live Discharges by Fiscal Year



Source: Analysis of FY 2010 through 2019 from CCW on January 15, 2021. Analysis of FY 2020 from MedPAC March 2022 Report to Congress.

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Hospice Margins

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Hospice Aggregate Margins

TABLE 11–16 **Hospice Medicare aggregate margins by selected characteristics, 2015 to 2019**

Category	Share of hospices 2019	2015	2016	2017	2018	2019
All	100%	9.9%	10.9%	12.5%	12.4%	13.4%
Freestanding	81	13.8	14.0	15.3	15.1	16.2
Home health based	9	3.3	6.2	8.1	8.4	9.6
Hospital based	9	–23.8	–16.7	–13.8	–16.5	–18.4
For profit	71	17.7	17.9	20.0	19.0	19.2
Nonprofit	26	0.1	2.2	2.5	3.8	6.0
Urban	82	10.4	11.4	12.9	12.6	13.6
Rural	18	4.8	6.3	8.9	10.3	11.5

Source: MedPAC March 2022 Report to Congress

Non Hospice Spending

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TABLE 11–22

Nonhospice spending and service use among hospice beneficiaries, 2018

Medicare services	Program spending and beneficiary cost sharing (in millions)	Share of spending	Share of beneficiaries with overlapping service
All	$1,256	100%	47.4%
Any Part A or Part B	748	60	34.4
Inpatient	173	14	0.9
SNF	18	1	0.1
Home health	18	1	1.8
Outpatient	177	14	10.1
Physician and supplier	301	24	28.5
DME	61	5	6.2
Part D	508	40	31.6*

Note: SNF (skilled nursing facility), DME (durable medical equipment). Spending reflects Medicare program spending and beneficiary cost sharing for nonhospice services received while a beneficiary was enrolled in hospice. For Part D, spending includes the plan payment amount, low-income cost-sharing subsidy, and beneficiary cost sharing. Nonhospice services furnished on the first day of hospice election or the day of a live discharge are excluded. Data are not wage adjusted.
*The 31.6 percent of hospice beneficiaries with a Part D overlapping service is calculated using data for all hospice beneficiaries, including those without Part D. Among hospice beneficiaries with Part D, the percentage with an overlapping Part D prescription is about 40 percent.

Spending Outside the Hospice Benefit by Claim Type

Claim Type	FY 2016	FY 2017	FY 2018	FY 2019
Durable Medical Equipment	$38,702631	$40,740,569	$46,385,066	$54,465,708
Home Health Agency	$19,860,890	$17,491,197	$16,181,405	$16,274,141
Inpatient	$136,926,412	$132,750,947	$139,348,335	$141,717,834
Outpatient	$104,866,171	$109,554,523	$120,840,000	$135,302,250
Physician Billing	$261,085,794	$272,239,518	$296,053,914	$335,142,715
Skilled Nursing Facility	$21,301,311	$15,271,476	$12,711,167	$9,249,967

Source: Analysis of 100% Medicare Part A and B claims analytic files, FY 2016 – 2019 from the CCW, accessed January 15, 2021.

Spending Outside the Benefit Example

- Primary diagnosis of a heart or circulatory condition
  - Had an inpatient hospital admission paid by Medicare FFS while on hospice
    - 27% of those hospital stays had a primary diagnosis of a heart or circulatory condition
  - Had physician or outpatient claims
    - 21% of claims had a primary diagnosis of a heart or circulatory condition

Looking at DME Claims

- Recent OIG audit of FFS claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) furnished to hospice enrollees between January 2015 and April 2019
- Evidence of inappropriate payments for these services (Office of Inspector General 2021b).
- OIG sample of claims and extrapolated:
  - Estimated that **$117 million out of $186 million** in Medicare payments to DMEPOS providers were inappropriate because the services were for palliation or management of the hospice enrollee's terminal condition or related conditions.
- **Factors contributing to inappropriate payments**
  1) DMEPOS supplier was unaware of the beneficiary's hospice status
  2) DMEPOS claims processing contractor's system edits that should have prevented the improper payments were not effective or did not exist
  3) Some DMEPOS suppliers inappropriately appended a modifier to the claim (the GW modifier) indicating the service was unrelated to the hospice enrollee's terminal condition or related conditions, when the service was actually related

Part D Details from 2018 Analysis

- $508 million in 2018
- 40% received a Part D covered prescription while enrolled in hospice
- Categories of drugs that accounted for the most 2018 Part D spending:
  - Antidiabetics ……..... $74 million
  - Psychotherapeutic and neurological agents …….. $47 million
  - Anti-asthmatic and bronchodilator agents …….. $44 million
  - Anticoagulants …….. $43 million
- Higher Part D spend:
  - Under age 65
  - Dually eligible for Medicare and Medicaid
  - Resided in long-term care facilities
  - Discharged alive or revoked their hospice election

Option 1 for Improving Non-Hospice Spending

- FFS Medicare could bundle into the hospice benefit **all services a beneficiary would need, regardless of whether they are related to the terminal condition and related conditions.**
- A fully bundled approach would have the benefit of simplicity in that there would be no need to distinguish between related and unrelated services.
- It would require hospices to take on more financial risk, and as a result, it might increase incentives for some providers to encourage patients to disenroll from hospice as a way to shift costs to FFS if a beneficiary incurs an expensive service.
- A live discharge penalty could potentially be paired with a bundled policy as one way to address concerns about live discharges under a bundled approach.

Option 2 for Improving Non-Hospice Spending

- Hospice providers with nonhospice spending **above a specified threshold could be subject to a penalty that would reduce their hospice payments by a certain amount**
- Penalty policy would place some financial risk on providers, but less risk than a bundled policy
- A penalty could give providers an incentive to ensure that they effectively educate families and beneficiaries about the scope of services available from hospice and who the family should call in an emergency
- It could also give hospices an incentive to coordinate with providers that previously provided services to the beneficiary to ensure that they do not bill Medicare for additional services once the beneficiary has enrolled in hospice

Q42021 Hospice PEPPER

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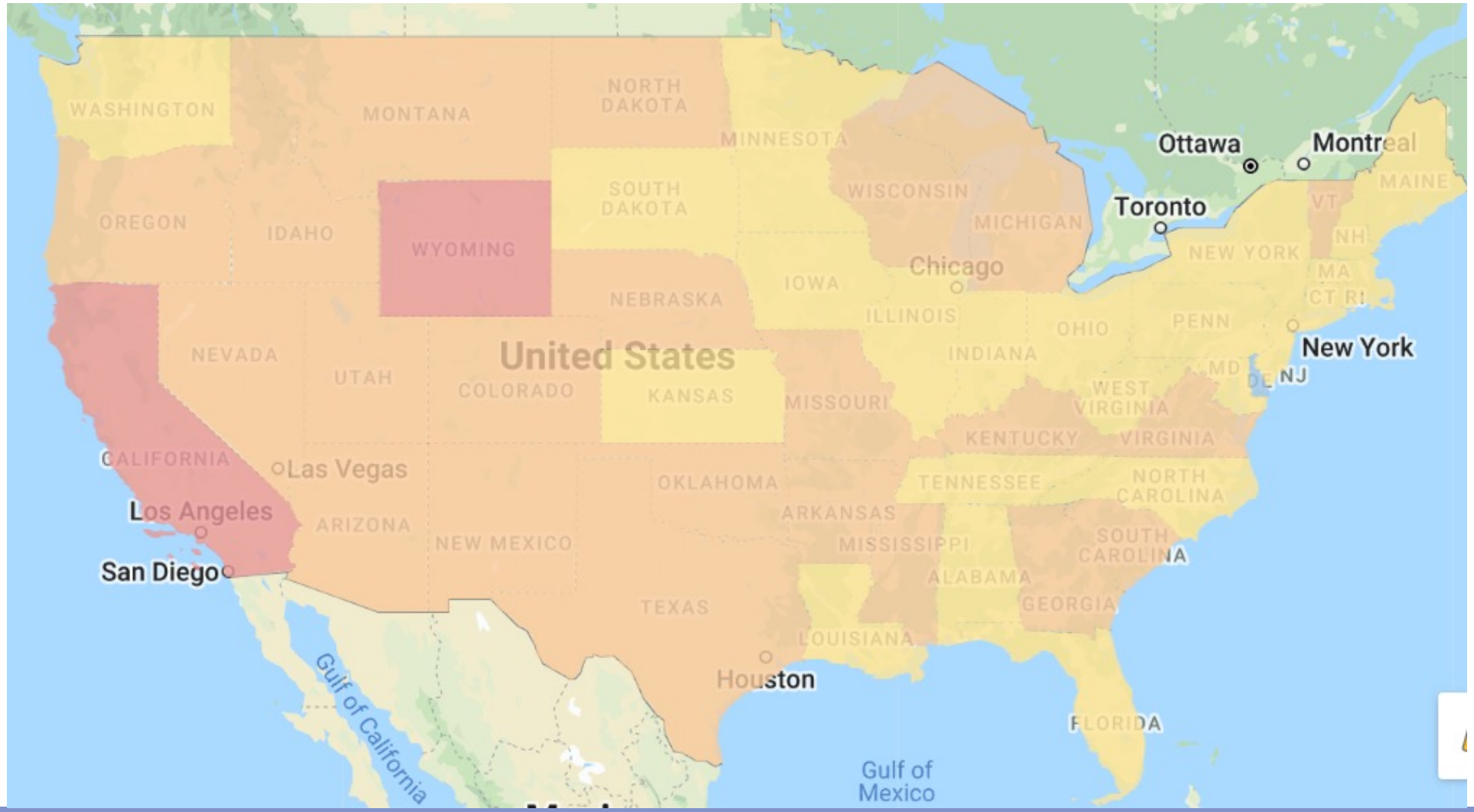
What's New in Hospice PEPPER

- Q4 2021 Hospice PEPPER released on April 5, 2022
- Three new target areas were added:
  - Average Number of Medicare Part D Claims for Beneficiaries Residing at **Home**
  - Average Number of Medicare Part D Claims for Beneficiaries Residing in an **Assisted Living Facility**
  - Average Number of Medicare Part D Claims for Beneficiaries Residing in a **Nursing Facility**
- One target area was deleted: Average Number of Medicare Part D Claims per Hospice Episode

Source: Hospice PEPPER: https://pepper.cbrpepper.org/

Percent of hospices that accessed PEPPER in the state: 80-100% 60-79% 40-59% 20-39% 0-19%



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PEPPER

Oklahoma Status

- Release: Q4FY21
  Available: 114
  Downloaded: 40
  Downloaded Percent: 35%
  National Download Rate: 32%

Why PEPPER?

- National hospice claims data analyzed
- Identifies areas within the hospice benefit, which could be at risk for improper Medicare payment
- These areas are referred to as “target areas”

Source: Hospice PEPPER: https://pepper.cbrpepper.org/

Participation in Hospice Quality Reporting

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Change to APU Reduction

- Beginning in FY 2024, a **4% reduction** will be applied to the coordinating APU year for failure to report HQRP data.
  - Data collection year: **Calendar year 2022**
- 2% reduction to the APU will remain through FY 2023
  - Data collection year: Calendar year 2021
- Impact on payments:
  - Annual market basket update could be less than the payment reduction
  - Payment rates could be less than payment rates for the preceding FY

APU UPDATE

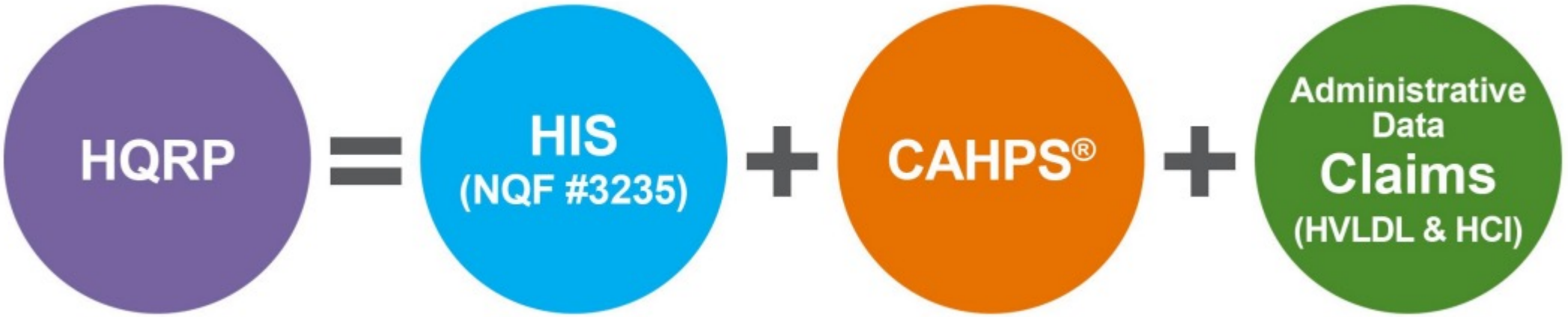
Compliance for no APU penalty

- Achievement of 90% HIS submission in a calendar year; there is no exemption for submitting HIS data
- Timely submission of 4 quarters of CAHPS data
  - There is a size and newness exemption for submitting CAHPS data https://hospicecahpssurvey.org/en/participation-exemption-for-size/

Reporting Year for HIS and Data Collection Year for CAHPS data (Calendar year)	Annual Payment Update Impacts Payments for the FY	Reference Year for CAHPS Size Exemption (CAHPS only)
CY 2020	FY 2022 APU	CY 2019
CY 2021	FY 2023 APU	CY 2020
CY 2022	FY 2024 APU*	CY 2021
CY 2023	FY 2025 APU	CY 2022

* Beginning in FY 2024 and all subsequent years, the payment penalty is 4 percent. Prior to FY 2024, the payment penalty is 2 percent.

The Updated HQRP



The New HQRP combines sources of data from the HIS, and CAHPS®, with administrative data (e.g., Medicare claims)

Source: The FY 2022 Hospice Final Rule: What Hospices Need to Know!
https://www.cms.gov/files/document/2021aug31hospice-final-rule-webinar.pdf

New Hospice Measures

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HQRP Quality Measure Summary

HIS Comprehensive Assessment Measure at Admission (NQF #3235)	• The proportion of patients for whom the hospice performed all seven care processes as applicable.
HVLDL (Claims-based)	• The proportion of patients who have received in-person visits from a registered nurse or a medical social worker on at least 2 out of the final 3 days of life.
HCI (Claims-based)	• A single measure comprising ten indicators calculated from Medicare claims.
CAHPS® Hospice Survey (NQF #2651)	• All eight of the CAHPS® Hospice Survey measures are endorsed under NQF #2651.

Hospice Visits in the Last Days of Life (HVLDL)

- The “Hospice Visits in the Last Days of Life” (HVLDL) measure is the respecified Hospice Visits When Death is Imminent” measure pair.
- Claims-based measure
  - Does not require the provider to collect/submit measure data
  - Data is collected from Medicare claims
- CMS will start publicly reporting the HVLDL measure beginning no earlier than **May 2022.**

Measure Description

Measure title	Hospice Visits in the Last Days of Life (HVLDL)
Measure type	Process
Data source	Hospice claims
Measure numerator	The number of patient stays in the denominator in which the patient and/or caregiver received **at least two days with visits from registered nurses or medical social workers in the final three days of life**
Measure denominator	All hospice patient stays enrolled in hospice except those meeting exclusion criteria.

Exclusion criteria

1. Patient did not expire in hospice care as indicated by reason for discharge
2. Patient received any continuous home care, respite care or general inpatient care in the final three days of life
3. Patient enrolled in hospice less than three days.

Hospice Care Index (HCI) Measure

Why this new measure?

- Solicitation of feedback from hospice stakeholders such as:
  - providers and family caregivers;
  - hospice and quality experts through a Technical Expert Panel (TEP);
  - interviews with hospice quality experts;
  - Consideration of public comments received in response to previous solicitations on claims-based hospice quality initiatives; and
  - a review of quality measurement recommendations offered by the HHS Office of Inspector General (OIG), MedPAC, and the peer-reviewed literature.

Hospice Care Index (HCI) Measure

- The HCI will provide more information to better reflect several processes of care during a hospice stay, and better empower patients and family caregivers to make informed health care decisions.
- **Key characteristics**
  - Composite measure with 10 indicators
  - Claims based measure – data is taken from Medicare claims for calculation
  - Represents different aspects of hospice services
  - Designed to help identify whether hospices have aggregate performance trends that indicate higher or lower quality of care relative to other hospices

HCI Score

- Each indicator is equal with a score of 1
- The sum of the points earned from meeting the criterion of each indictor results in the hospice's aggregated single HCI score
- Goal is to get the highest score possible -- a score of 10 is the highest hospice score
- As a claims-based measure, the HCI measure would not impose any data collection/submission requirements for the provider
- CMS has produced a You Tube video on the background of the HCI: https://youtu.be/by68E9E2cZc

HCI #1: No CHC or GIP care

Total number of CHC or GIP services days
provided by the hospice within a reporting period

Total number of hospice service days
provided by the hospice at any level of care within a reporting period.

Index Earned Point Criterion

1 point = Hospices earn a point towards the HCI if they provided **at least one CHC or GIP service day** within a reporting period.

HCI #2: Gaps in nursing visits greater than 7 days

Number of elections with the hospice where the patient experienced at least one gap between nursing visits exceeding 7 days (**more than 8 consecutive days**), excluding hospice elections where the patient elected hospice
for less than 30 days within a reporting period.

Total number of elections with the hospice,
excluding hospice elections where the patient elected hospice
for less than 30 days within a reporting period

Index Earned Point Criterion

1 point = Hospices earn a point towards the HCI if their individual hospice score for gaps in skilled nursing visits greater than 7 days falls **below the 90th percentile** ranking among hospices nationally.

Nursing visit = includes RN and LPN/LVN visits to recognize the frequency of skilled nursing visits and to maintain consistency in HCI when using revenue center code 055X.

HCI #3: Early Live Discharges

Total number of live discharges from the hospice occurring within the first 7 days of hospice within a reporting period.

The total number of all live discharge from the hospice within a reporting period.

Index Earned Point Criterion

1 point = Hospices earn a point towards the HCI if their individual percentage of live discharges on or before the seventh day of hospice falls **below the 90th percentile** ranking among hospices nationally.

HCI #4: Late Live Discharges

Total number of live discharges from the hospice occurring **on or after 180 days of enrollment** in hospice within a reporting period.

The total number of all live discharge from the hospice within a reporting period.

Index Earned Point Criterion:

1 point = Hospices earn a point towards the HCI if their individual hospice score for live discharges on or after the 180th day of hospice **falls below the 90th percentile** ranking among hospices nationally

HCI #5: Burdensome Transitions (Type 1) - Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission

Total number of live discharges from the hospice followed by hospital admission within 2 days, **then hospice readmission within 2 days of hospital discharge** within a reporting period.

The total number of all live discharge from the hospice within a **reporting period.**

Index Earned Point Criterion

Hospices earn a point towards the HCI if their individual hospice score for Type 1 burdensome transitions **falls below the 90th percentile** ranking among hospices nationally.

HCI #6: Burdensome Transitions (Type 2) - Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital

$$\frac{\text{Total number of live discharges from the hospice followed by a hospitalization within 2 days of live discharge with death in the hospital within a reporting year.}}{\text{Total number of all live discharge from the hospice within a reporting year.}}$$

Index Earned Point Criterion

1 point = Hospices earn a point towards the HCI if their individual hospice score for Type 2 burdensome transitions **falls below the 90th percentile** ranking among hospices nationally.

HCI #7: Per-beneficiary Medicare Spending

$$\frac{\text{Total Medicare hospice payments received by a hospice within a reporting period.}}{\text{Total number of beneficiaries electing hospice with the hospice within a reporting period.}}$$

Index Earned Point Criterion

1 point = Hospices earn a point towards the HCI if their average Medicare spending per beneficiary **falls below the 90th percentile** ranking among hospices nationally.

HCI #8: Skilled Nursing Care Minutes per Routine Home Care (RHC) Day

Total skilled nursing minutes provided by a hospice on all RHC service days within a reporting period.

The total number of RHC days provided by a hospice within a reporting period.

Index Earned Point Criterion

1 point = Hospices earn a point towards the HCI if their individual hospice score for Skilled Nursing Minutes per RHC day falls **above the 10th percentile** ranking among hospices nationally**.**

Nursing visit = includes RN and LPN/LVN visits to recognize the frequency of skilled nursing visits and to maintain consistency in HCI when using revenue center code 055X.

HCI #9: Skilled Nursing Minutes on Weekends

Total sum of minutes provided by the hospice during skilled nursing visits during RHC services days occurring on **Saturdays or Sunday** within a reporting period.

Total skilled nursing minutes provided by the hospice during RHC service days within a reporting period.

Index Earned Point Criterion

1 point = Hospices earn a point towards the HCI if their individual hospice score for percentage of skilled nursing minutes provided during the weekend is **above the 10th percentile** ranking among hospices nationally.

Nursing visit = includes both RN and LPN/LVN visits to recognize the frequency of skilled nursing visits and to maintain consistency in HCI when using revenue center code 055X.

HCI #10: Visits Near Death

The number of decedent beneficiaries receiving a visit
by a skilled nurse or social worker for the hospice
in the last 3 days of the beneficiary's life within a reporting period.

The number of beneficiaries with at least 1 day of hospice
during the last 3 days of life within a reporting period.

Index Earned Point Criterion

1 point = Hospices earn a point towards the HCI if their individual hospice score for percentage of decedents receiving a visit by a skilled nurse or social worker in the last 3 days of life falls above the 10th percentile ranking among hospices nationally.

Visits by RN, LPN/LVN and nurse practitioners (unless the nurse practitioner is acting as the beneficiary's attending physician) are reported under revenue code 055x

HCI Measure

- CMS added the HCI composite measure to the HQRP **starting in FY 2022.**
- The HCI measure will be added to public reporting beginning no earlier than **May 2022.**
- Update
  - CASPER - Hospice Reporting User's Guide
    - CMS updated Section 4 - Hospice Quality Reporting Program (v1.05) in August 2021 to include information about the HCI measure Hospice-Level Quality Measure Report.

Preview Reports Now Available for May 2022 Refresh

- **NOW AVAILABLE IN QIES - Preview Reports for the May 2022 Refresh**
- Providers can now access the latest Provider Preview Reports via the Certification and Survey Provider Enhanced Reports (CASPER) application. These reports preview data that will be displayed on the Care Compare website in May 2022.
- For this refresh, two new Claims-based measures will be added for public reporting:
  - Hospice Care Index (HCI)
  - Hospice Visits in the Last Days of Life (HVLDL)

Hospice CAHPS® Survey

Star Rating Update

- **Star Ratings Publicly Reported**
- Beginning with the August 2022 refresh of Care Compare, a Family Caregiver Survey Rating summary Star Rating will be publicly reported
  - for all hospices with 75 or more completed surveys over the reporting period
  - Star Ratings will be updated every other quarter
- **Preview Report**
  - During the provider preview period prior to each update of Care Compare.
  - Hospices will first see their Star Ratings in their Preview Reports during the preview periods for the February 2022 and May 2022 updates of Care Compare.
- **Dry Runs**

  February and May 2022

  Reporting period for the dry run is October 1, 2018 – December 31, 2019;

  July 1, 2020 – March 31, 2021.

Resources on **CAHPS®** Star Ratings

- **Star Ratings Overview**
  An overview of the purpose, timeline and methods for calculating CAHPS Hospice Survey Star Ratings is available here.
- **Star Ratings FAQs**
  Frequently asked questions regarding CAHPS Hospice Survey Star Ratings are available here.
- **National and State Distributions**
  The national and state distributions of Family Caregiver Survey Rating Summary Stars for the dry run reporting period are available here
- **Methods to Calculate CAHPS® Hospice Survey Star Ratings**
- A detailed description of the methods used to calculate CAHPS Hospice Survey Star Ratings is available here.

New Hospice Survey Process and Enforcement Remedies

NHPCO

Changes in Survey Requirements

- Application and Reapplication Procedures for National Accrediting Organizations (§ 488.5)
- Release and Use of State **and** AO Survey Findings (§ 488.7)
- Hospice Program Surveys and Hospice Hotline (§ 488.1110)
- Surveyor Qualifications/Conflict of Interest (§ 488.1110/1115)
- Multidisciplinary Survey Teams (§ 488.1120)

Source: CY 2022 Home Health Final Rule, November 2, 2021

Surveys and Deficiencies

- Code of Federal Regulations 42 CFR 488 - Survey, Certification, and Enforcement Procedures
- Subpart M: Survey and Certification of Hospice Programs:
- EXAMPES of the **NEW** definitions § 488.1105
  - Condition level deficiency: noncompliance as described in § 488.24
  - Standard level deficiency: noncompliance with one or more of the standards that make up each condition of participation for hospice programs.
  - Noncompliance: any deficiency found at the condition or standard level
  - Substantial compliance: compliance with all condition level requirements, as determined by CMS or the State.

Source: CY 2022 Home Health Final Rule, November 2, 2021

Surveys and Deficiencies (cont'd)

- **NOTE: IMMEDIATE JEOPARDY DEFINITION** (CMS SOM Appendix Q):
  - A situation in which the provider's noncompliance with one or more requirements of participation **has caused, or is likely to cause**, serious injury, harm, impairment, or death to a resident.
  - Only ONE INDIVIDUAL needs to be at risk.
  - Harm does NOT have to occur before considering Immediate Jeopardy.
  - Consider both potential and actual harm when reviewing the triggers in the table.
  - Psychological harm is as serious as physical harm.

Source: CY 2022 Home Health Final Rule, November 2, 2021

Surveyors

- Training must be completed by all surveyors – State survey agencies and Accrediting organizations
- Surveyor training can be accessed by hospice providers and others in the public:
  - https://qsep.cms.gov/
- Training includes testing to confirm surveyor competency
- Surveyors must declare a conflict of interest and recuse themselves if one exists
- Survey teams of more than one surveyor will be multi-disciplinary

Source: CY 2022 Home Health Final Rule, November 2, 2021

New Subpart N-Enforcement Remedies for Hospice Programs with Deficiencies

Effective October 1, 2022

Description of Enforcement Remedies

- General Provisions (§ 488.1210)
- Factors to be Considered in Selecting Remedies (§ 488.1215)
- Available Remedies (§ 488.1220)
- Action when Deficiencies Pose Immediate Jeopardy (§ 488.1225) and Termination (§ 489.53)
- Action when Deficiencies are at the Condition-level but do not Pose Immediate Jeopardy (§ 488.1230)

Five available remedies and termination

- Temporary Management (§ 488.1235)
- Suspension of Payment for all New Patient Admissions (§ 488.1240)
- Civil Monetary Penalties (CMPs) (§ 488.1245)
- Directed Plan of Correction (§ 488.1250)
- Directed In-Service Training (§ 488.1255)
- Termination of Provider Agreement (§ 488.1265)

Source: CY 2022 Home Health Final Rule, November 2, 2021

1. Temporary Management

- Temporary **appointment by CMS** or authorized agency of substitute manager or administrator
  - Must meet qualifications described in §§ 418.100 and 418.114
- Under the direction of the governing body and may be qualified internal organization or external individual.
- Authority to:
  - Hire, terminate or reassign staff
  - Obligate hospice program funds
  - Alter hospice program procedures
  - Manage hospice program to correct deficiencies
  - Related to Condition level deficiency(ies)
  - Deficiencies or hospice management likely to impair ability to correct deficiency(ies)
  - Refusal to relinquish control would result in termination of license
  - Hospice bears cost of the temporary management

Source: CY 2022 Home Health Final Rule, November 2, 2021

2. Payment Suspension

- Suspend payment for **new admissions only**.
- Payment suspension period not to exceed 6 months and would end when the hospice program had achieved substantial compliance or was terminated.
- CMS will provide written notice of the intent to impose a payment suspension remedy at least 2 calendar days before the effective date of the remedy in IJ situations or 15 calendar days before the effective date of the remedy for non-IJ situations.

Source: CY 2022 Home Health Final Rule, November 2, 2021

3. CMP - Civil Monetary Penalties

- Noncompliance with one or more conditions of participation regardless of whether the hospice program's deficiencies pose an immediate jeopardy (IJ) to patient health and safety.
- Impose per day or per instance
- Could impose CMPs for each day of IJ
- May impose for the number of days of noncompliance since the last standard survey, including the number of days of IJ.
- Immediate Jeopardy: CMS SOM Appendix Q

Source: CY 2022 Home Health Final Rule, November 2, 2021

3. CMP - Civil Monetary Penalties (cont'd)

- Not to exceed $10,000 per day
  - Upper, middle and lower range
  - Adjusted annually
- Considerations for penalty amount
  - Size of the hospice program and its resources
  - Evidence of a self-regulating QAPI system that indicates ability to meet the conditions of participation and to ensure patient health and safety.
  - Administrative Hearing Process

Source: CY 2022 Home Health Final Rule, November 2, 2021

CMP Ranges

Range	Description of Deficiency	Civil Monetary Penalty
Upper range	For deficiency that poses IJ to patient health and safety	$8,500 to $10,000 per day of condition level non-compliance
Middle range	For repeat and/or a condition-level deficiency that did not pose IJ but is directly related to poor quality patient care outcomes	$1,500 to $8,500 per day of noncompliance with the CoPs
Lower range	For repeated and/or condition-level deficiencies that did not constitute IJ and were deficiencies in structures or processes that did not directly relate to poor quality patient care	$500 to $4,000 per day of noncompliance

Source: CY 2022 Home Health Final Rule, November 2, 2021

4. Directed Plan of Correction

- Requires the hospice program to take specific actions to bring the hospice back into compliance and correct deficient practices.
- Could be guided by CMS, SA or temporary manager with CMS/SA approval
- Goal to ensure that underlying cause of cited deficiency(ies) do not recur
- Follow-up reports to the directed POC and/or a resurvey to ensure compliance with the directed POC will be at the discretion of CMS or the SA

Source: CY 2022 Home Health Final Rule, November 2, 2021

5. Directed In-Service Training

- Condition level deficiencies
- Implemented where staff performance resulted in noncompliance and in-service training program would correct the deficient practice.
- Instructors would need to have in-depth knowledge of the area)s) that require specific training.
- Hospices would need to utilize well established education and training services (i.e., schools of medicine or nursing, centers for aging etc.).
- Hospice responsible for payment.

Source: CY 2022 Home Health Final Rule, November 2, 2021

Termination

- CMS would terminate the provider agreement if the hospice program:
  - Failed to correct condition level deficiencies within 6 months unless the deficiencies constitute an IJ.
  - Failed to submit an acceptable POC
  - Failed to relinquish control to the temporary manager
  - Failed to meet the eligibility criteria for continuation of payments

Source: CY 2022 Home Health Final Rule, November 2, 2021

Termination

- Termination of the provider agreement would end all payments to the hospice including any payments that were continued.
- Would end enforcement remedies imposed against the hospice regardless of any proposed timeframe for the remedies originally agreed upon.
- If terminated, the hospice is responsible for providing information, assistance and arrangements necessary for the proper and safe transfer of patients to another local hospice program within 30 calendar days of termination.

Source: CY 2022 Home Health Final Rule, November 2, 2021

Continuation of Payments

- CMS may continue payments to a hospice program with condition level deficiencies that do not constitute IJ up to 6 months from the last day of the survey if:
  - An enforcement remedy, or remedies, has been imposed on the hospice and termination has not been imposed.
  - The hospice has submitted a POC approved by CMS
  - The hospice agrees to repay the payments received if corrective action is not taken in accordance with the approved POC and timetable for correction.

Source: CY 2022 Home Health Final Rule, November 2, 2021

Additional Survey Issues - CMS

- Separate from rule, CMS has been working on survey issues:
  - Updates to surveyor training and SOM (State Operations Manual) to emphasize assessment of quality of care in 4 Core CoPs:
    - § 418.52: Patient Rights
    - § 418.54: Initial and comprehensive assessment of patient
    - § 418.56: IDG, care planning and coordination of care
    - § 418.58 QAPI

- **REMINDER**: Survey focus on Infection Control (42 CFR § 418.60), Emergency/Pandemic Preparedness and Response, COVID-19 Response and Required Tracking **will continue to be a top survey priority in 2022.**

Resources for Hospice Survey Preparedness

NHPCO

Preparing for Surveys REMINDER: CMS Survey Types

- Initial Surveys
- Standard Surveys
- Every 36 months at minimum
- Review of select numbers of standards (Level 1)
- Extended Survey
- When any condition level deficiency is found
- **Complaint Survey**
- Validation Survey

- **NOTE: All CMS surveys are unannounced**

Survey Process Overview - Important Notes for Multiple Provider Types and Locations

- Hospices with Home Health service lines or separate Hospice CCNs are surveyed separately but may have similar issues identified (i.e., Governance, QAPI).
- Surveys conducted at multiple locations especially if additional locations added since last survey.
- **Deficiencies found at any location are applicable to the entire hospice**

Survey Process Overview

- The Survey Focus:
  - Patient outcomes
  - Implementation of requirements
  - Provision of care/services
- Surveyor addresses CoPs in the most efficient manner possible.
- Surveyor considers the inter-relatedness of the regulations while evaluating compliance through:
  - Observation
  - Interviews
  - Home Visits
  - Record Reviews (clinical and personnel records).
  - Other documentation (policies/procedures, QAPI, EP/Pandemic Plans, Governing Body minutes, Contracts, IDG communication, HR files, etc.)

CMS State Operations Manual Resources

- CMS State Operations Manual – Appendix M-Guidance to Surveyors: Hospice:
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf

Top 10 Survey Deficiencies: Hospice CY 2021

CoP/Standard	L-Tag	Tag Description
418.56(b)	L0543	Standard: Plan of care
418.60(a)	L0579	Standard: Infection Control - Prevention
418.54(c)(6)	L0530	Standard: Comprehensive Assessment – Drug Profile
418.56(c)	L0545	Standard: Content of Plan of Care
418.56(e)(2)	L0555	Standard: Content of Plan of Care – Coordination of Services
418.56(c)(2)	L0547	Standard: Content of Plan of Care – Scope and Frequency of Services
§418.76(g)	L0625	Standard: Hospice aide assignments and duties
§ 418.56(d)	L0552	Standard: Review of the plan of care
§ 418.54(b)	L0523	Standard: Timeframe for completion of the comprehensive assessment
§ 418.56(c)(4)	L0549	Standard: Drugs and treatment necessary to meet the needs of the patient

Source: S&C QCOR Home Page (cms.gov) Hospice Section, CY 2021

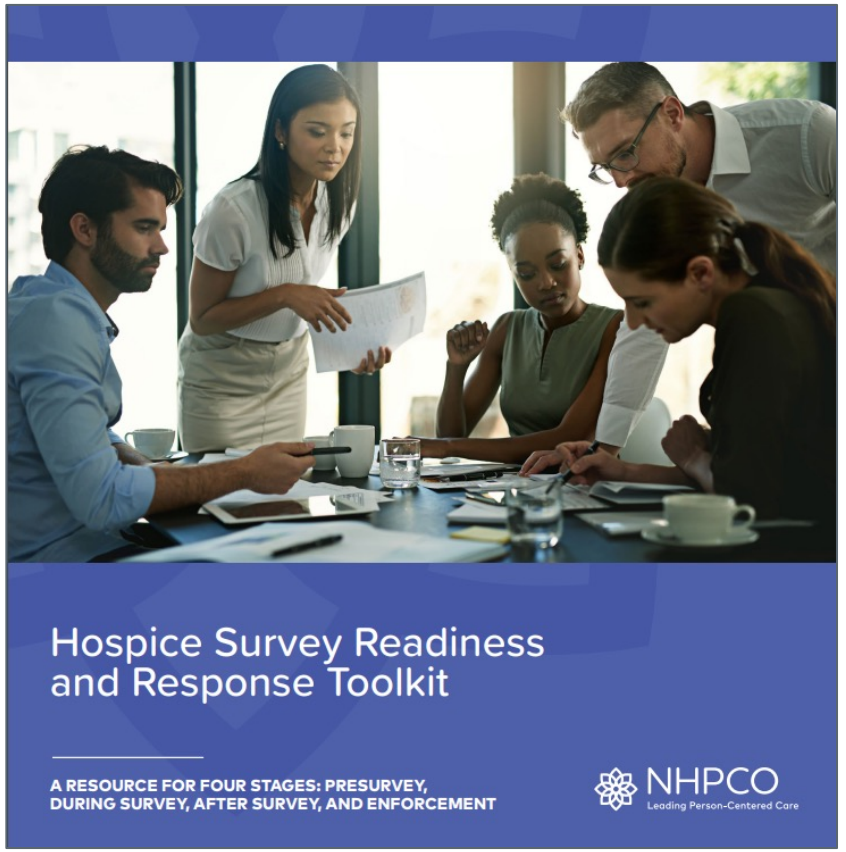
Hospice Survey Readiness and Response Toolkit

1. **Section One: Presurvey Preparation**
   a) SUBPART C – Patient Care
   b) Supplemental Resources – Subpart C
   c) SUBPART D – Organizational Environment
   d) Supplemental Resources – Subpart D

2. **Section Two: During the Survey**
   a) Supplemental Resources

3. **Section Three: After the Survey**
   a) Supplemental Resources

4. **Section Four: Enforcement**
   a) Supplemental Resources



Breaking Hospice Legislative and Regulatory News

NHPCO

1135 Waivers Discontinued

- **Waivers terminated for various providers in 60 days (June 6, 2022):**
  - Facility and Medical Equipment Inspection, Testing & Maintenance (ITM) for Inpatient Hospice, ICF/IIDs and SNFs/NFs
  - Life Safety Code (LSC) and Health Care Facilities Code (HCFC) ITM for Inpatient Hospice, ICF/IIDs and SNFs/NFs
  - Outside Windows and Doors for Inpatient Hospice, ICF/IIDs and SFNs/NFs
- **Questions about 5% requirement for volunteers**
  - This waiver will end once the PHE expires or is terminated.
  - **CMS is not expected to provide a ramp up period to recruit, train, and send out volunteers**. The PHE is expected to be renewed through July but it is unlikely to be renewed again.
  - Providers should start to plan for this process now. For more information on volunteer requirements, check out the Regulatory & Compliance Center Volunteer Services page.

Hospice Face to Face via Telehealth

March 10, 2022:

Congress passed H.R.2471, Consolidated Appropriations Act, 2022, an omnibus funding package which will keep the government funded through the end of fiscal year 2022 (September 30, 2022).

- **Hospice Face-to-Face Included:** **L**egislation included an extension for hospice face-to-face through telehealth for **151 days after the end of the COVID-19 PHE**. These flexibilities were initially enacted as part of the *CARES Act* in 2020.

- It is expected that the PHE will end sometime this summer, allowing this flexibility to continue to be used till December.

Cap Calculation and Sequestration

- Extends the provision for the cap to be updated at the same % as the rate update until FY 2031

- Moratorium for sequestration was **not** extended
- This means:
  - On April 1, 2022, claims submitted for payment will have **1%** of the amount withheld by the MAC
  - On July 1, 2022, claims submitted for payment will have **2%** of the amount withheld.
  - 2% is the original amount withheld (sequestered) prior to May of 2020 and will remain in place for the foreseeable future

MedPAC Releases March 2022 Report to Congress

Recommendations:

- For fiscal year 2023, the Congress should eliminate the update to the 2022 Medicare base payment rates for hospice
- Wage adjust and reduce the hospice aggregate cap by 20 percent
- The Secretary should require that hospices report telehealth services on Medicare claims

New CMS Hospice Transfer Guidance

- Change Request (CR 12619) is creating system edits to prevent gap billing between hospice transfers. Currently, there is no mechanism in place to prevent gap billing.
- Hospice transfers must occur on the same day – there cannot be a break in hospice care or a gap in billing
- If patient is transferring from outside the service area and receiving hospice can't arrange care until the patient reaches the new hospice, hospice may discharge. In this scenario, patient will be required to re-elect hospice coverage at the new hospice
- The hospice transfer will be rejected if the transfer doesn't occur immediately. If the receiving hospice's claim "from date" isn't the same as the "through date" with "patient status" indicating a transfer (codes 50 or 51), the transfer will be rejected
- Effective date is July 1, 2022
- Medlearn Matters has also published an article on this change

News from the MACs

Denial reasons

- Among most common: No response to ADR request

Reporting Post-Mortem Visits

- Post-mortem visits are not being correctly reported using the PM modifier
- Will be counted as an error in the review process
- Could cause SIA payments to be applied incorrectly on the claim

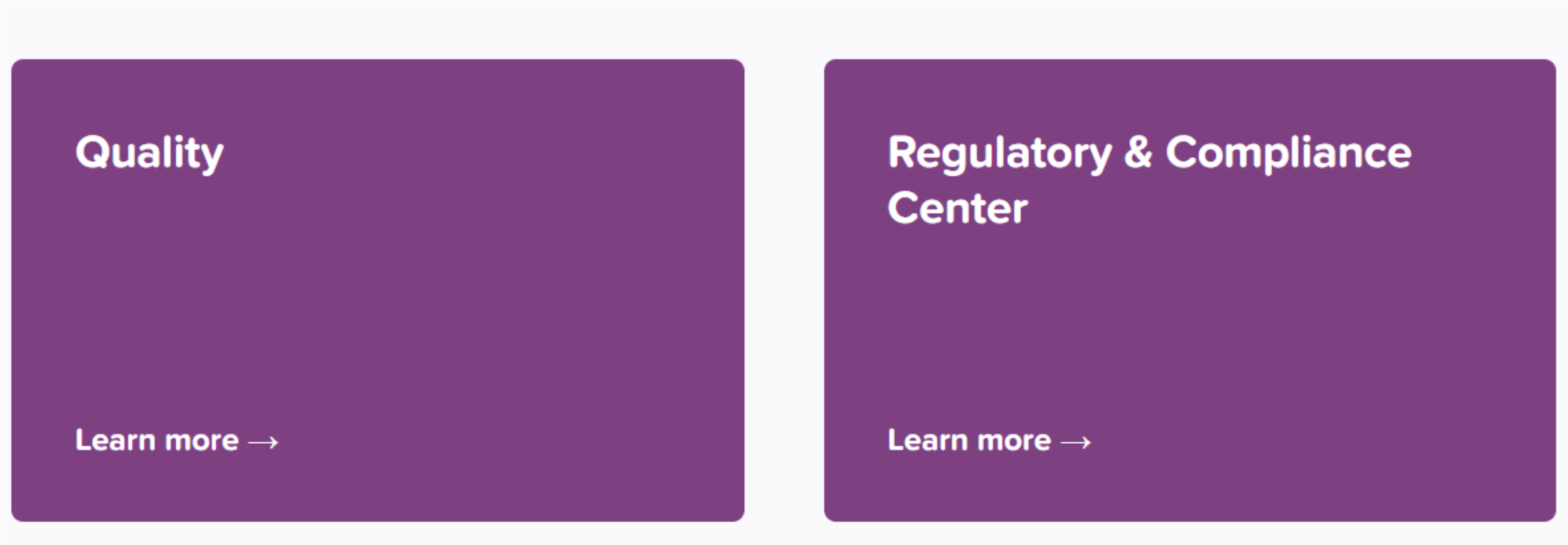
Additional clarity on attending physicians

- Look up NPI number for attending: https://npiregistry.cms.hhs.gov/
- On the hospice claim form:
  - Hospice enters the NPI of the physician certifying the terminal illness
  - Hospice enters the NPI and name of attending of attending physician
  - If no attending, hospice shall report certifying MD

Source: **Chapter 11 – Processing Hospice Claims**

https://www.cms.gov/Regulations-and-Guidance/Guidance/ Manuals/Downloads/clm104c11.pdf

New NHPCO Regulatory and Compliance Center



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Regulatory A to Z

Listing of Regulatory Topics. Hospice Acronym Index.

Learn more →

Beneficiary Notices and Coverage (ABN NOMNC)

Advance Beneficiary (ABN). Notice of Medicare NonCoverage (NOMNC). Detailed Explanation of Non-Coverage (DENC).

Learn more →

Billing and Reimbursement

Resources for Medicare billing, physician and NP billing and reimbursement. Medicare and Medicaid Rates. Hospice Cap. Hospice cost report. Q Codes.

Learn more →

Certification and Recertification

Technical Requirements for Certification, Recertification, Physician Narrative, Face to Face, Attestations. Signatures.

Learn more →

Data Sources

Data to assist in identifying risk areas. MedPac. NHPCO Facts and Figures. PUF. PEPPER. Proposed Rules.

Learn more →

Discharges, Transfers, and Revocations

Discharge No Longer Terminal. Discharge Leave the Service Area. Discharge For Cause. Revocation. Transfer (Change) of Designated Hospice Provider. Traveling Patients.

Learn more →

Details in Billing and Reimbursement Page

- Medicare Hospice Billing
- Medicare and Medicaid Reimbursement Rates
- Physician, Nurse Practitioner and Physician Assistant Billing
- Medicare Cost Report
- Hospice Cap
- Department of Veterans Affairs
- Care Plan Oversight
- Advance Care Planning
- Hospice Pre-election Evaluation and Counseling Services

Detail in Medicare Billing Page

NHPCO Member Resources and Compliance Guides

- Hospice Q Codes - Updated June 2021

Regulations

- Hospice Care Code of Federal Regulations 42CFR 418Subpart G §418.301, §418.302
  - eCFR :: 42 CFR 418.301 -- Basic rules.
  - eCFR :: 42 CFR 418.302 -- Payment procedures for hospice care.

Subregulatory Guidance

- Medicare Claims Processing Manual (cms.gov) Chapter 11 -

References

- FY 2022 Hospice Wage Index and Quality Reporting Proposed rule: Federal Register, April 14, 2021
  Final rule: Federal Register, August 4, 2021
- CY 2022 Home Health Proposed Rule: Hospice survey reform and enforcement remedies sections: CMS FY Home Health Final Rule (CMS 1747-F) Released: 11/2/2021: https://public-inspection.federalregister.gov/2021-23993.pdf
- OIG Reports
  - Part D: Medicare Still Paying Millions for Drugs Already Paid for Under the Hospice Benefit
  - Hospice survey reports:
    Hospice Deficiencies Pose Risk to Medicare Beneficiaries
    Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm
- MedPAC March 2022 Report to Congress

- CMS QSO Memos: Guidance for the Interim Final Rule- Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination:
  - December 28, 2021: https://www.cms.gov/files/document/qso-22-07-all.pdf
  - January 14, 2022: https://www.cms.gov/files/document/qso-22-09-all-injunction-lifted.pdf
  - January 20, 2022: https://www.cms.gov/files/document/qso-22-11-all-injunction-lifted.pdf
- CMS State Operations Manual
  - Appendix M – Hospice
  - Appendix Q – Immediate Jeopardy
  - Appendix Z – Emergency Preparedness