Hospice Success

Seeing the Forest and the Trees

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Roadmap

- The Forest: The hospice industry is "not in Kansas anymore"—facing heightened scrutiny and a redefining of "what hospice is"
- The Trees: The issues and risk areas that drive hospice risk management
  - Hospice coverage requirements
  - Relatedness determinations and implementation
  - Claims data and government data analysis
  - Risk areas in hospice audits and federal False Claims Act ("FCA") and anti-kickback statute ("AKS") cases
- Putting it Together: Discussing and evaluating where to go from here—how to be involved in and monitor the right risk areas at the executive level

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The Forest: The Hospice Industry Is Not in Kansas Anymore

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The Hospice Industry is Not in Kansas Anymore: Growth

- Between 2000 and 2012, Medicare expenditures on hospice more than quadrupled to approximately $15.1 billion
- In 2014:
  - More than 1.3 million Medicare beneficiaries used services from over 4,000 hospices
  - 47.8% of Medicare beneficiaries who died used hospice, up from 22.9% in 2000 (also up from 47.3% in 2013)
  - Average length of stay was 88 days, up from 54 days in 2000
  - Median length of stay has remained constant at 17 days
- **Takeaway: Hospice has become "mainstream" transcending beyond cancer patients to serve a growing geriatric population that is dying of "old age"**

Source: MedPAC Report to Congress, Ch. 11, Hospice Services (March 2016).

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The Hospice Industry Is Not in Kansas Anymore: Rapid Changes in Regulations

- Recent regulatory changes:
  - 2008: Overhaul of Medicare conditions of participation ("CoPs") for hospice
  - 2009: Physician narrative requirement added to certifications
  - 2011: Physician face-to-face encounter requirement implemented
  - 2012: Start of hospice quality reporting
  - 2013: Clarification that nonspecific diagnoses should not be primary hospice diagnoses
  - 2014: Attending physician added to required elements of hospice election; timeframe for submitting Notice of Election implemented
  - 2015: Hospice payment reform outlined through proposed and final rules
  - 2016: Implementation of hospice payment reform measures
- **Takeaway: Pace of regulatory changes far exceeds other provider types, reflective of significant growth in hospice spending**
- **Takeaway: Reframing of hospice; "medical model" v. "holistic" approach to care**

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The Hospice Industry Is Not in Kansas Anymore: Increasing Audits and Cases

- Recent audit activity: Countless ZPIC and MIC audits
  - Issues reviewed include long length of stay, GIP
  - Extrapolated overpayments (multi-million at issue; scope creep from a narrow issue (LLOS) to all claims billed within a timeframe)
  - On-site reviews
- Fraud cases and settlements
  - Multiple criminal indictments in recent years
  - At least nine hospice FCA cases initiated or settled in 2015
  - Hospice FCA settlements in 2015 combined for approximately $37 million
- **Takeaway: Hospice continues to be on the radar with significant resources being invested to recoup funds and develop fraud cases—not just focusing on quality**

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The Hospice Industry Is Not in Kansas Anymore: Rise of Surveys

- With passage of the IMPACT Act, hospices are beginning to see the "impact" of regular surveys (every three years)
- Seeing increased scrutiny, especially from accreditation bodies that have been criticized in recent OIG reports
- Hospices are being judged on issues that are generally not at the forefront of audits (*i.e.*, conditions of participation)
- **Takeaway: State surveys are no longer a rarity; it is harder to be anonymous as analysis moves beyond traditionally scrutinized areas**

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The Hospice Industry Is Not in Kansas Anymore: Government Data Analysis

- OIG reports shifting beyond traditional areas of concern
  - 2012: Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice
    - Found Medicare Part D paid approximately $33.5 million for drugs that are commonly related to end-of-life care for hospice patients
  - 2013: Use of General Inpatient Care
    - Found hospices with their own inpatient units provided more GIP to their patients and for 50% longer than other settings (average GIP length of stay was 6.1 days)
- **Takeaway: OIG is driving the focus of CMS's regulatory changes and the audit activities of government contractors**

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The Hospice Industry is Not In Kansas Anymore: More Data Collection

- Federal government is supporting its audit and enforcement efforts with data
  - Analyzing hospice data against national, regional and local averages (*e.g.*, PEPPER Reports)
  - May 2014: CMS released Abt Associates Reporta "watershed" report in terms of data (will discuss in more detail later)
  - Collecting more data on claims for future analysis
    - Each year the government adds more required detail
- **Takeaway: It is harder to be anonymous as focus moves beyond traditionally scrutinized areas (*e.g.*, length of stay)**

Where Is the Hospice Industry Going?

- Scrutiny will continue
- Payment reform implemented January 2016 (could be more in the future)
- Government audits will continue to evolve
- Additional regulatory changes in the future
- But: Hospice is here to stay—the hospice and palliative care philosophies have become "mainstream" even in general medicine

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The Trees: The Issues and Risk Areas That Drive Hospice Risk Management

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Current and Future Risk Areas: Where to Devote Time and Attention

- Hospice coverage requirements (or conditions of payment)
  - Is the hospice complying with the requirements to get paid?
- Relatedness determinations and implementation
  - What is the hospice paying for and not paying for?
- Claims data and government data analysis
  - What does the hospice's data say?
- Trends in hospice audits
  - What should the hospice expect?
- Common AKS, FCA and whistleblower allegations against hospices
  - What are the alleged "plus factors" that have elevated eligibility disputes to civil or criminal fraud cases?

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Hospice Coverage Requirements

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Hospice Coverage Requirements: Why Do You Need to Know?

- These are the requirements the hospice must meet to get paid
- However:
  - Many hospice managers, directors and clinical personnel do not know what the coverage requirements are, even though their jobs determine hospice compliance
  - As noted earlier, 2009 OIG report found that 82% of hospice claims for beneficiaries in nursing homes did not meet one or more coverage requirements

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What Are the Hospice Coverage Requirements?

- There is one basic set of Medicare coverage requirements
  - See Handout 1
  - Note cross-references to other regulations
  - These are the coverage requirements for routine home care (approximately $190 per day for days 1–60; $149 per day for days 61+)
- Beyond routine home care, there are three other levels of care that have additional or different Medicare coverage requirements
  - General inpatient care (approximately $734 per day)
    - Inpatient services must be medically necessary for pain, or acute or chronic symptom management that cannot be achieved in another setting

What Are the Hospice Coverage Requirements? (cont.)

- Medicare coverage requirements for other levels of care and services (cont.)
  - Respite care (approximately $170 per day)
    - Care to give the patient's family respite for no more than five consecutive days
    - Must be inpatient (*i.e.*, cannot provide "respite" in the patient's home)
  - Continuous care (up to approximately $964 per day)
    - Must be medically necessary to manage a "period of crisis" requiring predominately (more than half) nursing care for at least 8 hours in a 24-hour day (midnight to midnight)

Coverage Requirements: Ramifications for Noncompliance

- Potential ramifications: CoPs vs. conditions of payment
  - Coverage requirements for hospice or nursing home room and board services
    - Nonpayment for services (per visit, per day, downcoded)
  - Conditions of participation (418.52–418.116)
    - Survey citations, if uncorrected termination of provider agreement/license
- If hospice discovers a coverage requirement may not have been met, need to conduct a 60-day repayment analysis pursuant to the FCA

Coverage Requirements: Key Issues

- Coverage requirement issues could arise anywhere; for example:
  - Nurse discovered not to be documenting or possibly conducting visits
    - May implicate requirement for services to be provided consistent with plan of care
  - Prebilling audit finds physician face-to-face not timely completed
    - May implicate certification requirement
  - Compliance hotline tip that patients may not be eligible for higher level of care
    - May implicate medical necessity

Coverage Requirements: What Are the Right Questions?

- Who is trained in the coverage requirements and compliance?
- What would they say if asked the questions on Handout 2?
- How do you test their understanding?
- How do you track compliance with the coverage requirements?

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Relatedness Determinations and Implementation

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Relatedness Determinations: Why Do You Need to Know?

- Hospices must determine what items and services are "related to" and "reasonable and necessary for the palliation and management of" each patient's terminal illness and "related conditions"
  - Hospices may not have consistent process for relatedness determinations and little physician involvement
  - This has been and will continue to be scrutinized with additional claims data on hospice bills

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Relatedness Determinations: Enforcement

- Hospices must cover "virtually all" services
  - 1983 CMS commentary to initial hospice regulations
  - CMS FY 2014 Hospice Wage Index indicated refocus on hospices covering "virtually all" services
- This has become a key enforcement area
  - Abt Report: Approximately $1 billion paid to providers outside the hospice per diem for hospice patients
  - 2012 OIG report on Part D payment for drugs outside the hospice per diem suggested hospices are choosing not to cover related drugs
  - CMS expectation that hospices will report more than one diagnosis on claim form (terminal illness and "related conditions") and coverage will follow suit

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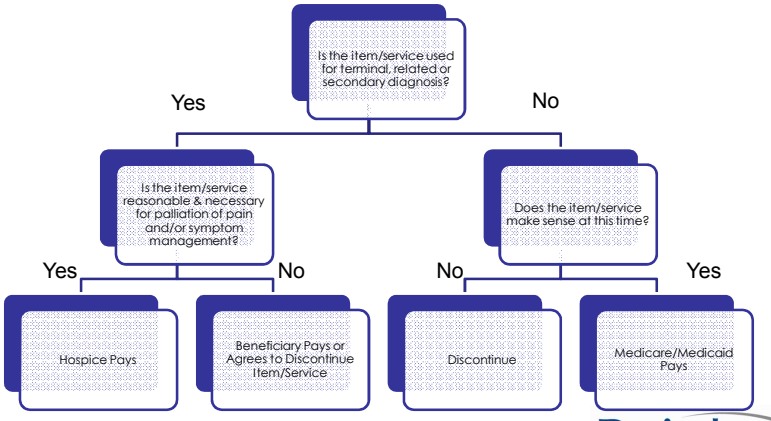
Relatedness Determinations: 4 Buckets



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Relatedness Determinations: Expectations

- CMS appears to expect:
  - Physician involvement
    - How is the physician involved in making relatedness determinations?
  - Documentation
    - Need to be prepared to prove "unrelatedness"
  - Hospice (or beneficiary) coverage of most common end-of-life drugs (antianxiety, analgesics, laxatives, antinausea)
    - How are medically unnecessary drugs addressed differently than unrelated drugs?
  - Diagnoses reported on claims to correspond with drugs reported
    - How many diagnoses are included on claims?
    - Note: This issue is not limited to drug coverage

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Relatedness Determinations: Process

- Process for determining relatedness generally includes four considerations:
  1. There is a determination that needs to be made
     - Default is that items and services are related to the terminal illness
     - Determinations made on case-by-case basis
  2. Who makes the determination?
     - Should be physician-driven
     - Consider role of PBM/pharmacy consultant
     - Consistency among physicians; high level reviews

Relatedness Determinations: Process (cont.)

  3. What is the standard for relatedness?
     - "Clear evidence" that item/service is "completely unrelated"
  4. The determination is documented and supported
     - Proof that physician is making determination
     - Conclusory statement vs. narrative explanation
     - Standardized form may help probe reasoning and encourage thorough documentation
     - Additional clinical support
     - Journal articles, reference texts

Relatedness Determinations: Root Causes

- Why are issues arising?
  - Hospices with only one diagnosis on claim form
    - Diagnoses could be cross-referenced with drugs on claim form
  - Vendors (primarily pharmacies) not implementing correct coverage decisions
  - Nursing homes, community attendings ordering items/ services without hospice knowledge
  - Medically unnecessary items/services billed to Medicare/ Medicaid instead of covered by patient
  - Hospices not having "tough conversations" about discontinuing unnecessary items/services

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Claims Data and Government Data Analysis

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Claims Data and Government Data Analysis: Why Do You Need to Know?

- Government data analysis is no longer limited to length of stay and abnormal billing patterns; it is collecting and analyzing more data to find hospice outliers in a wider variety of issues
  - Hospices need to expand their dashboards to capture the same data the government has—it is better to know what the government knows

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Abt Report: The Biggest Report No One Has Read

- Abt Associates, "Medicare Hospice Payment Reform: Analyses to Support Payment Reform" (2014), and more recently, "Medicare Hospice Payment Reform: Analysis of How the Medicare Hospice Benefit is Used" (2015)
- Issues raised in the Abt Reports predict future government enforcement areas in hospice
- Key issues include:
  - Coverage decisions and payments outside the hospice benefit
  - Managing to the aggregate cap
  - Live discharges
  - Hospice utilization at death
  - General inpatient care utilization
  - Continuous home care utilization

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Abt Report: Coverage Decisions

- Approximately $1 billion paid to providers outside the hospice per diem for hospice patients in addition to approximately $15 billion paid to hospice providers
- Estimated amounts paid outside the per diem:
  - $49.5 million in DME
  - $32 million in home health
  - $202 million in inpatient services
  - $385 million in Part B (physician and outpatient services)
  - $330 million in Part D
  - $40 million in SNF benefits
  - $135 million in beneficiary co-insurance
- Concern that hospices are cost-shifting expensive care to other government payors

Abt Report: Live Discharge

- Live discharges increased to 18.3% in 2013 (up from 13.2% in 2000)
- Concern about "burdensome transitions"—hospitalization within two days of hospice discharge and hospice readmission within two days of hospital discharge
  - Burdensome transitions increased to 6.4% in 2012 (up from 3.4% in 2000)
  - Pattern of discharge/revoke → inpatient stay → reelect could raise concerns of cost-shifting expensive inpatient treatment to Medicare

Abt Report: What Are the Right Questions?

- Do you know where your data falls in these categories?
  - How could your dashboard expand to track these data points?
    - Diagnoses reported on claims
    - Coverage of drugs and other items and services
    - Visits prior to death
    - GIP and continuous care utilization

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Risk Areas in Hospice Audits

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Risk Areas in Hospice Audits

- What types of hospice audits are we seeing?
  - More MIC cases
    - On-site visit with interviews
    - Request patient records, and policies and procedures
  - On-site ZPIC visits
    - Unannounced
    - Request patient records, contracts, staff lists
    - Interview variety of staff positions
  - RAC audits
    - Started seeing hospices with RAC audits again in Spring 2016

Risk Areas in Hospice Audits (cont.)

- What issues are we seeing in hospice audits?
  - Clinical eligibility
  - Eligibility for higher levels of care (GIP, continuous care)
  - Requests for business records (*e.g.*, contracts with facilities and physicians, information on ownership, policies)

Hospice Audits: Onsite Audit Response

- If ZPIC auditors arrived tomorrow, do your staff members know how to talk to auditors?
  - It is both what you say and how you say it (see Handout 3)
  - How would they answer the questions on Handout 2?
- If ZPIC auditors arrived tomorrow, how quickly could you respond?
  - Produce complete patient records, contracts
  - Produce a staff list
  - Know which staff would be best to interview

Hospice Audits: Identifying Potential Issues

- Know your risk areas and try to reduce if outlier
  - OIG identified risk areas (see Handout 4)
  - Where do you fall in relation to other hospices?
    - PEPPER Report
    - Dashboard compared to Abt Report
    - Length of stay
  - Prior denials

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Risk Areas in FCA (and AKS) Allegations

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Increased FCA Activity

- Recent increase in FCA cases against hospices involving a number of different practices
- Pre-2009: FCA activity relatively limited for hospices
- Since 2009: Over 20 FCA cases against hospices, including:
  - At least nine hospice FCA cases initiated or settled in 2015
  - Settlements combined for approximately $37 million
  - Five hospices entered into corporate integrity agreements (CIAs)
- FCA cases brought against both for-profit and not-for-profit hospices

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Causes of Increased FCA Activity

- Increase in FCA activity result of:
  - Growth in hospice ($15 billion in Medicare reimbursement)
  - Government incentives to investigate and prosecute fraud
    - Return on investment estimated at $8.01 for every $1.00 spent ($11.60 for every $1.00 spent on the Fraud Prevention System (FPS) data analytics)
    - In 2014, federal government recovered $5.69 billion in settlements and judgments from civil fraud cases, up from $2.8 billion in 2010
    - Multiple hospice settlements since 2012 over $1 million, up to $25 million
    - Criminal prosecutions

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What Is a False Claim?

- What is a false claim?
  - Submitting a claim for payment by the government that provider knew (or should have known) at the time was false
  - Submitting records to the government that are false (*e.g.*, in response to an audit request)
  - Not returning an identified overpayment within 60 days of identification
  - AKS violation per se violation of FCA

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What Are Issues in Hospice FCA Cases?

- Typical basis for hospice FCA case
  - Eligibility based on six-month prognosis or level of care
  - Plus allegations of a scheme or system of practices that hospice "knew" or "should have known" would lead to ineligible patients being admitted or retained
    - Not typically limited to one allegation—allegations varied and can be anything
    - Allegations can be based on information taken out of context (*e.g.*, e-mail, training)

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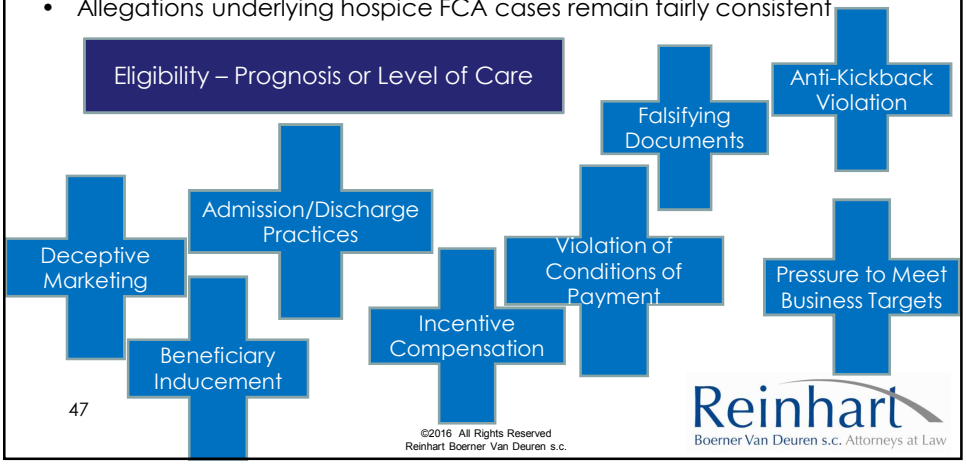
Hospice FCA Risk Areas

- Allegations underlying hospice FCA cases remain fairly consistent



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Risk Areas in FCA Allegations

- Examples of allegations regarding eligibility documentation in hospice FCA cases range from:
  - Documentation did not support that the patient was terminally ill or did not support that GIP or continuous care was needed or provided
  - Staff coached to use "creative documentation" or records falsified to support eligibility
- Examples of allegations in hospice FCA cases related to routinely not meeting coverage requirements include:
  - No physician narrative completed prior to billing
  - Forging physician signatures on certifications

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Risk Areas in FCA Allegations (cont.)

- Examples of allegations in hospice FCA cases related to admission and discharge practices range from:
  - Not involving IDT members or physician in discharge or eligibility evaluations
  - Admitting patients still receiving aggressive curative care
  - Mandatory 30-day discharge process
- Examples of allegations related to incentive compensation in hospice FCA cases include:
  - Setting goals for marketing and clinical staff to increase number of continuous care days
  - Bonuses based on number of long length of stay patients admitted

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Risk Areas in FCA Allegations (cont.)

- Examples of allegations regarding marketing in hospice FCA cases range from:
  - "Aggressive marketing" by promising continuous care regardless of medical need
  - Deceptive marketing, such as telling patients they can continue receiving curative care, not explaining waiver of other benefits, not explaining terminal illness requirement
- Examples of allegations of beneficiary inducements in hospice FCA cases include:
  - Promising continuous care regardless of need
  - Providing free services and supplies prior to hospice election

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Risk Areas in FCA Allegations: What Are the Right Questions?

- How are resources and energy spent in these risk areas?
  - Training on documentation, coverage requirements, and admission/discharge policies
  - Training on compliance regarding AKS and beneficiary inducement
  - Incentive compensation
  - Marketing
- Back to the dashboard—where does your hospice fall in these risk areas?

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Putting it Together: Discussing and Evaluating Where to Go From Here

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Where Do We Go From Here?

- What are you doing now with regard to the issues and risks we discussed?
- What could you be doing differently?
  - What questions should you be asking?
  - How can you monitor key risk areas?
- What is on your current dashboard and what could be added?
- What should you prioritize?
- What operational resources and support are needed?

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Questions?

Thank you!