Getting Ready for 2017

Subscriber Webinar
November 2016

Two Key Components of Readiness

1. Ability to identify & prioritize risks
2. Ability to respond to risks

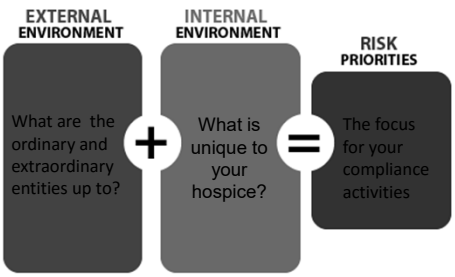
The Good News: An effective compliance framework supports both

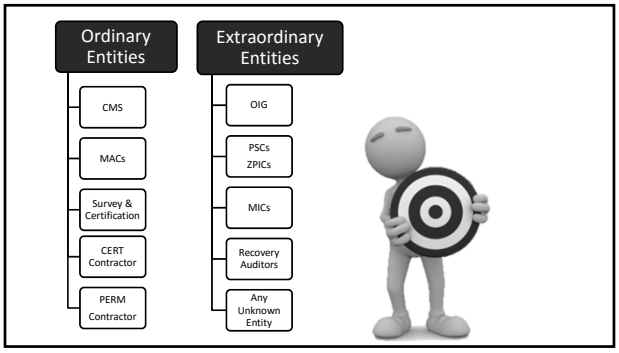
OIG Compliance Program, Guidance for Hospices
https://oig.hhs.gov/authorities/docs/hospicx.pdf

The Two Key Questions

1. What might we expect in 2017?
2. Based on that answer how can we best allocate scarce resources to meet our compliance needs?

Risk Assessment Prioritization





The Internal Environment

- Past Performance
- Outliers
- New Programs
- Resources
- Staff Turnover
- Regulatory Competence
- Culture
- What else?

Their Common Interests

Extraordinary Entities

- OIG
- ZPICs
- UPICS
- MICs
- Recovery Auditors
- Any Unknown Entity

Did the services that Medicare or Medicaid paid for meet the requirements for coverage and payment?

If not, why not?

Was there fraud involved?

How much money should be recouped?

What other penalties should be levied?

CMS Compliance Group Interactive Map

www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html

2016 OIG Reports

Date	Title
3/2016	Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care (OEI-02-10-00491)
9/2016	Hospices Should Improve Their Election Statements and Certifications of Terminal Illness (OEI-02-10-00492)

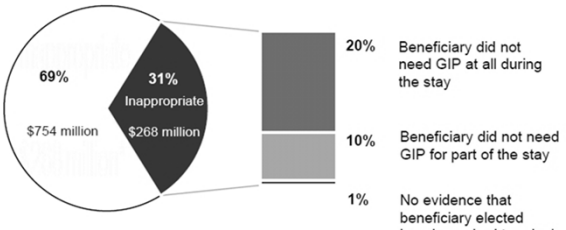
History of the GIP Project

Providers started getting record requests in April 2013 for claims for services provided in 2012

- Each claim included some days at GIP in the various allowable settings.
- Appeared to be random requests within that group of claims

OIG issued a memorandum report *Use of General Inpatient Care* in May 2013; data pulled from 2011 claims

Percentage of Inappropriate GIP Stays, 2012



From Report OEI-02-10-00491

GIP Report: OIG Recommendations to CMS

The findings in this report make clear the need to address the misuse of GIP and hold hospices accountable when they bill inappropriately or provide poor-quality care. We recommend that the Centers for Medicare & Medicaid Services (CMS)

- increase its oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries
- ensure that a physician is involved in the decision to use GIP
- conduct prepayment reviews for lengthy GIP stays
- increase surveyor efforts to ensure that hospices meet care planning requirements
- establish additional enforcement remedies for poor hospice performance
- follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor-quality care.

OEI-02-10-00491

A New Wrinkle: OIG Letters

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

The OIG believes the amount [redacted] was paid for dates-of-service for GIP level care which should instead have been billed as routine hospice care was $21,426.64.

This conduct may constitute a violation of the CMPL. Under the CMPL, the OIG is authorized to impose a civil money penalty of up to $10,000 for each item or service and an assessment of damages of not more than three times the total amount claimed for each such item or service.

In addition, the OIG may exclude a provider from participation in the Federal health care programs, as defined in section 1128B(f) of the Act. The OIG has issued a Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, the [redacted] can be found at:

http://www.oig.hhs.gov/exclusions/effects_of_exclusion.asp

In determining the sanction to be imposed, against [redacted], OIG will take the following into account: (1) the nature of the claims and the circumstances under which they were presented; (2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims; and (3) such other matters as justice may require.
See 42 U.S.C. § 1320a-7a(d); see also 42 C.F.R. §§ 1003.106(a) and (b).

The Second Report: EOBs & CTIs

OIG reviewed 565 claims in order to evaluate content of the election of benefits and certification of terminal illness forms

Election Forms
- Did form include required elements as defined in §418.24?
- Was information presented with clarity?

Certification of Terminal Illness Forms
- Quality of the physician's brief narrative
- Presence or absence of physician's attestation as defined in §418.22

OEI-02-10-00492

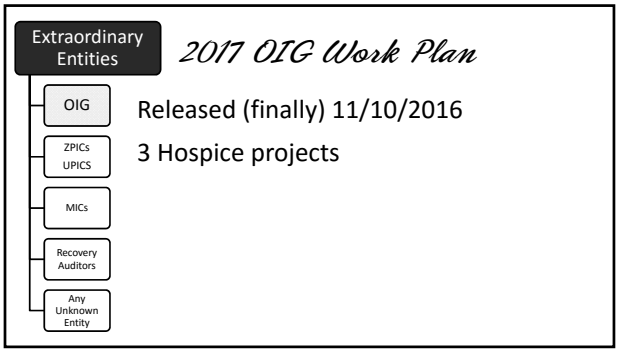
EOBs & CTIs Report: OIG Recommendations to CMS

The findings in this report make clear that hospices should improve their election statements and ensure that physicians meet requirements when certifying beneficiaries for hospice care. We recommend that CMS
- develop and disseminate model text for election statements
- instruct surveyors to strengthen their review of election statements and certifications of terminal illness,
- educate hospices about election statements and certifications of terminal illness, and
- provide guidance to hospices regarding the effects on beneficiaries when they revoke their election and when they are discharged from hospice care

OEI-02-10-00492

§418.200 Requirements for Coverage

To be covered, hospice services must meet the following requirements.
1. They must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.
2. The individual must elect hospice care in accordance with Sec. 418.24.
3. A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program as set forth in Sec. 418.56.
4. The plan of care must be established before hospice care is provided.
5. The services provided must be consistent with the plan of care.
6. A certification that the individual is terminally ill must be completed as set forth in Sec. 418.22.



2017 OIG Work Plan

Released (finally) 11/10/2016

3 Hospice projects

Project 1

NEW: Medicare Hospice Benefit Vulnerabilities and Recommendations for Improvement: A Portfolio

The Medicare hospice program is an important benefit for beneficiaries and their families at the end of life. However, OIG and others have identified vulnerabilities in payment, compliance, and oversight as well as quality-of-care concerns, which can have significant consequences both for beneficiaries and for the program. We will summarize OIG evaluations, audits, and investigative work on Medicare hospices and highlight key recommendations for protecting beneficiaries and improving the program.

OEI: 02-16-00570 Expected issue date: FY 2017

Project 2

NEW: Review of Hospices' Compliance with Medicare Requirements

Hospice provides palliative care for terminally ill beneficiaries and supports family and other caregivers. When a beneficiary elects hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary's terminal illness and related conditions. Federal regulations address Medicare conditions of and limitations on payment for hospice services (42 CFR Part 418, Subpart G). We will review hospice medical records and billing documentation to determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.

OAS: W-00-16-35783; various reviews Expected issue date: FY 2017

Subpart C Payment for Hospice Care

418.301	Basic rules
418.302	Payment procedures for hospice care
418.304	Payment for physician services
418.306	Annual update of the payment rates and adjustment for area wage differences
418.307	Periodic interim payments
418.308	Limitation on the amount of hospice payments
418.309	Hospice cap amount

Project 3

NEW: Hospice Home Care — Frequency of Nurse On-Site Visits to Assess Quality of Care and Services

In 2013, more than 1.3 million Medicare beneficiaries received hospice services from more than 3,900 hospice providers, and Medicare hospice expenditures totaled $15.1 billion. Hospices are required to comply with all Federal, State, and local laws and regulations related to the health and safety of patients (42 CFR § 418.116). Medicare requires that a registered nurse make an on-site visit to the patient's home at least once every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs (42 CFR §418.76(h)(1)(i)). We will determine whether registered nurses made required on-site visits to the homes of Medicare beneficiaries who were in hospice care. OAS: W-00-16-35777 Expected issue date: FY 2017

§418.76(h) Standard: Supervision of hospice aides

1) A registered nurse must make an on-site visit to the patient's home:
   i. No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.

Extraordinary Entities

- OIG
- ZPICs UPICS
- MICs
- Recovery Auditors
- Any Unknown Entity

Meet the UPICs

Unified Program Integrity Contractor

"in support of CMS audit, oversight and antifraud, waste and abuse efforts…to maintain Medicaid and Medicare program integirty by detecting, preventing, and proactively determining healthcare fraud, waste and abuse."

Meanwhile, ZPIC activities continue

Extraordinary Entities

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The MICs

Medicaid Integrity Contractors – come out of CMS Central not the state

Out and about – still not clear that they know what they are doing

Hard to draw conclusions from what they will focus on

Extraordinary Entities

- OIG
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The Recovery Auditors

Bounty hunters of the system; 4 geographically based RAs

5th was to have come on line in 2014 to focus nationally on home health, hospice & DMEPOS; contract finally awarded 10/31/16 to Performant Recovery, Inc.

Not clear when activity will start

Extraordinary Entities

- OIG
- ZPICs
  UPICS
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Summing Up

- Keep your fundamentals strong
- What would you do if an extraordinary entity showed up unannounced at your door?
- Know when to call a healthcare attorney
- See attached Reinhart Law resource: 10 Questions Every Hospice Employee Should Be Able To Answer

Ordinary Entities

- CMS
- MACs
- Survey & Certification
- CERT Contractor
- PERM Contractor

The Four Faces of Medicare

Code of Federal Regulations
Title 42, Volume 2, Parts 400 to 429
PART 418 — HOSPICE CARE

42 CFR 418 Subparts

- **A.** General Provision and Definitions
- **B.** Eligibility, Election and Duration of Benefits
- **C.** Conditions of Participation – Patient Care
- **D.** Conditions of Participation - Organizational Environment
- **E.** Conditions of Participation – Removed and Reserved
- **F.** Covered Services
- **G.** Payment for Hospice Care
- **H.** Coinsurance

How CMS Spent 2016

	Payment & Coverage	Quality of Care
Testing the claims processing systems to see if it they could accommodate tiered routine home care rate and SIA payments (they could not)	x	
Continuing on the three-year survey cycle	x	x
Moving forward on public reporting	x	x

NEW QUALITY MEASURE #1

Hospice Visits When Death Is Imminent Measure Pair

Data Source: *Four new items added to the HIS discharge record*
When: *April 1, 2017*

MEASURE A: *% of patients recieving at least 1 visit to address case management and clinical care from an RN, physician, NP or PA in the last 3 days of life.*

DAY 7	DAY 6	DAY5	DAY 4	DAY 3	DAY2	DAY 1 *(death)*

MEASURE B: *% of patients recieving at least 2 visits from medical social workers, chaplains or spiritual counselors, LPNs or hospice aides in the last 7 days of life.*

Measure Specific Exclusion Criteria
1. *Patient received continuous home care, general inpatient care, or respite care during the final 7 days of life* **(A & B)**
2. *Patient admitted and died on the same day* **(B only)**

HOSPICE FUNDAMENTALS

NEW QUALITY MEASURE #2

Hospice and Palliative Care Composite Process Measure:
Comprehensive Assessment at Admission

PROPOSED Composite Measure

How: *The measure will be calculated using existing HIS measures*

When: *April 1, 2017*

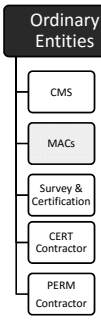
Existing HIS Measures
1. Patients Treated with an Opioid who are Given a Bowel Regimen
2. Pain Screening
3. Pain Assessment
4. Dyspnea Screening
5. Dyspnea Treatment
6. Treatment PReferences
7. Beliefs/Values Addressed *(if desired by patient)*

HOSPICE FUNDAMENTALS

Moving Forward on Public Reporting: Data

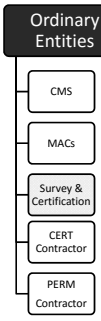
What	Where
Data.Medicare.gov Hospice Data Sets 1. Hospice List 2. ASPEN/CASPER Contacts	https://data.medicare.gov/data?tool=hospice-directory&tag=&sort=relevance&q=
Hospice Payment Public Use File – The Hospice PUF	https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Hospice.html

The MACs



- Medicare Administrative Contractors
- Carrying out routine activities
- Working on backlog of claim processing errors for SIA and RHC tiered payments

Survey Agencies



Getting up to speed on surveys

Anecdotal reports of some surveyors with knowledge deficits – be a strong advocate and appeal deficiencies if you believe them to be incorrect

Other: MedPAC

Independent Congressional agency established by BBA 1997 to advise Congress on issues affecting Medicare

The Thinkers – seventeen commissioners appointed by the Comptroller General - no regulatory authority

Meeting transcripts available (and searchable); reports issued to Congress in March and June

The majority of the changes we have seen in the past ten years are a direct result of MedPAC recommendations

Pretty quiet in 2015 & 2016 – most of the changes they have suggested have been approved and implemented

http://medpac.gov/

Other: Alternative Payment Model Categories

The Administration set goals of having 30 percent of all Medicare fee-for-service payments made via alternative payment models by 2016 and 50 percent by 2018 – 2016 goal achieved by 3/2016

1. Accountable Care
2. Episode-based Payment Initiatives
3. Primary Care Transformation
4. Initiatives Focused on the Medicaid and CHIP Population
5. Initiatives Focused on the Medicare-Medicaid Enrollees
6. Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models
7. Initiatives to Speed the Adoption of Best Practices

?

Other Activities – PEPPER

Q4 FY 2015 PEPPER issued in April 2016

- Program for Evaluating Payment Patterns Electronic Report
- Information only – but the same data is available to all regulatory and investigatory entities
- Expanded from 6 to 10 areas
- May only be accessed by hospice leader or compliance officer
- Report available showing how many reports have been accessed by state

https://www.pepperresources.org/

Other Activities – HIPAA

Phase 2 audits underway

Include covered entities and business associates

What does this mean for hospices?

Other Activities – ACA Section 1557

Nondiscrimination provision of the Affordable Care Act (ACA)

Protections against discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities

Broadened existing protections familiar to healthcare providers to include other entities

If OCR audits or get complaints they will want to see the entity's communication plan

http://www.hhs.gov/civil-rights/for-individuals/section-1557

Other Activities: NH Final Rule

Final rule of rewrite of LTC Requirements of Participation released 10/4

Regulations effective 11/28/2016 but with 3 year phase in schedule (providers had pushed for 5)

Huge undertaking for our NF partners

Little specific to hospice but continued challenges regarding use of antipsychotics

Increased training requirements, particularly for dementia, that also apply to contractors

Other Activities: Emergency Preparedness Final Rule

Proposed rule issued 12/2013; final issued 11/2016 with an implementation date of 11/2017

Calls for community-wide coordination

Built around four core elements

1. Risk assessment and planning
2. Development of policies and procedures
3. Formulation of a communication plan
4. Training and testing

Where Did the Darts Cluster?

The Review of Activities

- Eligibility / LOS
- General Inpatient LOC
- Live Discharges
- EOBs & CTIs
- Cost Shifting

On the Horizon

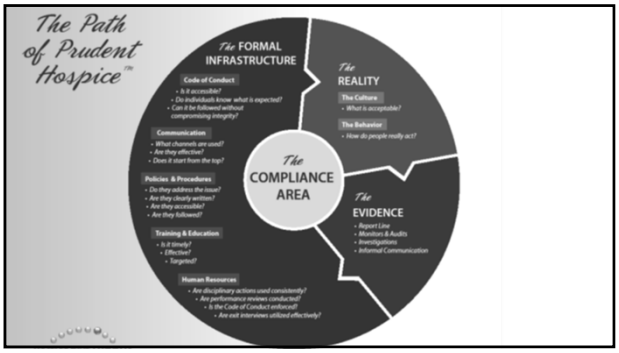
- Public Reporting
- Recovery Auditors
- GIP Claims Reviews
- Emergency Preparedness
- Election Unknowns

Readiness Component #2

1. Ability to identify & prioritize risks
2. Ability to respond to risks

Once a risk area is identified

- What regulations guide the area?
- How compliant are current operations?
- What changes need to be made?
- How will effectiveness of changes be assessed?
- How will individual compliance with changes be assessed?



Summing It All Up

1. Assess external and internal risks
2. Establish or continue monitors and audits
3. Prioritize activities
4. Evaluate readiness using the Path of the Prudent Hospice
5. Establish work plan, adjust as needed
6. Let Hospice Fundamentals know what areas are most challenging for you

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Essential Tools for Your Right-Hand Drawer

10 Questions Every Hospice Employee Should Be Able To Answer

The following is a sampling of questions that auditors have often posed to hospice staff members at all levels when conducting onsite interviews:

1. Have you received training about Medicare regulations?
2. Do you have access to the hospice's policies and procedures, and know where are they kept?
3. What are the criteria for admitting a patient?
4. Who determines if a patient is appropriate or eligible for hospice?
5. Do you know the process for recertification?
6. What is your discharge process, and who determines if and when a patient will be discharged?
7. Do you know why a patient is admitted to GIP or continuous care?
8. Who determines if a patient starts or ends GIP or continuous care?
9. Who determines the primary terminal diagnosis?
10. Can anyone—you, upper management or IT—make changes to your documentation or someone else's documentation?

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