A Summer Potpourri

Subscriber Audioconference
July 2014

Today's Topics

- Medicare Part D
- CR 8358 Additional Data Elements on Claims
- Wage Index Proposed Rule
  - Timeframe for Submitting Notice of Election
  - Attending Physician Designation
  - Diagnosis Coding
- Hospice Item Set
- CAHPS®

Three Current Lines of Inquiry Underway

1. Payment Methodology: How should the hospice Medicare payment methodology be updated?
2. Payment
   A. Is the beneficiary eligible to receive hospice care?
   B. Is the hospice meeting its financial coverage responsibilities or is it shifting costs to other Medicare programs or to the beneficiary?
   C. Is there evidence of fraud?
3. Quality of Care
   A. Do beneficiaries have access to quality care?
   B. What are the quality indicators for hospice?
   C. How are individual hospices performing?
   D. Do beneficiaries have access to all four levels of hospice care?

The Inquiring Parties

CMS	Centers for Medicare and Medicaid Services
OIG	Office of the Inspector General
MedPAC	Medicare Payment Advisory Committee

The Worker Bees

Payment Methodology	CMS ABT Associates (via CMS contract) MedPAC
Payment	CMS Contractors: MACs, CERT ZPICs, & MICs OIG, Department of Justice, FBI Recovery Contractors
Quality	CMS OIG MedPAC

Part D & Hospice Coordination of Benefits

- Very effective public advocacy underway around this issue
- Speaking out
  - National Hospice & Palliative Care Organization / Hospice Action Network
  - National Association of Home Care
  - MedPAC
  - Elected Officials
  - Growing Coalition of Associations and Advocacy Groups
- CMS convened a stakeholders meeting with more than 30 organizations in attendance on June 25th
- Issue Differentiator: Negative impact to beneficiaries

MedPACs Message to CMS

With respect to coordination of drug coverage between hospices and Part D plans, we agree that mechanisms such as prior authorization or other procedures should be in place to ensure that the appropriate party – either the hospice or the Part D plan - pays for needed drugs for hospice enrollees. However, we are concerned that the current prior authorization process established through subregulatory guidance is administratively burdensome for hospice beneficiaries and families and does not ensure that hospice beneficiaries maintain timely access to needed drugs. We urge CMS to suspend the current Part D prior authorization process for hospice enrollees and issue a regulatory proposal to establish an improved prior authorization process consistent with our comments as soon as possible.

Suggestion #1: Change Terminology

Goodbye

Prior Authorization

Hello

Clearing the A-3 Reject Code

#2: If Possible, Use the Model Form

- Form designed to proactively get information into the system to avoid an A-3 reject code
- Thanks to the National Council of Prescription Drug Plans (NCPDP) Hospice Task Group
- The more hospices that use the form the better
- Included in your handouts and available on the NHPCO website
- Remember: A plan has the right to require that their own form be used

#3: Support Front-Line Staff

Access May Webinar in the Members Only Section

Part D & Hospice:
Having the Conversations
Gary Gardia

If you don't remember your password, e-mail linda@hospicefundamentals.com

CR 8358 Additional Data Elements

- Mandatory reporting began 4/1/2014; it continues to be a huge challenge
- Balance between maintaining cash flow & getting data on the claims
- May submit adjusted claims but CMS does not expect to see providers doing that all the time
- Claims will process without data - no reports yet on how much detail is coming in
- Providers with less data will stand out

Hospices are expected to submit completed claims. ***Provider-submitted adjustments (Type of Bill 8X7) are allowable during the timely filing period, but hospices should not make claims adjustments their standard practice.*** The UB-04 form states, "Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete." ***We would be concerned if a hospice routinely submitted incomplete claims and then later routinely submitted adjustments to those claims.***

CMS CR 8358 Updated Q&As
4/25/2014

Note on Wage Index Rules

- Medicare rates are updated annually
- Proposed rule > 60-day comment period > final rule
- In recent years usually has included policy clarifications and as well as new rules unrelated to rates
- Sometimes surprises, sometime we have an inkling of what is coming
- FY 2014 Wage Index final rule: refers to what was first published as proposed rule in summer of 2013
- FY 2015 Proposed rule published 5/8/2014, comment period ended 7/1/2014

Provisions of the FY 2015 Proposed Rule

A. Hospice Payment Reform: Research and Analysis
B. Solicitation of Comments on Definitions of Terminal Illness and Related Conditions
C. Guidance on Determining Eligibility
D. Cap Timeframes
E. Proposed Timeframes for Filing NOE and NOTR
F. Proposed Addition of Attending Physician to the Election Form
G. FY 2015 Wake Index and Rates
H. Proposed Updates to Hospice Quality Reporting Program
I. Solicitation on Comments on Coordination of Benefits & Appeals – Part D
J. Update on ICD – 10 & Coding Guidelines

E. Notice of Election and NOTR

Notice of Election
- Within 3 calendar days after effective date of election
- No payment for days pre-filing if you miss target

Notice of Termination / Revocation
- File within 3 calendar days of discharge
- Not needed if claim has been filed
- No penalty

F. Addition of Attending to NOE

- Focus on beneficiary's right to choose attending physician
- Hospice "attending" versus rest of healthcare "attending"
- The Marcus Welby model of attending
- NPs as attendings in hospice facilities
- Proposed rule
  - Notice of Election would identify attending
  - Changes possible but require a form completed by beneficiary or representative
  - Wording re change being patient's choice

J. Update on ICD – 10 & Coding Guidelines

- Reiteration of wording from FY 2013 and FY 2014 Wage Index rules: "should include appropriate selection of principal DX as well as the other, additional and coexisting DX related to the terminal illness and related conditions."
- Claims submitted on or after 10/1/2014 will RTP if
  - primary DX is debility or adult failure to thrive
  - they fail to clear Medicare Coding Editor (MCE)
- Dementia codes will be address in a yet-to-be-released change Request

The Coding To-Do List

What	Requirement Found in These Proposed & Final Rules	Date Required By
Expanding Coding on Claims	FY 2013 Wage Index FY 2014 Wage Index FY 2015 Wage Index	Some time back
Curtailing the Use of Debility and Adult Failure to Thrive as Primary Diagnoses	FY 2014 Wage Index	10/1/2014
Using Correct Dementia Codes	FY 2014 Wage Index FY 2015 Wage Index	10/1/2014
Transitioning to ICD-10	Everywhere	10/1/2015

Troublesome Statistic

"Analysis conducted on FY 2013 hospice claims shows that 67% of hospice claims still only report a single, principle hospice diagnosis."

CMS Proposed FY 2015 Wage Index Proposed Rule

Purpose of HIS

Standardized the collection of data elements that are needed to calculate the following

- NQF # 1617 – Patients Treated with an Opioid who are Given a Bowel Regimen
- NQF # 1634 – Pain Screening
- NQF # 1637 – Pain Assessment
- NQF # 1638 – Dyspnea Treatment
- NQF # 1639 – Dyspnea Screening
- NQF # 1641 – Treatment Preferences
- NQF # 1647 – Beliefs / Values Addressed (if desired by the patient)

HIS Admission and Discharge

- Administrative data
- Data for quality measures
- And at discharge, reason for discharge
- Do not need patient consent in order to collect the data for quality measures
  - CMS has statutory authority under Section 3004 (c) of ACA

HIS Completion & Submission

- Electronically completed and submitted on an ongoing basis
- Must be completed by
  - Admission Day + 14 days of admission
  - Discharge + 7 days of discharge
- Submitted to CMS within 30 days from admission or discharge
- Will have the ability to update if necessary

General Questions

- Do we still need to collect and report Comfortable Dying Measure now?
- If the patient is on service for less than 7 days, do we still submit the HIS data?
- If the hospice does not have a Medicare provider number, does it still submit HIS data?

Admission

- Is the HIS completed on all patients or just Medicare?
- Is a HIS completed on patient transfers?
- What about the admissions prior to 7/1/14 who are discharged after 7/1/14?
- Scenario: Patient is discharged from a hospital to a SNF. Hospice admits the patient in the SNF. How would you answer: Immediately preceding this admission where was the patient?

Preferences

- How & when do you assess for preferences regarding the use of CPR?
- Do you assess for preferences regarding other life-sustaining treatments?
- How & when do you ask about preferences regarding hospitalization?
- How & when do you assess for spiritual / existential concerns?

Pain

- Are you using a standardized pain screening tool?
- How do you rate the patient's pain severity?
- Does your comprehensive pain assessment include
  - Location
  - Severity
  - Character
  - Duration
  - Frequency
  - What relieves/ worsens pain
  - Effect on function or quality of life

Respiratory Status

- How & when are you screening for shortness of breath?
- How do you determine what date a treatment for shortness of breath was initiated?
- Can you easily determine what treatment was initiated & if for multiple purposes does it specifically address shortness of breath?
  - Opioids
  - Other medications
  - Oxygen
  - Non-medication

Medications

- If there is a Comfort Kit / E-Kit ordered at admission for future needs, would that be considered a PRN opioid?
- If the patient is not on a scheduled or PRN opioid, but is on a bowel regimen, do you leave the bowel regimen question blank?

Using Data From HIS

- Once you have the process down pat, begin looking at the results
- These are clinical process measures – good processes lead to better outcomes
- Share results with the clinical staff - tie back to the clinical assessments
- Benchmark with others

CAHPS® Hospice Survey

- Purpose: To Understand
  - Patient experiences throughout their hospice care as reported by their family members / friends
  - The perspectives of family members /friends with regard to their own experiences with hospice vs. satisfaction
- Goal
  - Produce comparable data to allow objective & meaningful comparisons between hospices on domains that are important to consumers
  - Create incentives for hospices to improve quality of care through public reporting
  - Hold hospices accountable by informing public about the providers' quality of care

CAHPS® Hospice Survey

- Developed based on principles used in development of other CAHPS surveys
- Topics will include
  - Hospice provider communication with patients & family members
  - Treatment of symptoms
  - Pain medication
  - Cooperation among caregivers
  - Treating patients with dignity & respect
  - Spiritual support offered
  - Patient & family member characteristics
  - Overall rating of the hospice
  - "Would you recommend" question

CAHPS® Hospice Survey

- Three different surveys administered based on location of death
  - Home
  - Nursing home
  - Inpatient settings (acute care hospital / freestanding hospice inpatient units)
- Where did the questions come from?
  - Items addressing communication, shared decision making, and overall ratings – adapted from other CAHPS item sets
  - Items address symptom management and emotional and spiritual support – adapted from FEHC survey

What We Know Today

- Survey contains 47 items
- Estimated to take about 10 to 12 minutes
- Anticipate administering the survey about 2 – 3 months following the patient's death
- Must outsource survey to 3rd party vendor
- Vendors will be required to offer the survey in English and Spanish
- CMS proposed sample sizes for all hospices in FY 2015 proposed rules
  - Hospices with fewer than 50 deceased patients during the prior calendar year are exempt
  - Hospices with 50 – 699 decedents in the prior year will be required to survey all cases
  - Hospices with 700 or more decedents in the prior year, a sample of 700 will be drawn
  - Hospices will not be responsible for certain response rates

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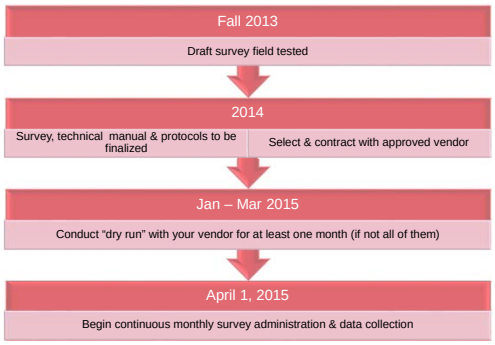
- Must outsource survey to 3rd party vendor
- Vendors required to offer the survey in English & Spanish
- Proposed sample size included in FY 2015 Wage Index proposed rules

Decedents Prior CY	Sample Size
Fewer than 50	Exempt
50 - 699	All
700+	Sample of 700

CAHPS® Hospice Survey Quality Measures

- Hospice Team Communication
- Getting Timely Care
- Treating Family Member with Respect
- Providing Emotional Support
- Getting Help for Symptoms
- Information Continuity
- Understanding the Side Effects of Pain Medication
- Getting Hospice Care Training (Home Setting of Care Only)

Timeline for CAHPS® Hospice Survey



What to Do Now

- Read the FY 2014 Hospice Wage Index Final Rule – section III.B.6 – *The CMS Hospice Experience of Care Survey for the FY 2017 Payment Determination and that of Subsequent Fiscal Years*
- Read the FY 2015 Hospice Wage Index Proposed Rule – section H.6 – *Proposed Adoption of the CAHPS® Hospice Survey for the FY 2017 Payment Determination*
- Review CMS websites related to Hospital & Home Health CAHPS to begin to get comfortable with the process & language
- Review the field test survey samples & supporting materials

What to Do Next

- Contact your EMR vendor to see how they can help support this requirement
- Start discussions with potential vendors and choose one from the approved CAHPS® Hospice Survey vendors
  - Approval process will begin Summer of 2014
  - Allows time to get comfortable with the process
- If currently using a satisfaction survey keep using for now
- Focus on improving return rates of current survey

The Process for Public Reporting

- CMS committed to providing public reporting
- HIS (standardized instrument) first step
- Establishment of reliability and validity of the HIS measures
  - First 2 quarters typically reflect learning curve & not used to establish reliability & validity (3rd & 4th quarter 2014)
  - Analysis will be from data in Q1, 2, & 3 of CY 2015
  - Decisions to report some or all publically will be based on the findings of analysis of the CY2015 data
- CMS will provide reports to individual hospices on the performance measures in the future
  - Will occur before public reporting
  - Specifics of the reporting system and when specific measure will be available to be determined

Resources

CMS Quality Reporting website-Google CMS Hospice Quality or use this link:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html?utm_medium=email&utm_source=govdelivery

2014 Hospice Wage index

https://www.federalregister.gov/articles/2013/05/10/2013-10389/medicare-program-fy-2014-hospice-wage-index-and-payment-rate-update-hospice-quality-reporting

2015 Wage Index

http://www.ofr.gov/OFRUpload/OFRData/2014-10505_PI.pdf

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