LEADERSHIP FORUM 2023

IMPORTANT TOPICS FOR HOSPICE LEADERSHIP

- Medicare Oversight and Audit Activities
- PEPPER Report
- Medicare State Surveys and Plans of Correction
- Medicare Hospice Quality Reporting Program (HQRP)

MEDICARE OVERSIGHT AND AUDIT ACTIVITY

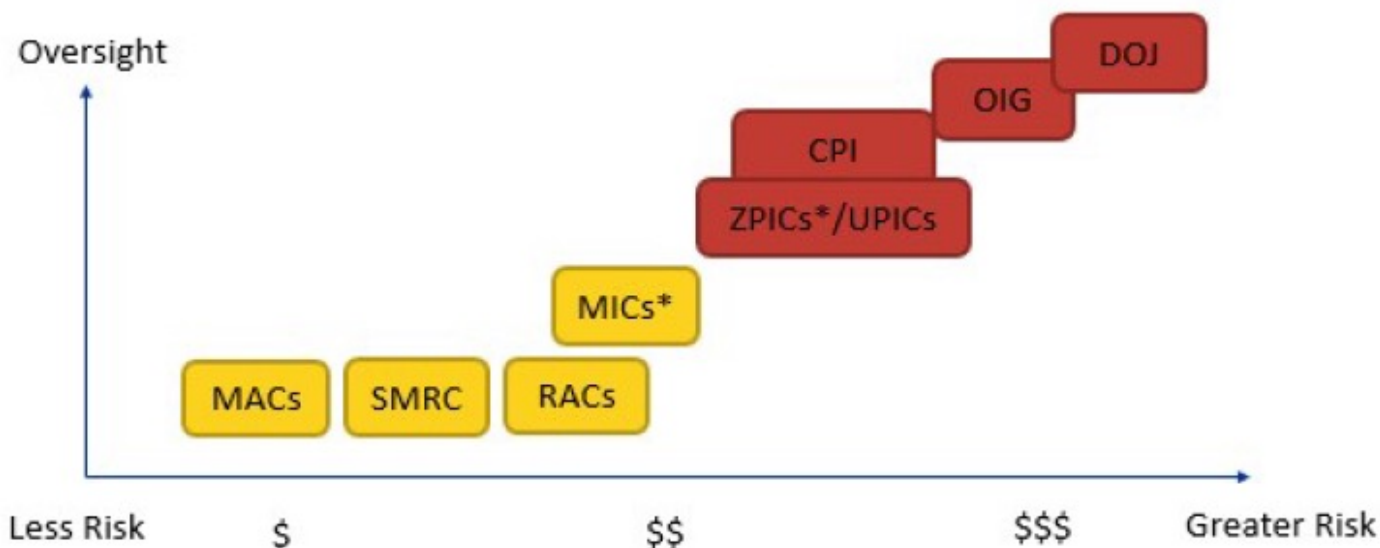
OVERSIGHT TO STRENGTHEN HOSPICE COMPLIANCE

- Medicare (CMS)
- U.S. Department of Health and Human Services (DHHS)
- Office of the Inspector General (OIG)

INCREASED USE = INCREASED SCRUTINY

- As hospice use increases, so does the amount of money Medicare spends on hospice care. This means the government steps up enforcement in an effort to control costs.
- Medicare hospice expenditures rise by about $1 billion annually, according to CMS.
- Also, the release of investigative reports from OIG identifying both quality concerns and billing and reimbursement issues.
- Hospices may now find themselves under more intense scrutiny while continuing to navigate other regulatory challenges

LEVEL OF RISK



*NPHCO Person Centered Care

TYPES OF CURRENT GOVERNMENT AUDITS

OIG

- Office of the Inspector General (OIG) - concerns have been raised about patients who are hospitalized, elect hospice, and move directly to GIP status. The OIG has noted in data that there are increases, in some hospitals, of direct GIP admissions when a patient has been hospitalized for longer than the average for the DRG for which the patient has been treated.
- The OIG questions if this is for the hospitals financial gain, or to side-step a risk in quality reporting. If these direct admissions are motivated by these issues, it certainly could be questioned if there was a true medical necessity for the GIP Level of Care by the Hospice.
- Must have a vigorous evaluation process done by physicians/APRNs or other qualified staff prior to each admission to determine eligibility.

SUPPLEMENTAL MEDICAL REVIEW CONTRACTOR (SMRC)

- The Centers for Medicare & Medicaid Services (CMS) contracts with a Supplemental Medical Review Contractor (SMRC) to help lower improper payment rates and protect the Medicare Trust Fund.
- The SMRC conducts nationwide medical reviews of Medicaid, Medicare Part A/B, and DMEPOS claims to determine whether claims follow coverage, coding, payment, and billing requirements.
- The focus of the medical reviews may include issues identified by CMS data analysis (claims), the Comprehensive Error Rate Testing (CERT) program, professional organizations, and other Federal oversight agencies.

- Supplemental Medical Review Contractor (SMRC) – Currently reviewing:
  - Routine level of care stays >91 days for patients with heart disease, alzheimers, CHF, protein-calorie malnutrition, and cerebral infarction for DOS in 2021. *This was announced on June 30th
  - Post-payment review of GIP claims for DOS in 2020.

RAC

Performant Recover Audits Contract (RAC)

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- This was announced on June 30th and are post-payment reviews

CERT

Comprehensive Error Rate Testing (CERT)

- CMS created the CERT Program to measure the error rate of improper Fee-for-Service payments.
- The CERT contractor reviews a sample of processed claims. If a claim doesn't meet Medicare's coverage, coding, and billing rules or the provider fails to submit medical records, it's counted as a total or partial improper payment.
- MACs analyze CERT error rates to reduce improper payments by updating their internal processes and educating providers.

UPIC

Unified Program Integrity Contractors (UPIC)

- UPICs perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims
- Perform integrity related activities associated with Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice (HH+H) and Medicaid
- UPICs integrate functions previously performed by the Zone Program Integrity Contractor (ZPIC), Program Safeguard Contractor (PSC) and Medicaid Integrity Contractor (MIC) contracts.
- Can be pre or post-payment reviews

TARGETED PROBE AND EDUCATE (TPE)

- According to CMS, the Targeted Probe and Educate (TPE) program is designed to help providers reduce claim denials and appeals through one-on-one help.
- Medicare Administrative Contractors (MACs), such as CGS, work with providers to identify errors and help correct them

COMMON ERRORS FOR TPE DENIALS

- Signature of certifying physician not included
- Documentation did not support all elements of eligibility (Home patients and GIP)
- Documentation does not meet medical necessity (Physician/APRN documentation)
- Missing or incomplete certifications or recertifications

HOW DOES TPE WORK

- If chosen for TPE the provider will receive a letter from the MAC
- The MAC will request 20-40 Additional Documentation Requests (ADRs) from your claims.
- The MAC will review the medical records submitted and make a determination
- Error rate is calculated based on claim dollars denied. If the provider's error rate exceeds 25%, they will proceed to Round 2.
    - Providers will be invited to a one-on-one education session and given 45 days to make changes and improve

WHAT IF THE PROVIDER STILL DOESN'T IMPROVE?

- If providers fail to improve after 3 rounds of TPE they will be referred to CMS for the next steps. These steps may include:
  - 100% prepayment review
  - Extrapolation
  - Referral to a RAC
  - "Other action"

ADDITIONAL DOCUMENTATION REQUEST (ADR)

- Responding to all types of audits is a similar process. SMRCs, RACs and TPE all request medical records via an ADR
- An ADR is the collection and clinical review of medical records and related information to ensure that payment is made only for services that meet all Medicare coverage, coding, billing, and medical necessity requirements.

HOW TO RESPOND TO AN ADR

- When preparing the documentation, the provider must attach a copy of the ADR letter as the first page to ensure the documentation is matched to the appropriate patient and claim. There is a QR code on the letter that makes sure the ADR is routed appropriately
- Providers should submit the necessary documentation to support the services for the billing period being reviewed. This may include documentation that is prior to the review period.
- Documentation may be received by either US Mail, esMD, your MAC provider portal (myCGS), Fax, or on compact disc (CD), digital video disc (DVD), or universal serial bus (USB).

  **myCGS is easy to submit and track the ADR through the entire process.*

WHAT TO INCLUDE IN AN ADR RESPONSE

- Initial assessment and visit notes for all services provided during the billing period
- Plan of Care updates and IDG documentation to cover all days during the billing period
- Physician/APRN orders and visit notes
- Old records from hospital, etc
- Certifications/recertifications
- Pertinent info from before/after billing period. (for instance, patient died 3 days after billing period)
- Signed Notice of Election with hospice effective date

ADR, CONT'D

- Cover letter/case summary: review of order changes, symptom changes, required medications, etc
- Page numbers for entire medical record, if possible
- Section Dividers and Table of contents
- Signature policy for e-signatures or signature attestation

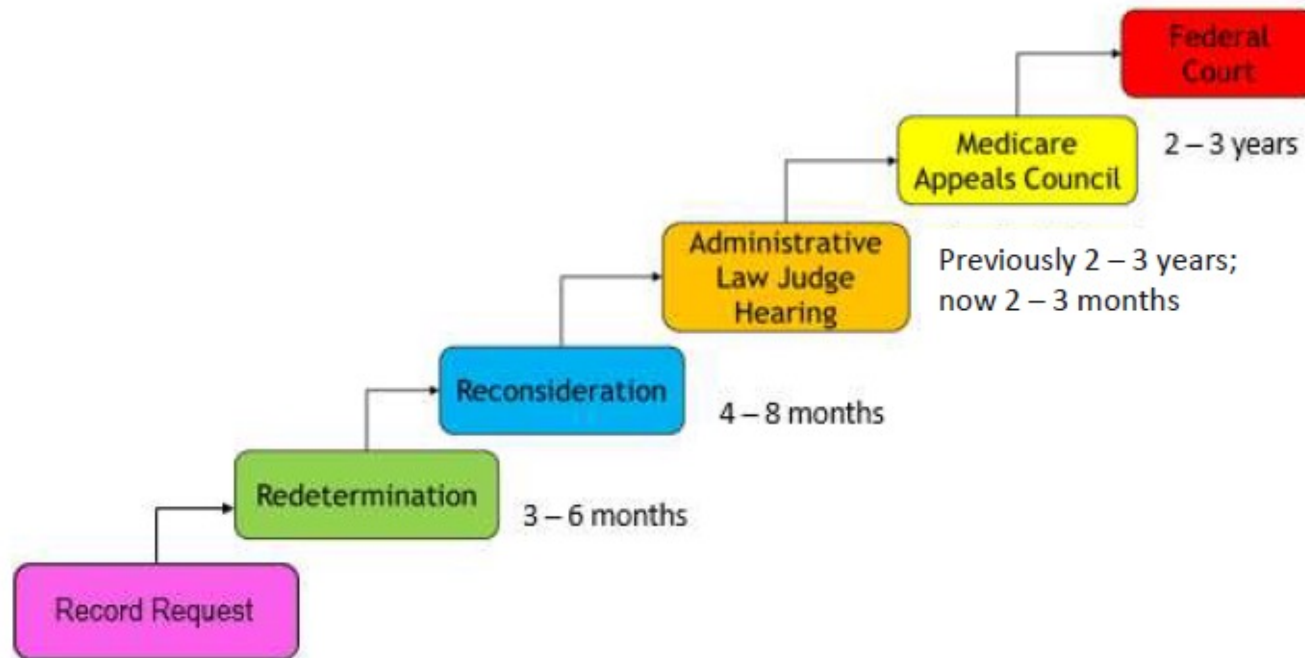
BE SURE TO SUBMIT BY THE DEADLINE

- UPIC pre and post-payment Reviews – 30 calendar days
- SMRCs, RACs, TPE and other pre and post-payment ADRs – 45 calendar days

What if the provider can't meet the deadline?

The contractor may accept documentation received after 45-calendar days for good cause. Good cause means situations such as natural disasters, interruptions in business practices, or other extenuating circumstances that the contractor deems good cause in accepting the documentation.

WHAT IF THE ADR IS DOWNCODED OR DENIED



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PEPPER REPORT

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- The Program for Evaluation Payment Patters Electronic Report (PEPPER) is a report summarizing provider-specific Medicare claims data for target areas often associated with Medicare improper payments due to billing or admission necessity issues.
- Target areas are determined by Medicare (CMS).
- Each hospice receives a PEPPER, which contains statistics for these target areas

PEPPER, CONT'D

- The report shows how a hospice's data compares to national, MAC jurisdiction, and state statistics.
- Data in PEPPER is presented in tables and in graphs that depict the hospice's percentages over time.
- Designed to assist hospices with the identification of potentially improper payments.
- Released yearly and an email is sent to the agency with instructions how to access

HOW TO ACCESS YOUR PEPPER

- It is available via the PEPPER Portal at PEPPERFILE.CBRPEPPER.org.
- The contact from the Provider Enrollment, Chain, and Ownership System (PECOS) will be sent an email with a validation code. The validation code may be shared with others in the hospice, as deemed appropriate.

TARGET AREAS

- Live discharges - no longer terminally ill
- Live discharges – revocations
- Live discharges with LOS 61-179 days
- Long length of stay (> 180 days)
- Continuous Home Care provided in an assisted living facility (ALF)
- Routine Home Care provided in an ALF
- Routine Home Care provided in a nursing facility (NF)
- Routine Home Care provided in a skilled nursing facility (SNF)
- Claims with a single diagnosis coded
- No General Inpatient Care or Continuous Home Care
- Long General Inpatient Care stays (> 5 consecutive days)

TARGET AREAS, CONT'D

- Average number of Medicare Part D claims for patients residing at home
- Average number of Medicare Part D claims for patients residing in an ALF
- Average number of Medicare Part D claims for patients residing in a NF
- Average number of Medicare Part B claims for patients residing at home
- Average number of Medicare Part B claims for patients residing in an ALF, NF or SNF

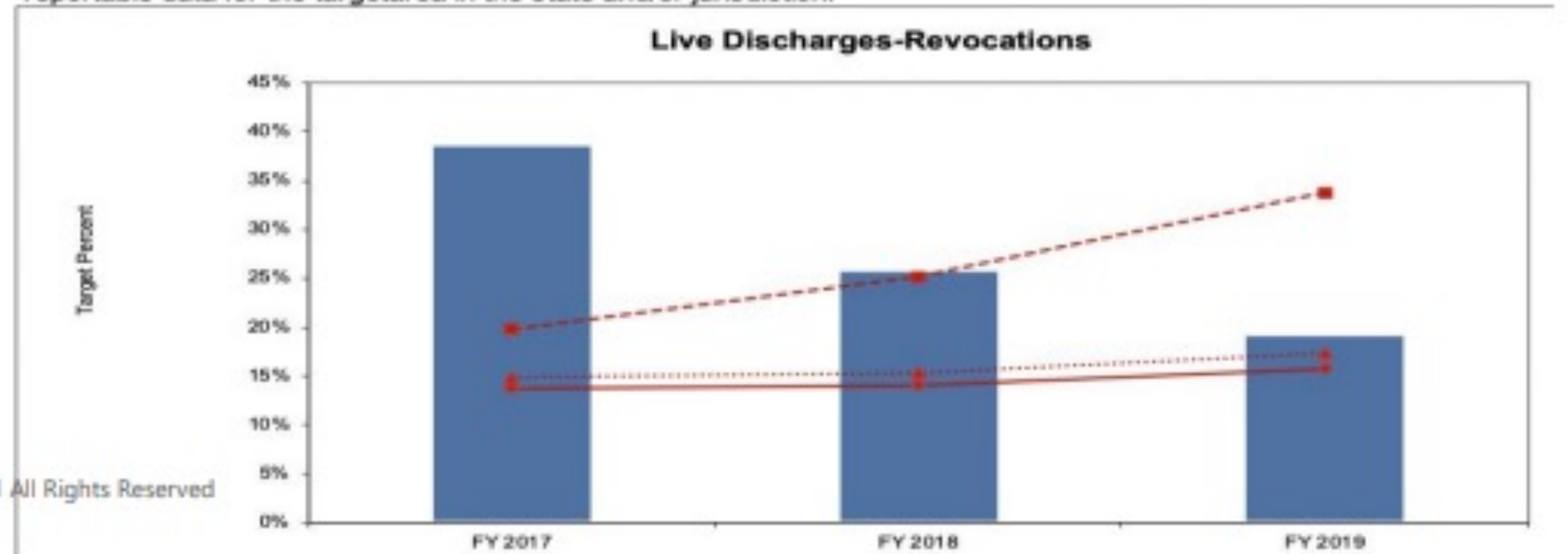
SAMPLE PEPPER

YOUR HOSPICE	FY 2017	FY 2018	FY 2019
Outlier Status	High Outlier	High Outlier	High Outlier
Target Area Percent	38.7%	25.9%	19.3%
Target Count	41	56	54
Denominator Count	106	216	280
Target (Numerator) Average Length of Stay	56.2	127.6	124.3
Denominator Average Length of Stay	46.0	85.7	118.8
Target (Numerator) Average Payment	$9,943	$20,590	$20,809
Target (Numerator) Sum of Payments	$407,648	$1,153,041	$1,123,681

Table 6 Comparative Data for Live Discharges-Revocations

COMPARATIVE DATA	FY 2017	FY 2018	FY 2019
National 80th Percentile	13.8%	14.1%	15.8%
Jurisdiction 80th Percentile	19.8%	25.2%	33.8%
State 80th Percentile	14.9%	15.3%	17.4%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the targetarea in the state and/or jurisdiction.



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WHY IS THE PEPPER IMPORTANT

- Helps identify potential risk areas for billing errors or eligibility issues
- Outlier target areas may put provider at risk for audits
- Provider can see high outliers and low outliers
  - Example: low outlier for LOS indicates an exceptionally low LOS
- PEPPER has suggested interventions for hospices for outliers for each target area

WRITING AN ACCEPTABLE AND
PURPOSEFUL PLAN OF CORRECTION

OBJECTIVES

Attendees will be able to:

1. Distinguish between the different levels of deficiencies given by Medicare Surveyors
2. List the required components of a Plan of Correction and how to apply them to different deficiencies
3. Create meaningful plans that will satisfy the State and lead to improvement in performance.

MEDICARE RECERTIFICATION SURVEY

- Required every 3 years for Medicare Certified hospices
- CMS Survey Guidelines were recently revised and became active in March 2023
  - No changes to actual COPs or Standards
  - Now 2 phases
    - Phase 1: Surveys the quality of care delivered directly to patients, caregivers and families. Focuses on Patient Rights, I and C Assessment and IDG/care planning/coordination
    - Phase 2: Surveys the CoPs that focus more on administrative functions and operations

SO YOU'VE HAD YOUR SURVEY, NOW WHAT?

- Exit Conference: Surveyors communicate preliminary findings and provide an opportunity for the exchange of information with the hospice's administrator, designee, or other invited staff. The Exit Conference is both a courtesy to the hospice and a way to expedite the hospice's planning for the Plan of Correction
- Surveyors have 10 business days to send the hospice a Statement of Deficiencies (Form CMS-2567)

STATEMENT OF DEFICIENCIES

- Survey team will name the COP or “tag” that the deficiencies falls under

  example: L0530 Content of the Comprehensive Assessment

- They will list the actual rule or “CFR” under the COP that was deficient. Under this they will site the rule/expectation. You will use this language to build the Plan of Correction.
- They will detail the deficient practices observed. For instance: “The standard is not met as evidenced by” or “The condition is not met as evidenced by”

DETERMINING THE TYPE OF DEFICIENCY

- An isolated incident that has little or no effect on the delivery of patient services may not warrant a deficiency citation. Conversely, isolated or not, an incident may be considered deficient if it constitutes a significant or serious problem that adversely affects or has the potential to adversely affect the patient
- Deciding the level of deficiency depends on factors such as frequency of occurrence, poor patient outcomes and impact on delivery of care.

TYPES OF DEFICIENCIES

Standard Level Deficiency

- This type of deficiency is given when a provider is not compliant with one of the **standards** under a condition of participation.
  - Survey outcome - A hospice remains certified with this type of deficiency, but they will need to submit a plan of correction to the survey agency describing how the deficiencies will be mitigated.
  - Plan of Correction due to the State within 10 calendar days of the survey exit date
  - Plan of Correction must be implemented within 60 days of the survey exit date
  - It is the prerogative of CMS to have the surveyors do a return visit, but it is less likely with only standard deficiencies

TYPES OF DEFICIENCIES

Condition Level Deficiency

- This type of deficiency is given when the surveyor has assessed significant noncompliance with the entire condition of participation or multiple standards within a condition.
  - Survey outcome – The surveyors will initiate termination process. If the deficiency is not corrected, a termination of the provider agreement will result.
  - Plan of Correction due to the State within 10 calendar days of the survey exit date
  - Plan of Correction must be implemented within 45 days of the survey exit date ***Completion date should be at least 10-14 days before the 45th day, as the re-visit by the State must be completed by the 45th day.*
  - Onsite re-visit is required for a condition level deficiency. Surveyors will:
    - Assess the hospice's correction of the deficiencies previously cited
    - Re-evaluate specific care and services cited during survey.
    - Home visits may be required.

TYPES OF DEFICIENCIES

Immediate Jeopardy

- This is the highest level of deficiency.
- This level is applied when the degree and manner of the non-compliance has caused or is likely to cause significant injury, harm, or death to a patient.
- Survey outcome:
  - CMS immediately terminates the hospice program provider agreement

  OR

  - CMS terminates the hospice program provider agreement no later than 23 calendar days from the last day of the survey, if the immediate jeopardy has not been removed by the hospice program.
  - In addition to a termination, CMS may impose one or more enforcement remedies such as civil money penalties or temporary management of the hospice program.

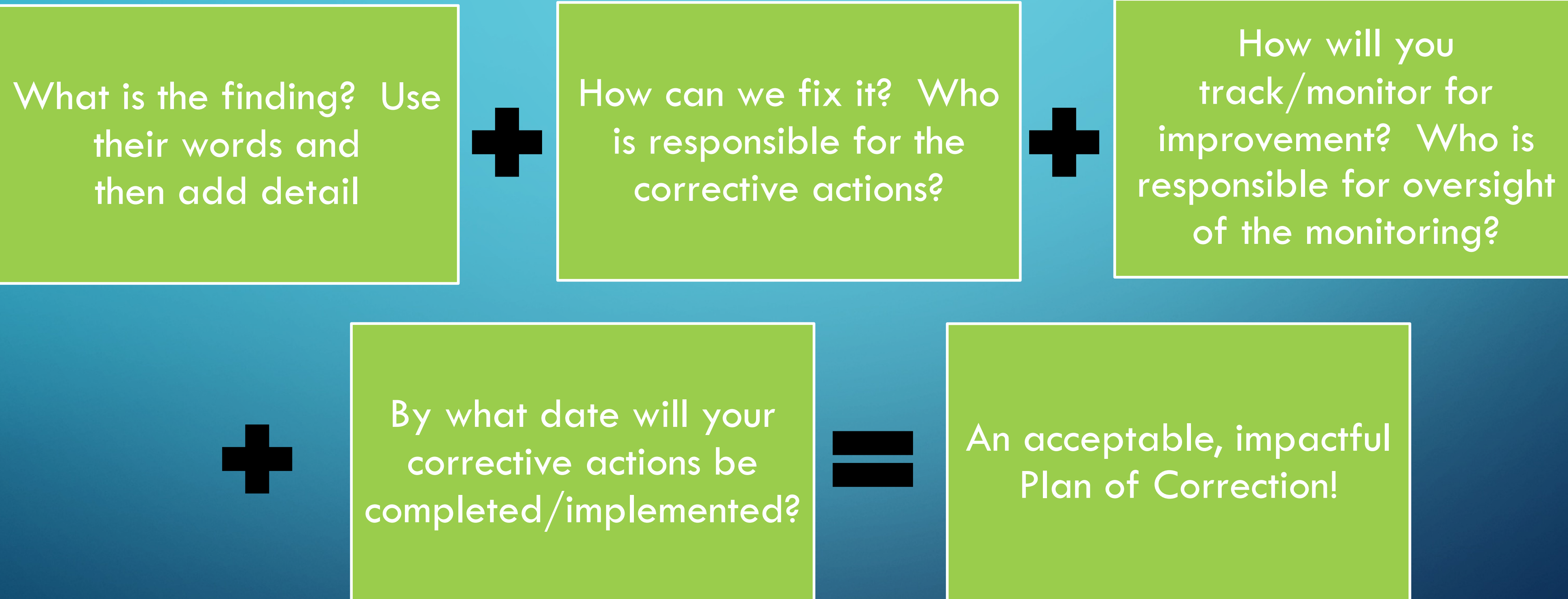
**Providers with this level of deficiency during a survey are advised to contact legal counsel immediately.*

LET'S WRITE THIS PLAN OF CORRECTION!

A POC must describe the corrective actions that the hospice will take to remedy a deficiency and come into compliance with applicable regulations. It should be developed for all cited deficiencies, whether the deficiency is a standard or condition level deficiency. A POC has the following components:

- Action that will be taken to correct each specific deficiency cited. Directly and specifically describe the measures the hospice will put into place to take corrective action and ensure the alleged deficient practice does not recur.
- The title of the person responsible for the corrective actions.
- The monitoring procedures the hospice will institute to ensure compliance is maintained
- The title of the person responsible for the monitoring procedures.

THE FORMULA FOR A GREAT POC



LET'S BREAK IT DOWN

- Review the finding
  - What Rule/Tag did the surveyor site?
  - How did we fail to meet the standard? The detail is provided record by record.
  - Use the verbiage of the Rule/Tag in building the Plan of Correction

L0545	CONTENT OF THE PLAN OF CARE CFR(s): 418.56(c) The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

WHO IS RESPONSIBLE FOR THE CORRECTIVE ACTIONS?

Identify the Administrator responsible for making sure corrective actions are implemented and maintained.

Sample Language:

Under the direction of the Director of Quality and Regulatory Compliance and the Director of Clinical Services, all clinical staff will be educated regarding the Content of the Plan of Care. This will include:

IDENTIFY ACTIONS THAT WILL HELP US IMPROVE

- In many cases, educating staff is a necessary first step. We must make sure staff understand the regulation and what is expected
- Beyond education, what else is needed to remediate the problem? A process change? A policy update? In person supervisory visits?

This reflects the actual language from the regulation

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This is the detail from the actual findings

Sample Language

This education will include:

- The hospice must develop an individualized written plan of care for each patient.
- The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments.
- The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions.
- The plan of care must include interventions/instructions and goals for problems that are identified, such as pain mgmt., wounds/drains, urinary retention/foley care, ostomy care, PICC Line usage, oxygen therapy, etc

STAFF EDUCATION

- Track attendance. Make sure there is a sign in sheet or a way to track virtual attendance
- Have staff complete a quiz or a return demonstration
- Keep a notebook with copies of the education, attendance and quizzes, etc. This is important if you have a return visit by the State

EXAMPLES OF OTHER ACTIONS BESIDES EDUCATION

- 100% of LTC Binders updated to include all the required documents
- Written notice of the Patient Rights updated with correct toll-free hotline hours of operation and new notice provided to all current patients.
- Disinfecting supplies provided to all clinical staff, including Social Workers and Chaplains.
- Family refrigerator will be monitored daily for items not labeled or dated
- Temperature of the refrigerator/freezer will be monitored and logged daily

WHO IS RESPONSIBLE FOR OVERSIGHT OF THE MONITORING?

Identify the Administrator responsible for the monitoring procedures instituted to ensure compliance is maintained

Sample Language:

Monitoring: Monitored by the Hospice Care Managers through a documentation audit representing 20% of the average daily census to assure ongoing compliance over 6 months with a target threshold of 80%. The Director of Quality and Regulatory Compliance is responsible for oversight of the corrective action and monitoring.

EXAMPLES OF TYPES OF MONITORING

- Chart audits
- Direct observation/supervisory visits. e.g., home visits to check if patient's medications are correctly reconciled to med list; observe staff for infection control techniques
- Visits to LTC to check if Coordinated Task Plan of Care is updated correctly. Talk with LTC staff about collaboration with hospice

Create a form so that these activities can be documented.

COMPLETION DATE AND SUBMISSION OF THE POC

- Completion Date should be within 60 days of the survey exit for a Standard Deficiency
- For a Conditional Deficiency, the completion date should be 10-14 days prior to the 45 day requirement. This is due to the return visit.
- Hospice Administrator should sign and date page 1 of the statement of deficiencies. This page should be returned along with the Plan of Correction.

AND FINALLY! STATE ACCEPTANCE OF THE POC

- The State may respond and ask for clarifications or changes
- These should be submitted as an addendum
- Examples of changes:
  - Chart audit target threshold of 80% wasn't good enough. Surveyor wants it to be 90%
  - Did not address all the parts of the deficiency. E.g., education was too vague and should be more focused on LTC which is where the deficiency occurred.
  - Education was going to only nurses and should be to all disciplines

CMS HOSPICE QUALITY REPORTING PROGRAM (HQRP)

HOSPICE QUALITY REPORTING PROGRAM (HQRP)

- The HQRP includes data submitted by hospices through the Hospice Item Set (HIS), data from Medicare hospice claims, Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.
- All Medicare-certified hospice providers must comply with these reporting requirements.
- The HQRP is currently "pay-for-reporting," meaning it is the timely submission and acceptance of complete data that determines compliance with HQRP requirements. The Performance level is not a consideration when determining compliance

PENALTIES FOR FAILURE TO REPORT

- Effective with the FY 2022 Final Rule, beginning with the FY 2024 Annual Payment Update (APU) and for each subsequent year, the APU penalty is increased from 2% to 4% for hospices that do not comply with the HQRP for that FY.

PUBLICLY REPORTED

- Care Compare on Medicare.gov is the official CMS website for publicly reporting quality measures
- Created to help consumers compare hospice providers' performance and assist in making decisions that are right for them.
- You can search and download the publicly reported data displayed on Care Compare in the Provider Data Catalog on CMS.gov.

HOSPICE ITEM SET (HIS)

The publicly reported HIS Comprehensive Assessment represents the percentage of patients who received all seven care processes. The care processes include:

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

HOSPICE CARE INDEX (HCI)

THE HCI IS A SINGLE MEASURE COMPRISING TEN INDICATORS CALCULATED FROM MEDICARE CLAIMS DATA. THE POTENTIAL RANGE OF SCORES IS FROM 0 TO 10. THE INDICATORS ARE:

1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided
2. Gaps in Skilled Nursing Visits
3. Early Live Discharges
4. Late Live Discharges
5. Burdensome Transitions (Type 1) – Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission

1. Burdensome Transitions (Type 2) – Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital
2. Per-beneficiary Medicare Spending
3. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day
4. Skilled Nursing Minutes on Weekends
5. Visits Near Death

HOSPICE CAHPS SURVEY

THE CAHPS HOSPICE SURVEY IS A NATIONAL SURVEY OF FAMILY MEMBERS OR FRIENDS WHO CARED FOR A PATIENT WHO DIED WHILE UNDER HOSPICE CARE. THE QUESTIONNAIRE CONTAINS 47 QUESTIONS COVERING TOPICS OF INTEREST TO FAMILY CAREGIVERS AND HOSPICE PATIENTS.

1. Rating of Patient Care
2. Would You Recommend this Hospice
3. Communication with Family
4. Getting Timely Help

1. Treating Patient with Respect
2. Emotional and Spiritual Support
3. Help for Pain and Symptoms
4. Training the Family to Care for the Patient

⭐STAR RATINGS⭐

- With the August 2022 refresh of Care Compare, the Hospice CAHPS Star Ratings were publicly reported for all hospices with 75 or more completed surveys over the reporting period.
- Star Ratings will be updated every other quarter.
- Hospices will have the opportunity to see their CAHPS Hospice Survey Star Ratings in their official CMS Preview Report prior to each update of Care Compare.
- Star Ratings for 4th Quarter 2020 – 3rd Quarter 2022 reporting period are available

RESOURCES

- CMS State Operations Manual https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf
- Revisions to SOM and Hospice Surveyor Training https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf
- "Hospice Survey Plan of Correction - Compliance Guide for Hospice Providers" - NHPCO https://www.nhpco.org/wp-content/uploads/Hospice_Survey_Plan_Correction.pdf
- "Hospice Training & Resources." *PEPPER Resources*, pepper.cbrpepper.org/Training-Resources/Hospices
- "Hospice Quality Reporting Program." CMS.Gov, www.cms.gov/medicare/quality/hospice.

QUESTIONS OR COMMENTS?

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