



The Hospice Guide to Quality Care and Reporting

*Promoting Sustainability in an
Evolving Regulatory Climate*

Diane Link, RN, MHA



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About the Author



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Diane Link, RN, MHA, is a senior clinical consultant with BlackTree Healthcare Consulting whose career in home health and hospice began in the 1990s. Her roles have included field nurse, performance improvement nurse, clinical manager, and executive director. She has also served as a Community Health Accreditation Partner surveyor in the home health, hospice, and private duty service sectors.

Link draws on her extensive knowledge of federal hospice regulations and major industry accreditors to help organizations prepare for surveys, respond to Medicare audit requests and claim denials, and develop successful plans of correction. A certified Lean Six Sigma Green Belt, she routinely helps performance improvement project teams boost quality indicators in all aspects of hospice care. She also empowers organizations with proactive strategies for compliance, including ongoing staff education and comprehensive process review.

In addition to serving as president of the board of directors for the Maryland-National Capital Homecare Association (MNCHA), she has received MNHCA awards for her leadership and healthcare policy advocacy. She is also on the policy committee for the National Association for Home Care & Hospice's Financial Managers Group and has served as a board member for the Hospice & Palliative Care Network of Maryland. She regularly presents on hospice and homecare issues at state and national conferences and is often cited in industry publications.

Link holds a master's degree in healthcare administration from Mount Saint Mary's University in Maryland and maintains her RN license in Maryland, Pennsylvania, and New Jersey. Although home health and hospice have been her primary professional focuses, Link also has expertise in long-term care and acute care.

Part I:

Background and Context

Chapter 1

From Concept to Culture of Reform: A Brief History of Hospice Care in America

At its most basic level, hospice is the provision of care to the terminally ill. Over the years, however, the term has evolved into a rich philosophy that addresses the physical, psychosocial, emotional, and spiritual needs of terminally ill patients and their families in whatever place the dying individual calls home.

Today, hospice is a comprehensive service that an interdisciplinary team of care professionals delivers to patients during their final months, weeks, and days of life and to their loved ones. Hospice professionals have a profound impact on patients' overall state of being at the end of life, and they provide invaluable support to families as they cope and grieve.

Goals and Approaches

Hospice does not hasten death. Rather, it supports the natural dying process by focusing on many different aspects of care for patients and their families. Fittingly, some fundamental goals of hospice are as follows:

- Affirming life, promoting dignity, and helping patients fulfill their final wishes
- Providing care for the “whole person” by fostering physical, emotional, psychosocial, and spiritual well-being
- Managing pain and other physical symptoms for patients
- Conveying that dying is a natural part of life and that grief is a normal response to loss
- Supporting families and caregivers through a loved one's death and into the grieving period that follows

Hospice care is palliative in nature, which means that it promotes the highest level of comfort and quality of life for patients and their families rather than offering curative intervention. It is provided when a patient decides to stop aggressive treatment for a terminal disease. Because the hospice philosophy treats the patient and family as a unit of care, its overarching goals address both groups.

Origins and Formative Events

Hospice has evolved considerably over the years, shaped by a number of important events and people. The following sections describe the development of the modern hospice philosophy and its travel to the United States.

Dame Cicely Saunders

Although use of the term “hospice” can be traced back as far as medieval times, today’s understanding of this end-of-life philosophy grew out of the work of Dame Cicely Saunders, a British nurse, social worker, and physician who cared for dying patients from the mid-1900s until her death in 2005.

Saunders was determined to provide better care than the traditional end-of-life services that institutions offered at the time, and she dedicated her career to revolutionizing pain management. Her most celebrated contribution to the cause is St. Christopher’s Hospice, the world’s first modern hospice, which she founded in 1967 and which serves terminally ill patients and their families in South London to this day.

St. Christopher’s approach

Prior to the 1970s, most people died in hospitals with poor pain control and little spiritual care. A 1979 study conducted by Colin Murray Parkes, MD, FRCPsych, illustrates this point.

In the study, entitled *Terminal care: evaluation of in-patient service at St. Christopher’s Hospice*, Parkes compared the end-of-life experience of patients who had died while receiving care at St. Christopher’s Hospice between 1967 and 1971 with those of patients who had died in hospitals in that same time frame. For each care environment, Parkes evaluated responses from 34 spouses of decedents.

In the hospital group, 79% of respondents were familiar with the facility in which their spouse received end-of-life care. Although these patients were most often housed in wards with 11 to 20 beds, 24% lived on wards of more than 20 beds. The spouses’ responses indicated that 48% of the patients suffered from severe terminal pain. Of those, only 36% experienced relief from the pain. Only seven respondents knew that their hospital had a chapel, and only four recalled someone saying prayers on the wards.

Patients at St. Christopher’s Hospice had a dramatically different end-of-life experience. Because St. Christopher’s was new at the time of the study, only two of the interviewees had heard of the hospice house prior to their loved one’s referral. Most of the patients resided in partitioned units of 4 to 6 beds,

and three had private rooms. The study results reflected St. Christopher's emphasis of pain management: Responses indicated that fewer St. Christopher's patients suffered from severe pain at the end of life (18%) than did their counterparts at hospitals (48%). Furthermore, of the St. Christopher's patients who suffered from severe pain, about half experienced relief thanks to interventions by the hospice staff. St. Christopher's also addressed spiritual care more openly: 94% of spouses were aware of the facility's chapel, and ward prayers were said daily.

Pain management

In addition to breaking new ground in physical hospice establishments, Saunders pioneered many tenets of modern hospice care, including death with dignity and effective pain control that eases the natural process of dying.

Saunders began disseminating these principles in 1963, when she was invited to lecture medical students, nurses, social workers, and chaplains at Yale University on holistic hospice care. Her presentation featured case studies on how symptom management—including pain control—improved the quality of life for terminally ill patients and their families. It was a turning point in the history of hospice in the United States.

In traditional medical settings, pain medication is often administered only when the patient requests it. In contrast, the hospice approach championed by Dr. Saunders involves the regular provision of medication to manage pain effectively without causing unnecessary sedation and immobility. Administering medication before there's an urgent need prevents recurring pain, as well as the symptom control issues that can arise when pain reaches a high level.

Dr. Elisabeth Kübler-Ross

In 1969, Dr. Elisabeth Kübler-Ross published findings from interviews with more than 500 dying patients in a seminal book entitled *On Death and Dying*. Through her research, Kübler-Ross identified five stages that a terminally ill patient moves through during the last days of life, now applied more globally as the five stages of grief: denial, anger, bargaining, depression, and acceptance. By delineating this emotional arc, Kübler-Ross normalized conversations about dying and gave terminally ill patients and their loved ones a vocabulary with which to discuss their experiences.

Kübler-Ross also championed several other key focuses today: providing homecare rather than institutional care at the end of life and empowering patients to have a say in their care.

The advantages of dying at home include the comfort of a familiar setting and the ability to control the environment. A patient who lives at home during the end of life has the right to choose which visitors come and to dictate his or her schedule, including when to wake up and when—or if—to eat. He or she can decide what treatments to undergo and when those treatments will occur. Finally, he or she has the opportunity to achieve personal closure and say goodbye to loved ones in the privacy of his or her own home.

Hospice hits the U.S.

The hospice movement in the United States began with the philosophical frameworks of Saunders and Kübler-Ross, and it gained momentum thanks to several landmark domestic events.

The U.S. Senate's Committee on Aging

The advocacy of Saunders and Kübler-Ross for holistic care of the terminally ill contributed to the formation of a special Committee on Aging in the U.S. Senate.

In 1972, Kübler-Ross testified before this committee at the first national hearing on death with dignity, entitled *Death With Dignity: An Inquiry into Related Public Issues*. Senator Frank Church (D-Idaho), chair of the committee, introduced the hearing to start the discussion on the impact of chronic and terminal illness on the older population. The event focused on defining the issues that elders face at the end of life.

At the time of the hearing, at least 80% of the U.S. population died in an institution. During his opening remarks, Sen. Church stated that Medicare's emphasis on institutionalizing patients was costly and caused anxiety. He addressed the importance of determining when the fight against a terminal illness should end. The battle cry at the end of his speech still resonates today: "There should be public discussion and greater public understanding of issues related to death and dying in the United States."

Dr. Kübler-Ross's subsequent testimony centered on her interviews with terminally ill patients. She stated that most patients with a terminal illness do want to die at home and identified two of their primary needs: hope and reassurance that they will not be deserted. For a dying individual, the focus of hope shifts from curing or prolonging life to relief from illness-related distress and love ones' ability to cope with loss.

Kübler-Ross identified several efforts that would support those two basic needs, including the following:

- **Preventing the hospitalization of dying patients.** This can be achieved by providing in-home support, including homemakers, physicians, and caseworkers who serve both the patient and the family.
- **Informing the public that death is a part of life.** Kübler-Ross said Americans often denied death, were uncomfortable with facing their own mortality, and shied away from discussing end-of-life issues.
- **Training physicians.** Although physicians were well versed in curing and treating disease to prolong life, they required more education on caring for dying patients. Kübler-Ross said that the need for this specific education encompasses nursing schools, social worker schools, and even school-age children.

Kübler-Ross testified that shifting the focus of Medicare and Medicaid funding from institutional services to programs that promote care in the home would help address dying patients' needs. She described a system of care that resembles today's interdisciplinary team of physicians, nurses, social workers, aides, clergy, and volunteers. She advised against building institutions solely for dying patients, unless they were founded on love, care, and acceptance. She argued against attempting to replicate St. Christopher's Hospice in the United States because of the differences in reimbursement and allowed medications.

First U.S. hospice

In 1974, two pediatricians and a chaplain founded the first U.S. hospice in Branford, Connecticut. Although the organization provided homecare rather than institutional services, staff modeled their patient-centered care approaches after those used at St. Christopher's Hospice. Volunteers were an integral part of the program and provided support in patients' homes.

In 1978, the organization became the first teaching hospice. Two years later, it opened an inpatient facility. Today, Connecticut Hospice provides care to more than 2,000 patients annually.

The Medicare Hospice Benefit is born

Senators Frank Moss (D-Utah) and Church presented the first hospice legislation in 1974 to provide federal funding for hospice care. The bill lacked widespread support and never made it to a vote on the senate floor. Four years later, the U.S. Department of Health, Education and Welfare Task Force identified hospice as a viable philosophy of care for Americans with terminal illness and recommended federal support for dedicated programs.

In 1979, the Health Care Financing Administration (HCFA)—now the Centers for Medicare & Medicaid Services (CMS)—kicked off a demonstration that included 26 hospice providers. The goal of this demonstration was to determine the cost-effectiveness of hospice services and to set federal care expectations for providers in the sector. According to a 1987 Health Care Financing *Extramural Report* entitled the *Medicare Hospice Benefit Program Evaluation*, the demonstration showed that hospice care often generated cost savings when compared to conventional end-of-life services. The report also found that hospice programs could better manage patients' pain and other symptoms than a hospital could.

In 1982, based on its findings during the demonstration, the Health Care Financing Administration created the Medicare Hospice Benefit. Although the initial legislation contained a four-year sunset provision, the benefit was a resounding success, and in 1986, the Administration made hospice care a permanent Medicare benefit.

Hospice utilization ramps up

Over the next 10 years, hospice care in America blossomed. According to a 2004 report by the Centers for Disease Control and Prevention (CDC) entitled, *Health Care in America: Trends in Utilization*, of the 2.2 million people who died in the United States in 1992, 9.1% were enrolled in a hospice program. In 2000, 22% of decedents were enrolled. The CDC attributes this growth to the Medicare hospice benefit's increasing availability and patients' preference of receiving hospice care in their home.

In 1991, the Veterans Health Administration (VA) recommended the inclusion of hospice services in veteran benefit programs and initiated a pilot program to explore the possibility. In 1995, the VA implemented the CHAMPUS Hospice Benefit (now TRICARE) for veterans, which mirrors the Medicare Hospice Benefit.

Participation in the Medicare program lags

Despite the hospice philosophy's steady expansion, less than a quarter of providers were Medicare-certified by September 1987, according to a 1988 report entitled, *Medicare Hospice Benefit: Early Program Experiences*. This disparity may have been triggered by the program's low reimbursement rates for hospice care. Providers' reluctance to participate in the program resulted in the first increase in Medicare hospice reimbursement since the benefit was piloted in 1979.

During the first three years of the program, hospice certification rates varied by provider type. According to the 1988 report, which was conducted by Ann Davis Feather of the HCFA, home health agency-based hospices boasted the highest certification rates, with almost half of all providers certified by June 1987. In comparison, 14% of hospices based in hospitals and skilled nursing facilities and 21% of freestanding hospices had achieved certification by that time.

Administrators' reluctance to apply for certification was based primarily on the financial risk, but certification seemed to pay off in certain respects. In the 1988 report, Feather found some striking differences between certified and uncertified hospices. Medicare-certified hospices were larger both in patient census and budgets. They employed systematic administrative procedures believed to contribute to higher quality care. Documentation in the medical record reflected goal-oriented nursing services and treatment plans developed using an interdisciplinary team assessment.

However, the study also revealed several universal shortcomings in hospices. Regardless of certification status, hospices had insufficient documentation of psychosocial, spiritual, and bereavement services. In addition, about one-third of the hospices failed to provide evidence of informed patient consent. These issues raised other quality concerns and prompted further investigation.

The GAO steps in

In a 1989 report entitled *Medicare Program Provisions and Payments Discourage Hospice Participation*, the General Accounting Office (GAO) delved deeper into hospices' low participation in the Medicare program. The GAO verified the existence of financial risk issues. It identified additional concerns, including incomplete cost reporting, inaccurate data, and the quality of hospice care.

At the time of the GAO report, there were five Medicare requirements dedicated to promoting quality hospice care:

1. Hospice providers must develop and implement an ongoing quality assurance program focused on self-assessment and monitoring of care quality, problems, and potential improvement measures.
2. The interdisciplinary group must consist of a physician, RN, social worker, and counselor who develop and periodically review patients' plans of care.
3. Services must be provided in accordance with the plan of care to meet the patient's needs.
4. A governing body must establish policies and provide quality of care oversight.
5. Hospice must directly provide nursing care, social work, physician services, and counseling services to promote competent control of patient care.

The GAO found that of the 52 state survey agencies, 47 were able to ensure that hospices were providing quality care. Four agencies indicated there were no certified hospices in the state, and one offered no comment.

Interestingly, 71% of the state officials spoke favorably of Medicare's requirement that certification surveyors conduct home visits to patients as a quality assurance measure.

The GAO study inspired hospice regulatory changes found in the Omnibus Budget Reconciliation Act (OBRA) of 1989.

OBRA '89 brought a 20% increase to Medicare payment rates. It also introduced several new care provisions:

- The requirement that a beneficiary be certified as terminally ill within two days of admission to a hospice program.
- The ability to recertify patients beyond the prior limit of 210 days, as long as the patient is certified as having a terminal illness.
- The possibility of covered respite care—short-term inpatient services provided to hospice patients to relieve their primary caregivers when the need arises (e.g., a crisis occurs or the caregiver falls ill). Respite care is covered for up to five consecutive days at a time.
- The requirement that patients be given the right to participate and direct healthcare decisions.

CMS introduces (and eventually revamps) hospice CoPs

The *Medicare Hospice Conditions of Participation (CoP)* first took effect in 1983, and in spite of the extensive research revealing quality shortcomings, they remained unchanged for the next 18 years, save for the OBRA updates in 1989. Finally, through the 2008 *Hospice Conditions of Participation Final Rule*, CMS released a revised set of *CoPs*, which featured updated policies and requirements on a range of hospice program aspects.

Historically, quality assurance in hospice centered on identifying poor quality care, correcting these lapses, and booting providers that failed to do so from the Medicare program. In contrast, the revised *CoPs* focus on a patient-centered, outcome-oriented, and transparent approach to care that promotes quality for every patient, every time.

The 2008 *CoP* updates were concentrated primarily in four core requirements:

- 1. Patient rights.** The update added four new standards and enhanced the existing requirement to secure informed consent from patients before providing hospice care:
 - a. Notice of rights. Patients have the right to receive verbal and written notice of their rights and responsibilities (including those related to advance directives and controlled drug policies) before receiving hospice care and to confirm their understanding of these rights by signing a document.
 - b. Personal rights. Patients have the right to respectful treatment of their property and person, to voice grievances, and to not be subjected to discrimination or reprisal.
 - c. Symptom control. Patients have the right to receive pain management and symptom control services from their chosen hospice provider.
 - d. Confidentiality. Patients have the right to confidential clinical records.
 - e. Payment information. Patients have the right to be informed about any costs they may incur as part of their hospice care.
- 2. Comprehensive assessment.** In response to the high number of deficiencies cited on plans of care during certification surveys, the 2008 *CoP* rule introduced new assessment requirements. In particular, surveyors found that hospices were not addressing all care needs. Per the 2008 updates:
 - a. Within 48 hours of a patient's election of the hospice benefit, an RN must perform an initial assessment to determine the immediate needs of the patient and his or her family.
 - b. Within five days of the patient's election, the interdisciplinary team (assembled based on the RN's findings during the initial assessment) must collaborate with the patient's attending physician to complete a comprehensive assessment—a deeper and more holistic evaluation of the patient's and family's needs. The information captured in the comprehensive assessment drives the development of the hospice plan of care.
 - c. The plan of care must be updated at least every 15 days.

- 3. Interdisciplinary team care planning and coordination.** Under the updates, the hospice must designate an RN to coordinate care, to ensure that ongoing assessments occur, and to implement the interdisciplinary team's plan of care. This written plan must be founded on the assessed needs of the patient and family and address all services the hospice plans to provide. The hospice should also educate the patient and caregiver on their role in planned care.
- 4. Quality assessment and performance improvement programs (QAPI).** The *CoP* updates introduced the QAPI approach, which involves 360-degree surveillance of operations and patient care. It's executed primarily through performance improvement projects (PIP), which target individual areas that require improvement and ongoing evaluation. **Chapter 3** takes a deeper dive into QAPI.

In addition, to these core changes, the Secretary's Advisory Committee on Regulatory Reform identified the need for clarification on the relationship between nursing facilities and hospices. The final *CoP* rule assigned hospices the responsibility of managing the plan of care for facility-based hospice patients. It stated that hospices must provide the core services to patients residing in facilities, just as they would for hospice patients residing in their own home. The rule also provided a comprehensive list of specific requirements that must be included in hospice-nursing facility contracts to clearly define the role of each party.

The *CoP* overhaul signified a movement toward quality regulation in hospice.

The Modern Hospice Landscape

Today, a large number of aging baby boomers are changing the course of elder care. Many baby boomers have complex or chronic medical conditions that require the support of diverse healthcare services, including those offered by hospice providers.

In part because of these changes, the scope of hospice care has expanded over the years. When the Medicare hospice benefit was first introduced, most patients who sought coverage had a cancer diagnosis. Today, hospice providers serve people with a variety of end-stage diseases, a reality that has contributed to the significant growth of hospice in the United States over the past 35 years.

Questionable growth

The availability of hospice care in the United States increased dramatically between 2000 and 2009, with a 50% spike in the number of providers during this nine-year stretch, according to a 2014 Abt Associates Inc. report entitled *Medicare Hospice Payment Reform: A Review of the Literature (2013 Update)*. The number of hospice providers has climbed almost every year since. This influx has brought a significant increase in the number of patients receiving hospice care, especially among those with non-cancer diagnoses. According to the 2005 and 2014 editions of the National Hospice and Palliative Care Organization's (NHPCO) annual *Facts and Figures* report, hospices served 1.5 million patients in 2013, compared to 1.2 million in 2005.

In addition to increasing access, hospice's rapid expansion is also tied to some troubling trends, including a rise in patients' average length of stay and a corresponding increase in Medicare dollars spent on hospice care. According to the NHPCO reports, the average length of stay in 2013 was 72.6 days, compared to 59 days in 2010.

Although a greater volume and diversity of patients receive hospice care today, the higher expenditures and prolonged use of this benefit—which is intended for individuals with a prognosis of six months or less—has led some federal authorities to question the validity of the sector's care practices. For example, a 2008 MedPac report, *Evaluating Medicare's Hospice Benefit*, suggests that increasing lengths of stay may be tied to financial incentives in the Medicare hospice payment system.

The OIG's investigative work in the hospice sphere

The U.S. Department of Health and Human Services (HHS) oversees a number of federal agencies that regulate healthcare in the United States. The Office of Inspector General (OIG) is one such agency. The OIG's mission is to protect the integrity of HHS programs and the health and welfare of their beneficiaries.

To accomplish its mission, the OIG conducts audits, investigations, and evaluations of various federal programs, including healthcare. In follow-up reports, the agency shines light on potential areas of fraud and abuse and issues recommendations on cost-saving measures and healthcare policy updates. The agency also investigates and prosecutes criminal, civil, and administrative matters related to healthcare fraud and abuse.

Every year, the OIG publishes a *Work Plan* identifying the priority areas that the agency will target through its enforcement projects in the coming fiscal year (FY) and beyond. In this plan, the OIG carves out different activities for major HHS entities, with emphasis on the healthcare providers that participate in Medicare and Medicaid. The watchdog group prepares and disseminates specific reports on the findings from its *Work Plan* audits.

In 2007, the OIG released one such report, *Medicare Hospices: Centers for Medicare & Medicaid Services Oversight*, which revealed apparent oversight lapses in the hospice sector. For example, the OIG reported that in 2005, Medicare had scheduled hospice recertification surveys once every six years but in 2006 had lengthened this time frame to once every eight years. The result was that Medicare-participating hospices were being evaluated for their continued compliance with program requirements far less frequently than their counterparts in hospitals, nursing homes, and home health agencies. For example, under federal statute, home health agencies must receive a survey every 36 months, and skilled nursing facilities must receive one every nine to 15 months.

In 2011, the OIG again put hospice regulations under the microscope in a report titled *Medicare Hospices That Focus on Nursing Facility Residents*. This report found that Medicare spending on hospice care for nursing home residents had soared by 70% between 2005 and 2009, due only in part to a 40% spike in the number of hospice beneficiaries residing in nursing facilities during that time frame.

In addition to this broad-based scrutiny in the hospice sector, there are mounting enforcement activities at the individual provider level. In 2014 alone, the OIG settled three hospice cases involving provider fraud and abuse, which resulted in a total of \$4.9 million in penalties. The alleged offenses were as follows:

- Provider 1 submitted claims for patients whose health records indicated that they were ineligible for hospice care
- Provider 2 employed a licensed practical nurse who was excluded from participation in federal healthcare programs
- Provider 3 submitted claims for hospice services that did not meet federal healthcare program requirements

Such high-profile settlements have contributed to the significant uptick in regulatory oversight that hospice providers have experienced in recent years. To recap, so have the following:

- The OIG's broader investigations into the hospice industry
- The care philosophy's steady growth since its introduction in the United States
- Federal initiatives to standardize healthcare governance across the continuum

Quality regulations on the rise

The expansive Patient Protection and Affordable Care Act (ACA), which took effect in 2010, posed numerous regulatory changes for providers across the care continuum. Because the hospice sector has historically been governed by fewer and laxer regulations than have other healthcare environments, many hospice providers have struggled in the aftermath of the ACA's implementation.

Since the ACA was signed into law, hospices have faced new requirements on a number of major fronts: documentation, quality reporting, billing, and reimbursement. The following sections overview some of the most significant developments.

Certification and recertification

In 2010, CMS moved to promote appropriate use of the Medicare Hospice Benefit by finalizing an additional certification requirement for hospice providers. This change means that when certifying or recertifying a Medicare beneficiary for hospice care, a physician must compose a narrative describing how clinical findings support that the beneficiary in question has a terminal illness and a life expectancy of six months or less.

In 2011, CMS introduced another measure to ensure that hospice care is limited to the individuals who truly need of it. A hospice physician or nurse practitioner must now conduct and document a face-to-face visit with patients before certifying them for a third benefit period and for any subsequent benefit periods.

Quality reporting

The ACA also ushered in a quality-reporting program (QRP) for the hospice sector, which tasks providers with submitting a wide array of performance-related data to CMS. The hospice item set (HIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice survey both fall under this umbrella. Providers who fail to comply with timely filing requirements face reductions to their annual pay rate.

The first QRP initiative, which ran from October 1 through December 31, 2012, involved the collection and evaluation of the following performance criteria:

- At least three QAPI metrics related to patient care quality.
- Data on the hospice's ability to manage patients' pain levels. This ability was based on NQF #0209, which measures the percentage of patients who report pain during the initial assessment and who later report that pain had been reduced to a comfortable level within 48 hours. This measure has since been removed from the hospice QRP program due to variances in provider reporting methods and the high volume of patients who were excluded from it because they reportedly didn't experience uncomfortable pain upon admission.

Hospices were required to submit data on performance in the first category by January 31, 2013, and on performance in the second category by April 1, 2013. Failure to comply with these deadlines resulted in a 2% reduction in an agency's annual payment update during FY 2014.

GIP

Some patients with complex medical needs receive Medicare-covered hospice services in inpatient facilities. The billing category for this care is general inpatient (GIP). The difference in the per diem rate of GIP care and routine home care (RHC) can be \$500 or more. In recent years, CMS has introduced new measures to tamp down unnecessary use of the pricey service level.

In some cases, a hospice may determine that a patient who has been receiving GIP care no longer has a reasonable medical need for this high-cost level of service and should instead receive hospice care in a private residence. Per Change Request 8371, which took effect in 2014, the provider must give the beneficiary an advance beneficiary notice (ABN) so that the individual can decide whether he or she wants to appeal this decision or pay for continued GIP care out of pocket.

Since 2014, hospices have also been required to document a host of additional information on claims related to GIP levels of care, including the following:

- All visits that hospice staff make to a contracted facility (including any made post-mortem)
- The facility's National Provider Identifier (NPI) number
- Prescription drugs, identified by fill date, price of medication, and any accompanying infusion pumps and cassettes

HIS

In 2014, CMS rolled out the HIS. This data collection tool captures information on each hospice patient's condition and receipt of essential services at two critical junctures: admission and discharge. Items measured include the following:

- Treatment preferences (e.g., CPR, intravenous infusions)
- Discussion on beliefs/values (e.g., spiritual needs)
- Pain screening and assessment (e.g., use of a standardized pain tool)
- Dyspnea screening and treatment (e.g., provision of care based on assessment)
- Treatment of opioid-related constipation (e.g., identification of an appropriate bowel program)

Hospices must capture and submit HIS data at designated intervals throughout the year. Non-compliance results in a 2% reduction to the provider's annual payment update (APU). See **Chapter 4** for in-depth coverage of HIS requirements.

CAHPS

In 2015, CMS introduced a hospice-specific version of the CAHPS survey, which measures patients' and caregivers' experience of care. CAHPS had previously debuted in a number of settings across the continuum, including hospitals, home health agencies, and ambulatory surgery centers.

Under the CAHPS program, each hospice must contract with a CMS-approved vendor to distribute the survey among primary caregivers whose loved one has died while receiving hospice services. The survey, which currently consists of 47 questions, is conducted on a voluntary basis by mail, phone, or a combination.

Vendors must submit hospices' CAHPS data on a quarterly basis. Noncompliance results in a 2% reduction to the provider's APU. See **Chapter 5** for in-depth coverage of CAHPS requirements.

Reimbursement changes

As reflected in the penalties imposed for noncompliance with HIS and CAHPS submission requirements, quality regulations are increasingly tied to reimbursement.

Another example: In its fiscal year (FY) 2016 payment rule for Medicare-participating hospice providers, CMS introduced a new, two-tiered payment structure for RHC, the most common service designation in the sector.

As of January 1, 2016, providers receive higher reimbursement during the first 60 days of RHC service delivery to a patient and a lower rate for any additional days thereafter. Like recent updates to certification requirements, this stipulation aims to ensure that hospice care is provided to eligible beneficiaries for the appropriate length of time.

The FY 2016 final rule also included a new service intensity add-on (SIA) payment that awards hospices a higher rate of reimbursement for stepping up the number of visits during the last seven days of a patient's life. More specifically, payments related to care during the last seven days of a patient's life are now determined by multiplying the continuous care rate by the number of direct care hours that social work and nursing provide, up to a total of four hours per day. The SIA payment is intended to better accommodate the heightened service needs and costs that often arise during the final days of a person's life. By creating the potential for additional reimbursement, CMS hopes to incentivize providers to better support patients and their families during this critical time, especially those who have only been in hospice briefly.

The Future of Hospice

Hospice care in the United States has evolved significantly over the past four decades. The rapid-fire regulatory transformations throughout the care continuum seem to signify even more change for hospices in the years ahead.

More scrutiny on the horizon

Hospice providers are already feeling the weight of increasing federal scrutiny surrounding healthcare reimbursement and regulatory compliance. Medicare has ramped up claims auditing. There's also been an uptick in the number of additional development requests (ADR) aimed at the hospice sector (see **Chapter 7**). Such trends will likely pick up speed in the coming years as value-based payment models gain ground.

But also more growth

In spite of these challenges, there is good news ahead: A growing number of Americans seek quality hospice care—and providers—at the end of their life. According to NHPCO's 2015 *Facts & Figures* report, more than 30% of Medicare decedents receive three or more days of hospice care.

Palliative care

Palliative care is also on the rise. According to the Center to Advance Palliative Care (CAPC), 66.5% of hospitals had a dedicated palliative care program in 2015—which reflects a 3.5% increase in palliative programs over the past four years. Outpatient palliative care programs are also growing, according to CAPC.

As hospital systems face Medicare reimbursement penalties based on outcomes and readmissions, they are increasingly banding with providers in other settings, including hospices, to forge collaborative healthcare groups, including accountable care organizations (ACO). ACOs have begun investigating whether palliative care programs are a cost-effective way to meet the needs of patients with chronic diseases who are not yet ready for hospice care.

Payment reform

As Medicare strives to accommodate the ballooning elder population and temper the rising costs of healthcare programs, payment models that prioritize efficiency and quality, rather than volume of services delivered, will likely shape the future of hospice reimbursement.

VBP

Medicare has launched value-based purchasing (VBP) programs in several healthcare settings and plans to do the same in hospice. Such programs reward providers who achieve positive outcomes relative to their peers and penalize those that don't stack up.

For example, in the home health VBP pilot program, which kicked off in January 2016, CMS sets state benchmarks for 21 different care measures. Based on providers' performance compared to their baseline outcomes and the achievement threshold for their state, their payment for the relevant FY will increase, decrease, or hold steady. The possible extent of this reimbursement impact increases throughout the pilot, from 3% in the first payment year to 8% in the last.

Bundled payments

CMS is also in the process of testing several bundled payment models. Current pilots involve episodic reimbursement for certain diagnoses (e.g., joint replacements) and reward providers that achieve lower treatment expenditures during a beneficiary's entire episode of care.

CMS is also in the process of developing communitywide programs based on per-capita beneficiary spending. These pilot programs will calculate the average Medicare spending by geographic area and reward health systems that are able to reduce the Medicare dollars spent in their area. Currently, these pilots are focused on hospital and outpatient settings.

Although most bundled payment programs have yet to hit hospice, they promise to influence future outcomes and cost savings in the sector.

Findings from collected data

The more immediate future of hospice reimbursement may depend on CMS' analysis of the data it's currently collecting in the sector, which has already given rise to tiered RHC reimbursement and SIA payment.

If events in other care environments are any indication, data analysis could spur additional reimbursement changes, such as the following:

- Payment predicated on patient care needs. For example, home health PPS reimbursement is based on the initial assessment (OASIS), which includes numeric responses to specific questions that measure the patient's clinical status, functional status, and service needs.

The patient's diagnosis and OASIS scores result in a case mix score that determines the reimbursement amount. This payment structure encourages home health agencies to manage visits and supply costs according to patients' needs and Medicare reimbursement.

- Reimbursement based on the location—not just the level—of care provided
- Payment that corresponds to the number or type of medications a patient takes

The Takeaway

Amid the volatility in today's hospice industry, one thing seems certain: To continue fulfilling their mission to provide quality end-of-life care to terminally ill patients and their families, hospices must learn to partner with other healthcare providers and adapt to an ever-changing healthcare climate.

The Hospice Guide to Quality Care and Reporting

Promoting Sustainability in an Evolving Regulatory Climate

Diane Link, RN, MHA

As the hospice industry continues to grow and attract the attention of federal regulators, providers must learn to embody their long-standing commitment to delivering quality end-of-life care in defensive documentation, consistent reporting, and robust compliance programs. With expansive analysis on the industry's most important Medicare quality regulation topics, *The Hospice Guide to Quality Care and Reporting: Promoting Sustainability in an Evolving Regulatory Climate* empowers providers to do just that.

Author **Diane Link, RN, MHA**, draws on her wealth of industry experience as a nurse and consultant to help hospices remain viable as CMS continues to refine its methods for measuring outcomes, collecting quality data, and tying these processes to provider reimbursement.

The Hospice Guide to Quality Care and Reporting arms providers with the depth of understanding and breadth of strategy they need to build organizationwide systems for regulatory compliance, and to readily adapt to the changes still ahead.

This resource will help you to do the following:

- Understand how the intensifying movement toward federal scrutiny and quality measurement is playing out in the hospice sector
- Identify where new and evolving Medicare regulations fit in hospice's greater quality landscape
- Build compliance systems and quality-focused best practices that are dynamic enough to accommodate both current and future regulatory requirements

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