Hospice – Moving into the Future

Judi Lund Person, MPH
National Hospice and Palliative Care Organization

Think like a US policy maker
Medicare Beneficiaries to 2030
The number of people Medicare serves will nearly double by 2030.

Number of Medicare Beneficiaries

<table>
<thead>
<tr>
<th>Year</th>
<th>Disabled &amp; ESRD</th>
<th>Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>20.4</td>
<td>0.6</td>
</tr>
<tr>
<td>1980</td>
<td>20.4</td>
<td>25.5</td>
</tr>
<tr>
<td>1990</td>
<td>28.4*</td>
<td>31.0</td>
</tr>
<tr>
<td>2000</td>
<td>34.3</td>
<td>34.1</td>
</tr>
<tr>
<td>2010</td>
<td>39.6*</td>
<td>38.6</td>
</tr>
<tr>
<td>2020</td>
<td>45.9</td>
<td>52.2</td>
</tr>
<tr>
<td>2030</td>
<td></td>
<td>68.2</td>
</tr>
</tbody>
</table>

* Numbers may not sum due to rounding.
Source: CMS, Office of the Actuary.

Medicare

- Problems facing Medicare are even worse than those of Social Security
- Benefits paid out expected to exceed tax revenues from 2008 forward!
- The Medicare trust fund is projected to be depleted by 2019 or just 11 years from now.
- The long-term (75-year) present value shortfall in the trust fund could be corrected by an immediate 51% reduction in program benefits

Source: MFS Investment Management Report
3/31/08
Public Enemy #1

- Medicare expenses are expected to be $396 billion during the current fiscal year
- 14% of total government spending
- Alan Greenspan has characterized rising Medicare expenses as the #1 threat to our economy, greater than the current mortgage/housing crisis

Average Length of Stay in Community Hospitals by State, 2005

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2005, for community hospitals.
Site of Death

<table>
<thead>
<tr>
<th></th>
<th>1989</th>
<th>1997</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>63.4</td>
<td>51.7</td>
<td>49.2</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>17.7</td>
<td>23</td>
<td>23.7</td>
</tr>
<tr>
<td>Home</td>
<td>16.2</td>
<td>22.5</td>
<td>23.2</td>
</tr>
</tbody>
</table>

2001 data updated in 2004

www.chcr.brown.edu/Dying/factsondying.htm

Know Your Hospice Statistics
Number of Hospice Deaths in US

2,400,000
U.S. Deaths

930,000
Hospice Deaths

How does your community do?

US Hospice Patient Growth 1982 - 2006

Total Admissions (estimate)

Year


0 25,000 200,000 400,000 600,000 800,000 1,000,000 1,200,000 1,400,000

1,300,000
Total Hospice Providers by Year

Hospice Spending Tripled between 2000 and 2007

Source: CMS Office of the Actuary

National Hospice and Palliative Care Organization
Average and Median Length of Stay

Source: NHPCO National Data Set 2001 – 2007

Patients by Payer Source

<table>
<thead>
<tr>
<th>Payer</th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Medicare Benefit</td>
<td>83.6%</td>
<td>83.7%</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>8.5%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Hospice Medicaid Benefit</td>
<td>5.0%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Other Payment Sources</td>
<td>2.9%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>
Location of Death

<table>
<thead>
<tr>
<th>Location of Death</th>
<th>2007</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Place of Residence</td>
<td>70.3%</td>
<td>74.1%</td>
</tr>
<tr>
<td>Private Residence</td>
<td>42.0%</td>
<td>47.1%</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>22.8%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Residential Facility</td>
<td>5.5%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Hospice Inpatient Facility</td>
<td>19.2%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Acute Care Hospital</td>
<td>10.5%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

Know the Priorities and Issues
Hospice Wage Index
FY2009

- Phase out the budget neutrality factor that has been applied to the hospice wage index for many years
- Implementation: FY2009 on October 1, 2008
- Average national impact over 3 years: -4.6%

What is the Budget Neutrality Adjustment Factor?

- A multiplier applied to the hospital wage index
- Uses the hospital wage index pre-floor and pre-reclass
- Put in place in 1990s to keep hospice rates even as the source of the data for the hospital wage index changed
3 Year Effect of BNAF

<table>
<thead>
<tr>
<th></th>
<th>FY2009</th>
<th>FY2010</th>
<th>FY2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget Neutrality Adjust</td>
<td>-1.1%</td>
<td>-3.1%</td>
<td>-4.1%</td>
</tr>
<tr>
<td>ment Factor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Marketbasket</td>
<td>3.6%</td>
<td>3.5%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Increase (inflationary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>adjustment)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Effect</td>
<td>2.5%</td>
<td>0.4%</td>
<td>-0.6%</td>
</tr>
</tbody>
</table>

• Final rule published by CMS in Federal Register
• Hospital Marketbasket is 5 year average increase for FY2010 and FY2011

Impact on Providers

• Proposal keeps the 0.80 wage index floor
• Dependent on hospital wage indices and their variations from year to year
• In FY2011, providers should expect a decrease in payments, even after the full hospital marketbasket is applied
NHPCO Lawsuit

- NHPCO sued CMS over FY2009 Wage Index rule
- Trying to protect hospice services that are delivered to patients and families all across the country.
- Hospice programs cannot absorb cuts of 4% or more.
- Administrative costs can only be cut so much. Then, the only thing left to cut will be patient and family services.
- These cuts are particularly serious given that normal operating costs keeping going up -- and hospices feel even more cost pressures with the record setting gasoline prices.

Lawsuit Timeline

- The lawsuit was filed in U.S. District Court for the District of Columbia on Friday, September 5.
- The judge met with lawyers from both CMS and NHPCO September 9.
- The entire case is to be decided by the end of October.
- CMS agreed to pay hospices retroactively to October 1 if the judge rules in NHPCO’s favor.
Legislative Fix

- House bill introduced
- Senate bill introduced
- Action to date
- What you can do

Atmosphere at CMS

- On a mission to scrutinize hospice industry
- 3 of 4 high level CMS administrators had “bad” hospice experiences with family members
- Why?
  - CMS goal to align hospice with other healthcare entities
    - Data collection
    - Reimbursement system
  - Hospice cap issues
  - Increased costs to Medicare for hospice overall
  - Suspect fraud & abuse in hospice industry
Atmosphere - Hospice industry

- Medicare Hospice Benefit is their life
- Nervous about coming changes
- New entrants
- Data collection coming – are we prepared?
  - Visit information
    - Collected?
    - Available for reporting on claim form?
  - Other data points?
  - Cost data – analysis of the cost report.
- Performance measures coming

Think like a Hospice Staff Member
Current CMS Efforts

Data on:
- Data on location of patient
- Continuous care in 15 minute increments
- Payment for hospice care based on location where care is furnished - distinguishes hospice inpatient care from home care
- Visits by patient, by discipline, by week (CR5567)
- Patients discharged for cause (CR6651)

Other Realities
- We MUST have tangible, patient level data
- More data collection will be required by CMS
- Reporting data is part of doing business today
Medicare Hospice
Conditions of Participation

- Subpart C – Patient Care
  - 4 core CoPs
    - Patient rights
    - Patient/family assessments
    - Interdisciplinary care planning and coordination of services
    - Quality Assessment/Performance improvement

Medicare Hospice
Conditions of Participation

- Subpart D – Organizational Environment
  - Clinical Records
  - Drugs and administration
  - Inpatient care
  - Hospice care in the nursing facility
  - Personnel qualifications
  - Criminal background checks
NHPCO Resources for Providers

- Look for this logo at www.nhpco.org/regulatory
- Implementation Checklist
- Tip sheets by discipline
- Tip sheets by topic
- Quality Partners – your guide to QAPI

Survey and Certification

- **Hospice surveys – Tier 4**
  - Initial certification surveys – new requirement
  - Accreditation organizations performing deemed surveys
- **State reciprocity**
  - Hospices providing care across state lines
  - Problems and proposed solutions
- **Multiple locations**
  - Approved by state survey agency
  - Approved by CMS Regional Office
Survey and Certification

Companions to New Conditions of Participation
• Interpretive Guidelines – in clearance
• State Operations Manual (SOM)
• Appendix M
• State surveyor training – November 18-20, 2008

Medicare Summary Notice
Post CR5567
• May have patient/family confusion over wording
• Watch for Medicare secondary payor or supplemental payments
• Train social work staff and billing staff to explain the visit reporting requirement
• Send a letter to patients and families explaining the charges change
CMS Advanced Beneficiary Notice of Non-coverage

- **Effective date:** March 1, 2009
- **Form to be used:** CMS-R-131
- **CMS resources:**
  - Beneficiary Notice Initiative (BNI) web page: [ww.cms.hhs.gov\bni](http://ww.cms.hhs.gov/bni)

---

Reasons a Hospice Uses ABN

- **Four reasons for a hospice to use an ABN**
  - Ineligibility because the beneficiary is not “terminally ill”.
  - Specific items or services that are billed separately from the hospice payment, such as physician services, are not reasonable and necessary.
  - The level of hospice care is determined to be not reasonable or medically necessary specifically for the management of the terminal illness and/or related conditions.
  - Services delivered by non-hospice providers
    - Example: non-contract facility
When are ABNs not required for hospice services?

- Revocations
- Respite Care Beyond Five Consecutive Days
- Transfers

Electronic Signatures on the CTI

- CMS CR 5550 – Program Integrity
  - Originally issued August 24, 2007
- Clarifications issued in CR 5971 in March 2008
  - Signature(s) of the physician(s) must be handwritten on the certifications of terminal illness for hospice.
  - Faxed, handwritten and authenticated physician signatures acceptable.
  - Stamped physician signatures not acceptable.
Discharge for Cause Data

- Effective January 1, 2009
- Hospices required to identify patients who were discharged for cause
- Condition code: H2
  - To be used in addition to the discharge status code.
  - Develop a policy addressing discharges for cause and the appropriate documentation.

- CMS Resource: Transmittal CR6115

OIG Work Plan

- Hospice care in nursing homes
- Physician billing for hospice services through Part B
- Trends in hospice utilization
- Duplicate drug claims for hospice beneficiaries by hospice and Part D
Nursing Homes and OIG

- December 20, 2007 - (OIG) released a report (OEI-02-06-00220) “Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings.”
- September 30, 2008 - OIG Supplemental Compliance Program Guidance for Nursing Facilities

OIG Supplemental Guidance

- September 30, 2008
- OIG issues “OIG Supplemental Compliance Program Guidance for Nursing Facilities”
- Identifies fraud and abuse risk areas
  - Inducements for referrals:
    - Remuneration in the form of free nursing services for non-hospice patients;
    - Additional room and board payments;
    - Inflated payments for providing hospice services to the hospice’s patients.
Anti-Kickback Warnings

Some of the practices that are suspect under the anti-kickback statute include:

- Offering free goods or goods at below-fair-market value
- A hospice referring its patients to a nursing facility to induce the nursing facility to refer its patients to the hospice;
- Paying room and board payments to the nursing facility in excess of what the nursing facility would have received directly from Medicaid
- A hospice providing staff at its expense to the nursing facility.

Nursing Homes

- Companion COP for nursing homes expected as proposed rule in 2009
- State surveyors required to look at a hospice patient’s chart when surveying the nursing home
- Deficiencies could include the hospice: “Failure to coordinate care and services”
- Expect change
Home Health/Hospice Medicare Administrative Contractor Jurisdictions (HH MAC)

A/B MAC Jurisdictions
Performance Measures

- Apply to both hospice and palliative care
- Based on the National Consensus Project Guidelines
- Must be approved by NQF process before CMS can use them
- NHPCO measures already approved
  - FEHC
  - End Result Outcome Measures
    - Pain
    - Unwanted hospitalization

MedPAC Update

- MedPAC – Medicare Payment Advisory Commission
  Commissioners appointed – high level economists and health policy experts of stature in the field
- Medicare Hospice Benefit is "ripe for a major overhaul"
- 2008 Analysis included:
  - Cap
  - Hospice access
  - Changing demographics
  - Margins
- No recommendations in the June 2008 Report to Congress
MedPAC Report on Margins

<table>
<thead>
<tr>
<th>% of Providers (2005)</th>
<th>2001</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freestanding</td>
<td>58.90%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Provider-based</td>
<td>41.10%</td>
<td>-10.5</td>
</tr>
<tr>
<td>For profit</td>
<td>43.20%</td>
<td>12.0</td>
</tr>
<tr>
<td>Non-profit</td>
<td>47.70%</td>
<td>-4.4</td>
</tr>
<tr>
<td>Urban</td>
<td>64.00%</td>
<td>1.4</td>
</tr>
<tr>
<td>Rural</td>
<td>36.00%</td>
<td>-1.8</td>
</tr>
<tr>
<td>Non-cap</td>
<td>90.90%</td>
<td>n/a</td>
</tr>
<tr>
<td>Cap</td>
<td>9.10%</td>
<td>n/a</td>
</tr>
<tr>
<td>ALL</td>
<td>100</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Source: MedPAC presentation March 2008

MedPAC Update – Further Investigation

- Does hospice care save money for the Medicare system?
- Overhaul to the hospice payment system?
  - Alternatives to the per diem payment system
  - Adjustments in eligibility
  - Case mix adjustment
  - Payment variations by diagnosis or length of stay
Palliative Care

Hospital Based Palliative Care

- In 2004 there were 1,250 hospital-based palliative care programs
  (2004 AHA data)
- In 2008, 53% of hospitals with 50 beds or more report a palliative care program
  (2006 AHA data)
CAPC Releases State-by-State Report Card

- Released on October 2, 2008
- Can be viewed at www.capc.org/reportcard
- Contains information on hospital based palliative care by state
- Searchable data base by state by hospital

Summary of CAPC Report

- Overall grade = C
- Three states earn a grade of A
- Half of 50 states receive a grade of A or B
- Almost 40 percent get a grade of C
- More than 20 percent receive unacceptable grades of D and F
States with A Grade

- Vermont A (5/5)
- Montana A (7/8)
- New Hampshire A (11/13)
States with B Grade

- **District of Columbia** B (4/5)
- **South Dakota** B (7/9)
- **Minnesota** B (27/36)
- **Missouri** B (49/67)
- **Oregon** B (18/25)
- **New Jersey** B (41/57)
- **Iowa** B (23/33)
- **Maine** B (11/16)
- **North Carolina** B (55/80)
- **Michigan** B (57/83)
- **Ohio** B (75/110)
- **Colorado** B (18/27)
- **Maryland** B (28/42)
- **North Dakota** B (6/9)
- **West Virginia** B (20/30)
- **Washington** B (22/34)
- **Wisconsin** B (37/58)
- **Virginia** B (34/54)
- **Kansas** B (20/33)

Palliative Care in Other Settings

- What do we know?
- How can we expand non-hospice palliative care to home care and nursing home settings?
- Think outside the Medicare hospice box
Quality as our Guide

CMS

- QAPI
- New Medicare Conditions of Participation
- Performance Measures with Public Reporting
- Pay for Performance
- Increased Transparency
Medicare.gov

- Nursing Home Compare 2002
- Home Health Compare 2003
- Hospital Compare 2003
- Physician Focused Quality Initiative 2004
- ESRD Quality Initiative 2004
- Physician Voluntary Reporting Program 2006

Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives.

William A. Foster
Call to Action

- Pay attention to the trends
- Be involved at the state and national level
- Work toward the vision
  - Provide quality care
  - Empower excellent leaders among staff
  - Plan for the future
  - Think outside the Medicare Hospice box
- Give us your feedback

Alone we can do so little; together we can do so much

Helen Keller