Goals

- To review the ethical issues raised in the current healthcare environment
- To understand physician and nurse involvement in these issues
- To describe a new paradigm of ethics in clinical practice

Disclaimer

- This pre-course is designated as part of the Hospice Medical Director knowledge base and is focused on physicians
- I am a physician and I primarily use the terms "physician", "doctor"
- I mean no disrespect to my professional nursing colleagues who face the same issues
- This is 'Keep it Simple'

Recent headlines

- Chemotherapy Shortages
  - Which of an oncologist's 5 newly diagnosed Stage IV breast cancer patients get the 3 available courses of Doxil?
- Childhood Vaccinations
  - What does the pediatrician do when faced with a mother who refuses MMR vaccination of her daughter because she is convinced the thimerosal causes autism?

 Recent headlines

- PSA Testing
  - What does the IM/FM doc do with the 60 yo asymptomatic man who requests PSA testing?
  - Option A:
    - The doc spends 30 – 45 minutes educating the patient re: guidelines and evidence, advising no test
    - The patient is unhappy – not getting "life-saving" testing
    - The other patients in the waiting/exam rooms who have been sitting there are unhappy – time lost
    - The doc is unhappy
**Option B:**
- The doc says: “this isn’t necessary, but OK, whatever”
- The patient is happy
- The patients in the waiting/exam rooms are happy
- The doc is unhappy
- The system is now at risk for the cost of the test, potential scans, biopsy, etc
  - Benefit = ????

**Recurrent theme in all of these:**
- The person at the nexus of all these issues is the clinician
  - Never seems to be a happy outcome for that person
- Physician personality is very much:
  - Take charge
  - Make decisions
  - Be in control

**Physician personality is very much:**
- Take charge
- Make decisions
- Be in control

**We self-select for this profession because of our personalities**
- Reinforced by training
- But control and power are illusory and relative
- Especially when compliance enters the room

**We are Strangers in a Strange Land**
- The world we knew has changed on us
- Many practitioners of HPM came to this model of care as second career
  - Many transitioned because of the regulatory changes in acute care practice

**“New Reality”**
- We have to face our new reality
- There is a “new world” and a “strange land” that we function in
  - Whether we like it or not
  - Whether it’s fair or not
  - Whether it’s ethical or not
Goals for our discussion

- Overall goal is NOT pass out whistles and drums and have us "Occupy the Department of HHS" or "Occupy CMS"
  - We are not marching on Bethesda to live in the parking lot
- Goal IS to increase understanding
  - How much do we really know about this Strange New World
  - How do we Strangers fit in?

Factors present in the New Reality

Power vs Powerlessness

- Many physicians now view their position in this situation as "powerless"
  - We have seen the transition from "Doctor" → "Provider" → "Clinician" → "Prescriber"
    - An ever-changing descriptor of what we are
  - Skilled professionals of all disciplines have now been transformed into technicians
  - Everyone’s power has been reduced
- Leads to frustration and dissatisfaction

“Evidence”

- New buzzword in healthcare
- "Show me the evidence"
- Are we shifting from the “authority” of accumulated medical judgment to the "tyranny" of evidence?
  - Especially when reimbursement may be tied to evidence, or lack thereof

“Evidence”

- Evidence may well be useful in determining which chemotherapy regimen is more efficacious, which antihypertensive, etc
- What happens in our field?
  - Research is in early stages
  - Research may be handicapped by reality of frail, vulnerable population
  - Evidence may conflict with patient’s goals of care

“Evidence”

- The "evidence" shows that Medication X is better than Medication Y for relief of a common symptom
  - Medication X is parenteral; Medication Y is oral
- Patient says “I’m dying, no more needles, ever”
- Clinician is “evaluated” (competency score?) on using evidence-based therapies
  - Go talk to a computer data base re: patient goals of care
“Evidence”

- If the physician supports the patient’s goals of care, s/he is a caring physician
- If the physician educates (‘coerces’?) the patient on Medication X, his/her “rating” on use of evidence-based medicine is better
- Classic conflict of values and ethics
- Classic realignment in view of power

Scrutiny issue

- Physicians still have ultimate responsibility to determine a patient’s terminal status
- Yet find ourselves increasingly in-between proverbial “rock” and “hard place”
  - Certification is “prospective” – we guess (based on judgment)
  - Review is “retrospective” – they know what happened
  - And say we should have known as well

Scrutiny issue

- Review agencies have increased over past few years
  - MACs
  - RACs (both pharmaceutical and non-pharma billing)
  - MICs
  - ZPICs
  - OIG

Fragmentation

- Healthcare delivery now marked by increasing fragmentation at all levels
- Patients care often “hand off” after “hand off” after “hand off”
- Work-hour rules in physician training
- Residents no longer able to follow case from beginning to end

Scrutiny issue

- Question:
  - When does the diversion of resources (fiscal and workforce time) to prepare charts and defend care and actions adversely impact our core value: optimal care of the dying?
- Is there a tipping point when so much heat and light is needed to interact with agencies that patient care must suffer?

Fragmentation

- Private practice disappearing (↓ 40% → 20% in 7 yrs)
- Physicians becoming employees with defined work hours
- Nursing and pharmacist shortages
  - “I don’t know, I didn’t have this patient yesterday”
- Who is the “attending” of the patient?
  - Doc in the clinic? ARNP in the facility? Hospitalist?
Fragmentation

- Question:

- Who is in charge of the patient?
- Who has the ultimate responsibility.....really?

Technology

- Response to fragmentation is EMR
  - "Solves" the problem of different, disparate care-givers
  - All knowledge is in one place
- Many EMRs “flatten out” patient differences
  - Every patient looks like every other patient
  - Due to “cut and paste”?

Technology

- Many EMRs based on checklist data entry
- Checklists useful (airplane cockpit, OR) but this is not how physicians think
  - Medical decision-making based on developing and “telling the story”, based on a “narrative”
  - Do checklists of symptoms and findings actually encourage data to be left out?
  - Technology drives thinking
    - Exhibit A = “Death by PowerPoint!”

Compliance Issues

- Narratives required at certification and recertification
- To explain clearly why a patient requires these services – Great!!
  - Good documentation can only lead to good patient care
- To require a licensed professional to state “I personally generated this narrative.....”
  - A signature is no longer trusted?

Compliance Issues

- Face-to-face encounter
- Attempt to ration hospice care?
  - By increasing the burden of documentation after 6 months, what is the effect on longer surviving eligible patients?
  - Especially since “6 months” is not based on “evidence”
- Can this be viewed as violation of patients’ rights?
  - Beneficiary is entitled to HMB
  - Refusal of F2F results in discharge from entitled service

New Paradigm of Ethics in Practice
Can help better define the relationships and responsibilities that exist between those of give care and those who receive care
Is patient-centered
Defines the important issues in care

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Is patient-centered
Defines the important issues in care

Truth
- Relationships between providers and consumers of healthcare should be respectful and truthful
- Each side should be open and truthful with each other
- The importance of the patient-clinician relationship must retain its primacy in all interactions

Truth
- Records must remain accurate and truthful
- Patients must not distort the truth to obtain benefits, nor expect their clinicians to be less than truthful

Responsibility and Accountability
- All stakeholders in the relationship must share responsibility for the appropriate use and stewardship of health care resources
- Health care must be distributed equitably
- Evidence must be obtained and distributed as to what constitutes optimal, beneficial care
- Clinician’s primary duty is to the patient for the patient’s good

Case in Point
- 80 yo man under care for end-stage Parkinson’s, entering 3rd benefit period. Because of hospice services, weight has stabilized and episodes of aspiration have decreased. Wife “can’t imagine what she would do without hospice”, and is afraid lack of deterioration will mean discontinuation of care.
  To avoid increasing caregiver distress, team requests that physician doing F2F encounter not discuss reason for evaluation. “Just say it’s to see how Bob is doing”

Case in Point
- 70 yo woman under care for Adult Failure to Thrive due to weight loss from an abdominal mass the patient declines to evaluate. She also has congestive heart failure well-controlled on multiple medications. The family asks if the diagnosis could be changed to Cardiac so the medications could be covered by the hospice

Case in Point
- 85 yo woman under care in facility for Dementia. Referred after weight loss due to episode of pneumonia. Status has stabilized over 3 benefit periods and patient scheduled for discharge for extended prognosis. Family asks “can’t you fudge the weight a little to keep her? She’s going to lose weight eventually, right?”
Case in Point
- 65 yo woman referred to hospice for end-stage CHF. Has had multiple ICU admissions for CHF. Once under care, with medication provided by hospice and use supervised by RN, patient has no further CHF exacerbations and is discharged for extended prognosis. Referred back within one month after admission to ICU. Becomes clear neither patient nor spouse can understand medication regimen, Home Health services inadequate for care needs.
- Patient “terminally ill” only when NOT under hospice care

Case in Point
- 75 yo man referred from hospital with advanced dementia. Bed-confined, losing weight, multiple decubiti, non-communicative. Family attentive and want patient to return home; large extended-family live together and share care.
- Family trying their best but care needs too great. Family adamant that patient remain at home and will not discuss LTC. Eventually becomes clear that house belongs to patient, and patient’s Social Security check makes income sufficient for family to survive

Responsibility and Accountability
- Practice of health care must be efficient and effective
- Providers must explain fully what is and what is not covered during care delivery and why

Ethics
- The environment of healthcare delivery must remain ethical for all involved
- Clinicians should not be asked to engage in activities that jeopardize professional ethics

Conclusion
- The world we work in is changing
- Yet if we continue to focus on the core-value of patient-centered care, the conflicts will be manageable and the issues going forward will clarify themselves

THANK YOU
**Hospice/Nursing Home Compliance Issues**

Cherry Meier, RN, MSN, LNHA
Vice President of Public Affairs

**Objectives**

- Identify the regulatory requirements for the provision of hospice care in the nursing home
- Identify potential compliance issues in arrangements between hospice and nursing home providers
- Describe alternative behaviors that demonstrate compliance

**Regulatory Interface**

**Philosophical Match**

**Regulations for Both Providers**

- In addition to meeting the conditions of participation for hospice providers, a hospice that provides care to residents of a SNF/NF, ICF/MR must meet additional standards in 418.112
- Companion rule to 418.112 has been proposed for Nursing Homes that is anticipated to be passed in 2012
- Nursing homes must meet the standards in Appendix PP of the State Operations Manual: "Review of a Residents Receiving Hospice Services"

**MDS 3.0 A1800 Coding Instructions**

- Enter the two-digit code that corresponds to the location or program the resident was admitted from for this admission.

<table>
<thead>
<tr>
<th>Code</th>
<th>Location/Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Community/growth home/age, hospice/assisted living group home</td>
</tr>
<tr>
<td>02</td>
<td>Another nursing home or assisted living facility</td>
</tr>
<tr>
<td>03</td>
<td>Psychiatry hospital</td>
</tr>
<tr>
<td>04</td>
<td>Psychiatric hospital</td>
</tr>
<tr>
<td>05</td>
<td>Transitional psychiatric facility</td>
</tr>
<tr>
<td>06</td>
<td>MDD facility</td>
</tr>
<tr>
<td>07</td>
<td>Hospice</td>
</tr>
<tr>
<td>08</td>
<td>Other</td>
</tr>
</tbody>
</table>
MDS 3.0
A2100 Discharge Status

- Review the medical record including the discharge plan and discharge orders.
- Select the code that corresponds to the resident’s discharge status.

MDS 3.0
Election of Hospice

- Electing or revoking the hospice benefit requires a significant change in status assessment.

A0310A Hospice Benefit

- Electing or revoking the hospice benefit requires a significant change in status assessment.

J1400 Coding Instructions

- Code 1. Yes only if the medical record contains documentation of terminal illness, hospice services, or condition/chronic disease.

Contracts

- Hospice required to have written agreement before services are provided in 418.116 (c)
- Proposed Nursing Home Companion Rule 483.75(r) requires nursing home to have a written agreement
- OIG statement acknowledges that an exclusive or semi-exclusive arrangement can promote efficiency and safety but could increase vulnerability to fraud and abuse
- Trolling for patients
- HIPAA violations

Duplicate Drug Claims
OIG FY 2010 Work Plan

The OIG will review the appropriateness of drug claims for beneficiaries who receive hospice benefits under Medicare Part A and drug coverage under Medicare Part D. Hospice providers are required for the drugs related to the beneficiary’s terminal illness and Part D drugs should not pay for drugs that should be covered under the beneficiary’s Medicare hospice benefits under Part A.
Supplies and Durable Medical Equipment

- Duplication in both per diem rates
  - Hospice responsible for providing services at the same level and to the same extent as those services would be provided in the patient’s home
  - OIG warns of a suspected kickback if a hospice pays amounts to the nursing home for services that Medicaid considers included in its room and board payment to the nursing home

OIG Suspected Kickbacks
March 1998

- A hospice offering free goods or goods at below fair market value to induce a nursing home to refer patients to the hospice.
- A hospice paying “room and board” payments to the nursing home in amounts in excess of what the nursing home would have received directly from Medicaid had the patient not been enrolled in hospice.
- A hospice paying amounts to the nursing home for “additional” services which Medicaid does not consider to be included in its room and board payment to the hospice.
- A hospice paying above fair market value for “additional” non-core services which Medicaid does not consider to be included in its room and board payment to the nursing home.

General Inpatient Care

- Hospital or SNF has 24 RN, providing direct care
- Short-term stay
- Management of acute symptoms, psychosocial crisis, imminent death requiring skilled nursing interventions
- Documentation reflects skilled nursing care
- Hospice may receive “added pressure” to utilize GIP

Financial Arrangements

OIG Suspected Kickbacks
March 1998 (cont)

- A hospice referring its patients to a nursing home to induce the nursing home to refer its patients to the hospice.
- A hospice providing free (or below fair market value) care to nursing home patients, for whom the nursing home is receiving Medicare payment under the skilled nursing facility benefit, with the expectation that after the patient exhausts the skilled nursing facility benefit, the patient will receive hospice services from that hospice.
- A hospice providing staff at its expense to the nursing home to perform duties that otherwise would be performed by the nursing home.

Continuous Care

- Similar to General Inpatient Care in that it must be a crisis situation to initiate care
- Patient does not want to go to the hospital
- Short term basis
- Documentation must reflect skilled nursing care is provided over 50% of the time
- Must have a minimum of 8 hours in one day to bill
Billing

Dual Skilling

- A resident can access their Medicare Part A Skilled Nursing Home Benefit and Hospice simultaneously
- If accessing both, the diagnosis for the Nursing Home Benefit must not be related to the terminal illness
- Who is in control of the plan of care?
- MAC transition will be able to pick up situation
- This should be a rare event!

Location of Care
CMS Change Request (CR) 5245

Clarified billing codes for levels of care while a patient resides in a nursing home:
- The patient must be in a Skilled Bed (5004) in order to bill for GIP
- Continuous Care is provided in a Non-Skilled Bed (5003) and will be returned if the code is 5004

Additional Concerns

OIG Report, September 2009
OE-02-06-00221

Eighty-two percent of claims for Hospice Benefit in the Nursing Home did not meet at least one Medicare coverage requirement pertaining to election statements, plans of care, services or certification of terminal illness.

Source: 2005 statistical abstract of the United States
OIG Report, July 2011
Medicare Hospices that Focus on NF Residents

- Medicare spending on hospice care for NF residents has grown nearly 70% since 2005
- 263 hospices had more than 66% of their beneficiaries in NFs
- High-percentage hospices received more Medicare payment per beneficiary
- High-percentage hospices enrolled beneficiaries whose diagnoses required less complex care

OIG Recommendations

- Monitor hospices that depend heavily on nursing facility residents. CMS will share information in the report with Recovery Audit Contractors (RAC) and Medicare Administrative Contractors (MAC).
- Modify the payment system for hospice care in nursing facilities. CMS agreed that financial incentives may exist and they are in the early stages of reform.

MedPAC

- Suggested changes in reimbursement for Hospice providers
- Question as to whether there will be a specific per diem for patients residing in nursing homes
- Problem with duplication of services in the Hospice Benefit and the Medicaid Room & Board payment

Hospitalization

Cost of Hospitalization

- Among 1.5 million NH residents in the US, about 1/3 will be hospitalized in one year which equals about 450,000 hospitalizations
- The cost of each hospitalization is about $6,500 for a hospital DRG payment, plus a 30-day SNF stay for 1/3 of those hospitalized at $350/day equals about $10,000/hospitalization
- The total cost is $4.5 billion

Hospitalization of Nursing Home Residents

- Often traumatic to the resident and family members
- Result in complications such as pressure ulcers, delirium, incontinence/catheter insertion, polypharmacy, etc.
- May be an inappropriate use of the emergency room & acute hospital
CMS Activities

- Recovery Audit Contractors (RAC) examining medical necessity of hospital stay and recouping payments
- Georgia study to develop and pilot tools that would reduce avoidable hospitalization through:
  - Improving skills to assess acute changes
  - Increased involvement of physicians/nurse practitioners
  - Improved advance care planning
  - Provision of less futile care

More CMS Activities Impacting Hospitalization

- QIO 9th Scope of Work
- Value Based Purchasing Demonstration in AZ, Miss, NY, WI for residents of a nursing home
- Bundling payments for episodes of care
  - One payment for 30 days of care for specific conditions
  - Hospitals, physicians, home health agencies, nursing homes


- 26% of SNF claims were not supported by medical record
- Concerns about improperly billing for therapy to obtain additional Medicare payments
- Identified 348 SNFs that:
  - had unusually long average lengths of stay
  - billed much more frequently for higher RUGs than others
  - were in the top 1% for the use of ultra high therapy

CMS SNF PPS Final Rule: FY 2012

- Effective October 1, 2011
- Payment under RUG IV must be budget neutral
- Overall net reduction in SNF payment rate of 11.1% (decrease in about $60 - $65 ppd)
- Reductions are targeted in rehab RUGs
- Changes in assessments and calculations for therapy

Center for Gerontology and Health Care Research, Brown University

Susan Miller, Ph.D. has found in her research that:

“Successful collaborations are partnerships where care planning, coordination and provision are performed in care environments where mutual respect dominates; providers routinely share knowledge; and policies and procedures clarify the roles of each collaborating party; but, much unwritten, and importantly, hospice presence, consistency and communication are key – a customer service approach facilitates success.”

In Review

- Identify potential compliance issues in arrangements between hospice and nursing home providers.
- Describe alternative behaviors that demonstrate compliance
§ 418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/MR.

In addition to meeting the conditions of participation at § 418.10 through § 418.116, a hospice that provides hospice care to residents of a SNF/NF or ICF/MR must abide by the following additional standards.

(a) **Standard: Resident eligibility, election, and duration of benefits.** Medicare patients receiving hospice services and residing in a SNF, NF, or ICF/MR are subject to the Medicare hospice eligibility criteria set out at § 418.20 through § 418.30.

(b) **Standard: Professional management.** The hospice must assume responsibility for professional management of the resident’s hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to § 418.100 and § 418.108.

(c) **Standard: Written agreement.** The hospice and SNF/NF or ICF/MR must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by authorized representatives of the hospice and the SNF/NF or ICF/MR before the provision of hospice services. The written agreement must include at least the following:

1. The manner in which the SNF/NF or ICF/MR and the hospice are to communicate with each other and document such communications to ensure that the needs of patients are addressed and met 24 hours a day.
2. A provision that the SNF/NF or ICF/MR immediately notifies the hospice if—
   (i) A significant change in a patient’s physical, mental, social, or emotional status occurs;
   (ii) Clinical complications appear that suggest a need to alter the plan of care;
   (iii) A need to transfer a patient from the SNF/NF or ICF/MR, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related conditions; or
   (iv) A patient dies.
3. A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
4. An agreement that it is the SNF/NF or ICF/MR responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by
the primary caregiver at home at the same level of care provided before hospice care was elected.

(5) An agreement that it is the hospice’s responsibility to provide services at the same level and to the same extent as those services would be provided if the SNF/NF or ICF/MR resident were in his or her own home.

(6) A delineation of the hospice’s responsibilities, which include, but are not limited to the following: Providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary and bereavement); social work; provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident’s terminal illness and related conditions.

(7) A provision that the hospice may use the SNF/NF or ICF/MR nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/MR to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient’s family in implementing the plan of care.

(8) A provision stating that the hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or ICF/MR administrator within 24 hours of the hospice becoming aware of the alleged violation.

(9) A delineation of the responsibilities of the hospice and the SNF/NF or ICF/MR to provide bereavement services to SNF/NF or ICF/MR staff.

(d) **Standard: Hospice plan of care.** In accordance with § 418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this hospice plan of care.

(1) The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.

(2) The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the extent possible.

(3) Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/MR representatives, and must be approved by the hospice before implementation.
(e) **Standard: Coordination of services.** The hospice must:

1. Designate a member of each interdisciplinary group that is responsible for a patient who is a resident of a SNF/NF or ICF/MR. The designated interdisciplinary group member is responsible for:
   
   i. Providing overall coordination of the hospice care of the SNF/NF or ICF/ MR resident with SNF/NF or ICF/MR representatives; and
   
   ii. Communicating with SNF/NF or ICF/MR representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family.

2. Ensure that the hospice IDG communicates with the SNF/NF or ICF/ MR medical director, the patient’s attending physician, and other physicians participating in the provision of care to the patient as needed to coordinate the hospice care of the hospice patient with the medical care provided by other physicians.

3. Provide the SNF/NF or ICF/MR with the following information:
   
   i. The most recent hospice plan of care specific to each patient;
   
   ii. Hospice election form and any advance directives specific to each patient;
   
   iii. Physician certification and recertification of the terminal illness specific to each patient;
   
   iv. Names and contact information for hospice personnel involved in hospice care of each patient;
   
   v. Instructions on how to access the hospice’s 24-hour on-call system;
   
   vi. Hospice medication information specific to each patient; and
   
   vii. Hospice physician and attending physician (if any) orders specific to each patient.

(f) **Standard: Orientation and training of staff.** Hospice staff must assure orientation of SNF/NF or ICF/MR staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.
Review of a Resident Receiving Hospice Services.

When a facility resident has also elected the Medicare hospice benefit, the hospice and the nursing home must communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy, and is based on an assessment of the individual’s needs and unique living situation in the facility. The plan of care must include directives for managing pain and other uncomfortable symptoms and be revised and updated as necessary to reflect the individual’s current status. This coordinated plan of care must identify the care and services which the SNF/NF and hospice will provide in order to be responsive to the unique needs of the patient/resident and his/her expressed desire for hospice care.

The SNF/NF and the hospice are responsible for performing each of their respective functions that have been agreed upon and included in the plan of care. The hospice retains overall professional management responsibility for directing the implementation of the plan of care related to the terminal illness and related conditions.

For a resident receiving hospice benefit care, evaluate if:

- The plan of care reflects the participation of the hospice, the facility, and the resident or representative to the extent possible;
- The plan of care includes directives for managing pain and other uncomfortable symptoms and is revised and updated as necessary to reflect the resident’s current status;
- Medications and medical supplies are provided by the hospice as needed for the palliation and management of the terminal illness and related conditions;
- The hospice and the facility communicate with each other when any changes are indicated to the plan of care;
- The hospice and the facility are aware of the other’s responsibilities in implementing the plan of care;
- The facility’s services are consistent with the plan of care developed in coordination with the hospice, (the hospice patient residing in a SNF/NF should not experience any lack of SNF/NF services or personal care because of his/her status as a hospice patient); and
- The SNF/NF offers the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The resident has the right to refuse services in conjunction with the provisions of 42 CFR 483.10(b)(4), F155.

Note: If a resident is receiving services from a Medicare certified hospice and the hospice was advised of concerns by the facility and failed to address and/or resolve issues related to coordination of care or implementation of appropriate services, refer the concerns as a complaint to the State Agency responsible for oversight of this hospice, identifying the specific resident(s) involved and the concerns identified.
Federal Overview & Update:
Hospice and Palliative Care

Sue Ramthun
Principal & Sr. Vice President
Hart Health Strategies
March 7, 2012

Topics to be covered:
• Hospice Overview & Data
• Affordable Care Act (ACA) Implementation
• Deficit Reduction
• Pending Legislation
• Congressional Health Issues for 2012

Medicare Hospice Benefit
• Established in 1982
• Provides palliative and supportive services
• Team of health professionals and caregivers provide care for the “whole person,” including physical, emotional, social, and spiritual needs
• Prognosis of life expectancy of 6 months or less, if your illness runs its normal course.
• Beneficiary elects enrollment in place of other Medicare coverage

Overview of Medicare Hospice, 2010
• >1.1 million beneficiary users (over the last decade, hospice use has grown particularly rapidly among beneficiaries age 85 and older.)
• 44% of decedents (In 2010, >50% of decedents age 85 and older used hospice.)
• >3500 providers
• $13 billion in Medicare spending (~2%)

Medicare Beneficiaries’ Utilization of Selected Medical and Long-Term Care Services, 2006

MedPAC Recommendations, 2009
• Payment system reform - U-shaped curve to better align payments with service intensity of care throughout an episode,
• Increased accountability - narrative implemented Oct 2009,
• Face-to-face recertification - implemented 2011,
• Focused medical review - stays >180 days for hospices with unusually high rates of long-stay patients. PPACA adopted a similar requirement, but not implemented yet,
• Office of Inspector General (OIG) - studies underway or completed
• Data collection - claims, cost reports

NOTES: Analysis excludes beneficiaries enrolled in Medicare Advantage.
Office of Inspector General (OIG): Hospice and Nursing Homes
- OIG recently completed a study on hospices that focused on nursing home patients.
- Recommended that:
  1. CMS monitor hospices that focus on nursing facilities; and
  2. CMS reduce payment rates for hospice care in nursing facilities.

MedPAC Recommendations, 2012
- Update hospice payment rates for 2013 by 0.5%
- MedPAC plans to reprint the U-shaped curve payment recommendation in its March 2012 report.

Affordable Care Act (ACA)
- Rate Cuts:
  - Budget Neutrality Adjustment Factor
  - Productivity Adjustment
- Face-to-Face Encounter
- Medical Review: hospices with high % of long stay patients
- Payment Reform
- Quality Measures
- Concurrent Care:
  - Medicare Hospice Concurrent Care Demonstration
  - Medicaid Pediatric Concurrent Care

Budget Neutrality Adjustment Factor (BNAF)
What is it?
- Multiplier to the hospice wage index each year
- Gives providers a % "bump up" compared to standard wage index rates
- Multiplier is a complex calculation done by CMS

Reductions
- Began in FY2010
- 2013 reduction will be -0.6% (year 4 of 7 year phase-out)
- Final result = 4.2% rate decrease (2010-2012 = -1.6%)

Productivity Adjustment Reduction
What is it?
- Designed to measure production of more output with the same amount of labor and capital

Reduction for all Medicare providers
- 1.3% reduction in hospital market basket

Additional reduction for hospices:
- Beginning in FY2013, an additional -0.3%

Net market basket increase:
\[ 2.4\% - 1.3\% - 0.3\% = 0.8\% \]
2012 AAHPM & HPNA Annual Assembly

Changes in Hospice Rates

Moran Study - Profit Margin Analysis
- Estimated profit margins using Medicare costs of statutorily required services (bereavement and volunteer)
- Commissioned by NHPCO
- Findings –
  - Median Medicare profit margin will decrease from 2% in 2008 to -14% by 2019
  - Hospices serving mostly rural patients would be most severely impacted (-19% by 2019)
  - 88% of hospices could have negative margins by 2019 (92% of moderately rural and 91% for mostly rural hospices)

Face-to-Face Encounter (F2F)
- Implementation date: Jan 1, 2011
- Enforcement date: April 1, 2011
- Each patient at or before (up to 30 days prior to) the 180-day recertification
- For each recertification visit after 180 days
- Face to face encounter by hospice physician or nurse practitioner
- Failure to meet F2F requirements = patient ceases to be eligible for Medicare hospice benefit

Medical Review
Secretary will medically review certain patients in hospices with high percentages of long-stay patients

- 100% FI/MAC medical review for patients over 180 days
- Expectations
  - 40% or more of patients with long lengths of stay
  - Guidance directly to the FI/MAC

Hospice Payment Reform:
- Health reform gave HHS Secretary authority to revise hospice payment system as she determines appropriate, no earlier than October 1, 2013 or FY2014
- Revise methodology for routine home care
- Not required to change other payment structures for other levels of care
- Most likely will recommend some version of U-shaped curve, as recommended by MedPAC

Quality Measures
- Currently, no publicly available quality data covering all hospices.
- 2013 – reporting on 2 quality measures will begin: (1) pain measure (specifically whether patients who were uncomfortable due to pain at admission were comfortable within 48 hours), and (2) process measure (hospices will report whether they track at least three patient care quality measures and what those measures are.)
- -2% penalty for non-reporters, starting in FY 2014.
- NQF in the process of considering additional quality measures for endorsement.
Concurrent Care: Medicare Demo

- Allows hospice patient to also receive all other Medicare covered services while receiving hospice care
- Up to 15 sites for 3 years
- Urban and rural areas
- Independent evaluation of its impact on:
  - Patient care
  - Quality of life
  - Medicare spending

Concurrent Care: Medicaid/SCHIP

- Requires States to make hospice services available to children eligible for Medicaid/CHIP programs without forgoing any other service to which the child is entitled under Medicaid for treatment of the terminal condition.
- States with stand-alone CHIP must comply with new requirements if they cover hospice services.

Deficit Reduction - Budget Control Act (BCA)

- **First Stage** – Cuts to Discretionary spending (no impact on Medicare/Medicaid)
- **Second Stage** – Failure of Super Committee triggered sequestration.
  - Medicaid exempt
  - Medicare providers cut maximum 2% per year, starting Oct. 1, 2012.

Pending Legislation

- **Hospice Evaluation & Legitimate Payment Act (HELP), S 722/HR 3506**
  - Introduced by Sens. Wyden (D-OR) and Roberts (R-KS), and Reps. Reed (R-NY), Paulsen (R-MN) and Thompson (D-CA)
  - **Face-to-Face**: Provides flexibility by expanding the time frame for F2F and expands range of eligible professionals.
  - **Payment Reform**: Requires the Secretary to demo any new payment reform proposals (2-years, 15 sites) to test impact on access and quality.
  - **Survey Frequency**: Requires hospices be surveyed at least every three years.

- **Palliative Care & Hospice Education and Training Act (PCHETA)**
  - **Personalize Your Care Act, HR 1589**
  - **Medicare Hospice Care Access Act, S 891**

Hospice Evaluation and Legitimate Payment (HELP) Act (S 722/ HR 3506)

- **Establishes** palliative care workforce programs modeled after current geriatric programs
  - **Education Centers** – interdisciplinary training
  - **Physician Training** – trains physicians to teach
  - **Academic Career Awards** – career development for HPM junior faculty
  - **Workforce Development** – fellowships to encourage re-training for mid-level physicians
  - **Career Incentive Awards** – grants/contracts for those agreeing to teach in PC for 5 years
Personalize Your Care Act (HR 1589)
- Introduced by Rep. Earl Blumenauer (D-OR); 7 cosponsors
- HHS grants to establish/expand statewide physician orders for life-sustaining treatment (POLST) programs.
- Requires HHS to adopt standards for a qualified EHR to display a patient’s current advance directive and/or POLST.
- Requires Medicare/Medicaid providers recognize out of state advance directive or if no valid advance directive, requires recognition of any authentic expression of a person’s wishes with respect to health care.

Medicare Hospice Care Access Act (S 891)
- Introduced by Sens. Grassley (R-IA) and Conrad (D-ND)
- Recognizes PAs as attending physicians for hospice patients
  ▫ Promotes continuity of care
  ▫ Improves access in rural areas

Congressional Health Issues for 2012
- Medicare Physician Payment - SGR formula
- FDA User Fee Authorizations - by Sept 30, 2012
- Deficit Reduction – sequestration effective Oct 1, 2012
- Health Reform - Supreme Court decision by June 2012, state insurance exchanges by Jan 2013, essential benefits before that
- Election
  ▫ Presidential
  ▫ House of Representatives
  ▫ Senate: GOP = 10 seats; Dems = 23 seats

Supreme Court Review of ACA
- Key questions: Is the individual mandate Constitutional?
  ▫ Individual mandate = Requirement to purchase health insurance or face a financial penalty
  ▫ Expanded coverage (to 133% of FPL) not necessarily tied to increased funds
- Related questions: Is the individual mandate severable? When can the individual mandate be formally challenged?
  ▫ What additional programs, incentives are tied to the individual mandate (e.g., pre-existing conditions)?
  ▫ Are formal challenges moot until the first individual mandate penalty is paid in April 2015?
Possible Outcomes of Supreme Court Decision

- Decision due June 2012 – deep into implementation process:
  - Move forward, alter, or abandon policies
  - Severability of mandate
    - Concerns about market turmoil if mandate is struck
  - Medicaid
    - Whether states are coerced into new program
  - Anti-Injunction Act
    - Decision could be put off until the penalty (“tax”) is effective in 2014

5 things the Supreme Court won’t Settle--

1. Essential Benefits Package: too restrictive vs. too expensive
2. Independent Payment Advisory Board (IPAB)
3. Affordability: if mandate goes, cost concerns will increase
4. Abortion/Birth Control: federal funding
5. Delay implementation: alternative to repeal?

Questions?