



## **Recommendations for Reform in the Hospice Community**

The National Hospice and Palliative Care Organization has submitted a set of principles that we hope the Congress and new Administration will use to evaluate end-of-life care priorities as we undertake healthcare reform.

Numerous independent studies have documented the disproportionate healthcare expenditures incurred in the final months of life. Unlike many areas of healthcare, Medicare already has a system in place to reduce these costs while increasing the quality of care delivered to patients and their family caregivers. Encouraging timely and appropriate use of the Medicare hospice benefit would yield an instant “wins” for patients, family caregivers, and the Medicare budget.

Over the years, the patient population served by hospices has changed. And just as this patient base has evolved, the benefit itself must be modernized to best meet patient needs and match payments in a cost-effective manner. We urge the Congress and Administration to consider this important dynamic to assure that deliberations make a constructive contribution to this important Medicare benefit and to Medicare beneficiaries facing the end of life.

Paramount among our beliefs is making sure that future patients and families can access, in all service settings, the high-quality care that hospice and palliative care have come to symbolize. Eligibility for care should be based upon an assessment of the patient to ensure appropriate eligibility and supported, to the extent practical, by evidence-based guidelines. Patients and families should know what to expect and receive – consistent, and measurable, high-quality services delivered by a skilled interdisciplinary team within every hospice program in the country. Equally as important, the hospice and palliative care community must continuously demonstrate their commitment to program integrity, transparency, accountability and fiscal responsibility.

General issues that should be considered include:

### **Hospice Payment Rate Changes**

**Roll Back of Rate Cut Regulation** -- Maintaining fiscally responsible hospice providers is an important issue if more patients and families are going to be served by hospice programs. The previous administration issued a regulation that drastically reduces hospice payments and must be reversed. Congress and President Obama already have acted to suspend these reductions, but further action to rescind the regulation is required. Without such action, the narrow margins that hospice programs now show (MedPAC reports average margins of 3.4%) will be wiped out and hospices will be forced to reduce coverage areas or limit admissions

**MedPAC Payment Reform Model** -- CMS should be directed to collect comprehensive data and then model the MedPAC proposal, along with a number of other models (i.e., outlier payment for high cost patients) prior to the 2013 implementation date. Particular attention should be given to the unintended consequences of such models so that large patient groups, either by diagnosis or length of stay, are not inappropriately displaced. Also, care should be taken to not “build in” inappropriate incentives to admit or discharge patients based on criteria other than appropriate clinical conditions.

**Cap Review and Adjustment** -- Unlike hospice payment rates, the hospice aggregate payment cap is not currently adjusted geographically. Congress should direct CMS to geographically adjust hospice cap amounts using the same wage index calculation, and in the same manner, as is used to determine hospice payment rates, but increasing the index to 1.00 for any locality in which it is less than 1.00, in order to protect hospices in rural areas. In addition, the Secretary of Health and Human Services should be given authority to extend more favorable terms (including, but not limited to lower interest rates and longer payment periods) to those programs that can demonstrate financial hardship upon receipt of a final determination of their cap liability.

## **Reducing End-of-Life Expenditures and Improving Patient Quality of Life**

### **Demonstration Projects to Provide Upstream Services to Reduce End-of-Life Costs**

- **Concurrent Care** -- Conduct a demonstration program which would eliminate the current requirement that patients electing the hospice benefit waive their right to payment for curative care, and provide coverage of “concurrent care” (e.g., hospice services provided to hospice eligible patients currently receiving curative therapies).
- **Care Coordination** -- Conduct a care coordination demonstration project that would allow the hospice team to provide palliative care services to patients with a life expectancy of more than six months, but limited to some finite prognosis. Such an up-stream model would yield important data and potential cost savings if the hospice concept and approach to care is introduced far earlier in the patient’s disease trajectory.

### **Increased Beneficiary Autonomy and Knowledge**

**End-of-Life Care Information and Advance Directive Clearinghouse** -- In order that patients be more fully informed about the range of options at the end of life and to exercise reasonable steps to see that their wishes at the end of life are more likely to be honored, the Secretary of Health and Human Services should be directed to establish a national, toll-free, information clearinghouse that the public may access to locate and download state-specific information regarding advance directives and end-of-life decisions.

**Advance Directive Portability** -- With our more mobile population, especially among the elderly who have a need and/or desire to travel to accommodate caregiver needs, there should be national legislation that assures, to the extent allowed by state laws, for the enforceability of advance directives, legally executed in another state. In addition, consideration ought to be given to a national promotion of POLST (Physician Orders for Life Sustaining Treatment), an out-of-hospital do-not-resuscitate order developed and signed by the physician and patient.

**Integrity, Transparency, Accountability and Comprehensive Data Collection** -- To improve transparency in the hospice reimbursement system and to expand upon the ongoing efforts of CMS, Congress should require hospices to report more comprehensive data to reflect the number, type and length of services (including telephonic contacts) provided to Medicare patients by all members of the hospice interdisciplinary group and by all hospice employees and volunteers. These data collection mandates should be implemented following development of an appropriate data set. Data collection requirements should take into account the unique features of the Medicare hospice benefit, including the patient-centered focus on palliative care, the interdisciplinary team approach to providing care, and the provision of counseling and other services not otherwise covered by Medicare. CMS should first implement the enhanced data collection requirement through a pilot program of limited duration to test the accuracy and consistency of the data collection systems.

**Hospice Financial Data** -- Hospice cost reports should be changed to add new data fields to capture the full range of hospice revenues in order to provide a more accurate picture of hospice's financial performance for both freestanding and provider-based hospices. Such an effort should be undertaken with hospice community input, collaboration and cooperation, as well as input from other end-of-life care stakeholders.

**Recertification of Long Stay Patients** -- MedPAC recommended a requirement that either a hospice physician or other qualified healthcare professional visit the patient to determine continued eligibility prior to the 180-day hospice recertification and each subsequent recertification and attest that such visits took place. In addition, all recertifications should include a brief narrative describing the clinical basis for the patient's prognosis. All stays in excess of 180 days should be medically reviewed for programs for which stays exceeding 180 days make up more than 40 percent of their total cases. Special consideration ought to be given to the unique issues facing rural and small hospice providers in assessing the impact and implementation of such measures.

**Increased Review by Appropriate Government Entities** -- With the increased utilization of hospice care and growth in the number of providers, it is prudent to encourage appropriate local, state and federal government entities to review financial and contractual relationships between hospices and other healthcare facilities that may give the appearance of a conflict of interest and potentially influence referrals to hospice. If any instances of fraud and/or abuse are discovered, they should be immediately reported to the appropriate authorities.

**Increased Survey Frequency** -- In order to assure that hospice patients and their families are receiving the highest quality of care available, CMS ought to be allocated adequate resources to implement a mandatory system of standard site surveys that are more timely than current practice and which occur at least as frequently as every three years. Such surveys should be undertaken by highly trained and competent governmental professional using the recently revised Hospice Conditions of Participation.

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