



June 10, 2009

Dear Member of Congress:

On behalf of the 1.5 million patients and their families served last year, and the hundreds of thousands of others who could have appropriately benefited from hospice services, the hospice and palliative care community would like to respectfully submit a set of proposals that we hope the Congress and the Administration will use to evaluate end-of-life care priorities as we progress toward 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 advances the compelling need for compassionate and cost-effective care at the end of life.

Paramount among our beliefs is making sure that future patients and families can access the high-quality care that hospice has 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 sound 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 important, the hospice and palliative care community must continuously demonstrate their commitment to program integrity, transparency, accountability and fiscal responsibility.

### **Hospice Payment Rate Changes**

***Roll Back of Rate Cut Regulation*** -- 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. In addition, some programs, especially in rural settings, will have little alternative but to close, thus denying care to eligible patients and families. Independent research conducted under a grant from the Robert Wood Johnson Foundation (Duke University, 2007) showed that, on average, hospice saves Medicare approximately \$2,300 per patient, amounting to more than \$2 billion in savings each year, based on current patient utilization. Maintaining fiscally responsible hospice providers is an important issue if more patients and families are going to be served by hospice programs.

### **MedPAC Hospice Recommendations**

***Payment Reform Model*** -- MedPAC has recommended that Congress direct the Secretary of Health and Human Services to implement, no earlier than 2013, a new per diem routine home care payment methodology with relatively higher payments at the beginning and end of services and with lower payments in the middle period of services to a patient and family. While MedPAC has identified a number of issues that might provide a foundation for payment reform, we urge caution in this area given the inherent nature of hospice referrals. There is wide-spread agreement that patient-level cost data is not currently available in sufficient quantities to inform such a payment reform proposal.

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 potential “over corrections” that might limit appropriate access to hospice care.

***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. In addition, other refinements are necessary to ensure clarity and accuracy of data. Provisions should be made for cost reports to be audited by the fiscal intermediary to increase the accuracy of cost report data. Data can then be used more reliably in analyzing hospice payment issues. Such an effort should be undertaken with hospice community input and collaboration, as well as input from other end-of-life care stakeholders.

***Recertification of Long Stay Patients*** -- MedPAC recommended, and we support, 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, we support the part of the recommendations that provides for all recertifications to include a brief narrative describing the clinical basis for the patient’s prognosis. In addition, 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 professionals using the recently revised Hospice Conditions of Participation.

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

***Demonstration Projects to Provide Upstream Services to Reduce End-of-Life Costs*** -- Research shows that there are disproportionate expenses in the last year of a patient’s life. Many of these expenses are incurred due to complicated and intensive interventions of questionable value and with questionable outcomes. Research, via various models of care, might be able to show that many of these costs could be avoided and more appropriate care delivered that meets the patient’s and family’s needs.

- **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).

- **Transitional Care Management** -- Develop a transitional care management model that would allow the hospice team to provide palliative care and advance care planning consultations to patients with a life expectancy of more than six months, but limited to some finite prognosis, such as 18 months. The findings based on this model would yield important data and potential cost savings of introducing the hospice concept and approach to care 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, or contract through a not-for-profit entity, 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. Appropriate funds for the operation of such a clearinghouse should be authorized.

***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, 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) and similar programs, which provide for an out-of-hospital do-not-resuscitate order developed and signed by the physician and patient. The goal ought to be to honor the patient's knowledgeable and clear expression of their wishes, to the extent practical.

***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 team and by all hospice employees and volunteers. 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 Cap Review and Adjustment**

Unlike hospice payment rates, the hospice aggregate payment cap is not currently adjusted geographically. Starting in the cap year that begins November 1, 2009, 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.

Hospice care is part of the solution for patients and families, and is a model of cost-efficient and high-quality healthcare delivery. In service to the patients and families who choose compassionate, high-quality end-of-life care, the National Hospice and Palliative Care Organization is committed to assisting Congress and the Administration in this most important endeavor. Please consider the hospice community your partner as you strive to meet President Obama's goal of "an open, inclusive, and transparent process where all ideas are encouraged and all parties work together to find a solution to the health care crisis."

Respectfully,

A handwritten signature in black ink, reading "J. Donald Schumacher". The signature is written in a cursive style with a large, stylized initial "J".

J. Donald Schumacher, PsyD  
President and CEO