View from Washington – Hospice and Palliative Care

Judi Lund Person, MPH
National Hospice and Palliative Care Organization
Session Objectives

• Describe the current Washington policy environment, including data on the delivery of hospice care
• Discuss Medicare/Medicaid innovations, hospice and palliative care.
• Describe the implementation of hospice payment reform and current activities and time frames.
• Discuss options for hospice and palliative care to be provided upstream.
National Press and Hospice
Terminal neglect? How some hospices decline to treat the dying

This is the first installment in the “Business of Dying” series.

A photo of Ying Tai Choi, part of a small shrine dedicated to her by daughter Ching Cheung in Tampa, Fla. As she lay dying, a hospice nurse left the house, leaving the family on its own to handle Choi’s final moments. (Brian Blanco/For The Washington Post)

By Peter Whoriskey and Dan Keating  May 3, 2014  

TAMPA — The 85-year-old hospice patient was close to death.

Ying Tai Choi lay on a hospital bed arranged in the living room of her
N.Y. / REGION

Fighting to Honor a Father’s Last Wish: To Die at Home

By NINA BERNSTEIN  SEPT. 25, 2014

Maureen Stefanides at NewYork-Presbyterian Hospital with her father, Joseph Andrey, waiting to move to a nursing home despite their efforts to arrange for 24-hour care at his apartment.

Victor J. Blue for The New York Times
The “bottom line” for Mr. Andrey

• His last year of life included about 4 nursing home stays, many more ERs and hospitalizations
• Cost > $1million to Medicare and Medicaid
• And he did not get his only wish... To be at home.
Impact of Articles

• Attention on Capitol Hill
• Attention at CMS
• Washington Post overwhelmed by number of positive responses about hospice
Why does this matter?

• In FY2016 Hospice Wage Index proposed rule, CMS says:
  – ... the hospice industry has come under increased media scrutiny, much of it related to hospices enrolling patients who may not be eligible for the benefit because they are not terminally ill and enrolling patients with certain diagnoses that typically have a longer length of stay, mainly non-cancer diagnoses.

• Hill reaction:
  – Questions about hospice to lobbyists
National Focus

END OF LIFE CARE
AND FUTILE CARE
Spotlight on the IOM Report: “Dying in America”

What is the hospice and palliative care community’s role in prioritization and implementation?
IOM Report – Key Areas for Findings and Recommendations

1. Delivery of person-centered, family-oriented care
2. Clinician-patient communication and advance care planning
3. Professional education and development
4. Policies and payment systems
5. Public education and engagement
Leading new discussions on the end of life

- 30 weeks on NY Times best seller list
- Engaging, personal style
- Articles on futile care also appearing in The New Yorker
  - Overkill: An avalanche of unnecessary medical care is harming patients physically and financially. What can we do about it? (May 13, 2015)
The Conversation Project

Angelo Volandes, MD, MPH

- Physician and researcher at Harvard Medical School and Massachusetts General Hospital
- Leads a team of scientists and innovators across the country who create and study short, easy to understand videos, for patients and their families.
- [www.acpdecisions.org](http://www.acpdecisions.org)
Does this help?

• Focuses attention on end of life
• Much broader than hospice
• New focus on advance care planning conversations
• Hospice can play a role – must position locally
Legislative Update
2015 Advocacy Intensive

• The Advocacy Intensive took place in mid-July
• Over 288 attendees covering 49 states and the District of Columbia
• The entire IDT was represented
• Attendees made over 400 Congressional meetings
• Impact great – because caregivers told their stories…. Very powerful with members of Congress and their aides
Care Planning Act of 2015

- Introduced by Senators Warner (D-VA) and Isakson (R-GA) – SB 1549
- Recognizes the importance of advance care planning
- Creates a new Medicare benefit called Planning Services for those with advanced illness
- Allows for a team-based approach of care planning discussions with doctors, nurses, and other healthcare professionals
- Creates a pilot program for Advanced Illness Coordination Services to allow for home-based support of patients with multiple and complex chronic conditions
Other Legislation Supported by NHPCO

- **Hospice CARE Act** (H.R. 2208) (5/6/2015)
- **Care Planning Act of 2015**
  Comprehensive resources on [www.hospiceactionnetwork.org](http://www.hospiceactionnetwork.org)
- **Hospice Care Access Improvement Act of 2015** (H.R. 3037)
  **Palliative Care and Hospice Education and Training Act** (H.R. 3119) (PCHETA) Supported by the Patient Quality of Life Coalition
KEY VULNERABILITIES FOR HOSPICICES:
Driving the hospice discussion among policymakers
Key Vulnerabilities

- Visits in last 48 hours of life
- General Inpatient Care, Continuous Care, Inpatient Respite
- Live discharges
- Non Hospice Spending In Medicare Parts A, B And D: “Leakage”
- Pre-hospice spending and “cost savings”
- OIG reports
VISITS IN THE LAST 48 HOURS OF LIFE
### % of Patients with No Skilled Visits

<table>
<thead>
<tr>
<th>Days before Death</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last day of life</td>
<td>28.9% of patients</td>
</tr>
<tr>
<td>Last 2 days of life</td>
<td>14.4% of patients</td>
</tr>
<tr>
<td>Last 3 days of life</td>
<td>9.1% of patients</td>
</tr>
<tr>
<td>Last 4 days of life</td>
<td>6.2% of patients</td>
</tr>
</tbody>
</table>

Skilled visits include nurse, social worker, therapies (OT, PT, Speech). Does not include aide, chaplain, volunteer.

CMS CY 2012; FY2015 Hospice Wage Index Final Rule
**Lowest % of Patients with No Visits in Last 2 Days of Life**

<table>
<thead>
<tr>
<th>State</th>
<th>% with No Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>WI</td>
<td>5.7%</td>
</tr>
<tr>
<td>ND</td>
<td>7.3%</td>
</tr>
<tr>
<td>VT</td>
<td>7.5%</td>
</tr>
<tr>
<td>TN</td>
<td>7.5%</td>
</tr>
<tr>
<td>KS</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

CMS CY 2012; FY2015 Hospice Wage Index Final Rule
Highest % of Patients with No Visits in Last 2 Days of Life

<table>
<thead>
<tr>
<th>State</th>
<th>% with No Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>NJ</td>
<td>23%</td>
</tr>
<tr>
<td>MA</td>
<td>22.9%</td>
</tr>
<tr>
<td>OR</td>
<td>21.2%</td>
</tr>
<tr>
<td>WA</td>
<td>21%</td>
</tr>
<tr>
<td>MN</td>
<td>19.4%</td>
</tr>
</tbody>
</table>

CMS CY 2012; FY2015 Hospice Wage Index Final Rule
We further examined hospice utilization data and **developed a provider-level file to identify aberrant hospice behavior.** The provider level file contains information on beneficiaries who were discharged (alive or deceased) in Calendar Year (CY) 2012 and includes claims data from January 1, 2010 through December 31, 2012.
GENERAL INPATIENT CARE, CONTINUOUS HOME CARE, AND INPATIENT RESPITE CARE UTILIZATION

Levels of Care
### Percentage of days by level of care

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Percentage of Total Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Home Care</td>
<td>97.4%</td>
</tr>
<tr>
<td>Continuous Home Care</td>
<td>0.4%</td>
</tr>
<tr>
<td>Inpatient Respite Care</td>
<td>0.3%</td>
</tr>
<tr>
<td>General Inpatient Care</td>
<td>1.9%</td>
</tr>
</tbody>
</table>
GIP Utilization

• Patient utilization:
  77.3% of patients electing hospice did not have a GIP stay during their hospice election

• Hospices providing GIP
  28% of hospices did not bill for a single day of GIP in CY2013

Source: MedPAC analysis of hospice claims, CY2013
GIP Utilization

- National average = 1.9% of days are GIP
- Do not provide GIP?
  - 66% for-profit
- Provide GIP?
  - 5-10% = 195 hospices
  - 10% or more = 46 hospices

<table>
<thead>
<tr>
<th>Any GIP Provided?</th>
<th>Number of Hospices</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>760</td>
</tr>
<tr>
<td>Yes</td>
<td>2,758</td>
</tr>
</tbody>
</table>

Hospice claims data from CY 2010-CY 2012 for beneficiaries who were discharged (alive or deceased) in CY 2012
Location of GIP

Source: CMS CY 2012; FY2015 Hospice Wage Index Final Rule
Length of GIP Stay by Location

Average Length of Stay in Days

Source: CMS CY 2012; FY2015 Hospice Wage Index Final Rule
Policy Questions

• Was the hospice able to provide GIP?
• Was the hospice “cherry picking” patients who were “less sick?”
• Does the hospice comply with COP requirement for a contract for GIP?
• Was quality of care compromised?
MedPAC Reports on Levels of Care

Some hospices did not provide certain levels of hospice care to any patients in 2013

<table>
<thead>
<tr>
<th>Category</th>
<th>No General Inpatient</th>
<th>No Continuous Home Care</th>
<th>No inpatient respite</th>
<th>No GIP or CHC</th>
<th>No GIP, CHC, or respite</th>
</tr>
</thead>
<tbody>
<tr>
<td>All hospices</td>
<td>28%</td>
<td>58%</td>
<td>25%</td>
<td>19%</td>
<td>12%</td>
</tr>
</tbody>
</table>

% of Hospices by total number of patients in 2013

<table>
<thead>
<tr>
<th>Less than 100</th>
<th>57</th>
<th>71</th>
<th>54</th>
<th>41</th>
<th>28</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-199</td>
<td>25</td>
<td>60</td>
<td>22</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>200-</td>
<td>15</td>
<td>58</td>
<td>11</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>300-499</td>
<td>8</td>
<td>50</td>
<td>6</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>500 or more</td>
<td>2</td>
<td>39</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: MedPAC analysis of Medicare hospice claims data CY2013

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LIVE DISCHARGES
Live Discharges – FFY 2013

• In FFY 2013 there were
  – 1,159,852 discharges
  – 212,574 (18.3%) were live discharges

• In FFY 2013, there were 3,096 hospices with 51 or more discharges
  – Median live discharge rate is 18.3%
  – 10\textsuperscript{th} percentile equals 9.5%
  – 95\textsuperscript{th} percentile equals 50%
  • $888 million in hospice payments (5.9% of all hospices payments for the 3,096 hospices)
Lowest Rates of Live Discharge
FFY2013

KY: 11.6%
IL: 11.7%
NE: 12.3%
CT: 13.1%
MI: 13.5%

Highest Rates of Live Discharge
FFY2013


<table>
<thead>
<tr>
<th>State</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>MS</td>
<td>37.0%</td>
</tr>
<tr>
<td>AL</td>
<td>30.3%</td>
</tr>
<tr>
<td>SC</td>
<td>29.8%</td>
</tr>
<tr>
<td>DC</td>
<td>29.5%</td>
</tr>
<tr>
<td>AZ</td>
<td>25.8%</td>
</tr>
</tbody>
</table>
Live Discharge: Hospice Variation (FFY 2013)

• Hospices above the 90th percentile for live discharges
  – Provided 3.97 visits per week on average
  – **Had an average LOS equal to 159.4 days**
  – Had a rate of not providing skilled visits for the last two days of life (RHC days) equal to 22.3%

• Hospices below the 90th percentile for live discharges
  – Provided 4.48 visits per week on average
  – **Had an average LOS equal to 90.8 days**
  – Had a rate of not providing skilled visits for the last two days of life (RHC days) equal to 13.7%

## Reasons for Live Discharge FY2014

<table>
<thead>
<tr>
<th>Reason for Discharge</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revocation</td>
<td>38.2%</td>
</tr>
<tr>
<td>Transfer to another hospice</td>
<td>11.6%</td>
</tr>
<tr>
<td>No longer meeting eligibility criteria</td>
<td>43.1%</td>
</tr>
<tr>
<td>Moved out of service area</td>
<td>5.3%</td>
</tr>
<tr>
<td>Discharge for cause</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

Live Discharge and Readmissions

Hospice Discharge → Hospital Admission → Expensive test/procedure ($126 M)

2010 Data
13,770 patients of 182,172 live discharges – 7.5%

Source: CMS CY 2012; FY2015 Hospice Wage Index Final Rule
Live Discharge and Readmission by State – Highest %

$56.0 M (44%) of the hospitalization costs from these 10 states

CMS CY 2012; FY2015 Hospice Wage Index Final Rule
Non Hospice Spending In Medicare

Parts A, B And D: “Leakage”
Part A and B Expenditures During a Hospice Stay

• FY2013
  – Paid by Medicare: $694.1 million
  – Paid by beneficiaries: $132.5 million

Source: FY2016 Hospice Wage Index proposed rule, April 30, 2015
Medicare A and B Outside Hospice Benefit

<table>
<thead>
<tr>
<th>Part A or B Service</th>
<th>Percentage of $$ Spent – FY2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>DME</td>
<td>6.4%</td>
</tr>
<tr>
<td>Inpatient care</td>
<td>28.6%</td>
</tr>
<tr>
<td>Outpatient Part B services</td>
<td>16.6%</td>
</tr>
<tr>
<td>Other Part B services (physician, practitioner, labs and diagnostic tests, ambulance transports, and physician office visits)</td>
<td>38.8%</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>5.3%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>4.3%</td>
</tr>
</tbody>
</table>
DME Expenditures
Outside the Hospice Benefit

TOTAL: $27,104,022
Four case studies on frequent hospice diagnoses

• Case studies presented for following diagnoses
  – chronic airway obstruction
  – congestive heart failure
  – cerebral degeneration
  – lung cancer

• Citation of:
  – Typical symptoms
  – Evidence-based practice interventions/recommendations

• Comments on Medicare spending outside the hospice benefit
Concurrent Payments for Services Provided to Hospice Patients Lung Cancer, CY 2013

Total $3,405,083

Source: CMS FY2016 Hospice Wage Index Final Rule
Concurrent Payments for Services Provided to Hospice Patients with COPD, CY 2013

Total $10,400,319

Source: CMS FY2016 Hospice Wage Index Final Rule
CMS Concern

• Analysis reveals:
  – Services clinically indicated and recommended were provided outside the hospice benefit
  – A violation of requirements regarding the Medicare hospice benefit

• Attributed to:
  – Incorrectly classifying conditions as unrelated
  – Not communicating and coordinating the care and services needed to manage care needs
  – Deliberately avoiding costs

Source: CMS FY2016 Hospice Wage Index Final Rule
“Virtually All” Care and Services

• CMS states:
  – Since the implementation of the Medicare hospice benefit in 1983, we have stated that it is our general view that hospices are required to provide virtually all the care that is needed by terminally ill individuals and
  – We would expect to see little being provided outside of the benefit

Source: CMS FY2016 Hospice Wage Index Final Rule, August 6 2015
## Location of Care for Part A and B Outside Hospice Benefit

<table>
<thead>
<tr>
<th>Location of Care</th>
<th>% of Total “Leakage”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>56.0%</td>
</tr>
<tr>
<td>Nursing facility</td>
<td>25.7%</td>
</tr>
<tr>
<td>Inpatient setting</td>
<td>1.9%</td>
</tr>
<tr>
<td>Assisted living facility</td>
<td>15.1%</td>
</tr>
<tr>
<td>Other settings</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

Source: CMS FY2016 Hospice Wage Index Final Rule, August 6 2015
States where Medicare A and B Outside the Hospice Benefit is Highest

Source: FY2016 Hospice Wage Index proposed rule, April 30, 2015
Part D Expenditures During a Hospice Stay

• FY2013
  – Total Part D spending after hospice election: $439.5 million
  – Paid by Medicare: $347.1 million
  – Paid by beneficiaries: $50.9 million

Source: FY2016 Hospice Wage Index proposed rule, April 30, 2015
Highest Part D Expenditures by State

CMS CY 2012; FY2015 Hospice Wage Index Final Rule
Total Spending Outside Hospice Benefit
FY2013

Medicare payments
- Parts A and B: $694.1 million
- Part D: $347.1 million
- TOTAL: $1.0 billion

Beneficiary liability
- Parts A and B: $132.5 million
- Part D: $50.9 million
- TOTAL: $1.2 billion
Average Pre-hospice Medicare Spending Estimates – 180 days before hospice election

- Alzheimer's, Dementia, and Parkinson's
- All Other Diagnoses
- Lung (COPD and Pneumonias)
- Heart (CHF and Other Heart Disease)
- CVA/Stroke
- Cancers
- Chronic Kidney Disease

Average Daily Medicare Payments, 180 Days Before First Hospice Admission

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Analysis of Pre-Hospice Spending...

- Different resource needs based on diagnosis
- Initial analysis for possible case mix adjustment payment system
- Patients with longer LOS had lower pre-hospice spending compared to hospice patients with shorter LOS
Focus on Cost Savings

• Medicare expenditures were 1% lower for hospice enrollees with cancer than for patients without hospice

• Medicare expenditures for hospice enrollees without cancer were 11% higher than for non-enrollees

• Medicare expenditures rise for hospice enrollees in nursing homes -- net increase of $6,761
  – Greater expenditures for hospice -- $10,191 compared to reduced hospital care -- $3,430
Medicare Care Choices Model
Medicare Care Choices Model

• CMS awards to 141 hospice providers
• List of grantees now posted on CMS website
• Two start date cycles for 5 year project
  – January 1, 2016
  – January 1, 2018
• Awardees randomly selected for each start date
MCCM Awardees
California Awardees

• Assisted Home Hospice
• Assisted HomeCare Inc. dba Assisted Hospice Care
• Sea Crest Hospice Services, Inc.
• CareChoices Hospice and Palliative Care Services, Inc.
• Hospice of Saddleback Valley
Services provided by hospice

• Patients are hospice eligible but have not elected their hospice benefit
• Hospice provides “supportive care” through hospice staff
• Medicare Parts A, B and D provide all other services that can be billed separately
• The patient’s attending physician is in charge
• Curative treatment is possible, together with palliative
Goals for MCCM

• Answering the question of whether providing both palliative and curative care concurrently impacts quality of care, as well as patient and family satisfaction
Payment

• CMS will pay a per beneficiary per month fee ranging from $200 (for less than 15 days in a month) to $400 (for 15 days or more in a month) to participating hospices
Beneficiary characteristics - MCCM

• Specific diagnoses:
  – advanced cancers
  – chronic obstructive pulmonary disease
  – congestive heart failure
  – human immunodeficiency virus/acquired immune deficiency syndrome
BEYOND HOSPICE: 
THE FUTURE OF SERIOUS ILLNESS
The Top 5% of Patients Account for 50% of All Healthcare Spending

Percentile Ranked by Health Care Expenditures, 2012

Top Five Most Costly Medical Conditions

1. Heart disease
2. Trauma-related disorders
3. Cancer
4. Mental disorders
5. COPD/asthma

Benefits of Upstream Palliative Care/Patient Management

• Patients have better quality of life
• Patients are more likely to use hospice, less likely to use expensive hospital care
• Patients cost less to care for (when appropriately selected)
• They may even live longer

Upstream Care Types

• Advanced illness management (AIM) programs
• Community based palliative care
• Post-acute transitional care
• Pre-hospice programs
New Payment Models for Upstream Palliative Care

- Transitional Care Management
- Chronic Care Management
- Advance Care Planning
- Split/Shared Visits – Part B billing opportunity
- Physician Quality Reporting System (PQRS) requirements for palliative care physicians
Upstream Partners for Hospices

Seeking those at risk for health expenses:

• Hospitals and health systems
• ACOs in your service area
• Medicare Advantage plans
• Commercial Insurers
• Large self-insured employers (including hospitals)
High-Impact Target Areas for ACO Initiatives

1. Prevention and wellness
2. Chronic disease
3. Reduced hospitalizations
4. Care transitions
5. Multi-specialty care coordination of complex patients

Source: Accountable Care Guide for Hospice & Palliative Care, Toward Accountable Care Consortium, Raleigh, North Carolina.
WHAT CAN HOSPICE DO?
Transferrable Hospice Skills

• Managing patients under a risk-based payment method – controlling costs
• Managing patients with high needs and high levels of frailty
• Managing patients with complex, life-threatening illness
• Managing patients in a home or home-like setting
• Managing patients out in the community
Now more than ever...

Hospices need to be:

• Nimble
• Know the metrics
• Know the community
• Demonstrate value
• Be active participants in networks
• Be LEADERS in the market
Moments of Life Campaign

• What’s needed:
  – Stories that show situations that might not be the norm
  – Serving patients in rural areas would be terrific
  – Photos (and descriptions) that can be submitted online
  – Blog posts and articles

• [www.momentsoflife.org](http://www.momentsoflife.org)
  – Place to share photos and description
  – Place to share blogs
Don’s Honor Flight