804: How to Deal with Current and Future Changes: Hospice Policy Roundup Part II

National Association for Home Care & Hospice Annual Meeting & Exposition
Nashville, TN
October 30, 2015

Theresa M. Forster
VP Hospice Policy & Programs
NAHC
tmf@nahc.org

Katie Wehri
Hospice Operations
NAHC
Katie@nahc.org
State of the Industry

Value Based Care
Bundled Payments for Care Improvement Initiative

Link payment for multiple services during an episode of care

Payment arrangements include
financial & performance accountability

Expected outcomes:
– higher quality care
– more coordinated care
– lower cost
Comprehensive Care for Joint Replacement (CCJR) Pilot

- July 2015 – Proposed CCJR project in 75 geographic areas for hip/knee replacement, covers:
  - Surgery/hospital stay
  - 90 days post-discharge care INCLUDES hospice
- Exclusion for care of conditions not linked to replacement but no discussion of excluding hospice services when not related to replacement
- First mandatory bundled payment model

Accountable Care Organizations

- Groups of doctors, hospitals, and other health care providers
  - Coordinated, high quality care
- Goals
  - Ensure people get the right care at right time
  - Avoid duplication
  - Prevent medical errors
- Shared savings
Back to the Basics

Holistic care
Pain and symptom management
Patient decision maker
Fully informed
Coordinated care
Quality of life
Prevent hospitalizations and re-hospitalizations

Palliative Care
Medicare Care Choices Model

Palliative care services from hospice providers WHILE receiving curative care services

CMS will evaluate whether hospice services can
• Improve quality of life
• Increase patient satisfaction
• Reduce Medicare expenditures

Medicare Care Choices Model

• Medicare-certified hospices to provide RHC and INPT respite, coordination of care, counseling and other services for $400 PBPM – All other services covered under Parts A, B, and/or D
• Patients must be hospice eligible
• Advanced cancers, COPD, CHF and HIV/AIDS
• http://innovation.cms.gov/initiatives/Medicare-Care-Choices/
Quality

• National Quality Strategy
  – Established as part of the ACA
  – National focus on quality improvement efforts and approach to measuring quality

• Measures
  – Matter
  – Not be burdensome
  – Align across the entire system

National Quality Strategy

Six priorities
• Making care safer by reducing harm caused in the delivery of care.
• Ensuring that each person and family is engaged as partners in their care.
• Promoting effective communication and coordination of care.
• Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
• Working with communities to promote wide use of best practices to enable healthy living.
• Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.
Quality and Value

• Home Health Value Based Purchasing PROPOSED
  – Financial and quality accountability
• Star Ratings
  – Same as other providers
  – Publicly reported
  – Used to compare providers

Managed Care

• Managed Care is a health care delivery system organized to manage cost, utilization, and quality
• Capitated payment (per member per month)
• www.Medicaid.gov
Hospice and Managed Care

• 2014 MedPAC recommendation – bring hospice under MA bundle of services

• Same benefit “bundle” as under FFS

• Potential impact:
  – Insufficient payment
  – Selective contracting (no consumer choice)
  – Copays for patients

Hospice and Managed Care

• Medicaid – growing number of states including hospice in MCO contracts; absent state rule otherwise, payment mechanism/level at MCO discretion

• Threats and opportunities of new health care environment (ACOs, MCOs, etc.) demand that hospices KNOW THEIR CARE COSTS / create coherent charge structures
**MedPAC**

- Medicare Advantage “carve-in”
- Hospice – cost saver or spender?
  - June 2015 Report “Spending in the Last Year of Life and Impact of Hospice on Medicare Outlays” -- spending at “market level”
  - Costs for cancer patients on hospice are lower; others generally higher
  - Does not reflect full benefit of hospice
- Variability in profit margins (CAP, high NF population, P/NP, etc.)
- Use of claims data-based measures as quality measures
- Hospital observation status -- Hospice as part of post-acute transfer policy?

**Congress**

- Concerns about spending, political pressures to move Medicare toward more sustainable spending path
- Reluctance to micromanage or to arbitrate between providers/CMS
  - Overall Medicare reform: Merge A & B (uniform deductible, copays). Will hospice be included or excluded?
  - Delegate management to private sector:
    - ACOs
    - Medicare Advantage
    - Bundling
    - Cost as quality measure (VBP)
Congress

• Other issues:
  – Sen. Mike Enzi (R-WY)/ S. 1354 -- Medicare Patient Access to Hospice Act of 2015 -- PAs as Attendings
  – Rep. Tom Reed (R-NY) and others/H.R. 2208 -- The Hospice Commitment to Accurate and Relevant Encounters Act (Hospice CARE Act) – refine Face to Face requirements
    • 7 days for “exceptional circumstances” encounter – further refinement needed?
    • PAs, others could conduct encounter

Advance Care Planning

• ACA Advance Care Consultations/“Death Panels”

• Congressional efforts to incorporate advance care planning into Medicare/Medicaid:
  – S. 1549 “Care Planning Act”
    • authorizes Medicare to fund discussions of health conditions, treatment options, and development of advance directives by IDT for seriously ill beneficiaries
Advance Care Planning

- CMS proposed physician fee schedule changes
  - payment to physicians for advance care planning sessions they have with patients, family member(s) and/or surrogate

- Numerous states legislative activity and advocacy

Behavior and Trends Raising Concern

GIP
Level of Care
GIP

• OIG 2013 Memorandum Report to CMS
  Medicare Hospice: Use of GIP Findings:
  – Majority provided in hospice inpatient units
  – 23% of hospice beneficiaries received this care
  – Hospices with inpatient units provided more GIP care to their beneficiaries and for longer periods of time
  – Concerns with hospices providing no GIP

Forthcoming: Review of claims, election stmt, medical records/assess appropriateness

Office of the Inspector General

• LONGSTANDING concern about hospices that “seek out” patients in nursing facilities; 2011 report:
  – Certain hospices have high proportion of NF patients
    • Less complex care
    • Longer lengths of stay
    • Higher profit margins

• Recommendation: Reduce payments for care in NFs
Office of the Inspector General

- January 2015: Medicare Hospices Have Financial Incentives To Provide Care In Assisted Living Facilities (ALFs) –
  - Longer lengths of stay
  - Fewer services
  - Less intensive diagnoses
  - Higher profits

Hospice Payment Reform & Program Integrity

FY2015 Proposed Hospice Rule (May 2014): Focus on behavior and trends that raise program integrity concerns; “market-driven” goals rather than preserving intent of the Medicare Hospice benefit:

“An initial step of hospice payment reform in this proposed rule is to clarify and enforce hospice payment policy, when necessary, in order to safeguard beneficiaries and the Medicare hospice benefit.”
Behavior and Trends Raising Concern

- Long lengths of stay
- Live discharges
- Appropriate levels of care
  - CHC in ALF; RHC in ALF, NF, SNF
- “Burdensome” transitions
- Skilled visits in last days of life
- Care in facilities
- Spending outside of hospice

CMS’ Continuing Concern

Unbundling of the Medicare Hospice Benefit
Terminal Illness Definition

• “Abnormal and advancing physical, emotional, social and/or intellectual processes which diminish and/or impair the individual’s condition such that there is an unfavorable prognosis and no reasonable expectation of a cure;

• not limited to any one diagnosis or multiple diagnoses, but rather it can be the collective state of diseases and/or injuries affecting multiple facets of the whole person, are causing progressive impairment of body systems, and there is a prognosis of a life expectancy of six months or less”.

Related Conditions

• “Those conditions that result directly from terminal illness; and/or
  – result from the treatment or medication management of terminal illness; and/or
  – which interact or potentially interact with terminal illness; and/or
  – which are contributory to the symptom burden of the terminally ill individual; and/or
  – are conditions which are contributory to the prognosis that the individual has a life expectancy of 6 months or less”.
Hospice Payment Reforms

• Create challenges for Hospice Stakeholders:

  – Concerns about reliability of systems information
  – Future shifts in payments contingent on use of SIA (budget neutrality)
  – Overall reduction in predictability of payment rates

Future Hospice Payment Reforms

• CMS to monitor data sources (claims data, expanded cost report); may consider case-mix based system
• Rebasing of RHC – legislative authority needed?
• Address higher profits for hospices with high nursing home population
The Future

- Experts believe costs need to be reduced 10-20% over the next 3-5 years
- Must find efficiencies
- Must involve everyone

How To Deal With The Future

- Ensure compliance
- Prepare for slow down/shortages in CASH FLOW
- Know your DATA including QUALITY MEASURES
- Be able to show your VALUE
- Know and monitor key PERFORMANCE INDICATORS
- PARTNERSHIP
How To Deal With The Future

• INNOVATION

• RISKS

• EXPANSION/GROWTH

Theresa M. Forster
VP Hospice Policy & Programs
NAHC
tmf@nahc.org

Katie Wehri
Hospice Operations
NAHC
Katie@nahc.org
FY2016 Hospice Rule
HQRP Update

New Providers

• Effective FY2018 payment determination year
• Begin reporting quality data on date they receive their CCN notification letter