HOSPICE NEWS NETWORK

Recent News On End-of-Life Care

Volume 19, Number 20 June 16, 2015
A Service of State Hospice Organizations

MEDPAC RESPONDS TO CMS PROPOSAL ON HOSPICE PAYMENT RATE

MedPAC sent a letter to CMS responding to "the Centers for Medicare and Medicaid Services proposed rule entitled Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Report Requirements, *Federal Register*, Vol. 80, No. 86, 0. 25832 (May 5, 2015.)" (See HNN Volume 19, Number 17, May 5, 2015)

MedPAC agrees that changes are needed and cites a number of issues of concern within the current payment system.

- With more costs at beginning and end of hospice care, "Long stays in hospice are more profitable than short stays."
- Hospices can, if they wish, "focus on patient populations likely to have long stays and high profitability."
- **"**Substantial profit opportunities within the current payment system may have spurred for-profit provider entry into the hospice field and led some providers to pursue revenue-generation strategies such as enrolling patients likely to have long stays who may not meet the hospice eligibility criteria."
- Short hospice stays may result in reimbursement below cost under the current reimbursement plan.
- **"**The substantial profit opportunities from long stays and the less favorable reimbursement for short stays has led to wide variation in margins across providers based on the length of stay of their patients."

In response to the CMS proposal, MedPAC expresses support for changes to the "u-shaped pattern of hospice visits throughout an episode." MedPAC comments that the proposed changes are "modest and incremental" and will allow for changes when more is learned about how these changes work.

MedPAC urges CMS to include nursing facility patients in plans to offer additional payments in the last days of life, because "regardless of setting we would expect hospice patients to have increased needs for nursing support and symptom management in the last days of life."

"CMS has proposed that the episode day count would follow the patient if he or she switches providers or has a break in hospice enrollment of 60 days or less. For breaks in hospice enrollment of more than 60 days, CMS has proposed that upon re-enrollment the patient would begin a new episode and the hospice would be eligible for the higher RHC base rate for days 1-60," says MedPAC's letter. MedPAC agrees with this.

MedPAC agrees with higher reimbursements during the last the last seven days of life, but believes that payments during the last days of life should be based on the actual care received by patients from nurses and social workers.

MedPAC clearly calls for service intensity adjustments for all patients, including nursing home patients. The overall costs of serving nursing home patients would be better addressed, says the letter, by adjusting the routine home care payment for nursing home patients. "Analysis from our June 2013 Report to the Congress suggests that the RHC rates paid in nursing facilities should be lower than in the home due to the overlap in responsibilities between the hospice and the nursing facility staff."

While a variety of structures might "better align hospice payments with the u-shaped pattern of visits," MedPAC's letter says, CMS's proposal of "two base rates for RHC – a higher rate for the first 60 days and a lower rate for days 61 and beyond – is a reasonable initial approach."

MedPAC also urges CMS to move ahead quickly in implementation of the changes for FY 2016. The complete letter is available online. (MedPAC, 6/2, **http://www.medpac.gov/documents/comment-letters/medpac-comment-on-cms's-proposed-rule-on-the-hospice-wage-index-and-payment-rate-update-and-hospice-quality-report-requirements-2.pdf?sfvrsn=0;** *Federal Register*, 5/5, https://www.federalregister.gov/articles/2015/05/05/2015-10422/medicare-program-fy-2016-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting**)**

PHYSICIAN IS MOST IMPORTANT FACTOR FOR CANCER PATIENTS CHOOSING HOSPICE CARE

A new study in *Health Affairs,* completed by doctors at Brigham and Women's Hospital, finds that the most important factor for whether poor-prognosis cancer patients enter hospice is which physician is caring for them. If a doctor who is in the top 10% of hospice referrals cares for a patient, the patient is 27% more likely to enter hospice. This variance held true even when controlling for other factors such as age, ethnicity and geography.
The study examined almost 200,000 cancer patients nationwide.

The research findings have implications for both physician education and controlling healthcare costs, which tend to skyrocket at the end of life. Nearly a quarter of Medicare spending is for care in the last six months of life. **A small amount of focused education, says the article, could make a big difference in the number of patients choosing hospice care.** Fifty percent of cancer patients are seen by 10% of doctors. Encouraging those doctors to have conversations

about end-of-life options could substantially increase patients in hospice. Doctors, according to the researchers, tend to see death as failure and are therefore hesitant to send patients to hospice, where life-prolonging care is stopped.

There are also several structural factors that work against doctors sending patients to hospice. Doctors at for-profit hospitals send fewer patients to hospice because they make money from continued procedures and testing. Medical oncologists and doctors at not-for-profit hospitals, on the other hand, send a higher rate of their patients to hospice. Hospice use is also not encouraged by insurance companies, says the article, because insurers are more likely to pay for treatments than to pay for conversations about end-of-life care.

The National Hospice and Palliative Care Organization hopes to reach out to doctors with information about what hospice can offer their patients. We hear often from families, especially after patients have died, 'We wish we had known about this sooner,'" says executive vice president John Mastrojohn. "It's not just a matter of access, but timely access for patients and families." (*Health Affairs*, 6/2015, content.healthaffairs.org/content/34/6/993.abstract?sid=a3cddd28-8518-4eea-89e4-ba3191ae2737**;** *The Boston Globe*, 6/9, www.bostonglobe.com/metro/2015/06/08/doctors-play-pivotal-role-determining-end-life-decisions-brigham-study-finds/vlkw2Cb5urAtgguvp7n7QL/story.html**;** *Health Day*, 6/8, consumer.healthday.com/cancer-information-5/mis-cancer-news-102/briefs-emb-6-8-4pmet-doctors-end-of-life-care-health-affairs-bwh-release-batch-1782-700143.html**;)**

HOSPICE NOTES

***Circulation*, the American Heart Association journal, published a study showing that heart failure patients given a hospice referral on discharge where significantly less likely to be readmitted to the hospital within 30 days. T**his could make a significant impact on the numbers of patients readmitted to the hospice. Heart failure is the leading cause of readmittance to the hospital, but most eligible heart failure patients to not receive a hospice referral. (*Circulation*, 5/11, circheartfailure.ahajournals.org/content/early/2015/05/27/CIRCHEARTFAILURE.115.002153.abstract)

* **The Hospice Action Network and the National Hospice and Palliative Care Organization have announced their support for the newly introduced Care Planning Act of 2015.** The bill would support and encourage patients to have conversations with their families and care providers about their healthcare preferences. **"The Care Planning Act creates a new Medicare benefit called Planning Services for those with advanced illness, allowing for a team-based approach of care planning discussions with doctors, nurses, and other healthcare professionals. It also creates a pilot program for Advanced Illness Coordination Services to allow for home-based support of patients with multiple and complex chronic conditions."** HAN plans to lobby for the bill's passage. Additional resources are online at the links below. (*National Hospice and Palliative Care Organization*, 6/10, www.nhpco.org/press-room/press-releases/care-planning-act-introduced; *Hospice Action Network*, 6/11, http://hospiceactionnetwork.org/get-informed/supported-legislation/care-planning-act/)

*** An article in the *Dallas Morning News* examines Medicare fraud.** According to Mike Fields, U.S. Department of Health and Human Services' Department of the Inspector General, **Medicare abuse and waste in Dallas are often concentrated in the areas of home health care, hospice care and durable medical equipment.** A special team has been set up in Dallas to crack down on illegal schemes that cost Medicare more than half a billion dollars. The investigations in Dallas, ongoing since 2010, have resulted in 63 indictments and 43 convictions. (*The Dallas Morning News,* 6/11, www.dallasnews.com/business/health-care/20150611-medicare-fraud-is-often-cloaked-as-free-services-for-seniors.ece**)**

END-OF-LIFE NOTES

*** The number of Americans 50 and older that self identify as LGBT is expected to more than double by 2030.** This population comes with particular end-of-life challenges centered on "chronic health care, caregiving, financial security for long-term care, social isolation, building resiliency and where to find trusted help." (*PBS Newshour,* 6/11, www.pbs.org/newshour/updates/lgbt-older-adults-emerging-community/)

*** An article in *US News and World Review* encourages readers to complete basic tasks to prepare themselves and their loved ones for end-of-life decisions.** The article stresses the importance of having a designated spokesperson or decision maker. The article encourages readers to be sure to select someone who knows their wishes in sickness and death, and understands what decisions are likely to have to be made in either situation. (*U.S. News and World Report,* 6/8, health.usnews.com/health-news/patient-advice/articles/2015/06/08/end-of-life-wishes-what-everyone-needs-to-talk-about-but-no-one-wants-to)

*** A research letter in *JAMA Internal Medicine* examines how end-of-life directives impacted the treatment and mortality of pneumonia patients in a hospital setting.** "Almost half of the deaths occurred among patients who, at the time of admission, had appropriately decided to forgo aggressive treatment. The deaths of these patients cannot be assumed to represent poor-quality care because survival was not necessarily the goal of therapy. In many other cases, care was ultimately withdrawn, but we were unable to determine whether the overall quality of care contributed to the patient's death," the researchers wrote. Researchers also suggested that enhanced mortality measures be used to take into account patients' wishes for treatment and end-of-life care. (*MD Magazine,* 6/6, www.hcplive.com/journals/internal-medicine-world-report/2015/May-2015/Pneumonia-Death-in-Hospitalized-Patients-with-End-of-Life-Care-Preferences-)

*** The new Israeli film "The Farewell Party" examines serious issues such as assisted suicide, dementia and terminal illness.** The movie exposes the complexity of end-of-life decisions. (*The Boston Globe,* 6/11, www.bostonglobe.com/arts/movies/2015/06/11/farewell-party-celebrates-value-life-and-eath/H3th39PiUEgcWP3k4fz0FN/story.html?s_campaign=8315)

* The new book **"Birth, Breath and Death: Meditations on Motherhood, Chaplaincy and Life as a Doula" is penned by Amy Wright Glenn.** Glenn explores her experiences of both helping women giving birth and being present when someone dies. She explains the connections

she sees between the two. (*Huffington Post*, 6/8, www.huffingtonpost.com/-camalo-gaskin/how-to-care-at-the-beginn_b_7502572.html)

* **"Wishes To Die For: Expanding Upon Doing Less in Advanced Care Directives"** is a new book by Dr. Kevin J. Haselhort. He writes on the value of having advanced directives that are fluid and that change with our health, age and life situation. (*Inforum*, 6/7; www.inforum.com/shesays/3760376-minding-our-elders-why-end-life-documents-should-be-fluid)

PHYSICIAN ASSISTED SUICIDE NOTES

***The Tennessee legislature is considering a bill to allow physician assisted suicide in the state.** The Senate Health and Welfare Committee heard testimony from both supporters and detractors as they learned about the bill. The bill will not be considered again until the General Assembly reconvenes in January. (*The Tennessean*, 6/9, www.tennessean.com/story/news/politics/2015/06/09/tenn-physician-assisted-death-law-anything-certain/28763851/)

*** *The New York Times* published an opinion piece by actress and author Annabelle Gurwitch, who supports California's law to legalize physician-assisted suicide. Gurwitch recounts the efforts that she and a group of friends made in assisting a friend in death.** She details the circumstances and events, and shares some of the unwanted outcomes of the experience. She writes, "If medical aid in dying had been legal, her doctor could have written the right prescription and allowed her to have the more graceful exit she wanted. Still, as imperfect as it was, we gave her a memorable send-off." (*The New York Times*, 6/10, opinionator.blogs.nytimes.com/2015/06/10/death-without-dignity/?ref=opinion&_r=0)

OTHER NOTES

***Writing on *Pallimed*, Gary Buckholz, family physician and palliative care specialist, expresses his concern about the American Academy of Family Physician's recent recommendation that no fellowships be provided for secondary certificate programs, including hospice and palliative care.** Because trainees do not bill for their services, he argues, funding for fellowships is vital for primary care physicians gaining additional certifications. Buckholz sees geriatric and palliative care as being important parts of his practice as a primary care physician. (*Pallimed*, 6/5, www.pallimed.org/2015/06/aafp-opposes-funding-for-hospice-and.html)

***A new study from the Health Policy Institute at the University of California, San Francisco anticipates the need for at least 2.5 million more long-term care workers by 2030.** The biggest expected need is in home health and personal care workers. One author of the study expresses concern, saying, "These are currently very low-paid, high-turnover, entry-level positions. A lot of people in these jobs are living in poverty while working full time. We have to figure out how to make them sustainable. (*HealthDay*, 6/8, consumer.healthday.com/senior-

citizen-information-31/misc-aging-news-10/millions-more-long-term-care-workers-needed-by-2030-700135.html)

*** Charles Ornstein, speaking on *NPR's All Things Considered,* reflects on his parents' undeleted voice mails he discovered on his cell phone after their deaths.** The messages are meaningful to him because they capture everyday, mundane things and were such an unexpected connection with his deceased family members. (*NPR*, 5/25, www.npr.org/sections/alltechconsidered/2015/05/25/408845097/kiss-everybody-voice-mails-live-on-after-parents-are-gone)

* **An article in *General Surgical News* explores the ethical and practical difficulties in decision-making about providing surgery to frail, very old, and critically-ill persons.** Margaret Schwartz, MD, observed the poor outcomes that surgery can have on these patients. Schwartz, via focus groups of surgeons, and her own experiences and observations, feels the determination of surgery is especially difficult because of the uncertainty of outcomes and the difficulties in assessing quality of life. **"This," says the article, "is why having a conversation with the patient, the family and, occasionally, the consulting physician is so critical to delivering the best possible care. In some instances, this conversation can save a patient from undergoing a costly procedure that likely will not improve his or her life."** (*General Surgical News*, June 2015, www.generalsurgerynews.com/ViewArticle.aspx?d=In+the+News&d_id=69&i=June+2015&i_id=1197&a_id=32602)

Thanks to Kathy McMahon for contributions.