Harnessing the Power of Data for Hospice Leaders, Part 2

In Partnership with: THE HOPE of WISCONSIN
The Hospice Organization and Palliative Experts of Wisconsin

Cordt T. Kassner, PhD
Principal, Hospice Analytics

2011 HOPE Fall Conference
October 26, 2011

Introduction & Background

Cordt T. Kassner, PhD

Principal
Hospice Analytics
2355 Rossmere Street
Colorado Springs, CO 80919
P: 719.209.1237
E: CKassner@HospiceAnalytics.com
W: www.HospiceAnalytics.com

HOSPICE ANALYTICS MARKET REPORT

Letter to the Editor

JPSM, published 6/11

Abernethy AP, Kassner CT, Whitten E, Bull J, Taylor DH

- **Systemic Cost:** From a policy standpoint, it is most important to consider hospice expenditures in the context of the "systemic cost" of end-of-life care, that is, the total cost of care from all care settings for the patient who dies on a specific service (especially important given the cross-over of patients from one setting to another, making clear distinctions of hospice and non-hospice problematic).
- **Hospice Cost Savings:** Aggregate cost analyses support continued and substantial Medicare spending on hospice care, both to enhance end-of-life experiences for patients and their loved ones and to make end-of-life care more affordable. Notably a North Carolina patient receiving end-of-life care through hospice received $11,354 less in care paid for by Medicare than did a patient receiving hospital-based care.
- **Death Service Ratio:** DSR offers a simple and pragmatic measure for monitoring hospice utilization, tying change in utilization to cost reduction/increase, and, with further development, monitoring quality of care, access, disparities, and performance against national benchmarks. We found that, in the 10% of counties with highest DSR compared to all counties, per patient hospice costs were higher (mean $8,063 vs. $7,031; difference of $1,032) but hospital costs were lower (mean $24,567 vs. $27,632; difference of -$3,065). On balance, in counties with higher use of hospice, the use of hospital care was reduced; this observation is consistent with a hypothesis that increased hospice use reduces overall Medicare costs at the end of life. Further, we found evidence that external grant funding to support the development of hospice and palliative care was related to increase in hospice use, which correlated with the cost savings observed in these counties.

Presentation Outline

Part 1: Connecting Clinical Care to National Policy

1. In the Beginning… Early Questions & Answers
2. Data Available
3. Data Applications for Hospice Administrators

Part II: Connecting National Policy to Clinical Care

1. **WFA (Nursing Facilities, Caps, Long LOS, DC Alive)**
1. MedPAC (Net Margins, U-Shaped Curves)
2. Palliative Care
3. Dartmouth Atlas

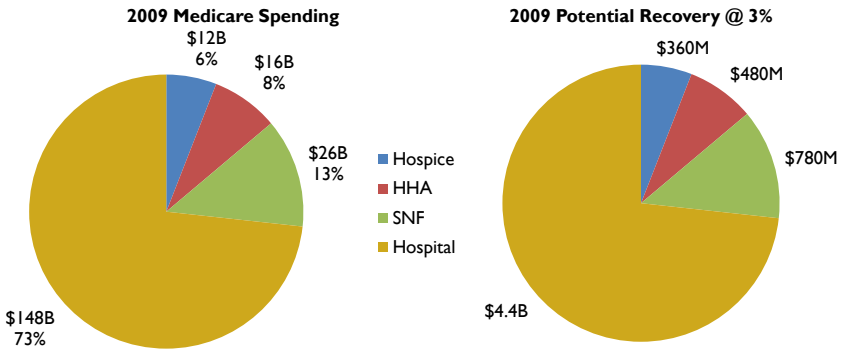
Hospice Waste, Fraud, and Abuse
The Problem

- In 2007, $2.26 trillion was spent on health care
- The National Health Care Anti-Fraud Association (NHCAA) *conservatively* estimates 3% of total health care spending ($68 billion) is lost per year to health care fraud
- Other estimates by government and law enforcement agencies estimate up to 10% of total health care spending ($226 billion) may be lost per year to health care fraud

(http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centr&wpscode=TheProblemOfHCFraud)

Hospice Waste, Fraud, and Abuse
Potential Recovery

2009 Medicare spending and potential recovery of fraudulent funds using the National Health Care Anti-Fraud Association's estimate of 3%:



Hospice Waste, Fraud, and Abuse
Actual Recovery

- Between 1987 – 2008, the US Department of Justice's Civil Division reported recovery of $21.6 billion, averaging $1.7 billion / year over the past 5 years
- $1.7B / $68B = **2.5%** of potential fraud is actually recovered

http://www.taf.org/FCA-stats-DoJ-2008.pdf

- During FY 2010, the HHS / DOJ national Health Care Fraud and Abuse Control Program won or negotiated ~$2.6 billion in health care fraud judgments and settlements
- In FY 2010, the DOJ had 1,767 health care fraud criminal investigations pending involving 2,977 potential defendants, and opened 942 new civil investigations
- 726 defendants were convicted in criminal investigations

http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf

Hospice Waste, Fraud, and Abuse
Actual Recovery

FY 2010 Health Care Fraud and Abuse Control Program Report:

- Hospice not mentioned in this 90-page report
- DME & HIV Infusion Therapy Providers:
  - Miami, Los Angeles, Detroit, Houston, Brooklyn, Baton Rouge, Tampa
  - 140 indictments against 284 defendants who billed Medicare $590 million
  - 217 guilty pleas negotiated, 19 jury trials litigated – winning guilty verdicts against 23 defendants
  - 146 defendants imprisoned averaging more than 40 months of incarceration
  - At least $62 million recovered in restitution

http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf

Hospice Waste, Fraud, and Abuse
Actual Recovery

FY 2010 Health Care Fraud and Abuse Control Program Report:

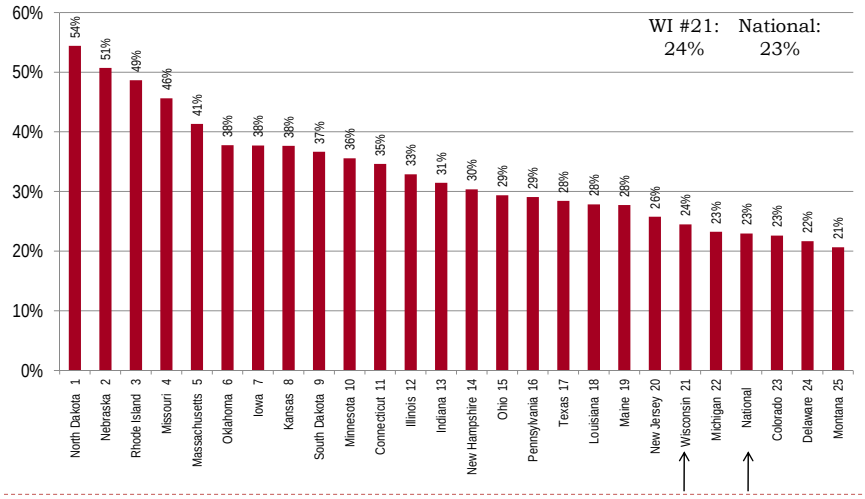
- Pharmaceuticals & Devices:
  - Allergan / Botox: $600 million paid to resolve guilty plea to misdemeanor misbranding
  - Novartis / 6 products: $185 million paid to resolve guilty plea to misdemeanor misbranding
  - AstraZeneca / Seroquel: $520 million to resolve allegations of off-label use and physician kickbacks
  - 17 cases

http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf

Hospice Waste, Fraud, and Abuse
Questions…

- Do estimates of all health care fraud (3%-10%) apply to Medicare?
  To Medicare Hospice? More / Same / Less?
- Do estimates of fraud recovery (2.5%) apply to Medicare?
  To Medicare Hospice? More / Same / Less?
- New "Exposure Reports" available.

2009 Medicare Percentage Beneficiaries Hospices Reported Caring for in Nursing Facilities



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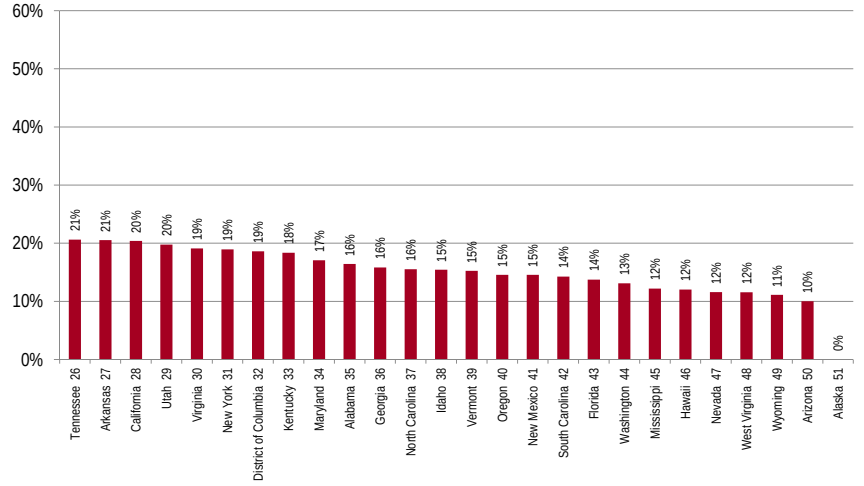
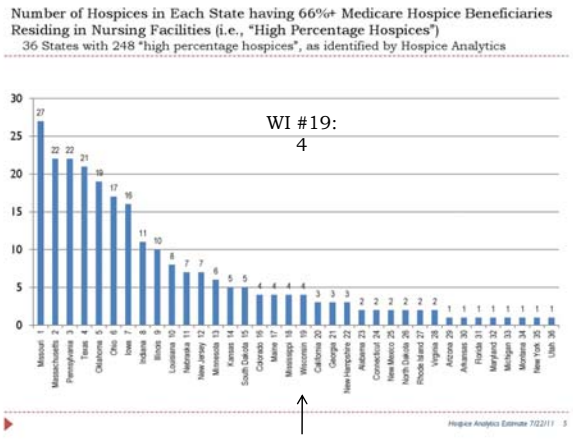


"High Percentage Hospices" per the 7/19/11 OIG Hospice in Nursing Facilities Report
Cordt T. Kassner, PhD, Principal of Hospice Analytics



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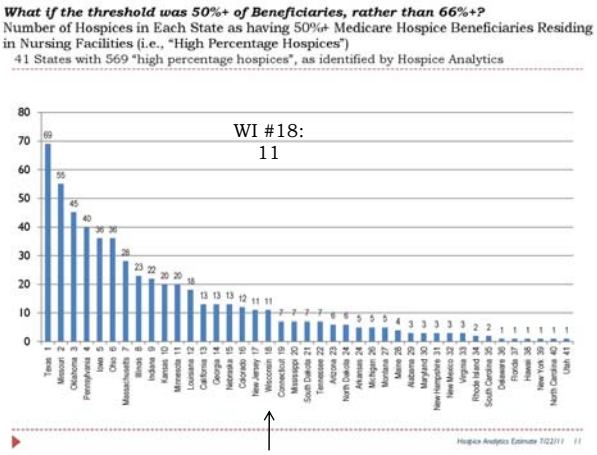


Palliative Care Best Practice – LTC / Hospice, 1

Palliative Care Best Practice – LTC / Hospice

Colorado Health Care Association/Colorado Center for Hospice & Palliative Care

CHCA QIS Committee February 2008

RELEVANT FEDERAL AND STATE REGULATIONS	**F309,310,311,312,314,315,317,318,319,320,325,327,329-regarding Quality of Care (F309-revised guidance regarding pain). F279 regarding Coordinated and Comprehensive Care Plans. F241 and 242 regarding Quality of Life**
RELEVANT AHCA / CHCA STANDARDS OF CARE	**CHCA Publications: Pathways to Excellence AHCA Publications at: http://www.ahcancal.org/facility_operations/clinical_practice**
RELEVANT NHPCO / COCHPC STANDARDS OF CARE	**Hospice Care in Nursing Facilities (Volume 2, $75.00) Publisher-NHPCO available at NHPCO Marketplace National Hospice & Palliative Care Organization Quality Partners, Appendix II Nursing Facility Hospice Care, www.nhpco.org .**
RELEVANT JCAHO REQUIREMENTS	**Provision of Care Standards; PC.5.10, PC.8.10, PC.8.70**
ADDITIONAL RESOURCES	**Hospice in a Skilled Nursing Facility – a model for success; http://www.cdphe.state.co.us/hf/download/hospicenh.pdf CFMC/QIO information regarding pain management: http://www.medqic.org http://cfmc.org See Appendices for further references/resources**

Palliative Care Best Practice – LTC / Hospice, 2

PALLIATIVE CARE TIMELINE	Highly Recommended	Optional	Practices
ADMISSION	X X X	 X X	1) **Advance Care Planning – ranging from treatment practices to funeral services - What is in place? - CPR Directive, Living Will, MDPOA, POLST** 2) **Assessment of current medical and functional status** 3) **Administer MDS at admission and calculate Flacker Mortality Scale from it. Administer quarterly thereafter until Flacker Scale results identify a prognosis of 12 months or less.** 4) **Life review and Legacy planning discussions** 5) **Vision Mapping**
QUARTERLY	X X		1) **Re-administration of MDS and re-calculate Flacker Mortality Scale.** 2) **Review Advance Care Plan – is it still current and appropriate.**
12-MONTH PROGNOSIS	X	X	1) **Discussion with resident and family of current prognosis and goals of care** 2) **Palliative care consultation.**
6-MONTH PROGNOSIS	X X X X X		1) **Explanation of hospice, hospice services, and resident choice of services** 2) **Re-evaluate the patients understanding of the disease process, expectations, goals and values; Advance Directives (Clarify preferences: hospitalization, antibiotics, IV fluids, nutrition, etc.)** 3) **What is Hospice Care?** 4) **Developing coordinated Plan of Care** 5) **Aggressive management of symptoms, pain, and suffering**
DEATH PRACTICES	X X X	 X	1) **Informing residents of pending deaths and allowing them to say goodbye** 2) **Create a consistent practice done upon death – ringing a bell, etc.** 3) **Ideas and examples for death practices and memorials**
BEREAVEMENT	X X X		1) **Resident family** 2) **Resident community** 3) **LTC staff**
APPENDIX			1) **Resources for Understanding and Accommodating Religious, Cultural, and Ethnic Variations** 2) **Resources for Conducting Difficult Conversations** 3) **Resources for Life Review, including scan of Vision Map** 4) **Resources for Palliative Care & Hospice in the Long-Term Care Setting** 5) **Palliative and Hospice Care Resources** 6) **Hospices Providers in Colorado** 7) **Hospices by County**

Palliative Care Best Practice – LTC / Hospice, 3

- This tool is currently being updated and will be available in print and online ~October 1, 2011. For additional information, please contact:
  - Jennifer Ballentine, MA, Executive Director of the Life Quality Institute, at phone 303-398-6317 or email jballentine@lifequalityinstitute.org.
  - Web site: www.LifeQualityInstitute.org.

2009 Estimated Cap on Aggregate Hospice Reimbursement

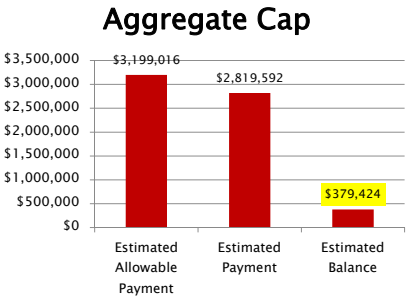
The Regulation

- The cap period runs from November 1st of each year through October 31st of the next year. The total payment made for services furnished to Medicare Beneficiaries during this period are compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice.
- The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.
- The beneficiary must file an initial election during the period beginning 9/28 of the previous cay year through 9/27 of the current cap year.
- When a beneficiary elects to receive hospice benefits from two or more different Medicare certified hospices, proportional application of the cap amount is necessary.
- Medicare Claims Processing Manual; Rev. 1738; 5/15/09; p. 36. See Manual for additional detail, particularly if maximum is exceeded.

Should you be concerned?

Yes (WI Hospice)

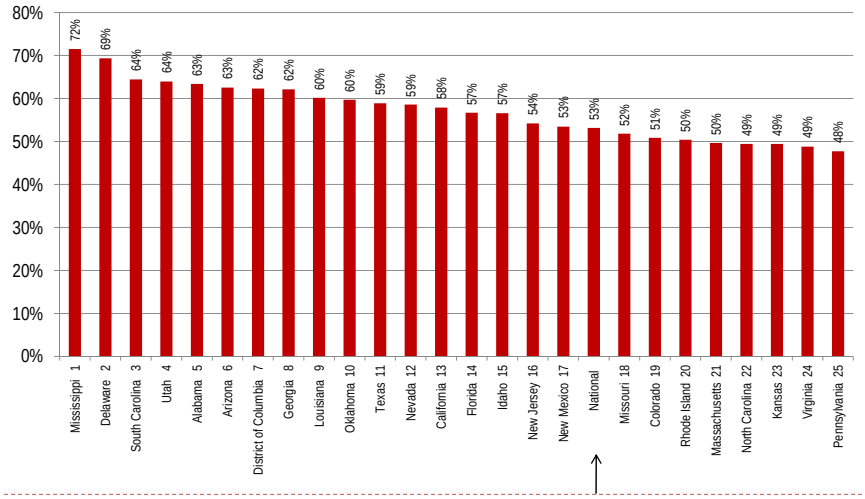
Operating at 88%-108% of overall cap.



- Estimated Allowable Payment= Total Patients x 2009 Cap Amount ($23,014.50).
- Estimated Payment= Total Medicare Payments.
- National mean hospice cap on overall hospice reimbursement percentage (estimated payment/estimated allowable payment)= **53%**.

2009 Estimated Hospice Aggregate Caps

National= 53%; WI= 47% (#27)
Adjust Similar to MedPAC= +20%



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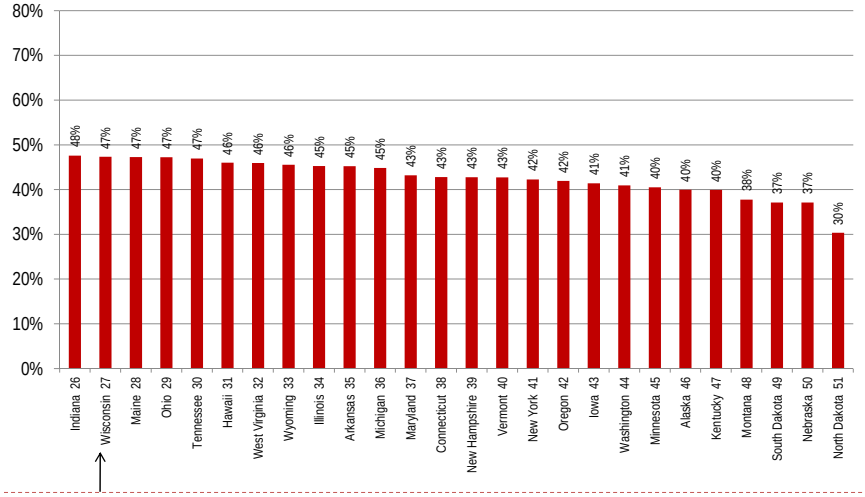
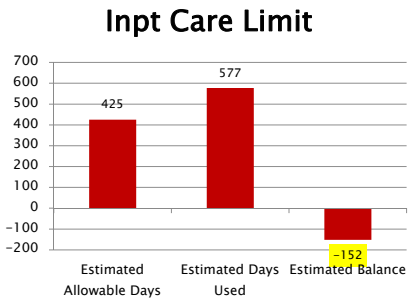


2009 Estimated Limitations on Payments for Inpatient Care

The Regulation

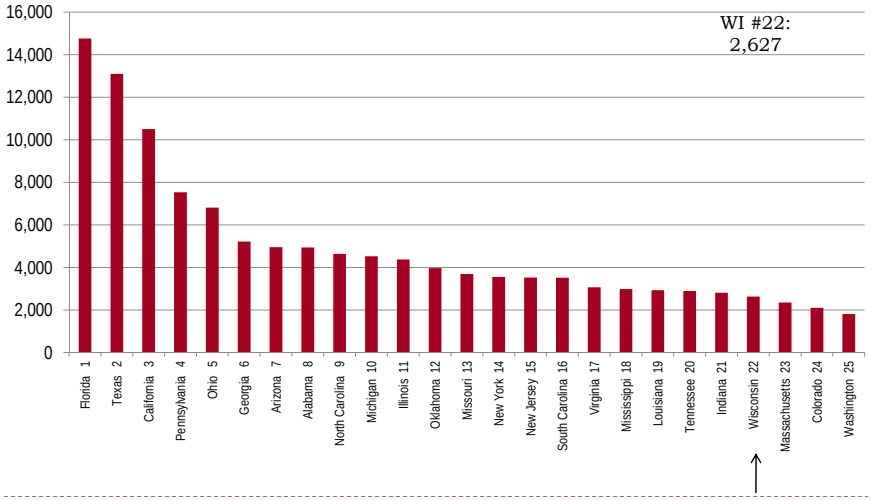
- During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicare beneficiaries during that same period.
- Calculated by the FI as follows: The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicare hospice care by 0.2.
- Medicare Claims Processing Manual; Rev. 1738; 5/15/09; p. 35. See Manual for additional detail, particularly if maximum is exceeded.

Should you be concerned? Yes
(Different WI Hospice), Est. Payback= $59,395
Operating at ~136% of Inpatient Limit



- Estimated Allowable Days= Total Days x 0.20.
- Estimated Days Used= Total GI + Respite Days.
- National mean limit on payments for inpatient care (estimated days used / estimated allowable days)= **10%**.

2009 Physician F2F Narratives for Patients at 180 Days
Who Does That Impact? Shown by Total Number of Patients
National= 148,323 (13% of all hospice patients)



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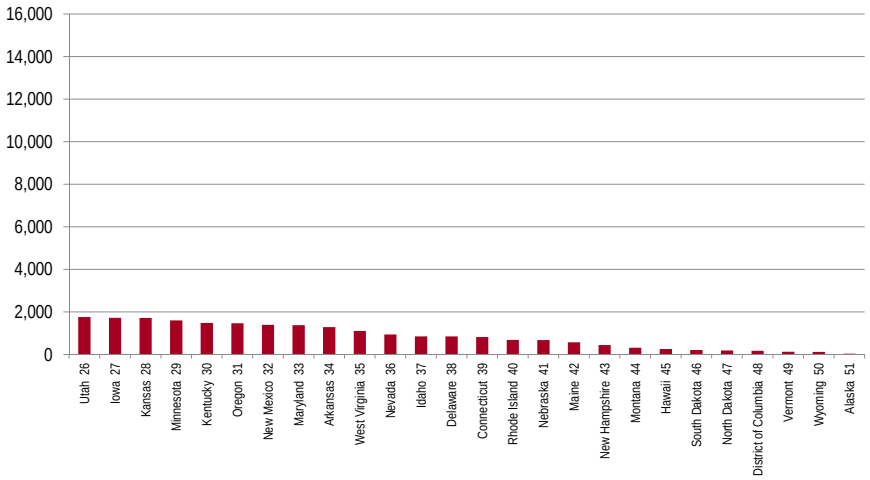

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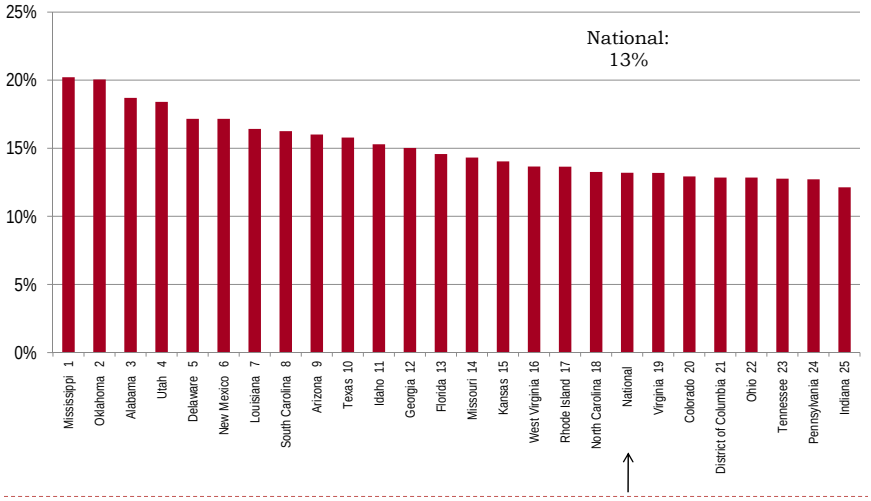

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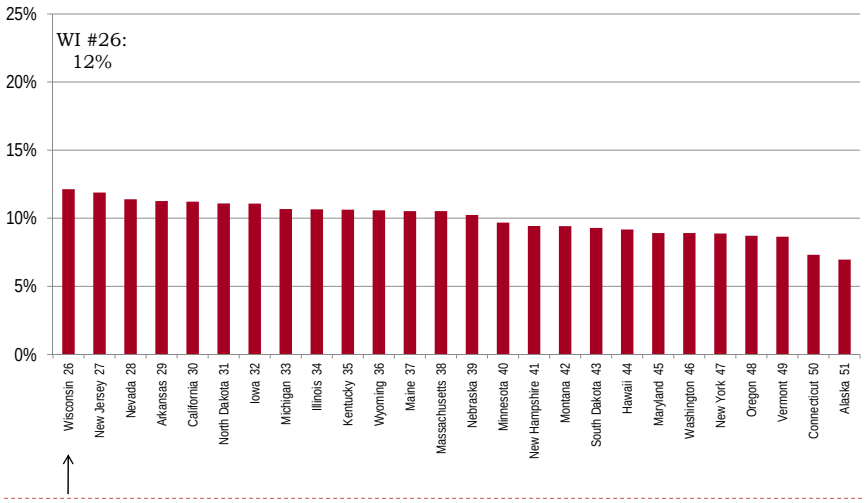
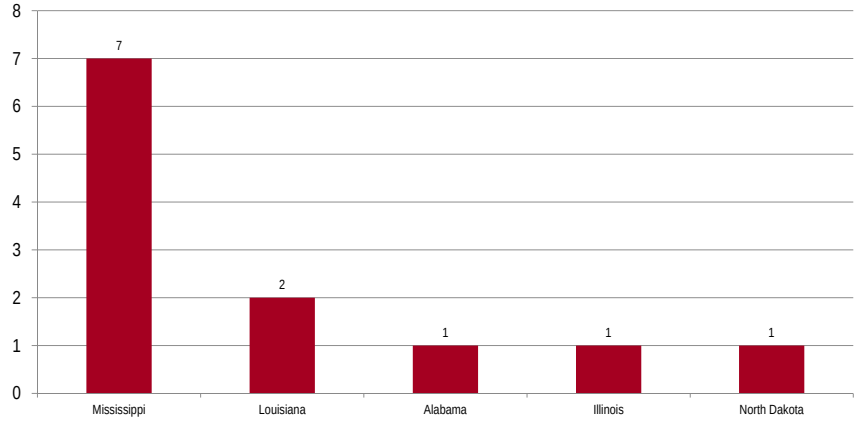


2009 Targeted Medical Review for All Patients With LOS >180 Days

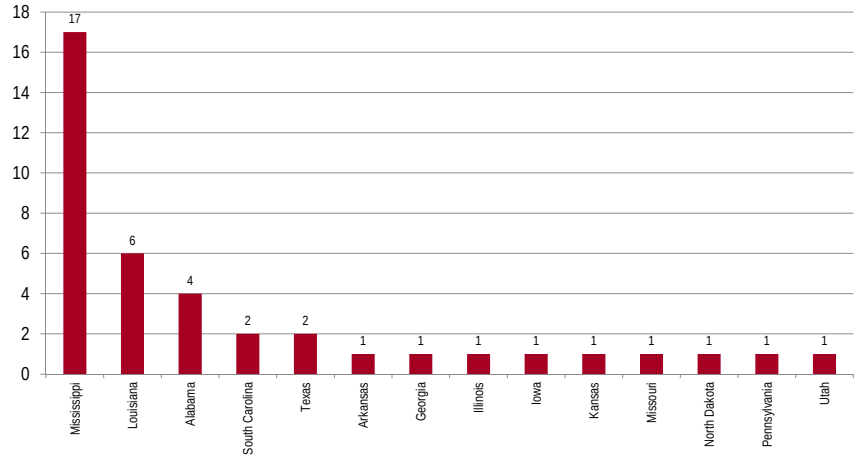
If XX Percentage of Patients Exceed LOS 180 Days. If the Percentage= 50%,

How Many Hospices Are At Risk? National= 12 (0.3%)



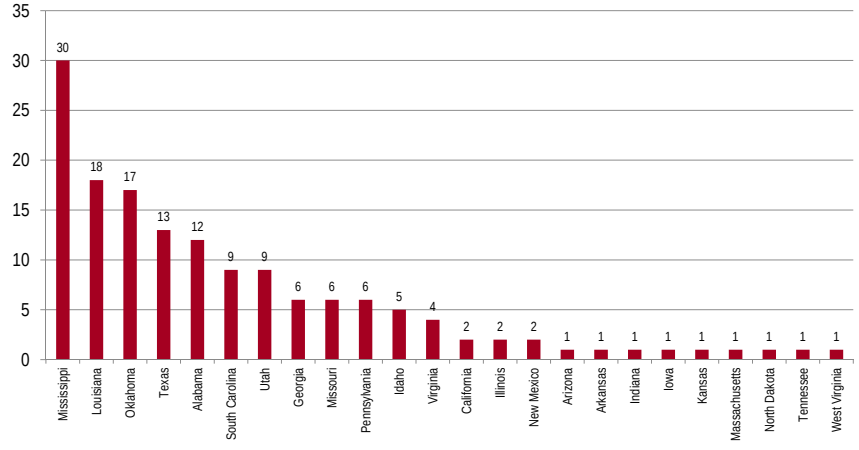
2009 Targeted Medical Review for All Patients With LOS >180 Days

If XX Percentage of Patients Exceed LOS 180 Days. If the Percentage= 40%, How Many Hospices Are At Risk? National= 45 (1%)



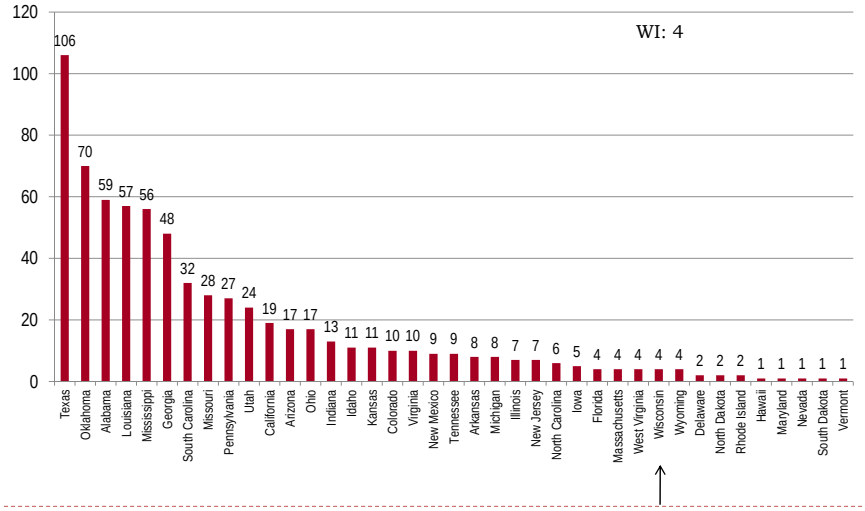
2009 Targeted Medical Review for All Patients With LOS >180 Days

If XX Percentage of Patients Exceed LOS 180 Days. If the Percentage= 30%, How Many Hospices Are At Risk? National= 165 (5%)



2009 Targeted Medical Review for All Patients With LOS >180 Days

If XX Percentage of Patients Exceed LOS 180 Days. If the Percentage= 20%, How Many Hospices Are At Risk? National= 736 (22%)

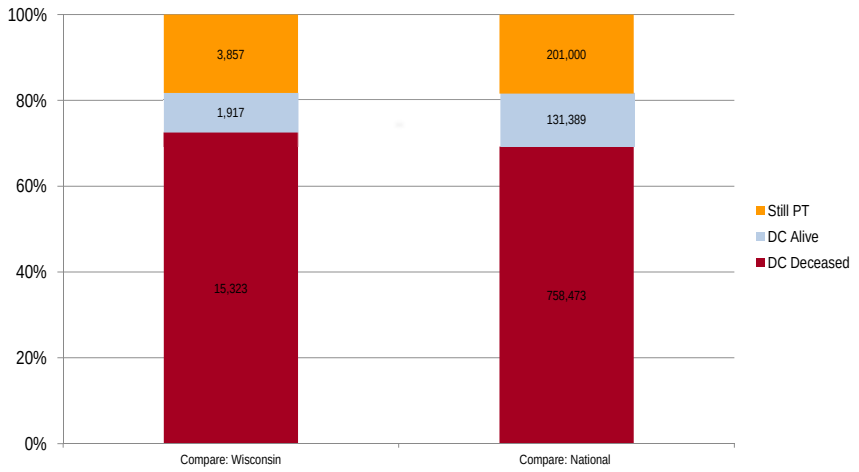


2009 Targeted Medical Review for All Patients With LOS >180

Which States Are NOT at Risk If the Percentage= 20%?

1. Alaska
2. Connecticut
3. District of Columbia
4. Kentucky
5. Maine
6. Minnesota
7. Montana
8. Nebraska
9. New Hampshire
10. New York
11. Oregon
12. Washington

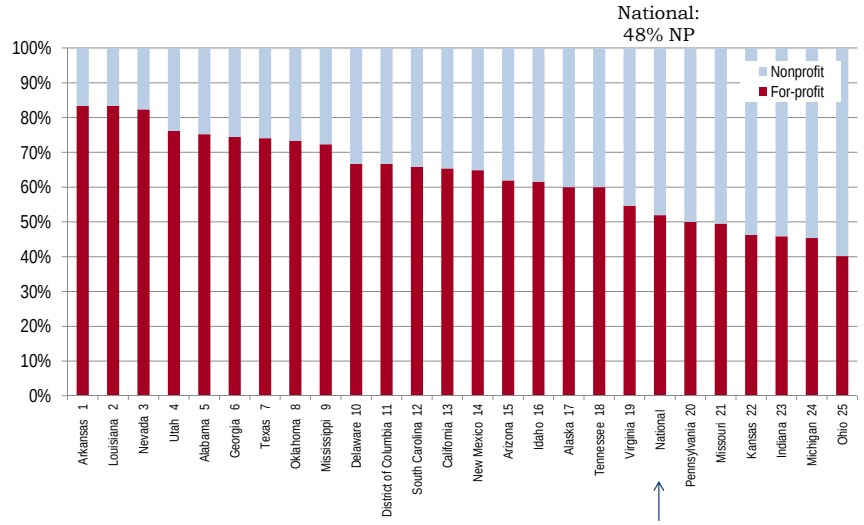
2009 Patient Status at Discharge



Hospice Beneficiaries Discharged Alive: All Hospices

- 3,336 Medicare certified hospices served beneficiaries in 2009
  - 1,603 (48%) were nonprofit, government, or other
  - 1,733 (52%) were for-profit
- All 3,336 hospices' mean discharged alive percentage= **19.3%**
  - 1,603 nonprofit hospices mean discharged alive percentage= **15.1%**
  - 1,733 for-profit hospices mean discharged alive percentage= **23.2%**

2009 Medicare Hospices: All Hospices
Percentage Nonprofit / For-profit Hospices by State
National= 3,336 Hospices; 1,603 Nonprofit, 1,733 For-profit



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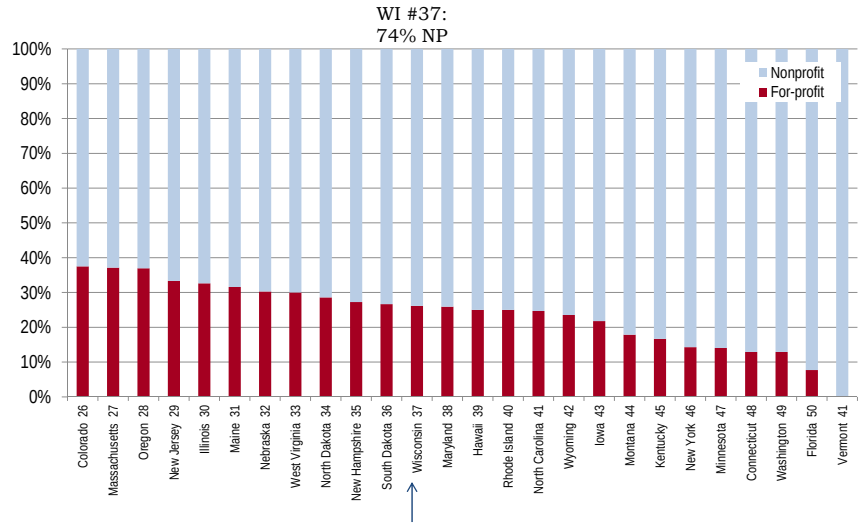
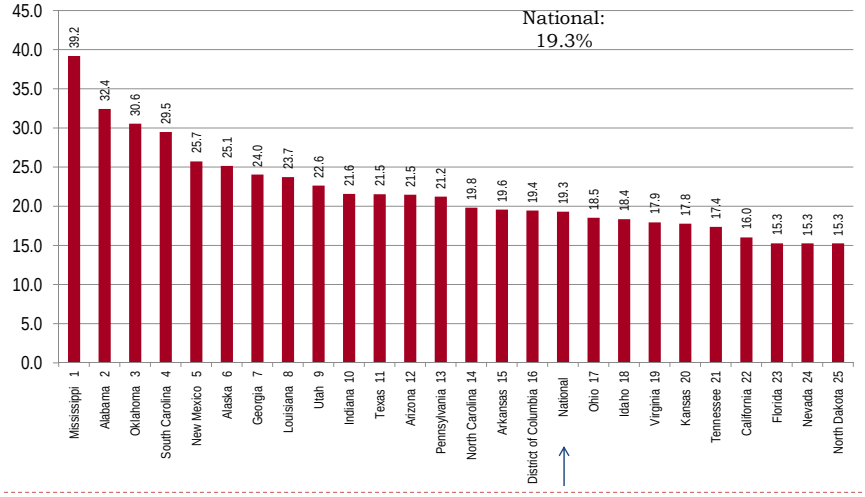


2009 Medicare Hospices: All Hospices
Mean Hospice Discharged Alive Percentage by State
National= 3,336 Hospices; Mean= 19.3% Discharged Alive



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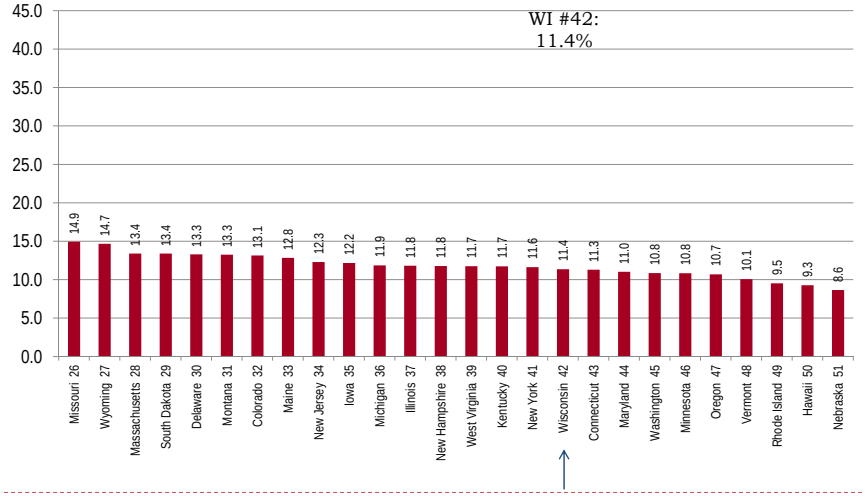
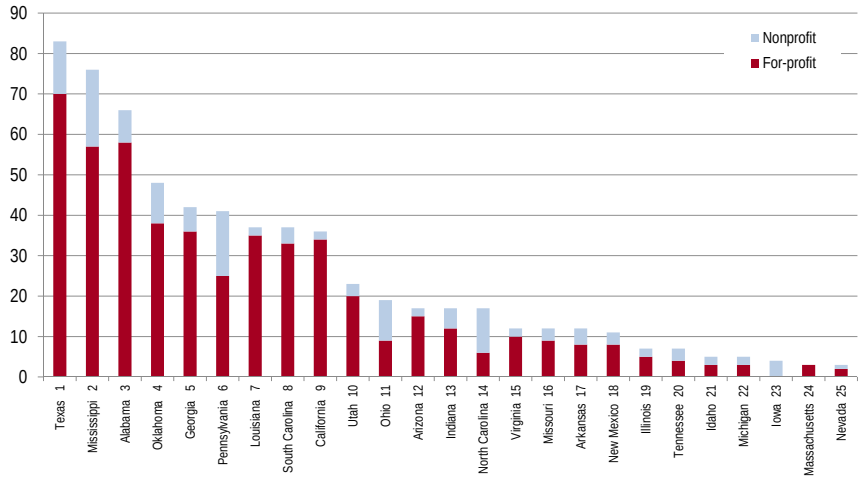


Results: Hospices >25% Discharged Alive

- **690 / 3,336 (21%)** Medicare certified hospices served beneficiaries in 2009
  - **171 / 690 (25%)** of hospices with ≥25% beneficiaries discharged alive were nonprofit, government, or other
  - **519 / 690 (75%)** of hospices with ≥25% beneficiaries discharged alive were for-profit
  - **171 / 1,603 (11%)** of all nonprofit, government or other hospices
  - **519 / 1,733 (30%)** of all for-profit hospices

2009 Medicare Hospices: Hospices With >25% DC Alive
Number Nonprofit / For-profit Hospices by State

National= 690 Hospices (21%); 171 Nonprofit, 519 For-profit



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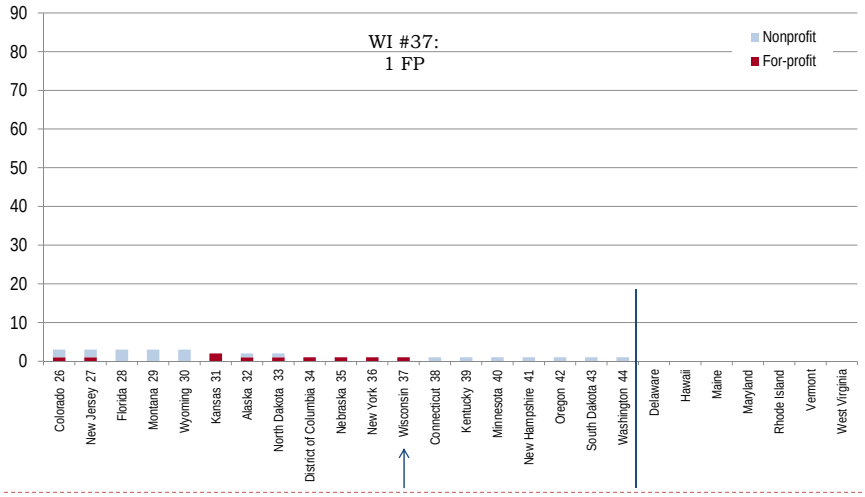

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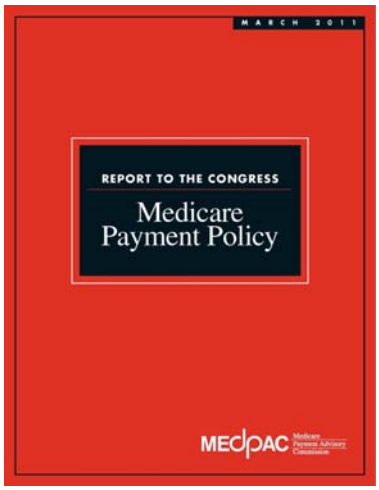
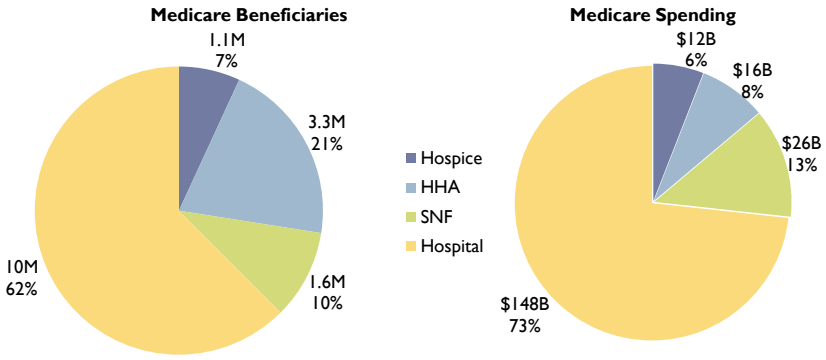
MedPAC's March 15, 2011 Report to Congress



Hospice Highlights

What might be impacting MedPAC reimbursement recommendations?



Mean Hospice $/PT= $10,909
Mean SNF $/PT= $16,250

Mean HHA $/PT= $4,848
Mean Hospital $/PT= $14,800

What Does MedPAC Consider?

	Hospice	Home Health	SNF	Cent Hospitals
Patients:	•ALL: Number of Patients, Payer, Age, Race, Gender, Urban / rural			
		•Episodes / therapies	*•Clinical complexity*	
Providers:	•ALL: Number of Providers, Nonprofit / for profit / gov, Urban / rural, Access to capital			
	•Freestanding / HHA-based / Hospital-based / SNF-based		*•Freestanding / Hospital-based*	*•Type of service* *•Employment* *•Teaching*
Spending:	•ALL: Total Medicare Spending, Average cost / day, Net margins – high / low			
	•Aggregate cap			
Length of Stay:	•ALL: Mean, Median			
Diagnosis	•ALL: Primary Diagnosis			
Discharge disposition	*•Live discharges*	*•Live discharges*	*•Community* *•Hospital*	*•Readmission rates*
Quality	*•NA* *•Growing concern regarding waste, fraud, and abuse in hospice*	*•Fraud and abuse challenges – temp. moratorium for new providers, suspension of payments to providers with high risk of fraud* *•Functional measures* *•Adverse events*	*•Percent discharged to community* *•Percent re-hospitalized for any of 5 conditions* *•"Efficient providers"*	*•Mortality rates* *•Patient safety indicators* *•Patient satisfaction* *•Readmission rates* *•"Efficient providers"* *•Value-based incentive pay*

Hospice Highlights

1. The Congress should update the payment rates for hospice for fiscal year 2012 by 1 percent.
2. The Congress should direct the Secretary to change the Medicare payment system for hospice to:
   A. have relatively higher payments per day at the beginning of the episode and relatively lower payments per day as the length of the episode increases,
   B. include a relatively higher payment for the costs associated with patient death at the end of the episode, and
   C. implement the payment system changes in 2013, with a brief transitional period.
   D. These payment system changes should be implemented in a budget neutral manner in the first year. *(First recommended in March 2009)*
3. The Secretary should direct the HHS Office of Inspector General to investigate:
   A. the prevalence of financial relationships between hospices and long-term care facilities such as nursing facilities and assisted living facilities that may represent a conflict of interest and influence admissions to hospice,
   B. differences in patterns of nursing home referrals to hospice,
   C. the appropriateness of enrollment practices for hospices with unusual utilization patterns (e.g., high frequency of very long stays, very short stays, or enrollment of patients discharged from other hospices), and
   D. the appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admissions practices. *(First recommended in March 2009)*

Hospice Highlights

1. The Congress should update the payment rates for hospice for fiscal year 2012 by 1 percent.

Historical Trend:

	MedPAC Recommendation	Market Basket Adjustment
2012	+1%	+2.5%
2011	+2.6%	+2.6%
2010	NA	+2.1%
2009	NA	+3.6%
2008	NA	+3.3%
2007	NA	+3.4%
2006	NA	+3.7%
2005	NA	+3.3%

Hospice Highlights

MedPAC reimbursement recommendations for other industries:

	Hospice	Home Health	SNF	Hospital
2012	+1%	0%	0%	+1%
2011	+2.6%	0%	0%	+2.4%
2010	NA	0%	0%	2.7%
2009	NA	0%	0%	3.0%

Note: Per 8/4/11 *CMS Provider e-news*:

On Fri July 29, CMS today announced a final rule reducing Medicare skilled nursing facility (SNF) Prospective Payment System (PPS) payments in FY2012 by $3.87 billion, 11.1 percent lower than payments for FY2011. The FY2012 rates correct for an unintended spike in payment levels and better align Medicare payments with costs.

"CMS is committed to providing high quality care to those in skilled nursing facilities and to pay those facilities properly for that care," said CMS Administrator Donald M Berwick, MD. "The adjustments to the payment rates for next year reflect that policy."

Hospice Highlights

What might be impacting MedPAC reimbursement recommendations?

Net Margins:

	Hospice	Home Health	SNF	Hospital
2009	NA	17.7%	18.1%	-5.2%
2008	5.1%	17.0%	16.6%	-7.1%
2007	5.8%	16.5%	14.7%	-6.0%
2006	6.4%	15.9%	13.3%	-4.7%
2005	4.6%	17.3%	13.0%	-3.1%

* MedPAC has commented that 10%+ net margins are too high

Hospice Highlights

Hospice Net Margins:

	2008 Net Margin
All	5.1%
Freestanding	8.0%
Home health based	2.7%
Hospital based	-12.2%
For profit (all)	*10.0%*
For profit (freestanding)	*11.3%*
Nonprofit (all)	0.2%
Nonprofit (freestanding)	3.2%
Urban	5.6%
Rural	1.3%
Below cap	5.5%
Above cap (excluding cap overpayments)	1.0%
Above cap (including cap overpayments)	*19%*

Summary of MedPAC's March 2011 Report to Congress

Key Points	Findings / Recommendations
MedPAC is an independent Congressional agency established to advise the U.S. Congress on issues affecting the Medicare program. MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.	MedPAC is analyzing hospice and trying to develop a reimbursement model intending to increase access to hospice care, improve the quality of hospice care, and to reduce waste, fraud, and abuse within the Medicare Hospice Benefit.
The growth of hospice – now exceeding $10B.	Annual review of hospice and inclusion in March Congressional Reports.
The numbers of hospice patients, length of stay, and providers are all growing.	This suggests growing awareness of hospice services, although length of stay has increased almost exclusively among those with long LOS, and new providers are almost exclusively for profit providers.
Limited data to assess the quality of hospice care.	The PPACA of 2010 mandates that CMS publish quality measure in 2012 and hospices will be required to report quality data in FY2014.
Hospice net margins are increasing, although there is significant variance between provider types.	Hospice mean net margin= 5.1%; although nonprofits= 0.2% and for profits= 10.0%.

What Is The U-Shaped Curve Intended To Do?

MedPAC's 3/11 Report to Congress	Recommendation / U-Shaped Curve
Compared with the current hospice payment system, this payment model would: 1. Result in a much stronger relationship between Medicare payments and hospices' level of effort in providing care throughout an episode, and 2. Promote stays of a length consistent with hospice as an end-of-life benefit.	1. Intuitively it makes sense that more intensive hospice services would be provided on admission and death, and this is consistent with some preliminary data provided to MedPAC. However, NHPCO has conducted a study that suggests relatively stable amounts of hospice services provided across the admission – perhaps like an ICU. So we don't know… 2. What exactly does this mean…?

What Is The U-Shaped Curve Intended To Do?

MedPAC's 3/11 Report to Congress	Recommendation / U-Shaped Curve
This second point ties MedPAC's role of analyzing Medicare services and making reimbursement recommendations to the mission, purpose, and integrity of the Medicare Hospice Benefit.	It appears that MedPAC is hoping the U-Shaped Curve helps reduce outliers and align the hospice industry according to the MHB's purpose. Perhaps other areas of the MedPAC report give insight into some of the inequalities: • Increased spending due to increased beneficiaries served, although minorities and those in rural areas receive less hospice, and there is an increase in non-cancer diagnoses. • Nearly all provider growth has been among for-profits. • Nearly all LOS change has been in the 4th quartile (75%+). • Increasing numbers of hospices exceeding caps. • Increasing numbers of beneficiaries discharged alive. • Hospice net margins have remained fairly stable between 2002-2008, with the greatest difference between nonprofit (0.2%) and for-profit (10.0%) providers.

Reimbursement Methodologies

- Flat reimbursement cuts (i.e., cuts applied evenly across all hospices) hurt those with the smallest net margins the fastest and hardest.
  - Eliminating the Budget Neutrality Adjustment Factor and imposing Productivity Factor Cuts are flat cuts with tremendous negative impact on all hospices. NHPCO released a study in March 2011 projecting median hospice profit margins will decrease 10% or more by 2019, and that 60%+ of hospices will have negative profit margins by 2019.
  - Community Hospice Partnership conducted a similar study last year and had similar findings. CHP projects the impact of these cuts will quickly close nonprofit and rural hospices (i.e., those with the smallest margins).
- Alternatives to flat reimbursement cuts may help – or they may not.
  - MedPAC's proposed U-Shaped Curve is an alternative to flat reimbursement cuts, but will it help protect the most vulnerable hospices?

Testing the Impact of Various U-Shaped Curves in Hospice Reimbursement

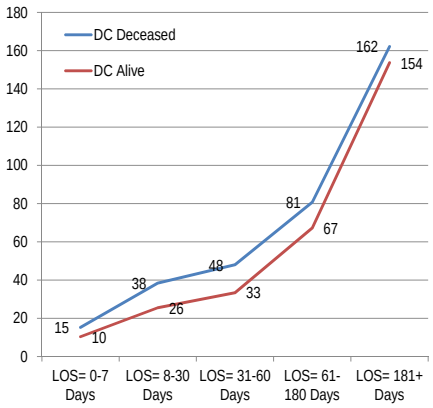
Criteria	All Hospices	Nonprofit	For-profit	Urban	Rural
RHC Baseline Revenue	100.0%	100.0%	100.0%	100.0%	100.0%
5% and 30 Days*	98.5%	98.8%	98.2%	98.5%	98.4%
10% and 30 Days	97.0%	97.6%	96.3%	97.0%	96.7%
5% and 14 Days	97.1%	97.3%	96.8%	97.1%	97.0%
5% and 7 Days	96.2%	96.4%	96.0%	96.2%	96.1%
10% and 14 Days	94.1%	94.6%	93.6%	94.1%	93.9%
25% and 30 Days	92.4%	94.0%	90.8%	92.5%	91.8%
10% and 7 Days	92.4%	92.7%	92.1%	92.4%	92.3%
25% and 14 Days	85.3%	86.5%	84.1%	85.4%	84.8%
25% and 7 Days	81.0%	81.8%	80.2%	81.1%	80.7%
Mean of all 9 models	**92.7%**	**93.3%**	**92.0%**	**92.7%**	**92.4%**

*For example, "5% and 30 Days" means: Reimbursing 105% of current RHC per diem for the first 30 days, followed by 95% for the remainder of days, with an increase to 105% for the last 30 days if the beneficiary dies. This model results in all hospices being reimbursed 98.5% of the current per diem rate.

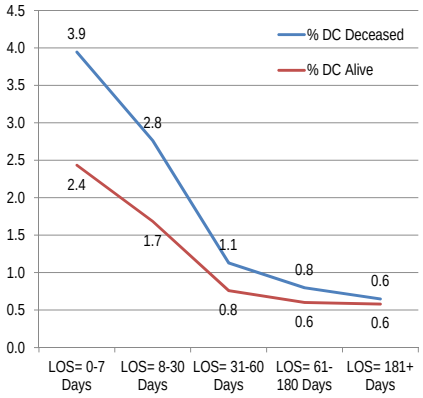
Conclusion: The impact of these 9 models has very little variation across different hospice provider groups – therefore the overall impact of these models is more like a flat reimbursement cut.

Length of Stay and Visits Per 2009 100% Hospice SAF / LDS

Total Visits (mean x LOS category)

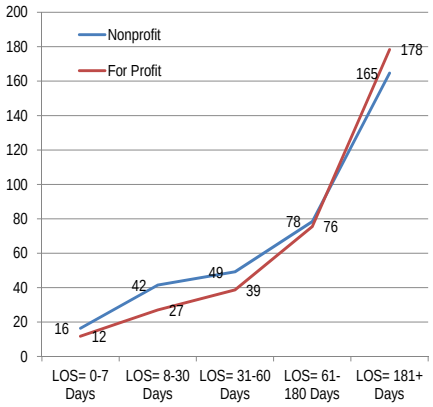


Mean Visits / Day

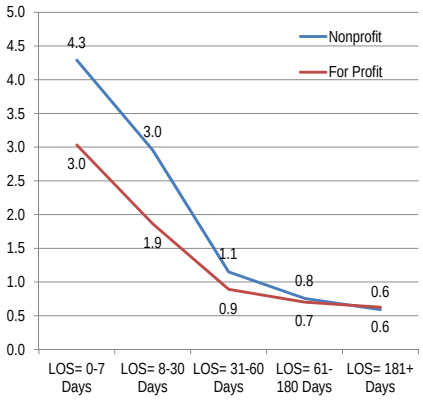


Length of Stay and Visits
Per 2009 100% Hospice SAF / LDS

Total Visits
(mean x LOS category)



Mean Visits / Day



Length of Stay and Visits
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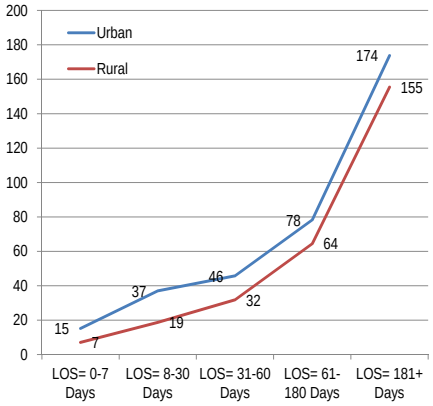
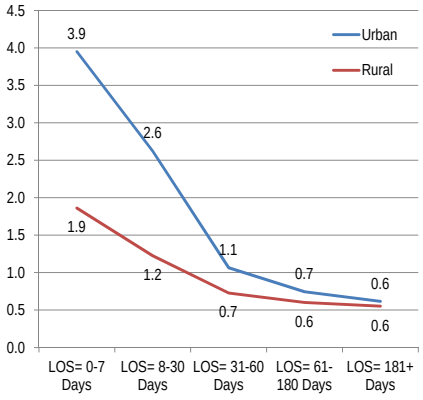
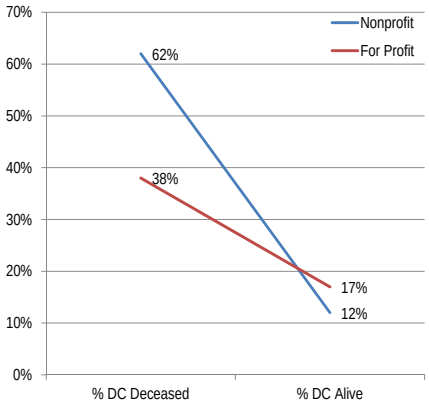


Mean Visits / Day

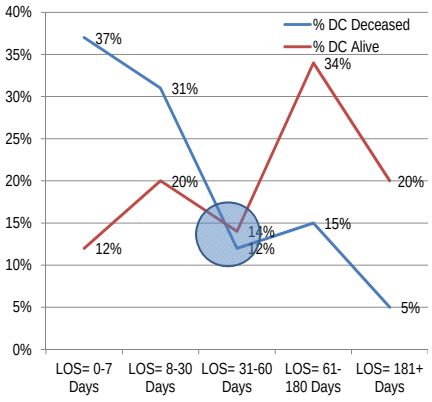


Discharge Status, Type of Control, and Length of Stay Per 2009 100% Hospice SAF / LDS

DC Status x Type of Control



LOS x DC Status



Conclusions Based on Preliminary Analysis

- MedPAC is correct – the hospice industry is changing.
- How do we support increasing access to quality hospice service, while decreasing the potential for waste, fraud, and abuse?
- Flat reimbursement cuts devastate hospice providers with small net margins – i.e., nonprofit and rural providers.

Conclusions Based on Preliminary Analysis

Does the U-Shaped Curve Work?

- While intuition suggests it might support quality hospice services and decrease the potential for WFA, preliminary data analysis suggests there is little differentiation between provider groups, suggesting it might not.
- Testing various shaped curves indicates the most vulnerable hospice providers would be hurt least by a wide / flat U-shape – although the impact is much like a flat reimbursement cut.

New Questions…

- Does the current hospice reimbursement via per diem work? Preliminary analysis suggests it does, although some regulatory changes (and perhaps statutory changes) need to be implemented to address MedPAC concerns.
- Does a U-Shaped hospice reimbursement curve alleviate MedPAC's concerns (e.g., cap excesses, live discharges, net revenues, etc.)? Preliminary analysis suggests it does not.

Conclusions Based on Preliminary Analysis

If the hospice per diem is maintained, what alternatives might help address MedPAC concerns?

- Clarify hospice cap definitions, strengthen CMS' right to recover excess payments, and *reduce* the aggregate hospice cap.
- Eliminate flat hospice reimbursement cuts (e.g., productivity factor).
- Place a temporary moratorium on new hospices.
- Hold hospices accountable for meeting statutory volunteer requirements.

Conclusions Based on Preliminary Analysis – Additional Thoughts

If the hospice per diem is maintained, what alternatives might help address MedPAC concerns?

- Increase appropriate hospice admissions by implementing clearer admission criteria guidelines – particularly regarding non-cancer diagnoses.
- Decrease the number of beneficiaries discharged alive. Review eligibility criteria more carefully at 30 days (where 70% of those who will die have died, and 70% of those who will be discharged alive are still on service).
- Longer hospice lengths of stay are not problematic – and in fact might be encouraged to maximize positive impact of hospice services (~60 days; compared to current median LOS= 24 days).
- Consider calculating hospice caps more frequently.

Presentation Outline

Part 1: Connecting Clinical Care to National Policy

1. In the Beginning… Early Questions & Answers
2. Data Available
3. Data Applications for Hospice Administrators

Part II: Connecting National Policy to Clinical Care

1. WFA (Nursing Facilities, Caps, Long LOS, DC Alive)
2. MedPAC (Net Margins, U-Shaped Curves)
3. **Palliative Care**
4. Dartmouth Atlas

Palliative Care

- Palliative Care was approved as a medical subspecialty 10/6/06
- Several interesting palliative care studies have recently been released, including (per PalliMed blog):
  - Hospitals increasingly offer palliative care - Washington Post
  - Critical (Re)thinking: How ICU's are getting a much-needed makeover - Wall Street Journal
  - Special needs, Special care (Pediatric Palliative Care) - Boston Globe
  - Many doctors still focus more on cure than managing pain - NPR
  - Hit by the reality of cancer treatment - NYT Well Blog
- We're seeing that, like hospice, palliative care:
  - Increases quality of care
  - Reduces suffering
  - Costs less
  - Improves patient transitions between providers
  - Is growing – fast

Palliative Care

- However, nearly all palliative care studies have small samples – e.g., "at my hospital", or perhaps with a small number of providers.
- Enter CMS billing code V66.7:
  - "Encounter for palliative care." Subheadings include "end-of-life care," "hospice care" and "terminal care."
  - V66.7 is always a secondary diagnosis with the underlying disease coded first.
  - V66.7 is not tied to reimbursement of any kind. Physicians generally bill under counseling time.
- V66.7 became effective 10/1/96

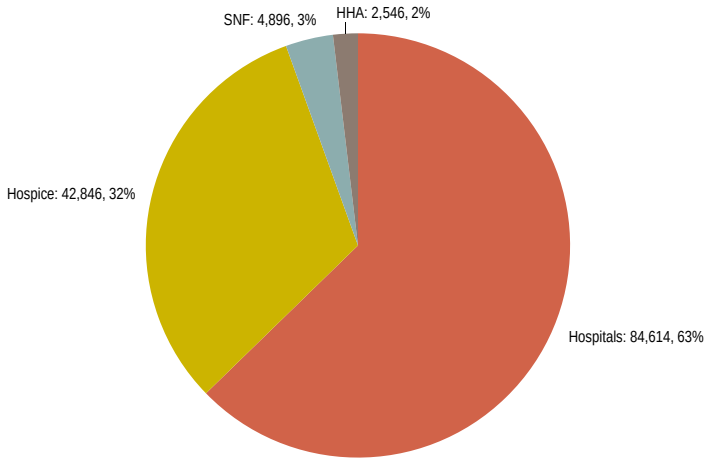
Palliative Care

- V66.7 Strengths:
  - The only palliative care billing code able to be used to easily and consistently track palliative care consults, outcomes, and costs.
  - The palliative care community has been encouraging the use of this code for years, particularly in the late 1990's.
  - Some hospitals (e.g., University of Colorado Hospital) have implemented an automatic process to include V66.7 on all palliative care consultations.
- V66.7 Weaknesses:
  - There is no detailed definition of when V66.7 can be used or shouldn't be.
  - The code isn't used consistently.
    - Sometimes "legitimate" palliative care consults do not include the V66.7 code on claims.
    - Sometimes "illegitimate" non-palliative care services include the V66.7 code on claims.
      - Radiation oncology might use this code as V66.7 is an exclusion criteria for some hospital mortality calculations.
      - Home based primary care programs may use this code (unsure why).
  - Some billing software may include only the first 4-5 (out of 10) diagnosis fields, so if V66.7 is used in a later field it may be inadvertently dropped.

Palliative Care

- Conclusions:
  1. At this point we cannot verify the reliability of V66.7, so results must remain in this context.
  2. However, the vast majority of providers would have no use in using a V-Code for "Encounter for Palliative Care".
  3. Let's look at the data and see if there might be benefit for the palliative care field.

2009 Total Medicare Beneficiaries Who Received At Least One Palliative Care Consult



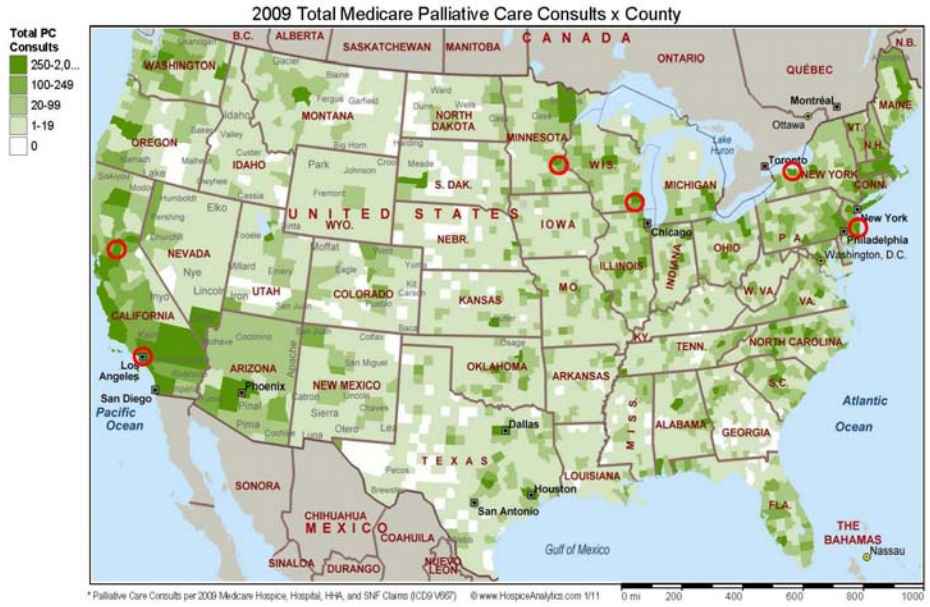
Palliative Care

- How often is V66.7 used?

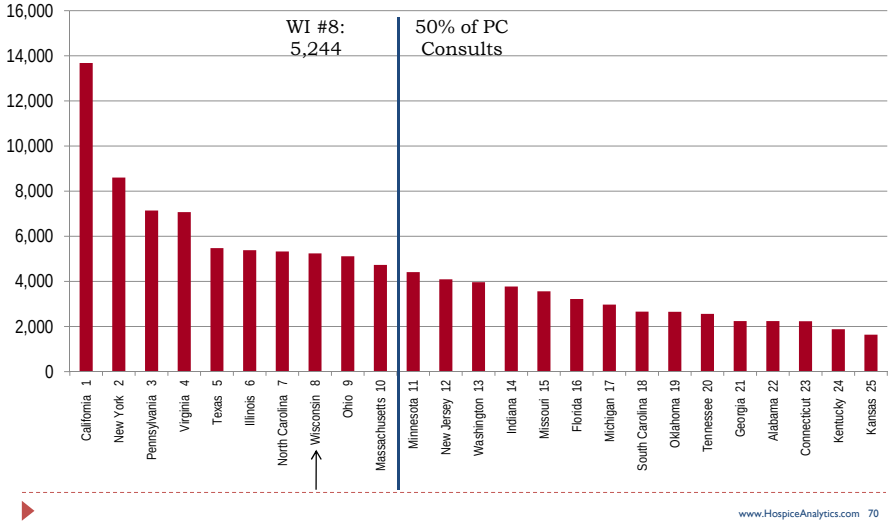
2009	# Beneficiaries	# PC Consults	# Died (%)	# Died in Hospital (%)	# Died in Hospice (%)
Medicare Total	131,696	134,904	110,512 (84%)	40,661 (30%)	58,956 (45%)
Wisconsin	5,023	5,244	3,271 (65%)	1,305 (40%)	2,517 (77%)

- Where was V66.7 used?

2009	# INPT Hospital (%)	# Hospice (%)	# SNF (%)	# HHA (%)
Medicare Total	84,614 (63%)	42,845 (32%)	4,896 (4%)	2,549 (2%)
Indiana	2,826 (54%)	2,015 (38%)	170 (3%)	233 (4%)



2009 Total Medicare Beneficiaries Who Received At Least One Palliative Care Consult
National= 131,696



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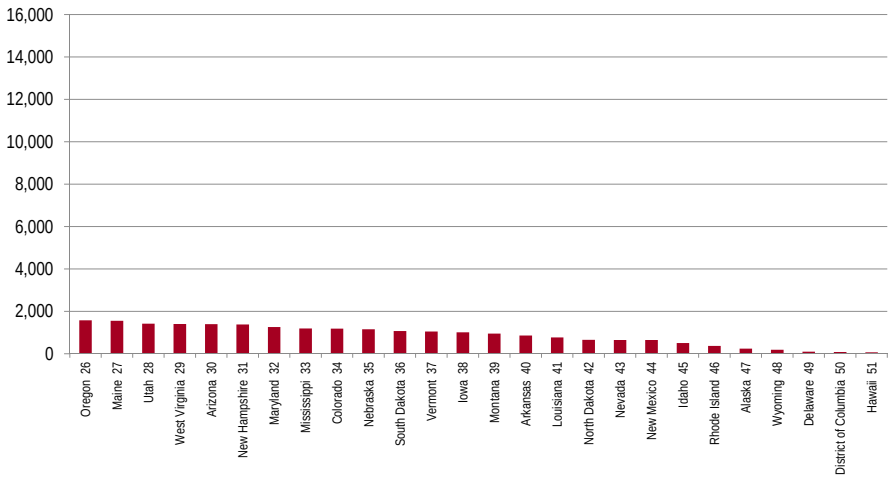

2009 Total Medicare Beneficiaries Who Received At Least One Palliative Care Consult

Provider Type	PC Consults	PC Benes Who Died	PC Benes Admitted to Hospice	Setting Where PC Benes Died
Hospices	42,846	33,100 (77%)	42,846 (100%)	*30,686 Hospice (93%)* *2,414 W/O Hospice (7%)*
Hospitals	84,614	74,475 (88%)	35,605 42% of PC Consults	*27,123 Hospice Alone (36%)* *39,001 Hospital Alone (52%)* *1,132 Both (2%)* *7,219 Neither (10%)*
Skilled Nursing Facilities	4,896	4,119 (84%)	1,490 30% of PC Consults	*868 Hospice Alone (21%)* *2,776 SNF Alone (67%)* *119 Both (3%)* *356 Neither (9%)*
Home Health Agencies	2,546	1,586 (62%)	1,079 42% of PC Consults	*789 Hospice Alone (50%)* *336 HHA Alone (21%)* ** Both (*%)* *454 Neither (29%)*
Total	**134,902**	**113,280 (84%)**	**81,020** **60% of PC Consults**	***60,724 (54%) With Hospice*** ***52,556 (46%) W/O Hospice***

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The Dartmouth Atlas of Health Care

- http://www.dartmouthatlas.org/
- LOVE:
  - An excellent resource for Medicare ***HOSPITAL*** claims information
  - An excellent application of Medicare ***HOSPITAL*** claims to public health and policy concerns
  - An excellent example of presenting clear methods and results
- HATE:
  - How others misunderstand Dartmouth Atlas findings and present information out of context!

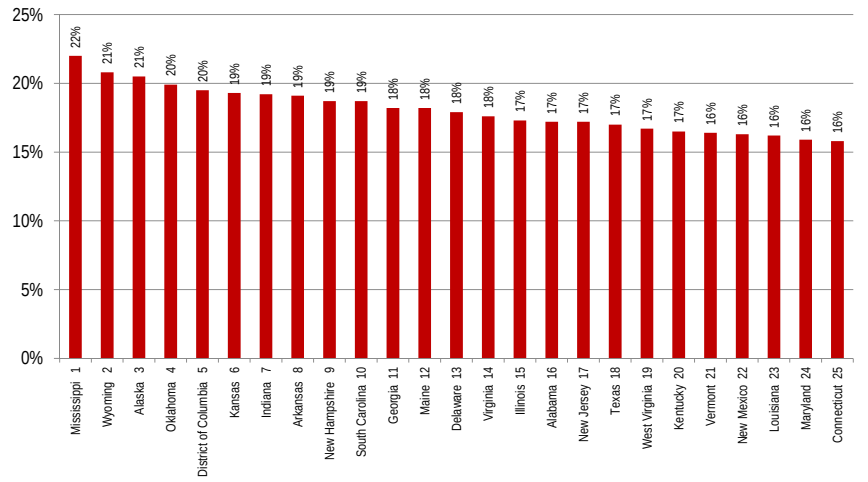
The Dartmouth Atlas of Health Care: EOL Reports

- What ***HOSPITAL*** information is included in Dartmouth Atlas End-of-Life Care Reports?
  - Medicare beneficiaries – accounting for ~40% of hospitalized patients
  - Who died over a 5-year period
  - Who where hospitalized in an acute care hospital at least once during the last 2-years of the life
  - Who were hospitalized for a medical (non-surgical) condition
  - With one or more of nine chronic illnesses associated with a high probability of death:
    - Malignant Cancer / Leukemia; Congestive Heart Failure; Chronic Pulmonary Disease; Dementia; Diabetes with End Organ Damage; Peripheral Vascular Disease; Chronic Renal Failure; Severe Chronic Liver Disease; and/or Coronary Artery Disease
  - Most recent data reported on: 2003-2007

The Dartmouth Atlas of Health Care: EOL Reports

- ***HOSPICE*** is discussed as Medicare beneficiaries meeting the above ***HOSPITAL*** criteria, who received ***HOSPICE*** post-hospitalization
- Per discussion with Dartmouth Atlas researchers, the Medicare Hospice claims dataset has ***never*** been used as the denominator in any of their studies

The Dartmouth Atlas of Health Care: EOL Reports
What Percentage of ***HOSPICE*** Beneficiaries are Included?



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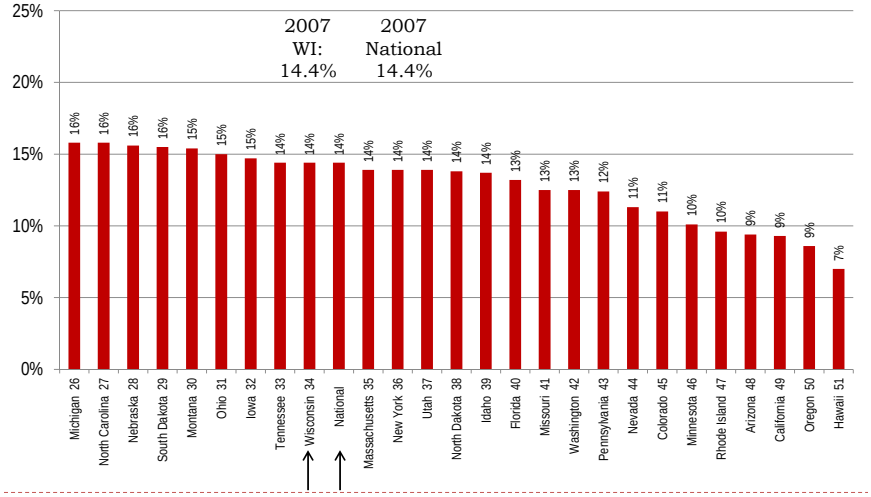
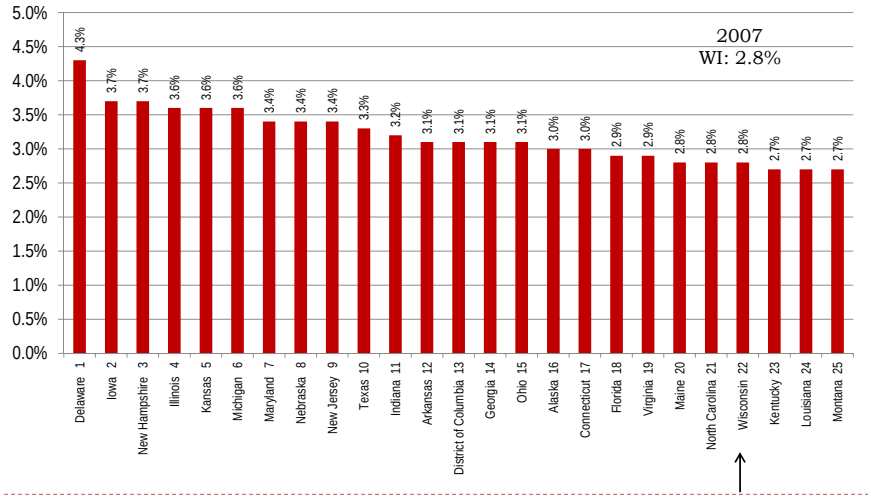


The Dartmouth Atlas of Health Care: EOL Reports
What Percentage of ***HOSPICE*** Days of Care are Included?



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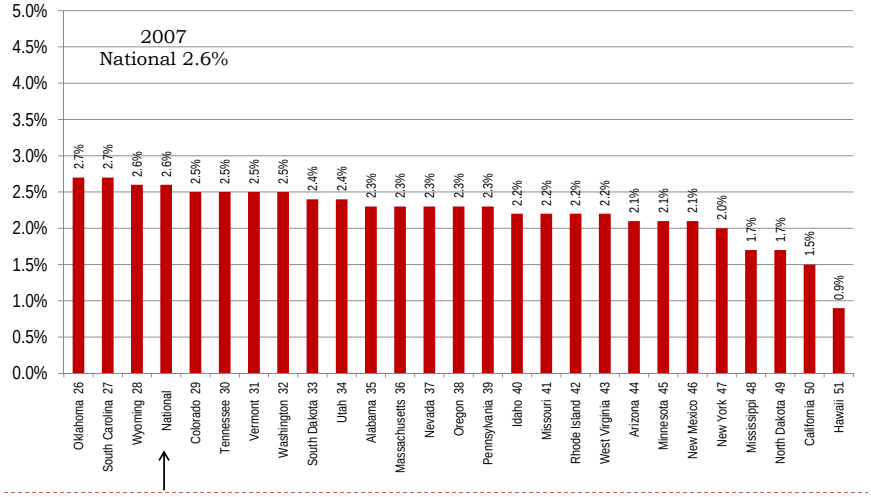

The Dartmouth Atlas of Health Care: EOL Reports

Conclusions:

- The Dartmouth Atlas of Health Care is extremely useful in describing and understanding Medicare ***HOSPITAL*** utilization and trends.
- It is helpful to understand (in context) what happens to Medicare beneficiaries post-hospitalization, including care provided by hospices and others, mortality, etc.
- ***Caution:*** Do not interpret Dartmouth Atlas of Health Care findings as representative of hospice – it isn't, nor was it intended to!

Thank you

Please contact Hospice Analytics with any questions, comments, feedback, or for additional information:
W: www.HospiceAnalytics.com
P: 719-209-1237
E: Info@HospiceAnalytics.com