HEALTH CARE REFORM WILL BRING PAYMENT REVISIONS

“Brace for Payment Revisions Under Health Care Reform,” in a recent Hospice Management Advisor, says, “The hospice industry's focus has shifted from lobbying for or against proposed parts of the health care reform legislation to working to ensure that implementation requirements are reasonable and appropriate for hospice.”

NHPCO’s Jonathan Keyserling, vice president of public policy and counsel, states, “NHPCO will work feverishly with legislators to soften or eliminate some of the planned rate cuts, but our advice is to begin planning for cuts that will occur in FY 2013.” He also warns of the possibility that the “entire hospice payment system will be revised sometime after 2013.”

Carla Braveman, president and CEO of Big Bend Hospice in Tallahassee, says that hospices can help assure realistic payment reforms by submitting “the best possible data” to CMS. CMS is requiring more data “for use in billing and cost reports,” and Braveman says that information should be reported as precisely as possible. NHPCO has contracted with The Moran Co. to collect data which will be used to model alternative payment systems. The models will be used in discussions with MedPAC and CMS about payment reform strategies.

Braveman also thinks hospices will face pay for performance, but says that will “pose a challenge for development of outcome measures.” Hospice measures will report on moments in time rather than on goals reached when a person is discharged. Some possible measurement outcomes could be pain control, family satisfaction, falls, and dying at the place of one’s choosing.

Keyserling says that the implementation time line could possibly be changed. According to him, “We know that a CMS administrator must be appointed to oversee these activities, but I anticipate that the demonstration project details will be announced in the next six to nine months, and the second part of our rate cut will be in FY 2013. The good news throughout all of this process is that hospice has been recognized as an important part of the health care solution as opposed to part of the problem.” (Hospice Management Advisor, 6/4)

PUBLIC POLICY NOTES

* Florida has a new law that will strengthen regulation of pain management clinics in the state. Beginning October 1, felons will be prevented from owning clinics, only 72 hours worth of
medicine may be purchased for cash, specific treatments such as oxycodone may not be advertised, and doctors will be required to undergo specific training to practice in pain management. (*The Florida Times-Union, 6/4, jacksonville.com/news/metro/2010-06-04/story/crist-signs-pain-clinic-reform-legislation*)

* The National Association for Home Care (NAHC) 2010 legislative priorities are online at the link below. The priorities are grouped under several main home health categories, and include several items for hospice: full market basket update for the MHB, preserving the BNAF, access to hospice care in rural areas, support for demonstration projects for concurrent hospice and curative care, and modernization of the MHB and payment system. (*Congressweb.com, www.congressweb.com/nahc/legislative_priorities.htm*)

* The Federal Trade Commission has announced that it will delay enforcing the “Red Flags” rule through December 31. The statement does not affect other federal agencies’ enforcement of the November 1 deadline. The rule requires agencies to develop prevention programs that “help identify, detect, and respond to patterns, practices, or specific activities – known as ‘red flags’ – that could indicate identity theft.” (*Federal Trade Commission, 5/28, www.ftc.gov/opa/2010/05/redflags.shtm*)

* End-of-life-reform advocates in Colorado say that the new laws in that state “intended to expand hospice care and make it easier for people to communicate their dying wishes will push the state to the forefront in end-of-life care.” The revised Living Will Act will now apply to patients in a persistent vegetative state, and a POLST-type form will be legal. A state law now allows terminal patients to receive hospice care nine months before death, rather than six, but must receive federal approval before it takes effect. The legislature discussed a statewide database of DNR orders and advance directives, but failed to pass it because of concerns over funding it and over privacy and control. (*The Denver Post, 6/3, www.denverpost.com/commented/ci_15215291*)

* In Montana, many of the doctors who supported legalizing medical marijuana are angry at the results of that initiative. Hundreds of state residents have gotten marijuana cards at “mass clinics staffed by out-of-state doctors.” One internist said, “I didn’t envision there would be marijuana stores on every corner of Grand Avenue and these fairs at the Holiday Inn. Most of us envisioned it would be through your personal physician and part of a comprehensive plan of care.” One physician who runs a primary care clinic said, “We have reached the point in Montana where medical marijuana certification is for sale with a physician's signature.” (*The Missoulian, 6/1, missoulian.com/news/local/article_c82327c6-6d37-11df-bcdc-001cc4e03286.html*)

* In Sherman, Texas, Harris Hospice has filed a suit that challenges the “validity of the Medicare regulation used to calculate the aggregate annual provider cap.” Harris claims that the regulation “is contrary to the plain language of the Medicare Act and is arbitrary and capricious and is in excess of statutory authority,” and that the Hospice “has been materially prejudiced by Medicare's refusal to abide the Congressional mandate regarding the methodology for calculation of the cap.” The lawsuit asserts that “multiple federal courts have determined that the regulation that Medicare uses to perform the cap calculation is invalid.” (*The Southeast Texas Record, 5/27, www.setexasrecord.com/news/227179-hospice-lawsuit-challenges-medicare-regulation*)

RESEARCH & RESOURCE NOTES
* Guided Pathways to Medicare Resources has been revised, and addresses topics such as billing, coverage, reimbursements and overpayments in basic and intermediate versions. There are separate intermediate versions for suppliers and providers who use the Medicare 855 A form versus those who use the 855 B, I, or S forms. See the link in the citation for more information. How to Use the Medicare Coverage Database can be downloaded from the MLN Publications page at www.cms.gov/MLNProducts/MPUB/list.asp. Put the words “how to” (without the quotes) in the “Show only items containing the following word” box. (CMS Website, 5/21, www.cms.gov/MLNEdWebGuide/30_Guided_Pathways.asp)

* An innovative program from the University of Medicine and Dentistry of New Jersey is pairing medical students with patients who are dying alone. The program began with a $3.2 million grant from the Healthcare Foundation of New Jersey, which is part of a movement to emphasize the “human side of medical care.” Another organization in the movement is the Arnold P. Gold Foundation, which supports the Gold Humanism Honors Society, and also the white coat ceremony. In the latter, “first-year medical students take the Hippocratic Oath, pledge to provide compassionate care, hear from prominent figures in the humanism movement and receive their first white coats.” (The New York Times, 6/3, www.nytimes.com/2010/06/03/health/03chen.html)

* The continuation of a study of personal digital assistants (PDAs) followed terminal cancer patients enrolled in home hospice. Patients recorded their symptoms on the PDA when they “took rescue medications,” and when a preset alarm sounded. The response rates exceeded 90% for the alarm, and 80% when medications were taken. The users overwhelmingly rated the device as user friendly (8.8 on a 10 point scale). The researchers say the system may be “useful for managing symptoms such as pain and mood states in patients with cancer.” (Journal of Palliative Medicine, 2010, 13(6), www.liebertonline.com/doi/abs/10.1089/jpm.2009.0350)

* The New York Times recently profiled the Alzheimer’s research on the villagers of a mountain town in Colombia, where intermarriage and a gene that causes early-onset Alzheimer’s have combined to create the “world's largest family to experience Alzheimer's disease.” The research will focus on whether treatment given before the symptoms of the disease occur can prevent it altogether. (The New York Times, 6/2, www.nytimes.com/2010/06/02/health/02alzheimers.html)

* NHPCO Newsline has published “Advances in Hospice and Palliative Care Research,” a brief summary of some of the most important research in hospice and palliative care in the last 18 months. Each entry summarizes the study and provides a short commentary about the article. The original source of each is also included. (NHPCO NewsLine, www.nxtbook.com/nxtbooks/nhpco/newsline_201006/#/6)

* In light of the number of recent CMS change requests that affect hospice providers, NHPCO has issued “Recent Regulatory Changes: Your Questions Answered.” The article reviews some CMS issues and clarifications, and groups them together by subject area. (NHPCO Newsline, 5/2010)
* The 6th Research Congress of the European Association for Palliative Care (EAPC) was recently held in Glasgow, Scotland. The highlights of the congress included the results of research on the “effect of genetics in cancer patients on their response to pain-killers like morphine, new strategies to avoid inappropriate transfers of terminally ill nursing home residents to hospitals at the end of life,” helping clinicians understand the causes and management of “mental clouding,” and breathlessness. (The Medical News, 6/4, www.news-medical.net/news/20100604/6th-Research-Congress-of-the-EAPC-reflects-research-in-palliative-care.aspx)

* The American Cancer Society and the National Palliative Care Research Center have announced $1.8 million in grants to 12 institutions “for studies aimed at reducing suffering for seriously ill patients and their family caregivers.” Since 2007, the two organizations have award grants in this area totaling nearly $7 million. The initiative is “designed to support clinician investigators conducting patient-oriented research in palliative care in hopes of bringing more funding from federal agencies, which have supported some research in palliative care, but for whom it is not a priority area. Pilot data results are typically needed before a federal agency will consider funding a research project.” (EurekAlert, 6/3, www.biosciencetechnology.com/News/Feeds/2010/06/products-lab-tools--18-million-awarded-for-palliative-care-research-t/)

* “Sitting With You in Your Suffering,” in the current Journal of Palliative Medicine, tells the story of a patient whom, for several reasons, the hospice and palliative team were unable to palliate. The authors say that “administrative and medication constraints” contributed to the patient’s suffering, as did errors in communication between the palliative team and the pharmacy. Side effects of medication and spiritual and psychological issues compounded the problems. The authors say that whether or not this was the way this patient needed to die, his life and death “touched everyone on the palliative care and hospice service in a profound way. In caring for you, we learned important lessons about pain management, administrative loopholes that need remediing, and the need to tend to psychosocial and existential as well as physical suffering.” (Journal of Palliative Medicine, 2010, 13(6), www.liebertonline.com/doi/abs/10.1089/jpm.2009.0325)

* In Medscape Today, a senior scientist from the Paul P. Carbone Comprehensive Cancer Center at the University of Wisconsin discussed the effect of Risk Evaluation and Mitigation Strategies (REMS) on long-lasting or extended-release opioid use. REMS are intended to ensure that the benefits of opioids “outweigh the risks for misuse, abuse, accidental or intentional overdose, and use in opioid-nontolerant or improperly selected patients.” REMS are required to be both effective and safe. REMS have characteristics representing “Element to Assure Safe Use” (ETASU), but those are not yet formalized. The article says, “Although the final ETASU characteristics have yet to be formalized, it remains imperative for the FDA to consider possible unintended effects. As research on prescription monitoring programs has demonstrated, imposing onerous requirements with respect to certain medications can lead many clinicians to prescribe other products. Some practitioners may avoid the education/certification process, and because they will be unable to prescribe these products, they will be less able to treat patients with severe pain. Also, the medical use of short-acting opioids not covered by the REMS (eg, hydrocodone combination products) may increase.” (Medscape Today, 6/4, www.medscape.com/viewarticle/722732)

OTHER NOTES
* In Ocala, Florida, Earl Smith “had a urinal, cane and oxygen. I had no quality of life,” he said. But he credits “the focused individual care from the social, medical and volunteer staff of Hospice of Marion County for the turnaround that gave him back his life.” Lily Ivey, community outreach director for the Hospice of Marion County, calls an improvement such as Smith’s a “revocation.” (Ocala.com, 5/31, www.ocala.com/article/20100531/ARTICLES/5311002/1402/NEWS)

* CBS affiliate KDKA, in Pittsburgh, aired a short piece on Forbes Hospice, where a program matches veteran volunteers with patients who are also veterans. One spokesman said, “That makes it much more meaningful to the patient. When you’re able to share your war experience with somebody else who completely understands what you’re saying, because they’ve been there.” (KDKA, 5/31, kdka.com/local/hospice.care.veterans.2.1724773.html)

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