MEDPAC REVIEWS MEDICARE HOSPICE BENEFIT

The Medicare Payment Advisory Commission (MedPAC), on November six, had a meeting to review issues relating to the Medicare Hospice Benefit (MHB). Several draft recommendations, noted below, were presented which focused on reform of the payment system, accountability and data collection.

* Congress should modify the payment system so that the first and last days receive higher reimbursement than the middle days. The recommendation is “revenue neutral,” in that the total payment for a patient’s care would remain the same, but would be redistributed over the time that a patient is in hospice.
* The HHS Secretary should require hospice physicians or advance practice nurses to visit patients at every recertification to re-evaluate eligibility, and require that a brief narrative documenting a patient’s eligibility be submitted. Further, if a hospice has an average length of stay longer than 120 days, the medical director of the Medicare claims payment contractor would be required to review any stay longer than 180 days.
* The HHS Office of Inspector General should “investigate financial relationships between nursing facilities and hospices to identify potential conflicts of interest.”
* Additional data should be required from hospice providers as a condition of paying claims. Such data should include information on all visit providers, including the duration of the visit.
* Cost reporting should be changed to reflect the new data requirements and to increase accuracy.

After the analysts’ presentation, NHPCO President and CEO Don Schumacher urged the commission to “undertake comprehensive data collection and analysis before pursuing any changes in the payment methodology,” and offered “the hospice community’s considerable data and information, from multiple sources, so that you can make fully informed decisions about the future of hospice care in America.”

Schumacher concluded by saying, “As has been discussed today, over the years, the patient population hospices serve has changed. And just as our patient base has evolved, the benefit itself must be modernized to better meet patient’s needs and match payments in a cost effective manner. We would urge MedPAC to consider this important dynamic to assure that your recommendations make a constructive contribution to this important Medicare benefit. Paramount among our beliefs is making sure that future patients and families can access, in all service settings, the high quality care that hospice has come to symbolize. Eligibility for care should be based upon an assessment of the patient to ensure appropriate eligibility and supported by evidence-based criteria. Patients and families should know what to expect and receive consistent – and measurable – high quality services delivered by a skilled interdisciplinary team within every hospice program in the country. At the same time, and importantly, the hospice community is committed to program integrity, transparency, accountability and fiscal responsibility.”

The presentation by analysts to the commissioners can be downloaded from the MedPAC website at [http://www.medpac.gov/transcripts/20081104_Hospice_final_public.pdf](http://www.medpac.gov/transcripts/20081104_Hospice_final_public.pdf) and the transcript of the meeting is also available. NHPCO’s report on the meeting is online at
HOSPICE EMERGENCY PLANS WORK WELL FOR HURRICANE IKE

_Hospice Management Advisor_ says, “The good news for Texas hospice and home health organizations is that their emergency plans worked well” for Hurricane Ike. Wyona Freysteinson, director of Memorial Hermann Hospital’s home health and hospice unit, said that their hospice knows which patients are in the evacuation area and how they can be contacted. They also call agencies in the destination areas to arrange for care for the evacuees.

Additionally, as soon as Ike was identified as a severe storm, the hospice checked to make sure patients had at least 7-10 days worth of medication, and added the names of any who would need transportation to the county’s 2-1-1 list. In some cases, however, the use of the 2-1-1 list revealed problems in understanding. In Jasper, Texas, the county didn’t have the money for transportation from residences, and so set up central locations where persons could meet to be evacuated. Unfortunately, many of the people registered with 2-1-1 had neither cars nor caregivers who could take them to the central locations. County workers volunteered their private vehicles to go retrieve the patients, and discussions are now underway to revise the plan.

One item especially needed during the aftermath of the hurricane was paper records, as many offices and homes were without power, and there was no way to recharge laptop batteries. One office plans to rent an emergency generator the next time a disaster threatens.

Another difficulty, anticipated in the area affected by the hurricane but not elsewhere, was the shortage of gasoline. Texas and Louisiana refineries were shut down in advance of the hurricane, and the resulting gasoline shortages affected hospices as far away as Atlanta. There, Visiting Nurse Health System employees searched the web and called gasoline distributors to find stations with gas. They then sent email messages to staff to let them know where their cars could be filled.

Freysteinson says it’s important to recognize the work of the staff once everything is back to normal. Her organization has had parties at each office. The staff members who sat the longest in a gas line got a crossword book for a prize, and the person without power for the longest received a flashlight. Freysteinson adds, “This was a scary experience with winds and trees crashing into homes. It is important to set aside time to say that we're glad to be alive.” (_Hospice Management Advisor_, 11/1)

PUBLIC POLICY NOTES

* Congress recently passed, and the President signed, the Military Pain Care Act of 2008 and the Veterans Pain Care Act. The Military Pain Care Act is intended to “help the military improve the health of active duty service members by developing a ‘best practices’ approach to pain care management and evaluating the effectiveness of existing DOD pain care programs.” The Veterans Pain Care Act “establishes a comprehensive and integrated pain care initiative across the U.S. Department of Veteran Affairs (VA) health care system.” (_Pharma Investments, Ventures & Law Weekly_, 11/16)

* Washington’s Initiative-1000, which allows terminally ill patients to request lethal doses of barbiturates from physicians, passed with 59% of the state’s voters approving it. Unless
legally challenged, the law will take effect in March, 2009. The initiative is modeled after Oregon’s Death With Dignity Act. (*The Seattle Times*, 11/5; *The Oregonian*, 11/9)

**END-OF-LIFE NOTES**

* Motl Brody is a 12-year-old patient at Children’s National Medical Center, which wants to remove all life support since the boy has no brainstem activity. His Orthodox Jewish parents disagree, and want to continue the respirator and intravenous drugs that keep his heart beating. District of Columbia law allows physicians to declare patients dead if there is no brain activity, and experts in Orthodox Jewish law say “there is no consensus within the faith on the definition of death.” Rabbi Edward Reichman, professor at Albert Einstein College of Medicine at Yeshiva University, said that some Orthodox Jews do not accept lack of brain activity as certainty of death. (*The Washington Post*, 11/7)

* The husband and sister of Heather Lavers are battling in court over who has the right to make end-of-life decisions for her. Lavers has been in a persistent vegetative state since a cardiac arrest several weeks ago. Lavers has recently been moved from a hospital in Tampa to Ohio, where her sister lives. The sister, Heidi Kaczala, has petitioned for guardianship. (*Tampa Tribune*, 10/30)

**PAIN & PALLIATIVE CARE NOTES**

* Research into the uses of medical marijuana has found that it contains molecules that can kill methicillin-resistant staphylococcus aureus (MRSA) in the laboratory, and others can “slow the growth of lung tumors in mice, decrease hardening of the arteries in rats, and boost the egg-binding capability of tobacco smokers’ sperm.” Other research offers hope that cannabis and other similar compounds may be useful in treatment of “traumatic brain injury, inflammatory bowel diseases, allergic contact dermatitis, atherosclerosis, osteoporosis, and Alzheimer’s disease.” (*Slate*, 11/6)

* Rebecca Kirch, director of policy of the American Cancer Society, told a recent Washington pain seminar that “nearly all cancer pain can be relieved, but fewer than half of our patients report adequate pain relief.” A survey by the Harvard School of Public Health found that one-third of patients in hospitals in 40 metropolitan areas said their pain wasn’t well-controlled. Will Rowe, executive director of the American Pain Foundation, said that medical schools give a “paltry” one hour of training in understanding and treating pain. (*McClatchy Newspapers*, 10/29)

* Patricia Murphy is an advanced practice nurse in bereavement and ethics and also associate professor of the University of Medicine and Dentistry of New Jersey. Speaking at Care Alternatives Hospice’s conference, “The Future of Hospice and Palliative Medicine,” Murphy said that grief is the price paid when we lose a loved one. She calls grieving “an exhausting process,” and says that the bereaved obsess about whether the deceased was alone at the time of death, whether they were in pain, and if they asked for the bereaved person. Murphy cited an excerpt from Marcel Proust’s *Letters*: “You will not be cured, but … one day — an idea that will horrify you now — this intolerable misfortune will become a blessed memory of a being who will never again leave you. But you are in a stage of unhappiness where it is impossible for you to have faith in these reassurances.” (*Hospice Letter*, 11/2008)
* A study of eight hospitals, conducted by the Center to Advance Palliative Care and the National Palliative Care Research Center, has found that hospital palliative care programs save an average of $279 per patient per day for patients who are discharged, and up to $374 per day for patients who die. The authors say that “significant cost reductions in pharmacy, laboratory, and intensive care unit costs were seen.” (Hospice Management Advisor, 10/1)

* Dr. Charles von Gunten, editor-in-chief of the *Journal of Palliative Medicine*, was the keynote speaker at “The Future of Hospice and Palliative Medicine,” a conference sponsored by New Jersey’s Care Alternatives Hospice. He sees palliative care emerging as a sub-specialty, as more physicians express interest and the knowledge base grows. Von Gunten cited a Mount Sinai Hospital study where “patients receiving palliative treatment saw a major drop in pain, nausea and dyspnea symptoms … Severe pain became mild to moderate, moderate pain dropped below mild, and mild dropped to almost none … Nausea and dyspnea took similar paths.” (Hospice Letter, 11/2008)

**OTHER NOTES**

* President George W. Bush recently proclaimed November as National Hospice Month, 2008. In the proclamation, the President said, “I encourage all Americans to observe this month with appropriate programs and activities. I also ask Americans to recognize our health care professionals and volunteers for their contributions to helping provide comfort and care to those facing terminal illness.” (States News Service, 10/31)

* In an article explaining hospice, *US News & World Report* says that a growing demand for hospice “is coming from dementia patients, including those with Alzheimer’s disease, who now account for 10.1 percent of hospice admissions nationwide, up from 5.5 percent in 2000.” Some dementia patients are too difficult to handle in nursing homes and must be cared for at home. Some hospices, such as Phoenix’ Hospice of the Valley, have instituted special dementia programs. One dementia program spokesman says that too few hospices have such programs and too few patients are referred to the ones that exist. One problem with referral of dementia patients to hospice is the difficulty of predicting when death is likely to occur. (US News & World Report Website, 11/4)

* NHPCO and the National Association of Social Workers (NASW) have jointly developed “the premier credential for social workers who specialize in hospice and palliative care.” Designed by and for social workers, the new credential requires a master's degree in social work from an accredited university, two or more years of supervised social work in the hospice and palliative care field, 20+ CEUs in the specialty, a “commitment to compliance with NASW Code of Ethics and the NASW Standards for End of Life Care,” and membership in both NASW and NHPCO. For more information, see www.socialworkers.org/credentials. (States News Service, 11/3)

When advice columnist Ann Landers died, two of her assistants, Kathy Mitchell and Marcy Sugar, started their own nationally distributed column, “Annie’s Mailbox.” One respondent to a recent discussion about being tolerant of angry cancer patients said, “Anger and frustration mean the patient is suffering and deserves help. It doesn't mean he gets to take it out on those nearest. I'd like to recommend this excellent piece that I found on the National Cancer Institute website.” The

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