HOSPICE INDUSTRY TO FIGHT “GRIM” MEDPAC REPORT

A November 27 Inside CMS article reported on a November 6 MedPAC meeting. “MedPAC staff sharply described for-profit services as ‘gaming the system,’” the article says, “by artificially increasing lengths of stays and is poised to recommend a sliding-scale cut to hospice spending based on length of stay.” In response, the National Alliance for Hospice Access (NAHA) asked its 500 member hospices to encourage NHPCO and the National Association for Home Care and Hospice (NAHC) to join NAHA in responding to MedPAC.

NAHA, which includes both for-profit and nonprofit members, strongly objected to a suggestion by MedPAC staff that for-profit and freestanding hospices get a 3% cut in reimbursement. The cut was proposed “after commission staffers reported a substantial increase in lengths of stays in hospices, telling commissioners that the top 10 percent of the longest stays were at least 212 days in 2005, up 50 percent from 2000. And, they added, these long stays directly lead to large profit margins, which they found topped 15 percent in 2005.” MedPAC researchers said that these long stays “led to Medicare spending that could have been avoided if beneficiaries had not chosen to enroll in hospice.”

Hospices responded by “telling commission members and staff in a Nov. 17 letter that these conclusions and others are the result of poor research and short memories.” Among the points disputed by the hospices and hospice organizations are these:

* MedPAC asserts that many hospices “operate in areas of the country with considerable market saturation.” Lois Armstrong and David Daucher, NAHA co-founders, say that the market is “hardly saturated,” since only 41% of terminally ill patients even have a choice between hospices, and hospice access “that hits greater than 50 percent” is available in only 11 states.

* The MedPAC staff report said that “for-profit hospices grew by nearly 230 percent between 2000 and 2006.” NAHA’s spokesmen responded that “for-profit/non-profit ratio is still only 50/50 nationally.”

* MedPAC alleges that the rapid growth in hospice use is “due to misbehavior by for-profit hospitals,” according to Daucher. But, he says, “It’s just not the right story. The right story is that CMS and Congress both did what they intended in ’98 — providing more access and more timely access.”

* MedPAC’s report finds that the largest Medicare savings are available in the last couple of months of life, and says that CMS “has an incentive to ensure that the timing of the hospice admission reflects optimal use of this benefit.” A Duke University study from 2007, however, found that Medicare could save costs by increasing hospice access and length of stay for 70% of hospice patients.
The hospice industry is concerned about the hospice cap, which Armstrong and Daucher call “a blunt, ineffective and in fact inhumane instrument.” Inside CMS cites NAHA as saying, “Growth approaching and surpassing the hospice cap is systemic because beneficiaries are statutorily promised unlimited days of care, the cap limits providers’ average length of stay and the LCDs [local coverage determinations] cause hospices’ average length of stay to exceed that allowed by the cap.”

NHPCO’s Judi Lund Person says that MedPAC staff “missed a crucial piece by not digging into why the cap is being hit by so many hospices: The mix of short-stay and long-stay patients has long been perceived to average out in the end, but the patient population has changed over time — namely the inclusion of non-cancer diagnoses like congestive heart failure — and more and more patients are less predictable in terms of their deaths.”

Lund Person also says that MedPAC ignored data subtleties in their report. She calls “CMS’ recent proposal to include visit time as an indication for intensity of services a ‘step in the right direction’ away from painting with too broad a brush.”

Armstrong says, “MedPAC staff seem to view every health care benefit within its own silo and are looking only at the absolute dollars being spent on hospice, and not considering the fact that hospice is the one Medicare benefit proven to save money for other parts of Medicare.” “When a patient is dying on hospice care, when you take away hospice you still have a dying patient,” she adds. “Only instead of dying on hospice, they’re dying in emergency rooms; they’re dying in intensive care units, in other highly expensive Medicare Part A services.” (Inside CMS, 11/27)

PUBLIC POLICY NOTES

* US District Judge Colleen Kollar-Kotell has dismissed, on procedural grounds, NHPCO’s lawsuit against CMS, which sought to block the portion of CMS’ Final Rule which phased out the budget neutrality adjustment factor. The judge did not consider NHPCO’s request, but ruled that CMS “should first be given the opportunity to consider those claims in an administrative appeal by affected hospices.” Jonathan Keyserling, executive director of the Alliance for Care at the End of Life, said, “While we had hoped that the court would be able to make a decision to settle the suit now, we do understand that the court must allow the government the appropriate process for the case. However, NHPCO and the Alliance for Care at the End of Life will continue to aggressively work to stop what are essentially cuts to hospice’s reimbursement rates. This includes ongoing efforts to rally Congressional support for hospice.” NHPCO’s press release is available at www.nhpco.org. Click on “Hospice Rate Protection.” (NHPCO Website, 11/25)

* A Billings, Montana man, along with Compassion & Choices and four physicians who treat terminally-ill patients, sued the state for the right to self-administer a legal prescription obtained from his doctor for the purpose of taking his own life. A judge ruled in his favor, saying, “The Montana constitutional rights of individual privacy and
human dignity, taken together, encompass the right of a competent terminally (ill) patient to
die with dignity.” The Montana Attorney General expects to appeal the ruling, and says,
“It’s a major constitutional issue and the Supreme Court should rule on it.” (The New York
Times, 12/6)

* The Joint Commission has submitted a deeming application to CMS to continue
to be recognized as a hospice national accrediting organization. The Medicare Act
requires that notice of the application be published, and a 30-day public comment
period be allowed. For more information, search The Federal Register at
www.gpoaccess.gov/fr/ for “CMS-2294-PN” (with the quotes). (Health and Human Services
Department Documents and Publications, 11/28)

**RESEARCH & RESOURCE NOTES**

* “Physicians’ Preferences and Attitudes About End-of-Life Care in Patients With an
Implantable Cardioverter-Defibrillator,” in a recent Mayo Clinic Proceedings, says,
“Clinical guidance is deficient regarding deactivation of implantable cardioverter-
defibrillators (ICDs) in patients with terminal illnesses.” Forty-six percent of
physicians responding to an anonymous survey “either thought it was illegal or were not sure
if it was legal to deactivate an ICD” when a patient is dying. When reassured that it was legal
to deactivate the devices, 91% of the same respondents indicated a willingness to discuss
voluntary deactivation with patients who were dying. (Mayo Clinic Proceedings, 2008;83:1139-
1141)

* “Comparison of Prospective and Retrospective Indicators of the Quality of End-of-
Life Cancer Care,” in the November 10 Journal of Clinical Oncology, found that
prospective and retrospective measures “identified similar physician and hospital
patterns of end-of-life care.” Both found an “underuse of palliative care at the end of
life,” and hospice admission within three days of death, and death in an acute care
hospital, were similar for both. Patients of small oncology practices got more
chemotherapy and less hospice that patients in large group practices. Patients in non-
teaching hospitals were “more likely to receive chemotherapy … and to have toxicity” but
were “less likely to receive opiates … and hospice.” (Journal of Clinical Oncology, 2008.16.3956)

* The website of the President’s Council on Bioethics has the transcripts of four
November 20 sessions on medical futility. The transcripts are online at
www.bioethics.gov/transcripts/november08/nov20.html. (President’s Council on Bioethics
Website)

* The National Quality Forum and other partner organizations have established the
National Priorities Partnership, a group of 28 organizations “that are uniquely
positioned to improve American's health and healthcare system.” One of the six foci
of the group will be palliative and end-of-life care. See
www.nationalprioritiespartnership.org. (NHPCO Website, 11/17)
* Let's Talk Pain is a new coalition established by the American Pain Foundation, American Academy of Pain Management, and the American Society for Pain Management Nursing. The coalition will offer a national campaign which will “provide information to encourage individuals with pain and their healthcare professionals to improve how they communicate with each other about pain and its treatment. By providing those affected by pain with helpful tools and up-to-date information, the Coalition will help foster improved communication between those affected by pain and their healthcare professionals, which will result in improved treatment outcomes.” See www.letstalkpain.org. (Let's Talk Pain Website)

* An article in the November 24 Journal of Clinical Oncology, “What Are Terminally Ill Cancer Patients Told About Their Expected Deaths? A Study of Cancer Physicians’ Self-Reports of Prognosis Disclosure,” says that oncologists “report routinely informing their terminally ill patients that they will die. However, they are divided in describing themselves as either always discussing a terminal prognosis or doing so if it is consistent with their patients’ preferences for prognostic information. Most medical oncologists say they do not routinely communicate an estimated survival time to their patients.” (Journal of Clinical Oncology, 2008.17.2221)

* From Birth to Death and Bench to Clinic: The Hastings Center Bioethics Briefing Book for Journalists, Policymakers, and Campaigns is a new Hastings Center report. The book “contains 36 overviews of issues in bioethics of high public interest.” The book is online at www.thehastingscenter.org/Publications/BriefingBook/Default.aspx, and Chapter 11 is on end-of-life care. (The Hastings Center Website)

**HOSPICE & END-OF-LIFE NOTES**

* Thirty-two-year-old Rosaria Vandenberg died of a brain tumor. While her family brought her home to die, they weren’t really sure that’s what she would have chosen to do. So her sister-in-law, Alexandra Drane, has made it her mission to get families to discuss end-of-life wishes. This past Thanksgiving, internet bloggers around the country promoted end-of-life discussions around the dinner table, and Drane’s website, www.engagewithgrace.com, supplied the tools to make it easy. (The Boston Globe, 11/26; USA Today, 12/1)

* In 2005, 35% of deaths were of people enrolled in hospice, and in 2007, the rate rose to 39%. NHPCO says that the number of non-cancer patients cared for by hospice continues to increase, while the average length of service increased from 59.8 days in 2006 to 67.4 days in 2007. The NHPCO “Facts and Figures” report can be seen at www.nhpco.org. Click on “About NHPCO,” then on “News Room,” then on “NHPCO Reports Growth in Number of Hospice Patients Served…” (Eli’s Home Care Week, 11/17; NHPCO Website)

* Trinity Hospice in Wichita recently closed, another is for sale. Still another has laid off staff, and all are looking for ways to trim costs. Most of the problems are
coming from the October 1 reimbursement cuts.  (*The Wichita Eagle, 11/25; Eli’s Home Care Week, 11/17*)

**ALZHEIMER’S NOTES**

* The increasing number of Alzheimer’s patients in hospice is a big factor in the doubling of new hospice enrollees in the last decade.  *US News & World Report* provides an overview of hospice requirements, care, history, and challenges facing the industry.  (*US News & World Report, 12/15*)

* An article in the Fort Myers *The News-Press* says, “Alzheimer’s is striking Hispanics and blacks in disproportionate numbers.  The disease has become so prevalent among both groups that the Alzheimer’s Association has put out national calls to action urging more research and outreach.”  Though experts say both groups tend to care for their elders at home, one caretaker says she regrets not learning more about specialized care and about the disease itself.  She thinks she would have been better prepared to meet the challenges of caring for her father.  (*The News-Press, 12/1*)

**OTHER NOTES**

* Since 1996, the number of men who provide care has risen dramatically, from 19% of all family caregivers in 1996 to 40% now.  *The New York Times* says, “Often they are overshadowed by their female counterparts and faced with employers, friends, support organizations and sometimes even parents who view caregiving as an essentially female role.  Male caregivers are more likely to say they feel unprepared for the role and become socially isolated, and less likely to ask for help.”  (*The New York Times, 11/28*)

* Dr. Dave McGrew, who has been medical director of Florida’s Hernando-Pasco Hospice for nearly 30 years, is the recipient of this year’s Josefina B. Mango Distinguished Hospice Physician Award.  The award is given by the American Academy of Hospice and Palliative Medicine as a lifetime achievement award.  (*St. Petersburg Times, 11/30*)

* Dr. Diane Meier, director of the Center to Advance Palliative Care, and professor of geriatrics and internal medicine at Mt. Sinai School of Medicine, was interviewed for *Hospitals & Health Networks* magazine.  Meier is the recent recipient of McArthur Foundation “genius” grant.  Meier says, “Palliative care is medical care focused on relief of suffering and support for best possible quality of life for patients with serious illnesses and their families.  It is delivered at the same time as all other appropriate therapies, including curative and life-prolonging treatments.”  She says she can retire to gardening and baking when “the Joint Commission decides to require palliative care consultation programs as a condition of accreditation,” because the support that CAPC has been offering will be available in all hospitals.  (*Hospitals & Health Networks, 11/2008*)
A survey by the American Association of Colleges of Nursing shows that enrollment in baccalaureate nursing programs rose 2% from 2007 to 2008, down from the 16.6% growth in 2003. Enrollment in master’s degree nursing programs has also decreased, while entry in research-focused doctoral programs remains flat. (PR Newswire, 12/3)

Thanks to Kathy McMahon and Don Pendley for contributions.

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There will be no issue of The Hospice e-News on December 23 or December 30, 2008.