Judi Lund Person, MPH, CHC

Vice President, Regulatory and Compliance

National Hospice and Palliative Care Organization

September 2019

What is Happening in Washington for Hospice and Palliative Care

MedPAC March 2019 Report to Congress

Hospice Content

Released March 15, 2019

Levels of Care and Utilization

Level of Care	Description	FY2019 Base Daily Rate	Utilization
Routine home care	Days 1-60	$196	31.6%
	Days 61+	$154	66.4%
Continuous home care	Home care provided in periods of crisis	$42 per hour	0.2%
Inpatient respite care	Provide respite to family	$176	0.3%
General inpatient care	Treat symptoms that cannot be provided in another setting	$758	1.4%

Source: MedPAC March 2019 Report to Congress, Table 12-1

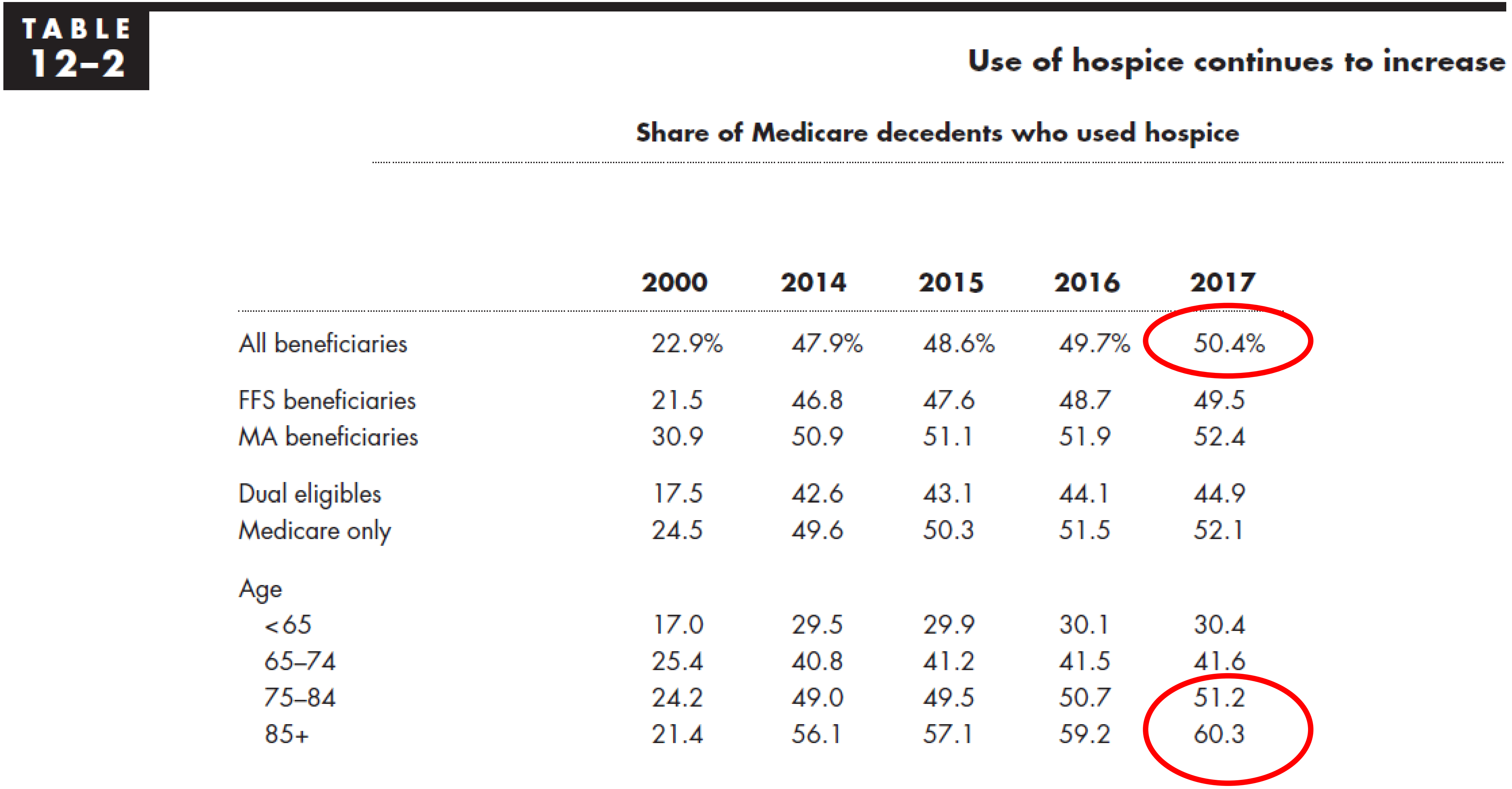


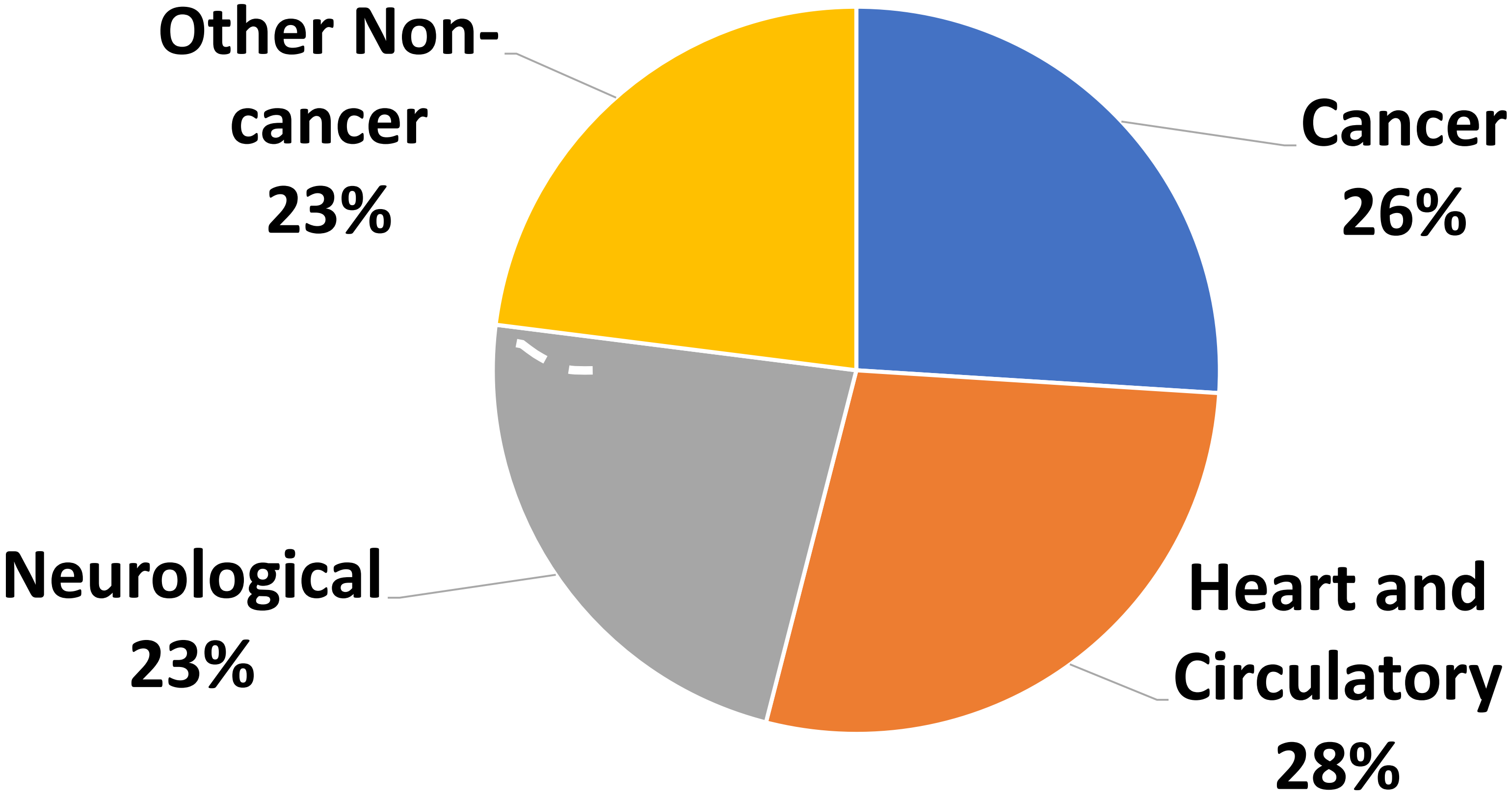
TABLE
12–2

Use of hospice continues to increase

Share of Medicare decedents who used hospice

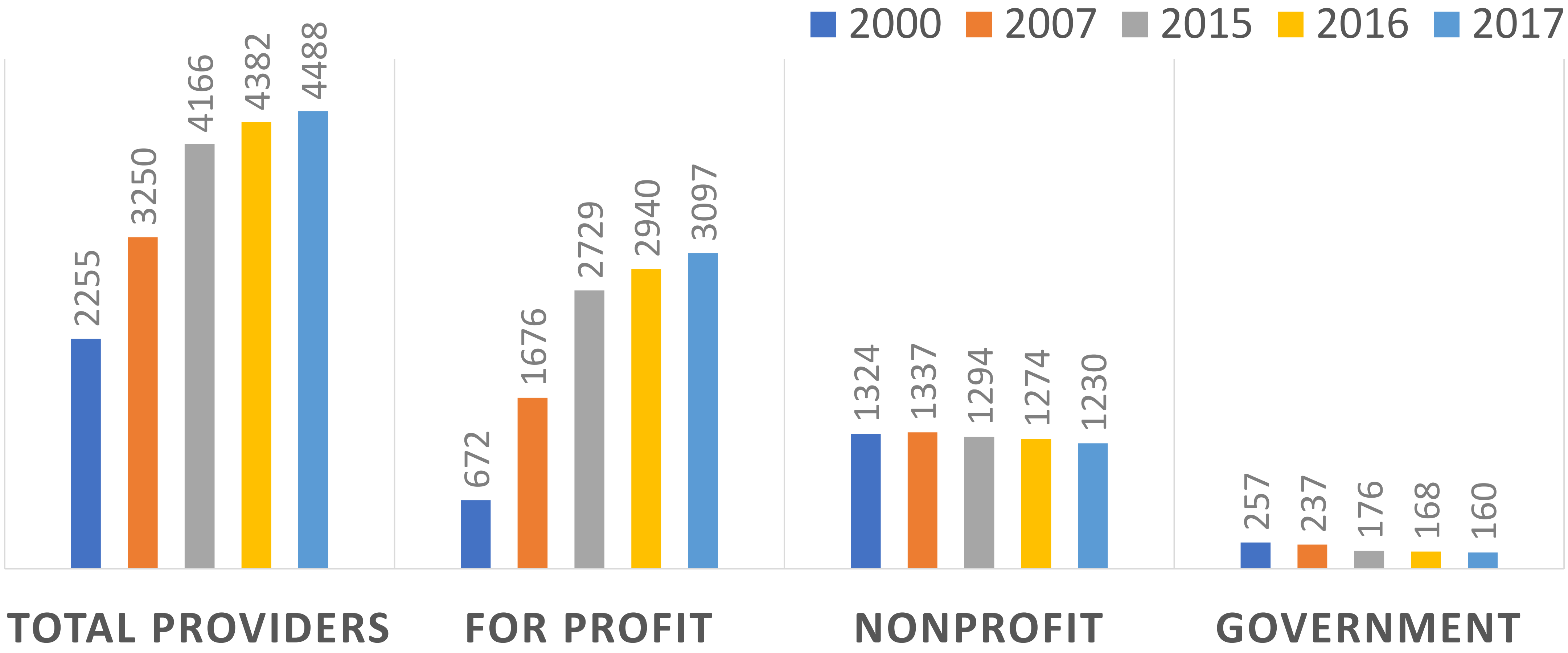
	2000	2014	2015	2016	2017
All beneficiaries	22.9%	47.9%	48.6%	49.7%	50.4%
FFS beneficiaries	21.5	46.8	47.6	48.7	49.5
MA beneficiaries	30.9	50.9	51.1	51.9	52.4
Dual eligibles	17.5	42.6	43.1	44.1	44.9
Medicare only	24.5	49.6	50.3	51.5	52.1
Age					
<65	17.0	29.5	29.9	30.1	30.4
65–74	25.4	40.8	41.2	41.5	41.6
75–84	24.2	49.0	49.5	50.7	51.2
85+	21.4	56.1	57.1	59.2	60.3

Diagnosis Mix in 2017

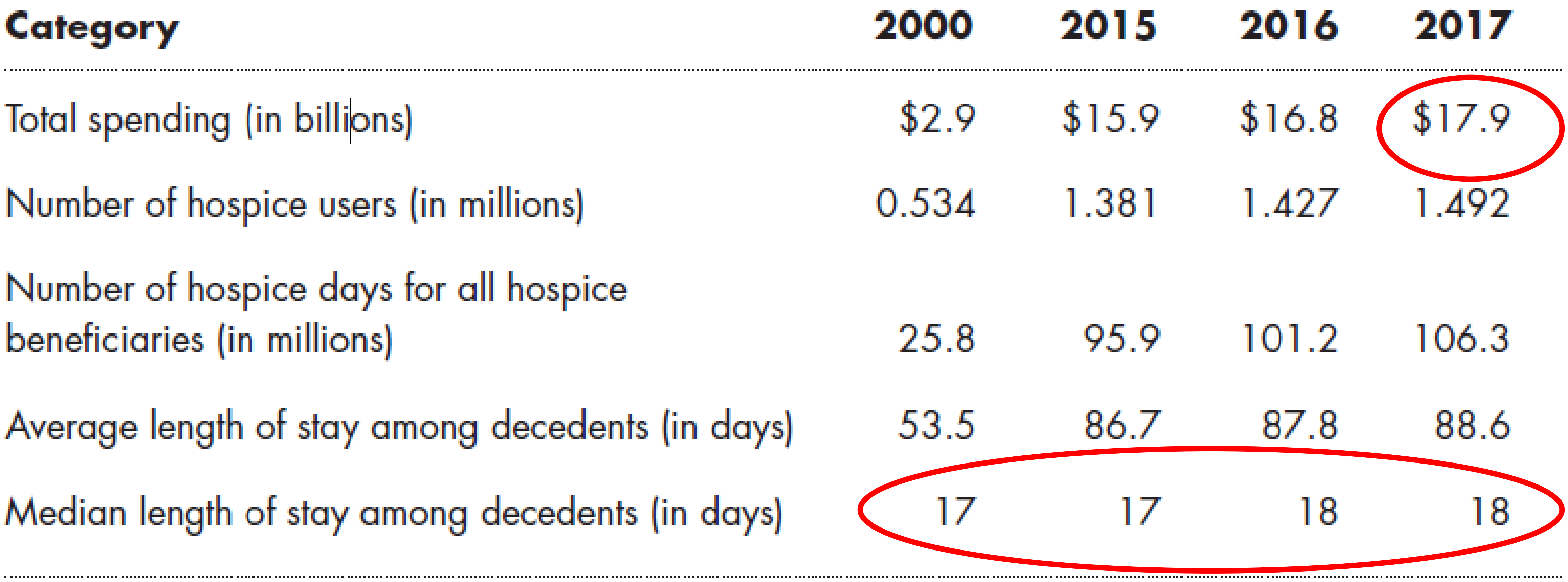


Source: MedPAC March 2019 Report to Congress, Table 12-1

Growth in Hospices



Hospice Utilization and Spending Increases in 2017



Category	2000	2015	2016	2017
Total spending (in billions)	$2.9	$15.9	$16.8	$17.9
Number of hospice users (in millions)	0.534	1.381	1.427	1.492
Number of hospice days for all hospice beneficiaries (in millions)	25.8	95.9	101.2	106.3
Average length of stay among decedents (in days)	53.5	86.7	87.8	88.6
Median length of stay among decedents (in days)	17	17	18	18

New Models and Services for End of Life Care

MCCM

- Participants in program an average of 64 days
- received about 11 visits, calls, or mail or email contacts per month
- 75% of contacts in person
- 83% transitioned to hospice
- Average LOS 30 days

Advance Care Planning Codes

- Died in 2016 8.4%
  - Used hospice 5.0
  - Did not use hospice 3.5
- Died in 2017 7.3%
  - Used hospice 4.4
  - Did not use hospice 2.9

Source: MedPAC March 2019 Report to Congress, Table 12-6

Long Stays in Hospice

Characteristic	Average Length of Stay (in days)
Beneficiary	
Diagnosis	
Cancer	52
Neurological Disorders	149
Heart/Circulatory	94
COPD	118
Other	94
Main Location of Care	
Home	91
Nursing Home	105
Assisted Living	153

OIG Reports – July 2019

OIG Report #1

- 95% of hospices that provided care to Medicare beneficiaries were surveyed from 2012 through 2016 and included in the sample
- 2 reports released in July 2019
  - **Hospice Deficiencies Pose Risks to Medicare Beneficiaries**
    - **Key Takeaway:** The majority of hospices had at least one deficiency in the quality of care they provide.
    - It is essential that CMS take action to hold hospices accountable and protect beneficiaries and the program.

OIG Report #2

- **Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm**
  - **Key Takeaway** Some beneficiaries have been seriously harmed when hospices provided poor care or failed to take action in cases of abuse.
  - These cases reveal vulnerabilities in beneficiary protections that CMS must address, including strengthening reporting requirements, to better ensure that beneficiary harm is identified, reported, addressed, and, ultimately, prevented.

What the OIG Found

- **Report #1**
- Poor care planning
- Hospice aide training and management
- Beneficiary assessment
- Vetting of staff
- Failure to provide needed services

- **Report #2**
- Untreated wounds resulting in gangrene and amputation
- Maggots
- Suspected sexual abuse
- No intervention when patient harmed by caregiver
- Repeated theft of medications

Poor Performers

- 313 hospices identified as poor performers
- 18% of all hospices surveyed in 2016
- Poor performer characteristics:
  - At least one serious deficiency or
  - One substantiated severe complaint in 2016
  - 88% (275 hospices) had a history of other violations, including one other deficiency or substantiated complaint
- About half of these hospices had deficiencies or substantiated complaints in multiple years

What OIG Recommends

Adjust the penalties available to regulators

Could apply a series of gradually increasing sanctions depending on the severity, frequency and history of deficiencies

Include public warnings, more stringent surveys and reporting and civil penalties, with expulsion from Medicare as a final recourse.

Educate hospices about common deficiencies and identify those with beneficiary harm

Make it easier for patients and families to figure out which hospice is best for them.

Add information to [Hospice Compare]

Add survey results from state survey agencies and accrediting organizations

What the Congress Sees

Abuse in hospice program

While most agree that it is not systemic, members of Congress want to “do something”

Under consideration - program integrity measures

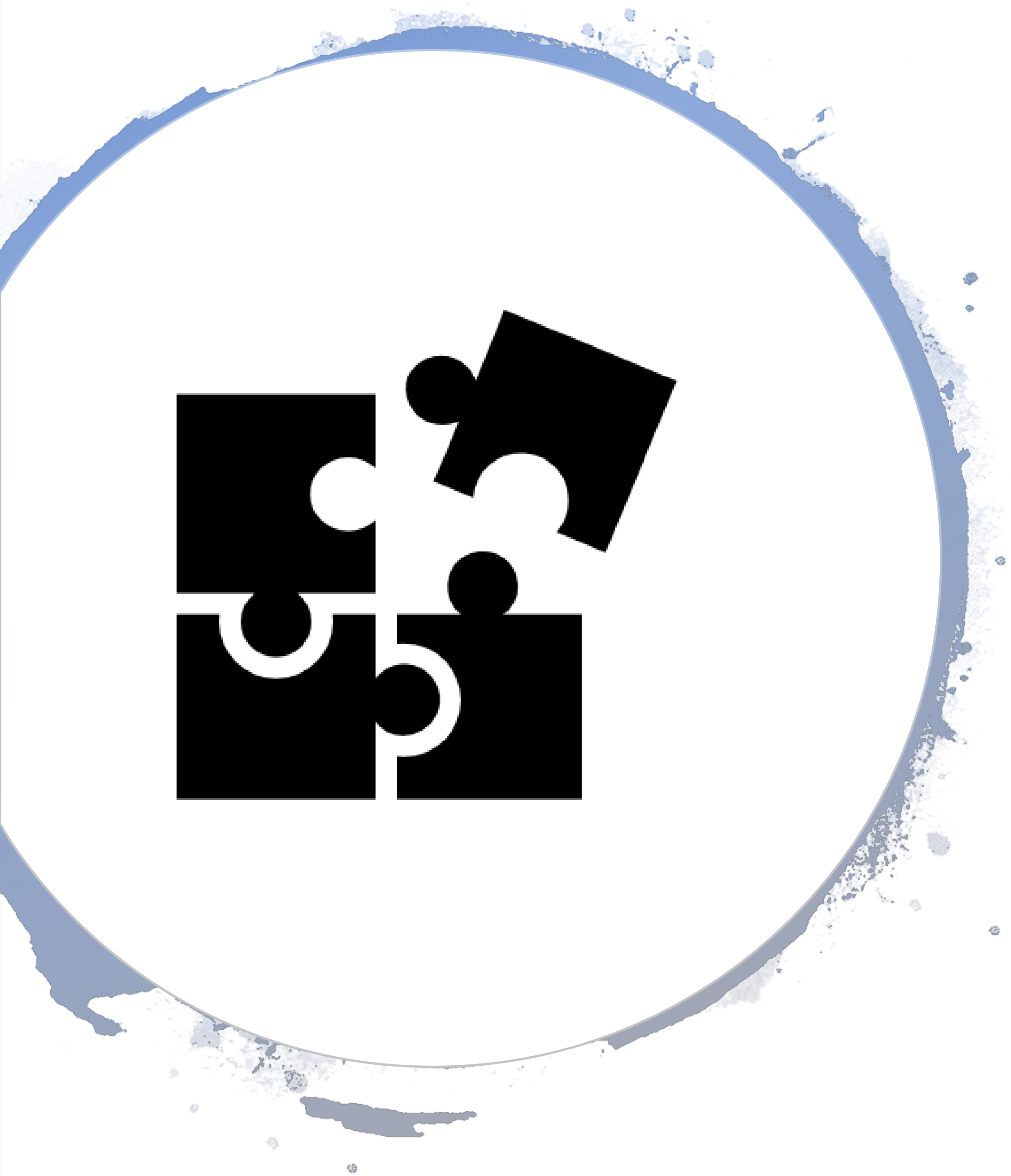
- Intermediate sanctions
- Increase in % penalty for not participating in quality reporting
- Remedial education

Expected Next Steps

- Program integrity measures developed by NHPCO, vetted through committees and presented to House Ways and Means
- Legislation to be introduced addressing quality of care concerns
- Congressional hearings possible
    - Could focus on poor performers
    - Could focus on hospice more broadly
- High media attention

Supplemental Benefits

Authorized by CY2019 Call Letter



Medicare Advantage Flexibilities

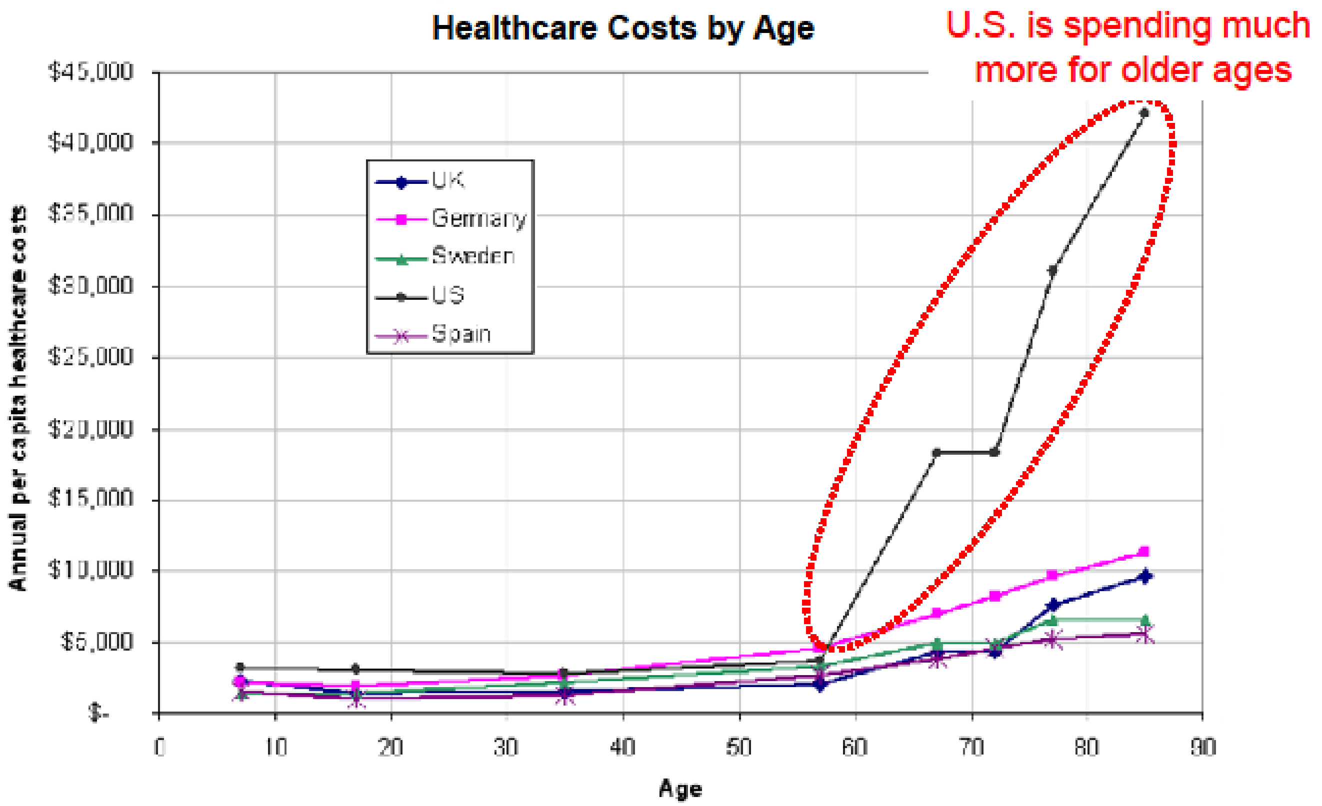
- ➢ Targeted supplemental benefits based on beneficiaries’ socioeconomic status, health conditions, or both
- ➢ Expanding the scope of rewards and incentives programs
- ➢ Greater use of telehealth; requirements for wellness and health care planning (advance care planning)
- ➢ And an integrated hospice benefit (2021)

MA Plans Empowered to Cover New Modes of Palliative Care in 2019

Expands “primarily health related” standard for Supplemental Benefits to include:

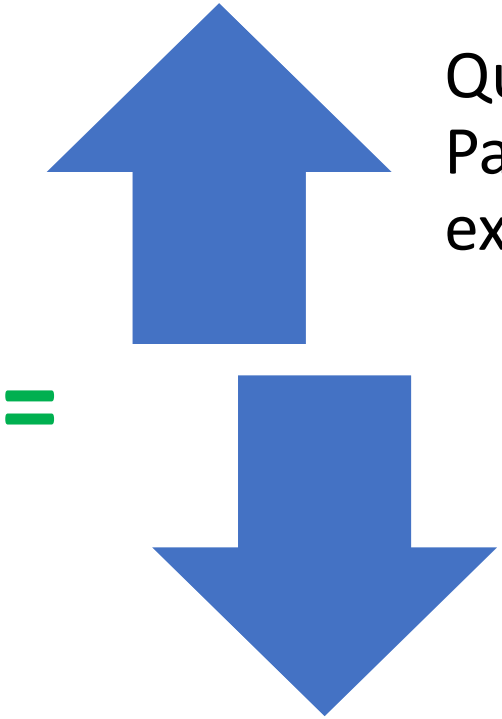
Home-Based Palliative Care services to diminish symptoms of terminally ill members with a life expectancy of greater than six months not covered by Medicare (e.g., palliative nursing and social work services in the home not covered by Medicare Part A).

Costs by Age Categories



Source: Fischbeck, Paul. "US-Europe Comparisons of Health Risk for Specific Gender-Age Groups." Carnegie Mellon University; September, 2009.

The Palliative Care Value Proposition



VALUE =

Quality of care &
Patient/family
experience

Utilization of
emergency room
and hospital &
Total cost of care

Value Based Insurance Design (VBID)

CY 2021 VBID

Include Hospice as an Intervention

Model goal is to increase access to hospice services and facilitate better coordination between patients’ hospice providers and their other clinicians.

Release additional information and guidance in the coming months

Open Door Forum type events

CMMI CY 21 VBID Policy Considerations

Beneficiary Access	Ensuring beneficiaries access hospice consistent with their preferences and eligibility, and addressing short and long length of stay issues. Providing access to and choice of hospice care for MA enrollees in model-participating plans
Payment	Ensuring both financial stability and sustainability for MA plans and hospice providers, as well as creating opportunity for innovation
Quality	Measuring and monitoring to ensure that MA hospice beneficiaries are receiving appropriate and high-quality care

CMMI CY 21 VBID Policy Considerations

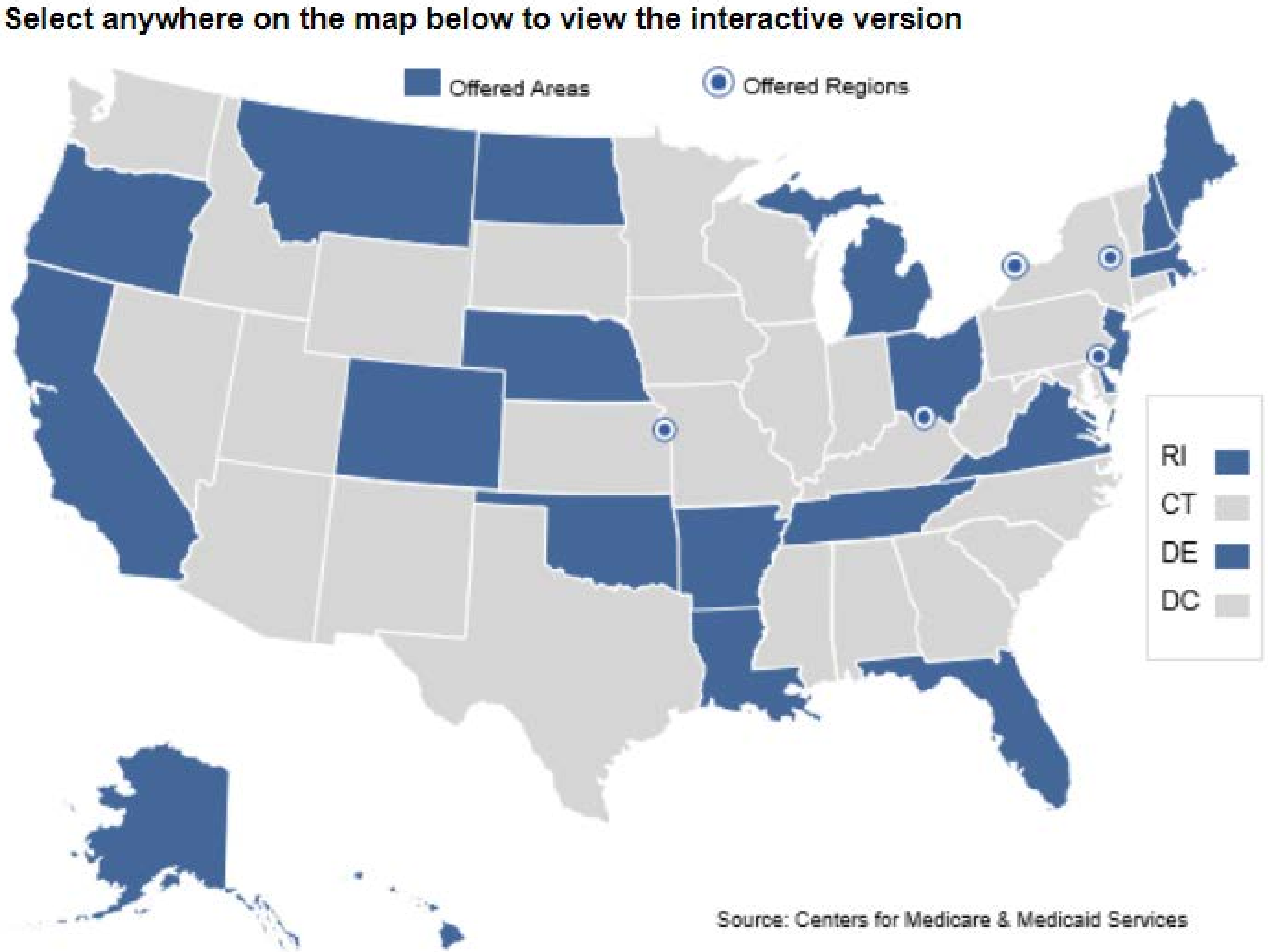
Evaluation	Evaluating the impact of the model on cost and quality, consistent with the CMS Innovation Center's mission and statutory requirements
Collaboration Approaches for Plans and Hospices	Consideration of different approaches for collaboration in ways in which the CMS Innovation Center can facilitate

5 Key Policy Principles

- Beneficiary access
- Integrity of the hospice benefit
- Quality oversight and accountability
- Reimbursement model and financial sustainability
- Administrative burden and data collection

New Models: Primary Care First & Serious Illness Population (SIP) Models

In 2020, Primary Care First will include 26 diverse regions:



Source: Centers for Medicare & Medicaid Services

Primary Care First Overview

- 5-year alternative payment model
- Offers greater flexibility, increased transparency, and performance-based payments to participants
- Payment options for practices that specialize in patients with complex chronic conditions and high need, seriously ill populations
- Fosters multi-payer alignment to provide practices with resources and incentives to enhance care for all patients, regardless of payer type

Practice Eligibility Requirements for the Primary Care First Model Option

- ✓ Demonstrate experience with value-based payment arrangements
- ✓ **Use 2015 Edition Certified Electronic Health Record Technology (CEHRT**), support data exchange with other providers and health systems via Applicable Programming Interface (API), and connect to their regional health information exchange (HIE)
- ✓ Attest via questions in the Practice Application to a limited set of advanced primary care delivery capabilities, including 24/7 access to a practitioner or nurse call line, and empanelment of patients to a primary care practitioner or care team
- ✓ Include primary care practitioners (MD, DO, CNS, NP, PA), certified in internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine in good standing with CMS
- ✓ Provide health services to a **minimum of 125 attributed Medicare beneficiaries***
- ✓ Have primary care services account for the predominant share (e.g. 70 to 80 %) of the practices' collective billing based on revenue*
- ✓ Demonstrate experience with value-based payment arrangements

Eligibility Requirements for the PCF High Need Population Model Option

Practices receiving SIP-identified patients (identification is based on risk score) must:

- ✓ Include practitioners serving seriously ill populations (MD, DO, CNS, NP, PA) in good standing with CMS
- ✓ Meet basic competencies to successfully manage complex patients and demonstrate relevant clinical capabilities (e.g. interdisciplinary teams, comprehensive care, person-centered care, family and caregiver engagement, 24/7 access to a practitioner or nurse call line)
- ✓ Have a network of providers in the community to meet patients' long-term care needs for those only participating in the SIP option
- ✓ Use 2015 Edition Certified Electronic Health Record Technology (CEHRT), support data exchange with other providers and health systems via Applicable Programming Interface (API), and connect to their regional health information exchange (HIE)

Hybrid Total Primary Care Payments replace Medicare FFS

✚

Professional Population-Based Payment (PBP)

Practice Risk Group	Payment PBPM
☐ Group 1 (lowest risk)	☐ $24
☐ Group 2	☐ $28
☐ Group 3	☐ $45
☐ Group 4	☐ $100
☐ Group 5 (highest risk)	☐ $175

Payment adjusted to account for beneficiaries seeking services outside the practice

Flat Primary Care Visit Fee

$50.00

- Per face-to-face patient encounter
- (Regardless of practitioner type: MD, DO, CNS, NP, PA)

- These payments allow practices to:

✓ Easily predict payments

✓ Decrease time spent on claims processing and increase time with patients

PCF: High Need Population Payment Model Option

PCF incorporates the following unique aspects for practices electing to serve seriously ill populations (SIP) to increase access to high-quality, advanced primary care

Eligibility and Beneficiary Attribution

- ❖ Practices demonstrating relevant capabilities can opt in to be assigned SIP patients or beneficiaries who lack a primary care practitioner or care coordination.
- ❖ Medicare-enrolled clinicians who provide hospice or palliative care can partner with participating practitioners.

Payments

- Payments for practices serving seriously ill populations
  - First 12 Months

✓ One-time payment for first visit with SIP patient: $325.00

✓ Monthly SIP payments up to 12 months: $275.00 PBPM

✓ Flat visit fees: $50.00

✓ Quality payment up to $50

Key Hawai‘i Community Resources for Those with Serious Illness

Kōkua Mau
Continuous Care
A Movement to Improve Care

What is Palliative Care? ***Palliative Care*** is sometimes referred to as **Supportive** or **Concurrent Care**, and provides strong support for individuals and their loved ones with a serious illness or condition, or have complex health issues. It is not the same as hospice care, and individuals using this benefit can continue to receive curative treatments as desired. Comfort-directed services are focused to help people manage the symptoms and stresses of serious illness. Contact your health plan for further details on this beneficial service. (Please turn over for in-home palliative care programs.)

Hospital-based (Inpatient) Palliative Care Programs

Castle Medical Center: 808-263-5253
Kaiser Permanente: 808-432-7100
Kapi‘olani Medical Center for Women & Children: 808-983-6000
Maui Memorial Medical Center, Palliative Care Coordinator: 808-442-5801
North Hawai‘i Community Hospital: 808-885-4444
Pali Momi Medical Center (ask for palliative care consult): 808-486-6000
Straub Medical Center (ask for palliative care consult): 808-522-4000
The Queen's Health System: 808-547-4726
Wilcox Medical Center (ask for palliative care consult): 808-245-1100

Community-Based (Outpatient) Palliative Care Programs

Franciscan Care Plus (St. Francis): 808-595-7566
HMSA Case Management Program: toll free 1-844-378-9997 or 808-948-5377
Humana and UnitedHealthcare: toll free 1-800-851-7110 or 808-532-6989
Kaiser Permanente: 808-432-8046
Kōkua Kalihi Valley Home-based Palliative Care Services: 808-791-9410
Kupu Care (Hawai‘i Care Choices, Hilo): 808-934-2913
Palliative Medicine Partners (Kaua‘i): 808-245-7277
UHA Comfort Care: toll free 1-800-458-4600 #300 or 808-532-4006

What is Hospice Care? Hospice is a special kind of care helping those with a life-limiting illness, with a prognosis of six months or less, live with dignity and comfort, either at home or in an inpatient care setting. It is a philosophy of care that goes beyond cure, offering the services of an Interdisciplinary Team consisting of a physician, nurses, nurse-aides, social workers, spiritual counselors, nutritional and other therapists, and specially trained patient-care volunteers, focusing on the whole person; mind, body and spirit. Most hospice programs are funded through reimbursements from patients' health insurance plans (e.g. Medicare, Medicaid and private insurance) and is provided on all islands. In cases where there is no insurance coverage, most hospice programs will provide core services at no cost. All hospice providers offer *Community-Based Palliative Care*. Contact your preferred hospice directly.

O‘ahu:	
Bristol Hospice	808-536-8012
Hospice Hawai‘i	808-924-9255
Islands Hospice:	808-550-2552
Mālama Ola Health Services	808-543-1188
St. Francis Hospice:	808-595-7566
Veterans Administration	808-433-7676
Kaua‘i	
Kaua‘i Hospice:	808-245-7277

Island of Hawai‘i:	
Hawai‘i Care Choices:	808-969-1733
Hospice of Kona:	808-324-7700
North Hawai‘i Hospice:	808-885-7547
Maui:	
Hospice Maui:	808-244-5555
Islands Hospice Home, Kahului	808-856-8989
Lana‘i: Hospice Hawai‘i	808-565-6777
Moloka‘i: Hospice Hawai'i	808-553-4310

UHA and HMSA offer in-home palliative care programs. UHA's program is '***Comfort Care***' and '***Supportive Care***' is an HMSA benefit. The goal is to improve quality of life for patients who have a serious or life-threatening disease. Typical goals of care would be to prevent or treat symptoms of a disease, side effects caused by treatment, and psychological, social, and spiritual problems. The person receives comprehensive clinical and psycho-social support while maintaining their usual care and, typically, supportive care includes skilled nursing, case management, psycho-social support, personal care aid and spiritual support. Most durable medical equipment and comfort medications related to the supportive care diagnosis are covered. Supportive care is provided by hospice teams, who are available by phone or in-person 24 hours a day, 7 days a week. (As of January 2019)

ADVANCE CARE PLANNING – MAKING LIFE DECISIONS

Everyone needs an Advance Directive – Not Everyone needs a POLST

A) The Advance Health Care Directive, commonly known as an Advance Directive, allows you to appoint your Health Care Power of Attorney, the person who can speak for you if you cannot speak for yourself in a medical situation. It allows you to specify your wishes for care at the end of life. There are many versions of the Advance Directive. You can download a free version at kokuamau.org/resources/advance-directives. **Everyone 18 years and older needs an Advance Directive.**

B) What is POLST? POLST (**P**rovider **O**rders for **L**ife-**S**ustaining **T**reatment) is a portable medical order meant for **seriously ill or medically frail individuals** and takes effect as soon as it is signed. It can follow you from home into a medical setting, and after discharge to your home or other setting such as a nursing or care home. POLST is a form that contains medical orders that specify the type of care you would like in the event of a medical emergency. This form can be quickly understood by all healthcare professionals, including first responders and ambulance personnel. Transferable to all healthcare settings, POLST must be a signed by a physician or APRN to be valid and can only be completed after having in-depth conversations with your provider. Completing a POLST form encourages communication between healthcare providers and patients and loved ones, enabling patients to make more informed decisions. More at kokuamau.org/polst

C) Free Speakers Bureau: Kōkua Mau wants to get our community talking about wishes for care at the end of life. Our **Let's Talk Story Program** will go to where people work, live and pray for interactive sessions facilitated by our trained experts. To arrange a free workshop on this important topic, contact us at speaker@kokuamau.org or call us.

OTHER WEB RESOURCES:
Grief and Bereavement Support (pdf 11 pages): The Bereavement Network of Hawaiʻi maintains a comprehensive, constantly updated list of support groups and services in Hawaiʻi. Visit the Kōkua Mau website for the Bereavement Support List as a PDF file. Or go to: www.kokuamau.org/services/caregiving

Aging and Disability Resource Center (ADRC), State of Hawaiʻi
If you have questions about aging and disability ADRC is your source in Hawaiʻi for answers, with information about the home and community services you may need. ADRC is a one-stop resource for long-term care, information and services. Call statewide at 808-643-2372 or visit www.HawaiiADRC.org. The service is free.

Kōkua Mau - A Movement to Improve Care
Visit www.kokuamau.org for further information and to download resources available for professionals and the general public, including Advance Directives, POLST, palliative care, hospice and other local resources.

Kōkua Mau
PO Box 62155
Honolulu HI 96839

www.kokuamau.org
Phone: 808-585-9977
info@kokuamau.org

Please note: The list was compiled and updated by Kōkua Mau as a community service June 2019. Please call the number listed to find out details about the specific group or program. We need your help to maintain this list: Please send any additions or edits to: info@kokuamau.org. For additional resources, visit: www.kokuamau.org/services/caregiving

Who is Kōkua Mau and how can we help you?

Kōkua Mau
Continuous Care
A Movement to Improve Care

Kōkua Mau is the only organization in Hawaiʻi that supports and assists the health care professionals who work with people facing life limiting illness and their loved ones in one organization.

- Kōkua Mau provides networking with expert and experienced leaders, clinicians, educators, and advocates.
- Kōkua Mau offers tailored education opportunities in relation to palliative and end-of-life care through workshops, special speaker events, and seminars.
- Please sign up for our free monthly e-newsletter for updates on national and local news, events, trainings and workshops (including CME events).

As a community benefit organization, our purpose is to improve quality of life for people living in Hawaiʻi by promoting excellence in hospice, end-of-life, and palliative care, and early advanced care planning. We offer:

- Public and professional education
- Advocacy and public policy
- Statewide leadership
- Promotion and fostering of a collaborative membership
- Development of professional and organizational healthcare capacity

POLST, Free Advance Directive and Other Kōkua Mau Resources

Our website **www.kokuamau.org** offers up-to-date information on hospice and palliative care. It provides information and resources for people with life threatening illnesses and their caregivers, help for the bereaved, materials for professionals, and local and national news. Resources and written materials that can be downloaded as a pdf file or viewed online include:

- Information on POLST (Provider Orders for Life-Sustaining Treatment), including instructions for the public and for professionals as Kōkua Mau is the lead agency for implementing this essential legislation
- Free advance directives
- 5 booklet series on end-of life planning and care for caregivers (18 pages each)
- “Breaking the Ice”- Personal Stories on End-of-life Issues” a locally produced DVD
- “Living your Dying” an inspiring 57 min. DVD with the late Rev. Dr. Mits Aoki

Join Kōkua Mau

Our collaborative-driven membership includes hospice care providers, innovative hospitals, palliative care experts, educational institutions, and passionate community champions. Kōkua Mau creates a unity of practice and service where clinical providers, advocates, and collaborating organizations come together to exchange knowledge and resources and to guide the future of end-of-life care and support in the state of Hawaiʻi. Visit www.kokuamau.org and click on the “Donate 3 Options” under ‘Quick Links’ or call 808-585-9977 for more information.

Kōkua Mau • P.O. Box 62155 • Honolulu, HI 96939
Website: www.kokuamau.org • Tel: 808-585-9977 (please leave message) • Email: info@kokuamau.org