National Partnership for Hospice Innovation
IMPROVING THE CARE EXPERIENCE

National Partnership for Hospice Innovation: Policy Recommendations and Priorities

NPHI is a nationwide collaborative of not-for-profit, community-integrated hospice and palliative care provider members who serve as a crucial safety net for the sickest, most vulnerable patients in the communities we serve. Our organizations are mission-driven and committed to improving access to high-quality care. In addition to advancing policies that protect vital hospice and palliative care benefits for our terminally-ill seniors, we design and operate hospice programs for special populations, such as children, minorities, and prisoners. Our members are leaders in hospice and palliative care innovation, such as hosting integrated professional training programs and using telehealth, and in the empirical development of quality benchmarking metrics. Because of the scope of our services and our commitment to take all appropriate patients, regardless of diagnosis, insurance status, or life circumstances, our programs survive with small margins, and many leverage philanthropic dollars both to deliver innovative care as well as to be able to serve as safety-net providers. Although we understand the need for efficiency and accept the importance of value-based purchasing, we must also advocate for fairness and support from our primary payer, the federal government.

NPHI strongly believes that the long-term benefits of hospice for an aging population can be advanced through an active and ongoing collaboration between our community of not-for-profits and the federal government. Through this collaboration, our members can assist policymakers in the development and evaluation of policies that promote quality, safety, and efficiency, while concurrently providing actionable feedback on federal initiatives that are onerous or unfair in execution.

NPHI has developed a list of policy concerns and priorities that focus on the following four areas of focus: innovation to preserve and enhances access to care, program integrity, payment reform, and regulatory improvements. We seek a specific approach by which we can jointly address some or all of these issues.

Innovation: Access to and Removing Barriers to Care

Late Referrals to Hospice and the Opportunity for Innovation around the Six Month Designation & Concurrent Care: The median length of stay in hospice is less than 3 weeks and more than one-quarter of patients referred to hospice die within a week. This short length of stay is not in the best interest of any stakeholder. It limits the clinical benefits associated with hospice care, stresses our patients, families and organizations, and constrains the benefits that the payer community could achieve with more appropriate use of the hospice benefit. Late referrals are driven by three phenomena: 1) physicians are unable to accurately prognosticate a 6-month survival, 2) eligibility linked to prognosis has promoted the public's perception that hospice is solely care for the actively dying and there is a cultural reluctance to openly address issues related to death and dying, and 3) creation of hospice as a full-risk managed care benefit without the potential for any payment to support costly disease-modifying therapy provides no margin for hospice agencies to assume high-cost patients. The new demonstration sponsored by the Center for Medicare and Medicaid Innovation (CMMI)—the Medicare Care Choices Model (MCCM)—illustrates CMS's recognition of these issues and many NPHI members will be participating in the demonstration.

- NPHI supports a broader process of review that could lead to program changes or pilot projects that go beyond MCCM. NPHI supports efforts to develop and evaluate models in which hospice eligibility is linked to diagnosis plus demonstrated need for specialist palliative care.

- Additionally, we support efforts to develop other types of payment models that would allow for concurrent care with disease-modifying therapies, such as outlier payments for specific therapies.

In order to actualize these models, NPHI supports efforts to modernize the certification methodology based on the six-month designation of prognosis, which relies excessively on demonstration of decline. Other factors should be taken into account, such as data related to epidemiology or treatment duration and patient and family need for services.

Face-to-Face Requirement: NPHI recommends modernizing the implementation of face-to-face requirement to account for other innovations in healthcare delivery, such as telehealth. Other policies could increase flexibility by allowing hospices to utilize nurses, physician assistants, or other qualified health professionals to complete the face-to-face encounter.

Innovation in Medicare Advantage: NPHI is currently creating a nation-wide demonstration pilot to test the concept of carving the hospice benefit into Medicare Advantage (MA). This pilot will identify what type of contracting requirements and safeguards would be necessary to protect the integrity of the Medicare hospice benefit and the full scope of hospice services. As legacy hospice providers, NPHI members have unparalleled experience in delivering interdisciplinary, quality care under the existing benefit. NPHI is testing the carve-in of the hospice benefit to the MA program so that integrity of the benefit and the full scope of hospice services are protected and provided regardless of the payer.

Outlined below are categorical safeguards that should exist in any carve-in, but strongly recommend that our pilot be allowed to be fully implemented in order to test these ideas and gather data for Congress to consider.

- Access: There are well-established networks of community-integrated hospice providers throughout the country – and any consideration of a carve-in for hospice benefits should build on these existing, integrated networks and not create incentives to dismantle them.

- Quality: Quality, measured based on outcomes and on patient and family satisfaction, should play a substantial role in the design of a potential MA hospice benefit. Quality metrics should be considered both in MA contracting policy and in the revision of the MA star rating program.

- Reimbursement: Concerns exist that direct negotiation of rates with MA plans directly for hospice services could result in larger, for-profit providers, potentially with lower quality indicators, underbidding for services to gain market advantage – thereby excluding community-based not-for-profit providers. This would further compromise the ability of this critical group of not-for-profit, safety-net hospice providers from continuing mission-critical operations in many parts of the country, and have adverse spillover effects on care for the fee-for-service population.

- Minimizing Administrative Burdens: The design of a carve-in's approach to provider contracting should minimize administrative burdens to hospice providers, especially not-for-profit, safety-net community based providers for whom existing administrative burdens threaten the viability of the programs.

Program Integrity

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), which became law in 2014, includes new requirements to measure and improve hospice care. The new law will mandate quality surveys every 36 months, increase medical review for long lengths of stay, and align the increase in the aggregate cap with reimbursement over the next decade. NPHI urges that such program integrity efforts

be driven by data; a data driven approach will allow for new documentation and other requirements to focus on outlier providers rather than on the majority of hospices who are not engaging in bad behaviors.

Focused Medical Review for Outlier Programs: NPHI recommends focused medical review of hospice programs with: 1) Unusually high shares of patients with stays exceeding 180 days; 2) Unusually high rates of patients discharged alive; 3) Low utilization of skilled visits to patients during the last days of life; 4) Programs with a patient diagnosis mix that disproportionately favors conditions that often warrant long lengths of stay; 5) Disproportionately high numbers of patients in facilities; 6) Focus on hospices with high costs outside the benefit; and 7) Who misuse or do not administer all four levels of care. This type of review would focus on the outlier programs for scrutiny which would save the taxpayers' money without unnecessarily burdening not-for-profit, high quality hospice providers for whom any additional administrative burdens place further financial pressure on their abilities to meet the needs in their communities.

Targeted Diagnosis Reporting Documentation Requirements: Similarly to focused medical review, NPHI recommends imposing new documentation requirements only on hospice providers who are outliers on metrics such as unusually long lengths of stay, unusually high rates of patients discharged alive, and low utilization of skilled visits to patients during high service intensity periods (beginning and end of a hospice stay), and others outlined above. Targeting this type of documentation requirement would ease the burden on providers with already slim margins who are already providing high quality care while allowing those providers who may be shifting care to be targeted for program integrity investigations.

Changes to General Inpatient Care (GIP): Requirements should be clarified for GIP eligibility and CMS should pay no more for GIP nursing home than the skilled nursing facility daily payment. This change would remove incentives for providers to overpay nursing homes for hospice referrals. Hospices who do a high proportion of GIP service in the nursing home should be a target for focused medical review. Additionally, NPHI recommends eliminating the visit collection data requirement for hospices who operate their own inpatient unit with GIP patients. The current policy is discriminatory, since hospitals do not have to substantiate patient contacts to receive DRG payment that is at least 10 times the cost of a day of GIP in a hospice facility, and there is no accurate method to collect the data.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys: Almost all hospices are required to contract with CAHPS survey vendors in order to assess patient family experiences with care provided across several areas including team communication and coordination, support for religious and spiritual beliefs, support for family members, and other important metrics. However, the CAHPS surveys must be re-examined to better reflect the experience of patients and family caregivers and to provide more timely feedback. For example, the CAHPS survey is too long and if not all of the questions are answered, the survey does not count. CAHPS data should be able to be used to differentiate and highlight the best providers as well as to target outliers who may not be providing quality care. NPHI supports revisions to the CAHPS surveys to ensure that the highest quality of care is provided to patients and ample support is offered to caregivers.

Payment Reform

Adjusting the Hospice Aggregate Cap Amount: The hospice aggregate cap amount determines the maximum amount a hospice will be reimbursed for services for one year. We recommend reassessing the Medicare hospice cap and utilizing a portion of these savings to support the efforts and sustained effectiveness of community-integrated and rural not-for-profit providers. For instance, there could be an

outlier policy that would allow for a 15 percent adjustment to the cap for rural hospices. NPHI recommends a 15% reduction in the annual aggregate hospice cap amount with a safe harbor adjustment for rural hospices.

Diagnosis Versus Prognosis: NPHI recommends that payment for hospice services be based on those issues related to a patient's terminal diagnosis rather than on all the issues that "influence" a patient's diagnosis, many of which are outside of the control and expertise of a hospice provider.

Elimination of the Hospice Market Basket Update Caps Set to Begin in 2018: Included in the Medicare Access and CHIP Reauthorization Act (MACRA) was a provision that capped market basket updates for all post-acute care providers, including hospice programs. The provision, which is to start in 2018, limits the annual market basket update for all providers to one percent in any given year. Given the other payment reductions experienced since 2009, NPHI asserts that this cut would disproportionately impact smaller, rural, and not-for-profit hospices whose thin margins can ill-afford another payment reduction. NPHI recommends the elimination of these market basket update caps and safe harbors for not-for-profit providers in future reimbursement decisions.

Regulatory Changes

NPHI has identified regulatory changes that we see as high impact. Changes in these areas would have an immediate, ameliorating effect on our budgets and ability to survive as high quality, not-for-profit providers for years to come.

Costly Recovery Audits: The limited resources of the not-for-profit hospices increase the burden associated with cumulative Additional Document Requests (ADRs). The withholding of payment for unresolved ADRs is financially crippling. Limiting multiple unresolved ADRs would offer some relief. We recommend reforming the parameters for triggering audits to target providers that are the true drivers of inappropriate behavior. We also recommend restraining the authority granted to auditors when reviewing programs that operate at low margins and whose metrics such as diagnosis mix among patients and PEPPER scores demonstrate consistency with the intent of the Medicare hospice benefit. NPHI also supports identifying ways to mitigate the financial risk associated with multiple unresolved ADRs on community-based, safety-net hospice providers that do not have high levels of reserves.

Continuous Care Timeframe: NPHI recommends the current continuous care timeframe change from midnight to midnight to a new timeframe of noon to noon. NPHI also recommends that visits from other providers such as chaplains and home health aides count toward the continuous care timeframe.

Part D Drug Prior Authorization: Drugs in four categories that are used to treat common symptoms at the end-of-life, including pain and nausea, require costly prior authorizations. NPHI recommend reassessing this requirement in order to ensure timely access to critical medications.

Notice of Election (NOE) Time Frame: Effective October 1, 2014, hospice providers have a maximum of 5 days to have the NOE submitted and accepted by their Medicare contractor. The Medicare Administrative Contractor (MAC) has 15 days to respond and if the NOE is denied for any reason, the hospice is not paid for any days that the beneficiary has been on service. No retroactive claims are accepted, so no corrections can be filed. NPHI recommends that the MACs be made to respond to NOEs in the same abbreviated time frame as the hospices submit them – 5 days. If the MAC had a required time to respond back to hospices, this would help to reduce lost revenue. Alternatively, the time in which the NOE had to be submitted by the hospices could be increased to 10 days but the MACs should be held to the same standard.