Health Care Reform – The View from Washington

What It Means for Hospice

<table>
<thead>
<tr>
<th>Number of Medicare Beneficiaries (millions)</th>
<th>1980</th>
<th>1990</th>
<th>2000</th>
<th>2010</th>
<th>2020</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled &amp; End-Stage Renal Disease</td>
<td>17.6</td>
<td>20.8</td>
<td>24.3</td>
<td>28.4</td>
<td>32.2</td>
<td>37.6</td>
</tr>
<tr>
<td>Non-Institutional</td>
<td>20.4</td>
<td>25.6</td>
<td>31.0</td>
<td>36.1</td>
<td>41.4</td>
<td>47.2</td>
</tr>
<tr>
<td>Total</td>
<td>38.0</td>
<td>46.4</td>
<td>55.3</td>
<td>64.6</td>
<td>73.6</td>
<td>84.8</td>
</tr>
</tbody>
</table>

* Numbers may not sum due to rounding.

Source: CMS, Office of the Actuary.

The Facts
Recurring Theme in Health Care Reform

- Bending the cost curve
- Permanent reductions in provider reimbursements
  - Hospice: $6.8 billion over ten years

$$$$$$$$

Rate Cuts

Budget Neutrality Adjustment Factor (BNAF)

What is it?
- Multiplier to the hospice wage index each year
- Gives providers a % “bump up” compared to standard wage index rates
- Multiplier is a complex calculation done by CMS

Reductions
- Began in FY2010
- Spread over 7 years
- Final result = (4.2%) rate decrease
Productivity Adjustment Reduction

What is it?
- More output with the same amount of labor and capital

Reduction for all Medicare providers
- 1.3% reduction in hospital marketbasket

Additional reduction for hospices:
- Beginning in FY2013, an additional -0.3%

Net marketbasket increase:

\[2.4\% - 1.3\% - 0.3\% = 0.8\%\]

Sample Routine Home Care Rates

<table>
<thead>
<tr>
<th></th>
<th>No Cuts</th>
<th>BNAF</th>
<th>Productivity Factor</th>
<th>All Cuts</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 1, 2010</td>
<td>$164.91</td>
<td>$154.84</td>
<td>$150.44</td>
<td></td>
</tr>
<tr>
<td>October 1, 2015</td>
<td>$164.91</td>
<td>$154.84</td>
<td>$150.44</td>
<td></td>
</tr>
<tr>
<td>October 1, 2016</td>
<td>$145.68</td>
<td>$145.64</td>
<td>$145.64</td>
<td></td>
</tr>
</tbody>
</table>

- Next 10 years
- $8.45 increase in routine home care rate

Changes in Hospice Rates
Other Hospice Provisions

Face to Face Encounter

- Concerns
  - Billable visit?
  - Availability of physicians and nurse practitioners
  - Distance traveled and time spent to see one patient
  - Budget impact
  - Available information on previous hospice use
- Comment letter submitted to CMS on September 14
- Final rule due in late fall

Medical Review

- Hospices with a high percentage of long stay patients (> 180 days)
- **100% medical review** of those patients over 180 days by the fiscal intermediary
Cost Report

- Modifications being developed now
- NHPCO submitted sample worksheets to CMS with recommendations
- Expect cost report as vehicle for more data collection

Concurrent Care Demonstration Project

- Medicare Hospice Concurrent Care Demonstration Program
  - 3 year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare covered services while receiving hospice care
  - CMS will develop an application process
  - 2011: Applications available
  - 2012: Demonstration project to start

Concurrent Care for Children

- For children in Medicaid and CHIP
- Effective immediately on enactment – March 23, 2010
- CMS published state Medicaid Director Letter giving direction to the state Medicaid agencies
- Children electing the hospice Medicaid benefit may also receive curative treatments
Hospice Payment Reform

- No earlier than FY2014
- Pay more – beginning and end of care
- Pay less – time in between
- Originally proposed by the Medicare Payment Advisory Commission (MedPAC)

NHPCO Response

- Large data collection and analysis project with The Moran Company
- Data from 550 hospice providers being analyzed
- Questions to answer:
  - Is the data representative?
  - What kinds of payment methodologies can be modeled for CMS and MedPAC
- Meetings with CMS and MedPAC late fall 2010

Performance Measures

- 12 measures being tested now in New York State
- Examples:
  - Pain, dyspnea, anxiety, nausea
  - Family prepared for changes in patient’s condition
  - Adverse events – falls, medication errors, complaints
Hospice Quality Reporting

- Mandatory reporting on hospice performance measures – expect Hospice Compare
- Those who don’t report face a 2% reduction in marketbasket update
- Measures to be published in 2012 for reporting to begin in 2014

Other Provisions of Interest

Accountable Care Organizations

- Secretary must establish by 1/1/2012
- ACO could consist of:
  - Physicians and other professionals in a group practice
  - Networks of practitioners, partnerships or joint ventures between hospitals, employing practitioners and other groups
- Must have shared governance and:
  - Accountable for quality, cost and overall care
  - Have structure to receive and distribute payments
  - Include primary care physicians (or others) to have 5,000 beneficiaries
  - Information availability
  - Leadership and management structures
  - Define processes to promote evidence-based medicine
  - Demonstrate that it is patient-centric
Medical Homes

- Focused on primary care and prevention
  - Stresses coordinated team approach facilitated by information technology
  - Typically, internal medicine, family practice, geriatrics and general practice physicians

Creation of Health Benefit Exchanges

- PPACA expands access to health insurance through the creation of Health Benefit Exchanges.
- Exchanges can be administered by:
  - a governmental agency
  - a nonprofit entity established by the state.
- If a state does not create an Exchange by Jan. 1, 2014, HHS will create and operate one.

Benefit Structure

5 Tiers of Benefit Plans
- Bronze Plan: Minimum level of health coverage, covers 60% of costs of medical benefits
- Silver Plan: Cover 70%
- Gold Plan: Cover 80%
- Platinum Plan: Most generous, covers 90%
- Catastrophic Plan: Available only to individuals
Minimum Essential Benefit Plan Details

Essential Benefit Plans (EBPs)

- States must cover the cost of benefits over and above the Essential Benefit Plan.
- At a minimum, the EBPs must include:
  - outpatient services
  - emergency services
  - Hospitalization
  - maternity and newborn care
  - mental health services, including behavioral health treatment;
  - prescription drugs
  - laboratory services
  - preventive and wellness services
  - chronic disease management
  - rehabilitative services
  - pediatric services, including dental and vision care

Our Goal

Ensure that coverage for hospice is included in the Essential Benefits Package.

Reviews, Audits and the OIG
New Levels of Scrutiny

Examples

- **Cert Audits: Comprehensive Error Rate Testing**
  - Review medical records and claims for compliance with Medicare coverage, coding, and billing rules

- **RAC: Recovery Audit Contractors**
  - No hospice specific audits yet
  - Expect audits in 2011

- **MIC: Medicaid Integrity Contractors**
  - Proposed recoupment in one audit: $3 million
  - Questions about eligibility

- **ZPIC: Zone Program Integrity Contractor**
  - Active in 17 states
  - Most serious of the audits – payment errors, high volume, high costs
  - Results of analysis extrapolated to entire billing

OIG Report on Physician Billing Practices

- Released on September 22, 2010
- $165,000,000 in Part B physician services billed in 2009 for hospice patients
- $566,000, or 0.3% of the billings, fell into the "questionable" category
- No further action recommended, except for ongoing CMS monitoring
OIG Areas of Risk in 2011

- Duplicate drug claims for MHB and Part D
- Medicaid
  - Services reasonable and necessary?
  - Reimbursement follows federal requirements
- Utilization of the hospice benefit in the nursing home
  - Utilization patterns
  - Business relationships between nursing homes and hospices
  - Assessment of marketing practices and materials
- Hospice services provided to nursing home residents
  - Coordination of care
  - Nursing home as the site of GIP

Opportunities in these times

- Focus on the continuum of care
- What is my hospice the best at?
- How can my hospice partner with others to meet the needs of patients and families?
  - PACE
  - Palliative care
  - Pediatric palliative care
  - Bereavement counseling
  - Serving veterans

We Honor Veterans: A National Awareness and Action Campaign
Did You Know…

• 28% of Americans who die each year are veterans
• Over 1,800 veterans die each day
• Veterans have special care needs at the end of life, especially if they are combat veterans
• It is imperative that hospices step up, acquire the necessary skills and serve these veterans with the dignity they deserve

What does We Honor Veterans mean?

• Asking about military history and knowing what to do with the answer
• Partnering to design care specific to veteran needs
• Extending VA and agency “reach” to improve care and access
• Improving quality by measuring the impact of VA and agency interventions

In Support of the Goals

www.WeHonorVeterans.org
launching in October 2010

• Centralized Information
• Educational Resources
• Enhancing Partnerships
Enroll Your Hospice as a *We Honor Veterans Partner Now*

- Recruit: Get oriented and commit
- Level 1: Provide Veteran-centric education
- Level 2: Build organizational capacity
- Level 3: Develop and strengthen relationships
- Level 4: Increase access and improve quality

NHPCO’s Campaign for a National Center
Why a Campaign for the National Center?

Facts

- Opportunity to acquire a permanent headquarters in Alexandria, VA
- Moved into an ideal building with a three-year "lease-to-buy" option to be executed by December 31, 2012.
- Convenient location offers access to policymakers and federal government agencies. This factor is equally important for employees and visitors, as it is just two Metro stops from Ronald Reagan Washington National Airport.

Financial Facts

- End the cycle of leasing
- Return nearly $200,000 per year in savings back into our programs and resources, benefiting NHPCO members
- Average rent in 2010 - $600K per year
- Annual mortgage payment - $390K fixed for all 30 years.
- Will save over $100K per year
Timeline
• $10M Five-year Campaign 2010-2015
• 2010 - Quiet Phase
  - Goal to raise $500,000
  - Donor recognition event: Gratitude for Giving
  - Presentation materials:
    • Case Statement
    • Naming Opportunities
    • DVD
    • Gift/Pledge Commitment Form
    • Fund Agreement
  - Identify top 100 prospects and contacts
  - Cultivate, solicit, and secure leadership gifts
  - Commitment from NHPCO, NHF, FHSSA and HAN Boards

• 2011 Objectives – Public Phase
  - Goal: Raise a minimum of $1 million
  - Plan and execute Campaign Launch
  - Continue to cultivate, solicit, and secure major gifts from top 100 prospects
  - Identify next 150 prospects and contacts
  - Continue to solicit and secure major gifts and pledge support

• 2012 – 2015 Objectives – Public Phase
  - Goal to achieve $10 million
  - Continue identification, cultivation, solicitation and stewardship for the Campaign

How Do We Achieve the $10M Goal?
• Identify and Research
• Cultivate and Solicit
• Stewardship
• YOU!!

For more information please contact:
info@nationalhospicefoundation.org or call 703-516-4928
Change is the law of life and those who look only to the past or present are certain to miss the future.

—John F. Kennedy