Eli's Hospice Insider

PAYMENT AND REGULATORY UPDATE: Hospices Battle Industry Trends as Lawmakers Mull Cuts

CMS also discusses billing changes, new COPs at industry conference.

If you're wondering why policy- and lawmakers are targeting hospice for potential cuts this year and overall benefit changes in the long term, you just need to look at the underlying statistics.

That was the message the **Centers for Medicare & Medicaid Services** delivered at the National Association for Home Care & Hospice's March on Washington conference March 23.

The number of Medicare beneficiaries receiving hospice services has skyrocketed from 401,000 in 1998 to 986,000 in 2007, a 146 percent increase, noted CMS' **Lori Anderson** in a CMS hospice regulatory panel session. And the number of hospice providers has boomed from 1,834 with 20 percent for-profit to 3,200 with 51 percent for-profit in that time period. Medicare spending on hospice grew from $2 billion to $11 billion during that time.

States such as Texas, Utah, Oklahoma,and Mississippi have more than doubled their number of hospices since 2000, Anderson added. And the length of stay for hospices at the 90th percentile has risen from 164 days to 212 days.

"These sorts of statistics are why the OIG, MedPAC, and the GAO are saying 'you've got to understand more what you're paying for,'"Anderson said.

The Medicare Payment Advisory Commission has proposed a major restructuring of the hospice payment methodology, bumping up payment at the beginning and end of stays and lowering it in the middle, Anderson further explained.

Changes to the top 10 diagnoses in hospice and increases in their lengths of stay are alarming, Anderson said (see box, p. 28, for list). Of particular note is the jump of Non-Alzheimer Dementia from number 10 in 1998 to number one in 2006.

Providers Weigh In on Trends

Hospice providers in attendance were not happy about the changes either. An "overproliferation of hospice chains" is part of the problem,claimed **Gail Inderwies,** president and executive director of **Keystone Hospice** in Wyndmoor, Pa., during the session.

Hospices in Keystone's area are engaging in questionable practices such as "giving Coach bags to staff,"paying staff well above the going rate,compensating medical directors inappropriately, and using inpatient units to unfairly capture hospital referrals,Inderwies contended. CMS and other regulators need to deal with bad actors without harming legitimate providers, she urged.

"There's a lot of respectable providers you're going to hurt" if CMS adopts MedPAC's reimbursement proposal, Inderwies said.

Suggestion: CMS should consider implementing staffing level requirements for hospice nurses, **Deb Girard**, owner of Circle of Life Hospice in Reno, Nev., told CMS in the session. Some hospices give nurses caseloads of 20 to 25 patients when they should really have more like 10,Girard maintained.

For a truer picture of hospice, CMS should remove the top 10 percent of utilizers and look at the diagnosis and LOS numbers after that, suggested one attendee.

Policy- and lawmakers need to realize that a lot of hospice growth is legitimate, due to the aging population and growing

acceptance of the hospice end-of-life care model,Inderwies added.

Other Hot Topics on the Agenda

Other topics CMS addressed in the conference panel include:

• **Billing changes.** Last fall, CMS proposed increasing the visit data required on hospice claims, whichwould require line-item billing. CMS wants hospices to report visits in 15-minute increments for disciplines that already have NUBC revenue codes -- physical, occupational, and speech therapy, skilled nursing, aide, and clinical social work. Hospices would employ the G codes currently used on home health agency claims to report hospice visits, CMS proposes. CMS also suggests adding a new revenue code for social worker phone calls, also in 15-minute increments.

After looking at industry comments,CMS is finalizing its next phase of claims data collection, Anderson reported. The final plan will probably skew close to the proposal, she revealed. When implemented sometime in 2010,"hospice claims will look very similar to home health," she said in the session. Because about 30 percent of hospices are affiliated with HHAs, CMS hopes the burden of change won't be too great.

Cost report changes that would collect data on pastoral and volunteer services would come later, she added.

• **New COP surveyor guidelines.** This January, CMS released an advance copy of the surveyor interpretive guidelines to state surveyors,available at www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09-19.pdf. CMS has also hosted a series of surveyor training satellite broadcasts on the new COPs. The broadcasts are archived for Internet viewing at http://surveyortraining.cms.hhs.gov/pubs/archive.aspx.

The materials are for surveyor training but can help hospices understand their obligations under the new conditions of participation, recommended CMS' **Jan Tarantino** in the session.

Questions about the new COPs have slowed in the last few months, "so I'm hoping everybody is compliant,"said CMS'**Mary Rossi-Coajou.**Surveyor focus is still on quality of care, regardless the new COP details, Tarantino said.

• **Criminal background checks.** One new COP issue that seems to be a burden to hospices is criminal background checks, Rossi-Coajou noted in the session. Hospices have complained that they are having trouble getting partners and contractors to conduct criminal background checks on their employees who furnish hospice services, because such checks aren't required under their own COPs.

CMS isn't taking action on this issue now but is monitoring it, Rossi-Coajou promised.

"We will keep a close eye on this," she told attendees.