Hospice Rules and Regulations

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What is Hospice
• A program that provides coordinated palliative care for terminally ill patients and families
• In home or facility settings
• Through an interdisciplinary team of healthcare professionals

History
• 2500 BCE – India, Greece, Rome cared for sick and dying in religious temples
• Middle ages – religious orders provided hospitality for travelers and the dying
• Cicely Saunders – 1st modern hospice: St Christopher’s 1967 (outside of London)
• 1st US hospice 1974
• 2014-1.6 million patients cared for by hospice in the US

How Hospice is different than Palliative Care
• Palliative Care is umbrella term that includes hospice
• Hospice and Palliative Care:
  ➢ Attend to physical, emotional, and spiritual needs
  ➢ Family and patient are focus of care
• Hospice Only:
  ➢ Certified prognosis of 6 months or less
  ➢ Forgo curative care
Medicare Benefit

• Established in 1982; in 2006, ~36% of patients in USA died with hospice care
• Part A – covers 100% of all hospice services
  • Must have:
    - Terminal condition
    - Patient declines life-prolonging care
    - Can still receive aggressive care for non-terminal conditions

Benefit Periods

• Two 90-day benefit periods
• Then unlimited 60-day periods
• After 1st two periods must have MD/APN home eval each renewal to certify that patient still eligible
• Patients may revoke at any time
• Hospice can choose to discharge or not renew if criteria not met

Admission Criteria

• 2 physicians certify terminal illness
• Cancer: end-stage with no plan for life-prolonging therapies
• Non cancer: use NHPCO guidelines
  • Heart disease, pulmonary disease, dementia, HIV disease, liver disease, renal disease, stroke and, ALS
  • May consider functional status and progressive decline
• Hospices will evaluate for eligibility; some guidelines may vary slightly based on geographic region (regional fiscal intermediaries)

Example: Heart Disease

• The patient has 1 and either 2 or 3:
  • 1. CHF with NYHA Class IV* sx and both:
    • Significant sx at rest
    • Inability to carry out even minimal physical activity without dyspnea or angina
    • 2. Patient is optimally treated (ie diuretics, vasodilators, ACEI, or hydralazine and nitrates)
    • 3. The patient has angina pectoris at rest, resistant to standard nitrate therapy, and is either not a candidate for/or has declined invasive procedures.
  • 4. Supporting documentation:
    • EF ≤ 20%, Treatment resistant symptomatic dysrhythmias
    • H/o cardiac related syncope, CVA, 2/2 cardiac embolism
    • H/o cardiac resuscitation, concurrent HIV disease

www.NHPCO.org
Admission Criteria - patient

- Patient agrees to comfort-focused care
- Agree to no further hospitalization
- Patients do not have to be home-bound (different from home health)
- Advance directives and DNR not required for hospice care

Eligibility

- Use NHPCO guidelines for non-cancer diagnoses
  - Most common are heart disease, lung disease, kidney disease, and liver disease
  - Debility and adult failure to thrive no longer hospice diagnoses

Services

- Interdisciplinary team
  - RN, MD, HHA, MSW, Volunteers, chaplains, bereavement
  - Dietary, PT, OT, RT (as needed)
  - Pharmacist may consult
  - 24 hour availability of RN/MD
- Medications
- Supplies
- DME

CMS Guidelines

- Available to all qualified patients
- 24/7 availability
- Interdisciplinary team
- Unit of care is the family
- Coordinate with attending provider
Medicare Hospice Benefit

Medicare:
- Part A: Hospital Insurance- this is usually an 80/20 benefit
- Part B: Voluntary supplementary medical insurance

The Medicare Hospice benefit is in Part A
- 100% coverage, although a 5% charge for respite care and drugs may occur
- When enrolling, patients “waive” traditional Medicare for the terminal diagnoses
- Still covered under Part A for care not related to terminal illness (i.e. broke arm in a car accident)

~ 50/50 for and not-for profit; 50/50 cancer vs. all other illnesses

Variety of sites of care

37% free standing
44% affiliated with hospitals or hospital systems
22% affiliated with home health agencies
9% other

80% of aggregate days need to be spent in patient’s place of residence (decreases inpatient stays) otherwise hospices get paid on home based rate
Some Hispanic families may believe “hospice” is a place, and not a type of care- need to explain

Levels of Care

• Routine Home care
• General inpatient (GIP)
• Continuous Care
• Respite care

Reimbursement

• Medicare: per diem
• All services and supplies paid from per diem rate
• Varies depending on level of care
  - Routine home care: ~$131 per day- this is 93% of all care
  - Continuous home care: ~$31.81 per hour
  - General inpatient care: ~$582 per day
  - Respite inpatient care: ~$135 per day
More specifics:

Routine Home Care
◦ Can be at home or in a nursing home
◦ Room and Board fee in nursing home is not covered by the Hospice benefit

Continuous Home Care
◦ Crisis management of acute symptoms to maintain the patient at home
◦ Minimum of 8 hrs/day during each 24 hour period; does not have to be continuous
◦ >51% of care must be by licensed nurses; q15 minute documentation and billing

General Inpatient Care
◦ Control of acute symptoms that can’t be managed at home-SNF, hospital, hospice facility

Respite Care
◦ 5 consecutive days; not restricted to one pay period, but more frequent need is often red flag that new living situation is needed
◦ Patient liable for 5% co-pay

Physician Reimbursement

3 categories:
◦ Attending physician not employed by hospice; bills Medicare Part B (not hospice)
◦ Hospice Medical Director of physician employed by hospice- bills hospice (under Medicare part A)
◦ Consulting physician for terminal diagnosis- contracts with the hospice directly and must bill the hospice for services (under Medicare part A)
◦ (Consulting physician for non-terminal diagnosis- bill traditional Medicare, not hospice)

Concerns

• Late referrals
  • Median LOS 20.6 days in 2014
  • Caregivers who had hospice care <3 days vs. >30 days: increased risk depression and more likely to rate hospice experience poorly (VA)

• Excessive LOS (aggregate Cap)

• Need for expensive palliation and hospice

• Cannot receive hospice and skilled care simultaneously

• Exclusion of people with certain illness processes s.a. ESRD who are continuing dialysis (considered “double dipping”)

• Other?

Changes in 2016: Affordable Care Act

• Two-tiered reimbursement model: started January 2016
  • Higher per diem for first 60 days ($187.54); lower thereafter ($145.14)
  • Retrospective Service Intensity Add-on payments for the last week of life (4 hrs direct care by RN or SW at $38.75 per hour)
  • Currently, there is an Aggregate Cap, i.e. maximum amount that can be spent on one person before the Hospice needs to reimburse Medicare ($27,382.63 in 2015)
  • Discourages LOS > 180 days

• Payments to providers for advance care planning discussions

• Choices model
  • Concurrent curative and Hospice care- providers receive a monthly fee for providing this service
The future

“The success of the changes to Medicare hospice reimbursement in achieving CMS policy goals and avoiding unintended consequences is likely to continue to influence the future development of bundled payment mechanisms in state and federal government health care programs as well as commercial healthcare cost containment initiatives.”

McDermott, Will and Emery

Questions

References


Office of Geriatrics and Extended Care, Department of Veterans Affairs