



Hospice of the Twin Cities

Hospice Insights

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“Kind words can be short and easy to speak, but their echoes are truly endless.”
Mother Teresa

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Medicare Proposes Cuts to Hospice Reimbursement

Those of you involved in providing healthcare services to the ill and the elderly, recognize reimbursement rate cuts as an all too familiar scenario, having survived rate adjustments, rate freezes and cuts over the years. No doubt, you can probably relate to what the Hospice profession is struggling with today.

The National Hospice and Palliative Care Organization recently held its annual Management and Leadership Conference in Washington, D.C. Several Hospice of the Twin Cities employees attended the conference, met with our Congressional Leaders, and expressed grave concerns over the cuts Medicare has proposed to hospice reimbursement rates.

The Centers for Medicare and Medicaid Services (CMS) has released a proposed rule that would significantly impact hospice reimbursement in a devastating way. By phasing out the annual adjustment that is applied to the hospice wage index over the next three fiscal years, CMS will be cutting the reimbursement levels hospices receive for the care they provide to terminally ill patients and their family caregivers.

The National Hospice and Palliative Care Organization strongly opposes this proposed rule. At the National Management and Leadership Conference, J. Donald Schumacher, NHPKO president and CEO stated, "Regardless of how the administration chooses to characterize or couch this action in technical terms, it is a rate cut." "Through this

proposed rule, the administration is circumventing Congress to save money in a manner that may ultimately jeopardize the services provided by hospices to dying patients and their families."

Unlike most other healthcare providers, hospices are uniquely strained by the rising costs of gas, supplies and pharmaceuticals because they provide medical equipment, supplies and medications related to the patient's terminal illness.

Given that 80 percent of care is delivered in the home, hospice professionals must drive to reach those they serve and are subjected to inflationary pressures with every visit to the gas pump. This is but one example of the increased costs that this rule would ignore.

In recent years, regulators have been looking closely at hospice reimbursement levels and have expressed concern over the growth in hospice expenditures – which are \$11 billion per year. This follows two previous CMS administrators who voiced support for increased hospice usage to the broader healthcare community, encouraging more timely referrals and explaining that hospice is a key component of healthcare in this country and a valued benefit offered by Medicare. The growth in hospice spending is directly tied to the growing preference for hospice care by Americans coping with a life-limiting illness.

More than 1.3 million dying Americans received care from the nation's hospice providers last year.

Basic End-Stage Indicators:

1. Overall physical decline;
2. Life-limiting condition;
3. Clinical progression of the disease as evidenced by
 - A. Multiple ER visits;
 - B. Inpatient hospitalizations;
 - C. Serial physician assessment;
 - D. Laboratory studies;
 - E. Radiologic or other studies.
4. Impaired nutritional status
 - A. Decrease in appetite; increase in weight loss;
 - B. Serum albumin <2.5mg/dl (not to be used in isolation)
5. Multiple co-morbidities;
6. Decline in functional status (ADLs)

Specific Guidelines for determining Prognosis: Amyotrophic Lateral Sclerosis (ALS)

Must fulfill 1, 2, or 3

1. **The patient must demonstrate critically impaired breathing capacity as evidenced by all of the following occurring within the twelve months preceding initial hospice certification.**
 - A. Vital capacity (VC) less than 30% of normal.
 - B. Significant dyspnea at rest.
 - C. Requiring supplemental oxygen at rest.
 - D. Patient declines artificial ventilation.
- 2.1. **Patient must demonstrate rapid progression of ALS as evidenced by all of the following occurring within the twelve months preceding initial hospice certification.**
 - A. Progression from independent ambulation to wheelchair or bed-bound status;
 - B. Progression from normal to barely intelligible or unintelligible speech;
 - C. Progression from normal to pureed diet;
 - D. Progression from independence in most or all activities of daily living (ADLs) to needing major assistance by caretaker in all ADLs.
- 2.2. **Patient must demonstrate critical nutritional impairment as evidenced by all of the following occurring within the twelve months preceding initial hospice certification.**
 - A. Oral intake of nutrients and fluids insufficient to sustain life.
 - B. Continuing weight loss;
 - C. Dehydration or hypovolemia;
 - D. Absence of artificial feeding methods.
3. **Patient must demonstrate both rapid progression of ALS (2.1 above) and life-threatening complications as evidenced by all of the following characteristics occurring within the twelve months preceding initial hospice certification.**
 - A. Recurrent aspiration pneumonia (with or without tube feedings);
 - B. Upper urinary tract infection, e.g., Pyelonephritis;
 - C. Sepsis;
 - D. Recurrent fever after antibiotic therapy.

Proposed cuts, cont.

This number has risen and continues to grow as more patients learn of the wide range of beneficial services and the compassionate care hospice offers.

Considered to be the model for high-quality care at the end of life, hospice involves a team-oriented approach to care that includes expert medical attention, pain-and-symptom management, and emotional and spiritual support. The quality of a person's life is emphasized, not the duration. Moreover, services and support are provided to family caregivers, in addition to the patient.

The economic value of hospice care has been validated by research. An [independent study](#) released late last year by Duke University found that the use of hospice saved Medicare an average of \$2,300 per patient who received this care (A total savings of \$2,990,000,000.00/year) . Additionally, a recent MedPAC report noted profit margins in the hospice community are running under 3.5 percent.

Hospice offers the services and support that Americans want when coping with life-limiting illness. A Gallup Poll commissioned by the National Hospice Foundation found that nine out of ten Americans, if faced with a terminal illness, would want to remain in their homes and receive the services that hospice provides. In fact, over 80 percent of hospice care in the U.S. is provided in the home.

Patient satisfaction data collected by NHPCO shows the 98.5 percent of families would recommend hospice to others, reflecting the high level of family satisfaction with care. Coupled with the fact that hospice can be cost effective to Medicare, it seems illogical to put rules in place that would cut down on the care hospice providers could offer. The result of this proposed rule would potentially mean less care to patients and family caregivers during the end of life.

In the beginning, hospice was a "grass roots movement." Now is the time for supporters of hospice care to start another "grass roots movement" and contact your Congressional Leaders asking them to **NOT** support the proposed cuts. The only way we can make change happen is to demonstrate our strength to those in Washington, D.C., who are in a position to make a difference. Simply go to <http://capwiz.com/nhpco/home/> and follow the instructions. Now is your time to make a difference in the lives of all of those who are currently being served by hospice and in the lives of all of those individuals who are yet to be served by hospice.

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We're on the Web!
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Mission Statement

Hospice of the Twin Cities' mission is to enhance the quality of the lives of our patients and their families by providing respectful care based on maintaining dignity, alleviating physical, psychosocial, and spiritual suffering, advocating for fundamental rights, and affirming the sacred value of life.