

University of Maryland, Baltimore Presents

Palliative Care Chat: Episode 2

Date: December 12, 2016

Description: In this episode of Palliative Care Chat, Dr. McPherson interviews Todd Stern, BBA, MBA, CHA, chief executive officer of Seasons Hospice and Palliative Care.

Lynn McPherson: Hello, this Dr. Lynn McPherson, and welcome to Palliative Care Chat, the podcast brought to you by the online Master of Science degree and graduate certificate program at the University of Maryland. I'm very excited to introduce my guest today, Mr. Todd Stern, who is the Chief Executive Officer of Seasons Hospice and Palliative Care. Seasons has a presence in 19 states in the US, and they provide hospice care, both home-based and in-patient, hospice and palliative care services across the continuum. Mr. Stern, welcome. I'm very excited to be speaking with you today.

Todd Stern: Nice to spend time with you Lynn.

Lynn McPherson: Thank you. As you know, hospice came to the US in the 1970s. It was very much a grassroots effort, a lot of volunteerism. As a pharmacist, I can speak to the drugs. Everyone got a ham sandwich, Haldol, Ativan, and Morphine, and that was about it. I guess you could say this is not your mama's hospice anymore. Would you agree?

Todd Stern: Oh yes. There's been a lot of change since the 70s and reimbursement for hospice care.

Lynn McPherson: What would you say were some of the biggest challenges for hospice in 2016?

Todd Stern: Even slightly before 2016, the hospice industry has gone through a tremendous amount of change. Lynn, you highlight that the hospice movement arrived in the US in the 70s. It became a Medicare funded program in the 80s, and a lot of time has passed since the 80s. The government has been looking at hospice and how to manage quality, how to perhaps reorganize its repayment structure, and they've been studying hospice for quite a while. In the last 20 years hospice has really taken off in terms of adoption. A lot of that has been because there's been a cultural shift towards accepting the value of hospice that 30, 40 years ago was a greater challenge. We've seen utilization of hospice rise steadily over the course of the 2000s.

That, of course, caused the government to pause and say, "How do we interpret this? What does this mean?" Largely it's a sign of positive trends in that folks are valuing the gift of hospice towards the end of life. From a quality of care perspective, the government clearly believes that it is positive, but, when

anything's growing rapidly that Medicare is funding, they tend to take a moment and really analyze it and make sure that it's not a negative sign of something.

What we saw in 2016 actually was the first major change to how hospice care is funded. The vast majority of hospice care is really under the level of care "Routine Home Care" which can be provided in a nursing home, assisted living facility, or patient's private. That's where 95 plus percent of hospice care is provided under that level. The government actually tweaked that level of care from a reimbursement perspective, and it was the first true change to how hospices were reimbursed since the benefit was founded in the 80s. From a hospice perspective, that was a pretty significant change.

If you were a provider that was in line with industry averages, you really were largely unaffected. The way you are paid is now different. You're paid 17% for the first 60 days of care on routine home care, and you're paid around 9% less for all days over 60 days. If were within the industry average, you were largely unaffected. If you had a lower length of stay than the industry average, you may have gotten slightly more reimbursement, and if you were a little bit longer on the length of stay spectrum statistically, you may be getting a little bit less reimbursement. I should note that the shift was budget neutral. The intent was budget neutral. It wasn't to save the government money; it was to adjust the way in which hospices are reimbursed. I suspect it was largely driven to better align the government's goals for hospice with the way it's paying for them.

The other component that they mixed into that was, in addition to getting more reimbursement for the first 60 days and less for any days after 60, you now get an additional payment during the last seven days of life for visit intensity. The amount of care you deliver by nurse and social work services, RN and social work services, you get actually an additional payment during the visits that are received for the last seven days of life. Of course, nobody can predict the actual death, so it's a matter of providing the right care to our patients always and insuring that would align with the government's reimbursement shift for the last days of care being paid this what they call "Service Intensity Payment."

I'm actually a big fan of the new reimbursement model. I know that the government has had many concerns that they wanted to address within hospice, and I think they did a very nice job at tweaking. I'm using that word on purpose, because no matter where you fell on the spectrum you may be slightly enhanced or slightly reduced with this new model. Nobody is, in my opinion, wildly harmed or empowered by the new shift, but it starts to affect the way hospices provide care.

Seasons has always been a very balanced provider. We have been largely unaffected by this change because we have been focused on doing the right

things for the right reasons for a long time. I'm confident that providers that have that same mindset will have found themselves in a very similar position. As far as your question of 16, that was a major change. Change that hospice hasn't seen in over 30 years, and so I would say that's probably the biggest philosophically.

Though the government, and predominantly through the Affordable Care Act, and I know we just exited an election period and there's been a lot of talk around the Affordable Care Act, and so it remains to be seen exactly what happens in the near future, but at present the Affordable Care Act drove a major shift in the entire healthcare space. Not just to insure working Americans who may not have currently had insurance or could afford insurance or may have been disqualified for a preexisting condition, that's what the media typically focused on, but there were also a number of substantial changes that affected Medicare providers. Hospices as well.

The continuum, hospitals, long-term care facilities, other providers within the continuum of care, have also seen tremendous change from the Affordable Care Act that has less so been noted by the media. Changes that relate to accountability for quality like penalties for hospitals based on a certain amount of readmissions within a certain period of time from when a patient left a hospital. There are a number of carrots and sticks, Lynn, that have gone into the continuum of care that are actually forcing behaviors or focus earlier in patients' disease process that I feel have substantially aligned with the quality and value that hospice provides. Actually, a former CMS director Don Berwick coined the triple aim which is really the focus of the current, again we'll see what changes, but the current CMS policy directives which is really to enhance quality and reduce cost and make our community safer.

Hospice has always been aimed at those three things, but now, because folks caring for our patients earlier in their disease processes and we largely depend on for utilization and referrals to hospice when appropriate are now seeing in their objects even more aligned with appropriate hospice utilization, because using hospice appropriately for those eligible and those who desire that level of care will likely keep patients safe in the community and reduce readmission. Again, appropriate readmission. We're seeing, through readmission penalties, which is more of a stick, or carrots like eight compatible care organizations or bundle payment methodologies, that folks in the continuum of care are actually looking at hospice in addition to its value that has long been recognized to patients and families directly, but looking at it relative to what they're now accountable for. That's been an exciting shift that we've seen over the last several years relative to how hospice better aligns with the continuum of care as current fiscal coming from Medicare is facilitated.

Lynn McPherson: Lot of changes.

Todd Stern: Yes. Those are some of the positives. I would add one more positive. As an industry provider, I've been in hospice 16 years. As you mentioned, Seasons is a large footprint. We see a lot of different activity and a lot of different communities around the country. One thing that always bothered myself and Seasons as a whole is that hospices did not have a required survey interval. There were hospices that had been licensed, could've been licensed, for 10 years and have never been surveyed. What came to pass in the last couple of years is an act that was passed by Congress, referred to as the Impact Act. The Impact Act had a variety of different components, but the component that affected hospice was that it actually requires now, legislatively, that a hospice is surveyed at a minimum every three years.

Seasons has been committed to more frequent surveying independent of this law, and we've actually elected to become Joint Commission Accredited. We're the nation's largest Joint Commission Accredited provider, and we've been Joint Commission Accredited for over a decade. We've been self-selecting to be surveyed in that level of frequency for a long time, but it's exciting to see that the industry as a whole will now be required to be surveyed every three years. We think that's not only good from a quality perspective, but it's good to make sure that integrity of hospice and the value of hospice is preserved so that the Medicare hospice benefit is supported for the next 30 to 40 years.

Lynn McPherson: I think that's a good idea too, to ensure that level of quality.

Todd Stern: Lot of very positive changes. Some relative to aligning Medicare's goals for hospice; some related to aligning the continuum of care to better support appropriate, high-quality, and efficient end of life care for that are eligible and those that want that level of care, and holding hospices accountable, both through the way we're now being paid and both by the required survey interval being a minimum of every three years.

We have our challenges. There has been a number of administrative challenges that have made running a hospice much more challenging in terms of "i" dotting and "t" crossing, largely because of behaviors of hospice that might not have been doing everything as well as they should have. The combination of the changes and some of the additional administrative requirements, I think, while may be a distraction some days in terms of our core focus on the quality of our patients' and families' care, I think that these changes will ensure that hospices follow the path that the government envisions, and, again, will ensure our support and the benefits' support for the next 30 for 40 years.

We have some general challenges. At a time of unprecedented alignment with the greater healthcare continuum, physician staffing can be a challenge

because, as we've seen in a tremendous growth of the use of hospice and palliative care in the last 10, 15 years, we need high-quality practitioners to fuel our support of that demand. Actually, change occurred in the last several years where, in order for a physician to be eligible to become board certified in hospice and palliative medicine, they now have to have a fellowship. That has substantially slowed the volume of newly certified and boarded hospice and palliative care physicians. We've seen a supply versus demand shift relative to board certified physicians. That's been a staffing challenge for us.

Lynn McPherson: There's the Hospice Medical Directors Exam now also.

Todd Stern: That's true.

Lynn McPherson: Which has helped.

Todd Stern: That's true, but for so long the board certification, and in many areas of medicine board certification is a standard that a lot of our patients and families and acute care partners expect or prefer. That's a challenge that, as a provider, we're certainly working through and are supporting fellowships as well, but there's been a shift in the timeframe. Hopefully that's a one-time shift as folks now go through those fellowships in the next couple of years, hopefully we'll see that delayed development of more certified physicians being a one-time delight. We shall see.

Lynn McPherson: I think there's still only about 140 fellowships available in the United States. I don't see this backlog clearing any time real soon. We'll see.

Todd Stern: We will see when. I'm going to choose to be more optimistic.

Lynn McPherson: I'll join you in that optimism then.

Todd Stern: With respect to other challenges, I'd say the biggest challenges that hospices are facing today is that we're seeing shifts in a lot of Medicaid plans or states moving Medicaid to managed care. That has all sorts of challenges for all types of providers, but unique to hospice one of the elements that's in the Social Security Act that's always been a part of the hospice program is that when a patient elects their hospice benefit inside of a long term care facility, the hospice actually has to bill Medicaid on behalf of the nursing home instead of the nursing home continuing to bill direct. We actually get paid a reduced amount.

Nonetheless we bill on behalf of the nursing home which puts us in a unique position because not only do we have to bill for our hospice services, and those may not even be being billed to Medicaid, we have the additional responsibility to bill Medicaid for the nursing home services. It's a pass-through, as it's

referred to. With so many Medicaid programs outsourcing Medicaid or shifting it to managed care, we now have to deal with the challenges of managed care which come with all sorts of additional complexities. To be honest, in the early stages of those conversions, a lot of confusion even on behalf of those managed care providers.

There's been a lot of stress administratively to collect and educate these managed care providers, because a lot of them are ignorant to why hospices even bill for the room and board. Just because they've taken on this burden of Medicaid doesn't always mean that they're fully understanding of all the nuances. We've seen substantial administrative challenges and some unique requirements relative to authorization that they've asked for that don't necessarily make a whole lot of logical sense once you're educated, but in the meantime we're at their mercy to keep the wheels turning day to day in our ability to support the pass through expectations of the government and of course our facilities that want to be paid.

Lynn McPherson: It seems like you'd have to hire quite a few more administrative personnel to help process all that.

Todd Stern: Lynn, you're 100% correct. We've had to add a number of staff members, and of course, we try to focus on taking care of our patients and their families, and of course my job is to make sure that our staff are well cared for so that they're empowered to do that, so any of these changes become a distraction or a detraction from our ability to focus as intently on those core objectives of supporting our staff so they can put our patients and families first. I always cringe at having to detract or distract myself from doing that. Nonetheless, it's our responsibility.

Those are some of the active challenges. The Medicaid MCO migration and the physician supply. I really say, Lynn, the only sort of unknown challenge that's ahead of us has been this ongoing discussion around the Medicare Advantage hospice carve out where, currently when a patient is enrolled in a Medicare alternative plan, a Medicare Advantage plan, when they elect hospice, hospice actually bills Medicare directly. That has actually resulted in more utilization of hospice for Medicare Advantage beneficiaries than those that are not enrolled in Medicare Advantage Plan.

That essentially means that we've seen greater utilization, more adoption of hospice, for patients who are through a Medicare Advantage Plan than not, yet there has been recommendations we've seen from MedPAC. It was not a formal recommendation, but it was discussed at the Senate Finance Committee's meetings, that the Senate Chronic Care Work Group was contemplating a recommendation in line with MedPAC's that they actually carve in the Medicare hospice benefit through Medicare Advantage. My perception of it is the

statistics demonstrate that it isn't broken. We're actually seeing greater collaboration, so why fix it?

Lynn McPherson: Don't change it. Right.

Todd Stern: If a change were made, you'd see a tremendous increase in workload for a hospice administratively between contracting with all these plans, increased authorization and reauthorization expectations, some fear and ambiguity around what would they pay us and would a reduced reimbursement rate affect our stability because we manage based on our mix of patients? Only 30% of Medicare patients are enrolled in Medicare Advantage, so if we were to have a rate impact on that 30%, could that jeopardize our our ability to serve the other 70% that are traditional Medicare? Between administrative burden, delay in collection, which could add tremendous financial burdens to our ability to support ourselves from a working capital perspective, authorization burden, and the risk of reduced adoption and our overall payment rates, if anything that's what keep me up at night looking forward.

Lynn McPherson: That is concerning. Seems very counterintuitive.

Todd Stern: We've been working, both as a provider ourselves as well as an industry with the National Hospice and Palliative Care Organization, we've been working with MedPAC and the Senate Finance Committee directly, and we've been advancing our thoughts and potentially some alternatives to perhaps better meet the goals of those recommendations. I'm hopeful that we come to a good result there, but that's the upcoming unknown that I would say is what I'm focused on as a hospice and palliative care provider in the United States.

Lynn McPherson: Let's hope that cooler heads prevail there. I just have one last question. I know that institutional based palliative care services struggle to convince administration that their value-added service brings such value to it instead of a fee-based service. Do you see this argument or mindset affecting hospice at all?

Todd Stern: I'm not sure if I'm fully appreciating your question. I think that palliative care has been long studied to reduce cost in an institution. That's been documented many a time by many different organizations. Hospice, similarly, can provide value because hospice patients and the way hospices are required to deliver services allow us to manage patients' symptoms more proactively. We're able to provide a certain level of care in a patient's home and to, in our organization, what we define as seeing around the corner, predicting the disease shift and appropriately addressing those needs to avoid higher cost hospitalizations that would otherwise likely happen, or ER visits and those types of interventions, that would likely transpire if a hospice provider wasn't involved.

Lynn McPherson: Do we have that data at present?

Todd Stern: Oh yes. Our recidivism rates are very, very low. There have been many studies on hospice and its value. NHPCO, The National Hospice and Palliative Care Organization, has published many studies cost-value of hospice. It is widely accepted and has been studied many a time as well.

Lynn McPherson: That's wonderful. I'd like to thank Mr. Todd Stern. He certainly is a very well-spoken national thought leader in hospice and palliative care. Again, he's the Chief Executive Officer of Seasons Hospice and Palliative Care. Thank you again for listing to the Palliative Care Chat Podcast. This Dr. Lynn McPherson, and this presentation is copyright 2016, the University of Maryland. For more information on our completely online Master of Science degree and graduate certificates in palliative care or for permission requests regarding this podcast, please visit graduate.umaryland.edu/palliative. Thank you.