



HOSPICE COMPLIANCE LETTER

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Hospice Conditions of Participation Implemented Dec. 2 *Compliance Network members say they're ready, but some concerns linger*

The much anticipated new Hospice Conditions of Participation (COPs), the first wholesale change in the basic rulebook for Medicare-certified hospices in nearly 25 years, became effective December 2. Implementation follows months of discussion, trainings, publications and other resources from the National Hospice and Palliative Care Organization (NHPCO) and others. Some providers might feel that the snail's pace of hospice recertification survey visits in recent years justifies the gamble of not yet being fully in compliance with an extensive, time-consuming and in some cases costly-to-meet set of new regulations. But it is known that some hospices have already been surveyed under the new COPs. In fact, a government spokesperson announced during the December 9 CMS Open Door Forum conference call for home health, hospice and DME providers that when Medicare surveyors show up, they will expect hospices to be living up to the new COPs,

“Are providers ready? I don't know; it's too soon to tell,” says Heather Wilson, PhD, founder of Weatherbee Resources, Inc., and the Hospice Education Network of Hyannis, MA, which offered 7 two-day regulatory “boot camps” on the COPs for hospices during 2008. “A lot of hospices started doing things to get ready, especially with regard to QAPI (Quality Assurance/Performance Improvement), starting three years ago when the proposed rules were first published. I didn't see a lot of panic among providers before the deadline, like there was a few years ago with HIPAA (Health Insurance Portability and Accountability Act patient record privacy requirements). But are they just being naïve?” Wilson wonders.

“In our experience, some people did not want to change their current practice too much, preferring to just retrofit existing policies and procedures. That's not going to work with the new COPs. I'm also concerned about the variability of understanding—I just don't know what some hospice people don't know. I also wonder if there is some misinformation being conveyed out there,” she says.

Assessment and other Challenges

The most substantial requirements for hospices in the new COPs, along with the mandate for 360-degree QAPI programs, focus on the initial and comprehensive assessment, admission and care planning process—not just the paperwork but the whole process and how it relates to the onset of billing, which team members go out and when, with all of it done in a demonstrably patient-centered way. “The time lines in the new COPs are very explicit. Any hospice program wanting to be in compliance would need to look carefully at its current assessment processes and tools and revise its policies and procedures in light of the new process requirements. I can’t imagine anyone’s old forms would be sufficient,” Wilson says. And yet she sees an elegance in the new assessment process, making explicit what has always been implied by the Medicare hospice benefit. Diagramming how and when these inter-related activities unfold is recommended for hospices, as is making them a major target for QAPI measurement activities.

In addition to QAPI and the admission and assessment process, other outstanding concerns, challenges and question marks related to the new COPs include:

- Getting all necessary revised contracts in place, which can be time consuming for a hospice that contracts with multiple nursing homes. Orientation content and materials for training contract agencies’ staff is another concern;
- New pharmacy requirements, especially related to prescription drug analysis and monitoring for each patient. The COPs don’t require a pharmacist, but if the hospice wants to use a nurse or physician to lead the drug review, that person needs to be specially trained;
- Dietary counseling and the need for the hospice to have a W-2 employment relationship with the person providing this core counseling service. Many hospices have not employed staff dietitians in the past and may not see the point of hiring one for their imminently dying patients, preferring to have their nurses, if qualified, provide dietary counseling, or to use a volunteer if one is available. Others have questioned what the “counseling” core service really means, and whether some other services such as art or music therapy could be interpreted as the core hospice “counseling.”
- Patients’ rights, a broad and detailed area of new requirements in the COPs, including notice of the agency’s privacy practices and the patient’s right to participate in care plan development and to choose his or her physician;
- Criminal background checks are required for all staff who have either patient contact or access to patient records, but what the hospice can and must do regarding criminal background checks for employees of agencies with which it contracts, such as nursing homes, is less clear;

- The medical director's role on the hospice team has been upgraded, which could be a benefit to the clinical team, but there are costs involved and not enough available physicians trained and credentialed in hospice and palliative medicine;
- Oxygen therapy needs to be provided by a DMEPOS (durable medical equipment, prosthetics, orthotics and supplies) accredited provider although, again, how this relates to contract entities such as nursing homes, is not clear; and
- The role of the Board of Directors is another area of heightened focus, which will be addressed in an upcoming issue of Hospice Compliance Letter.

Agency Planning for Compliance

Samira Beckwith, CEO of Hope Hospice in Fort Myers, FL, says her hospice paid close attention to the new COPs from their earliest draft versions. "In our view, the revised COPs formalize what NHPCO has talked about as best practice for years. We tasked out the various processes to responsible individuals, and our internal Organizational Excellence Council has been responsible for the quality measures. In Florida, we've had annual state surveys, so we feel we're ready."

"I don't know that I'll be confident until we actually get surveyed, but we have been Joint Commission-accredited for years, and many things in the new COPs follow Joint Commission requirements," says Jeri Conboy, director of Blessing Hospice in Quincy, IL. "I thought we were in pretty good shape before we got started. With QAPI, we didn't have to start from scratch, but I tweaked our policy. We also added functionality to our documentation. The COPs require a different way of thinking in terms of how staff document clinical processes. We've updated things with a more technologically savvy version of our documentation, but we also hope that will enhance our ability to collect data."

Darla Schueth, executive director of HospiceCare of Boulder and Broomfield Counties in Colorado, says her agency has worked hard on compliance with the COPs since the final rule was published in June, 2008. "We participated in NHPCO trainings. I have a performance improvement/compliance director, who I could task with various assignments. We went about preparing systematically with a task force of people within the organization, brainstorming different systems. Updating our SNF contracts was the last piece," she says.

But Schueth is concerned about the proliferation of hospice providers. "Many of them are very small. Do they have the breadth and depth of human resources to go through the kind of process we did? The lack of oversight of the regulations could really come back to haunt hospices. As I sit on NHPCO's Regulatory Committee and I hear some of the conversations going around, I think some programs are really at risk. And I think we as an industry, sooner rather than later, are going to need to take this issue on."

Other Issues on the Horizon for 2009

Life under the new COPs in 2009 is obviously a concern for hospice providers, and scrutiny from MedPAC (see following article), the Office of Inspector General and others is another. A number of other major concerns facing the hospice industry in the New Year were identified through interviews with leaders in the field. They include:

- The Final Interpretive Guidelines within CMS' State Operations Manual, issued on November 18, 2008, which may provide additional guidance and challenges for hospices striving to meet the COPs;
- Data and the need to develop consistent systems for generating accurate and useful data reflecting the true nature of hospice care delivery;
- Inconsistency in practice between hospice providers in an era when quantifiable demonstrations of quality, outcomes and consistent practices are mandated for all health providers;
- Meeting requirements for patient eligibility and responding to heightened scrutiny of admission decisions by fiscal intermediaries, including pre-payment audits, additional data requests and the new process of extrapolation from claim samples. Hospices will need to be scrupulous about their admission decisions and the documentation they provide to support them;
- Hospice general inpatient care and physician billing are likely to get particular scrutiny from payers, since they are the areas of fastest growth in hospice reimbursement;
- Switches in fiscal intermediaries represents a major wild card for the field;
- Further belt-tightening in a recession, and how providers can meet demands for quality while enhancing efficiency and making do with less. Some that launched services depending primarily on philanthropic support may be particularly hard hit by the demand for belt-tightening; and
- Where does hospice fit in the national debate on health care reform expected to emerge in the Obama Administration?

Rate Cuts, MedPAC Scrutiny Pose Double Threat

Legislation, lawsuit, coalition-building provide advocacy for providers

At the end of 2008, U.S. hospices were confronting a double-barreled threat to their Medicare livelihoods, comprised of actual loss of reimbursement from administrative rule-making by the Centers for Medicare and Medicaid Services (CMS) and potential major changes in the hospice benefit arising from concerns by staff at the Medicare Payment Advisory Commission (MedPAC) over growth in hospice providers, lengths of stay and total Medicare outlays for hospice care.

In August, CMS published a final rule for the Medicare hospice wage index, including phased-in elimination of the Hospice Budget Neutrality Adjustment Factor (BNAF), which was a provision adopted when the hospice wage index was revised in 1997 to better reflect regional cost-of-living differences. The BNAF is to be eliminated over three years, 25 percent for fiscal year 2009, 50 percent for 2010 and the final 25 percent for 2011. CMS estimates that eliminating the BNAF will save the government \$2.2 billion in hospice reimbursement over the next five years. The first phase, implemented October 1, 2008, was relatively painless when combined with a 3.6 percent cost-of-living rate increase, resulting in a net rate increase of 2.5 percent for the coming year. A bigger hit will be felt October 1, 2009, and NHPCO estimates that the net effect on hospice reimbursement will be a permanent 4.5 percent overall decrease in Medicare rates.

To combat that premium wallop, which will be compounded by its effect on future hospice cost-of-living increases, NHPCO has pursued a two-pronged approach. The Medicare Hospice Protection Act to overturn the CMS rule eliminating BNAF was introduced in both houses of Congress (H.R. 6873 and S. 3487) in September. However, it failed to pass before the 2008 Congress adjourned and will have to be reintroduced in 2009.

NHPCO also filed a lawsuit in Federal Court in Washington, DC, challenging CMS' process of enacting the rule. In November, the court granted summary judgment in favor of CMS, in effect sending the case back to Medicare's Provider Reimbursement Review Board to hear NHPCO's concerns. Insiders tell *Hospice Compliance Letter* they believe the case is not dead and that PRRB will conclude it doesn't have jurisdiction, possibly sending the case back to U.S. District Court for reconsideration. But it is less clear that this process will ultimately result in relief from the rate cuts for hospices.

The government obviously wants to slow the growth of the hospice program in Medicare, which topped \$10 billion in 2007, notes NHPCO president Don Schumacher. The effect of eliminating the BNAF, in concert with rising salaries, transportation and other expenses and shrinking philanthropy, means further belt tightening for many hospices, especially in trying to provide care to remote, difficult and costly patients. "Self-education for all hospices is critical," Schumacher adds. "Actively attend meetings, pay attention to our emails, and talk to your members of Congress about how the rate cuts affect your ability to care for terminally ill patients."

Darla Schueth, executive director of HospiceCare of Boulder and Broomfield Counties in Colorado, says the BNAF cuts are significant for her agency. "As reimbursement tightens, our costs continue to go up. Sooner or later, we'll face challenges, especially in the context of current economic realities. We raise \$1 million in annual giving, but in the current environment, can we hold onto that million, let alone raise more. So our approach has to be to look for cost reductions that don't involve staff," she says. "My board is strategically thinking about whether we need to integrate with other agencies or start to form national relationships. Yes, these are serious concerns, but in the short term, we'll weather the storm with another round of belt-tightening."

MedPAC Takes Aim at Hospice Growth

The second barrel pointing at hospice has not yet taken clear shape but potentially could have greater impact. That has led to even more concerted efforts to present a unified advocacy voice for the hospice industry. MedPAC has been looking at the growth of hospice services for a while. Its staff report, "Hospice Services Payment System," released in October, noted increased Medicare expenditures on hospice care (\$10 billion in 2007, up from \$2.9 billion in 2000), numbers of providers (up 45 percent in the same time span), and the for-profit hospice sector (up 230 percent from 2000 to 2006). "CMS data show continued acceleration in use of the hospice benefit," the October report notes.

Discussions at a November 6 MedPAC meeting underscored staff concerns that the hospice program has inadequate controls to prevent long lengths of stay or cost increases and that the rapidly growing for-profit hospice sector has been "gaming the system" by artificially increasing lengths of stay. It is believed that MedPAC will be discussing approaches to restructuring the hospice benefit, perhaps a sliding scale with higher rates at the beginning and/or end of the stay and lower rates in the middle of long stays. MedPAC staff also wants more physician involvement in hospice admission, recertification and related processes. Behind these considerations is lingering concern over some hospices exceeding Medicare's average, aggregate per-patient "cap," currently pegged at \$22,387.

MedPAC reconvenes January 8-9 at the Ronald Reagan Building International Trade Center in Washington, and its agenda includes a session on "Reforming Medicare's Hospice Benefit" January 9 from 10 to 10:30 am. The advance meeting brief for the hospice session notes, "The payment system and supporting policies should be designed to ensure that the level and structure of payments are sufficient to ensure appropriate hospice care for Medicare beneficiaries who elect this benefit. The current system does not necessarily fulfill this goal." The brief promises additional information for the commissioners to consider in evaluating potential changes to the hospice benefit, and several draft recommendations for their vote.

In response to this looming challenge to hospice coverage, an unprecedented meeting of the Medicare Hospice Benefit Working Group was held in Washington on December 10 to discuss strategy. The coalition includes NHPCO, the National Association for Home Care, the National Hospice Work Group, The Hospice and Palliative Nurses Association, the American Academy of Hospice and Palliative Medicine and the National Association for Hospice Access, a group representing 500 hospice providers formed to advocate around cap concerns.

This coalition is expected to meet again just before the January MedPAC meeting. "Our goal was to get everybody to speak with a common voice on behalf of hospice patients, and we agreed to do that," Schumacher reports. "We will do our darnedest to make sure that any changes in the hospice benefit don't harm patients or families."

In a November letter to MedPAC commissioners, NAHA's co-founders assert that MedPAC staff is building a case to slash funding and access to hospice. NHPCO's Judi Lund Person says it is premature to consider changes in the hospice payment system

without more data and exploration of the nuances of what the data mean. Hospice care has been notoriously difficult for policy-makers to understand, except in terms of its emotional appeal, since it is inevitably tied to considerations of human mortality.

Some hospice leaders believe MedPAC's deliberations are just an opening salvo in wider scrutiny of hospice care under Medicare since, at \$10 billion per year, it can no longer be considered mere "budget dust."

South Carolina Medicaid Eliminates Hospice Benefit

Any time a state faces a budgetary crisis, health benefit commitments and, in particular, optional Medicaid benefits such as hospice care become an obvious target. In recent years, a number of state hospice communities have rallied to prevent proposed elimination of the Medicaid hospice benefit in their state, usually by persuading state officials or legislators that such cuts would be false economy by driving terminally ill Medicaid patients to more expensive hospitals and emergency rooms.

In South Carolina, the Medicaid agency announced by email in November that it had unilaterally eliminated Medicaid hospice coverage effective January 1, 2009, for new hospice enrollees (later pushed back to January 31) and stopping Medicaid coverage for those already enrolled in hospice effective March 31. Judy Brunger, president and CEO of the Carolinas Center for Hospice and End-of-Life Care, says providers were caught by surprise by this announcement. But she expresses confidence that elimination of the hospice benefit in the state would be overturned, either by executive action, lobbying from sympathetic legislators or legislative action in the New Year.

Brunger notes that the hospice benefit was the only program to be completely eliminated in South Carolina's proposed Medicaid cuts. There were approximately 525 Medicaid patients actively enrolled in hospice care in the state in December, with 1,495 Medicaid patients in the state receiving hospice care in 2007.

"There appear to be many other states with similar budgetary pressures," she adds. "It is disappointing, but we will get it reversed," starting to work in earnest after the holidays. The challenge will be to explain the complexities of hospice coverage and what it means to overall health spending. At press time, Florida's Agency for Health Care Administration was said to be considering a similar elimination of the Medicaid hospice benefit. The state of Connecticut, by contrast, finally enacted a Medicaid hospice benefit, effective January 1, 2009.

Palliative Care Quality Roundup

The intersection between palliative and hospice care can be complex and fraught with management and compliance challenges. With those challenges in mind, the *Hospice Compliance Letter* has decided to add a brief section on palliative care news and issues.

- CMS recently announced its recognition of the practice of hospice and palliative medicine, currently certified by the American Board of Medical Specialties and nine of its constituent specialty boards, as a medical subspecialty. This new recognition will simplify and improve Medicare reimbursement to hospice and palliative medicine practitioners for care and services provided to patients and families. According to a letter from Whitney May, deputy director of the Division of Practitioner Services, Hospital and Ambulatory Policy Group, this recognition is due in large part to “the important work physicians carry out in hospice, home health, and inpatient hospital settings.” The most recent HPM certifying exam was given on October 29, 2008.
- NHPCO and the National Association of Social Workers (NASW) recently announced a new professional qualification for advanced certified hospice and palliative social worker, available from NASW starting November 1, 2008. This is the first national credential designed to capture the specialized knowledge, skills and ability of social workers in hospice and palliative care settings. Unlike the testing methods employed by other health professional credentialing bodies, social work credentialing systems use supporting documentation of education, employment and experience. Applicants must be members of both NASW and NHPCO’s National Council of Hospice and Palliative Professionals, and commit to NASW’s code of ethics. For more information on this credential, see <http://www.socialworkers.org/credentials/credentials/achp.asp> or call NASW at 202/408-8600 X447.
- The Joint Commission is conducting a survey to determine if there is sufficient interest to support further development of a voluntary palliative care certification program. Palliative care certification would focus on how well an organization integrates national palliative care guidelines into the delivery of patient care services, with an emphasis on patient-centered care and teamwork to meet the needs of seriously ill patients and their families. To complete the confidential, ten-minute online survey, go to www.jointcommission.org/PalliativeCareCert.

- The Center to Advance Palliative Care (CAPC) recently released a national and state-by-state report card on access to palliative care in hospitals, concluding that America does a mediocre job of caring for its sickest patients. Overall, the health care system got a C grade, and 20 percent of states got a D or F. Only Montana, New Hampshire and Vermont got As, based on the proportion of state hospitals offering palliative care services. To learn more about this report, see www.capc.org/reportcard. In September it was announced that CAPC's director, Diane E. Meier, MD, head of the Hertzberg Palliative Care Institute at Mount Sinai School of Medicine in New York City, was one of 25 recipients of the prestigious MacArthur "Genius" Award from the John D. and Catherine T. MacArthur Foundation for her pioneering national leadership in palliative care development.
- CAPC's most recent eNewsletter summarizes information from the National Conference on State Legislatures on 2008 legislative developments in at least four states to move palliative care into the mainstream of medical treatment. New York passed a law authorizing \$4.5 million in grants for palliative care education and creating a state advisory panel. Vermont and Illinois enacted legislation to create study committees to develop plans for coordinating and improving delivery of palliative care, while Tennessee passed two bills expanding access to palliative care.
- The National Priorities Partnership (NPP), convened by the National Quality Forum, has named access to palliative and hospice care as one of six key focus areas for improving the nation's health care system. NPP's 28 partner organizations have significant influence over health care and the six priorities are proven ways to eliminate harm, waste and disparities in the health care system. NPP's recommendations in the area of end-of-life care are that all patients with life-limiting illnesses have access to effective treatment for relief of suffering and for help with psycho-social and spiritual needs, effective communication from their health providers, and access to high-quality palliative care and hospice services. For more information, see www.nationalprioritiespartnership.org

Hospice News and Notes

OIG Examines Hospice Respite Care

The Health and Human Services Office of Inspector General's Fall 2008 Semiannual Report to Congress looked at hospice beneficiaries' utilization of the per-diem respite level of hospice care, finding that only two percent of beneficiaries received respite care, and most of them were within the five-day limit defined in the Medicare

hospice benefit. A total of 54 beneficiaries received respite care for more than five days, based on hospice claims filed in 2005. Since Medicare pays \$152 for respite days and \$140 for routine home care days, and since an inappropriate respite day would simply revert to the routine rate, this report seems rather anti-climactic, given OIG's past expressions of concern about hospice utilization. Of greater concern is OIG's yet-to-be-released report on hospice care in the nursing home.

Washington Adopts Assisted Suicide Measure

On November 4, voters in the state of Washington passed Initiative 1000, a measure to allow terminally ill patients to request a lethal prescription from their physicians to end their suffering. This measure, which received 59 percent of the vote, is modeled on Oregon's Death with Dignity Act, which took effect in 1998, and makes Washington the second state to legalize physician-assisted suicide. The measure takes effect July 1, 2009, and is available to mentally competent state residents who have six months or less to live according to two physicians, and who repeat their request 15 days after the first time, orally and in writing. Hospices and other health providers in the state are still clarifying how they will relate to this initiative, although Hospice of Spokane recently announced it would not participate in assisted suicide. There is no requirement that health providers need to participate in such a request from patients. Hospices in Oregon have lived under their state's PAS law for a decade. It is rarely utilized, only an average of 34 times per year statewide.

Growth in U.S. Hospice Care

In November, NHPCO released data on hospice services provided in the United States in 2007, including an estimated 1.4 million patients enrolled by the nation's 4,700 hospice providers that year and hospice involvement with 39 percent of all deaths, up from 35 percent in 2006. Just over 30 percent of those patients were enrolled for seven days or less (usually until death), while 13 percent received hospice care for more than 180 days. Cancer accounted for 41 percent of all hospice patients, followed by heart disease with 12 percent, debility unspecified, 11 percent, Alzheimer's and other dementias, 10 percent, and lung disease, 8 percent. NHPCO's "Facts and Figures on Hospice Care in America" can be obtained at www.nhpc.org.

Access for Underserved Veterans

NHPCO also announced a program to increase access to hospice and palliative care for rural and homeless veterans, with funding from the Department of Veterans Affairs. This project will identify innovative programs caring for veterans at the end of life and then recommend to the VA ways to improve outreach to those who are homeless or live in rural areas. At least 10 "Reaching Out" grants of \$5,000 to \$25,000 will be awarded to existing providers working collaboratively with the Department of Veterans Affairs, with grant recipients announced at the end of January 2009. For more information, see www.nhpc.org/veterans.

Hospice Employee Embezzles \$400,000

A former accountant for an Ohio hospice was arrested in November on charges of embezzling more than \$400,000 from the hospice between 2003 and her arrest, according to published reports. The former employee was indicated on one count each of aggravated theft, forgery and engaging in corrupt activity. Jeff Lycan, president of the Ohio Hospice and Palliative Care Organization, said that this case is a warning not just to other hospices but to all non-profits. He advises his provider members to carry an insurance policy that covers losses from theft, and to routinely audit operating procedures and books.

Greetings from the New Editor

I write to you at the end of 2008, looking ahead to a challenging and news-filled year for America's hospices. I am pleased to be back covering the hospice "beat" and the nuts-and-bolts business and quality concerns facing hospice providers, in collaboration with Jay Mahoney and members of the Hospice Compliance Network. My experience encompasses more than 20 years writing about the hospice business for trade and professional publications, including the *Hospice News Service*, the *Hospice Manager's Monograph* and *Hospice Management Advisor*. I was on staff at NHPCO in 1999 and 2000 and have continued to do a variety of writing projects for them since returning to the more favorable climate of California, most recently *We Can Do This! The Adventures of Mary Maven and Hospice of the Good Intentions*, a short manual on how to actualize QAPI and other quality requirements.

I am co-author, with Dr. Diane Meier, of the "Notes from the Field" column in the *Journal of Palliative Medicine*, and I also do other medical writing for trade publications such as *The Hospitalist* magazine and *Anesthesiology News*. I welcome your comments and suggestions on what the *Hospice Compliance Letter* should be covering, what your biggest compliance concerns are, and how we can connect formal compliance activities by hospice providers with actually making hospice care better for patients and families. Email me at larryberesford@hotmail.com.

HOSPICE COMPLIANCE LETTER

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