



HOSPICE COMPLIANCE LETTER

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The Future of Hospice Report Cards

Are hospices missing opportunity to practice reporting quality data?

One of the hospice-related provisions in the Senate Finance Committee's draft version of comprehensive health care reform, released in mid-October, is a proposal to require public Medicare hospice quality reporting by 2014, along with better hospice data collection by the federal Centers for Medicare and Medicaid Services (CMS). Hospice quality experts have warned for years that the reporting of comparable hospice quality data was inevitable for hospices—just as for every other health care sector. Public reporting of comparable quality metrics, such as Hospital Compare, Home Health Compare and Nursing Home Compare, sometimes referred to as “report cards,” reflect the growing emphasis on *transparency* of health providers' performance and quality.

What was not known was when this industry might see implementation of “Hospice Compare,” what actual measures would be used, and whether providers would view them as fair, reasonable, feasible—and likely to give consumers a helpful way of comparing and choosing among hospices. Another question was whether the hospice industry as a whole would embrace the need for quality reporting in advance of mandatory programs—and perhaps help to shape the metrics and processes by demonstrating to the government its commitment to transparency, quality and accountability. Or would providers rather wait until hospice report cards are imposed, and deal with implementation issues at that time? Our exploration of the issues has uncovered a perhaps not surprising lack of interest by providers in hospice report cards. Based on the lack of response to a request for feedback in the last *HCL*, it would seem that the wait-and-see approach is a more likely one.

But that kind of initial response to the issue should not have been unexpected, even though it is disappointing, says Naomi Naierman, CEO of the American Hospice Foundation (AHF), which has developed one of the more advanced hospice report card initiatives in collaboration with several state hospice associations, including Georgia and Virginia. “Other provider groups haven't exactly rushed to embrace report cards either. But public reporting of quality data is definitely coming to hospice in the foreseeable future.” Naierman believes that industry leaders should be inspiring their peers to participate in the development of tools that could satisfy the needs of consumers and

payers without placing undue reporting burdens on providers. “I believe the alternative is to be passive and then get saddled with a more onerous data reporting system that we will have no input on. My pitch: why not be a leader? Take charge and be pro-consumer. Be the first in your community to report your quality data,” Naierman says.

“We get calls all the time from the public asking: Which hospice should I go to? I have no answer for them. That’s what started this whole process for me, back in 1996. We set out to design the ideal public reporting tool. We hired a consultant and convened an expert panel and came up with what the public wants to know.”

Sources of Quality Data

There are really only two active programs at this time that could be considered report cards, says Melanie Merriman, health care consultant and quality expert in North Bay Village, FL. One is AHF’s initiative, now in pilot-testing but not publicly released, and the other is the state of Florida’s public reporting of NHPCO Family Evaluation of Hospice Care (FEHC) survivor satisfaction survey data. “When my mother needed a nursing home placement, I logged on and looked at Nursing Home Compare, because I didn’t know where else to look. Lots of the things they report are not particularly helpful,” she says. But this is something many hospice consumers crave, as well.

Merriman confirms that public reporting is certain to come for hospice. CMS’s Office of Clinical Standards and Quality has contracted with its Quality Improvement Organizations to test PEACE (prepare, embrace, attend, communicate, empower) measures of end-of-life care quality developed by a research team from the Carolinas Center for Medical Excellence and the University of North Carolina (<http://tinyurl.com/yaqq3tl>), working with CMS. The National Quality Forum will be reviewing and endorsing end-of-life care quality measures, and the United Kingdom’s Department of Health is going through a similar process with its Quality Markers and Measures for End of Life Care. Evidence that public reporting of quality measures improves the quality of care is mounting. (For example, see the Oct. 27 *Wall Street Journal*, “Compare and Contrast: When Doctors Are Given a Public Report Card, the Resulting Competition Can Serve Patients Well.”)

What Constitutes Quality in Hospice?

Joanne Lynn, MD, who was involved in developing the PEACE measures for CMS, says that defining and then quantifying what constitutes quality hospice care is difficult, and goes deeper than some of the standard measures now in use. “Do you take patients who need any of a list of services, drugs or devices? Do you cover more than X hours of aide care (per week)?” she poses. To take another example, how long does it take to get ordered opioids delivered to the patient’s home? How readily can the hospice nurse get a physician out to the home for an urgent medical need? “The problem is that no one knows what to do with these kinds of questions—it’s not clear that we really want to see the results, or that hospices could honestly answer!” Lynn says. The wide variation

in performance and quality between hospices is another big question mark, while traditional health quality outcomes such as mortality don't apply and counting pressure ulcers and falls may not be the right markers of quality, either.

While acknowledging that more work is needed on the metrics, Merriman urges that hospices participate in some kind of organized quality measurement. "I believe that the sooner you begin to get ready for public reporting, the more ready you'll be. But if we as an industry come up with measures we like, will CMS listen to our input? One possibility is they will allow us to give them input on quality measures, in which case we should now have a bunch of hospice people measuring a bunch of things. If they don't want our input, then we will want to be ready with the Hospice Compare measures that we want—to put them forward as an alternative."

There are a number of opportunities for hospices to get involved in compiling quality data and reporting them to benchmarking repositories, both fee and no-fee, some developed by private vendors or state or national associations, Merriman says. In some cases Medicare-required QAPI (quality assessment/performance improvement) activities could drive reportable quality measures. NHPCO announced at its September conference in Denver that it was planning its own report card initiative.

Jennifer Hale, director of the Georgia Hospice and Palliative Care Organization (GHPCO), says providers are too focused on what is happening in the payment process to worry about a potential change in reporting methods that may not come for years. "For consumers, the urgency is growing, but not quite there yet to force CMS to make a change sooner than expected," she adds. However, Hale is encouraged that the GHPCO board proactively chose to participate in AHF's pilot report cards project. "We embraced the idea of developing our own report card, rather than waiting for CMS to tell us what they want," she says. At a recent meeting with a representative of Georgia's Department of Community Health, Hale presented a brief overview of the report card project and current status of Georgia's participation, and the response was a request for more information.

State associations want to encourage movement in cutting-edge demonstration areas like quality report card comparison tools, PACE programs or dual eligibility demonstration projects, Hale says. "But most of us can't spend a whole lot of time promoting those things when it is our providers who drive what we do." She adds that hospices' mandated QAPI programs may be the best opportunity to start to learn about quality reporting. "Having a tool to measure their own agency's performance is paramount to preparing for quality reporting—whether they use FEHC or another tool." The collection of diverse QAPI data by hospices eventually might motivate CMS to designate one QAPI question that every provider has to collect in the same way.

Les Morgan, who founded the Growth House online library of end-of-life care (www.growthhouse.org), recently posted a blog arguing that it's time for the government to launch a Hospice Compare website (<http://tinyurl.com/ydlv8nj>). Descriptive data such as location, length of stay and death counts could be posted immediately. "Cost data is also easy (sort of). As an information technologist, when I see what Medicare is already doing with consolidation of existing data feeds, I believe they could decide to post

hospice cost report data next week and call it Hospice Compare Version 1.0.” Hospices might not like the form it takes, but that would force them to engage with the issues and negotiate with CMS to come up with a reporting system they liked better. “What would follow would be helpful conflict,” Morgan says.

“I have to wonder why there isn’t a Hospice Compare already. Congress should say that’s unacceptable, and there should be a national hospice quality database because of the tremendous variation in quality. The hospice industry continues to operate in a pre-health-care-transparency mode, but technology will drive another outcome,” he asserts. “What the hospice industry may not fully appreciate is that the drive for data transparency in government spending may accelerate the appearance of a Hospice Compare website designed without their control.”

(To learn more about the American Hospice Foundation’s report card pilot project and webinars, contact Marsha Nelson at: mnelson@Americanhospice.org.)

Hospice in Nursing Home Requires Focus on Quality

How can the hospice industry demonstrate its value-added benefits?

The September 7 Office of Inspector General (OIG) report, “Medicare Hospice Care for Beneficiaries in Nursing Facilities” (see *HCL*, September 2009, p. 1) primarily highlighted technical requirements and violations related to hospice care planning, documentation and eligibility, rather than finding serious fraud-and-abuse issues. Some hospice advocates breathed a sigh of relief at this outcome, but Meg Pekarske, co-chair of the Hospice and Palliative Care Practice Group and legal counsel to nursing homes in the Wisconsin law firm Reinhart Boerner Van Deuren, believes that OIG’s findings have not received the attention they deserve from the hospice industry. “For OIG to be talking about care planning—that’s huge. I wasn’t expecting OIG to be asking: are hospices meeting all of their regulatory requirements? They’re fraud people (at OIG). If they see care planning and documentation as legitimate fraud targets, will others in the government follow suit?”

Hospice care in the nursing home remains an identified risk area for OIG and an ongoing issue for others in the government who are concerned that it does not provide full value for the rapidly growing expenditure. Care planning can be more than just a clinical issue, also raising compliance, risk management and fraud implications, Pekarske says. A lot of nursing home hospice patients have dementia, which often means longer stays, raising regulatory risk in two categories. Combine that with concerns about aggressive marketing by some hospices, the rapid growth in this sector, hospice eligibility concerns raised by Medicare Administrative Contractors and other government representatives, and the problem of poor documentation and inadequate care planning identified by OIG, “and you have the potential for a perfect storm,” Pekarske says.

The government’s concern about quality as a potential fraud-and-abuse issue in other health care sectors was confirmed in a talk to the American Health Lawyers

Association Fraud and Compliance Forum Oct. 6 by Assistant U.S. Attorney Margaret L. Hutchinson for the Eastern District of Pennsylvania, quoted in the *BNA Health Care Daily Report*. Hutchinson noted that the Fraud Enforcement and Recovery Act of 2009 makes it easier for the government to advance the theory of substandard quality of care constituting a false claim. Although this theory has primarily been applied to hospitals and nursing homes, the government is looking in other directions as well.

“Are claims denials the only avenue to fraud investigations of hospices? Absolutely not!” Pekarske says. The quality of hospice care in the nursing home, and the value the government gets for its investment, are going to remain active concerns for the foreseeable future. “For years, people wondered if the hospice benefit in the nursing home was in jeopardy. Eliminating it would be a difficult step to take, but the government could change the reimbursement,” she says. But there are things hospices can be doing to add value and enhance the quality of care they provide in the nursing home, which could have the effect of forestalling or postponing government attempts to change or limit the benefit.

Nursing Home Population Is Changing

The nursing home population as a whole has changed in recent years, Pekarske notes, with higher acuity of need and with the residents who used to populate nursing homes now more likely to be found in assisted living facilities. “When you look at dementia and failure to thrive as major diagnoses for hospice patients in the nursing home, you’re looking at a higher incidence of wandering, aggressive behaviors, especially those directed at other residents, and the risk of falls,” Pekarske says. “Those are the concerns of nursing home patients, and thus of nursing home staff and their surveyors. How is the hospice care planning and controlling for those issues?” she wonders.

“When dementia patients aggressively grab at other residents, it can lead to immediate jeopardy citations for the nursing home. The magnitude of this issue is new for the field. But what value is hospice adding in these situations? A lot of my nursing home clients don’t find hospice particularly relevant.” Hospice is known for its proficiency in managing pain, with a growing emphasis on pain assessment techniques for patients who can’t verbalize their pain intensity. That skill, by and large, is recognized by nursing home staff. But is it the most important symptom for residents with dementia or adult failure to thrive? Perhaps hospices are too narrowly defining what is related to the terminal illness or not, she suggests.

Hospices might argue that Medicare eligibility guidelines mostly limit their dementia admissions to residents who are already bed bound. “But I don’t find that’s necessarily true in practice,” Pekarske responds. “You can be confined to a wheelchair and still engage in aggressive behaviors. These can be pretty common occurrences.” Care planning is key, she says—addressing the real concerns of these patients, doing joint care planning with the nursing home, and making sure that documentation is appropriate, complete and accessible for both partners. “Very often the nursing home can’t find the

hospice plan of care in the chart when asked by surveyors. That's very bad. There needs to be much more cross-referencing between the two care plans."

What Is Hospice's True Value?

Although OIG may be looking in new and unexpected directions regarding the provision of hospice care in the nursing home, the real questions for HCN members involve the state of the art of quality hospice care in this setting, what are the most important quality concerns and problem areas, and what can providers do to address them. Can the industry document the value it brings and the difference it makes for these patients, advancing the case that this benefit needs to be preserved?

Research by Susan Miller of Brown University and others has quantified benefits from hospice care such as improved pain relief, reduced hospitalizations, fewer invasive treatments and enhanced perceptions of care by family members—not only for nursing home residents enrolled on hospice care but even for other residents of facilities that have a higher hospice presence. But those data are some years old and, as Pekarske says, the setting, the patients and their needs are all quickly evolving.

"I'm not convinced that all of the hospice patients in the nursing home truly benefit from the hospice care they receive," observes veteran hospice consultant Jay Mahoney of the Summit Business Group. "What does the hospice do that adds value to the services the nursing home already provides—especially for those who present without significant pain issues? Does the hospice act as a patient advocate with the nursing home, or do we turn our backs on care we shouldn't tolerate rather than risk offending a referral source. What is it that the hospice brings to the table—or should bring to the table, but doesn't? Can we actually demonstrate what we are doing and what we believe we are contributing? What concerns me is that if some hospices are just going through the motions, then it will be that much harder for the industry as a whole to show our impact." And if the government decides to take an even closer look at hospice in the nursing home, it may not take a very nuanced or surgical approach, Mahoney says.

Participants on the Hospice Compliance Network listserv and elsewhere offer complaints about the use of the Medicare Part A skilled nursing benefit for patients who are nearing the end of their lives and might get more appropriate support from hospice. But Medicare Part A pays a higher rate to the nursing home than hospice does and temporarily relieves many families of paying a room-and-board rate for their loved one's care. So it is unlikely that patients would eschew this benefit in favor of hospice care, even if their needs are primarily end-of-life-related. Hospices have looked for solutions to this dilemma of choosing between hospice care and the skilled benefit. Meanwhile, Mahoney says he is seeing an upward trend in the number of nursing homes wanting to establish their own certified hospice programs—a trend that could dramatically alter the landscape of hospice providers and the ability of hospices in the community to operate in the nursing home.

Creating a Customer Service Culture

Susan Miller was project director for the Robert Wood Johnson Foundation-funded initiative, “Nursing Home/Hospice Partnerships: A Model for Collaborative Success through Collaborative Solutions.” This project set about to identify best practices in these partnerships, based on site visits to successful programs. Many of its recommendations could be summarized as good customer service, recognizing the nursing home as an important customer and providing a level of service that the nursing home finds valuable, but without getting ensnared in regulatory prohibitions against so-called inducements. The final report, issued in February 2007 and posted on the NHPCO website (<http://www.nhpc.org/i4a/pages/Index.cfm?pageID=5053>; may require membership login), offers hallmarks of successful collaboration such as the following:

- Systematic processes are created to facilitate communication between the partners and at all levels of staff;
- Hospice CEOs are well-versed in nursing home regulations and care environments;
- Mechanisms are in place to facilitate regular assessment of the partnership;
- Dedicated hospice teams are employed in the nursing home setting; and
- The hospice responds promptly to nursing home requests.

“If I were in charge of a hospice’s care in the nursing home, I would develop a system where I’m getting regular feedback from the nursing homes’ staffs and administrations: Are we meeting their expectations? How do they want our staff to relate to their staff?” Miller tells *HCL*. “I’d also be collecting and analyzing data about what we’re doing—the number of visits, the intensity of visits, the mix of professionals, length of stay, documenting what we’re doing for the resident and their family.” She recommends that hospices consider carefully who they place in the nursing home, choosing staff who are flexible, good formal and informal educators, and able to leave their egos at the door. Targeted training for the hospice’s long-term care team could emphasize a better understanding of nursing homes’ needs, concerns and regulations and problem-solving and relationship-building skills.

“A couple of the facilities we visited told us, ‘I told the hospice what I expect. I don’t want a Monday to Friday, 9 to 5 hospice,’” Miller relates. Nursing home-based services can be viewed as a distinct product line, with important differences in approach from home-based hospice care, even though the clinical approaches and set of services are the same. “There are a lot of opportunities for meeting their needs, and enough they need from hospice that is not outside of compliance safe harbors. There’s a lot that hospices can do, such as helping the nursing home during its surveys and providing education for its staff. They always need educational hours, although one-on-one education is even more important. Also, the exchange of knowledge should not be one way. Ask nursing home staff for their input. Ask them what works for their patients.”

Miller, who is recognized as one of the foremost experts on hospice care in long-term care, doesn’t see hospice in the nursing home as a disaster area or in serious

jeopardy. “I think there are problems and an infusion of inexperienced new providers. There certainly is variability in quality between providers. I think the overall utilization is what policy-makers are most concerned about. But I don’t see how they can not provide the hospice benefit to nursing home residents,” she concludes. Meanwhile, hospice providers should stay on top of their care. “Be very transparent about what you’re doing, and monitor the data, so that you can defend the benefit if you need to.”

“Basically, you need to understand the nursing home business to really understand your role as the hospice, and where you can add value,” Pekarske says. “Improving nursing home relationships requires understanding their issues and speaking their language. Good joint care planning will also strengthen the relationship. If you show up with your protocols for aggressive behavior and falls prevention already developed, recognizing the need to address the root causes of these problems on an individualized basis, then they will know you’re in tune with their concerns. As the OIG points out in its report, care plan development and implementation is a Medicare coverage requirement. ”

San Diego Palliative Care Psychiatry Program Honored

The Palliative Care Psychiatry Program at San Diego Hospice and the Institute for Palliative Medicine, directed since 2006 by psychiatrist Scott Irwin, MD, PhD, was recently honored with the Gold Achievement Award from the American Psychiatric Association. The program addresses the psychiatric and psychological issues that cause additional distress for hospice and palliative care patients, performing rapid screening, identification and treatment of psychiatric symptoms of hospice patients—often within hours of admission. That can make a dramatic difference in the quality of their lives and their families’, Irwin says.

Perhaps the only full-time staffed mental health program specifically for hospice and palliative care patients, it also emphasizes research to identify and test clinical interventions; consultations for community physicians and others; and rotations for psychiatry students at the University of California-San Diego and for palliative care fellows from around the world. The program also employs a psychologist and uses hypnotherapy to alleviate suffering. Mental health services in hospice settings are limited, particularly for patients at home, while significant psychological symptoms—whether sequelae of life-threatening illness or from pre-existing conditions—can go unacknowledged, unassessed, under-diagnosed and under-treated, Irwin says.

Although other hospices are unlikely to develop psychiatric services as extensive as those at San Diego Hospice, there are things hospices can do to better address mental health issues, starting with recognition of the need, he says. “Your current staff can start screening for things like depression, anxiety and agitation—which is associated with both dementia and delirium.” The medical literature includes tools to help with these assessments, ranging from the Hospital Anxiety & Depression Scale to a simple one-item depression scale used by Dr. Harvey Chochinov at the University of Manitoba: “Are you depressed most of the time?”

Interventions for these symptoms are both pharmacological and non-pharmacological, such as environmental manipulations—even warm milk and a massage to help induce sleep in agitated or confused patients. “Some common medications used by hospices, like lorazepam (Ativan) can make it all worse,” Irwin says. “It’s also important to make sure that these patients have access to their usual sensory aids, like eyeglasses and hearing aids,” he advises.

“Also realize that there are psychiatrists in your community who are interested in these issues but don’t know how to get involved. Reach out to them.” Irwin encourages treating mental health delivery in hospice as a quality improvement issue and for hospice representatives to advocate with their national organizations for including psychiatric services as an essential component of high-quality hospice care. “You can do this,” he says; “we have a sustainable model.” As is done by San Diego Hospice, these consultations can be billed to Medicare and other payers. (For more information about psychiatry in hospice, contact Dr. Irwin at sirwin@sdhospice.org.)

Quality Perspectives on Hospice Bereavement Services

An article published online Oct. 16 in the *American Journal of Hospice and Palliative Medicine* examines the correlation between hospice patients’ diagnosed diseases and increased need for bereavement services by their survivors. The study by Brian W. Jones, CEO of Hospice of Western Kentucky, Owensboro, examined nearly 600 patients who died under the hospice’s care in 2007 and 2008. Survivors of those with Alzheimer’s disease, lung cancer and renal disease consistently (at least 50 percent of the time) requested increased bereavement services, such as additional home visits by the hospice bereavement coordinator, while patterns for other disease types were less clear.

The results were limited because only one hospice was involved in the study, Jones wrote, and further research is called for. “If certain disease types indicate a greater need for bereavement care for survivors, this may cause a hospice to better align its staff and resources based on the percentage of certain types of deaths they are historically more inclined to provide these services for.” For example, a large Alzheimer’s caseload may suggest intensified pre-bereavement support for family caregivers. He added that similar research could be conducted by any hospice with an electronic health record and an interest in better targeting its bereavement services.

Meanwhile, a new book by George A Bonanno, clinical psychologist and professor at Columbia University in New York, suggests that most people who experience loss are resilient, fluctuating between pain and happier emotions, and likely to get better on their own, without the need for professional help. *The Other Side of Sadness: What the New Science of Bereavement Tells Us about Life after Loss*, is reviewed in an Oct. 22 *New York Times* blog by Paula Span (see <http://tinyurl.com/yf8xwxw>).

This book emerges out of ongoing controversy in the psychology field over the efficacy of—and purported potential harm from—grief support interventions. Widely

cited claims of harmful effects of grief counseling are based on a single, non-peer-reviewed student research project of questionable methodology that has received multiple generations of citations and re-citations that ignore the initial methodologic concerns, notes Dale Larson, PhD, professor of counseling psychology at Santa Clara University in California. (For more information on this controversy, see “Negative views of grief counseling are not substantiated by the research, experts say,” on the website of the American Psychological Association, http://www.apa.org/releases/grief_counseling.html.)

Actually, Bonanno’s conclusion, as well as his acknowledgement that 10 to 15 percent of mourners have longer lasting depression and distress and could benefit from professional intervention, isn’t terribly far removed from the operating assumptions of most hospices’ bereavement programs. Generally, hospices offer supportive outreach such as informational letters, scheduled phone calls, peer groups and memorial services for a client population expected to experience normal grief, while assessing for those individuals who might need more formal mental health interventions. Documenting the assessment and successful identification of those who may have additional needs, and the follow-up with those so identified, could be a significant quality improvement project for hospices.

Quality News in Hospice and Palliative Care

End-of-Life Care for Patients with Dementia: A study of patients with advanced dementia living in nursing homes, published in the Oct. 15 *New England Journal of Medicine*, found that 41 percent received at least one burdensome intervention (e.g., hospitalization, emergency room visit, parenteral therapy or feeding tube) in the last three months of their life, even when their identified goal of care was comfort. Family caregivers need to understand that advanced dementia is a terminal illness in its own right, said lead researcher Susan Mitchell. When families clearly understood the prognosis and complications of advanced dementia, they were better able to make treatment choices reflecting the goal of helping the patient remain comfortable.

Another recent study, published online last month by the *American Journal of Alzheimer’s Disease and Other Dementias*, surveyed hospices regarding their caseloads of patients with dementia. Those hospices that offered bridge or transition programs for non-hospice patients were found to have a four times higher dementia census. Said authors McCarthy and Volicer, “Hospice is still underused for individuals dying of dementia,” with the most highly ranked barriers to hospice access identified by respondents as prognosis, education and finance.

Palliative Care Overview Presented: Dr. Russell Portenoy, chair of pain medicine and palliative care and medical director of Continuum Hospice at Beth Israel Medical Center in New York City, presented an audio conference, “The U.S. Palliative Care Movement in 2009: Challenges and Progress,” sponsored by the American Academy of Hospice and

Palliative Medicine, on Oct. 27. Dr. Portenoy outlined recent landmarks in the growth of hospice and palliative care, some of the forces behind that growth, and barriers to further growth for the field to overcome widespread deficiencies overall in the care provided to patients with serious illnesses and their families. One key to operationalizing palliative care across venues of care, he said, is to view it as a therapeutic model with best practices during the routine care of all patients with serious or life-threatening illnesses (i.e., generalist-level care) and access to specialist-level palliative care for those patients who need a more intensive interdisciplinary approach (the palliative care consult service).

Dr. Portenoy highlighted significant workforce issues for all disciplines in palliative care, fragile support for the field's continued growth, a business model that depends on demonstrating cost reductions, and the need to improve continuity of care in transitions and linkages beyond the hospital. He predicted significant changes for the hospice movement because the government is anxious to lower its costs, but with implications that are difficult to predict. Quality concerns in hospice have been identified, which the industry is trying to address.

Dr. Portenoy recommended expanding access to hospice while enhancing its quality and exploring open access models (which may require changing the reimbursement system); supporting the growth of institution-based palliative care; creating meaningful bridges between the two; and supporting workforce expansion in hospice and palliative medicine. He called for strategies to permit mid-career shifts into HPM by physicians who are not in a position to take a year off for a fellowship. (After 2013, board certification in HPM will require completing a year-long fellowship.) Current fellowship programs graduate only about a hundred HPM physicians per year, while the need is in the thousands, Portenoy noted.

ESRD Podcast Explores Palliative Care: The *Kidney News* website of the American Society of Nephrology on Oct. 12 posted a podcast interview with Dr. Mark Swindler of Mount Sinai School of Medicine and Dr. Alvin Moss of the University of West Virginia. This interview on end-of-life care highlights the interdisciplinary approach to palliative care and offers palliative care resources for nephrologists and other physicians. Access the 38 minute podcast at <http://asn-online.org/publications/kidneynews/podcast.aspx> by searching previous postings.

Regulatory and Compliance Updates

Mob Links to Health Care Fraud: The Home Care Law Blog of Oct. 9 (<http://tinyurl.com/ygnf3rr>) discusses a growing connection between organized crime and fraud in home health care, a link that CMS seems to have overlooked—judging by its current methods for identifying Medicare fraud, writes blogger Robert Markette. He cites an Oct. 6 Associated Press article by Kelli Kennedy (<http://tinyurl.com/y9gn6g9>) highlighting violence associated with Medicare fraud schemes and the involvement of former drug dealers and mobsters seeking higher profits and lower criminal penalties than

they might face for other criminal activities. “Federal investigators have been threatened (and) an informant’s body was found riddled with bullets,” Kennedy writes. The most common locales for Mob-linked Medicare fraud are Miami, Los Angeles, Detroit and Houston.

“Let’s be honest—criminals who are intent on defrauding Medicare are not going to hesitate to lie on the Medicare provider application,” Markette concludes. “I think that this is a problem that is going to require investigations and prosecutions.” Meanwhile, six Democratic senators on the Judiciary Committee are pushing legislation they say would strengthen the hand of federal investigators and prosecutors in their efforts against health care fraud, reports the Oct. 29 *Modern Healthcare*. The Health Care Fraud Enforcement Act of 2009 would allocate \$20 million more for fraud investigations and strengthen sentencing guidelines and False Claims Act provisions.

Hospice Cap Challenges Continuing: What will be the upshot of a successful legal challenge to hospice reimbursement cap-implementing regulations brought by Los Angeles Haven Hospice (see *HCL*, September 2009, p. 11) is still not clear. There have been at least seven similar cases in federal courts, says David Daucher of Sojourn Hospice, Tulsa, OK. “The Haven Hospice case is just the best, clearest and most recent.” Daucher is co-founder of the National Alliance for Hospice Access (www.hospiceaccess.com), an organization formed to advocate for hospices impacted by hospice cap recoupments.

These suits argue that CMS’ methods for implementing the hospice cap, adopted a year after the original Medicare hospice legislation passed, wind up unfairly trapping unused cap allowances in prior cap years. U.S. Judge George Wu ordered CMS to either refund Haven Hospice’s cap recoupments for 2006 or recalculate them. “There is talk of a group appeal by hospices affected by cap recoupments,” Daucher says. “What we think the Haven Hospice case means is that sooner or later the federal courts will say to CMS, you can’t use an invalid regulation to demand money back from hospices. At a minimum it will cause HHS and CMS to look at the cap-implementing regulation and write a new one.”

Hospice and Health Care Reform: A number of provisions in the Senate Finance Committee’s version of national health care reform, released on Oct. 13, address hospices, the Medicare hospice benefit, and recommendations contained in the March report to Congress by the Medicare Payment Advisory Commission. The released draft contains “productivity factor adjustments” for years 2013-2019, which would reduce hospice’s annual inflationary rate increases, predicated on the assumption that hospices, like other health care providers, will get more efficient over time.

NHPCO and its allies in Congress have been working to minimize cuts in hospice rates, arguing that a phased-in elimination of the Budget Neutrality Adjustment Factor already amounts to a cut in hospice rates. On Nov. 2, NHPCO announced that it was continuing to work with Sen. Ron Wyden (D-OR) in seeking relief from the reform-associated rate cuts. Sen. Wyden sent a letter to key Congressional leaders, asking their

“sign on” to an amendment to rescind the productivity cuts. NHPCO is urging its members to contact their senators to sign on.

Overall, hospice advocates say, the Medicare hospice benefit seems to remain essentially in its current form in the reform proposals, and that hospices have escaped what could have been potentially far more devastating cuts. Other provision still on the table include requirements for public Medicare hospice quality reporting by 2014 (see cover story); better data collection to inform future hospice payment reforms; and the need for a hospice physician or nurse practitioner to visit the patient in person at the time of recertification for continued hospice eligibility. Another provision of health care reform would establish a 26-site hospice concurrent care demonstration project in Medicare to test simultaneous models of hospice and curative care.

CR 6440 Revised: A May 15 transmittal from CMS confirms that the Hospice Change Request (CR 6440) has been revised for additional data reporting on hospice claims to describe patient visits by certain provider categories in times rounded to the nearest 15-minute increment. A previous transmittal said to “round up” to the nearest 15-minute increment. CMS still requires hospices to report these data under routine home, continuous care and respite levels of care for visits by nurses, aides and social workers employed by the hospice. Billing by physicians is not affected, and chaplains and volunteers are specifically excluded, although the government intends to add them in a future phase of data collection. Effective Jan. 1, physical therapy, occupational therapy and speech-language pathology visits should also be reported in 15-minute increments.

These changes are part of a more comprehensive data collection strategy by CMS to better evaluate trends in utilization of the Medicare hospice benefit. Another recent transmittal aims to correct a problem reported to the government by providers. Nurse and social worker visits listed on claims, which do not actually affect payment under the all-inclusive hospice per diem, were appearing as “non-covered visits” on the Beneficiary Medicare Summary Notice sent to patients, creating confusion among beneficiaries that they might be liable for these bills. Effective Oct. 5, CMS has instructed Medicare Administrative Contractors to process these individual professional visits as “covered”. (For more information, see <http://www.cms.hhs.gov/Transmittals/downloads/R1738CP.pdf>.)

Other recent regulatory developments include the following:

- The House of Representative in mid-October passed a bill limiting application of the Federal Trade Commission’s “Red Flag rule,” which would require various categories of business acting as “creditors” (possibly including hospices) to develop policies aimed at preventing personal identity theft. The House bill specifically excludes health care practices and certain other groups with fewer than 20 employees from having to comply with the rule, while creating a process allowing for certain other categories of business, possibly including hospices, to apply for exclusions. The red flag rule was set to go into effect after a couple of

- delays on Nov. 2, but on that date FTC announced that it was further extending the deadline until June 1, 2010, at the request of Congress.... Meanwhile DHHS's Office for Civil Rights issued an interim final rule amending Health Information Portability and Accountability Act privacy regulations, effective Nov. 30. The amended rule incorporates provisions of the 2009 Health Information Technology for Economic and Clinical Health Act intended to strengthen the civil monetary penalty authority for enforcing HIPAA.
- *Medicare Hospice Data Trends for 1998-2008*: a report released by the federal government in October, documents increases in hospice benefit expenditures of about one billion dollars per year from \$2.2 billion in fiscal year 1998 to \$12.1 billion in 2008. The frequency of some hospice-admitting diagnoses has changed, with cancer overall dropping from 53 percent to 31 percent of total admissions over the same period. In 2006, non-Alzheimer's dementia became the most common diagnosis among Medicare hospice patients. There have also been notable increases in neurologically based diagnoses and in non-specific diagnoses such as debility not otherwise specified and adult failure to thrive. Average length of stay in hospice care rose steadily from 48 days in 1998 to 73 days in 2006, after which it dropped slightly to 71 days and leveled off. ALOS by disease varies widely, from 28 days for chronic kidney disease to 105 days for Alzheimer's disease. (See <http://www.cms.hhs.gov/center/hospice.asp>.)
 - Active participants on the Hospice Compliance Network listserv report recent questions about whether hospices need to have contracts in place with assisted living facilities (ALFs) when they enroll residents of those facilities on the Medicare hospice benefit. Medicare and Medicaid are not involved in paying for the room-and-board services provided to ALF residents, and the recent OIG report on hospice in the nursing home (see p. 4) declined to address this setting. But some states view the issue differently, and some facilities may request contracts spelling out mutual responsibilities, even though no money changes hands between the two providers. "NHPCO warned us quite a while ago that this may happen," one poster noted. Others have looked to templates for such contractual or service agreements to sources such as the document library of the law firm Reinhart Boerner Van Deuren, to help them get started in this process.

HOSPICE COMPLIANCE LETTER

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