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CMS Releases Revised Hospice Conditions of Participation: New CoPs Contain Significant Changes, Including to Hospice Relationships with Nursing Homes and Medical Directors

Today, the Centers for Medicare and Medicaid Services (CMS) published a final rule amending the hospice Conditions of Participation (CoPs)[1], which establish the requirements for hospices to participate in the Medicare or Medicaid programs. The revised CoPs, which will become effective December 2, 2008, contain a number of new provisions that will require significant changes in hospices' operating procedures and contractual relationships. In explaining its reasons for revising the CoPs, CMS observed that many of these regulations have remained unchanged since they were introduced in 1983. CMS noted that, over the years, its approach to quality assurance has evolved from merely identifying and penalizing individual health care providers that failed to meet minimum standards, to an approach designed to stimulate broad-based improvements in the quality of care. According to CMS, the revised hospice CoPs "focus on a patient-centered, outcome-oriented, and transparent process that promotes quality patient care for every patient every time."

There is much to digest in the new rules and accompanying commentary. Of particular importance are the changes involving hospice relationships with nursing homes and the role of the medical director. Due to the significance of these changes, hospices will undoubtedly need to review, and likely revise, their agreements with nursing homes and medical directors. The following information briefly highlights some of the changes in the text of the rule, as well as CMS's commentary. CMS is expected to provide additional guidance prior to the effective date, which should help to provide more detail and clarify questions about these provisions.

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Providing Hospice Care to Nursing Home Residents (42 C.F.R. § 418.112)

The final rule introduces a new CoP specifically governing how hospices should work with nursing homes when hospice patients are nursing home residents, recognizing for the first time a separate rule for hospices providing care to

patients residing in nursing homes. The interface between hospices and nursing homes is complicated and has been a subject of regulatory scrutiny for many years. While the new CoPs do provide some specific bright-line rules for hospices to follow in their relationships with nursing homes, this continues to be a complex area, and some questions remain about how these rules can be practically implemented. Given this complexity, reviewing CMS's comments to the final rule can provide helpful background information and context to the rules. Additionally, CMS has stated that it will be updating the Conditions of Participation for long-term care facilities, located at 42 C.F.R. § 483.75(r), so that nursing homes will be bound by obligations similar to those in the hospice CoPs when their residents are receiving hospice care.

- **Scope of the Rule**. This new CoP applies only to hospices that provide hospice care to residents of nursing homes and intermediate care facilities for mental retardation (in the rule, CMS refers to these types of facilities with the abbreviations SNF/NF and ICF/MR). The requirements do not apply to assisted living facilities. However, it is important to note that state law may impose specific requirements on a hospice's relationship with assisted living facilities. Furthermore, even if not required by state law, hospices may still find it helpful to enter into contracts with assisted living facilities so that the responsibilities of each party are clear.

- **Written Agreements**. As before, the hospice must have a written agreement with the nursing home. However, the regulations identify new specific requirements for these agreements, which are outlined in 42 C.F.R. § 418.112(c). In addition to the specific provisions required by the rule, CMS's comments address other issues that should be addressed in the contract, such as identifying how a hospice may rely on nursing home staff in crisis situations.

- **Coordination of Care**. The hospice must designate a member of the interdisciplinary group (IDG) to coordinate the resident's overall hospice care with the nursing home. Under the new CoP, the hospice must also provide the nursing home with a host of information, including the patient's election forms, certifications and recertifications of terminal illness, and physician orders.

- **Plan of Care**. The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the services identified in the plan of care. CMS's commentary states that hospices and nursing homes "must have a single plan for each patient."

- **Professional Management Responsibility**. The comments clarify that hospices are only responsible for furnishing and managing a patient's hospice care related to the terminal illness and related conditions. They are not responsible for managing all of the patient's care.
- **Facilities Providing Respite Care**. In a separate CoP addressing the requirements for facilities providing respite care, 42 C.F.R. § 418.108, CMS removed the portion of the regulation that had required facilities to have a registered nurse on each shift providing direct patient care. However, a registered nurse still must be available 24 hours per day in facilities providing general inpatient care. By eliminating this requirement for respite care, nursing facilities that might have previously been ineligible to provide respite care may now be able to do so. However, assisted living facilities remain ineligible to provide respite care, as only Medicare-certified hospitals, Medicare- or Medicaid-certified nursing facilities, and Medicare-certified hospice inpatient units are eligible to provide respite care.

The Medical Director (42 C.F.R. § 418.102)

- **Medical Directors As Independent Contractors**. The CoPs had previously stated that the medical director had to be an employee of the hospice. However, the Balanced Budget Act of 1997 had changed this rule, permitting medical directors to be independent contractors, rather than employees, of the hospice. CMS updated the regulations to reflect this fact. However, hospices must still consider their state's corporate practice of medicine doctrine (if any) to determine whether they can directly employ physicians to serve as medical directors.[2]
- **Associate Medical Directors / Physician Designees**. Hospices are now specifically required to employ or contract with a "physician designee," who must be an identified physician who will be available to serve as the medical director in the medical director's absence. These physicians are sometimes referred to as "associate medical directors." It will be important for hospices to have agreements with these physicians, in addition to written agreements with their medical directors.
- **Physician Supervision**. The CoPs now specify that the medical director is responsible for supervising all hospice physicians.
- **Contracting with the Medical Director's Physician Group**. CMS clarified that

the hospice can contract with the medical director's physician group or professional entity, but the contract must specify the physician who will be responsible for performing the medical director's duties.

- **Certification and Recertification of Terminal Illness**. The CoP contains a list of factors the medical director or physician designee should consider when certifying a patient as terminally ill. CMS reiterated that it is the responsibility of the medical director (and attending physician, if any) to certify and recertify the terminal illness. Although contributions of the IDG should be considered in recertifying the patient as terminally ill, CMS makes clear that a patient's continued eligibility will be based on the medical director's judgment.
- **Medical Director Qualifications**. The CoP does not establish specific qualifications for medical directors, other than the requirement that the physician be appropriately licensed as a doctor of medicine or osteopathy. However, CMS states that the medical director should have the knowledge and skills necessary to meet the needs of the hospice's patients. CMS acknowledged that these skills may vary according to the size of the hospice and the daily duties of the medical director.
- **QAPI**. In the proposed rule, CMS had considered requiring the medical director to be responsible for directing the hospice's quality assessment and performance improvement (QAPI) program. CMS removed this requirement in the final rule, although the medical director still must actively participate in the QAPI program.
- **Dual Medical Director Roles**. CMS clarified that the CoPs do not prohibit a hospice medical director from also serving as a nursing home medical director. However, these relationships can raise complicated issues under the anti-kickback laws.

As this brief overview illustrates, the final rule contains extensive changes with significant implications for hospices' policies and procedures, including their relationships with nursing homes and medical directors. The Reinhart Hospice & Palliative Care Practice Group has developed two toolkits that can help you comply with the CoPs. One is the *Hospice and Nursing Home / Assisted Living Contracting Toolkit*, which includes, in addition to commentary, sample contracts with nursing facilities for routine home care, inpatient services, and respite care, as well as a sample contract for routine home care provided in assisted living facilities. We also have the *Medical Director and Physician Contracting Toolkit for*

Hospice and Palliative Care, designed to help hospices comply with the CoPs in their medical director and associate medical director contracts. This toolkit also contains sample contracts with extensive drafter's notes, allowing you to customize contracts to meet your needs, as well as summaries of important regulatory and reimbursement issues. If you have already purchased these toolkits, we will be sending you free updates of the materials that are affected by the amendments to the CoPs. If you have not yet purchased one of the toolkits, but would like to do so please access the order form for the *Hospice and Nursing Home/Assisted Living Contracting Toolkit* and the *Medical Director and Physician Contracting Toolkit for Hospice and Palliative Care*.

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[1] The final rule is available online at http://edocket.access.gpo.gov/2008/pdf/08-1305.pdf

[2] For general summaries of the corporate practice of medicine in each state, see http://www.nhpco.org/files/public/palliativecare/corporate-practice-of-medicine-50-state-summary.pdf.