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Ten Tips When Considering a Hospice House: Balancing the Bottom Line with Legal and Regulatory Considerations

When hospices consider building a hospice facility, whether residential only, in-patient only, or some combination, the fundraising part is the tip of the iceberg. The following, gleaned from working with a number of hospices that have evaluated the need for (and sometimes decided to go forward with) building a hospice facility, is intended to provide some general considerations to assist hospices from both a legal/regulatory and business perspective. While many of these tips may seem more "financial" than "legal," there is a clear inter-play between them. A hospice that budgets for too few RNs, for example, may find itself in a heap of regulatory trouble.

1. Be certain that the hospice clinical infrastructure is solid.

A hospice that has a weak Medical Director or clinical team, with admission guidelines that are too stringent, not stringent enough or are not understood; or a hospice that is vulnerable to survey deficiencies or recoupment actions will only exacerbate the problems.

2. Develop stellar fundraising capabilities.

While a Hospice House can be a financial magnet attracting new contributions to the hospice, once the building is built, the ongoing operations can squeeze the hospice budget. Hospices without an exceptionally strong donor base should establish that donor base first.

3. Develop operating efficiencies in your home-based program before embarking on facility-based care.

If your DME, pharmacy or staffing costs are too high, fix the problem before it becomes worse. This should happen years before opening the doors of a Hospice House!

4. Be conservative in your operational budget projections.

Hospices without pre-existing expertise in facility-based care may have unsophisticated budgets. Room and board rates may be set too low, staffing may

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assume that CNAs can do it all. Research, site visits and interviews with others in the field in order to learn from their triumphs and mistakes, and outside consultants can all help.

5. Be aware that conventional wisdom indicates that some in-patient care is needed in order to break even.

Hospices need to develop very sophisticated budget projections with a variety of assumptions: If the facility has 10 beds and they are all RHC, how will that affect the budget? What if 5 are inpatient? How will things change at 8 beds or 12 or 15? If the hospice does not have the expertise to carefully study the budgetary implications, outside help is essential. Is your community willing to subsidize your hospice operationally--not just build a beautiful building?

6. Understand the implications of providing free care.

If patients residing in the Hospice House are not billed the true cost of their room and board, the anti-kickback provisions of the federal false claims act may be implicated. Billing in the Hospice House should be carefully reviewed to avoid any inference of an impermissible inducement. Carefully constructed sliding scales, based on ability to pay, should be instituted.

7. Be vigilant in understanding the reimbursement regulations and applying historical data to operating assumptions.

If the hospice has only 2% of total patient days in inpatient in its current program, and its budget assumptions, in order to break even, call for 15% inpatient care in the hospice facility, how and why will that change occur?

8. Conduct a needs assessment/feasibility study.

It is important that the process of whether to build, what to build, where and how, be thoroughly reviewed, and that "buy-in" occur early. This needs assessment can be very important in evaluating whether other options (a wing in a hospital or nursing facility) already exist. Strongly held beliefs that there is only one way to proceed can be devastating for the hospice--and the community.

9. Think about the impact of changing direction mid-stream.

More than one hospice has started a capital campaign before it completed its feasibility study. When plans are stopped midstream, the PR and tax implications can be enormous.

10. Manage expectations.

Many hospices have focused partially or even exclusively on general inpatient care, only to find out that their community thinks they have built a building for every hospice patient who needs end of life care. If the facility will be available only for short stays or for inpatient care, it is important to be very forthcoming, both during the capital campaign and after.

Conclusion

As a final note, consider meeting community needs with existing space. Many hospices, after conducting a thorough needs assessment/feasibility study, have determined that the community already has excess beds, and that the needs can be met through creative collaboration with hospitals and nursing facilities within the community. Bricks and mortar may be the right answer--but not always!