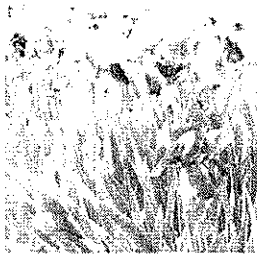
Hospice

Medicare's Perspective



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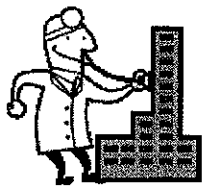
Hospice-Medicare Perspective

- Medicare is the steward of the Nation's largest health care programs and their funds

- Committed to quality services and responsiveness to our beneficiaries-especially important during end of life



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Hospice-Medicare Perspective

- CMS Core Values demonstrate our commitment:
  - Public service
  - Integrity
  - Accountability
  - Excellence
  - Respect

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Hospice-Medicare Perspective

- New Conditions of Participation
- Compliance with minimum standards of care
- To receive Medicare payments for hospice care the hospice must meet the conditions of participation and have a valid Medicare provider agreement.
- Certification verses payment

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Hospice-Medicare Perspective

Hospice care is an approach to caring for terminally ill individuals that stresses palliative care (relief of pain and uncomfortable symptoms), as opposed to curative care.

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other issues.

Hospice-Medicare Perspective

The emphasis of the hospice program is on keeping the hospice patient at home with family and friends as long as possible.

A hospice uses an interdisciplinary approach to deliver medical, social, physical, emotional, and spiritual services through the use of a broad spectrum of caregivers-

Bereavement services for family

Hospice – COPs

- Focuses on the care delivered to patients and their families by hospices and the outcome of that care
- Reflect the unique interdisciplinary view of patient care and allow hospices flexibility in meeting quality standards.
- Effective on December 2, 2008.

Hospice – COPs

- Patient's Rights
- Initial and Comprehensive Assessment of the Patient
- Quality Assessment and Performance Improvement
- Infection Control
- Hospices that Provide Hospice Care to Residents of a SNF/NF or ICF/MR

Hospice – Settings

Own Home

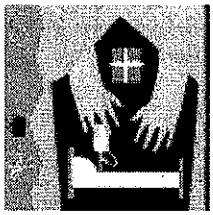
LTC facility

ICF/MR

Assisted living facilities

Group homes or boarding homes

In-patient hospice facility



Hospice – Levels of Care

Routine Home Care – time under Hospice care from time of election and not receiving one of the other categories of hospice care.

Continuous Care - least 8 hours in a 24-hour period (midnight to midnight) to achieve palliation or management of acute medical symptoms -
- Only during a period of crisis and
- Only as necessary to maintain the terminally ill individual at home.

Respite Care - in an approved inpatient facility, maximum of five continuous days at a time, family/caregiver relief

Short-term Inpatient Care - in an approved inpatient facility, pain control, symptom management

These are payment issues-not certification

Hospice – Other Payment Issues-MACs cover these issues

Payment rates for levels of care
Aggregate cap amount
ICD9 Coding
Change Request (CR) #5567
Claims processing issues
Eligibility criteria of the beneficiary
Medical Review of Hospice Claims
Care Plan Oversight – physician services
Deductible and Coinsurance
Caps and Limitations on Hospice Payments
Limitation on Payments for Inpatient Care
Cap on Overall Hospice Reimbursement

Hospice - Staffing Waivers

Extraordinary circumstances

Maintain professional management responsibility for all services

Care of contracted staff consistent with the hospice philosophy and the patient's plan of care

Hospices may not routinely contract for a specific level of care (i.e. continuous care) or during specific hours of care (i.e. evenings and weekends).

Hospice - Staffing Waivers

Non-urbanized area of the parent office (not the ML) as determined by the Bureau of Census.

This waiver does not waive the hospice's responsibility to provide PT, OT, SLP, and dietary counseling; only to provide them (as needed) on a 24-hour basis.

There is no waiver for the provision of Social Services (core service) or the qualifications of the MSS.

There are no limit restrictions to the number of extensions a hospice may request to the original waiver request.

Hospice – Initial/Re-Cert Surveys

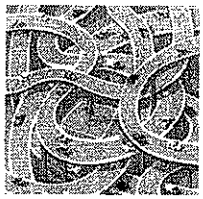
- Initial survey
  - Must meet licensure laws before certification survey
  - Not before 855 review
  - Tier 4
  - Must be fully operational-core/required services and contracts in place
  - Waive start-up numbers
    - Area is a medically underserved area,
    - Reduction of the minimum number of patients from 5 to 2 with at least 1 of the 2 required patients to be receiving care from the hospice at the time of the initial Medicare survey
- Recert survey
  - Low numbers or no active patients might not be operational
  - Survey at a multiple location of the hospice especially if serve a lot of patients
  - Whenever possible, visit all locations of the hospice during the survey.
  - Deficiencies found at any multiple location(s) are applicable to the entire hospice.

Hospice – Multiple Location Request

- Multiple locations-alternate sites-branches-worksites regardless of what called must be assessed to determine if meet definition of ML
- Must have RO approval
- Process for approval-first step notify the CDPHE
- Lack of a written reciprocal agreement precludes the provision of hospice/home care services across state lines.

Why CMS Approval is Important

- Always been a requirement for CMS approval of a ML per State Operations Manual now in the COPs
- Parent Office is accountable for all services-at ML too
  - Patients listed on unduplicated census
  - All hospice care and services at all sites
  - Responsive to the needs of the patient/family at all times and in all settings
  - A deficiency found at any location will result in a compliance issue and possible enforcement actions for the entire hospice.
- CMS/SSA needs be aware of the locations services are provided for survey purposes
  - All locations must meet COPs
  - If across state lines-involves two SSAs and maybe two ROs
  - If great distances-may make provisions of services and supervision more problematic
  - Clinical records chosen for review from the non-approved ML's
  - Licensure activities.

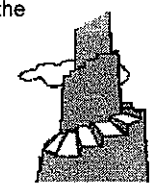


CMS Approval of a ML

- Medicare Administrative Contractor (MAC) role is a fiscal review of the organization and its owners
- MAC does NOT "approve" the site
- CMS approval of the requested change is required
- Contact SSA (CDPHE) for information needed

Hospice – Multiple Location Request

- How monitor services at the ML
- The Hospice agency/provider may not bill Medicare/Medicaid for services provided from a multiple location office or site until CMS has approved this location.
- Failure to obtain CMS approval of a ML site BEFORE providing services may subject the Hospice to citations of non-compliance. See §418.100(f) and §418.116(a)
- Distance issues: Hospice care requires the closest of interventions and a distant "parent" may not be able to provide the immediate access needed to ensure health and safety of their patients.



Hospice – Multiple Location Request

- How will core services (Physician, Nursing, Medical Social Services and Counseling) be provided at **EACH** Multiple Location
- Services on 24-hour basis if needed
- Short-term inpatient services, volunteers, therapies , DME, medications and supplies
- Hospice Medical Director assume overall responsibility for the medical component of the hospice's services
- Unique IDG – how will function, involvement with parent IDG

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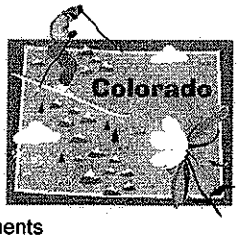
Hospice – Multiple Location Request



- Same policies/procedures
- Licensure requirements for all individuals and all sites
- Services on 24-hour basis if needed
- Across state lines - appropriate state reciprocal agreements
- Distant "parent" immediate access if needed

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Hospice – Multiple Location Request

- Approval of a HHA branch is not synonymous with approval of ML and vice versa. The ability to provide HHA services at multiple sites does not necessarily indicate a hospice has the ability to assure that all hospice care and services continue to be responsive to the needs of the patient/family at all times and in all settings.
- State Licensure of a ML is not synonymous with CMS/RO approval of the ML.

Hospice – Expended Role of NP

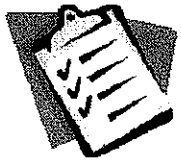
- Has a significant role in the determination and delivery of the individual's medical care
- Scope of practice is deferred to state laws
- May be patient's "attending" medical provider.
- See, treat and write orders for care, including the Plan of Care orders if state law permits
- Supervision by a physician, including review and/or countersigning orders-state law
- Can not initially certified or recertify the patient's hospice terminal status
- Can not fulfill the role of the Hospice Medical Director

Hospice- for Residents of a SNF/NF or ICF/MR.

- Patient (resident) must meet Medicare hospice eligibility criteria
- The resident does have the right to choose their own hospice **BUT**
- No requirement for the SNF/NF or ICF/MR to contract with a hospice for hospice care for its residents
- The LTC can also choose to contract with only one or two hospices.

Hospice- for Residents of a SNF/NF or ICF/MR.

- If decision is made (to contract or not), residents need to be informed (current as well as new admits).
- If a resident (current or new admit) does not want the hospice that the LTC contracts with, that is their choice.
- If the resident desires hospice services with a particular hospice and the facility does not want to contract with that hospice, the resident's choice is to move to a LTC facility that contracts with the Hospice they desire.



Hospice- for Residents of a SNF/NF or ICF/MR.

- The hospice must maintain professional management of the Hospice services-Hospice POC
- For the terminal illness
- Hospice core services must be routinely provided by the hospice and cannot be delegated to the facility. (Physician services, nursing, SS, Counseling)
- All supplies, medications, and DME needed for the palliation and management of the terminal illness and related condition
- Determination of the appropriate level of care to be given to the patient (routine homecare, inpatient, or continuous care).
- Arranging any necessary transfers from the facility,

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Hospice- Residents of a SNF/NF or ICF/MR.

- Supplement (not replace) the nurse aide services provided by the facility.
- Facility still responsible for the basic care of the resident under the LTC regulations – should not experience any lack of SNF/NF services or personal care
- MDS, physician visits, etc. requirements still apply
- Coordinated plan of care (reflective of hospice philosophy) for both providers
- Who provides what services
- Is the coordinated plan implemented
- What care/services provided to one resident must also be provided to a resident who has elected hospice benefit.

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Hospice- Written Agreement with the a SNF/NF or ICF/MR.

Key issues of agreement:

- Communications - 24/7 basis
- Hospice availability and responsiveness to the patient's needs
- A provision that the SNF/NF or ICF/MR immediately notifies the hospice if—

(i) A significant change in a patient's physical, mental, social, or emotional status occurs;

(ii) Clinical complications appear that suggest a need to alter the plan of care;

(iii) A need to transfer a patient from the SNF/NF or ICF/MR arises, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related conditions; or

(iv) A patient dies.

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Hospice for the Long-term Care What CMS will look for:

- LTC must be implementing Hospice plan for pain/symptom control
- Hospice may be non-compliant in this area too if not addressing/monitoring pain/symptoms
- Resident receiving hospice services may be part of survey sampling.

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Hospice for the Long-term Care What CMS will look for:

- *Hospice informed of concern by LTC but not respond or attempt to resolve*
- *LTC surveyor role is NOT to survey for Hospice regulations*
- *Refer the concerns as a complaint to the State Agency responsible for oversight of this hospice, identifying the specific resident(s) involved and the concerns identified.*

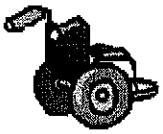
Hospice Training

- CMS has do extensive training on the new COPs-new surveyors as well as seasoned surveyors.
- CMS website with certification and fiscal information
- http://www.cms.hhs.gov/center/hospice.asp
- Provider outreach

Other Hospice Issues

- Criminal Background Checks- More research is being conducted regarding concerns expressed by the hospice industry on the requirements under §418.114(d) for criminal background checks. Future clarification will be forthcoming.

- Accreditation of DME: Regardless of the DME having its own Medicare supplier number, the hospice should have a letter in their file from the DME stating the DME has applied and is waiting for accreditation by the 9/09 date.
  - If the hospice owns its own DME, then no accreditation is needed.



Summary

- CMS-CDPHE-Hospice Providers (and lawmakers!) are on same team
- Mutual goal and commitment to quality care and services for the patient and family during end-of-life.
- Challenges for Colorado Hospice Providers
  - Urban verses Rural
  - Cost of End-of-Life Care
  - Payment for services provided
  - Care to LTC residents
  - Pediatric Hospice care
  - Access for all
  - Non-Medicare patients
  - Public Awareness of the Hospice benefit

Summary

- All have responsibility for:
  - Providing vision and leadership to shape Hospice care in Colorado
  - Acting as stewards to our resources
  - Being accountable to each other and to those we serve and care for
  - Ensuring continuous quality improvement
  - Communication of our needs, our goals and our barriers to others
  - Understanding and valuing the needs, abilities and contributions of everyone

All have responsibility for
A Commitment to Excellence

Questions?

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