MEMORANDUM

Date:	June 29, 2008
To:	AAHPM Public Policy Committee
From:	Howard Tuch, MD
Re:	Medicare Hospice Conditions of Participation

The final rule for the Medicare Hospice Conditions of Participation (CoPs) was published in the Federal Register (42 CFR Part 41) on June 5, 2008 and is scheduled to go into effect on December 2, 2008. The CoPs detail the requirements that Hospice providers must meet to in order to become certified by Medicare and receive reimbursement from the Medicare or Medicaid programs. The CoPs will be enforced by the individual state survey agencies and interpretative guidelines for the rule are scheduled to be published by the end of 2008. Draft copies of the guidelines are already in circulation.

The new CoPs are widely seen by hospice providers as a significant improvement over the existing rules which have been in place, largely unchanged, since 1983. They incorporate the statutory changes made to the Medicare Hospice Benefit in the 1997 Balanced Budget Act and the 2003 Medicare Modernization Act. Extensive input from providers received after the initial 2005 notification of the proposed rule change was incorporated into the final CoPs. CMS was very responsive to comments and objections submitted by providers.

CMS attempted to craft the CoPs, in their words, to "focus on a patient centered, outcome oriented, transparent process that promotes quality patient care for every patient every time". Detailed assessment, care planning, care coordination, quality assessment and performance improvement are central features. The new CoPs allow for greater flexibility in the processes used to meet the requirements. Specific areas that received the most attention included patient rights, relationships with nursing homes and performance improvement. As members of the IDT, medical directors and physicians are expected to be a part of the comprehensive assessment, care planning, quality improvement and overall coordination of care. The medical director or his/her designee must also collaborate with the patient's attending physician and be available to meet the needs of patients at all times. The new CoPs do <u>not</u> address any payment related issues. Also, they do <u>not</u> alter eligibility criteria, election periods or timing of certification for hospice care. These remain the same as in existing regulation. Other aspects of the rule change and their implications for hospice physicians are addressed below.

<u>How Do CoPs affect Medical Directors and Physicians Working in Hospice?</u>

The new CoPs expand on the specifics of physician involvement and accountability. They deal primarily with contractual relationships, oversight of other physicians and certification of terminal illness. Comments in the preamble to the rule provide insight into how CMS thinks about the responsibilities of the medical director and other physicians involved in improving the care of hospice patients.

Medicare Hospice Conditions of Participation and Hospice Physicians

Regulation	Comment
Definitions (418.3) Physician designee: doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director in his/her absence	Hospices are required to employ or contract with an identified physician to fill this role. Nurse Practitioners may serve as the patient's attending but may not certify the presence of a terminal illness
Medical Director (418.102) • Physician can be a hospice employee or be under contract to the hospice Responsibilities of the Medical Director • Supervise all hospice physicians • Medical director should have "knowledge and skills" necessary to meet the needs of the hospice's patients • Initial certification of the terminal illness (within 2 days, oral ok, written needed by 8 days of election, both hospice physician and attending (if any) must certify • Re-certification: must review available clinical information prior to making a determination of continued eligibility (must complete before renewal period) • Responsible for the medical component of the hospice's patient care program • Be in compliance with state laws	Hospice may contract with a physician group or professional entity but must identify the individual physician who will serve as the medical director Hospice medical director may also serve as the attending physician or as the medical director of the nursing home served by that hospice Provide written certification that the patient has 6 months or less to live if the illness runs its usual course. Must consider the following in making this determination: primary diagnosis, related diagnoses, subjective and objective medical findings, current medications and treatments and information about the medical management for unrelated conditions. Note: re-certification is the responsibility of the medical director or physician designee alone, not that of the interdisciplinary team. Re-certification is based on review of "clinical information"
Standard Physician services (418.64) • Attending physician need not designate any other doctor to cover for his/her hospice patients. • Under supervision of the medical director	Hospice physician is responsible for the palliation and management of the terminal illness and related conditions; Must manage the patient's terminal condition in coordination with attending If the attending is not available, the hospice physician is responsible for meeting all the medical needs of the patient

Other Physician Responsibilities

§418.106

- Physician services must be routinely available 24 hours a day, 7 days per week

§418.64; 418.114, 418.116

- The requirements for initial training, skill assessments, background checks and current licensure requirements that are delineated for all hospice employees also apply to physicians. State requirements need to be met even if they are more stringent than federal requirements.

§418.52 Patient Rights

- Pain management and symptom control
- Right to refuse care
- Right to choose one's attending physician
- Right to be free of restraints or seclusion: the CoPs include extensive procedures detailing the use of restraints. Physician orders for restraints are required (or the physician must be consulted as soon as possible after restraints are applied). Restraints may not be ordered on a prn basis. The renewal of restraint orders is limited to 4 hour intervals (for adults) and may not exceed 24 hours. If additional time is required, the physician must see and assess the patient prior to the renewal of the restraint orders.

§418.54 Initial and Comprehensive Assessment:

- Initial assessment: the registered nurse will have 48 hours after the patient elects hospice care to complete the initial assessment. Physician involvement in the initial assessment is not required unless necessary to meet the patient's needs
- Comprehensive assessment: 5 days to complete; as member of the interdisciplinary team (IDT), the physician is expected to participate. This does not mean that the hospice physician is required to physically see the patient.
- Elements of the assessment should include: the nature of the condition causing admission, severity of symptoms, imminence of death , functional status and drug profile (including effectiveness, side effects, potential interactions and duplications)

§418.56 Plan of Care (POC) must reflect or detail:

- Patient and family goals and documentation of the patient's (and or his/her representative) level of understanding, involvement and agreement with POC
- Interventions for pain and symptom management
- Scope and frequency of services necessary to meet patient and family needs
- Measurable outcomes of care from implementing and coordinating the POC
- Medications, therapy and supplies necessary to meet patient needs
- Consultation with attending physician (if any) and sharing of information with non-hospice providers caring for the patient's non-terminal or related conditions.
- Updated as often as necessary but no later than every 15 days

§418.58 Quality Assessment/Performance Improvement (QAPI):

- Hospice must develop a data-driven quality assessment and performance improvement program focused on improving palliative care outcomes
- Physicians are expected to be involved in the QAPI process but are not required to direct the QAPI program

§418.106 Drugs and Biologicals, Medical Supplies and Durable Medical Equipment

- An employee or contracted individual with education and training in drug management must ensure that drugs and biologicals meet each patient's needs. The education and training of the individual who serves in this capacity is not defined.
- Pharmacist services are necessary, however, if a hospice provides inpatient care directly. This service must include an evaluation of the patient's response to medication, identification of potential adverse drug reactions and recommendations for appropriate corrective action.
- Nurse practitioners can order medications in accordance with applicable state law

§418.108 Inpatient Care

- 24 hour RN coverage is not required to be on site providing for an admission to respite care
- 24 hour RN coverage is required to be on site for the provision of general inpatient care.