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Eli's Hospice Insider

Regulations: Medicare Includes Hospice In Its Regulatory Relief Proposals

Proposal aims to eliminate requirements related to aides, medication management, and facility staff training.

While any lightening of hospices' regulatory load is good news, Medicare's latest plan to cut red tape for hospices doesn't seem like it's going to make a whole lot of difference to many providers.

In late September, the **Centers for Medicare & Medicaid Services** issued a lengthy proposed rule containing a multitude of ideas for reducing Medicare providers' regulatory burdens. The proposed changes, trumpeted by CMS Administrator **Seema Verma**, would reduce providers' financial burden by $1.1 billion annually, CMS claimed in a release about the rule.

But like the changes proposed for many other provider types, the hospice revisions are on the minimal side, industry experts say. The three major areas for hospice change are in aide qualifications, medication management (see related story, this page), and training for facility partner staff.

None of these changes make much of an impact on hospices' burdens, maintains attorney **Robert Markette Jr.** with **Hall Render** in Indianapolis. While they are "nice," they just aren't the big changes hospices could really use to ease their burdens, he argues.

Most of the provisions offer "modest or little relief to regulatory burden for hospice providers," agrees **Judi Lund Person** with the **National Hospice & Palliative Care Organization**. "Their impact will be minimal," if finalized, Lund Person tells **Eli**.

When the **Trump** administration came in and began placing an emphasis on regulatory burden reduction with its "Patients Over Paperwork" and other initiatives, Markette was hoping to see some "radical rethinking" of regulations, Markette says. Instead, this rule contains some minor tweaks to requirements that may be annoying, but not much of a problem.

Instead of these small adjustments, hospices would benefit from big moves to decrease unnecessary requirements such as the face-to-face encounter and documentation, or certain signature requirements for certifications of terminal illness, Markette says. Another option might be relaxing the core services requirement for hospices, he adds.

The problem: Expecting a large bureaucracy to make changes to itself is likely to be self-defeating, Markette suggests. "Asking the agency in charge to dial back its own regulatory oversight - you're never going to get at it this way."

Aide Requirements Duplicative, CMS Admits

One of the three major areas for change, proposed in the rule published in the Sept. 20 Federal Register, addresses hospice aide qualifications. Currently under requirements at § 418.76, hospice aides must meet requirements that are about the same as those for home health aides. "We initially ... finalized these requirements in order to be consistent with the requirements that apply to home health aides," CMS explains in the rule. "Historically, a significant number of hospice agencies were HHA-based, meaning that the same entity provides both hospice and home health care services, often utilizing the same pool of staff to furnish both services. Using similar requirements for both hospices and home health agencies streamlines operations for hospices that are home health agency based."

However, the boom in the number of hospice providers has produced a much larger proportion of hospices that are not

HHA-based, CMS says. "As the streamlining benefits for the hospice industry as a whole have reduced, the burden/benefit ratio related to meeting the prescriptive home health aide qualification requirements ... has shifted," according to the rule.

An informal industry survey indicates that 76 percent of states currently have their own hospice aide qualifications for licensure, certification, or registration, the rule says. "Therefore, we assume that in 76 percent of states, hospice aides are required to meet two different qualification standards" - one state, one federal.

Result: "This regulatory approach has created unintentional burden during the hiring process for all of the non HHA-based hospices, as well as those HHA-based hospices that do not share staff with the home health agency portion of their organization," CMS concludes.

Instead: Medicare wants to fix the problem by revising § 418.76(a)(1)(iv) "to remove the requirement that a State licensure program must meet the specific training and competency requirements set forth in § 418.76(b) and (c) in order to be deemed an appropriate qualification for employment," CMS says. Under this change, the old requirements would exist only in states where no requirements exist and states could "set forth training and competency requirements that meet the needs of their populations."

"We do not believe that it is necessary for the Federal government to oversee the qualifications established by states because these states have already demonstrated their willingness and ability to regulate this area along with federally established requirements," CMS maintains. "This change would also streamline the hiring process for most hospices."

Cost benefit: This change would save hospices $2 million annually, CMS estimates in the rule.

For states that don't have aide requirements on the books, such as Indiana, nothing will change, Markette points out.

Change Aims To Minimize Training Overlap

CMS also proposes changing SNF/ICF employee orientation requirements. Section 418.112(f) of the current CoPs requires hospices "to assure orientation" of Skilled Nursing Facility/Nursing Facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities staff furnishing care to hospice patients. "The intent of this standard is to ensure that facility staff who furnish care to residents who are hospice patients are provided information on the hospice philosophy and approach to care," CMS notes. "It is the hospice's responsibility to coordinate the trainings with representatives of the facility. It is also the hospice's responsibility to determine how frequently training needs to be offered."

This requirement "may create duplication when multiple hospices provide care to the residents of a single facility," CMS points out. "Furthermore, by assigning sole responsibility for this effort to hospice providers, this requirement may impede joint hospice-facility collaboration and training innovations."

CMS proposes to remove § 418.112(f) and add a new requirement at § 418.112(c)(10), "Written agreement," to address this issue, it says. Moving the requirement "to the standard related to the written agreement established between hospices and facilities would ensure that both entities negotiate the mechanism and schedule for assuring orientation of facility staff. Additionally, enabling hospices and facilities to negotiate their now shared role would encourage collaboration between both entities, avoid duplication of efforts with other hospices that are orienting the same facility staff, and provide incentives to facilities to become more engaged in the hospice orientation process for facility staff," the rule argues.

Cost benefit: CMS expects this change to result in less than $1 million in burden reduction annually.

"We are very appreciative of CMS's efforts and ... the proposal to provide flexibility such that hospices and contracted facilities are permitted to determine the best way to ensure proper orientation for facility staff," notes **Theresa Forster** with the **National Association for Home Care & Hospice**.

CMS is taking comments on the proposals until Nov. 19. "CMS will most strongly consider comments that include data or evidence to support your position, offer suggestions to amend specific sections of the existing regulations, or offer particular additions," NAHC reminds in its member newsletter.

Note: The rule, including instructions for commenting, is at www.gpo.gov/fdsys/pkg/FR-2018-09-20/pdf/2018-19599.pdf.