



hospice compliance letter

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INSIDE THIS ISSUE

Public Reporting of Quality Data Looms—Are Providers Prepared?1

Fraud and Abuse Cases Involve Hospices4

Compliance News & Notes.....5

Hospice and Palliative Care News and Notes7

Key lessons from the looming public reporting of hospice quality data:

- ▶ It's important to be working on improving quality now because of the lag time between provision of service and reporting based on that service;
- ▶ "Teaching" caregivers about symptom management and their caregiving role is a significant focus of the government's quality measures;
- ▶ Identify low-scoring measures and target them with performance improvement projects. Then move on to the next measure; and
- ▶ If the hospice performs well on public quality measures, it should let its community know.

Public Reporting of Quality Data Looms—Are Providers Prepared?

Additional Hospice Item Set measures start April 1

As the federal Centers for Medicare and Medicaid Services (CMS) continues its inexorable march toward the long-awaited Holy Grail of publicly reported, comparable quality data on hospices to be posted on its planned "Hospice Compare" website, some new intermediate requirements for data reporting go into effect April 1. CMS' Hospice Quality Reporting Program (HQRP) is comprised of two principal elements, the Hospice Item Set (HIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey.

HQRP was created in 2010 to promote delivery of high-quality hospice services through required reporting of outcomes from hospice care. Hospices started reporting these data in 2014, and penalties are now up to 2 percent of their annual Medicare reimbursement update for failure to comply with reporting requirements.

The new HIS reporting requirements include seven elements for hospices to capture and report, three for every patient admitted starting April 1 and four for every patient discharged on or after April 1, including level of care and visits by discipline in final seven days of life. These HIS elements will be used to generate two new measures of quality: hospice visits when death is imminent, and hospice and palliative care composite process measure. The Hospice CAHPS 47-question, post-death survey on experience of care is sent to the identified primary caregiver two months after the patient's death by an authorized survey vendor with whom the hospice contracts.

You needed to start managing performance a while ago to have any effect on the data that are going to be seen on Hospice Compare when it launches.

— Liz Silva

The eventual public posting of quality data at Hospice Compare, now projected to start in late summer 2017, will offer a decision guide for consumers, data to aid hospices in internal quality improvement efforts and benchmarking with other providers, and information for CMS to use in monitoring care provision, with future annual payment updates tied to how a hospice performs on the reported outcomes measures.

"There is now another process of data gathering and review required of the hospice at the time of discharge," says Liz Silva, director of home health & hospice at [HEALTHCAREfirst-Deyta Analytics](#). "It can be challenging to accurately extract daily visits by discipline at the time of discharge. Hospices need to be aware of the regulatory deadlines and make sure data pulled by their electronic health record (EHR) vendor are correct. It sounds simple, but it's not necessarily a straightforward process for every hospice—or every EHR," she

(cont'd on p2)



says. At press time, some EHR companies had still not released their updates for April 1. Hospices must include these new HIS items in the XML files they submit to CMS or the records will be rejected, possibly exposing the provider to penalties.

Silva has seen a lot of activity by her company's hospice clients around quality data gathering, with the big push toward publicly reported data by the end of the summer. "We've been focusing our education efforts on the new requirements as well as how hospices can utilize their data to help drive performance improvement. The hospices we talk with are focused on their performance, improving quality of care, and how they will be perceived in their community once the data are publicly reported," she says.

A Spectrum of Responses

"There's definitely a spectrum of preparedness, but the folks who embraced it early on are on top of it. They are conditioned to the fact that changes come quickly and often. You needed to start managing performance a while ago to have any effect on the data that are going to be seen on Hospice Compare when it launches," Silva says. Fiscal Year 2018 reported data are based on the hospice's experience with patients in 2016. "But it's important to always be working on improving care. It's never too late to get started with performance improvement."

Specific details for implementing Hospice Compare have not yet been released. Providers have been looking at other Compare pages, such as for [long-term acute care hospitals](#), not so much for their specific measures as to see how the site is

constructed and the type of information people will be able to access once Hospice Compare is up and running, Silva says. Hospice Compare initially will not include the Star Ratings that are on other Compare websites. The specific methodology for hospice star ratings will have to go through the government's rule-making process. "But we know it's coming. Our goal at HEALTHCAREfirst is to make sure all of our clients are ready for the regulatory changes and help them use their quality data to improve the care they are providing," she says.

It's never too late to get started with performance improvement.

— Liz Silva

"It's better to focus your attention on individual measures rather than the composites to identify opportunities for improvement. The primary focus should still be on doing what's right for the patient and family—that's what should be driving your care processes. Ultimately, if you do that, it will show up in your reported data."

The California Hospice & Palliative Care Association recently offered a webinar on quality measurement, identifying the top ten most problematic questions from the CAHPS survey in terms of performance scores, starting with: How often did your family member get the help he or she needed from the hospice team for feelings of anxiety or sadness. (See also page 7 for more information on hospice caregiver anxiety.) Hospices are advised to start with their program's lowest score in a composite and develop a performance improvement project around it, says

(cont'd on p3)

HOSPICE COMPLIANCE LETTER

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This newsletter strives to provide timely and accurate information related to hospice care, corporate compliance issues and other selected matters. Items in the newsletter are brought to our readers from a variety of sources, all of which are thought to be accurate and reliable. Nevertheless, it is specifically understood that the publication is not intended to provide legal or other professional services, counsel or advice. Readers requiring such services are encouraged to contact appropriate professionals.

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Holly Swiger, CHAPCA's Director of Education. "If this improves, it will have the greatest impact of influencing your overall composite score. Once improvement is made, move on to the next lowest score."

Hospices should be working on encouraging or reminding families to complete the surveys when they are contacted, Swiger says. Increasing the number of surveys sent out could help offset a bad response. CHAPCA also recommends focusing on how to teach caregiving skills and the side effects of medications to caregivers, reinforcing those messages at every visit.

Learning the New Language of Quality

Peggy Richard, Education Manager and Compliance Officer for Serenity Hospice and Home in Oregon, Ill., says her hospice has wrestled with quality data reporting since 2014, trying to be as proactive as possible. "My job is to be interpreter for staff: This is how it matters to your daily work," she says. "I've been here 18 years. I have to say all this measuring has changed hospice care. It's like learning a new language. I've read all the manuals, attended the webinars, and still it's overwhelming, especially for a small hospice like ours."

Serenity Hospice has a census of around 60 and an inpatient facility, and Richard struggles to balance her time with other hospice regulatory and compliance demands. "It's now part of our orientation for new nurses—how this whole process works. Staff understands that it's coming and that all health care is going this way. But we have frustrations, for example with the CAHPS survey, which is answered (posthumously) by the family, not by the patient."

I have to say all this measuring has changed hospice care. It's like learning a new language. I've read all the manuals, attended the webinars, and still it's overwhelming.

— Peggy Richard

The focus in the hospice survey on "training" families for their caregiving responsibilities has also been challenging. Five questions are included under the heading "Getting Hospice Care Training," which in the past might have been more simply called educating families about the realities of hospice caregiving. But now the survey is asking: Did the hospice give you the training you needed? "I interviewed a family that had received service a year earlier, and to them, training implied something more organized than a nurse giving them information," Richard says. A quality committee at Serenity has been working on how to clarify this process for hospice families.

"We do a dashboard, using the composite measures. We are benchmarking with the Deyta Analytics' national scores. And we work with [Multi-View Inc.](#), using their model visit format and a primary nursing focus. We also do 'tuck-in calls' every Friday evening using a retired nurse who asks families if there is anything else they need to ask their primary nurse," she says. "I'm glad we got involved early and continued to be involved every month, really drilling down with quality," Richard says. "We were able to raise our score on the questions about training families on the side effects of pain management. It became part of a structured visit, not just addressed casually in conversation."

Serenity Hospice recently hired a marketing person, who helped to get the word out to the community when the agency became Joint Commission-accredited as part of its commitment to quality. It also plans to emphasize its performance on quality improvement. "Yes, we want to get our numbers up, and get them out to the community. But it's also just the right thing to do. Good things will come of it. Our measuring is a much more formalized way of doing what we used to do on an informal basis," she says.

"Quality of care was always our focus, but now we want to prove it with data and have Hospice Compare show that we are an excellent hospice." But will consumers actually use Hospice Compare?

"I think maybe it's a generational thing—with 40, 50 or 60 year olds going online to look for scores on who cares for their Mom and Dad."

For more information on hospice measures, contact Liz Silva at HEALTHCAREfirst:
Liz.Silva@healthcarefirst.com. ◆◆

Fraud and Abuse Cases Involve Hospices

Bradley Harris of Frisco, Texas, co-owner and operator of Novus Health Services and Optim Health Services, and 15 colleagues were charged February 28 with conspiracy to commit health care fraud and other charges alleging submission of false Medicare claims for hospice care. Novus, once one of the largest hospice providers in North Texas, is accused of recruiting ineligible beneficiaries by providing kickbacks while falsifying and destroying charting documents. The defendants face statutory penalties of up to 10 years in prison and fines of \$250,000 for each count of fraud. Novus started operations in 2009 and now appears to be shut down.

The government contends in a released statement that Novus billed Medicare and Medicaid for \$60 million in fraudulent hospice services between July 2012 and September 2016, \$35 million of which was paid. That means it only collected 58 percent of its hospice billing, which might have been a warn-

ing that something was amiss. Five of the Novus defendants are physicians, charged with providing little or no oversight on admissions and level-of-care decisions, with the hospice's clinical decisions driven instead by financial interests.

The hospice is charged with providing morphine to patients for no medical purpose in order to justify coverage of continuous care. In some cases the patients died soon after. A year ago, when the hospice's office was raided by the FBI, it was reported that Harris allegedly sent staff text messages such as, "You need to make this patient go bye-bye," reported [NBCDFW TV in Dallas](#). Those texts have made for some lurid headlines about hospice in Texas.

Another False Claims Act suit against Creekside Hospice II, LLC, Las Vegas, Nev., is said to be nearing a settlement agreement, according to recently filed court documents reported in a blog post by the law firm [Frohsin Barger & Walthall](#). Two qui tam lawsuits filed by former employees, under court seal since 2012, were combined by the government, which opted to intervene on their behalf. These suits allege that Creekside committed Medicare fraud by billing for hospice services for patients who were clinically ineligible for hospice care, knowingly submitted false claims, and directed staff to enroll patients regardless of their eligibility for hospice care.

The government further alleges that Creekside management instructed employees to alter medical records to make it appear that hospice doctors had visited patients when they had not. The blog post says recent progress in the case has centered on settlement discussions, with the parties having reached an agreement in principle to settle the action. A joint unopposed motion last summer to stay action on the case for 90 days has been extended several times. ♦♦

Notices for HCN Members

HCN members are invited to register for the next webinar in the 2017 HCN Webinar Series entitled "**Strategies for Managing Additional Development Requests (ADRs),**" on April 12, 2017 at 2pmET presented by Carrie Cooley, Weatherbee's Chief Operating Officer. The cost of HCN Webinars is included for HCN members subscribing at the Best Level of membership and available for all other HCN members or non-members for \$129.



[See list of remaining webinars and register!](#)



Have you visited the **HCN Forum** recently? Join the discussions on Hospice Item Set (HIS), secure texting with patients, and a new tool from the OIG for measuring effectiveness of your corporate compliance program. Visit www.forum.hospicecompliance.com today!



Want to upgrade your HCN membership to the Best level to receive all HCN Webinars and the Quarterly Roundtable for free? Call our office at (508) 778-0008 for more information.

In next month's issue of the *HCL* ...

We are still pulling together our cover story on all of the current action in community-based palliative care development, which is definitely heating up, and how hospices can get in on the action within their compliance and financial constraints. We'll also take another look at activities emanating from the alphabet soup of Medicare-contracting anti-fraud agencies and look ahead to the NHPKO Management and Leadership Conference starting April 29.

HOSPICE COMPLIANCE UPDATES, NEWS AND NOTES

Recovery Audit contractors; SMRCs; M&As; MedPAC

New RA (Recovery Audit) contractors are still trying to get the “lay of the land,” starting with durable medical equipment but eventually followed by home health and hospice. They don’t have active hospice issues yet, says NHPCO’s Vice President, Regulatory and Compliance, Judi Lund Person. After the RAs propose an issue—defining what they aim to investigate—to CMS, it takes at least six months to get the government’s go-ahead. The RAs are now required to maintain an overturn rate of less than 10 percent at the first level of appeal and an accuracy rate of 95 percent, as well as employing a Contractor Medical Director and providing consistent and detailed review information, according to a [February 16 webinar by Region 5 RA Performant, reported by the National Association for Home Care and Hospice](#).

A newer member of the regulatory alphabet soup of contractors that investigate hospices and other Medicare providers in pursuit of improper payments is the [Supplemental Medicare Review Contractor \(SMRC\)](#), based in the CMS Center for Program Integrity. SMRCs are paid by the government on a flat-fee arrangement, unlike RAs, which are paid on a contingency fee basis for identifying alleged overpayments. SMRCs conduct medical reviews of claims based on analysis of national claims data, rather than within an individual MAC’s jurisdiction. If they detect evidence of improper payment, they forward the information to CMS, which directs the relevant MAC to initiate claims adjustments or recoupments.

They are planning to issue ADRs (additional documentation requests) of general inpatient (GIP) stays to 65 hospices in response to OIG’s sharply critical re-

I am still doing feasibility studies for hospice inpatient facilities, but it’s a matter of planning carefully and knowing what you’re getting into.

— Sue Lyn Schramm

report last year on GIP utilization (see *HCL*, April 2016, page 3), Lund Person says. “It’s not clear what they are looking for and whether these hospices were chosen based on GIP rates or other markers.”

HCL plans to attend a pre-conference seminar on stemming financial losses in general inpatient care in hospice units and facilities, scheduled for April 30 at the upcoming NHPCO Management and Leadership Conference in Washington, D.C. Presented by Sue Lyn Schramm, director of NHPCO-Edge, and two

hospice managers of successful inpatient units, it will focus on the changing regulatory environment for GIP care and resulting sharp drops in GIP utilization and occupancy rates, as well as management strategies for maintaining facility revenues and keeping a balance between home and GIP utilization.

“The economics are tougher than they used to be, with so much scrutiny of each and every day of GIP,” Schramm tells *HCL*. “I am still doing feasibility studies for hospice inpatient facilities, but it’s a matter of planning carefully and knowing what you’re getting into.”

We will report back on the findings after the conference, but HCN members with an interest in more detailed answers to these dilemmas may want to look into NHPCO’s GIP preconference seminar on April 30. What questions do you have about GIP, its viability, and how to make it work? Tell Editor Larry Beresford: lberesford@weatherbeeresources.com.



The Department of Justice recently issued a new guidance, “Evaluation of Corporate Compliance Programs,” with implications

“To put this in plain language, if you are acquiring another hospice that may draw future scrutiny around compliance, you need to practice due diligence and make sure you know what skeletons are in the closet ...”

— Carrie Cooley

for the due diligence process in merger and acquisition (M&A) activity by health care providers, including hospices. “In the past, buyers who acquired hospice organizations conducted a pretty limited review of the target hospice’s compliance program and hoped to solve all future payment-related scrutiny problems through the use of indemnification clauses and escrow holdings,” explains Carrie Cooley, Weatherbee’s Chief Operating Officer. “DOJ is now saying that a target hospice’s compliance program should be fully examined pre-transaction and, most importantly, the acquiring hospice needs to have a plan in place to mitigate the identified risks once the transition is complete.”

The M&A provision is part of a larger “playbook” on how DOJ evaluates providers’ compliance programs generally. “To put this in plain language, if you

(cont’d on p6)



2017 Calendar
Weatherbee Resources, Inc.
Hospice Compliance Network

- **April 12** Webinar “Strategies for Managing Additional Development Requests (ADRs)”
- **May 1-2** NHPCO MLC, Washington
- **May 3** Quarterly Roundtable
- **May 10** Webinar “Clinical Record Auditing: Compliance with CoPs versus Payment Requirements”
- **June 14** Webinar “Fraud & Abuse: Part I”
- **June 19-20** Boot Camp, Boston, MA
- **June 21** “Specialty Topics for Hospice Professionals” / Optional 3rd day training Boot Camp, Boston, MA
- **July 12** Webinar “How Will Your Hospice Prepare for Survey: A Discussion of the Top 10 Survey Deficiencies”
- **August 2** Quarterly Roundtable
- **August 9** Webinar “Developing a Plan of Correction to Address Survey Deficiencies”
- **September 6** Webinar “Fraud and Abuse: Part II”
- **September 25-26** Boot Camp, Dallas, TX
- **September 27** “Specialty Topics for Hospice Professionals” / Optional 3rd day training Boot Camp, Dallas, TX
- **October 11** Webinar “Managing Hospice Complaints and Complaint Surveys”
- **October 15-17** NAHC, CA
- **November 1** Quarterly Roundtable
- **November 8-9** Hospice Federation, MA
- **November 15** Webinar “Fraud and Abuse: Part III”
- **December 6** Webinar “Preparing for 2018: Compliance Challenges”
- **December 11-12** Boot Camp, Las Vegas, NV
- **December 13** “Specialty Topics for Hospice Professionals” / Optional 3rd day training Boot Camp, Las Vegas, NV

**HOSPICE COMPLIANCE UPDATES,
NEWS AND NOTES**

(cont'd from p5)

are acquiring another hospice that may draw future scrutiny around compliance, you need to practice due diligence and make sure you know what skeletons are in the closet, because you may be held responsible for them,” Cooley adds. How the acquiring hospice addresses pre- and post-closing is important.

This provision may not affect a large number of Hospice Compliance Network members, but M&A activities in the hospice field continue to grow, she says. Home health and hospice M&A activity rose 12 percent in 2016 over 2015, according to Irving Levin Associates’ [Health Care Services Acquisition Report](#), reported in [Home Health Care News](#).



The Medicare Payment Advisory Commission (MedPAC), in its March annual report to Congress, recommended for another year that hospices receive no inflationary payment “update” for fiscal year 2018, which starts on October 1, because of its continued belief that hospice profit margins are already more than sufficient. “There’s nothing earth shattering in their recommendations,” says NHPCO’s Judi Lund Person. “But we always take a look at what they do with the statistics.”

The number of providers went up by 2.6 percent from 2014 to 2015, when Medicare paid \$16 billion to 4,200 hospices for care provided to 1.38 million Medicare beneficiaries. MedPAC’s projected profit margins for the hospice industry, based on 2015 data, do not reflect changes for providers resulting from the U-shaped or two-tiered per diem Medicare payment structure for routine hospice home care, introduced last year. Live discharge rate from hospice care was down, from 18.48 percent in 2013 to 16.78 percent in 2015, but still, in MedPAC’s view, a significant problem.

The recommendation that hospices get no rate increase for 2018 would require an Act of Congress to overturn previous legislation specifying a 1 percent increase—still significantly less than the inflationary cost increases many providers have experienced. MedPAC’s report also reprises its 2014 recommendation that hospice care should be included as part of the Medicare Advantage benefit package—as a “carve-in,” integrated into MA benefits, rather than the current carve-out to the Medicare Hospice Benefit. It also recommends that hospices failing to provide all four mandated levels of care may merit immediate scrutiny. ◆◆

Hospice and Palliative Care News and Notes

Depressed and anxious hospice caregivers; CON threatened in Florida

Research from the University of Missouri School of Medicine finds that up to one quarter of the family caregivers of terminally ill hospice patients experience moderate to severe depression. Up to one-third have anxiety.¹ Those found to be at higher risk for depression and anxiety are younger and caregivers of patients with Alzheimer's and other non-cancer diagnoses.

Debra Parker-Oliver of the Department of Family and Community Medicine at the university and colleagues analyzed assessments of 395 family caregivers and found a disconnect between the hospice philosophy—which identifies the patient and family together as the unit of care—and the reality that interventions targeting the family caregiver's particular needs and concerns are limited. That may be because the hospice team is more focused on the needs of the patient, not the whole family.

"Hospice programs need to take a hard look at these results and give family caregivers the same kind of focused symptom management for their mental health needs as they do for the patient," Oliver tells *HCL*. "Caregivers are impacted in their mental health, their physical health, their ability to care for their loved one, and nobody is taking care of the caregiver's needs. There's no one person on the hospice team who is responsible for caring for the

caregiver. When you think of such high incidence of mental health issues, why aren't we doing more to standardize assessments of caregiver distress? We know they don't seek help, and they're not being supported or encouraged to ask for it," Oliver says.

"There's not a standardized assessment of caregiver need in wide use by hospices. There's not a good set of evidence-based interventions to address anxiety or impact on quality of life. My work is trying to bring this disconnect to a deeper appreciation by providers. We have a pilot group of a standard

¹ Oliver DP, Washington K, Smith J, Urazee A, Demiris G. The Prevalence and Risks for Depression and Anxiety in Hospice Caregivers. *Journal of Palliative Medicine*. Published online ahead of print December 2, 2016.

intervention using a focused, problem-solving approach with a three-visit protocol. We also have seen good evidence outside of hospice for the benefits of online support groups," Oliver says.

"But I think it all needs to start with an assessment of the caregiver's needs. Then, when you identify an issue, what

do you do?" Caregivers who report as anxious or depressed, at a bare minimum,

should get a social worker and spiritual care professional intervention, she says. "As we build and test interventions, it will be the hospice's responsibility to look at them and learn how to build their agency toolbox for caregiver interventions." If hospices did nothing else but assess and then target and make visits for those caregivers who score high on the assessment, that would be a start, and it's analogous to the way hospices standardized pain assessments for patients. For more information about hospice caregiver needs and assessments, contact Oliver at: oliverdr@health.missouri.edu.



"Free market"-oriented legislation introduced with the support of Florida Governor Rick Scott when the legislature convened March 7 would repeal Florida's certificate of need (CON) requirements for opening new hospices and several other categories of health providers, notably hospitals and skilled nursing facilities. Hospice may just be collateral damage for the legislators' real target: hospitals. But Florida's hospices are fighting the proposal, and they made 4,300 phone calls to legislators and personal contacts with all of the freshman legislators who took their seats in March, says Paul Ledford, president and CEO of the Florida Hospice & Palliative Care Association. He adds that this outreach has a good chance of deleting hospices from the bill that proposes to eliminate CON for hospitals, although the vagaries of the legislative process make that far from certain.

"The states where they let the horse out of the barn (by eliminating CON) are never going back. It is customary in localities where the demographics say there is money to be made in hospice care for the

(cont'd on p8)

number of providers to go shooting up after CON is phased out," Ledford says. "In Florida it would be a nightmare that in no way would help consumers. It would make informed decisions about providers nearly impossible. Newcomers to the field would get desperate pretty quickly about building their census, and that's when fraud can occur," he says.

"A lot of hospitals and home health agencies would love to open hospices targeting Florida's aging demographic. The challenge for us is to explain

“It is customary in localities where the demographics say there is money to be made in hospice care for the number of providers to go shooting up after CON is phased out.

— Paul Ledford

this to legislators who are operating from a bumper sticker mentality that says the free market is always right. We have to explain that the price of hospice care is fixed by

the federal government and that demand for hospice is finite, while conveying the irreparable damage that ending CON would have for the quality and integrity of hospices in the state. They are going to lower quality and increase fraud without having any effect on the cost curve," he says.

"We did a study in 2013 with Cordt Kassner of [Hospice Analytics](#) comparing Florida's 30 statistical areas to similar regions in non-CON states, and estimated conservatively that the number of providers would rise from the current 46 to 196. But state officials told us we were being way too conservative." By comparing to what happened when CON was repealed for home health agencies in Florida, with 2,500 new providers popping up, the recalculation estimated that there would soon be 1,204 new hospices, a 26-fold increase, with two-thirds of them in Miami-Dade County.

Another bill related to hospice issues, this one sponsored by Florida's hospices, aims to make it easier for patients to access hospice care. The proposal grew out of several years of discussions by FHPCA's Public Policy Committee working with attorneys representing member hospices. It would align the reporting of quality measures established in Florida as a hospice report card in 2009 with new federal quality measure reporting (see also Page 1) while still preserving the concept of a Florida hospice outcomes report card.

The bill would also make it easier to safely dispose

of unused controlled substances after the patient's death and to share medical records of a deceased patient without requiring a court order. Finally, it would allow hospices in the state to develop private sector and government pilot projects to test palliative care models for seriously ill patients who don't yet qualify for hospice care. Current statutory barriers say a licensed hospice can only serve terminally ill patients.



Newly published research from Yale University concludes that longer periods of hospice service are associated with lower overall end-of-life spending—but this was only found in regions that have high expenditures in end-of-life care.² That is because the manner in which doctors practice medicine is critical



in determining whether or not increased hospice use (longer lengths of stay) results in considerable savings on health care expenditures.

"It is well established that physicians in different geographic regions practice differently," the authors note. "For example, physicians practicing in high-expenditure regions may be more likely than those in low-expenditure regions to recommend discretionary services for which strong evidence is lacking, and to test and treat patients intensively." Based on a review of more than 100,000 elderly Medicare fee-for-service patients who died of cancer from 2004 to 2011, they conclude that creating incentives for hospice use in high cost areas could have a significant impact on total health care spending. ♦♦

² Wang S, Hsu SH, Huang S, Soulos PR, Gross CP. Longer periods of hospice service associated with lower end-of-life spending in regions with high expenditures. *Health Affairs*; 2017 Feb; 36(2):328-336.