

Hospice Services

Certificate of Need Standards and Criteria



STATE OF TENNESSEE

**STATE HEALTH PLAN
CERTIFICATE OF NEED STANDARDS AND CRITERIA**

FOR

**RESIDENTIAL HOSPICE SERVICES
AND HOSPICE SERVICES**

The Health Services and Development Agency (HSDA) may consider the following standards and criteria for applications seeking to provide Residential Hospice and Hospice services. Existing providers of Residential Hospice and Hospice services are not affected by these standards and criteria unless they take an action that requires a new certificate of need (CON) for Residential Hospice and/or Hospice services.

These standards and criteria are effective immediately upon approval and adoption by the Governor of the State Health Plan updates for 2014. Applications to provide Residential Hospice and/or Hospice services that were deemed complete by HSDA prior to this date shall be considered under the Certificate of Need Standards and Criteria included in the State Health Plan updates for 2012.

Because of the unique nature of hospice services, the Division commits to reviewing these standards annually.

Definitions Applicable to both Residential Hospice Services and Hospice Services

1. **"Deaths"** shall mean the number of all deaths in a Service Area less that Service Area's number of reported homicide deaths, suicide deaths, and accidental deaths (which includes motor vehicle deaths), as reported by the State of Tennessee Department of Health. The number of reported infant deaths includes neonatal and post neonatal deaths and is reported separately under the respective cause of death; therefore, in order to prevent overlap, the number of infant deaths is not included discretely.

2. **“Residential Hospice”**¹ shall have that meaning set forth in Tennessee Code Annotated Section 68-11-201 or its successor.
3. **“Hospice”** shall refer to those hospice services not provided in a Residential Hospice Services facility.
4. **“Total Hospice”** shall mean Residential and Hospice Services combined.

STANDARDS AND CRITERIA APPLICABLE TO TOTAL HOSPICE

1. **Adequate Staffing:** An applicant should document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application. Importantly, the applicant must document that such qualified personnel are available for hire to work in the proposed Service Area. In this regard, an applicant should demonstrate its willingness to comply with the general staffing guidelines and qualifications set forth by the National Hospice and Palliative Care Organization.

Rationale: Health care professionals, including those who provide hospice services, are not uniformly located across the state, and rural areas showing some need for hospice services may not have a qualified hospice workforce. The Division believes that granting a CON for the provision of health care services without evidence that the applicant has a qualified workforce readily available to provide quality care to patients is not, in fact, providing access to quality health care.

2. **Community Linkage Plan:** The applicant should provide a community linkage plan that demonstrates factors such as, but not limited to, relationships with appropriate health care system providers/services and working agreements with other related community services assuring continuity of care focusing on coordinated, integrated systems. Letters from physicians in support of an application should detail specific instances of unmet need for hospice services.
3. **Proposed Charges:** The applicant should list its benefit level charges, which should be reasonable in comparison with those of other similar facilities in the Service Area or in adjoining service areas.
4. **Access:** The applicant must demonstrate an ability and willingness to serve equally all of the Service Area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing the factors concerning need on which an application

¹ The Division recognizes the Guidelines for Growth’s statement that “the purpose of residential hospice facilities is not to replace home care hospice services, but rather to provide an option to those patients who cannot be adequately cared for in the home setting.” The Division also recognizes that Residential Hospice and Hospice providers may in fact provide the same services.

may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed Service Area.

5. **Indigent Care:** The applicant should include a plan for its care of indigent patients in the Service Area, including:
 - a. Demonstration of a plan to work with community-based organizations in the Service Area to develop a support system to provide hospice services to the indigent and to conduct outreach and education efforts about hospice services.
 - b. Details about how the applicant plans to provide this outreach.
 - c. Details about how the applicant plans to fundraise in order to provide indigent and/or charity care.

6. **Quality Control and Monitoring:** The applicant should identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. Additionally, the applicant should provide documentation that it is, or intends to be, fully accredited by the Joint Commission, the Community Health Accreditation Program, Inc., the Accreditation Commission for Health Care, another accrediting body with deeming authority for hospice services from the Centers for Medicare and Medicaid Services (CMS) or CMS licensing survey, and/or other third party quality oversight organization. The applicant should inform the HSDA of any other hospice agencies operating in other states with common ownership to the applicant of 50% or higher, or with common management, and provide a summary or overview of those agencies' latest surveys/inspections and any Department of Justice investigations and/or settlements.

Rationale: This information will help inform the HSDA about the quality of care the applicant's common ownership and/or management provides in other states and the likelihood of its providing similar quality of care in Tennessee.

7. **Data Requirements:** Applicants should agree to provide the Department of Health and/or the Health Services and Development Agency with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard of practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

8. **Education:** The applicant should provide details of its plan in the Service Area to educate physicians, other health care providers, hospital discharge planners, public health nursing agencies, and others in the community about the need for timely referral of hospice patients.

RESIDENTIAL HOSPICE SERVICES

DEFINITIONS

9. **“Service Area”** shall mean the county or contiguous counties represented on an application as the reasonable area in which a health care institution intends to provide Residential Hospice Services and/or in which the majority of its service recipients reside. A radius of 50 miles and/or a driving time of up to 1 hour from the site of the residential hospice services facility may be considered a “reasonable area;” however, full counties shall be included in a Service Area. Only counties with a Hospice Penetration Rate that is less than 80 percent of the Statewide Median Hospice Penetration Rate may be included in a proposed Service Area.
10. **“Statewide Median Hospice Penetration Rate” (SMHPR)** shall mean the number equal to the Hospice Penetration Rate (as described in the following Need Formula) for the median county in Tennessee.

ADDITIONAL SPECIFIC STANDARDS AND CRITERIA FOR RESIDENTIAL HOSPICE SERVICES

Note that, while a “need formula” is set forth below, the decision to approve a CON application hereunder should be determined by the cumulative weight of all standards and criteria, including those set forth earlier herein.

11. **Need Formula:** The need for Residential Hospice Services should be determined by using the following Hospice Need Formula, which should be applied to each county in Tennessee:

$$A / B = \text{Hospice Penetration Rate}$$

Where:

A = the mean annual number of Hospice unduplicated patients served in a county for the preceding two calendar years as reported by the Tennessee Department of Health;

and

B = the mean annual number of Deaths in a county for the preceding two calendar years as reported by the Tennessee Department of Health.

Note that the Tennessee Department of Health Joint Annual Report for Hospice defines “unduplicated patients served” as “number of patients receiving services on day one of reporting period plus number of admissions during the reporting period.”

Need is established in a county (thus, enabling an applicant to include it in the proposed Service Area) if its Hospice Penetration Rate is less than 80% of the Statewide Median Hospice Penetration Rate; further, existing Residential Hospice Services providers in a proposed Service Area must show an average occupancy rate of at least 85%.

The following formula to determine the demand for additional hospice service recipients should be applied to each county included in the proposed service area, and the results for each county's calculation should be aggregated for the proposed service area:

$(80\% \text{ of the SMHPR} - \text{County Hospice Penetration Rate}) \times B$

Rationale: The use of an SMHPR is a methodology employed by many states; the Division paid particular attention to the Kentucky model (which employs an 80% rate), as Kentucky's population is similar geographically and culturally to that of Tennessee. The Division considered ranges from 70-85%, but felt that the results of rates lower than 80% were too restrictive. Only three additional counties showed need using the 85% rate as opposed to the 80% one, and those had low single-digit-need numbers. Thus, the 80% rate is proposed. The Division believes that using the median county rate supports the view that rural counties cannot quickly reach the higher penetration rates of Tennessee's metropolitan areas. The underlying purpose is to help encourage orderly growth by using an SMHPR that ratchets upward across the state as hospice providers strive to exceed 80% of the median county's hospice penetration rate. Thus, utilization should continue to increase, albeit gradually, and provide the opportunity in the underutilizing counties for more hospice services by agencies that can expect a market to exist for those services.

12. **Types of Care:** An applicant should demonstrate whether or not it will have the capability to provide general inpatient care, respite care, continuous home care, and routine home care to its patients. If it is not planning to provide one or more of these listed types of care, the applicant should explain why.
13. **Continuum of Care Regarding the Expansion from Non-Residential Hospice Services:** An applicant for Residential Hospice Services that provides Hospice Services should explain how the Residential Hospice Services will maintain or enhance the Hospice Services' continuum of care to ensure patients have access to needed services. An applicant should provide assurances that it understands and will comply with any existing Medicare reimbursement requirements (e.g., the provision of different levels of hospice care, including any total patient care day allowances) and evidence that there are a sufficient number of potential hospice service recipients that will enable it to so comply.

Rationale: Currently², Medicare pays nearly 90% of all hospice claims. The Medicare hospice benefit produces an incentive to recruit as many new patients as possible and to keep them on the service as long as possible. Unlike other segments of the health care

² As of January 9, 2015

industry, where revenues and costs can vary widely, Medicare pays a set daily rate for each person in hospice care, with higher allowances for patients that require more attention.

As part of its interest in ensuring that hospice programs serve only patients who are eligible and appropriate for hospice care, Medicare limits the total number of days of inpatient care (the sum of general inpatient care (GIP) and inpatient respite care days) for which a hospice may be reimbursed. The cap is set at 20 percent of the hospice's total patient care days. The Department of Health and Human Services' Office of Inspector General (OIG), in a May 3, 2013, memo to Marilyn Tavenner, Acting Administrator for Centers for Medicare & Medicaid Services (CMS), stated that CMS staff "have expressed concerns about possible misuse of GIP" by hospice programs and noted a \$2.7 million settlement with a hospice program for allegedly having billed for GIP when patients actually received routine home care (which has a lower reimbursement rate). "Long lengths of stay and the use of GIP in inpatient units need further review to ensure that hospices are using GIP as intended and providing the appropriate level of care. OIG is committed to looking into these issues further and will conduct a medical record review that will assess the appropriateness of GIP provided in different settings." The Division adds the above requirement as a way to ensure that the HSDA and applicants understand the importance that an applicant provide hospice services appropriately. The Division believes that the HSDA, through its application of appropriately developed CON standards and criteria, can serve an important role in reducing opportunities for Medicare/Medicaid fraud and abuse in Tennessee.

14. **Assessment Period:** After approval by the HSDA of a residential hospice services CON application, no new residential hospice services CON application – whether for the initiation of services or for the expansion of services – should be considered for any county that is added to or becomes part of a Service Area until JAR data for residential hospice services can be analyzed and assessed by the Division to determine the impact of the approval of the CON.

Assessment Period Rationale: This Standard is designed to ensure that the impact of the provision of hospice services as a result of the approval of a new CON is accounted for in any future need calculations for a Service Area.

HOSPICE SERVICES

DEFINITIONS

15. **"Service Area"** shall mean the county or contiguous counties represented on an application as the area in which an applicant intends to provide Hospice Services and/or in which the majority of its service recipients reside.

16. **“Statewide Median Hospice Penetration Rate” (SMHPR)** shall mean the number equal to the Hospice Penetration Rate (as described below) for the median county in Tennessee.

ADDITIONAL SPECIFIC STANDARDS AND CRITERIA FOR HOSPICE SERVICES

Note that, while a “need formula” is set forth below, the decision to approve a CON application hereunder should be determined by the cumulative weight of all standards and criteria, including those set forth earlier herein.

17. **Need Formula:** The need for Hospice Services should be determined by using the following Hospice Need Formula, which should be applied to each county in Tennessee:

$A / B = \text{Hospice Penetration Rate}$

Where:

A = the mean annual number of Hospice unduplicated patients served in a county for the preceding two calendar years as reported by the Tennessee Department of Health;

and

B = the mean annual number of Deaths in a county for the preceding two calendar years as reported by the Tennessee Department of Health.

Note that the Tennessee Department of Health Joint Annual Report of Hospice Services defines “unduplicated patients served” as “number of patients receiving services on day one of reporting period plus number of admissions during the reporting period.”

Need should be established in a Service Area as follows:

- a. For a hospice that is initiating hospice services:
 - i. The Hospice Penetration Rate for the entire proposed Service Area is less than 80% of the SMHPR;

AND

- ii. There is a need shown for at least 100 total additional hospice service recipients in the proposed Service Area, provided, however, that every county in the Service Area shows a positive need for additional hospice service recipients.

Preference should be given to applications that include in a proposed Service Area only counties with a Hospice Penetration Rate that is less than 80% of the SMHPR; however,

an application may include a county or counties that meet or exceed the SMHPR if the applicant provides good reason, as determined by the HSDA, for the inclusion of any such county and: 1) if the HSDA finds that such inclusion contributes to the orderly development of the healthcare system in any such county, and 2) the HSDA finds that such inclusion is not intended to include a county or counties that meet(s) or exceed(s) the SMHPR solely for the purpose of gaining entry into such county or counties. Letters of support from referring physicians in any such county noting the details of specific instances of unmet need should be provided by the applicant.

b. For a hospice that is expanding its existing Service Area:

- i. There is a need shown of at least 40 additional hospice service recipients in each of the new counties being added to the existing Service Area.

Taking into account the above guidelines, the following formula to determine the demand for additional hospice service recipients should be applied to each county, and the results should be aggregated for the proposed service area:

$(80\% \text{ of the Statewide Median Hospice Penetration Rate} - \text{County Hospice Penetration Rate}) \times B$

Rationale – 17a: The Division believes that hospice services in Tennessee are under-utilized, most likely as a result of community and societal norms and a need for more education to the general public on the benefits of hospice. Consequently, the Division believes that hospice services should be encouraged, within reason, in Tennessee and that providing broader opportunities for these services will help educate the public as to their value. Under 17a, the ability to include within a Service Area a county that meets or exceeds the SMHPR should assist in the grouping of counties within a Service Area, thus providing more hospice services opportunities, provided that there is no detriment to the orderly development of the healthcare system as a result.

The Tennessee Hospice Association and other stakeholders provided information that 120 hospice service recipients is a larger than necessary number to ensure economic sufficiency of a hospice that is initiating hospice services. Consensus opinion appears to agree that 100 hospice service recipients is a sufficient number.

Rationale – 17b: Other states provide for the ability of an existing hospice to expand its Service Area where positive need is shown at 40-50% of the criterion required for a new hospice to institute services, thus a number of 40 additional hospice service recipients is suggested. Existing agencies are presumed to have the infrastructure in place for such expansion.

18. Assessment Period: After approval by the HSDA of a hospice services CON application, no new hospice services CON application – whether for the initiation of

services or for the expansion of services – should be considered for any county that is added to or becomes part of a Service Area until JAR data for hospice services can be analyzed and assessed by the Division to determine the impact of the approval of the CON.

Assessment Period Rationale: This Standard is designed to ensure that the impact of the provision of hospice services as a result of the approval of a new CON is accounted for in any future need calculations for a Service Area.

Additional Comments and Rationale Statements for Revised and Updated Standards and Criteria for Hospice Services

Definitions

Deaths: The Division of Health Planning patterns its need formula off the Kentucky certificate of need formula that takes into account all deaths, instead of using a type of cancer death weighted formula that appeared in the Guidelines for Growth. Cancer patient utilization of hospice services has lessened in relation to non-cancer patients, while the utilization of hospice services continues to grow.

Residential Hospice and Hospice: The Division recognizes that residential hospice services and hospice services are able to perform the same level of services and has thus not distinguished between the need for hospice services based on the two types of service providers. However, certain standards and criteria, such as service area, provide for a difference in consideration of an application.

Standards and Criteria

Quality of Care: Providing for adequate and qualified staffing is an important part of providing quality care to patients, and is one of the State Health Plan's Principles for Achieving Better Health. A community linkage plan that assures continuity of care also falls within this Principle. Letters from physicians in support of an application should detail specific instances of unmet need for hospice services. Quality improvement, data reporting, and outcome and process monitoring fall under this Principle as well, as does accreditation/quality oversight of the hospice service program. Finally, it should be noted that Medicare currently requires all four levels of hospice care for reimbursement (which also supports the third Principle regarding Economic Efficiencies).

Access: The second Principle for Achieving Better Health in the State Health Plan focuses on access to care. Accordingly, the applicant must demonstrate an ability and willingness to serve equally all of the Service Area in which it seeks certification and provide a plan for its care of indigent patients. As well, in addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing the factors concerning need on which an application may be evaluated), the

HSDA may choose to give special consideration to an applicant that is able to show that there is limited access in the proposed Service Area. The revisions to the need formula in 17b are meant to encourage the provision of hospice services in counties that otherwise do not meet the need formula, thus providing better access for the community.

Economic Efficiencies: The third Principle for Achieving Better Health focuses on encouraging economic efficiencies in the health care system. The new standards and criteria provide that the applicant’s proposed charges should be reasonable in comparison with those of other similar facilities in the Service Area or in adjoining service areas. Educating the health care community on hospice services also falls within this Principle; the education component also addresses the fifth Principle of recruiting, developing, and retaining a sufficient qualified health care workforce.

Data Needs: The Division recognizes that hospice patients known as “general inpatients” receive hospice services in locations other than their homes, such as nursing homes and hospitals, and that these patients are not separately identified on the Joint Annual Report. The Division aims to correct this omission in the future to better account for the total utilization of hospice services.

NOTE: A previously proposed standard providing for the showing of an “unmet demand” has been deleted, for the following three reasons: 1) The Division believes that an unintended consequence of that proposed standard would have been the preclusion of a new, non-county-contiguous hospice agency ever to develop a Service Area from those counties and receive a CON to serve them; 2) After review of hospice utilization data for the past three JARs, the Division has learned that, in counties that showed a positive need of less than 40 under the existing need formula, existing hospice agencies met substantially all (if not all) of the positive need of additional hospice service recipients, providing evidence that the orderly development of hospice services in such counties currently exists; and 3) the Division recognizes that the HSDA already has the inherent authority to determine, based on evidence provided, that there is a need for expansion of hospice services into adjacent counties beyond that shown by the need formula.