LOUISIANA~MISSISSIPPI
HOSPICE AND PALLIATIVE CARE ORGANIZATION

We respectfully submit the following comments and suggestions to the Mississippi State Board of Medical Licensure and ask that you consider our suggestions before submitting a proposed amendment to the full board.

The staff's recommendation included three provisions that must be met to establish a proper physician-patient relationship.

Provision (i) - We agree with this provision with one recommendation for clarification purposes. We recommend that "every ninety (90) days thereafter" be changed to "at every certification period thereafter." Even though the initial certification period is 90 days, after the 2nd certification cycle, the period goes to 60 days. By using "at every certification period thereafter" it will eliminate any confusion and be in line with existing CMS requirements.

> That the treating hospice physician or medical director has thoroughly reviewed the medical records of the patient, as provided by the referring physician, has documented the review, and has determined just cause exists for hospice admission (expected death in six months or less), with documented follow-up review ~~every ninety (90) days thereafter~~ at every certification period thereafter;

Provision (ii) That the actions of the physician are otherwise deemed within the course of legitimate professional practice, as defined by the Centers for Medicare and Medicaid Services (CMS); and

We agree with this provision.

Provision (iii) That the physician's live-discharge rate for hospice patients does not exceed the national average as published by CMS.

While we understand the intent of this provision, we disagree with its inclusion as an indicator of whether a proper physician-patient relationship exists for purposes of prescribing.

We see three main concerns with using this data point as a requirement.

1. As acknowledged by CMS, "Live discharge from hospice can be appropriate, and the circumstances that lead to these events can be complex and are influenced by a range of factors including patient and family preference," (CMS, 2018). As referenced in the report from CMS, most studies regarding live discharges from hospice have shown that a vast majority of live-discharged patients are still considered terminally ill and thus would be appropriate for pain management associated with that terminal disease. Additional data regarding live-discharge can be found in the Medicare Payment Advisory Commission Report to Congress (Medicare Payment Advisory Commission, 2018).

2. Live discharge rates are statistically significantly higher in the African American community. This is a finding seen over and over in hospice, e.g. (Wang, 2016). Tying a physician's ability to prescribe to a live discharge rate will disproportionately impact physicians serving the African American communities of our state.

3. This provision would also potentially penalize newer physicians to hospice disproportionately. For example, a new medical director could have one of the first four patients change hospice providers, which would most likely put that physician's live-discharge rate above the national average.

We do share your concern over live discharges from hospice, but feel a better course of action to improve the quality of care for hospice patients would be to look at possible solutions to the problem of high-discharge rates.

We would first recommend that the Board of Medical Licensure work with the Department of Health to commission a study of live discharges from hospice in Mississippi to determine what causes are related to live discharges and formulate recommendations that can actively target these reasons.

For instance, a study (David Russell PhD, 2017) of hospice in New York City showed that 21% of the hospice patients in the study were discharged alive and that these discharges could be categorized in one of four categories:

1. Patient dialed 911 and was admitted to an acute-care hospital (42%)
2. Patient revoked hospice to resume disease-directed treatments (18%)
3. Patient no longer certified as terminally ill (14%)
4. Patient moved out of service area or transferred to another hospice (26%)

The conclusions from this study were:

> "Further research into factors that underlie live discharge events, especially acute hospitalization, is warranted given their cost and burden for patients/families. Hospices should develop strategies to address acute medical crises and thoroughly evaluate patients' suitability, unmet needs, and knowledge about end-of-life issues at the time of hospice enrollment, especially for those with non-cancer diagnoses."

CMS is developing a risk adjusted measure of hospice transition that is a potential data point to include in a study. The goal of the new measure is to identify hospices that have notably higher rates of live discharges followed shortly by patient death or acute care utilization, when compared to their peers. A study including this data point could be very valuable to quality improvements in hospice.

In addition to a study regarding live discharges, we would also recommend that the Board consider adding a minimum CME requirement for all Medical Directors and Hospice Physicians in a hospice/palliative care specific course. The Board could also consider adding a recommendation or requirement for physicians whose live discharge rates for any calendar year are above the national average to take a CME course specialized in addressing acute medical crises and evaluating patients' suitability (extraneous to illness) at the time of hospice enrollment.

References

CMS. (2018). *Draft Measure Specifications: Transitions from Hospice Care, Followed by Death or Acute Care.* Centers for Medicare and Medicaid Services.

David Russell PhD, E. L. (2017). Frequency and Risk Factors for Live Discharge from Hospice. *Journal of the American Geriatrics Society, Volume 65, Issue 8*.

Medicare Payment Advisory Commission. (2018). *Medicare Payment Policy.* Report to Congress.

Wang, S. A.-H. (2016). Transitions Between Healthcare Settings of Hospice Enrollees at the End of Life. *Journal of the American Geriatrics Society, Volume 64, Issue 2*.