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IN THIS ISSUE

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What do institutional ethics require of hospital bill collection processes?

Individual ethics also a factor in bill collection

President Obama may have signed the $787 billion stimulus package with the expectation that it will create jobs and jump-start the economy, but businesses — including those in the business of health care — are still feeling financial pain. As individuals either lose health care insurance or are unable to meet deductibles and afford what in many cases are higher co-pays, the health care system as a whole is pinched.

Do hospitals have a responsibility to patients that differs from other creditors, particularly related to bill collection policies and processes — and particularly in an economic downturn when current or former patients may have the will to pay but not the means?

"It's an issue that constantly comes up in any institution, and at UCI we're particularly affected, because we do more than our fair share of the county's indigent care," says **Felicia Cohn**, PhD, director of medical ethics at the University of California, School of Medicine, Irvine. "So, it's a constant struggle to maintain the bottom line to be able to provide the care that people need and deserve."

Cohn frames the issue of balancing an institution's desire to serve the greatest number of people and still get paid as a "constant balance of justice," because "every institution is having financial problems."

How a hospital responds to patients' financial difficulties could affect the institution's standing in the community if that community learns the hospital is responsible for overly aggressive collections practices.

"It's a relevant topic, because the way in which a hospital relates to its patients — both potential and actual patients — that is, both members of the community who have a certain image or perception of the institution, as well as members of the community who have been patients in the hospital, and may be again, partially assess that organization on the way in which it not only provides services within the hospital, that is, to patients, but also how they are treated following discharge," says **Paul B. Hofmann**, DrPh, president of Hofmann

Healthcare Group in Moraga, CA, and an editorial advisory board member for *Medical Ethics Advisor.*

Hofmann says it follows the aphorism, "You never get a second chance to make a good first impression."

"You know, you want your first impression to be as positive as possible, and you want your final impression to be as strong and positive, as well," he says.

Are hospitals experiencing non-payment?

Daniel Gialloreto, director of collections at Shafer Law Firm in Atlanta, notes that his firm's collections agreements spell out, in addition to what fees the firm will earn, such things as how many calls a guarantor of an account can expect to receive during a given month.

"We also have a signed HIPAA agreement, which deals with primarily the privacy of the former patient's information," Gialloreto says in an e-mail response.

From his vantage point, he says there has been a "dramatic increase in unpaid medical bills, to the point that [one] institution has a hiring freeze and a purchasing freeze on new medical equipment."

At Vanderbilt University Medical Center in Nashville, TN, director of patient accounting, **Gary Perrizo**, says, "We have not seen a big surge in our patient liability — for pure private pay — skyrocket. In other parts of the country, you would, or have. It could be because of our locality and who some of our main employers are."

One of those large employers is the state of Tennessee, and the hospital serves a large group of state employees. Another large employer is the university system itself.

"We've had layoffs here in the region, but I don't think we've had it hit as bad as other places," Perrizo says.

Perrizo also says that Vanderbilt has not seen an increase in the length of time in which bills are paid. However, he says, "I will say this: I see an awful lot of charity write-offs, based on our financial assistance policies."

Should hospitals be more lenient in a downturn?

In this economic downturn, when there are reports of 11 million people looking for jobs — with thousands of job layoffs announced in January alone — it follows that more people will have lost their employer-sponsored health care benefits, thus making it more difficult to pay when health care services are needed.

One question that could be posed is: Should hospitals be more lenient in an economic downturn?

"I think a distinction can and should be made between existing policies and procedures on the one hand, and their application on the other," Hofmann says. "That is to say that every hospital will have detailed policies and procedures pertaining to the collection of revenue from insurance carriers and patients.

"What is critical during this severe economic downturn is that those policies and procedures

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Managing Editor: **Karen Young**, (404) 262-5423, (karen.young@ahcmedia.com).
Associate Publisher: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).
Production Editor: **Ami Sutaria.**

Editorial Questions

Questions or comments?
Call **Karen Young**
at (404) 262-5423.

be flexible and applied judiciously, recognizing that the patients and their families — when it comes to deductibles, co-insurance, and self-pay responsibilities — have to be accommodated in a way that recognizes the fact that a larger proportion of that population [may] have less resources," he says.

Typically, the CFO or hospital finance committee would initiate a change in policy, most agree.

"Certainly, there are a set of metrics that are used by every hospital that monitor the billing cycle, and the number of outstanding days in accounts receivable is something that is very closely assessed, not only by the finance department, but obviously by the senior administration, the finance committee of the board, and the board itself," Hofmann says. "But the initiative in determining when and how existing policies and procedures might be modified or adjusted would begin within finance."

And while hospitals always should apply financial policies judiciously, according to Hofmann, "during exceptionally difficult times, a hospital has to demonstrate exquisite sensitivity to the way in which existing policies and procedures are applied, and that serves both the community and the institution."

In a series published by the *Baltimore Sun* in December 2008 on hospital practices in bill collection, one story focused on those individuals who wind up in what appears to be court, and the article maintains that these former patients believe they are, indeed, in a court of law.

Nancy Fiedler, senior vice president of communications for the Maryland Hospital Association, says her organization conducted studies that found that "a lot of these individuals who ended up in court are not the ones you might expect — the huge bill — because, as you might expect, those are the ones that the individuals come to the hospital and say, 'We've got to figure something out.'

"So, we're really talking about, for the most part — you know, $500, $1,000 — by the standards of health care cost, fairly modest costs," Fiedler says. "But there has been an increase of these kinds of outstanding bills, and, you know, this was before the economy even went south, and part of that is — at least the feeling from the hospital standpoint — is that the co-pays . . . even with employer-sponsored [policies], have increased."

Fiedler says another problem is that individuals who are out of work may buy a health insurance package that they believe to be comprehensive when, in fact, those policies may only be for catastrophic care.

"So, you go to the emergency room and you have to have an MRI, or a CAT scan or something like that, and you end up with a couple of thousand-dollar bill, which you are [unlikely] to be able to pay, in the case of individuals," she says.

What many hospitals do to help

Vanderbilt, for example, has three different types of financial assistance policies:

1) Pure charity, which is based on federal poverty guidelines, according to Perrizo. For this, Vanderbilt goes above 200% of the federal poverty level, and is today "right at" 250%, he says.

2) A catastrophic assistance policy. For this, "We will forego balances that you owe us, if your portions of the bill were greater than your annual [household] income."

3) A policy mandated by the state of Tennessee: For this program, Perrizo explains that the law provides for those who have been declared private pay with no insurance — meaning the patient is not eligible for Medicaid or other assistance programs, either federally sponsored or state-sponsored and is seeking "medically necessary services, they are entitled to a discount." That discount is based on Vanderbilt's averaged managed care contracted discounts, which is currently at 40%, Perrizo says.

For the most part, according to Fiedler and Perrizo, hospitals typically do not contract with the same collection agencies that may be employed for, say, a credit card balance. Furthermore, Perrizo says that Vanderbilt dictates what its collection agencies may or may not do with a patient.

"We call those shots," he says.

As for the types of actions the institution does not allow, Perrizo says, "We do not foreclose on anyone's real property; we do not take anyone's home; we do not take anyone's car; we do not go after personal or real assets of the guarantor of the account.

"What we do go after is future earnings," he says, noting that the hospital attempts to set up a "payment arrangement plan that is interest-free, so we try to work with them."

Piedmont Healthcare, which operates the private Piedmont Hospital in Atlanta, says in an e-mail response that the hospital has made no policy changes "due to the current economic landscape."

SOURCES

- **Felicia Cohn**, PhD, director of medical ethics, University of California, Irvine, School of Medicine. E-mail: fochn@uci.edu.
- **Nancy Fiedler**, senior vice president, communications, Maryland Hospital Association. Phone: (410) 379-6200.
- **Paul B. Hofmann**, DrPh, president, Hofmann Healthcare Group, Moraga, CA. E-mail: hofmann@hofmannhealth.com.
- **Gary Perrizo**, director of patient accounting, Vanderbilt University Medical Center, Nashville, TN.

However, the institution has begun utilizing Search America "to identify self-pay patients who qualify for charity care upon admission."

"This takes the burden off the patients and their families, who in the past had to provide paperwork in order to qualify for charity care," according to **Diana Lewis**, public relations director, in the e-mail. "We also use the program to qualify patients who ask for financial assistance, even though they have insurance."

Fiedler says she "will not say that hospital bills are particularly easy to understand. However, speaking for Maryland hospitals, she says most institutions "spend a very considerable amount of expense and time helping individuals who do qualify for health benefits: Medicaid, sometimes it's a state program that exists for breast cancer, or things like that, but getting people into programs where they would have health insurance coverage."

Such financial billing advisors essentially act as insurance "translators" for patients, who may have difficulty understanding what types of coverage their own insurance provides, or the types of financial assistance that may be available to them.

Is the right thing impossible?

When considering a question of how to achieve a desired end that satisfies everyone with regard to hospital payment, the University of California, Irvine's Cohn says, "I don't think it's possible."

"You are constantly going to have health care institutions struggling to meet their expenses, so that they can continue providing care to at least some people — if not everyone — while at the same time, people who really need care won't be able to get it, because there just won't be the resources available.

"You know, they say if you make a compromise that makes everyone unhappy, you've done something right. And I think that probably applies here. Every institution has some obligation to provide care for those in need, but they also have an obligation to stay in business, so that they can continue providing care for everyone else," Cohn says. ■

HHS physician conscience rule challenged in courts

Planned Parenthood Federation of America (PPFA) and Planned Parenthood of Connecticut were among those filing lawsuits asking the U.S. District Court for the District of Connecticut to invalidate the administrative regulation finalized in December by the U.S. Department of Health and Human Services that would allow physicians to deny services to patients based on their own religious or moral beliefs, such as abortion.

The Planned Parenthood organizations said that the "midnight regulation," pushed by the outgoing Bush administration, "poses a serious threat to women's health care by limiting the rights of patients to receive complete and accurate information and services.

"We filed this lawsuit today on behalf of the millions of women whose health care has been put in jeopardy by the Bush administration's parting shot at women's health. As a critical provider of health care information and services for women, Planned Parenthood cannot simply stand back and let this harmful regulation go into effect," said PPFA President **Cecile Richards** in a statement.

The complaint, the lawsuit charges, goes beyond the intent of Congress when it enacted previous conscience clauses, according to PPFA news release.

"The regulation is in conflict with other existing laws and regulations," the PPFA stated in its release. "In addition, in its rush to finalize the regulation, HHS failed to follow the appropriate regulatory steps, including failing to respond adequately to the many comments that raised significant problems with the legislation."

PPFA also reported that the Connecticut attorney general, joined by the attorneys general of California, Illinois, Massachusetts, New Jersey, Oregon, and Rhode Island filed a separate but parallel legal action challenging the regulation.

PPFA's Senior Director of litigation and law public policy, **Roger Evans**, JD, tells *Medical Ethics Advisor* that filing a lawsuit was "the one [option] that we could initiate when we did, which was after the rule was final but before the administration responsible for the rule could get out of town, so it would be clear that we were suing about what Bush had done and not what Obama had done."

The lawsuit also gives PPFA the ability to seek an injunction against the rule being enforced. As of early February, the organization had decided not to exercise that option, "while the litigation goes forward," he said.

"In addition, this is something that we could do, right," Evans says, in explaining why PPFA decided to file the lawsuit vs. pursuing other options. "It didn't require lining up 36 committee chairmen or White House aides. We could just do it."

Evans says that the Obama administration is "certainly aware of the problem — they're aware of the problem on multiple levels."

President Obama "talked about the issue as a candidate — they know there's a lawsuit," Evans says.

"So, I'm 100% confident they're aware of the situation and are considering what they think is the right thing to do," Evans tells *MEA*, noting that if the Obama administration takes action on this, it will be because the current administration thinks it is bad policy. But the court will only consider the question of legality of the conscience rule.

"We wanted to tee up the legality question," Evans says.

On the day that the HHS issued the final regulation, the American College of Obstetricians and Gynecologists (ACOG) in Washington, DC, issued a statement saying the rule had been approved "under the guise of "protecting" the conscience of health care providers.

However, ACOG said in the statement that the rule "is yet another reminder of the outgoing administration's implicit contempt for women's rights to accurate and complete reproductive health information and legal medical procedures."

"All patients, regardless of gender, age, ethnicity, race, religion, or sexual orientation, expect that their physicians will give them honest, complete, and unbiased information based on their specific health situations," ACOG said in its statement.

The legality question

Holly F. Lynch, JD, an attorney with Hogan & Hartson, LLP, in Washington, not only has written a book titled *Conflicts of Conscience in Health Care: An Institutional Compromise*, but she also addressed The President's Council on Bioethics in Washington, DC, in November 2008 on the issue of the physician conscience rule.

Lynch, who says her views do not represent those of Hogan & Hartson or the firm's clients, says one way to address the issue of conscience in health care is through a model of "doctor-patient matching, based on deeply held religious or moral beliefs." So, prior to any health care services being delivered, the potential patient would discuss the topic of religious and moral beliefs to determine if there was a "match."

"But, of course, you can only have matching when you have enough matches on both sides," Lynch tells *MEA*. "So, you have to have something to make sure that there are enough willing physicians such that patients can find physicians who are willing to provide the types of things that they're looking for.

"And that's the fundamental problem with this HHS rule and with various conscience clauses that are currently on the books, which is that they don't do anything to preserve access to willing physicians. They are just too one-sided," she says.

According to Lynch, there have been conscience clause statutes in place since the 1970s, and they offered "sweeping protection for physician refusal from other health care providers in the realm of abortion — but pretty much any service that you could imagine."

The new rule sets forth guidelines on how HHS is going to enforce the legislation. Lynch says that in the preamble to the final HHS rule, the agency responds to public comments made regarding the rule by saying that the new rule would not really change anything but is merely "clarifying the law."

"I think that's a bit disingenuous, because it is changing some things — it's adding definitions," she says.

For example, she suggests a law called the Church Amendment protects health care providers from "providing, or assisting in the

SOURCES

- The American College of Obstetricians and Gynecologists, Washington, DC. E-mail: communications@acog.org
- **Holly Lynch**, attorney at law, Hogan & Hartson, LLP, Washington, DC. E-mail: hflynch@hhlaw.com.
- Planned Parenthood Federation of America, Diane Quest, Director of Media Relations, Health Care. E-mail: mediaoffice@ppfa.org.

performance of medical services." That amendment could be open to interpretation.

"What the HHS rule does is define that term — assisting in the performance — and it offers a very, very broad definition of that term," Lynch says. "It defines it as anything with a reasonable connection to the activity. And it specifically includes counseling."

White House stay

The Obama administration, according to a White House memo signed by Chief of Staff Rahm Emanuel and dated Jan. 20, 2009, has issued a 60-day "stay," Lynch says, so that the new administration "can take a look" at regulations that were scheduled to go into effect from the Bush administration.

"I'm not sure what's going on with this particular rule, but I think it would be encompassed in that sort of 60-day hold," she says. ■

Legislation for physician payment disclosure

Sen. Chuck Grassley (R-Iowa) and Sen. Herb Kohl (D-WI) have introduced legislation that would require not only pharmaceutical companies, but also makers of medical devices and biologics, to publicly report any money over $100 that they give to physicians within a year.

In a news release, Grassley's office said the Physician Payments Sunshine Act of 2009 "would establish a nationwide standard requiring drug, device, and biologic makers to report payments to doctors to the Department of Health and Human Services." The legislation also would require that any payments be posted online for the public to review.

The legislation sets penalties as high as $1 million for those who knowingly fail to disclose payments. Grassley's release said the proposal incorporates many of the new recommendations of the Medicare Payment Advisory Commission (MedPac), an independent congressional agency that advises Congress on issues affecting the Medicare program.

Grassley's news release said this latest legislation is along the lines of S.2029, a bill that was introduced two years ago, which the 110th Congress never considered.

"Shedding light on industry payments to physicians would be good for the system," Grassley said in the statement. "Transparency fosters accountability, and the public has a right to know about financial relationships. Patients rely on their doctors' advice. Taxpayers spend billions every year on prescription drugs and medical devices through Medicare and Medicaid. They also fund tens of billions of dollars of medical research each year, and the doctors conducting that research have a big influence on the practice of medicine."

In addition, the release noted, Sen. Kohl is the author of legislation to create a federal "academic detailing" program to provide physicians and other prescribers with an objective source of information on all prescription drugs, based on independent, scientific research.

Thomas Novelli, director of federal affairs and policy for the Medical Device Manufacturers Association (MDMA) in Washington DC, tells *MEA* that he thinks "the movement toward transparency is a very good step in the right direction. I think there have been some legitimate concerns about some of the unfortunate players in the market, while the majority of the relationships, I believe, are legitimate relationships between device manufacturers and clinicians and physicians."

Novelli says, "I think some of the bad actors have really, unfortunately, put a gray area in the public perceptions about whether there's a level of impropriety in these relationships, and so I think that if it's crafted and implemented in the correct way, then that is beneficial to the practice of medicine in general."

Novelli noted that the $100 limit is probably "more appropriate" for pharmaceutical companies. He says the legislation was originally aimed at the items typically given to physicians with

drug branding.

But he notes that the relationship between medical device companies and physicians is different. Often, he said, "it is the physicians and the surgeons who help the device manufacturers develop the product, where you don't necessarily have that sort of relationship with a pharmaceutical company and a study."

Another issue of concern to MDMA is the ability to keep developmental information proprietary.

"Oftentimes, products are in the development stage, and we wouldn't necessarily call for a real-time disclosure of those sorts of relationships [between physicians and device makers]," Novelli said.

Another organization representing medical device makers weighed in on the legislation as well. On the same day the legislation was introduced, Stephen J. Ubl, president and CEO of the Advanced Medical Technology Asociation (AdvaMed) released a statement in response to the proposed act, stating: "AdvaMed and its member companies support the appropriate disclosure of payments made to physicians and were pleased to have supported S. 2029 as revised last year."

In the statement, Ubl said that AdvaMed was reviewing the proposed legislation, but "believe it is important that any federal disclosure legislation create a uniform national standard to prevent a patchwork approach by all 50 states."

The statement adds: "Physicians play a critical role in the continued innovation and advancement of medical technology, and federal disclosure legislation should be written in a way that allows for our unique research and development process to thrive." ■

SOURCE

• **Thomas Novelli**, director of federal affairs and policy for the Medical Device Manufacturers Association (MDMA), Washington, DC. Email: tnovelli@medicaldevices.org.

Hospice groups fight Medicare rate cut

Cuts were supported by Bush administration

[Editor's note: Medical Ethics Advisor *will update this story in the April issue. Prior to press time, NHPCO secured a one-year moratorium on cuts in the Medicare Hospice Benefit via President Barack Obama's signing of The American Recovery and Reinvestment Act of 2009.]*

Hospice providers and the organizations that represent them are attempting to blunt a cut to the Medicare hospice benefit, imposed by the Bush Administration last year, that took effect Oct. 1, 2008.

In the consensus statement passed by both the U.S. House of Representatives and the Senate in mid-February, when the legislation headed into the conference process to determine the final elements of the package between the House and Senate, the National Hospice and Pallative (NHPCO) said the moratorium provision "is critical to protecting thousands of hospice jobs and preserving access to quality end-of-life care for patients nationwide."

Originally, the provision passed in the House version of the Obama administration-supported stimulus package included language calling for a one-year moratorium on the elimination of rate cut to the Medicare hospice benefit.

Jon Keyserling, vice president of public policy and counsel of NHPCO in Alexandria, VA tells *Medical Ethics Advisor* that NHPCO "has pulled together a broad cross section of membership organizations that represent various elements of the hospice and palliative care community."

"And we have, where appropriate, tried to develop a consensus around specific topics, so that the hospice community speaks with one voice," Keyserling says.

Although that coalition has issued numerous consensus statements, the group specifically issued a statement in early January in response to anticipated recommendations made by MedPac, an independent oversight body for Medicare and Medicaid.

The consensus statement, issued Jan. 8, notes that "Since the inception of the Medicare Hospice Benefit in 1982, hospice has grown into a $10 billion industry that last year alone served more

than 1.4 million dying Americans and their family caregivers."

As the group tracked the progress of the stimulus package through both bodies in early February, Keyserling at that time told *MEA* that as the Senate considered its version of the stimulus package, there had been "a number of amendments offered on the Senate floor to the package.

"Because we are in the House-passed version, but not yet in the Senate-passed version, we're anticipating and we're hopeful that we will be added to the Senate package," he tells *MEA*.

Keyserling says the rate cut would result in the loss of "up to 3,000 jobs" nationwide.

"Now, that's 3,000 jobs in the first year," he says. "We are already hearing from hospice programs all across the country that they are cutting back service areas; that they are letting staff go and not hiring additional staff; and ultimately this is going to impact patients and their families. And that's our primary concern — that patients and families continue to have access to high-quality end-of-life care."

Asked why the Bush administration via HHS and CMS wanted the rate cut for hospice care funded by Medicare, Keyserling tells *MEA*, "I have been bewildered by the previous administration's actions in this area. And the only public explanation we have heard is CMS and the administration wanted to reduce hospice expenditures, and that just strikes me as odd, because, one: The increase in expenditures on hospice services … has been driven largely by an increased portion of Medicare beneficiaries accessing the benefits."

Keyserling also says that two previous CMS administrators "actively promoted the notion that physicians ought to feel comfortable referring patients to hospice, and patients should feel very comfortable accessing the Medicare hospice benefit."

For millions of Americans every year, "dying is not an option," Keyserling says. "It is going to occur. It's part of the natural cycle of life, but the question of where and how you are going to be served in that process is an option, and it should remain an option for patients and families."

The MedPac consensus statement

Among the elements emphasized in the consensus statement from the various hospice organizations regarding any changes in the Medicare Hospice Benefit was what Keyserling termed "the real need to collect and to analyze and to understand the comprehensive data that is needed to direct potential payment reform."

One recommendation made by MedPac in November suggested that the HHS Secretary "should direct the OIG to investigate the prevalence of financial relationships between hospices and nursing facilities that may represent a conflict of interest and influence admissions to hospice, differences in patterns of nursing home referrals to hospice, and the appropriateness of hospice marketing materials."

According to Keyserling, "I think the MedPac focus is to head off potential problems. I don't know that they have identified any particular practices but are concerned about the appearance of impropriety."

The HHS Office of Inspector General (OIG) is expected to issue the second part of a report first issued last year, with the first part primarily addressing the demographics of hospice services in the long-term care setting, he says.

Those actual recommendations are expected to be released in that group's March report to Congress, Keyserling says.

As for changes in payment methodology, thus far MedPac has made a recommendation that any change to be made not occur before 2013, Keyserling says. ■

SOURCE

• **Jon Keyserling**, JD, vice president of public policy and counsel, National Hospice and Palliative Care Organization, Alexandria, VA. Telephone: (703) 837-1500.

In-House Hospice opposes Medicare rate cut

Says increasing costs due to aging America

If you ask **Laura Ann Wagner**, president and CEO of In-House Hopice, based in Southfield, MI, the explanation why costs are increasing for the Medicare hospice benefit — the answer is a simple one: Baby boomers are aging, and more of them are taking advantage of that benefit.

Regarding the rate cut, she says, "It goes with-

out saying [that] it's going to threaten the access to compassionate, high-quality, end-of-life care."

Smaller hospice programs, which tend to serve rural areas, are particularly threatened. Wagner notes that out of 4,500 hospice providers in the U.S., 83% see fewer than 100 patients a day.

And while Wagner says it is "well documented" that hospice costs have increased for Medicare, she also notes that CMS "themselves put forth a very focused effort several years ago to communicate to physicians and hospitals and other health care providers along the continuum, encouraging them to refer their patients at end of life to hospice."

Wagner stresses that patients who do not choose hospice care end up in the emergency department and/or the intensive care unit — care she translates to anywhere from $1,000 to $3,000 a day — compared to hospice, which costs about $135 a day.

Wagner also notes that it is also well documented that hospice saves Medicare about $2,300 per patient.

Caps in place on hospice care today

There are caps in place for the Medicare hospice benefit, which is at about $22,300, Wagner says. That's true if a patient accesses the entire 180-day, or about six months, benefit, but typically patients do not receive the entire benefit, she says.

Wagner cites statistics from 2007, when the median length of stay in hospice was 20.6 days, or about 11.5% of the intended benefit. The average length of stay in 2007 was 59 days, about 33% of the intended benefit.

"So, you can derive from those numbers that there's not a lot of overutilization going on here," she says.

And she suggests that in today's continually downward spiraling economy, people need this Medicare benefit more than ever. ■

SOURCE

• **Laura Ann Wagner,** president and CEO, In-House Hospice, Southfield, MI. Phone: (800) 311-5635. E-mail: lwagner@in-househospice.com.

Why I Chose Bioethics as a Profession

*Q & A with **Felicia Cohn**, PhD, director of medical ethics, University of California, Irvine, School of Medicine.*

Q: Why did you decide to go into bioethics as a profession?

A: It's an interesting question, because it's not like a physician, where you can say, "I've wanted to do this since I was five, and when you're five, you don't even know how to spell it, much less that it exists.

And even now, I tell people I'm a bioethicist and I get these perplexed looks, like, "What does that mean, what do you do?"

So, now, I've just started telling people I meet at parties that I'm a teacher, or a professor.

I ended up in it, like a lot of people of my generation and older, by accident. I was a pre-law student in college, and when I started actually investigating what it was I would have to do — the kinds of jobs I would likely have when I finished — I no longer was interested.

But I really liked parts of it. And I loved health law, and environmental law, and the issues I would get to deal with in those areas. Unfortunately, you can't go to law school and just study those kinds of things. You have to do contracts and torts and tax law , and I really didn't want to do that.

I had taken a course — you know, every university has its list of professors whose courses you should take because of their interest in their subject matter, and because the professor is just that great. We had a few of those, and one of those professors was a man named Jim Childress, who is, I think, the father of bioethics. He and Tom Beauchamp wrote *Principles of Biomedical Ethics* . . . it's probably the premier bioethics textbook.

And it's just one argument about how bioethics should work. It's one theory, but it's probably now the dominant theory of principles. They developed this system of principles, really from the convergence of a couple of other theories — or what they claim is the convergence.

He was just a phenomenal teacher, and I loved the content. And I thought, How can I go to grad school to study this? There weren't really any programs at the time, but I started looking into different types of programs — the philosophy of science

and other ethics — general ethics programs, not really applied ethics, in philosophy departments, political and social thought — I think was the program I was looking into at Berkeley — and just a way I could get at this subject area without having to go to law school or medical school.

I ended up actually staying at the University of Virginia, where I had been in undergrad, so I could study with Jim Childress. Then there was another man there at the time, named John Fletcher, who worked in the hospital and in the medical school. So, I was fortunate to have both of them as my mentors, so I could combine the theory and the clinical practice.

Q: It's interesting that you thought about what you wanted to study and what you wanted to learn vs. a position.

A: I think this is similar to what happened to the people sort of above my generation. All of them were already in other fields; they were philosophers, theologians. The pioneers were mostly all theologians, or people in religious studies. But some philosophers, legal scholars, physicians — even anthropologists/sociologists, who were intrigued by some particular issue that raised ethical questions, and sort of became bioethicists, not on purpose, but just on the basis of what they were doing.

So, those were the founders of our field.

Q: What time was this?

A: Well, you can date it probably back to the 1960s. Joseph Fletcher and Paul Ramsey, and there are a number of others…those are probably two of the biggest names.

And then there were things happening in the world. You know, it was post-World War II, post-the Nuremberg Trials, research ethics was becoming a big problem, and we were developing codes [of conduct, such as] The Belmont Report, and with a president's commission were addressing some of these issues.

So, there was just kind of this whole almost hurricane of things going on that propelled our field into existence.

So, it was all these people who would never have called themselves bioethicists, who were actually doing bioethics. And then other people became intrigued by the stuff that they were doing and decided, "I'd kind of like to do that."

But they still went into PhD programs in philosophy and religious studies and went to law school and went to medical school, and they're coming at it situated from those professions.

There began to be this kind of core of knowledge that we still argue about the finer points of, but everybody agrees that this set of philosophical theories we should understand, some basic religious precepts, and then know a little about clinical medicine — at least so that you can speak the language — and you know, there's this core set of cases — they are legal cases, or big clinical cases that you need to know about as sort of paradigms.

And so based on that, there started to be master's programs and undergraduate concentrations, if not majors, and now there are even some PhD programs.

The people of my generation are probably among the first who will actually call ourselves bioethicists — to call ourselves that and to recognize it in that way, as a profession unto itself.

And now there are students who are actively looking for bioethics programs.

Q: So, that's a change from when you first looking at what you would study?

A: Right. And I haven't decided if it's an entirely good thing.

Q: What do you mean by that?

A: Well, it's been really helpful to be in a self-consciously multidisciplinary field. You know, when I go to the table for a debate, I'm bringing my religious studies background with me, and it's fascinating to have someone from law school and somebody from medical school and an anthropologist and a sociologist all sitting at the table with me.

And we're all doing bioethics, but yet we're situated in these very different professions . . . and bringing those perspectives with us. I think some of that richness and nuance will be lost if we have people who study just bioethics.

Q: Because they don't have the range of education and experience?

A: Right. ■

SOURCE

• **Felicia Cohn**, PhD, director of medical ethics, University of California, Irvine, School of Medicine. E-mail: fcohn@uci.edu.

NEWS BRIEFS

Alabama hospice settles fraud claims of $24.7M

SouthernCare Inc. and its shareholders agreed to pay the United States a total of $24.7 million to settle allegations that the company submitted false claims to the government for patients treated at its hospice facilities, the U.S. Justice Department reported in mid-January.

SouthernCare, based in Birmingham, AL, operates about 99 locations that provide hospice services in 15 states.

"The Medicare hospice benefit is intended to provide compassionate end-of-life care to terminally ill patients," said **Gregory G. Katsas**, assistant attorney general of the civil division. "This settlement sends a clear message that the Department of Justice will not allow health care providers to take advantage of beneficiaries in their attempts to game the reimbursement system."

The settlement results from two qui tam suits filed by two former SouthernCare employees, on behalf of the United States.

The False Claims Act authorizes private parties to file suit against those who defraud the United States and to receive a share of any recovery. The United States will pay $4.9 million to the individuals who filed the actions against SouthernCare.

"Our investigation showed a pattern and practice to falsely admit patients to hospice care who did not qualify and to bill Medicare for that care. This resulted in taxpayers bearing inappropriate costs," said **Alice H. Martin**, U.S. Attorney for the Northern District of Alabama. ■

New guidelines published for prescribing opioid meds

A panel of pain management experts representing the American Pain Society (APS) in Glenview, IL, and the American Academy of Pain Medicine also in Glenview, IL, has published what they call "the first comprehensive clinical practice guideline" to assist clinicians in prescribing opioid pain medications for patients with chronic non-

CME instructions

Physicians participate in this continuing medical education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge.

To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity with the **June** issue, you must complete the evaluation form provided and return it in the reply envelope provided to receive a credit letter. When your evaluation is received, a credit letter will be mailed to you. ■

CME objectives

After reading each issue of *Medical Ethics Advisor*, you will be able to do the following:

- **discuss** new information about hospital-based approaches to bioethical issues and developments in the regulatory arena that apply to the hospital ethics committee;
- **stay** abreast of developments in bioethics and their implications on patient care, risk management, and liability;
- **learn** how bioethical issues specifically affect physicians, patients, and patients' families. ■

COMING IN FUTURE MONTHS

- The CDC and ethics
- The ethics of fertility treatments – more scrutiny in store?
- Physician loses license over live birth abortion
- From PhDs to weekend seminars: training in bioethics

cancer pain.

The guidelines were published in a recent issue of *The Journal of Pain*.

"The expert panel concluded that opioid pain medications are safe and effective for carefully selected, well monitored patients with chronic non-cancer pain," said **Gilbert J. Fanciullo**, MD, a panel co-chair and director, Section of Pain Medicine, Dartmouth Hitchcock Medical Center.

APS, AAPM, and the Oregon Evidence-based Practice Center at Oregon Health and Science University collaborated for two years reviewing more than 8,000 published abstracts and non-published studies to assess clinical evidence from which their recommendations are based. ■

CME Questions

8. Paul B. Hofmann, DrPh, president of Hofmann Healthcare Group, suggests that hospitals' patient billing policies and procedures should be applied judiciously and with flexibility, particularly during an economic downturn.
   A. True
   B. False

9. Planned Parenthood Federation of America decided to challenge the physicians rule of conscience imposed by the U.S. Department of Health and Human Services under the Bush Administration using which option below:
   A. By filing a lawsuit
   B. By approaching the Obama Administration directly
   C. By approaching Congress and requesting a legislative change
   D. None of the above

10. Holly F. Lynch, JD, an attorney with Hogan & Hartson in Washington, DC, suggests doctor-patient matching to avoid potential problems associated with the physician rule of conscience regulation.
    A. True
    B. False

11. The Physicians Payment Sunshine Act is designed to impact the following types of companies:
    A. Biologics
    B. Pharmaceuticals
    C. Medical device companies
    D. All of the above

Answers: 8. A; 9. A; 10. A; 11. D.