Restoring Integrity and Quality in the Hospice Movement:
A VNAA Response to Current Issues in the Medicare Hospice Benefit

Background:
The hospice movement in the United States began as a charitable mission of religious and community-based organizations that offered palliative care and spiritual and emotional support to persons at the end of life in their homes or in specialized facilities. In 1982, the Medicare program was among the first insurers in the United States to recognize the value of hospice care and pay for hospice services as a humane and cost-effective alternative to expensive and often-futile curative care for beneficiaries who were terminally ill.

While the hospice benefit was initially characterized by under-use, Medicare payment and coverage improvements have now made it into one of the most rapidly growing Medicare benefits. The Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare and Medicaid Services (CMS) have raised concerns about the rapid entry of for-profits into hospice services and the integrity and structure of the benefit. These concerns have resulted in legislation requiring across-the-board cuts in hospice payments beginning in 2013 and proposals for basic changes in how hospice reimbursement is structured.

The Role of Nonprofit Providers:
Nonprofit, mission-driven hospices are patient centered care providers and believe that high quality care can be delivered in an individual's homes and in other settings to all patients regardless of their ability to pay or the complexity of their illness. Nonprofits recognize that the growth in the Medicare hospice benefit is a positive reflection of increased public awareness of the benefits of hospice care. But nonprofits also have concrete experiences with patients, family members, institutional providers and for-profit providers that raise concerns about inappropriate practices and financial incentives in the current Medicare benefit.

VNAA and its nonprofit, mission-driven hospice members have identified several current issues in the Medicare hospice program that suggest the need for reform and have developed recommendations for policymakers. These recommendations are designed to address potential fraud, abuse and misuse of the hospice benefit while preserving its core mission to provide high quality, compassionate care to individuals nearing the end of life.

The Role of the VNAA:
VNAA was established 28 years ago by nonprofit, community-based visiting nurse associations who developed the concept of homecare services in the United States over 125 years ago. The VNAA is a national association that supports, promotes and advocates for community-based, nonprofit home health and hospice providers that care for all individuals regardless of complexity of condition or ability to pay.
Part I: Current Issues in Hospice

1. **Medicare Hospice Cap**

   **Background on the Medicare Hospice Cap:** Medicare pays a hospice one of four pre-set payment rates for every day a patient is in the Medicare hospice benefit regardless of whether the patient receives services that day or not. For 2010 these daily rates range from $142.91 to $834.10 and are adjusted higher or lower to account for labor costs using the Medicare hospice area wage index. To help avoid excessive payments under this system, Medicare also limits the total amount that a hospice can collect per person from Medicare each year by a capped amount. This amount, known as the aggregate hospice cap, was originally set in Medicare law in 1983 at $6,500 per person and is updated each year for medical price inflation. For 2009, the cap was set at $23,014.50. The cap is expressed as an average amount that a hospice cannot exceed across all its patients in a year. The cap is applied as an aggregate rather than to each individual patient. If the hospice cap multiplied by the total number of patients a hospice serves exceeds the total Medicare payment the hospice received for these patients, it must repay the difference.

   Clearly, the most publicized and visible issue in Medicare hospice over the last several years has been the hospice cap. The hospice cap has never been a problem for nonprofit hospices and is considered adequate. Because it is applied in the aggregate, spending on a reasonable number of very expensive, long-stay outlier cases is not restricted by the cap, so extraordinary services to such individuals are not compromised by their cost. Nonprofits do encounter a limited number of patients whose end-of-life duration was not accurately predicted by physicians and who do require extended periods of hospice care. However, in nonprofit hospices, such patients are an exception and constitute a small percentage of total patients. As a result, the extraordinary costs of these few patients do not cause the nonprofit hospice to exceed the hospice aggregate cap.

   Data from MedPAC’s June 2008 report “Evaluating the Hospice Benefit” indicated that only eight nonprofit hospices out of 1,189 exceeded the cap while 104 of the 1,330 for-profit hospices exceeded the cap. According to the local medical review policies published by Medicare, VNAA members do not have difficulty complying with the hospice cap. MedPAC has suggested that the per diem rate structure of the Medicare hospice benefit provides a strong financial incentive for long lengths of hospice stay. VNAA agrees with that analysis and the implication that some hospices are responding to financial incentives rather than actual patient needs and compliance with Medicare guidelines. The hospice cap does provide some measure of control over providers that would otherwise generate high profits through very long lengths of stay.

2. **Underpayment for Short Hospice Stays**

   One of the most vexing problems faced by nonprofit hospices is patients who are referred to hospice very late in their end-of-life experience. Sometimes this means that patients receive only a day or two of hospice care prior to death and often less than three weeks. These late referrals give the hospice very little time to put in place the kind of comprehensive hospice support systems needed for the patients and their families. While nonprofits “pull out all the stops” to make a quality end-of-life experience possible for such patients, time works against the kind of optimal care that is consistent with their mission and the needs of the patient and family.
The Medicare payment system contributes to the problem by failing to recognize that the current daily rate system does not cover the full cost for short lengths of stay. Common agreement exists in the hospice community and by MedPAC that the first few days and last few days of hospice care are the most expensive; however, Medicare currently pays the same rate for high intensity, high cost days as for any other day. Moreover, the entire overhead associated with the admission and discharge of a patient cannot be absorbed with only a few days of payment at the current Medicare rates. Thus, a stay that only consists of a few days to a couple weeks is underpaid as a matter of the simple payment structure.

The stability of nonprofit hospice is dependent on a balance of short and long stay patients. Nonprofits routinely accept short stay patients recognizing the challenges of serving such patients from a service and Medicare reimbursement perspective. In some states, inappropriate marketing by profit-driven providers has focused on long-term care patients making it difficult for nonprofit hospices to retain a balance of short and long-term stay patients. In these circumstances, nonprofit hospices are in danger of being forced to preserve viability by reducing the number of short stay patients served or to close their program altogether. Neither is a good choice for a mission-driven hospice directed at meeting community needs.

Thus, the implications of the current Medicare system of underpayment for short stay cases is that nonprofit hospices that do not have an appropriate balance of short and long term stays will come under increasing financial pressure in markets in which other hospices are aggressively admitting predominantly longer-stay patients.

3. **Proliferation of Hospices**

The number of Medicare certified hospices continues to surge almost exclusively through the addition of for-profit hospices in states that lack meaningful certificate of need or strong licensure requirements. The number of Medicare hospices is growing in these states without regard for the actual demand or need for additional hospice capacity and often in regions where there is an oversupply of new hospices. The oversupply of any Medicare provider has historically resulted in a risk of provider induced demand for services, leading to reduced compliance, predatory competition among providers and increased fraud, abuse and waste. Aggressive competition creates access problems for less profitable, more challenging hospice patients as too many providers chase the higher margins associated with long-stay patients. This results in nonprofit hospices accepting the financial challenge of caring for a disproportionate number of high cost patients while predatory hospices accept more long-stay patients.

4. **Perverse Competition and Referral Abuse**

Competition based on quality and/or price, in concept, adds value to any service, including healthcare. But hospice competition under Medicare is not about price or quality. Medicare pays the same price for all patients to all hospices and has not established uniform standards of quality. As such, competition can take perverse forms such as preferential marketing activity under which hospices enter into a wide range of special “arrangements” with referral sources that hide or skirt compliance with government anti-kickback and inducement rules. **Offering or accepting anything of value for the sole purpose of encouraging referrals to a particular hospice leads to fraud and abuse of the Medicare hospice program.** Some examples include:

- Providing full-time hospice staff to nursing homes or assisted living facilities that agree to refer and maintain a specific number of patients from that hospice. While it is not inappropriate for a hospice to place full time staff in a nursing facility when they have a high hospice care census, it is inappropriate for the hospice to offer staff as a quid pro
quod inducement for nursing home referrals or for the hospice staff to perform tasks required of the nursing home.

- Hiring nursing home or assisted living staff as part-time hospice employees to create a referral network within the institutional provider.
- Having the same medical director for both a nursing facility and a hospice to generate preferential referrals.
- Hiring a number of medical directors in excess of those reasonably needed to meet patient needs or coordination with inpatient facilities to induce a high level of patient referrals from the practices of these physicians including their practice associates.
- Paying rates for hospice inpatient services far in excess of the rate Medicare pays them. Hospices are essentially coerced to pay excessive rates to maintain their support and/or referral network with institutional providers.
- Requiring person-by-person contracts for inpatient care for some hospices while accepting blanket contracts from others to favor hospices that provide additional inducements to them.
- Arrangements that deny or deter patient’s choice of hospice care providers. While it is not inappropriate for inpatient facilities or physicians to have preferred provider agreements based on services, arrangements that seek to deny or deter patient choice based on kickbacks, financial incentives or other illegal schemes are not acceptable.
- Inappropriate marketing of hospice care to nursing home patients to enlist large numbers of high margin, lower service cost patients.
- Seeking and accepting memorial contributions on behalf of patients served by a competing hospice.
- Guaranteeing payments for beds at inpatient facilities regardless of occupancy as a means to induce the inpatient facility to give preferential referral and admission to the hospice.
- Requesting or offering illegal inducements to influence the selection of hospices by nursing facilities.

It is clear that a wide array of anti-competitive arrangements have evolved and will continue to evolve in hospice as providers continue to proliferate with very little effective control or oversight.

5. Medicare Hospice Wage Index Adjustments

Wage index issues are not unique to hospices. However, the lower average margins experienced by nonprofit hospices make them more vulnerable to the inequities in the current Medicare hospice wage index system. Nonprofit hospices cannot continue to provide open access to high quality hospice care for Medicare patients in a payment environment that systematically underpays them for their labor costs. This leads to the inability to staff hospice services adequately.

While the Medicare system adjusts payments to most providers to account for differences in labor costs, the system of using hospital data to adjust labor costs for other types of providers while simultaneously exempting many hospitals from the system on a geographic basis has created serious problems for hospice providers. However, some of the inequity and inaccuracy in the application of hospital labor costs has historically been mitigated by a special budget neutrality adjustment. This adjustment was negotiated between hospices and CMS when CMS wished to convert hospices to the hospital based, wage index system. CMS began to unilaterally phase out that adjustment two years ago as an apparent budget saving mechanism. MedPAC has pointed out its many flaws and recommended change in its 2007 and 2008 reports. Meanwhile hospices suffer from an inaccurate system that does not have some
measure of equity afforded by the hospice budget neutrality adjustment (BNA) summarily removed.

**Background on Hospice Wage Index Adjustment:** Hospice payments under Medicare are adjusted higher or lower based on a system of wage index values that were originally created for hospitals using the relative costs of labor derived from a special schedule on the Medicare hospital cost report. Hospice payments were originally adjusted by an index based on data from the Bureau of Labor Statistics. However, CMS sought to move hospice payments to the system based on hospital labor costs to achieve consistency with other non-hospital Medicare payment systems.

To agree on a new wage index system for hospices, CMS and the hospice community entered into a special form of Federal rule-making in 1997 that had been pioneered by the Environmental Protection Agency (EPA) called “negotiated rulemaking.” Under this system, extensive meetings were held between CMS and the hospice community until a mutually agreeable compromise was achieved that was then reflected in a final Federal rule. This rule converted hospice wage index values to a system based on hospital costs and also guaranteed both a floor and budget neutrality with the previous hospice wage index as a matter of equity.

In the 2008 rulemaking, CMS proposed and subsequently repealed the budget neutrality provision that had been the basis for the prior agreement. This change forced hospices into the existing hospital wage index system that has been the subject of extensive criticism by MedPAC and most non-hospital provider groups subject to that index. Chief among the complaints is that hospitals are permitted exceptions to the wage index limits on a geographic basis while all other providers subject to the same limits are not. In addition there are systemic problems with the hospital index based both on inaccuracies in reporting and inconsistency in the geographic boarders used to apply them.

6. **Lax Quality of Care Oversight**

Given the roots of hospice as charitable, mission-driven services to the dying, it is perhaps understandable that no standardized measures of quality care have been developed for hospice. This may also explain why regular state surveys have not been conducted with the frequency expected with other Medicare providers. However, the rapid proliferation of hospices increases in payments, differences in the amount of services provided and complexity of hospice care suggests that more regular and standardized oversight must be considered.

Among the measures that would seem appropriate, include:
- Pain Control
- Dyspnea Control
- Anxiety Control
- Depression Control
- Nausea Control
- Constipation Control
- Emergency Room Admissions
- Curative Chemotherapy after Hospice Admission and Within 14 Days of Death
- Response Time by Hospice staff from Physician Referral to First Visit
- Amount and Type of Volunteer Training
- Availability and Level of Bereavement Care
7. **Undervaluing the Less Medicalized Services in Hospice**

CMS’ recent requirements to measure services actually provided by Medicare hospices is a necessary burden that nonprofit hospices gladly bear to help better understand the level of hospice care being provided. However, by measuring only visits that are payable, there is a risk in undervaluing those hospices services that are not measured, such as bereavement services. Nonprofit hospices have expressed that they may be the only hospices in the area providing significant bereavement services. In fact, some VNAA members have reported families served by certain for-profit hospices are being referred to their bereavement groups for service because the for-profit hospices do not offer meaningful services for families.

Similarly, while volunteer hours are tracked, the extent and type of training of volunteers is not. Nonprofit hospices have reported that while they provide extensive, in person training to their volunteers, other hospices in their area may only show volunteers a video and then send them into patients’ homes. The nature of payment systems is such that services that are not paid for or are not measured are not perceived as valued and prone to neglect. Similarly, if the costs of such services are not measured, they cannot be used to measure quality or determine adequate payments.

8. **Patients Whose Health Status Dramatically Improve Under Hospice**

By definition, hospice patients should be referred to Medicare hospice when they have a prognosis of less than six months to live. While hospice care can be expected to significantly improve a patient’s level of physical and emotional comfort, it is not expected to improve a patient’s prognosis. Yet VNAA members report that some patients admitted to hospice experience a dramatic improvement in their health status even to the point of no longer meeting the Medicare coverage criteria of a six-month terminal prognosis. In compliance with Medicare eligibility guidelines for hospice, VNAA members discharge such patients.

It is true that excessive numbers of live discharges from hospice could suggest poor initial assessments of patient eligibility. However, such marked improvement may actually reflect inadequate care prior to hospice admission. VNAA members have reported that sometimes they receive patients that have been so poorly cared for prior to hospice that the patient’s condition improves under hospice care and the expected duration of life is extended by the improved supportive care that their hospice provides.

While excessive numbers of live discharges from hospice may indicate that some persons were not actually eligible for hospice, a program integrity problem, a more limited number of live discharges from hospice raise the issue of the quality of care prior to hospice and the need for better continuity of care under Medicare for terminally patients whose life expectancy is greater than six months but who are still terminally ill. VNAA members report that most patients that they discharge alive remain quite ill with a life expectancy over six months but less than two years. They are generally discharged from hospice at a point where they do not qualify for Medicare hospice or home health because they do not meet the requirements for skilled services.
The dilemma is that without hospice or home health there is generally no comprehensive Medicare benefit for such persons to ensure continuity of care. These are individuals who are in the advanced stages of illness that generally end in death and who are likely to decline rapidly upon hospice discharge and will likely need expensive acute care without comprehensive care management and oversight until they are once again hospice eligible. This is an expensive and inhumane gap in Medicare coverage for such patients.

9. Overuse of General Inpatient Level of Care

General Inpatient (GIP) level of care is the second most highly paid type of hospice care under the Medicare benefit and is expected to be used only when the medical condition of the patient warrants such inpatient care. Nonprofit hospices have experienced pressure from inpatient facilities to use more of such care than is warranted or risk a reduction in referrals or access to the facility when needed. Similarly, nonprofit hospices are aware of hospices that regularly pressure their own staff to move patients to GIP to fulfill financial management needs apparently related to revenue or expectations of inpatient facilities that are referral sources. The potential for conflict of interest in justifying GIP care is most clear when the hospice and inpatient facility are under common ownership or control.

10. Unusual or Atypical Hospice Practice Patterns

We note that several unusual or atypical hospice practice patterns are emerging that suggest the possibility of abuse. We urge CMS to examine the frequency of these practices and determine if they, in fact, reflect attempts to circumvent Medicare coverage and medical necessity rules in hospice. Practices include but are not limited to:

- Situations in which a hospice and related home health agency serve a significant number of patients simultaneously.
- Hospices that accept a significant number of patients after they have been discharged from other hospices.
- Questionable practices that deny patient choice and instead steer patients to hospice providers based on inappropriate financial agreements.
**Part II: Recommendations for Hospice**

VNAA, based on input from its members, believes that Medicare payment reform is a critical step in ensuring the integrity of the Medicare hospice program and restoring the benefit to its caring mission. By providing incentives for positive behavior and reducing incentives that lead to unwanted hospice practices, payment policy can have the most immediate, positive impact on the Medicare hospice benefit.

1. **Maintain the Current Hospice Cap**

The current hospice cap is the best defense the program has against the incentive to artificially maximize hospice lengths of stay whether through selective admissions, aggressive marketing or non-compliance (either by willful action or ignorance) with Medicare local medical review guidelines. VNAA members see absolutely no reason to raise the hospice cap and believe doing so will only increase program cost and encourage provider practices, which are not consistent with the intent of the Medicare program or mission of hospice.

The current hospice cap is useful because it provides a meaningful barrier to excessive billing under Medicare and the temptation for providers to admit patients prematurely to hospice to achieve the financial advantages the current payment system affords to long stay patients. At the same time, because the cap is applied in an aggregate fashion, rather than on person-by-person basis, it does not create a financial disincentive to accept and serve those relatively rare patients whose terminal illness are less predictable.

2. **Focus Medical Review on Long Stay Cases at Long Stay Hospices**

Consistent with MedPAC recommendations, we recommend that hospices that have 40% of their patient stays at 180 days or more be subject to medical review.

3. **Reform Medicare Payment to Better Match Resource Use**

MedPAC has recommended that payments be increased for the beginning and ending days of hospice stays; this would maintain budget neutrality by reducing payments in the middle of hospice stays. This “U” shaped redistribution of payments would reduce the incentives for excessively long stays while better compensating shorter stays on which many hospices lose money. CMS is waiting to implement this change until a more comprehensive database can be developed to fine-tune the final characteristics of the “U” distribution and estimate impacts. VNAA agrees that more data is needed before a change is made and has offered support to CMS and MedPAC as appropriate to collect such data from nonprofit providers, which have unique costs and concerns.

Many of the issues that surround fraud, abuse and waste in the current hospice program are driven by shortcomings in the payment system that overpay for certain kinds of care and underpay for others. Providers that elect to chase these incentives are not only abusive in their own right, but the competitive pressures tempt other providers to become less compliant. Hospice payment reform is a topic of sufficient complexity that goes beyond the scope of this paper and is the subject of other work by the VNAA. But the Medicare hospice payment system clearly needs refinement that more closely matches program payment to the cost of the resources needed by hospice to provide quality care to each patient.

VNAA is working with other associations representing hospices to outline payment reforms that we believe would better match Medicare payments to the costs of the specific resources to
ensure quality care for each eligible hospice patient. We urge prompt action guided by complete data, thoughtful analysis of alternatives, careful impact analyses and pilot testing.

4. **Temporary Moratorium on New Medicare Hospice Certifications**

MedPAC has found no shortage of access to Medicare hospice services and has expressed concern with the prolific growth of for-profit providers. For that reason, VNAA recommends a temporary moratorium for new hospices to give CMS time to address concerns about fraud, abuse and misuse of the hospice benefit. (Authority for a temporary moratorium is included in the *Affordable Care Act* and regulations recently issued by the Department of Health and Human Services. Exceptions to a moratorium would include instances in which there is only one provider servicing an area and that provider is in jeopardy of closing or in rural communities as determined by CMS.)

Problems with the payment system are interacting with the incentives driving the proliferation of new agencies in a mutually reinforcing cycle. This is particularly problematic in states that have not effectively controlled the rapid proliferation of hospices far beyond any reasonable need for their services. As more agencies are created, the drive to chase financial incentives in the Medicare payment system increases. Given that MedPAC has found no shortage of access to Medicare hospice services yet growth continues, it is reasonable to break the cycle of provider induced payment increases with a temporary moratorium on new hospices. The moratorium would remain until payment and quality measurement reforms are in place or until the excess capacity for hospice care has been mitigated through certificates of need or licensure and stronger provider enrollment and conditions of participation.

5. **Accelerate Implementation of Standardized Assessment Instrument**

Hospice payment cannot benefit from value based purchasing until standardized quality measures exist and are valid, reliable and publicly reported. This is widely understood, yet CMS is in the very early stages of a limited contract in this area. Recent legislation requiring quality reporting by hospices will only add meaningful value if valid and reliable quality standards put in place. VNAA encourages acceleration of this effort and would welcome the opportunity to partner with CMS or AHQA in their development and testing. Among the measures that would seem appropriate, include:

- Pain Control
- Dyspnea Control
- Anxiety Control
- Depression Control
- Nausea Control
- Constipation Control
- Emergency Room Admissions
- Curative Chemotherapy after Hospice Admission and Within 14 Days of Death
- Response Time by Hospice Staff from Physician Referral to First Visit
- Amount and Type of Volunteer Training
- Availability and Level of Bereavement Care
- Medication Management
- Hospitalization
- Communication of Plan of Care
- Communication on End of Life
- Communication on Advance Directives
Even before the quality measurement system is mature enough to influence payment directly through value based purchasing, the public reporting of standardized performance measures would be an important addition to public and referral source information about hospice performance. It would also assist in the survey and certification process and in self-evaluation and quality improvement by the hospices. While the current Hospice Conditions of Participation require agency self assessment and quality improvement activities, until there are risk-adjusted comparative quality measures and public reporting, we believe the impact of the current quality assessment activities on substandard hospices will be modest. The measures that would seem appropriate include are the same as above.

6. **Investigate Changes to Payment Policies Between Financially Related Hospitals and Nursing Homes in Hospice Care**

Certain payment policy incentives in transfers or simultaneous service involving hospice and other providers can be abused when overt or covert financial relationships exist between the hospice and other providers. The most obvious of these involve patients in nursing homes who are simultaneously receiving both the paid care by the nursing home and paid care by Medicare hospice. While it is important to allow hospice-eligible nursing home residents the option of hospice enrollment, the current practice creates too strong an incentive for both the nursing home and hospice to collude in ways to maximize Medicare payment and margins. This is particularly true when a financial relationship exists between the providers that encourage each to feed the other’s financial interests. We believe that hospice and nursing home payments on behalf of nursing home patients receiving hospice care should reflect the actual level of service intensity patients receive in that setting to reduce the financial incentives for collusion and excessive lengths of stay.

7. **Restore the Hospice BNA Adjustment or Provide Interim Hospice Wage Index Comparability**

There is widespread agreement that the hospital wage index methodology is seriously flawed, that alternative measures under consideration will take time and that the status quo is only supported by hospitals because they enjoy special exceptions (reclassifications and rural floor). Hospices should not be expected to move to the pre-floor, pre-reclassified hospital wage index in this situation. Until a solution is developed for hospitals and all other providers, hospices should either be moved back to the BNA adjusted wage index that they negotiated with HHS or be given full comparability to the hospital wage index, including those of reclassified hospitals in the areas they serve.

8. **Provide Medicare Coverage for Advanced Disease Management**

There continue to be Medicare beneficiaries that are in the advanced stages of illness and do not qualify for hospice because of a slightly longer life expectancy than six months and who do not qualify for home health because they are not homebound or do not have a skilled nursing need, as currently interpreted by CMS.

Some of these individuals are live discharges from hospice because hospice care improved their life expectancy. Others are persons who are seriously ill, yet not close enough to death to be eligible for hospice, but who do not have access to comprehensive care management and coordination. Persons in the advanced stages of an illness with a terminal prognosis over a period greater than six months would benefit from comprehensive disease management and observation services.

VNAA urges policy makers to legislate a *new level of care before hospice* to close this gap and capture savings to Medicare as an important option. Another solution is the provision of
concurrent care. Demonstrations in the Affordable Care Act (such as the Medicare Hospice Concurrent Care Program) may offer short term solutions for some patients and options for long term changes in Medicare benefits for patients currently in the gap between hospice and home health.

9. **Enhance Hospice Conditions of Participation to Eliminate Substandard Hospices**

Nonprofit hospices believe that upgrading the Medicare enrollment and Conditions of Participation (CoPs) for hospices, while increasing the level of effort for all hospices would be a small price to pay to ensure the integrity and quality of this very valuable but increasingly vulnerable benefit. We suggest that in any state lacking effective Certificate of Need Authority for hospice that CMS be allowed to restrict enrollment in the hospice benefit to the number of hospice programs that represents full capacity for the number of potential hospice patients in the locality. We also suggest that CMS use its existing rule-making authority to enhance the Medicare CoPs requirements for hospice programs to ensure that hospices accept patients regardless of their relative profitability. The CoPs should also be upgraded to include the assurance of program integrity by adding a condition on business requirements and compliance plans developed in concert with the hospice trade associations, currently including VNAA, the National Hospice and Palliative Care Organization (NHPCO) and the National Association for Home Care and Hospice (NAHC).

Also, in the 2008 Hospice CoPs, CMS declined to specify any qualifications beyond those imposed by the hospice’s own governing body. Since hospice is now a mature program with significant regulatory requirements and risk of abuse, it would seem appropriate to both require that hospice administrators have at least two years of managerial or supervisory experience in a hospice or other Medicare certified provider (home health, hospital and nursing facility) before assuming the position of Administrator in a Medicare certified hospice. It would also seem appropriate to make it clear that the hospice Administrator must undergo the same criminal background checks required of employees of the hospice. To ensure objectivity in this process, the hospice’s governing body should be required to conduct the background check of the hospice Administrator and act on any findings.

10. **Develop an Interim Hospice Compare Website**

Until risk-adjusted measures comparing hospice quality are feasible, some existing information that would be helpful to consumers should be made available on an Interim Hospice Compare Website as long as it does not divert CMS resources from other hospice related initiatives.

Items that consumers and referral sources find useful could include: the full range of services delivered, hours of operation, explanation of how “on call” services are delivered 24 hours/7 days a week, staffing patterns, years of Medicare participation, external accreditation by deemed accrediting organizations, the date of last accreditation or state survey, average daily census, form of ownership (for-profit/nonprofit and independent, franchise or chain organization) and relationship to other area providers (e.g. common ownership or control). All of this information exists in one or more CMS systems: PECOS, OSCAR, Cost Report Files or Enrollment Files. There would be a need to consolidate these data into a reporting system similar to that used for public information on Medicare.gov.

11. **Develop Explicit Protections against Abusive Hospice Referral Practices**

While existing anti-kickback rules and incentive rules provide some protections against referral abuse, they are easily ignored or circumvented. Just as in the case of home health, VNAA believes that a much stronger and explicit set of rules and/or interpretive guidelines needs to be put in place to reduce referral abuse. Among the prohibited practices should be:
- Protections for patients subject to inappropriate marketing schemes by providers
designed to move patients from home health services to hospice when no medical need
exists for a change in type of service.

- Hospices providing an inducement for referrals by paying in advance for bed reserve
days at an institutional care provider when the inpatient capacity is not utilized.

- Hospices paying fees for Respite Care or General Inpatient Care (GIP) in excess of
Medicare payments hospices receive when used as an inducement for referrals rather
than as a means to assure access to essential inpatient or respite services.

- Inappropriate arrangements that seek to maximize respite or GIP care when it is not
medically necessary for patients but serves as an inducement for referrals from inpatient
providers.

- Prohibiting hospice management from implementing practices or procedures designed to
move patients out of routine to more expensive levels of hospice care on any basis other
than patient need. Ongoing staff education and communication about the appropriate
use of various levels of care matched to patient/family is acceptable and appropriate
management activity.

- Failing of a referral entity to give a patient and his/her family the names of other
hospices serving the community and advising them of the right to referral to the hospice
of their choice.

- Using the employment of medical directors or other employees connected to referral
sources with the sole intent of inducing the referral of patients to the hospice.

To provide a mechanism sufficient to prevent referral abuse, hospices should be required to
disclose all the financial relationships they have with organizations or individuals that have the
capacity to influence referrals to the hospice or gain through services provided by hospice.

All such financial relationships must be reflected in a written contract that details the specific
services, rates of payment and invoicing procedures sufficient to assure that any exchange of
money, item, or services are at fair market value and thus do not constitute an inducement or
gratuity in exchange for favorable referral practices.

12. **Conduct Expanded Medical Review of Hospice Claims Based on Profiles of At-Risk
Hospices**

Given the limited administrative resources for the medical review of claims, CMS should
develop an objective profile of those characteristics of hospices most likely to reflect aberrant
billing practices. Factors to be considered should include, but not be limited to: length of
participation in the Medicare program under current ownership, average length of hospice stay,
history of claims denials, frequency exceeding the hospice cap, type of ownership (for-
profit/nonprofit, freestanding/provider based), geographic location in areas of heavy hospice
concentration or patterns of aberrant conduct, Medicare margin and quality of care complaints.
An algorithm based on scoring such risk factors would be a useful tool to target limited medical
review resources.
Conclusion

The Medicare hospice benefit has made an important contribution to the Medicare program by enabling patients at the end-of-life to receive a caring alternative to costly, futile and often uncomfortable curative procedures which might otherwise have been employed for terminally ill patients. It offers not only palliative care to ease physical pain and discomfort but spiritual and emotional support. It touches the family of the patient, helps the family support the patient and also supports the family through their period of grieving and bereavement.

The core mission of hospice is to focus on the needs of the patient and family in achieving the highest quality of life at its end. The funding provided by Medicare has allowed hospice programs to achieve their mission more effectively and for greater numbers of individuals. Unfortunately, it has also brought operators into the hospice field that have begun to compromise the mission of hospice either out of ignorance or with the apparent intent to maximize Medicare payments. The result is an unnecessary drain on Medicare funding, reduced access for more challenging hospice patients and the real risk that the credibility and acceptance of hospice as a caring, mission-driven program will be eclipsed in the chase for Medicare dollars.

Medicare must take quick action to address the incentives and regulatory loop-holes that threaten to allow non-compliant hospices to tarnish the reputation of the entire hospice movement. We have outlined the key issues our members have identified and proposed reforms both in the Medicare payment system and quality control areas. We believe these reforms will support compliant providers and help assure continuation of the hospice mission while protecting the integrity of the Medicare program.

This paper is one of a series of papers. Other papers include:

“VNAA Principles: Refinement of Medicare Hospice Payment Methodology”

“Medicare Hospice Payment Reform: VNAA Reactions to “U” Distribution.”

This paper was prepared by VNAA at the direction of its nonprofit hospice members. VNAA is a member driven association representing nonprofit home health and hospices on a wide-range of issues. To find out more about VNAA, go to www.VNAA.org.

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