



HOSPICE COMPLIANCE LETTER

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HCL Special Report on Hospice’s Eligibility Challenge

Industry leaders discuss public policy implications of claims review

Introduction

Hospice care in America has changed dramatically since its origins in the 1970s, and since it became a covered benefit under Medicare in 1983. First of all, it has steadily grown beyond what its founders could have envisioned, into a \$12 billion industry¹ that serves 1.4 million patients per year. Some hospice programs are part of for-profit chains traded on Wall Street. In other communities, dozens of hospices, some of them recently opened and/or with limited experience regarding Medicare’s regulatory requirements, compete to enroll terminally ill patients.

Accusations of Medicare fraud committed by hospices have also increased, with successful whistleblower lawsuits, million dollar compliance settlements paid by some providers, and a growing “alphabet soup” of regulatory bodies and government contractors who are or soon will be poring over Medicare claims from hospices across the country.

In most cases, the basis of this scrutiny is the patient’s eligibility for the Medicare hospice benefit—which requires a prognosis of six months or less to live if the disease runs its normal course, as certified by the attending physician and the hospice medical director. Although this requirement for a six-month prognosis is a cornerstone of Medicare’s hospice benefit, the passage of time has highlighted the dilemmas of making reliable, accurate, evidence-supported predictions of how long a patient will live—as well as concerns about the focus and methods of hospice claims reviews.

¹ Medicare Payment Advisory Commission. Hospice Services Payment System: Payment Basics, October 2010: “Medicare payment for hospice grew from almost \$3 billion in 2000 to nearly \$12 billion in 2008.” See: http://www.medpac.gov/documents/MedPAC_Payment_Basics_10_hospice.pdf.

Physicians report that the six-month requirement can be a barrier to hospice access for patients, families—and themselves. A growing body of published research questions the scientific basis for reliably predicting a terminal prognosis. Most recently, a study of the government’s criteria for hospice eligibility for nursing home residents with dementia found these to be little better than chance in predicting prognosis.² Hospices report that many patients are ambivalent, fearful and reluctant to accept a service that requires acknowledgement that they have been given a terminal prognosis—until their circumstances absolutely demand it. In fact, consistently 30 percent or more of hospice admissions happen seven days or less before the patient’s death, typically in the kind of pain and turmoil that hospice care was designed to prevent.

And yet hospice eligibility, the growth of hospice providers, the number of patients enrolled in hospice care, Medicare outlays for hospice care and protracted lengths of stay for some hospice patients remain targets for the government. These concerns are reflected in investigations by the Office of Inspector General (OIG) and the Department of Justice; recommendations by the Medicare Payment Advisory Commission (MedPAC) for Congress to revise the hospice benefit’s payment structure; and scrutiny of hospice claims by Medicare and Medicaid contracting watchdogs—all seeking to put the brakes on hospice’s growth.

A variety of technical violations have been documented by OIG. Regulators are also concerned about whether some patients qualify for the higher billed rates of continuous or general inpatient care, and whether the growing volume of billed physician visits is necessary and appropriate. Hospice medical directors must now write brief narrative statements of their reasons for certifying patients’ terminal prognosis, and visit in person patients who live beyond 180 days on the benefit (see page 13). But in each case the underlying issue is eligibility.

CMS and its agents are concerned that too many patients are getting into hospice care too soon and receiving hospice benefits for too long, with the government paying for care for the dying for people who aren’t really dying—at least not soon enough. This scrutiny can jeopardize some hospices’ cash flow as they respond to denials, delays in payment, appeal processes and recoupment efforts. A few hospices have been forced out of business by this government scrutiny. But regulators have signaled that their determinations of ineligible claims could also form the basis for charges of Medicare fraud and abuse—with even

² Mitchell SL, Miller SC, Teno JM, Kiely DK, Davis RB, Shaffer ML. Prediction of 6-month survival of nursing home residents with advanced dementia using ADEPT vs. hospice eligibility guidelines. [JAMA](#) 2010 Nov 3; 304(17): 1929-35.

higher stakes for the provider—but without offering clear lines between merely ineligible claims and actual fraud.

In the past two issues of *Hospice Compliance Letter*, we explored the multi-faceted eligibility challenge now facing hospices and the measures some providers have appropriately taken to be more accountable by improving their admissions, assessment, documentation, billing, quality and compliance processes. But in addition to taking these steps to improve their processes, should hospices and the government also be asking if all of this scrutiny of eligibility is changing how hospices provide care to dying patients? Does it impede access to hospice care by appropriate patients? Is it good public policy or just regulatory bullying?

Does the scrutiny address real problems in hospice care delivery, or is it misdirected? How bad, really, are the fraud, abuse, misuse and inappropriate admissions by hospices that the government is trying to stamp out? And where is the scrutiny of the processes, providers and governmental policies standing in the way of timely referrals to hospice care—even when patients want it and the need is clear? We have asked experts on a variety of sides of this conundrum to consider the policy question: Is all of the government’s scrutiny of hospices’ eligibility decisions twisting the nature and delivery of hospice care in America? We also contacted CMS to try to include the government’s perspective, but no one was willing to talk on the record. This special report is what we learned.

What is the Eligibility Challenge?

There is something puzzling about the government’s focus on hospice eligibility. Why would large numbers of patients forgo curative care and consent to hospice care if they didn’t need it? Why would they accept that they are assessed as terminally ill, unless they are being denied informed consent and don’t realize what they are signing? Dr. Atul Gawande’s celebrated *New Yorker* article,³ among other recent examples, illuminates how terribly difficult it is for patients, families and physicians to acknowledge, or to make treatment choices and major life decisions based on death’s inevitable advance. ICUs are packed with patients who will never return to a full life, yet continue to receive invasive life-sustaining treatments that prolong their dying, because there is no advance directive and no one was willing to engage the patient and family in an honest conversation about what to expect. Health policy experts and budget planners struggle with “end-of-life care” and how to moderate mushrooming medical costs in the final years of chronically ill, elderly patients’ lives.

³ Gawande A. Letting Go. *The New Yorker* August 2, 2010.

There are no numbers for the extent of fraud, abuse and misuse of the Medicare benefit by hospice providers. If we knew the true extent of this problematic behavior, then it might be easier to talk about how to fix it. Anecdotal reports are repeated whenever providers come together, and a number of examples of questionable practices were cited as background by sources for this report. Some cases may be intentional; other hospices seem unacquainted with basic hospice regulatory requirements or cavalier in their disregard of them.

“The majority of hospices are making increased investments in quality and compliance,” says Christy Whitney, CEO of Hospice and Palliative Care of Western Colorado, Grand Junction. “But at least some of the industry doesn’t appear to know the regulations exist—or lacks the sophistication to understand them. I don’t know how to bridge that chasm.”

These real problems in hospice delivery will make it harder for industry advocates to press their case to the government to stop using regulatory instruments that some say are too blunt. Other commentators suggest that the industry’s apparent inability to clean up its own problems from within all but invites the heavy hand of government regulatory intervention. Despite friction between non-profit and for-profit providers, our experts say neither sector has a monopoly on good—or bad—behavior. In fact, some of the best known and admired hospices in America have recently run afoul of government scrutiny. “The government sees hospice profit margins and wants to do something,” says Claire Tehan, a former hospice CEO and current consultant based in Torrance, CA. “Is all this scrutiny the result of fraud uncovered—or simply of growth?”

“Both Medicare and CMS representatives have said to me—point blank—that their concern is that hospices are turning the Medicare benefit into a chronic care benefit, and they want to do whatever they can to slow that down,” relates National Hospice and Palliative Care Organization (NHPCO) President Don Schumacher. “They are also concerned about our role in the nursing home specifically—and nursing home residents who are admitted to hospice too soon.” Of particular concern are non-communicative dementia patients.

But are there data to show that chronic care in hospice is a real problem? Does it make sense to use regulatory resources to try to discourage the utilization of hospice care except where eligibility can be proven beyond a doubt—along with continued evidence of progressive decline? Does the system of oversight, with its financial incentives for the watchdogs, start to wring the fairness and reasonableness out of the system? And who provides oversight of the overseers? Clearly, while appropriate accountability by hospices is not negotiable, the hospice industry and the government should be talking about these issues.

Levels of Scrutiny

The most basic level of hospice scrutiny is the additional development request (ADR) issued by the fiscal intermediaries or Medicare administrative contractors (FIs or MACs) who process hospice claims. If the FI/MAC subsequently decides to deny the claim, there are several levels of appeal, up to the Administrative Law Judge, where hospices say the vast majority of their appeals of claims denials are reversed. Local coverage determinations (LCDs) provide guidelines for determining hospice eligibility, but may be applied inconsistently and in ways that are more prescriptive than their original intent—in effect, to keep people out of hospice care. Yet there has been no systematic validation of their predictive reliability; nor have they been updated in response to evolving medical evidence.

Other Medicare-contracting agencies now reviewing hospice claims include ZPICs (Zone Program Integrity Contractors) and MICs (Medicaid Integrity Contractors). RACs (Recovery Audit Contractors) have been evoked as a looming concern, because they are paid on a contingency basis—which could be an incentive for more aggressive denials. The Medicare RACs have not yet started looking directly at hospices, although inevitably they will. Another new challenge is Medicaid RACs, which will be operational by April 1, 2011. “It’s all coming together for the government, with better coordination, more sophistication, and state and federal agencies talking to each other. They’ve got a lot more money and incentive to scrutinize hospice claims,” says Heather Wilson, co-owner of Weatherbee Resources of Hyannis, MA.

“We have at least a dozen clients in ZPIC audits, in addition to run-of-the-mill ADRs,” says Joy Barry, Weatherbee’s co-owner. “One of them had 75 percent of its reviewed claims deemed ineligible and, with extrapolation, it’s looking at millions in repayments. This is a tremendous distraction to patient care, and the amount of resources that need to be devoted to fighting these audits is substantial. There are huge financial implications for the hospice, with an impact at the level of staff morale. There can also be an unnecessary but understandable overcorrection by the hospice in terms of who it is willing to admit. It can become difficult to refer to that hospice.”

“Those hospices caught up in a ZPIC audit are experiencing the worst possible financial implications,” says Mary Michal, attorney with the Wisconsin firm Reinhart Boerner Van Deuren and a specialist in hospice legal cases. “ZPICs can put hospices out of business. They typically do about 30 chart reviews. Hospices submit their paperwork and wait; six months later they get a response. In some cases, a high percentage of the claims are deemed ineligible and, not only that, extrapolated to an entire universe of claims, possibly over several years. So

the ZPIC says, for example, that \$7 million was overpaid to the hospice in error, and they're going to send it over to the MAC for recoupment," Michal relates. "For hospices without a lot of cash reserves, it's enough to put them out of business. And hospices caught in the net may not have brought on the problem, but are simply a statistical outlier in one form or another."

"In my opinion, the government has put us in this unfortunate situation," says Leanne Peterson, COO of Solaris Hospice in Decatur, TX. "Medicare set the LCDs and then informed us that they were guidelines only. My hospice and, I would imagine, most hospices, have always used the guidelines to help us with proving eligibility. But it seems the government now wants to hold our feet to the fire, not only requiring the patient to meet the guidelines to a 'T', but also requiring a 'continuous rapid decline' as well," Peterson says. "We constantly have to change our thought processes and procedures to meet the subjective audits we get."

Impact on Access

"Some hospices will be more reluctant to take patients until they're at death's door—and those patients won't receive what hospice set out to provide. Staff will be less confident in their decision-making," says Gretchen Brown, CEO of Hospice of the Bluegrass, Lexington, KY. "We were one of the early programs to get large numbers of claims reviews. Over the years we've continued to get them, and have gotten better at responding. When we get an ADR, it usually gets reviewed by three or four sets of eyes, to insure against technical denials and to follow up if a helpful note could strengthen the case."

The real problem, Brown says, will be for smaller hospices that can't afford to spread this level of administrative support across their smaller caseloads. "Now you're forced to spend scarce patient care resources on making sure you get paid. It's a bad time for this to happen, when hospice's resources have been reduced from rate cuts." Brown and other hospice leaders predict widespread consolidation of hospice providers. The most likely benefactors of these acquisitions could be the large national chains with access to capital. "Every hospice has had a patient who lived for years," she adds. "We're talking about life's biggest mystery. Why do some people live and some die?"

Linda Rock, executive director of Prairie Haven Hospice in Scottsbluff, NE, agrees that the impact of scrutiny on access will be felt more deeply in rural areas. "I believe that some programs may not be able to survive the increased scrutiny. Or they may limit their services or service areas, so patients and families who need and qualify for hospice care will not be served. So many of these hospices are a subsidiary of a small hospital," Rock says. "In these programs, staff

is shared, resources are shared, no one is truly advocating for hospice, and consequently no one is designated to monitor all of the issues around compliance.”

“All of this focus on finance and regulation at the national level—it totally absorbs the leadership of a hospice program—it just does,” says Tehan. “It changes the job. It’s tough being a hospice executive today. Back in 1982 we knew taking money from Medicare meant we would be accountable—but we had no idea what that really meant. I think good hospice care is still being delivered, but the emphasis is changing, and not in the direction of better quality of life for dying patients,” she says.

Christy Whitney believes that the current scrutiny of hospice care, which can jeopardize access, is off target in terms of real problems. “The intent to make hospice more ‘compliant’ through more oversight has made the hospice regulatory environment more complex—which makes it harder to comply. It inspires our staff to be more worried about breaking the law than advocating for patients’ real needs—as though we might give hospice care to someone who doesn’t deserve it. If you have to spend so much time fighting audits and pulling charts—that doesn’t seem right.”

Whitney, who says she tries to teach her staff not to overreact and to keep the hospice mission paramount, will be exploring these issues in a workshop on the ethics of regulatory compliance at the upcoming NHPCO management and leadership conference in Oxon Hill, MD, in April.

“We still don’t have good prognostic tools and, to compound the problem, we know hospice alters the natural trajectory of the terminal disease,” says Janet Bull, MD, Chief Medical Officer for Four Seasons in Flat Rock, NC. Some studies suggest that patients who receive hospice or palliative care live longer than matched patients who don’t—but does this outcome just create more problems with regulators? Disease trajectories change with new interventions. Meanwhile, documenting eligibility often requires additional prognosticating tools and, in some cases, invasive diagnostic testing for patients whose treatment course wouldn’t be altered by the test results.

“We are starting to see more in the literature about the use of bio-markers in prognostication. But we have to ask ourselves, are all these tests good for hospice patients?” Bull poses. “I’ve always said never do a medical test unless you plan to do something with the information. If lab tests allow you to keep the patient enrolled on hospice—that could be a good use for them,” she quips. But if the only purpose is to pass increasingly arbitrary government reviews, what’s the sense of that? Does hospice become what it set out to change?

Hospice physicians’ professional judgment gets questioned as staff tries to find the balance between eligibility, documentation and serving dying patients. “As a hospice physician, clearly my emphasis is on the issue of eligibility,” says

Joan Harrold, MD, medical director of Hospice of Lancaster County, PA. Consents must be signed, notice of privacy given, plans of care followed, and documentation completed. “But the assessment of our accuracy in determining eligibility seems to have been reduced to whether the patient died or met the LCD... a measurement against a set of flawed instruments without regard for medical knowledge, judgment or experience.” Harrold believes that hospices need to use the tools available to them to demonstrate good faith efforts at compliance. “In turn, hospices should be firm in demanding that proper use of these tools be considered sufficient when audits are conducted.”

How to Self-Police

Despite the industry’s concern with governmental overreach, there is another side of the coin—the actual abuses by some hospices and the industry’s inability to self-police or hold all hospices to the high ethical standards of the industry’s public image. It’s not even clear what self-policing would entail and whether there are examples from other fields that hospice and its professional associations should draw upon. Examples of problems cited by sources include providing continuous or inpatient level care automatically to all patients upon hospice admission, regardless of clinical justification; providing the higher paying inpatient level of care in nursing home hospice units without gearing up for a more intensive level of staffing and other services; and discharging and then rapidly readmitting patients because they opted to go to the hospital. On top of the basic flaws in care planning and documentation, programs with much higher-than-normal percentages of admitted hospice patients who are discharged alive naturally raise questions about the kind of service they provide.

While such examples may suggest a disturbing disregard for the rules by some hospices and, more egregiously, for the quality of the care provided to their patients, some hospice leaders suggest that the real abuse stems from the inattention of hospice executives to improve their own administrative and leadership skills and the professional skills of their staffs. For the better part of two decades, we have heard from hospice leaders and CMS that the documentation found in hospice medical records too often is inadequate to the task of supporting an ongoing determination of a six-month prognosis. And that doesn’t include the high rates of technical denials, documented by OIG and others. Yet 25 years after those concerns first surfaced, the problems seem greater than ever. Is it unreasonable to ask: where is the training? Where is the accountability? Where is the leadership required to solve these problems?

Nevertheless, it remains puzzling how a few hospices can have average lengths of stay approaching 365 days, but receive little or no regulatory attention,

while others are caught in a cycle of aggressive, repeated claims review and denials. The hospice aggregate cap, which puts a limit on average annual Medicare outlays per patient, was a safeguard on overuse contained in the original hospice law, although it wasn't intended as a tool against fraud and abuse. However, cap recoupments often don't happen until two years or more after the hospice exceeded the cap, limiting their ability to impact admissions practices for hospices with protracted lengths of stay.

Andrew Reed of the hospice data management firm Multi-View Incorporated Systems in Hendersonville, NC, believes that the aggregate cap, if indexed with quarterly immediate withholdings rather than protracted recoupment, could be a better way to manage hospice utilization than the current eligibility scrutiny or MedPAC's proposed U-Shaped Curve for reforming hospice's per-diem payment system. "With a few simple changes, the hospice aggregate cap could be devastatingly effective in reducing Medicare end-of-life expenditures and could elegantly solve the eligibility question," he writes in the January, 2011, *Multi-View FlashPage* (see www.multiviewinc.com).

"Some hospices feel they are doing God's work—and can't take time to track down their legal responsibilities," Barry observes. Adds Wilson, "I think the amount of intentional fraud in hospice is minimal. But the misinformation or ignorance among providers is staggering. Quite frankly, some hospices deserve scrutiny—while others don't," she says. "The scrutiny will weed out some hospices, yet we get calls every week from people wanting to start a new hospice without good reason."

"Combine questionable care with poor documentation, improper and inappropriate billing, and very aggressive incentives for admissions and you've got a recipe for disaster," says Mary Michal. "I think some of the regulatory scrutiny we're getting could have been prevented by hospices going back and reviewing OIG's 1999 Hospice Compliance Program Guidance.⁴ I'm concerned about some of what I'm hearing from the field, even if the government is picking up on the wrong things. I don't say it's the norm, but some hospices may not have updated their internal systems to conform to changes in regulation such as the revised conditions of participation. Whistleblowers, whether or not they ultimately prevail in court, are alleging that hospice leadership is asking staff to chart in ways that are inconsistent with care at the bedside, or to use cookie-cutter charting. Also, if the charting fails to demonstrate a connection between what the patient needs and what is provided—that's a problem," Michal says.

⁴ See: <http://oig.hhs.gov/authorities/docs/hospicx.pdf>.

What Can Hospices Do About it?

Experts recommend that hospices re-double their efforts to improve documentation and sharpen internal processes related to marketing, intake, assessment, care planning, team meetings, quality improvement and compliance—to make these processes work in an integrated way and permeate the culture of the organization. (See *HCL* November 2010 for more ideas.) “I don’t think you can go back to the basics too often,” says hospice consultant Janet Carroll in Lancaster, PA. “Re-read the conditions of participation and build your processes from there.”

“Every CEO should be asking: Are we really as good as we think?” says Michal. “A shared vision for compliance is more important than ever. There’s not a hospice in the country that couldn’t look at its systems and prepare better for this era of increased scrutiny.” Corporate compliance programs, although technically not required for hospices, increasingly will be an essential tool for surviving regulatory scrutiny.

Heather Wilson also recommends keeping a close eye on what the Medicare contractors are doing. “Hospices should be scrutinizing the scrutinizers.” Wilson’s RAC Assistance for Hospices website had 1,700 hospice professionals sign up to join, and it is now transitioning to www.hospicescrutiny.com to include tracking of other government contractors.

“How do you separate the bad apples from the majority? Maybe it’s time to start turning them in to the government,” says Connie Raffa, an attorney with Arent Fox in New York City. That approach may seem distasteful, but how else can providers stem problem behavior? Raffa also wonders why the government can’t use its computer programs to target the real bad apples, instead of broad-scale, subjective denials of eligibility. Others note, with a touch of cynicism, that perhaps the government doesn’t want to make those lines too clear.

Charles von Gunten, MD, Provost of The Institute for Palliative Medicine at San Diego Hospice urges hospices not to create a climate of fear in response to government scrutiny. “We must stay laser focused on the needs of the patient right in front of us.” Von Gunten does not believe there is intent by the government to limit hospice care for people who are eligible, and says its level of scrutiny is no more than what other categories of health providers currently face. Past, high-profile examples include scrutiny of the national hospital chains Tenet and Humana/HCA and the focus on mushrooming home health care expenditures in the 1990s.

“If there is no evidence of self-governance and self-policing, government remedies will always feel heavy handed. But when Wall Street says hospice is a ‘buy,’ that’s a problem.” Genuine physician judgment isn’t under attack, von Gunten says, but rapidly signing patient certification forms without knowing

anything about the patients or applying professional judgment to the certification is and should be. “There are real examples in the hospice industry of gaming the system—with the primary goal of making money. For all hospices, you want to double down on quality, and don’t pull back from your mission. Be prepared to ask: What makes hospice care the best option for this patient?”

For NHPCO’s Don Schumacher, the first solution to the regulatory challenge is mandated, regular, preferably annual, in-person certification survey visits by government agents, which have been done less often in recent years as post-payment audits were stepped up. “You can now get licensed in some states and not be surveyed for 11 years,” he says. “So for CMS, rather than taking it on themselves to root out the bad players on a case-by-case basis, everybody in hospice gets a haircut.”

More frequent certification surveys, especially if accompanied by teaching and an effort to ensure that the hospice is doing things right, might give providers a more specific sense in real time of where their problems lie. In Colorado, in an example of self-policing, hospices successfully lobbied recently for a law requiring hospice surveys every three years, paid out of hospice licensing fees, reports Christy Whitney. Certification surveys don’t directly address eligibility questions, but a hospice that passes a rigorous survey based on the Medicare conditions of participation is more likely to comply with the technical and other concerns of regulators.

CMS claims that there’s no funding for more frequent certification surveys, Schumacher relates. He thinks one possible answer could involve using the private accreditation organizations with deemed status for hospice care to survey all hospices, even though that may cost more to providers. He is also concerned that the government’s data gathering instruments, used to guide changes in the hospice benefit, may not be adequate to generate solid data and comprehensive analysis. “I think data is king—and we need more data,” he says, and to this end NHPCO is sponsoring a data-gathering tool and collection process called the Moran Study, with 500 participating hospices. “There’s nothing wrong with accountability, as long as it is done with the industry’s feedback, so that it makes sense.”

Is There a Bright Side?

John Mulder, MD, a hospice and palliative care physician in Grand Rapids, MI, affiliated with the Spectrum health system, describes four levels to eligibility considerations. “There are patients who are eligible throughout their hospice stay, patients who are eligible when they come into hospice but become ineligible later; patients who are ineligible when they come in, but then become eligible; and patients where the documentation does not support eligibility for hospice care

from start to finish. My contention is that all four of those conditions will exist in any hospice at any time,” reflecting the inherent ambiguities of prognostication. The real question is: what’s the preponderance of cases on the hospice’s caseload? Are they mostly admitting patients who die on service within a reasonable time frame—or not?

“I had an experience recently before an administrative law judge, at the request of a hospice that wanted me to represent its interests in appealing denied claims. I was very intrigued by the judge’s line of questioning: What does it look like to die with end-stage liver disease? How do we as physicians or hospices determine the difference between chronic and progressively terminal liver disease? He also asked me what I thought the FI was looking for in denying this claim,” Mulder relates.

“It’s clear to me that the documentation piece is absolutely critical for hospices. I’m finding that physician attestations of the patient’s terminal prognosis can be very helpful—if thoughtfully done. They can crystallize what the issues are. The face-to-face visit will also make it easier to see the logical defense of the hospice’s admission decision.”

“The wise hospice leaders are looking at this crisis as an opportunity,” Mary Michal says. “They can distinguish themselves in the marketplace and use documentation as the tool that it’s supposed to be—not just make-work. Yes, we have all of this government oversight going on. But let’s try to align our response to the scrutiny with our own vision and values as a hospice,” Michal says

“When I go out to state hospice meetings, I am heartened by the resolve of the hospice community: ‘We’ll get through this,’ they say. ‘Our eye is on care at the bedside and we’ll find a way to make the numbers work,’” reports NHPCO vice president Jon Keyserling. “That is a consistent theme in the hospice community. But at the same time, clearly, the government’s focus on scrutiny is not going to let up.”

Hospice’s Eligibility Crisis: Actionable Items

- Commit to improving the hospice industry’s ability to self-police. Be fully informed about the eligibility regulatory challenge, follow NHPCO’s and your state hospice association’s regulatory briefs, become a member and/or encourage others to join the Hospice Compliance Network (www.hospicecompliance.net), and track your FI/MAC’s web page.
- Commit to the creation of an efficient and effective corporate compliance program.

- As Weatherbee's Heather Wilson says, scrutinize the scrutinizers. Ask about their methods and validity and their professional qualifications for reviewing hospice claims. What are their financial incentives? Pool this information with your peers.
- Commit to gathering, analyzing and benchmarking quality, utilization and financial data. Join a national benchmarking program and work the numbers.
- Work with national and state professional associations to both demand appropriate behavior from all providers and advocate for appropriate government scrutiny, including streamlining and validating local coverage determination policies for hospice eligibility.

Face-to-Face Enforcement Postponed Three Months *Challenges Remain Unresolved for Providers to Meet Visit Need*

In late December it was announced that enforcement of the government-mandated face-to-face encounter (FFE) between a hospice physician or non-physician practitioner and a hospice patient about to enter a third or subsequent Medicare benefit period was being delayed by CMS for three months to work out some of the kinks in the system. Hospices must still be performing these FFE visits according to schedule, but they can use the three-month delay to solidify their own internal processes for scheduling and performing FFE visits. CMS, which has stated that it can't further postpone or modify this statutory requirement, issued guidance to notify FIs/MACs of the delay in enforcement. FFEs are also required for home health agencies, which received a similar enforcement reprieve.

Hospice providers have been concerned about this new requirement contained in the 2010 health care reform bill (see *HCL*, November 2010, p. 10), both because of the costs of sending physicians out to patients' homes but also because of the difficulty in determining whether any of their new admissions had previously been enrolled by another hospice. The only way to determine for certain is by checking Medicare's Common Working File, yet it is only on-line from 6 am to 6 pm EST Mondays through Fridays, and 8 am to 12 noon on Saturdays. If hospices admit patients referred to them Friday evenings or weekends and start providing billable services before ascertaining if the patient

was entering his or her third benefit period, the claim could be denied for the period prior to the FFE visit. This problem is exacerbated for bills for prior admissions that have not yet been submitted by other hospice providers.

Members of the Hospice Compliance Network listserv have expressed resignation about providing a certain amount of unreimbursed care under these circumstances, but some have suggested that could raise compliance problems of its own related to anti-kickback rules. Hospices will also be challenged by the issue of which FFE visits may be billable as medically necessary. CMS has opined that FFE visits, by themselves, are administrative and therefore not reimbursable. However, some hospice executives have countered that they believe these visits will also fall under the heading of medically necessary and therefore reimbursable. NHPCO has prepared a list of FAQs to assist hospice providers in complying with this regulation at www.nhpc.org/files/public/regulatory/FAQs_Face-to-Face_v2.pdf.

Cultural Differences Swirl in Hospice Care

Cultural beliefs can be a barrier to end-of-life care planning for some Chinese Americans, Anita Creamer reports in the Sacramento, CA, *Bee* newspaper.⁵ Creamer describes cases where the price of upholding traditions of not talking about death and dying can be unintended suffering for elderly patients. She profiles Sandy Chen Stokes, a geriatric nurse who founded and directs the Chinese American Coalition for Compassionate Care (CACCC) and works as a chaplain at the University of California-Davis Medical Center in Sacramento.

Stokes has been a leader in working to overcome cultural misunderstandings about advance care planning and end-of-life care for Asian-Americans. The CACCC website (<http://www.caccc-usa.org/>) includes a variety of bilingual resources. CACCC in January launched the first extensive volunteer training program designed to give Chinese-American volunteers with a passion for providing care the tools to provide linguistically and culturally sensitive care to Chinese patients in hospice or palliative care settings in the State of California. Stokes says only 1 percent of hospice patients nationwide are Chinese-Americans. The California Healthcare Foundation found that 83 percent of Chinese American immigrants say they would want life support removed if they were hospitalized without chance of recovery.

A sharp illustration of cultural differences comes from Vancouver, where dozens of Asian-Canadian condo owners at the Promontory high rise have been protesting plans to build a 15-bed hospice inpatient facility nearby on the campus

⁵ <http://www.sacbee.com/2011/01/16/3327218/cultural-beliefs-a-barrier-to.html>.

of the University of British Columbia. According to the Jan. 17 *Vancouver Sun*, protesters say that the proximity to death brings bad luck—and could lower their property values. The hospice facility proposed by the Order of St. John and UBC medical faculty, to be operated by Coastal Health, has been put on hold because of the protests. The Jan. 13 *Vancouver Globe and Mail* says it has been withdrawn from the agenda of the February meeting of UBC governors because of the controversy.

“It is all about cultural sensitivity,” Chinese-born immigrant Janet Fan told the *Globe*. “We came here as new immigrants with our own belief system. And in our beliefs, it is impossible for us to have dying people in our backyard.” However, as this controversy has roiled in the Canadian press, other Asian immigrants have stepped forward to challenge that view.

Specter of ‘Death Panels’ Still Shadows Hospices

In a recent article in *The Nation* magazine,⁶ Ann Neumann, a hospice volunteer who writes about religion and end-of-life care, describes “Anti-choice at the End-of-Life” and the links between anti-abortion activists and groups mobilized since the 1970s and the current opponents of an Obama Administration proposal to cover annual, voluntary advance care planning consultations between physicians and patients about end-of-life care options. Opponents labeled the measure “death panels.” Writes Neumann: “For the past decade, these same religious organizations have begun working to limit treatment choices for those facing the end of their lives, a development that increasingly impedes meaningful health care and resigns countless elders—including millions of aging baby boomers—to ‘health care’ that does little for, or even damage to, their quality of life.”

The proposal, Section 1233 of the Accountable Care Act, was removed from the bill because of widely publicized opposition from Betsy McCaughey, Sarah Palin and others during the health care reform debate. In November, the Obama Administration quietly reinserted it as a CMS administrative rule, but it was dropped for a second time three days after it was to go into effect. Jane Brody, writing in the Jan. 17 *New York Times*, said Obama essentially gave in to the political pressures for a second time. NHPCO also expressed disappointment at the decision and reiterated the importance of advance care planning (www.nhpc.org/i4a/pages/index.cfm?pageid=6411).

Meanwhile, Bradley Flansbaum, MD, Director of Hospitalist Services at Lenox Hill Hospital in New York City, in a January 17 blog titled “A Hospitalist’s

⁶ Jan. 13, 2011; see: <http://www.thenation.com/article/157751/anti-choice-end-life>.

Lament,”⁷ favorably cites the Atul Gawande *New Yorker* article but raises questions about the feasibility of advance care planning and the physician’s role in end-of-life care. “By that I mean, can we ask people how they want to die and what quality of life they desire ‘in the moment,’ knowing their illness will evolve and potentially change their perspective? The answer is no.”

He cites four recent, provocative articles in the medical literature challenging physicians to rethink conventional approaches to end-of-life care and advance care planning. Sudore and colleagues in *Annals of Internal Medicine* question traditional objectives of advance care planning and argue that it is better to prepare patients and surrogates to participate with clinicians in making the best possible in-the-moment medical decisions. Henry Perkins in the same journal says the advance directive concept itself may be fundamentally flawed, offering only limited benefit. Sulmasy and colleagues in *JAMA* explore an alternative substituted interest model of medical judgments. Fried and colleagues in *Archives of Internal Medicine* study changes in health status preferences in older adults over time. (All four articles are linked in Flansbaum’s blog.)

Other Hospice Regulatory News and Updates

- MedPAC held another discussion of hospice payment processes and adequacy at its January 14 meeting in Washington, DC. Based on its exploration of the supply of providers, volume of services, quality of care, access to capital, and Medicare payment and costs in 2008, MedPAC recommends that Congress increase hospice payment rates by 1 percent in 2012. It found that hospice profit margins were 5.1 percent in 2008, according to analysis of Medicare hospice claims and cost reports from CMS, with for-profits reporting higher margins than non-profits.
- The transition from fiscal intermediaries to Medicare Administrative Contractors for hospices and other community-based providers that bill Medicare continues to advance, with CIGNA Government Services of Nashville, TN, recently confirmed as the MAC for Jurisdiction C, including the states of Colorado, Delaware, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, West Virginia, Wyoming and the District of Columbia. No timeline has been set for the transition. The contract for Jurisdiction 6 is still under protest, but Palmetto GBA has been fully implemented as a MAC.
- In December, CMS issued its fourth national provider Comparative Billing Report, summarizing revenue codes used by approximately 5,000 hospice

⁷ <http://blogs.hospitalmedicine.org/SHMPracticeManagementBlog/?p=1096>.

providers nationwide. This report is designed to provide comparative data on how an individual hospice compares with other providers for utilization patterns of services, beneficiaries and diagnoses. Actual reports are only available to the provider that submits the data, with billing information summarized to ensure privacy. For more information or to review a sample of the hospice report, see www.cbrservices.com On Jan. 24, HHS Secretary Kathleen Sebelius and U.S. Associate Attorney General released a new report showing that government health care fraud prevention and enforcement efforts recovered more than \$4 billion for taxpayers during Fiscal Year 2010. This was said to be the highest amount ever recovered from people who attempted to defraud seniors and taxpayers. See their news release at: <http://www.hhs.gov/news/press/2011pres/01/20110124a.html>; and the annual Health Care Fraud and Abuse Control Program Report for Fiscal Year 2010 at: <http://go.usa.gov/Y1f>.

Hospice and Palliative Care Quality Trends

- In an article in *Healthcare Executive*,⁸ Andrea Kabcenell and James Conway of the Institute for Healthcare Improvement describe “six leadership actions in end-of-life care for health care executives.” Based on the work of the American College of Health Executives’ Ethical Policy Statement and the Expert Panel on End-of-Life Care in Massachusetts, they urge executives to play leading roles in making palliative care that honors the preferences of patients with advanced illnesses a reality. They also cite an estimate by NQF’s National Priorities Partnership that one million-plus Americans die each year without receiving important palliative care services. Among the actions they recommend are knowing your organization’s current performance through patient safety leadership WalkRounds, surveying patients and families after hospitalizations, and meeting with palliative care and chaplaincy staff and nursing home administrators.

- In the Hospice and Caregiving Blog at Hospice Foundation of America, Krista Renenger⁹ reports on HFA’s new resource, “Aging and End-of-Life Challenges in the Lesbian, Gay, Bisexual and Transgender (LGBT)

⁸ Kabcenell A, Conway JB. End-of-life care: Six leadership actions. *Healthcare Executive* 2011 Jan/Feb; 26(1): 74-76. See: http://www.ihl.org/NR/rdonlyres/D1D8FA60-CBFF-4FD5-81F2-795A51743436/0/KabcenellConwayEndofLifeCareSixLeadershipActions_HCExecJan11.pdf.

⁹ January 12, 2011; See: <http://blog.hospicefoundation.org/2011/01/new-program-focuses-on-aging-and-end-of.html>.

Community.” A free online webinar written by Kimberly Acquaviva helps organizations to meet the needs of older LGBT adults. The webinar is part of a larger online library, the Hospice Information Center, supported by CMS, which includes information on services, advocacy and available online resources.

- The Hastings Center Cunniff-Dixon Awards, honoring physician excellence in end-of-life care, were recently announced. Ann Allegra, MD, FACP, FAAHPM, director of medical programs at Kansas City Hospice and Palliative Care, Kansas City, MO, received the senior physician award of \$25,000. Anthony Nicholas Galanas, MA, MD, medical director of the Duke University Hospital Palliative Care Service, Durham, NC, received the midcareer physician award, also \$25,000. Early career awards of \$15,000 were given to Stefan J Friedrichsdorf, MD, of Children’s Hospitals and Clinics of Minnesota; Savithri Nageswaran, MBBS, MPH, of Wake Forest University Baptist Medical Center; and Eric W. Widera, MD, of the San Francisco Veterans Affairs Medical Center.... Meanwhile, recent research by Dale Lupu in the *Journal of Pain and Symptom Management*¹⁰ identifies an acute shortage of HPM physicians, with 4,487 hospice and 10,810 palliative care physician FTEs needed to staff existing programs at appropriate levels. But only 4,400 physicians now work in HPM, most of them part time.
- **More Palliative Care News:** A call for papers has been issued for the conference “Death: Its Meaning, Metaphysics and Morality,” planned for July 6-7, 2011, at Newcastle University in the United Kingdom (see: <http://www2.gsu.edu/~wwwcfe/9086.html>). Abstracts should be 150-300 words and submitted by Monday, Feb. 28 to Thom Brooks: t.brooks@newcastle.ac.uk Indiana University’s Melvin and Bren Simon Cancer Center just received a \$3.4 million grant from the Walther Cancer Foundation to launch a program in palliative cancer care research and education. It will train health care providers in palliative care practices, test novel interventions such as yoga or music therapy, develop and test programs to address the unmet needs of family caregivers, and assess the impact of palliative care on the health care system. Greg Sachs, MD, a professor at IU and a prominent researcher on palliative care for dementia patients, is co-leader of the new program (see:

¹⁰ December 2010; 40(6): 899-911.

<http://www.cancer.iu.edu/news/article.php?id=3994>) The American Osteopathic Association is releasing its Osteopathic Education in Palliative and End-of-Life Care curriculum, with four plenary sessions and 13 interactive educational modules on a spectrum of end-of-life concerns (see: <http://www.osteopathic.org/inside-aoa/development/quality/aoa-quality-initiatives/Pages/palliative-care.aspx>). These are based on the EPEC project housed at Northwestern University Medical School (<http://www.epec.net/EPEC/webpages/index.cfm>.)

HOSPICE COMPLIANCE LETTER

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