



Hospice Program Integrity Recommendations

Projected increases in the elderly population and the number of Medicare beneficiaries will likely result in continued growth in utilization of hospice services. As one of the more unique, patient-focused and coordinated health care delivery models, the hospice community is willing to work closely with Congress, CMS and other provider groups in the health care spectrum toward our shared goal of protecting Medicare beneficiaries and preserving access to hospice care for future generations.

The program integrity reforms recently enacted or scheduled for implementation in the near future, all have the support of the hospice community. In addition to the face-to-face requirement, the requirement for a brief physician's narrative as part of recertification and the 100% medical review of certain patients are important steps in guaranteeing that hospice patients are eligible for the benefit. The National Hospice and Palliative Care Organization (NHPCO) continues to support these provisions and looks forward to their full implementation.

NHPCO believes that the proposed recommendations outlined below will further ensure needed transparency and appropriate oversight of providers caring for patients and supporting families at the end of life.

Summary

NHPCO and the hospice community strongly support policies that promote transparency, integrity, and accountability. Compliance with state and federal operating guidelines and statutes promotes trust and confidence in providers. Moreover, adherence to regulatory requirements protects consumers who are turning to hospice in increasing numbers at the end of life. NHPCO proposes the following recommendations on how to strengthen program integrity within the Medicare program. These recommendations were developed by NHPCO's Public Policy Committee and the Hospice Action Network Board of Directors, and was approved by the NHPCO Board of Directors.

In 2012, NHPCO responded to the Senate Finance Committee's solicitation for recommendations on how to strengthen program integrity within the Medicare program. These recommendations are intended to promote continued patient choice, and preserve the existing trust and support of hospice as the provider community is called upon to provide high quality service to an increasing number of beneficiaries. These proposals are specifically aimed at balancing the need for appropriate access to hospice care and preserving the high level of program integrity that has been synonymous with the Medicare Hospice Benefit since its original implementation.

Recommendations

1. **Require all hospice programs to be surveyed by Medicare no less frequently than every three years:**
 - a. An HHS Office of the Inspector General (OIG) report¹ (<http://oig.hhs.gov/oei/reports/oei-06-05-00260.pdf>) found that the current certification system for hospice was not providing sufficient oversight relative to other Medicare providers. OIG noted that “the frequency of hospice certification is far different from the certification frequencies required by nursing homes, hospitals, and home health agencies” and recommended regulatory or statutory changes to increase certification frequency. According to the report, the majority of hospices were surveyed within 6 to 8 years (depending upon available resources), while almost 15 percent averaged 3 years past due. More frequent surveys of hospices would help identify those not operating in compliance with regulatory requirements and also improve quality of care.
 - b. This frequency requirement is consistent with OIG’s recommendation.
2. **By [one year after enactment], require all Medicare hospices to have an operational corporate compliance plan consistent with the Office of Inspector General’s Compliance Program Guidance for Hospices.**
 - a. First issued in 1999, The Department of Health and Human Services’ Office of Inspector General guidance is intended to help hospice providers design effective voluntary compliance programs to prevent fraud, waste, and abuse in government health programs, including Medicare and Medicaid.
 - b. OIG has noted that, “Encouraging the health care industry to adopt voluntary compliance programs is an important prevention strategy to reduce the risk of fraud, waste and abuse in federal health care programs.”
 - c. “The guidance is intended for all hospice providers, whether for-profit or nonprofit, large or small, urban or rural, with the expectation that each hospice will tailor a compliance program to meet its particular needs.”²
 - d. Similar to other guidance issued by the Office of Inspector General for clinical laboratories, hospitals, home health agencies, third-party medical billing companies, and durable medical equipment suppliers, the hospice guidance is based on the following seven elements: 1) implementation of written policies, procedures, and standards of conduct; 2) designation of a compliance officer; 3) development of training and education programs; 4) creation of a hotline or other measures for receiving complaints and procedures for protecting callers from retaliation; 5) performance of internal audits

¹ The Office of the Inspector General released a similar report in August 2013, “Frequency of Medicare Recertification Surveys for Hospices Is Unimproved,” which highlighted that the frequency of hospice certification surveys has not improved since 2005. The report suggested establishing a 3-year survey frequency mandate via statute or regulation. <http://oig.hhs.gov/oei/reports/oei-06-13-00130.pdf>.

² Office of the Inspector General. “Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight.” OEI-06-05-00260. April 2007. <http://oig.hhs.gov/oei/reports/oei-06-05-00260.pdf>

to monitor compliance; 6) enforcement of standards through well-publicized disciplinary directives; and 7) prompt corrective action to detected offenses.

- e. The guidance identifies specific compliance risk areas for hospice providers, such as admitting patients to hospice care who are not terminally ill, underutilization of services, improper arrangements with nursing homes, and high-pressure marketing of hospice care to ineligible beneficiaries.

3. Disclosure to the patient and family of ownership interests between the referral source and a hospice.

- a. Broadens existing statutory disclosure requirements so that consumers and stakeholders are better informed of existing relationships.
- b. Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.
- c. Person with an ownership or control interest may mean a person or corporation that—
 - (1) Has an ownership interest totaling 5 percent or more in a disclosing entity;
 - (2) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
 - (3) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
 - (4) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
 - (5) Is an officer or director of a disclosing entity that is organized as a corporation; or
 - (6) Is a partner in a disclosing entity that is organized as a partnership.

4. Require that owners of a hospice that ceases operations with an outstanding balance due to the Medicare program not be permitted to participate in the ownership and/or management of another hospice unless they are current on repayment of the outstanding obligation.

- a. In recent years, an increasing number of hospice programs have exceeded the aggregate hospice payment cap. This circumstance is believed, in part, to be the consequence of patient mix (i.e., service to patients who might have a propensity toward longer hospice stays) and admission patterns. Notwithstanding how hospice programs might reach the aggregate payment cap, the hospice community supports policies that recognize the value of the cap from a program integrity perspective. The cap serves as an effective mechanism to protect against excess hospice payments. When a hospice program exceeds the payment cap, arrangements must be made to reimburse the government for payments made in excess of the cap amount. Hospice providers must be held accountable until the obligation is satisfied, either by full repayment or entry into a repayment plan where the debt is paid over time.
- b. The implementation of a cap repayment assurance initiative protects taxpayers from assuming debt obligations associated with liabilities that are the result of programs that exceed the hospice revenue “cap.”

- 5. Direct CMS contracted Medicare Administrative Contractors (MACs) to issue notices of cap liability within 12 months of the end of the cap year.**
- a. As a complement to NHPCO’s proposed cap repayment assurance initiative, CMS MAC contractors should assist providers by furnishing timely information about potential cap liabilities. While the hospice payment cap calculation is straightforward, it is influenced by factors that add to its complexity. Identifying factors such as readmissions and discharges for reasons other than death make it difficult for providers to monitor their own cap status. Such complexities are best addressed with timely and accurate information that only the MACs can provide. Current contractor practices often leave providers waiting in excess of two years after the end of a cap year for such data. Such delays leave providers “in the dark” for too long and likely result in continuation of practices that perpetuate cap excesses.
 - b. The proposal to require contractors to give providers cap related information within one year will limit cap exposures, making repayment more likely, and promote compliance.
- 6. Allow physician assistants and clinical nurse specialists to perform the statutorily mandated face-to-face encounters, bringing them in alignment with nurse practitioners, and mandate that the face-to-face encounter occur not later than 7 calendar days after a new patient’s election of hospice, in order to address concerns of small and rural providers in meeting their compliance obligations.**
- a. The Affordable Care Act (ACA) included a MedPAC recommendation to require a hospice physician or nurse practitioner to have a face-to-face encounter with a hospice patient prior to the 3rd benefit period recertification, and again prior to each subsequent 60-day recertification. Because patients who are new to a particular hospice may have had a previous hospice admission elsewhere, hospices have to research the “hospice history” of every new patient in order to determine whether a face-to-face visit is required prior to admission. On weekends and holidays this information may not be available from Medicare, so a short “grace period” is needed.
 - b. The hospice community supports the intent of the face-to-face encounter requirement and is working hard to be in compliance, even as the requirement stretches hospice physician and nurse practitioner resources.
 - c. The current limits on who can conduct the face-to-face encounter and the tight timelines specified in the rule for compliance do not reflect the operational constraints of hospice programs, especially for small and rural hospices. Hospices may be forced to delay admission to certain patients seeking to elect hospice if they feel they will not be able to comply with the present timeline required to conduct the initial face-to-face encounter requirement.

- 7. The hospice community is asking that clinical nurse specialists and physician assistants also be allowed to conduct the face-to-face encounter, and that hospice programs be afforded 7 days after the initial election of services to fulfill the requirement. The Centers for Medicare and Medicaid Services (CMS) should fully evaluate the impact of the face-to-face requirement on patients with longer lengths of stay to determine if the regulation has had the intended effect.**
 - a. In its March 2009 report to Congress, MedPAC recommended that CMS implement policies “to increase provider accountability” especially with regard to long-stay hospice patients and address elements of the hospice payment system that “may have led to inappropriate use of the [hospice] benefit among some providers.”
 - b. Among the MedPAC recommendations was a requirement that a hospice physician or nurse practitioner have a face-to-face visit with a patient before recertification of the patient for the third benefit period (which typically begins after 180 days) and before the start of any subsequent benefit periods.
 - c. The ACA adopted the face-to-face requirement effective January 2011. The ACA does not provide for reimbursement for the cost to providers of administering this new requirement.
 - d. The hospice community has worked cooperatively with CMS to ensure compliance with the face-to-face requirement, but little data is available yet to identify whether implementation of the requirement correlates with appropriate or inappropriate hospice utilization.
 - e. Considering the burden of the face-to-face requirement and the precedent the policy might make for additional accountability provisions, NHPCO encourages CMS to assess whether the face-to-face requirement has had the intended effect.
 - f. NHPCO strongly endorses accountability and transparency and, in fact, was instrumental in establishing the face-to-face encounter. However, NHPCO believes that such requirements should be measured for their intended effect and appropriate action should be undertaken to recognize the results of the assessment.
- 8. Require nursing homes, who have a contract with a hospice program, to make a good faith effort to enter into contracts, with at least two certified hospices in their service area, if they exist. The proposal would make it a condition of certification for hospices to meet the requirement of a good faith effort to have the contracts in place a condition of certification.**
 - a. NHPCO has long supported policies that promote patient choice with regard to personal decisions about the care they receive and the site of care (i.e., home, nursing facility, assisted living facility, etc.)
 - b. This concept extends patient choice in nursing facilities that choose to make hospice services available in their facilities. Allowing patients to choose among hospice providers respects patient preferences while at the same time promoting rational competition among hospice providers.

- c. If patients are able to choose among hospice providers, the provider response will likely comprise better quality and range of services as providers seek to be included as a provider of hospice care.
- 9. Require as part of a hospital discharge planning process that any patient referred for possible admission to hospice be informed of all Medicare certified hospice programs in the service area, who ask to be included, as well as noting those with whom the hospital has an ownership relationship.**
- a. The Social Security Act (SSA) at §1861(ee) requires Medicare participating hospitals, as part of their discharge planning evaluations, to share with each patient, as appropriate, a list of Medicare-certified home health agencies (HHA) that serve the geographic area in which the patient resides and that request to be included on the list. In addition, the SSA prohibits hospitals from limiting or steering patients to any particular provider of post hospital care, and must identify those HHAs to whom the patient is referred in which the hospital has a disclosable financial interest or which the HHA has such an interest in the hospital.
 - b. The SSA, § 1861(ee) requires a hospital's discharge plan to include an evaluation of the patient's likely need for post-hospital services, including hospice care. But consistent with the current home health agency requirement applicable to home health agencies, the hospital also should be required to provide appropriate patients with a list of Medicare certified hospices that serve the area and that have asked to be included on such a list. Likewise, the discharge plan should not specify or limit the patient's choice of a qualified hospice, and the hospital should identify those entities to whom the patient is referred in which the hospital has a disclosable financial interest between it and any providers to which it refers.

If you have any questions regarding these proposals or would like additional information, please contact Angie Truesdale, Vice President of Public Policy, at atruesdale@nhpco.org.

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