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Levels of care in hospice:

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with pioneering hospice physician
Marcia Levetown, MD, MMM, HMDC, FAAHPM

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About the presenter

Marcia Levetown, MD, MMM, HMDC, FAAHPM

Objectives

- Clarify the 4 levels of care that Medicare requires of all hospices
- Understand eligibility and expectations for Continuous/Inpatient Care
- Understand the team's responsibility for and management of the Continuous Care/IPU patient

4 Levels of Care

- Routine Home Care
- Respite Care
- Continuous Care
- Inpatient Unit Care

CARE for ALL PATIENTS

- Patient or representative must agree to hospice and forgo other Medicare benefits
- Certification of terminal illness by 2 physicians
- Complete nurse assessment within 48 hours
- IDT initial plan of care within 5 days
- Recertification of terminal illness by an NP or MD via home visit on same calendar day if the patient is enrolling in the 3rd or later benefit period

Routine Home Care

- Patient is evaluated to be adequately cared for at his/her designated home. Visit frequency established by the IDT. Minimum standards of frequency set by CMS.
- Minimum of nurse visits once every 2 weeks.
- DME, Meds (with rare exception), Emergency med pack, PT/OT/RT as continue to benefit the patient, all tests and interventions are paid for by the hospice.
- XRT if continuing to be beneficial is paid for by hospice-shoot for reduced number of fractions at higher dose and negotiate the price.
- HHA, Chaplains, SW.
- 13 months bereavement support.

Respite Care

- Up to 5 consecutive days per episode, usually not >1x per benefit period
- Patient is stable on current treatment
- Must be moved to a Medicare certified inpatient facility (not a residential care home or ALF) that offers 24/7 nursing care for the respite period

Purpose of Continuous/ IPU Care

- **Continuous Care** may be provided during a period of crisis to maintain an individual at home
- **Inpatient Care** may be provided during a period of crisis to the patient who does not want to remain at home
- The "**period of crisis**" is defined as a patient requiring predominantly skilled nursing care to palliate or manage acute medical symptoms
- If the **caregiver** has been providing skilled care and is **unable or unwilling**, this may precipitate a crisis, necessitating a nurse to provide such care

Vagaries of Continuous Care (CC)

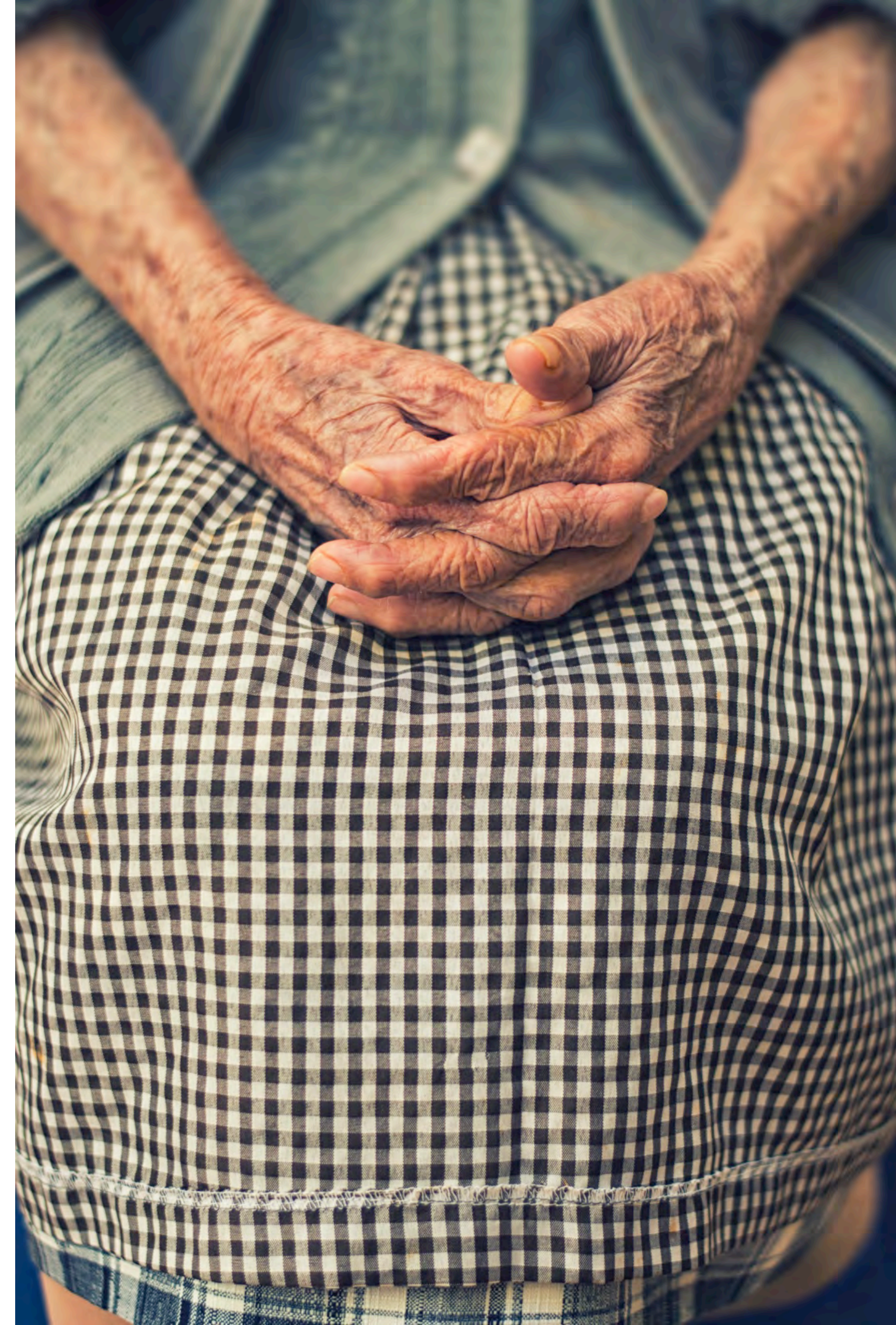
- Precipitating event is a PATIENT crisis (not family), generally symptoms out of control
- Care must be provided in the home, not in a nursing facility
- A minimum of 8 hours of care must be provided in the midnight to midnight period of 24 hours

Vagaries of Continuous Care (CC)

- A nurse (RN, LPN, LVN) must provide at least 50% of the care
  - If the hands on care is 12 hours, nurses must provide >= 6 hours
  - If 24 hours of care, the nurse must provide 12 hours
  - If nurse is present for 8 hrs + aide is present for 10 hrs, CC cannot be billed!
    CGS: https://www.cgsmedicare.com/hhh/coverage/coverage_guidelines/continuous_home_care.html
  - Not counting aide hours to get to 50% nursing is not allowed
    Palmetto: https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/JM-Home-Health-and-Hospice~A5AJF65004

Does This Patient Qualify for CC?

- 87 yo lady with lung CA, multiple meds, incl CNS. Develops new onset Sz, vomiting. RN eval, lorazepam and phenytoin are started
- RN remains w/ pt 4 hours (10 AM – 2 PM) until the seizures cease, provides skilled care and family teaching
- Pt's elderly husband is overwhelmed and states he cannot provide sufficient care for his wife. The children all live out of town.
- Does this scenario qualify for CC?
- What else needs to happen?



Scenario

- If your wife of 65 years was seizing at home for the first time, how would you feel?
- What would be helpful?
- What are the next steps?
- What does CMS expect/ require?
- What needs to be documented?

Scenario (continued)

- An LVN is assigned for the rest of the day, beginning at 2:00 PM-MN.
- An aide is assigned to pt from MN-8:00 am
- LVN returns at 8:00 x 4 h to administer meds, assess patient, provide family education.
- SW works w/ pt’s family to identify alternative care for the patient.
- LVN works 15:00-MN to monitor for BT szs, give sz meds, monitor for N/V, and administer anti-nausea meds

Scenario
(continued)

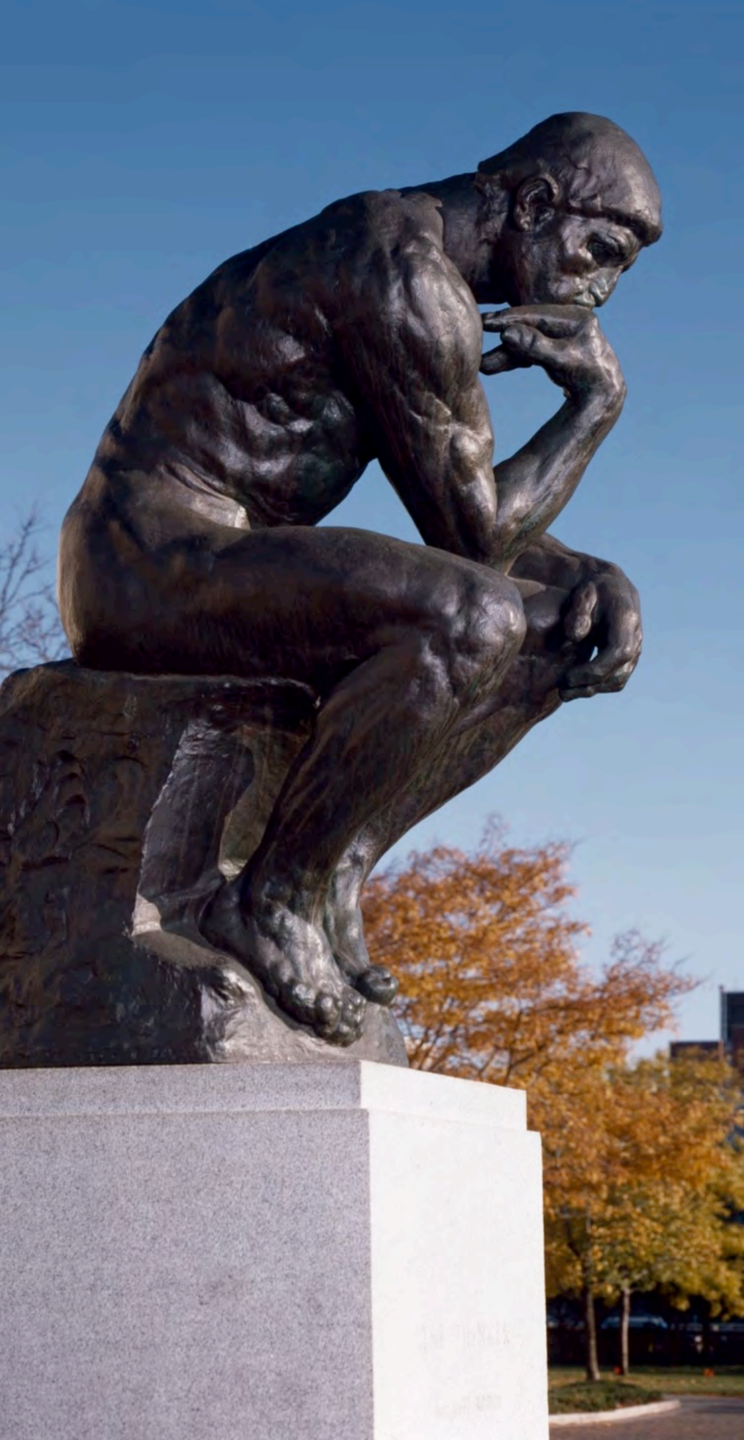
- Which of the services listed qualify the patient for CC?
- How long should CC generally last?

Criteria for Continuous/ IPU Care

- Intractable nausea, vomiting or diarrhea
- Uncontrolled pain
- Respiratory distress
  - Rales and/or rhonchi
  - Increased congestion
  - Periods of apnea
  - Rapid respirations
  - Labored respirations
  - Ineffective airway clearance

Criteria for Continuous/ IPU Care (continued)

- UNEXPECTED, ACUTE change in level of consciousness (i.e., delirium)
  - Increased lethargy, somnolence
  - Suddenly more alert
  - Increased restlessness
- UNEXPECTED, ACUTE difficulty swallowing
- Seizures
- Hemorrhaging
- Teaching for new or complex treatments

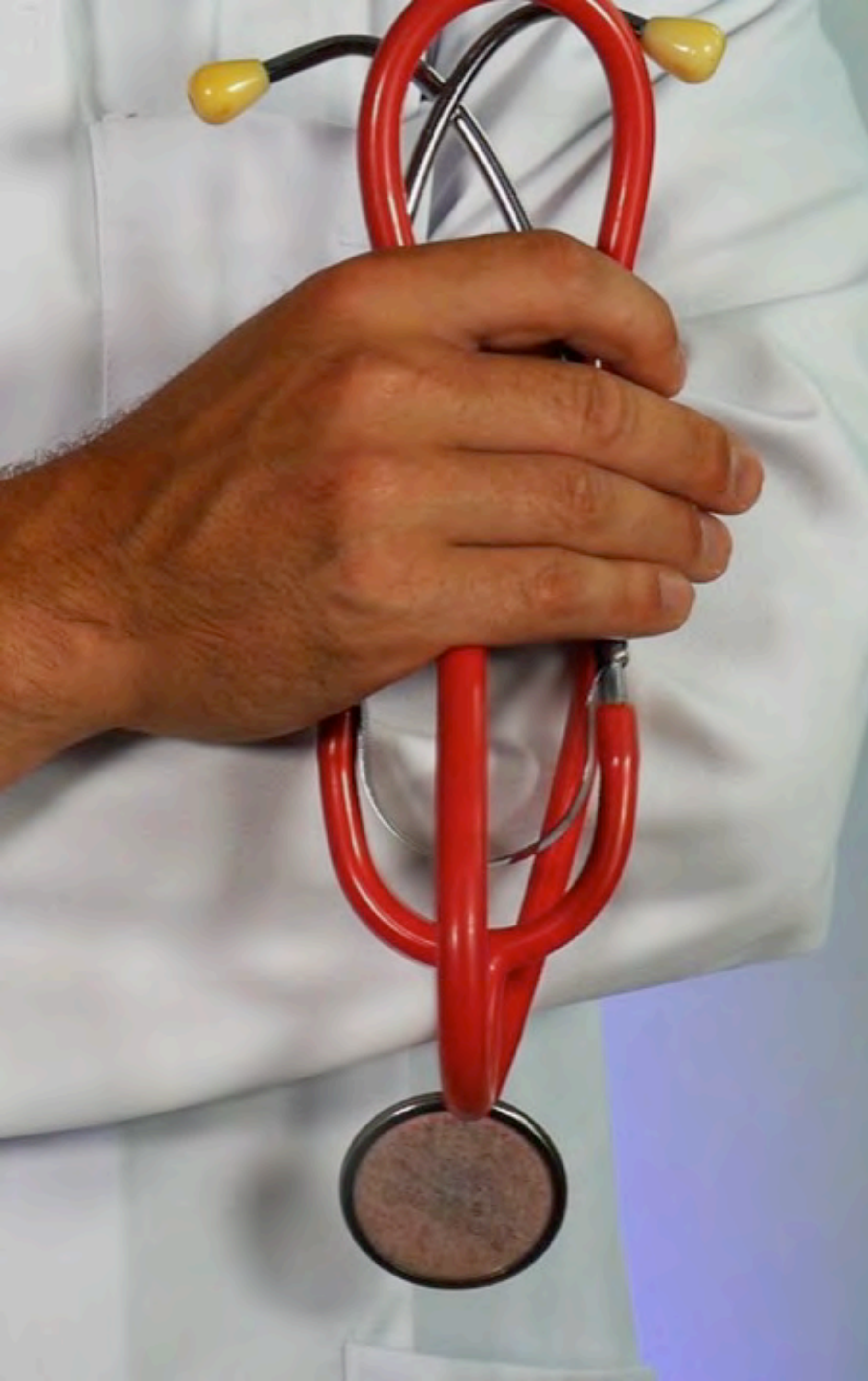


Recognizing the Need for Continuous/ Inpatient Care

- Increased calls and planned visits for pain or sx mgmt
- Unplanned or on-call visits, ED visits
- New and/or complex medications
- Patient is dissatisfied with current sx control
- Family or caregiver is dissatisfied with the patient's level of comfort
- Marked change in care plan for the patient, need for teaching to enable adequate care

Role of the Interdisciplinary Team (IDT)

- Recognizing
- Defining criteria
- Starting
  - Plan of Care for Shift Care
- Daily evaluation and documentation
  - IPU example
- Immediate and reinforced counseling discontinuing continuous/inpatient care
- Discharge planning



Patient Must Require SKILLED NURSING Care

- Documentation should clearly indicate nature of PATIENT-RELATED crisis and need for skilled care

Skilled Care

- Involves skilled observation and monitoring
  - Nursing assessments of pain/sx, VS as appropriate, administration of and documentation of response to medical interventions
- What do YOU think the MD role is/should be for CC?

Evidence for Skilled Need

- **Varying need** for pain or psychotropic medication
- Seizure activity
- Distressing alteration in level of consciousness
- Dressing changes/wound care - multiple sites/ complicated
- Ostomy care – new/complicated
- Patient and/or caregiver educational needs
- Suicide threats

Managing Symptoms

- **Distressing** sx assoc'd w/ impending death
  - Agitation
  - **Changes in blood pressure, pulse, respirations?**
- Dysfunctional / unmanageable behavior
- Uncontrolled pain
  - Sudden onset
  - Ongoing pain control/management
  - Alternative modalities of pain control

Assessment for Continuous/ Inpatient Care

Ask yourself the following questions:

1. Does the patient require a SKILLED level of NURSING care?
2. Does the patient lack the ability to perform the necessary skilled care themselves?
3. Does the patient have a caregiver that is unwilling or unable to perform the necessary skilled care?
4. Is the patient/family at risk for revocation?
5. Is there a marked change in pt care needs?

Each State Has Its Own Regs on CC Care.
Get to Know Yours!

- Ex: DHS in Texas requires daily physician oversight documentation for Medicaid recipients

Can this be billed as CC?

- LPN spends 4 hours caring for the patient
- HHA spends 6 hours

Can this be billed as CC?

- Pt has C line inserted to provide access for continuous opioid infusion for pain control + antiemetic for continuous N/V.
- On return home, Hospice Nurse spends 2 h teaching the family how to give IV medications, returns in evening for 1 h.
- HHA provides 3 h of care.
- Nurse spends 2 h phoning physicians, ordering meds, documenting and revising the plan of care.

Determination: NO

- Despite 8 h of service, this does not constitute CC
  - 2 of the 8 nursing hours were not activities related to direct patient care.

Does this scenario qualify for IPU/CC?

- Patient experiences severe pain and episodes of vomiting.
- Nurse remains with pt for 4 hrs (10a-2p) until the the pain is under control, providing skilled care and family teaching.
- Pt's wife states she is unable to provide care for her husband.
- HHA monitors for 24 h from 2p, total of 8 h of direct care the 1st day.
- Nurse returns intermittently for a total of an additional 4 hours to administer meds, assess pt & relieve aide
- SW provides 3 hrs of services to work w/ pt's wife to identify alternative methods to care for the patient

Determination: YES

- This qualifies as a continuous home care day.
- WHY?
  - Medical crisis, including collapse of family structure. Wife had been providing skilled care.
  - Change in the patient's condition requires the nursing interventions.
  - Since there is no overlap in nursing care, 16 hrs of care would be computed as CC.
- The SW hours do not count towards skilled care! 😩
- If the caregiver had been providing custodial care and his medical crisis resolved within a short time frame, this situation would not have qualified as CC.

Starting Continuous/Inpatient Care

- Discussions with family/caregiver about Continuous/Inpatient Care:
  - What do they feel they need?
  - What should they expect? SHORT TERM
- The RN visits Day 1 and daily contact thereafter to determine what level of care is needed- resolution of the problem re-initiates routine home care
- If family refuses to accept patient back from IPU, must convert to RHC and bill the family for room and board.

MD Order Required x 2

- An MD order is required for a change in “level of care”
- If patient is admitted to CC or IPU, the order is part of the IPOC/Admission Orders on Level of Care
- An order to d/c CC or IPU care is req’d to return to routine level of care
- For both the pt’s sake and for CMS, the goal is to return to standard home (“routine”) care as quickly as possible

Physician Role in CC

- Updates >=2x/ day
- Consider MD visit on day 1, 4, 7…
- Aim for resolution of crisis in 2-5 days

The Feds Are Monitoring This CLOSELY

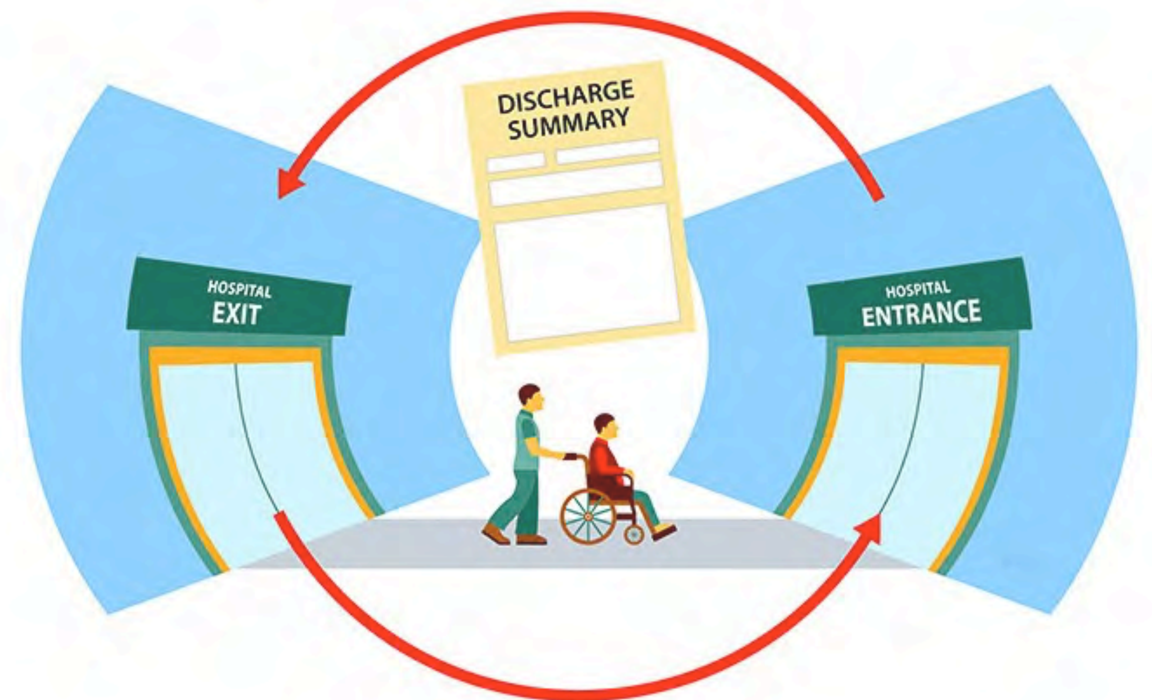
- Justification for higher intensity of services must be clear in every note
- Ongoing efforts to resolve the concerns and the effectiveness of what has been tried should be documented
- If new concerns arise, document these, too

Family Crisis vs Patient Crisis

- The regulations stipulate the crisis must be a PATIENT related crisis
- But what if the patient has no viable caregiver?

Is There an Elevated Risk for Revocation?

- Patient/family dissatisfied w/ Sx control
- Patient/family coping poorly
- Patient/family considering non-hospice treatment due to patient's uncontrolled symptoms or pain



77-yo pt w/ lung CA, caregiver is 80 yo

- Caregiver has been providing care for 4 mo, is now exhausted and scared
- Care consists of assist w/ bathing, ambulation, preparing meals, housekeeping and administering oral medications.
- Pt is dyspneic at rest, reqs assist w/ all ADLs = 9 h of assistance per 24-h

Determination: NO

Does not qualify as CC, since little care requires a nurse.

The patient would, however, be a candidate for an inpatient respite level of care.

Same patient/ caregiver dyad. Qualify for CC?

- Pt's condition deteriorates, now has circumoral cyanosis, RR= 44 and labored, intermittent apnea.
- Nurse performs complete assessment, teaches caregiver methods to make pt comfortable. Nurse returns 2x w/in 24h to assess pt, revises POC after conferring w/ pt's attending & hospice physician.
- The homemaker and HHA sent to assist the caregiver
- Within the 24 hrs, the following direct care was provided:
  - LPN/RN = 3 h,
  - homemaker = 2 h
  - HHA = 6 h

Determination: NO

- 3 of the 11 hours were skilled care requiring the services of a nurse, thus, does not constitute CC, since <50% of total.
- Cannot discount any portion of the home health aide’s hours or provide these services gratis in order to qualify for the CC benefit.

Does this Scenario Qualify?

- Pt's condition deteriorates, w/ incr'g dyspnea & apnea, continuous vomiting and increasing pain. BP decr'g, RR increasing.
- Nurse remains at bedside x 4 h, attempting to control her sxs.
- HHA provides 1h care while RN present. The nurse leaves and HHA remains at the bedside for 3 hours.
- SW talks with the caregiver and remains for 1 hour.
- Nurse returns while the HHA leaves. The nurse remains w/ pt until he dies (2h).
- SW returns and stays with the wife for 1 h until the mortuary arrives.

Determination: YES

- Nurse provided 6 hrs of direct skilled care
- HHA provided 4h of direct care
  - total of 10 h of RN and HHA care, RN>50%
  - Since at least 6 of the 10 hours were direct nursing care, and since nursing care was the predominant service provided during the 10 h, the care **meets the criteria for CC**.
  - Since the RN and HHA provided direct care for the pt simultaneously, it would be appropriate to bill for each, resulting in total of 10 billable hours.
  - The patient received 12 hours of care. The 2 hours for the social worker are **not** counted towards the CC hours.

78 yo Man admitted to IPU with Pick's disease, agitated delirium

- What should be in the IPOC?
- What should be documented daily?
- How long should this patient require IPU care?
- When should discharge planning begin?

78 yo in IPU with Agitated Delirium

- IPU LOS was 12 days
- Agitated delirium mentioned on day of admission and never again
- Failure of documentation, planning
- Potential consequences: accusations of fraud, repayment of reimbursement, fines, add’l audits due to ↑ suspicion

Visits and Documentation

- **Highest standard**: CC/IPU patients receive daily RN visit/contact
- Increased psychosocial support visits too
- Care plans should be updated daily.
  - Documentation should show that POC is being followed & reflect pt, fam response to interventions and changes.
  - Consider as a topic for AUDITS. EDUCATE as needed
- CC/IPU staff document >= q 2 h on CC

Does This Patient Qualify for CC?

- Patient is able to engage w/ visitors but is unsteady when OOB to BR, no other sx
- Daughter is sole caregiver, on FMLA, Mother is in her home. Many friends, family, co-congregants visiting
- Daughter "needs" to attend church 8 h/d

Does This Patient Qualify for CC?

- Same patient develops delirium at night, is lucid during the day

Confusion About Death Attendance

- Not = to being present at the moment of death
- Not a justification for CC
- Death attendance = being present w/in 1-2 hrs of the death.
  - High priority
  - Help with paperwork, emotional distress, transport of body

Documentation

- What is the problem that necessitated CC? Be specific:
  - Pain/ SX- severity, what has been tried to date, complicating factors (↓ LOC, fear of opioids, prior hx of addiction, other mitigating issues)
  - Change in Level of Consciousness
  - Seizures
- What is being done to resolve it and why does that require nursing hours?
- What is the pt’s response to interventions?

Documentation Reminders

- Following terms are NOT recommended:
  - "Stable" – improved due to interventions
  - "Unchanged" – still grossly ill
  - "No problems" – due to anticipatory care

Effective CC/IPU Charting

PIE

- Problem
- Intervention
- Evaluation

The “Contact Visit” Note

- The daily evaluation of the patient can be done as a telephone visit
- This note should be completed by an RN, usually the primary nurse
- It is imperative that the Contact Visit Note be complete and comprehensive, reflecting the patient’s ongoing need for Continuous/ Inpatient Care or a plan to change current LOC

The "Contact Visit" Note (cont.)

- The information obtained during this telephone visit should clearly describe:
  - Sx that are out of control, intensify, diminish or change
  - The pt/family response(s) to the intervention/plan of care
  - New orders, updates to POC

Discontinuing Continuous/ Inpatient Care

- Continuous Care may be discontinued if any of the following occur:
  - Sxs improve, pt/family and team agree that the Sxs can now be managed at the Routine Level of Care
  - Patient dies

Summary of Critical Points

- CMS's requirement for coverage of CC is >= 8 h of primarily nursing care is needed to manage an acute medical crisis and maintain the individual at home.
- **Hours count from MN to MN**
- When a hospice determines that a beneficiary meets the requirements for CC, **documentation must support that the services provided were reasonable and necessary and were in compliance with an established plan of care to address a specific crisis situation.**

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Informative links

Continuous Home Care web page from CGS®

https://www.cgsmedicare.com/hhh/coverage/coverage_guidelines/continuous_home_care.html

How to Prevent Hospice Claim Denials Related to Continuous Care Hours web page from Palmetto GBA®

https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/JM-Home-Health-and-Hospice~A5AJF65004

Attached Appendices

Managing Medicare Hospice Respite Care
A compliance guide from the National Hospice and Palliative Care Organization (NHPCO)

Managing General Inpatient Care for Symptom Management
A compliance tip sheet from NHPCO

Hospice Policy Compendium: The Medicare Hospice Benefit, Regulations, Quality Reporting, and Public Policy
An NHPCO publication

Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity
A portfolio from the US Department of Health and Human Services Office of Inspector General

National Hospice and Palliative Care Organization

Compliance Guide

Managing Medicare Hospice Respite Care

Compliance for Hospice Providers

Revised November 2016

DISCLAIMER

This Compliance Guidance has been gathered and interpreted by NHPCO from various resources and is provided for informational purposes. This should not be viewed as official policy of CMS or the Medicare Administrative Contractors (MACs). It is always the provider's responsibility to determine and comply with applicable CMS, MAC and other payer requirements.

WHAT IS RESPITE CARE?

Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may not be reimbursed for more than five consecutive days at a time, including the date of admission but not including the date of discharge. More than one respite period (of no more than 5 days each) is allowable in a single billing period (CMS, Chapter 11, Sec 30.1, 2011) There is no written guidance from the Centers for Medicare & Medicaid Services (CMS) which restricts the use of respite to one time per benefit period.

WHERE CAN RESPITE CARE BE PROVIDED?

Inpatient respite can only be provided in the following facilities:

- A Medicare-certified inpatient hospice facility
- A contracted Medicare-certified hospital or a skilled nursing facility that has the capability to provide 24-hour nursing if the patient's plan of care required that type of nursing intervention. (See section below: ***CONSIDERATIONS WHEN CONTRACTING FOR RESPITE CARE***)

WHERE RESPITE CARE CANNOT BE PROVIDED?

The respite level of care under the Medicare Hospice Benefit is inpatient, which means that the patient is cared for in a Medicare designated inpatient facility. Therefore:

- Respite care **may not** be provided in an assisted living facility (ALF) or a residential care facility because these facilities are regulated at the state level and do not meet the requirement of being a Medicare or Medicaid certified hospital or nursing facility.
- Respite care **may not** be provided in a patient's private residence.

WHEN IS RESPITE CARE APPROPRIATE?

Respite care is for short term caregiver relief, so there needs to be a caregiver involved in the patient's care. The Centers for Medicare and Medicaid Services (CMS) does not furnish a list of scenarios or examples appropriate for respite care, so it is at the hospice provider's discretion to determine the merit of the caregiver's need. Some examples for provision of respite care may include:

- The caregiver is physically and emotionally exhausted from caring 24/7 for the patient and requires a break.
- The caregiver would like to attend a family event, such as a wedding, graduation, or other event.
- The caregiver is ill and needs a break from patient care to recover.

While the patient and their caregiver have the right to respite care under the Medicare Hospice Benefit, hospice providers should thoughtfully consider the reason of the caregiver for the respite stay. If a caregiver is requesting frequent respite care, then a change in patient care environment may be warranted. The interdisciplinary group (IDG) should review the patient/family situation to ensure appropriate care planning.

WHEN IS RESPITE CARE NOT APPROPRIATE?

Respite care may not be provided in the following circumstances:

- There is no identified caregiver
- Patient resides in a nursing facility or a facility that provides 24/7 care
- There is no clear reason for caregiver relief

★ **NOTE:** Continuous home care is not intended to be used as respite care

HOW OFTEN CAN A CAREGIVER ASK FOR RESPITE CARE?

- More than one respite period (of no more than 5 days each) is allowable in a single billing period.
- If the beneficiary dies under inpatient respite care, the day of death is paid at the inpatient respite care rate.
- Frequent use of respite care for one patient or unusual patterns of respite care may be a red flag to your Medicare Administrative Contractor (MAC). Dcoumentation must justify the reason for the caregiver relief. (ie: 5 days of respite with a one day break and another 5 days of respite)
- Payment for inpatient respite care is subject to the requirement that it may not be provided consecutively for more than 5 days at a time. Payment for the sixth and any subsequent day of respite care is made at the appropriate home care rate. Counting respite care days example:
    - If the patient enters a respite period on July 1 and is returned to routine home care on July 6, the units of respite reported on the line item would be 5 representing July 1 through July 5, July 6 is reported as a day of routine home care regardless of the time of day entering respite or returning to routine home care.

CONSIDERATIONS WHEN CONTRACTING FOR RESPITE CARE

- **24 hour nursing** - The Medicare hospice Conditions of Participation (CoPs) no longer require that there be 24-hour nursing available when the respite level of care is contracted from a facility. The revised regulatory text at §418.108(b)(2) states that 24-hour nursing should meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. The contracted facility would provide room and board services and function as the patient's caregiver during the 5 days of inpatient respite per the contractual agreement language. (CMS, Hospice Conditions of Participation, 2008)

★ **NOTE:** Some state hospice licensure regulations have not eliminated the nursing requirement for respite care. Providers should check their state regulations to ensure that if 24-hour nursing is required, they only contract with facilities that meet the requirement.

- The hospice provider must ensure the following:
  - Provision of a copy of the patient's plan of care and specify the inpatient respite services to be furnished.
  - That the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients.
  - That the hospice patient's inpatient clinical record includes a record of all inpatient services furnished and events regarding care that occurred at the facility.
  - That a copy of the discharge summary be provided to the hospice at the time of discharge.
  - That a copy of the inpatient clinical record is available to the hospice at the time of discharge.
  - That the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the agreement.
- A contract for respite services is required if respite care is not provided in the provider's own facility, to meet the requirements of the Medicare Hospice Conditions of Participation to provide all four levels of care (§418.202 Covered services). The provider should document their efforts to secure a contract at the Medicare per diem respite rate and if a higher rate was negotiated, the reasons why.
  - Recommend referencing the regulations related to contract requirements for inpatient and SNF/IID (§ 418.112 (c) if the hospice provides respite in those settings.

A word about physician orders

CMS does not specifically state that a physician order is required to change from routine home care level of care to inpatient respite level of care. Check your state hospice licensure regulations for possible requirements and in the absence of any requirements, obtaining a physician order is at your organization's discretion.

Because of the increased scrutiny on physician orders, a best practice would be to have a physician order anytime there is a change in level of care.

How should the IDG document respite level of care?

A patient's plan of care during an inpatient respite stay would be the same as if the patient were receiving care in their home. The established plan of care visit frequency is followed by the hospice interdisciplinary group (IDG) and the facility staff would give care that the caregiver would provide in the home setting. Documentation in the clinical record should include the following:

- Reason for respite care
- Dates of respite care provision
- Visits by any hospice discipline to the patient during the respite stay
- Orientation of facility staff to:
  - patient's plan of care and advance directives
  - when and how to contact the hospice provider
  - hospice IDG visit schedule
  - how to contact patient's caregiver

- Note that the documentation for each day of respite care provided should demonstrate continued eligibility for this level of service.

TRANSITIONING FROM GENERAL INPATIENT TO RESPITE CARE

CMS revised the respite guidance in Chapter 9, section 40.1.5 of the Medicare Benefit Policy manual in 2014 to include specific examples of when respite may be appropriate, one of which contemplates transitioning a patient directly from GIP to respite. The guidance states respite may be provided for "a few days immediately following a GIP stay if the usual caregiver has fallen ill". While this guidance appears to allow respite in instances where the patient is not currently residing at home, the qualifying language (underlined) is important and signals an expectation that these transitions will be unique and likely rare.

TRANSITIONING FROM ACUTE HOSPITAL INPATIENT TO RESPITE CARE

The guidance in Chapter 9, section 40.1.5 of the Medicare Benefit Policy manual states that "respite care cannot be provided to a hospice patient who resides in a facility (such as a long term care nursing facility)". In the description of the Q code for the type of service location, this includes both Q5003 and Q5004. This is a relatively broad prohibition and could be interpreted as not allowing a patient to be transitioned from hospital inpatient directly to hospice respite when there is no interceding GIP stay. Even if there were an interceding period of GIP, the appropriateness of respite in the hospital would be subject to the narrow limits discussed in Chapter 9.

RESPITE BILLING AND DATA REPORTING

Hospice providers are paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of 5 continuous days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate and the patient would be liable for room and board. Payment at the respite rate is made when respite care is provided at a Medicare or Medicaid certified hospital, SNF, hospice facility, or NF. (CMS, Medicare Claims Processing Manual, Chap. 11, 2011)

Visit Data: Medicare requires hospices to report additional detail for visits on their claims. For all Routine Home Care (RHC), Continuous Home Care (CHC) and Respite Care billing, Medicare hospice claims should report each visit performed by nurses, social workers, aides, homemakers, OT's, PT's, SLP's who are employed by the hospice, and their associated time per visit in the number of 15 minute increments, on a separate line. (CMS, Medicare Claims Processing Manual, Chap. 11, 2011)

★ Respite care visits of **hospice staff only** is recorded on the claim form in 15 minute increments.

RISK AREAS IN RESPITE CARE

- Provision of respite services outside of the specified Medicare guidelines as an incentive for referrals or facility contracts is prohibited. To avoid the appearance of inducement, providers should:

    - Ensure that documentation for each day of Respite level of care evidences the reason for the caregiver relief
    - Ensure that contractual agreements do not contain language which may indicate a kickback or inducement arrangement
- It may be difficult in some areas to secure an inpatient respite care contract with a Medicare or Medicaid certified hospital or nursing facility. Facilities may require the hospice provider to contract at a higher reimbursement rate than the per diem rate the provider receives from Medicare.

RESPITE CARE AND THE INPATIENT CAP

The total number of inpatient days, including both general inpatient and inpatient respite care, used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed 20 percent of the total number of hospice days for which these patients had elected hospice care. (42 CFR 418.302(f))

Compliance Tip Sheet

National Hospice and Palliative Care Organization
www.nhpco.org/regulatory

MANAGING GENERAL INPATIENT CARE FOR SYMPTOM MANAGEMENT

TIPS FOR PROVIDERS

INTRODUCTION

General Inpatient (GIP) Care is one of the four levels of hospice care required to be available under the Medicare Hospice Benefit (MHB). GIP for symptom management is a valuable tool that allows hospice staff to provide clinical services to a degree that cannot typically be provided in a patient's home. It is intended for specific circumstances and for a short duration of time and thus must be carefully managed from start to finish.

This tip sheet will review:

- ✓ The Medicare hospice Conditions of Participation (CoPs) applicable to GIP care
- ✓ Management of GIP care
- ✓ Documenting GIP care
- ✓ Payment and data reporting requirements

The CoPs that relate primarily to GIP are found at sections:

- ✓ §418.108 (Short-term inpatient care)
- ✓ §418.110 (Hospices that provide inpatient care directly)
- ✓ §418.202 (e) (Covered Services)

There are references to GIP in other sections 42CFR418 Hospice Regulations (i.e.: 418.302, 418.309), but they relate primarily to payment issues.

Providers should also look closely at the corresponding Interpretive Guidelines and the preamble comments to the 2008 CoPs for more insight into the proper use of the GIP level of care. There is useful information in the Hospice Medicare Claims Processing Manual (section 30.1; 80.1) and the Hospice Medicare Policy Manual (section 40.1.5). In addition, a provider should check state specific hospice licensure regulations for specific requirements, keeping in mind that hospices must comply with whichever rules are the most stringent. Beyond the items specific to GIP, all other expectations for quality hospice care remain in effect.

WHAT IS GIP? **A general inpatient care day is a day in which a patient receives general inpatient care in an inpatient setting for pain control or acute or chronic symptom management which cannot be managed in other settings An inpatient setting can include a Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly as specified in § 418.110 or a Medicare-certified hospital or a skilled nursing facility that also meets the standards specified in § 418.110(b) and (e) regarding 24-hour nursing services and patient areas. (CMS, Subparts D – Conditions of Participation: Organizational Environment and G – Payment for Hospice Care, Updated 2008 and 2009).**

The CoPs state GIP may be required for pain control or acute or chronic symptom management that cannot feasibly be provided in any other setting. It is initiated when other efforts to manage

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symptoms are ineffective. Note that there is no particular disease, condition, or symptom specified that is a qualifier for GIP. Each patient and his or her symptoms will differ; GIP may be helpful to one patient and not to another with the same disease. GIP care carries specific requirements regarding where the services may be provided as well as types and levels of staffing. GIP care cannot be provided in the home, in an assisted living facility, a hospice residential facility, or in a nursing facility that does not have a registered nurse available 24 hours per day to provide direct patient care.

GIP is intended to be a **short term** intervention (similar to an acute hospital stay). There is no limit on the number of days or number of episodes of GIP each patient receives. GIP is the level of care for patients who cannot comfortably remain in a residential setting and require skilled nursing care around the clock to maintain comfort.

When is GIP Appropriate?

GIP may be initiated when the interdisciplinary group (IDG) determines that the patient's pain and symptoms cannot be effectively managed in the patient's home or other residential setting. This may occur suddenly after a period of gradual decline, with a sudden change in symptoms or condition, or when Continuous Home Care (CHC) has failed to relieve the problems.

When the IDG (including the attending physician and/or the hospice Medical Director) assess that the patient requires a higher level of skilled nursing care to achieve effective symptom management a change to the GIP level of care should be considered. It is the IDG's clinical skills and judgment that determine ***when*** and ***if*** GIP is appropriate. Documentation of the need for GIP is key to provide medical reviewers with a clear understanding of the GIP admission. Industry best practice also states that hospice providers are obtaining a physician's order to change the level of care.

If the hospice and the caregiver, working together, are no longer able to provide the necessary skilled nursing care in the individual's home, and if the individual's pain and symptoms can no longer be managed by the hospice IDG at home, then the individual may be eligible for a short term general inpatient level of care.

GIP may also be provided at the end of an acute hospital stay if there is a need for pain control or symptom management which

HELPFUL RESOURCES

418.108 Condition of participation: Short-term inpatient care.

Download the 418.10'8 " All Inclusive" document (regulatory text + interpretive guideline + preamble language)

Download the 418.108 tip sheet

418.110 Condition of participation: Hospices that provide inpatient care directly.

Download the 418.110 " All Inclusive" document (regulatory text + interpretive guideline + preamble language)

Download the 418.110 Tip Sheet

Download the "Restraints and Seclusion Requirements" Tip sheet addendum

418.202 Covered Services

Access the regulatory text for 418.202 at: http://edocket.access.gpo.gov/cfr_2002/octqtr/pdf/42cfr418.202.pdf

Hospice Medicare Claims Processing Manual

http://www.cms.gov/manuals/downloads/clm104c11.pdf

Hospice Medicare Coverage Policy Manual

http://www.cms.gov/manuals/Downloads/bp102c09.pdf

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cannot be feasibly provided in the home setting at hospital discharge.

The following examples of patient status triggers may lead to the change to GIP level of care:

- ✓ Pain or symptom crisis not managed by changes in treatment in the current setting or that requires frequent medication adjustments and monitoring
- ✓ Intractable nausea/vomiting
- ✓ Advanced open wounds requiring changes in treatment and close monitoring
- ✓ Unmanageable respiratory distress
- ✓ Delirium with behavior issues
- ✓ Sudden decline necessitating intensive nursing intervention
- ✓ Imminent death – **only** if skilled nursing needs are present

When is GIP NOT Appropriate?

It is also important to keep in mind what GIP is not.

- ✓ It is not intended for caregiver respite. If a caregiver is not in the home, or unable to help the patient adequately, other arrangements can or should be made.
- ✓ It is not intended as a way to address unsafe living conditions in the patient's home.
- ✓ It is not an "automatic" level of care when a patient is imminently dying. There must be pain or symptom management and skilled nursing needs present (intensity of care).

NOTE: CMS clarified in the final rule of the 2008 Hospice Wage Index that caregiver breakdown should not be billed as general inpatient care unless the coverage requirements for this level of care are met (CMS, Hospice Wage Index for Fiscal Year 2008, 2007). This clarification may seem to contradict the language in Chapter 9 of the Medicare Benefit Policy Manual. However, CMS expanded upon the Benefit Policy Manual language in the 2008 Hospice Wage Index to clarify when GIP for caregiver breakdown is appropriate (see "When is GIP Appropriate?")

Where Can GIP be Provided?

Per CoP 418.108, GIP must be provided in a participating certified Medicare facility as follows:

- ✓ A Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly as specified in §418.110.
- ✓ A Medicare-certified hospital or a skilled nursing facility that also meets the standards specified in §418.110(b) and (e) regarding 24-hour nursing services and patient areas.

§418.110(b) Standard: Twenty-four hour nursing services (CMS, 2008)

(1) The hospice facility must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

(2) If at least one patient in the hospice facility is receiving general inpatient care, then each shift must include a registered nurse who provides direct patient care.

§418.110(e) Standard: Patient areas (CMS, 2008)

The hospice must provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort, and privacy of patients.

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(1) The hospice must provide—
  (i) Physical space for private patient and family visiting;
  (ii) Accommodations for family members to remain with the patient throughout the night; and
  (iii) Physical space for family privacy after a patient's death.
(2) The hospice must provide the opportunity for patients to receive visitors at any hour, including infants and small children.

WHAT ARE THE HOSPICE MANAGEMENT RESPONSIBILITIES FOR GIP?

Admission and Documentation of GIP Need

- ✓ The hospice should arrange for transfer to the appropriate inpatient setting that can meet the patient's needs. Per CoP 418.56(e)(4) the hospice staff must share information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.
- ✓ The precipitating event (onset of uncontrolled symptoms or pain) which prompted the need to change to GIP level of care should be evident in the comprehensive assessment documentation
- ✓ Documentation of pain and symptom management interventions that were implemented in the home prior to initiating GIP level of care should be documented and available to the inpatient staff.
- ✓ The team needs to provide report to the inpatient staff and furnish a copy of the patient's current plan of care.

Professional Management and Oversight

Regardless of care setting, the hospice IDG is responsible for the professional management of the patient's care in accordance with the hospice plan of care as set by the IDG. Contracts with appropriate facilities for GIP services should be clear regarding the IDG oversight role, scope of services, communication, and all the other federal and state regulatory requirements regarding services by arrangement. The written agreements may also clarify payment rates and procedures (CMS, 2008).

Visits from the Hospice Team When GIP is in a Contracted Facility

While the frequency of IDG visits to a patient receiving GIP level of care is not specified in the regulations, a good standard of care is daily visits from an IDG member to assure professional management, coordination of the plan of care, communication with the patient and family, continuity of care and evaluation of continued eligibility for this level of care. Coordination through communication with the physician overseeing inpatient care is also essential for professional care management purposes and moving the patient toward discharge from GIP. The IDG should also continue services provided by Social Workers and Chaplains as needed and continue support and communication to the family and caregivers during a GIP stay.

Discharge Planning

Consideration of the discharge planning needs of the patient should occur the moment the patient transfers to the GIP level of care. The hospice (not the hospital discharge planners when the facility is a hospital) is responsible for managing the discharge. Documentation should show

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that the IDG is assessing the situation on a daily basis and planning for the transfer to another setting or level of care.

NOTE: General inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit. For example, a brief period of general inpatient care may be needed in some cases when a patient elects the hospice benefit at the end of a covered hospital stay. If a patient in this circumstance continues to need pain control or symptom management, which cannot be feasibly provided in other settings while the patient prepares to receive hospice home care, general inpatient care is appropriate (CMS, Chapter 9, IOM-40.1.5 - Short-Term Inpatient Care, 2004).

Quality Assurance & Performance Improvement (QAPI)

GIP is a challenging care level to manage, and providers may want to include some aspects of this service in their QAPI programs. Consider evaluating internal processes and policies related to assessing needs, providing and/or monitoring care, discharge planning and frequent problems that arise with GIP care such as unnecessary testing and procedures that are not palliative in nature and may add burden to the patient.

Audit Readiness

Clinical records are subject to review during an audit by a Medicare Administrative Contractor (MAC) and/or other oversight agencies. Providers should train their staff on best practice documentation standards and periodically conduct internal audits to ensure documentation supports the GIP level of care. The Carolinas Center for Hospice and End of Life Care Facility Based Workgroup developed a GIP chart audit tool (See *Resources*), which may be useful for reviewing patient records when the GIP level of care is implemented.

How Should the IDG Document GIP Level of Care?

Documentation during GIP level of care must be thorough and reflect the need and intensity of care for this level at all phases of care. Implementation of the plan of care must be directed to stabilizing the acute or chronic symptom management, obtaining a positive palliative outcome (did the care make a difference), and moving the patient to a lower level of care at the appropriate time.

When transferring a patient to GIP level of care, documentation should include:

- ✓ The skilled nursing interventions being provided to the patient and the patient's response
- ✓ A Plan of Care that reflects the change in level of care and interventions to stabilize the patient's acute pain and symptom crises
- ✓ Collaboration with the facility staff if in a contracted facility
- ✓ Discharge planning **(remember: GIP is short-term)**

All IDG members should document to paint a complete picture of the patient, including the pain and symptoms not adequately managed and why GIP level of care is necessary. Physicians and nurses need to address symptom management, observations, medications initiated and changes in medications, other changes in treatment, etc. Other IDG members need to document what they see in terms of symptom management, patient and family coping, discharge planning discussions, options for returning to the routine home care level, etc.

Policies, procedures and the patient's status should dictate visit and documentation frequencies. Keep in mind that the higher level of care demands that documentation and visits are more frequent than for patients at routine level of care. (See the *Resources* section for an example of a GIP documentation tool.)

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What Are the GIP Billing and Data Reporting Issues?

Billing: Billing for GIP is completed for each day the patient qualifies for GIP level of care. If the patient is in a facility, the day of discharge is billed as routine level of care. (EXCEPTION: If the patient dies on the final day, then the day is billed as GIP.) It is important for providers to understand that if a clinical record is requested by an RHHI/ MAC medical review department and it is determined that the patient was not eligible for part of the GIP stay, those days will be downgraded to routine home care days and the corresponding payment rate will apply. To ensure accurate billing to their Fiscal Intermediary or Medicare Administrative Contractor, a provider is encouraged to complete a pre-bill audit of their GIP claims for review of correct Q codes and documentation to support the GIP level of care for all days billed at that level.

Visit Data: Change Requests 5567 and 6440 require hospice providers to report visit frequency and time on claims for hospice nurses, social workers and hospice aides. For GIP stays in a contracted facility, only visits by hospice staff in these categories are reported (CMS, CR 5567, 2008). For GIP stays in a hospice owned facility, all services by hospice staff (nurses, social workers and hospice aides) that are medically necessary and included in the patient's plan of care must be included on the claim form as a visit. (Reporting visits in 15 minutes increments is not required for GIP.) See *Resources* for links to CMS guidance on data reporting requirements (CMS, CR 6440, 2009).

Visits which are part of room and board services should **NOT** be reported on hospice claims to Medicare. Room and board services may include, but are not limited to, delivery of meals, changing bed linens, housekeeping tasks, etc. Hospices should only report visits which are reasonable and necessary for the palliation and management of the terminal illness and related conditions (CMS, Q&A - ID 8901, 2010).

Note: Additional Q&A's related to visit data are located in the CMS Hospice General Inpatient Q&A's attachment.

Cap on Inpatient Care

There is a Cap on the amount of inpatient care that a hospice provider may provide. The total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed 20 percent of the total number of hospice days consumed in total by this group of beneficiaries. This standard applies to **Medicare** beneficiaries only. Compliance with this regulation is based on the total number of **Medicare** beneficiaries enrolled in the hospice program, and does not include patients from other payor sources (CMS, Hospice Conditions of Participation; Final Rule, 2008).

Resources

Sample GIP Documentation Tool and GIP Chart Audit Tool
http://www.carolinasendoflifecare.org/ - Click the link, select the 'Resources' tab and then select 'General Inpatient Documentation Tool.'

NHPCO Document with full Medicare Rules 42 CFR 418 Subparts A – H:
http://www.nhpco.org/files/public/regulatory/Medicare_RegHospice.pdf
Hospice General Inpatient Care: its Proper Use and Supporting Processes
http://www.nhpco.org/files/public/regulatory/Medicare_COPS_Updated_072911.pdf

NHPCO Information Sheet on Hospice Inpatient Care (more specifically addresses regulatory language applicable to this level of care)
http://www.nhpco.org/files/public/regulatory/Criteria_for_General_Inpatient.pdf

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NHPCO Tip Sheet on CoP 418.110 Hospices that provide inpatient care directly (Contains Regulatory text, interpretive guidelines, & preamble to the CoPs)
http://www.nhpco.org/files/public/regulatory/418.110_Provide_inpatient_directly.pdf

Caregiver Breakdown & GIP Information – Hospice Wage Index for Fiscal Year 2008
http://www.gpo.gov/fdsys/pkg/FR-2007-08-31/pdf/07-4292.pdf

Regulatory Resources – State Hospice Licensure Regulations
http://www.nhpco.org/custom/iMAP1123/index.htm

Data Collection & Reporting
Change Request 5567 - Reporting of Additional Data to Describe Services on Hospice Claims
http://www.cms.hhs.gov/transmittals/downloads/R1494CP.pdf

Change Request 6440 - Additional Data Collection on Hospice Claims
http://www.cms.hhs.gov/transmittals/downloads/R1738CP.pdf

Change Request 6791 - Associating Hospice Visits to the Level of Care
http://www.cms.hhs.gov/Transmittals/downloads/R1897CP.pdf

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CMS. (2009, May). *CR 6440*. Retrieved from CMS: https://www.cms.gov/transmittals/downloads/R1738CP.pdf
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National Hospice and Palliative Care Organization

Hospice Policy Compendium

The Medicare Hospice Benefit, Regulations, Quality Reporting, and Public Policy.

Updated January 4, 2016

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Hospice Policy Compendium
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Appendix A: Growth in Patients Served by Hospice and Growth of Hospice Programs
Appendix B: Hospice Provisions in the Patient Protection and Affordable Care Act (ACA)

Hospice Overview

Hospice is a patient-centered, cost-effective philosophy of care that utilizes an interdisciplinary team of healthcare professionals and trained volunteers to provide compassionate care for people facing a life-limiting illness or injury, including expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. At the center of hospice and palliative care is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so.

Hospice cares for people where they live. In most cases, care is provided in the patient's home. Hospice care is also provided in freestanding hospice centers, hospitals, and nursing homes and other long-term care facilities. Hospice services are available to patients of any age, religion, race, or illness. Hospice care is covered under Medicare, Medicaid, and most private health insurance plans, including HMOs and other managed care organizations.

Hospices now care for almost half of all Americans who die from cancer and a growing number of patients with other chronic, life-threatening illnesses, such as end-stage heart or lung disease. Hospice care is not limited to cancer patients.

Hospice care continues to grow. In 2014, an estimated 1.6-1.7 million patients received services from hospice.[1] The Medicare Payment Advisory Commission (MedPAC) estimates that 47.3 percent of Medicare decedents in the United States in 2013 received hospice care.[2]

Note: Statistics taken from the National Hospice and Palliative Care Organization's Facts and Figures 2012 may not match similar statistics provided by the Medicare Payment Advisory Commission (MedPAC) or the Centers for Medicare and Medicaid Services due to differences in the data analyzed. Information on the accuracy of the data presented in Facts and Figures can be found in "Appendix 2: How Accurate are the NHPCO Estimates?" in Facts and Figures 2012, 2013, 2014, and 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf.

[1] National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.

[2] Medicare Payment Advisory Commission. Chapter 12, Report to Congress: Medicare Payment Policy. March 2015. http://medpac.gov/documents/reports/chapter-12-hospice-services-(march-2015-report).pdf.

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Chapter 1: The Medicare Hospice Benefit

History of Hospice[3]

The term "hospice" can be traced back to medieval times when it referred to a place of shelter and rest for weary or ill travelers on a long journey. The name was first applied to specialized care for dying patients by physician Dame Cicely Saunders, who began her work with the terminally ill in 1948 and eventually went on to create the first modern hospice—St. Christopher's Hospice—in a residential suburb of London.

Saunders introduced the idea of specialized care for the dying to the United States during a 1963 visit to Yale University. Her lecture, given to medical students, nurses, social workers, and chaplains about the concept of holistic hospice care, included photos of terminally ill cancer patients and their families, showing the dramatic differences before and after the symptom control care.

In 1976, a U.S. Department of Health, Education, and Welfare task force reported that "the hospice movement as a concept for the care of the terminally ill and their families is a viable concept and one which holds out a means of providing more humane care for Americans dying of terminal illness while possibly reducing costs. As such, it is the proper subject of federal support." As a result, the Health Care Financing Administration (HCFA) initiated demonstration programs at 26 hospices across the country in 1979 to assess the cost effectiveness of hospice care and to better determine what exactly a hospice is and what types of care it should provide.

Congress subsequently included a provision to create a Medicare hospice benefit within the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), with a 1986 sunset provision. The Medicare Hospice Benefit was made permanent by Congressional action in 1986, and hospices were given a 10% increase in reimbursement rates. In that same year, states were given the option of including hospice in their Medicaid programs.

The Medicare Hospice Benefit

Considered the model for quality care for people facing a life-limiting illness, hospice provides expert medical care, pain management, personal care, and emotional and spiritual support individually tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well. Hospice focuses on caring, not curing. An interdisciplinary team of professionals is responsible for the care of each hospice patient. NHPCO estimates that approximately 1.6-1.7 million deaths in the United States in 2014 were under the care of a hospice program.[4]

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[3] "History of Hospice Care." National Hospice and Palliative Care Organization. http://www.nhpco.org/i4a/pages/index.cfm?pageid=3285.
[4] 2015, NHPCO Facts and Figures on Hospice Care.

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Medicare pays hospice at one of four levels of care – (1) routine home care, (2) continuous home care, (3) general inpatient care, and (4) inpatient respite. The payment covers all aspects of the patient's care related to the terminal prognosis, including all services delivered by the Interdisciplinary team, medication, medical equipment and supplies. In 2014, 85.5% of hospice patients were covered by the Medicare Hospice Benefit, versus other payment sources.[5]

Medicaid Hospice Benefit

In 1986, hospice was added as an optional benefit under Medicaid. In 2014, 6.9% of hospice patients were covered by the Medicaid Hospice Benefit, versus other payment sources.[6] States offer the hospice benefit as an optional benefit through their Medicaid programs. The structure of the hospice benefit offered by traditional state Medicaid programs and the Medicaid hospice reimbursement rates, by statute, are tied to the federal Medicare Hospice Benefit. States with Medicaid Managed Care may allow Medicaid Managed Care Organizations to reimburse hospice providers at rates that do not mirror the Medicare rates as long as they are actuarially sound. Medicaid is often the second largest expense in most states' budgets (after education). In the current fiscal environment, states are under pressure to reduce spending levels further, and are therefore scrutinizing the benefits available to Medicaid recipients. In recent years several states have proposed, or are currently considering, cuts in their optional Medicaid benefits, including hospice benefits. However, currently 49 states continue to offer a Medicaid hospice benefit to eligible beneficiaries.

For more information about the Medicaid Hospice benefit, click here:
Medicaid Issue Brief:
http://www.nhpco.org/sites/default/files/public/regulatory/Medicaid_Issue_Brief.pdf.

Medicaid Managed Care Issue Brief:
http://www.nhpco.org/sites/default/files/public/regulatory/MedicaidManagedCare-Issue-Brief.pdf.

Eligibility for Hospice Care

Certification and Recertification for Hospice Care

A patient is eligible for the Medicare Hospice Benefit if (a) the patient is eligible for Part A of Medicare and (b) two physicians determine that the patient has six months or less to live if the disease runs its normal course.

[5] 2014, NHPCO National Data Set and/or NHPCO Member Database.
[6] 2014, NHPCO National Data Set and/or NHPCO Member Database.

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For the first 90-day period of care, the attending physician (if any) **and** the hospice medical director/ hospice physician are required to certify terminal illness. For subsequent certification periods, only the hospice medical director/ hospice physician is required to certify terminal prognosis, unless otherwise specified by state hospice regulations.

The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms. A face-to-face encounter is required for patients entering the third benefit period recertification (at 180 days) and every subsequent benefit period. Documentation from the face-to-face encounter must be used as the physician completes the brief physician narrative and must include an explanation of why the clinical findings of the face-to-face encounter continue to support a life expectancy of 6 months or less.

For more information about certification and recertification for hospice care, visit: http://www.nhpco.org/admission-certification-and-recertification.

Face-to-Face Guidelines[7]
See Face-to-Face Guidelines.

Benefit periods[8]
An individual may elect to receive hospice care during one or more of the following election periods:

(1) An initial 90-day period;
(2) A subsequent 90-day period; followed by
(3) An unlimited number of subsequent 60-day periods, if needed.

As long as the patient meets the certification criteria, there is no limit on the amount of time a patient can then spend under hospice care, although the hospice must continue to monitor continued eligibility as a part of the recertification process every 90 days for the first 180 days, and when the 90-day periods are complete, prior to every 60-day benefit period. This monitoring function takes place through the face-to-face encounter, as well as ongoing interdisciplinary team review.

If the patient is a nursing home resident and chooses to elect hospice care, the Medicare Hospice Benefit covers all care and services related to the terminal prognosis. However, the patient may not, except in unusual circumstances, receive their Medicare Skilled Nursing Home benefit at the same time as their hospice benefits. For those eligible for both Medicare and Medicaid, the nursing home's room and board is paid by the state Medicaid program to the

[7] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.22.
[8] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.21.

hospice and paid to the nursing home under a contractual arrangement between the nursing home and the hospice.

Filing an election statement[9]

An individual who meets the eligibility requirements for hospice must file an election statement (Notice of Election or NOE) with a particular hospice. If the individual is physically or mentally incapacitated, his or her representative (as defined in §418.3)[10] may file the election statement on the patient's behalf.

The election statement must include:

- Identification of the particular hospice and of the attending physician that will provide care to the individual. The individual or representative must acknowledge that the identified attending physician was his or her choice.
- Identification of the particular hospice that will provide care to the individual.
- The individual's or representative's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal prognosis.
- Acknowledgement that certain Medicare services, such as any Medicare services that are related to the treatment of the terminal condition or related conditions for which hospice care was elected, are waived by the election.
- The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement.
- The signature of the individual or representative.

Notice of Election (NOE)

Once the patient or their representative signs the election statement, the hospice submits a Notice of Election (NOE) to the Medicare Administrative Contractor (MAC). Effective October 1, 2014, every hospice NOE must be submitted with the MAC electronically within five days after the effective date of the election statement. If a hospice does not submit the NOE timely, Medicare will not reimburse for days of hospice care from the effective date of election to the date of filing the notice of election (NOE). These days will be a provider liability, meaning that the provider will not be paid, although the services have been provided. In addition, the provider may not bill the beneficiary for them.

The hospice may file an exception request with the MAC to request consideration for payment of days of care if the NOE is not submitted timely. Each MAC has its own process for the consideration of exception requests. There are four reasons that an exception request may be granted:

1. Natural disasters or unusual events that may inflict extensive damage to the hospice's ability to operate;

[9] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.24.
[10] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.3.

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2. A CMS or Medicare contractor systems issue beyond the control of the hospice;
3. A newly Medicare-certified hospice notified of their certification after the Medicare certification date or awaiting its user ID from the Medicare contractor; or
4. Other situations determined by CMS to be beyond the control of the hospice.

Waiver of other benefits[11]
For the duration of an election of hospice care, an individual waives all rights to Medicare payments for any Medicare services that are related to the treatment of the terminal prognosis for which hospice care was elected. Exceptions include: services provided by the designated hospice, another hospice under special arrangements, or the individual's attending physician (if the physician is not an employee of the designated hospice or receiving compensation from the hospice for his or her services).

Delivery of Care – the Interdisciplinary Team (IDT)[12]

Typically, a family member serves as the primary caregiver and, when appropriate, helps make decisions for the terminally ill individual. The hospice team develops a care plan with the patient and the patient's family to meet the patient's individual needs and goals of care for pain management and symptom control. This interdisciplinary team usually consists of the hospice physician or medical director, nurses, hospice aides, social workers, bereavement counselors, clergy or other spiritual counselors, trained volunteers, and, if necessary, speech, physical, and occupational therapists. Members of the IDT make regular visits to assess the patient and provide additional care or other services. Hospice staff is on-call 24 hours a day, seven days a week.

Figure 1. Interdisciplinary Team

Attending Physician
Each hospice patient has the right to choose an attending physician who will provide care to the patient. Because the attending physician is typically someone with whom the patient had a relationship before electing to receive hospice care, the role of the attending physician is to provide a long-term perspective on the patient and family that takes into account their medical and personal history.

The choice of an attending physician belongs solely to the patient (or representative), and it is CMS' intent to safeguard and protect that beneficiary choice. A patient cannot be required or coerced to change his or her attending physician. No change in attending physician is necessary when a patient transitions to general inpatient care or other inpatient care for a short period of time. If a patient's attending physician does not have privileges at the hospital or other

[11] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.24
[12] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.78

inpatient setting, the hospital may designate a hospitalist to provide "attending physician" services, but this designation does not meet the requirements for a hospice patient's attending physician and no change in attending is needed. If no hospitalist is designated, then, according to the Medicare hospice CoPs at §418.64(a)(3), the hospice physician or NP must provide any needed physician's services. However, while the hospice can bill Medicare Part A for its employed or contracted physicians providing needed physician services, it can only do so for its NPs if the NP is the designated attending physician. The hospice may not change the patient's attending physician to a hospice NP unless the patient or their representative chooses that person to be the attending.

Effective October 1, 2014, if a patient (representative) chooses to change attending physicians, the patient (or representative) must file a signed statement with the hospice, a "change of attending physician" form.[13] This form identifies the new attending physician in enough detail so that it is clear which physician or NP is designated as the new attending physician.

This information should include, but is not limited to:

- Physician's full name
- Office address
- Physician NPI number or any other detailed information to clearly identify the attending physician
- Date that the statement is signed, along with the patient's or representative's signature;
- Date the change is to be effective
- Acknowledgement that the change in attending physician is the patient (or representative) choice.

Volunteers

The Medicare Conditions of Participation for hospice requires that volunteers provide at least 5% of total patient care hours. Hospice volunteers provide service in three general areas: [14]

- direct support: spending time with patients and families,
- clinical support: providing clerical and other services that support patient care and clinical services
- general support: helping with fundraising efforts and/or the board of directors

Direct support and clinical support activities can be applied to the required 5% of total patient care hours for a hospice.

Volunteer hours related to board and committee service, as well as fundraising activities **do not qualify** to be included in the required 5% of total patient care hours.

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[13] Centers for Medicare and Medicaid Services. Change Request (CR) 9114. May 8, 2015.
[14] National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.

NHPCO estimates that 430,000 hospice volunteers provided 19 million hours of service in 2014. The majority of volunteers (60.8%) assisted with direct support in 2014, while 20.2% provided clinical care support and 19.1% provided general support.[15]

Bereavement[16]

For a minimum of one year following the death of hospice patients, grieving families and friends of hospice patients can access bereavement education and support. In 2014, for each patient death, an average of 2 family members received bereavement support from their hospice. This support included follow-up phone calls, visits, support groups and mailings throughout the post-death year.

Levels of Care

Because patients require differing intensities of care during the course of their disease, the Medicare Hospice Benefit affords patients four levels of care to meet their needs: routine home care, continuous home care, inpatient respite care, and General Inpatient Care. Ninety-four percent of hospice care is provided at the routine home care level.[17]

- **Routine Hospice Care** is the most common level of hospice care. With this type of care, an individual has elected to receive hospice care is at their residence, which includes a private residence, Assisted Living Facility or Skilled Nursing Facility.
- **Continuous Home Care** is care provided for between 8 and 24 hours a day to manage pain and other acute medical symptoms. Continuous home care services must be predominately nursing care, supplemented with homemaker and hospice aide services and are intended to maintain the terminally ill patient at home during a pain or symptom crisis.
- **General Inpatient Care** is provided for pain control or other acute symptom management that cannot feasibly be provided in any other setting. General inpatient care begins when other efforts to manage symptoms have been ineffective. General inpatient care cannot be provided in a private residence, an assisted living facility, or a hospice residential facility. However, general inpatient care can be provided in a Medicare certified hospital, hospice inpatient facility, or nursing facility that has a registered nursing available 24 hours a day to provide direct patient care.
- **Inpatient Respite Care** is available to provide temporary relief to the patient's primary caregiver. Respite care can be provided in a hospital, hospice facility, or a long term care facility that has sufficient 24 hour nursing personnel present on all shifts to

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15 National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.
16 National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.
17 National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.

guarantee that patient's needs are met. Respite care is provided for a maximum of 5 consecutive days.

Locations of Care[18]

Patients may receive care at their place of residence, a hospice inpatient facility or an acute care hospital. Two-thirds of patients choose hospice care at home (Table 2).

Location of Death	2014	2013
Patient's Place of Residence	58.9%	66.6%
Private Residence	35.7%	41.7%
Nursing Home	14.5%	17.9%
Residential Facility	8.7%	7.0%
Hospice Inpatient Facility	31.8%	26.4%
Acute Care Hospital	9.3%	7.0%

Table 1. Location of Death

Hospice in the Nursing Home

As prescribed by statute, at least 80 percent of hospice services must be provided in a residential setting. For some Medicare recipients, the nursing home is their residence. As the American population lives longer, with more chronic conditions, more individuals will spend their final days in the nursing home. Hospice patients in nursing homes differ from hospice patients at home; nursing home residents are a very vulnerable, older population. The average age of nursing home patients is 76.6 years compared to 70.3 years for home patients. Nursing home patients are more often female (55.3% vs. 47.4%), unmarried, including widowed and divorced, (68.5%vs. 44.6%), and dually eligible for both Medicare and Medicaid. They also have higher rates of dementia and other non-cancer diseases as primary diagnoses.[19]

Nursing home residents who enroll in hospice continue to receive all of the services they are entitled to from the nursing home, much like the primary caregiver/supportive services provided by family and friends that the patient receives if he or she were at home. At the same time, these patients receive supplemental support and professional care for their terminal condition from the hospice agency. Additional benefits of hospice care delivered in the nursing home include enhanced pain management and increased family satisfaction with end-of-life care.

A 2010 study by Miller et al., examined the growth of Medicare-certified hospices providing hospice in the nursing home from 1999 to 2006. Using Medicare's minimum data set (MDS), the study found that the proportion of nursing home decedents who received hospice care rose from 14.0% in 1999 to 33.1% in 2006, a growth rate that closely paralleled the increase in

[18] 2015, NHPCO National Data Set and/or NHPCO Member Database.
[19] Stevenson DG, Huskamp HA, Grabowski DC, Keating NL. 2007. Differences in Hospice Care between Home and Institutional Settings. *Journal of Palliative Medicine*, 10(5):1040-1047.

Medicare-certified hospice programs. The demographic characteristics of hospice patients in the nursing home changed little during that time and are very similar to the overall characteristics of hospice patients.[20] Even though a large majority (87%) of nursing homes hold nominal contracts with hospice agencies, only 30% actually have any hospice enrollees and most of these have only one or two at a time.[21]

Today, it is increasingly common for dying nursing home residents to be admitted under the Medicare Skilled Nursing Facility (SNF) benefit for "end of life" care. Medicare beneficiaries who elect hospice care must waive their right to other Medicare Part-A payments for services related to their terminal prognosis, including the SNF benefit. The SNF benefit allows Medicare to pay for room and board services for a set number of days, unlike the hospice benefit, creating a financial incentive for families to choose the SNF benefit so that nursing home room and board is covered, even when hospice care is desired. The time spent deciding among care options contributes to later hospice referrals and an increased likelihood that residents will have hospital deaths and aggressive care at the end of life.[22]

A 2012 MedPAC report found that rehospitalizations from SNFs accounted for more than $700 million in hospital stays in 2005, with hospitalizations originating from a nursing home stay contributing an additional $1.9 billion.[23] These and other statistics have fueled development of programs to ease transitions of care and thereby reduce rehospitalizations.

For a fact sheet on hospice in the nursing home, click here: http://hospiceactionnetwork.org/linked_documents/get_informed/issues/nursing_home/NH_Fact_Sheet.pdf.

For regulatory resources on hospice in the nursing home, visit: http://www.nhpco.org/regulatory-locations-and-levels-care/hospice-nursing-facility.

For a process map for dually eligible Medicaid beneficiaries electing the Medicare Hospice Benefit while residing in a nursing home, click here: http://hospiceactionnetwork.org/linked_documents/get_informed/issues/nursing_home/MHB_NH_Map.pdf.

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[20] Miller SC, Lima J, Gozalo P, Mor V. 2010. The Growth of Hospice Care in U.S. Nursing Homes, *Journal of American Geriatrics Society*, 58:1481-88.
[21] Stevenson DG and Bramson JS. 2009. Hospice Care in the Nursing Home Setting: A Review of the Literature. *J Pain Symptom Manage*, 2009;38:440-451.
[22] Miller SC, Lima JC, Looze J, Mitchell SL. 2012. Dying in US Nursing Homes with Advanced Dementia: How Does Health Care Use Differ for Residents with, versus without, End-of-Life Medicare SNF Care? *Journal of Palliative Medicine*, 15(1):43-50.
[23] Medicare Payment Advisory Commission. Chapter 8, Report to Congress: Medicare Payment Policy. March 2015. http://medpac.gov/documents/reports/chapter-8-skilled-nursing-facility-services-(march-2015-report).pdf.

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Length of Service[24]

The total number of days that a hospice patient receives care is referred to as the length of service (or length of stay). Length of service can be influenced by a number of factors including disease course, timing of referral, and access to care. The median (50th percentile) length of service in 2014 was 17.4 days and has remained between 17 and 18 days since 2000. This means that half of hospice patients receive care for less than three weeks and half receive care for more than three weeks. The average service is 72.6 days.

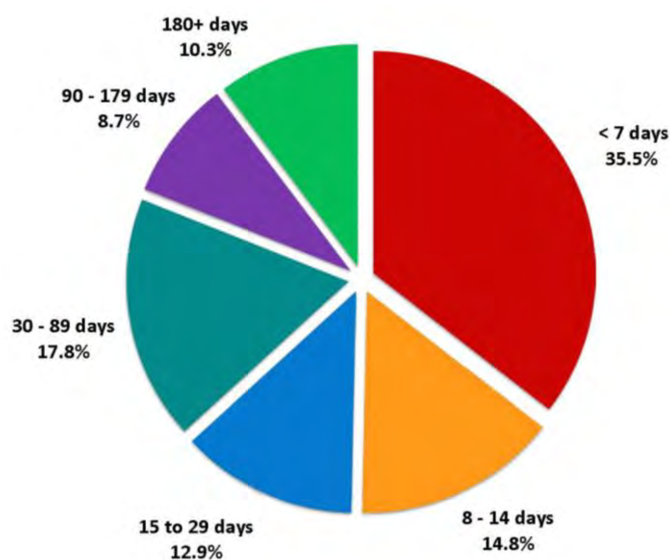

Figure 2. Proportion of Patients by Length of Service in 2014

Approximately 35.5% of hospice patients receive care for just seven days or less. In 2014, 50.3% of patients died or were discharged within 14 days of admission. Only 10.3% of patients remain under hospice care for longer than 180 days (Figure 2).

Discharge/Revocation/Transfer of Hospice Services

Discharge from Hospice Services[25]

The hospice benefit is available only to individuals who can be certified as terminally ill with a prognosis of 6 months or less to live if the disease runs its natural course; therefore, a hospice may discharge a patient if it discovers that the patient no longer fits these criteria. Discharge may also be necessary when the patient moves out of the service area of the hospice or there is a cause for discharge.

Effective October 1, 2014, when the hospice election is ended by discharge, the hospice must file a notice of termination/revocation of election (NOTR) with the Medicare contractor within 5 calendar days after the effective date of the discharge or revocation, unless the hospice has already filed a final claim for the beneficiary.[26] General coverage under Medicare Part A is reinstated on the date that the patient is discharged or revokes their hospice election.
Reasons for hospice discharge:

- The beneficiary dies;
- The patient moves out of the hospice's service area or transfers to another hospice.

[24] 2014, NHPCO National Data Set and/or NHPCO Member Database.
[25] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.26.
[26] Centers for Medicare and Medicaid Services. Change Request (CR) 8877. August 22, 2014.

- The hospice determines that the patient is no longer terminally ill.
- Discharge for cause: The hospice discharges the patient under a policy set by the hospice for the purpose of addressing discharge for cause, citing that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. The hospice must do the following before it seeks to discharge a patient for cause:
    i. Advise the patient that a discharge for cause is being considered;
    ii. Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation;
    iii. Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and
    iv. Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.

The hospice must make every effort to resolve these problems satisfactorily before it considers discharge an option. All efforts by the hospice to resolve the problem(s) must be documented in detail in the patient's clinical record and the hospice must follow the rules of the Medicare contractor and State Survey Agency regarding notification of the discharge.

Discharge order

If the hospice is initiating the live discharge, the hospice must obtain a written physician's discharge order from the hospice physician. If a patient has an attending physician involved in his or her care, documentation should appear in the clinical record that this physician was consulted prior to the discharge.

Effect of discharge

An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice—

1. Is no longer covered under Medicare for hospice care;
2. Resumes Medicare coverage of the benefits waived under § 418.24(d); and
3. May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

Discharge planning

1. The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.
2. The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

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Revocation of Hospice Care[27]

CMS allows an individual or representative to revoke the election of hospice care at any time in writing. To revoke the election of hospice care, the individual must file a document with the hospice that includes a signed statement that the individual revokes the election for Medicare coverage of hospice care for the remainder of that election period and the effective date of that revocation.

Effective October 1, 2014, when the hospice election is ended by revocation, the hospice must file a notice of termination/revocation of election (NOTR) with the Medicare contractor within 5 calendar days after the effective date of the discharge or revocation, unless the hospice has already filed a final claim for the beneficiary.[28]

An individual, upon revocation of the election of Medicare coverage of hospice care for a particular election period:

- Is no longer covered under Medicare for hospice care;
- Resumes Medicare Part A, B and D coverage of the benefits waived under § 418.24(e)(2); and
- May at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive.

Change/Transfer of Designated Hospice Provider[29]

An individual may change, **once** in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. The change of the designated hospice is not considered a revocation of the election, but is considered a transfer.

To change the designation of hospice programs, the individual must file a "Change of Hospice Providers" form (likely developed and available from either hospice) with the newly designated hospice and a signed statement that includes the following information:

- The name of the hospice from which the individual has received care;
- The name of the hospice from which they plan to receive care; and
- The date the change is to be effective.

If the patient chooses to transfer in the third or subsequent benefit periods, the transferring hospice must provide the receiving hospice with evidence that the face-to-face encounter was completed.

[27] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.28.
[28] Centers for Medicare and Medicaid Services. Change Request (CR) 8877. August 22, 2014.
[29] *Code of Federal Regulations*, CMS Regulations for Hospice, title 42, sec. 418.30.

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Hospice and Medicare Part D

When a patient elects hospice, the hospice provides all of the care related to the terminal prognosis, that constellation of diagnoses that contribute to the patient's terminal condition. Patients at the end of life may also have medical conditions with which they have struggled for years but do not contribute to the patient's terminal prognosis. In these cases, the other medical conditions may not be the responsibility of the hospice; they are the responsibility of the patient's primary insurer, which is usually Medicare, and Medicare Part D for medications. However, the hospice should ensure that the patient's medical conditions are clearly NOT related to the terminal prognosis and ensure that hospice does cover what is related to the prognosis. The hospice physician should document the reasons that the medical conditions are unrelated in the patient's medical record.

In June of 2012, the Department of Health and Human Services's Office of the Inspector General (OIG) released a report, "Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice" regarding the intersection of Hospice and Medicare Part D. Since 2010, NHPCO had been in active conversations with the OIG and with CMS about this issue, beginning when the OIG was researching the data for the 2012 report. The issuance of the OIG report increased the dialogue between CMS and NHPCO. Findings in the report showed that during calendar year 2009, Medicare Part D paid $33,638,137 for drugs for patients enrolled in the Medicare Hospice Benefit, specifically for drugs in the following categories:

- Analgesics,
- Antinauseants,
- Laxatives, and
- Anti-anxiety drugs.

In December 2013, CMS issued draft guidance noting that hospices were required to provide drugs used primarily for the relief of pain and symptom management related to the terminal illness and related conditions and that these drugs are NOT covered by Part D. CMS also indicated that some hospice providers were uncertain about the circumstances when Part D would cover drugs and that additional guidance was needed. Part D plan sponsors were encouraged to place beneficiary-specific prior authorization ("PA") edits in place for at least the four classes of drugs listed above. CMS stated in the December 6th draft guidance that "beneficiaries should only very rarely be taking drugs that are not covered under the hospice per diem."

NHPCO submitted a comment letter to CMS regarding this draft guidance in January 2014. In this letter, NHPCO addressed concerns about the proposed policy, including the blanket changes to all hospice providers rather than an identified subset of providers, timely updates of the notice of election and common working file, and prior authorization, among others.

On March 10, 2014 CMS issued final interim guidance to Part D Plan Sponsors and Medicare Hospice Providers detailing the clarification of policy regarding the use of Part D with hospice

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patients. CMS stated that in order for a drug to be covered by Part D after a beneficiary has elected the hospice benefit, the drug must be for "treatment of a condition that is completely unrelated to the terminal illness or related conditions; in other words, the drug is unrelated to the terminal prognosis of the individual." CMS expected that drugs covered under Part D for hospice patients would be under "unusual and exceptional circumstances."

The guidance also directed the Part D plan sponsors to place a beneficiary-level prior authorization (PA) process on ALL drugs for beneficiaries who have elected the Medicare Hospice Benefit to "determine whether the drugs are coverable under Part D." This means that the sponsor would "reject" all claims for drugs to be paid for under Part D, unless or until they have notification from the hospice, either prospectively or after a claim has been rejected through the PA process, of the drugs that are deemed unrelated to the terminal illness or related conditions. Once the hospice or other prescriber has provided information on medications unrelated to the terminal illness and related conditions to the sponsor, the sponsor would then direct the pharmacy to pay the claim under Part D.

After months of advocacy from NHPCO, the Hospice Action Network, hospice providers, and stakeholder groups, and letters from MedPAC, 86 U.S. Senators, and 202 U.S. Representatives, CMS issued revised interim guidance on July 18, 2014, to replace the March 10, 2014, guidance to hospices and Part D plan sponsors regarding payments for medications.

The revised guidance changes the prior authorization (PA) requirement to ONLY the four classes of drugs referenced in the OIG 2012 Report – analgesics, anti-emetics, laxatives, and anti-anxiety medications. **This guidance does not change the responsibility of the hospice to pay for all medications related to the terminal illness and related conditions, whether or not they are included in the four classes identified above**. That responsibility remains. However, if the hospice physician believes a medication in one of the four classes of drugs is being prescribed for a condition unrelated to the terminal illness, the hospice can file a "Hospice Information for Medicare Part D" form with the Part D sponsor. The guidance states that Part D sponsors should "accept the prescriber's or hospice provider's statement and retain the documentation." At that point, the Part D plan then assumes financial responsibility for that medication. No clinical documentation is required on the form, although clinical documentation should be available in the patient's clinical record.

For more information on the history of the hospice and Medicare Part D issue, as well as the Part D Compliance Guide, sample patient letters, other resources and NHPCO's comment letters on CMS guidance, visit:
http://www.nhpco.org/regulatory-compliance-hospices/new-interim-part-d-and-hospice-guidance.

"Hospice Information for Medicare Part D" form can be found here:
http://www.nhpco.org/sites/default/files/public/regulatory/HospicePA-andPlan-of-Care-file.pdf.

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For information on determining relatedness to the terminal condition, including NHPCO's algorithm, visit: http://www.nhpco.org/regulatory-compliance-hospices/determining-terminal-prognosis.

For links to Congressional sign-on letters to CMS Administrator Tavenner on Part D, and other Congressional actions on this topic, visit: http://hospiceactionnetwork.org/get-informed/issues/part-d/.

Additional resources

Hospice Action Network. 2014. The Medicare Hospice Benefit. http://hospiceactionnetwork.org/linked_documents/get_informed/policy_resources/Medicare_Hospice_Benefit_print.pdf

National Hospice and Palliative Care Organization. Hospice: A Historical Perspective. http://www.nhpco.org/history-hospice-care.

National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.

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Chapter 2: The Hospice Community

The number of hospice programs nationwide continues to increase — from the first program that opened in 1974 to over 6,100 locations (primary and secondary locations) today.[30] Hospices are located in all 50 states, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands.

The majority of hospices are independent, freestanding agencies (Table 3). The remaining agencies are either part of a hospital system, home health agency, or nursing home.

Agency Type	2014	2013
Freestanding/Independent Hospice	59.1%	58.3%
Part of a Hospital System	19.6%	19.8%
Part of a Home Health Agency	16.3%	16.7%
Part of a Nursing Home	5.0%	5.1%

Table 2. Agency Type

Hospice Reimbursement

Each hospice is reimbursed at a daily rate for each patient, depending on the patient's level of care. The daily rate is separated into two parts: labor and non-labor. The labor portion of the daily rate is adjusted based on geographic differences in wage rates.[31] The non-labor portion is a rate based on level of care. The Hospice Wage Index is updated annually. In the wage index for FY2016, changes in urban and rural areas were made, based on population changes in the 2010 US Census. In August 2015, the CMS services published the FY2016 hospice payment rates, effective October 1, 2015.[32]

[30] This estimate includes both primary locations and satellite offices of multi-site providers.
[31] Medicare Payment Advisory Commission. Chapter 11, Report to Congress: Medicare Payment Policy. March 2012. http://www.medpac.gov/documents/reports/mar12_ch11.pdf.
[32] Centers for Medicare and Medicaid Services, CMS-1629-F. "Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements." Display date July 31, 2015; Publication date August 6, 2015.

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Description	Rate	Wage Component Subject to Index	Non-Weighted Amount	Rate after Sequestration Reduction
Routine Home Care (October 1 – December 31, 2015)	$161.89	$111.23	$50.66	$158.65
Continuous Home Care Full Rate = 24 hours of care $39.37 hourly rate	$944.79	$649.17	$295.62	$925.89
Inpatient Respite Care	$167.45	$90.64	$76.81	$164.10
General Inpatient Care	$720.11	$460.94	$259.17	$705.71

Table 3. Hospice Reimbursement Rates Fiscal Year 2016[33]

Hospice Payment Reform

In its "FY 2016 Hospice Wage Index and Payment Rate Update," CMS established a two-tiered payment system for patients receiving routine home care (RHC).[34] Beginning on January 1, 2016, hospices will be reimbursed a higher per diem RHC rate for the first 60 days of a patient's care, and a lower rate for days 61 and after. The Medicaid hospice benefit is required to be the same in amount and method as the Medicare hospice benefit, although there are slight variations because there is no co-pay requirement for drugs and respite in the Medicaid hospice benefit.

Description	Rate	Wage Component Subject to Index	Non-Weighted Amount	Rate after Sequestration Reduction
Routine Home Care Patient Days 1-60	$186.84	$186.84	$58.46	$183.10
Routine Home Care Patient Days 61+	$146.83	$146.83	$45.94	$143.89

Table 4. Routine Home Care Rates: Two-Tiered Method (January 1 – September 30, 2016)

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[33] Centers for Medicare and Medicaid Services, CMS-1629-F. "Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements." Display date July 31, 2015; Publication date August 6, 2015.

[34] Centers for Medicare and Medicaid Services, CMS-1629-F. "Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements." Display date July 31, 2015; Publication date August 6, 2015. http://www.regulations.gov/#!documentDetail;D=CMS_FRDOC_0001-1752.

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Service Intensity Add-On
Beginning January 1, 2016, a service intensity add-on (SIA) payment will be made for visits conducted by an registered nurse (RN) and/or social worker up to 4 hours a day (combined) during the last seven days of a hospice patient's life. The patient must be receiving routine home care and direct care is provided by the RN and/or social worker. The amount of time spent on eligible visits, entered on the claim form in quarter hour increments, will be multiplied by the continuous home care rate. This SIA payment is disbursed to the hospice in addition to the RHC rate for the days the RN and/or social worker visits are made. Example: A nurse and/or social worker spent a combined 5.5 SIA-eligible hours visiting a patient in last 7 days of the patient's life.

5.5 hours x $39.37 (CHC hourly rate) = $216.34, in addition to RHC per diem for last 7 days of life.

Reimbursement Rate Cuts

BNAF
A 2009 CMS rule implemented a seven-year phase out of the Budget Neutrality Adjustment Factor (BNAF), a key element in the calculation of the Medicare hospice wage index. Elimination of the BNAF will ultimately result in a permanent reduction in hospice reimbursement rates of approximately 4.2 percent. The last year of BNAF reductions is FY2016. The reduction is figured into the wage index value, and is invisible in the rate setting process. The Patient Protection and Affordable Care Act further altered the Medicare hospice rate formula through the introduction of a "productivity adjustment factor," that will reduce annual hospice payments each year. The productivity adjustment is in two parts – one for all Medicare providers (at 0.4% for FY2015) and an additional adjustment for hospice providers of 0.3% each year.

Sequestration
Sequestration reductions affect several areas of federal spending, including cuts to Medicare. Sequestration took effect on March 1, 2013. However, it first affected the hospice community in April 2013 for claims filed for care provided beginning March 1, 2013.

- Reductions of 2.0% each year in most Medicare spending, including hospice (total Medicare savings: $123 billion over 10 years)
- Reductions in premium support (resulting in increased beneficiary costs) for Medicare Part B and other spending changes (Medicare savings: $31 billion)
- The 2% sequestration reduction is likely to continue until 2025. Sequestration cuts are calculated by the Medicare Administrative Contractor and subtracted from reimbursement for claims submitted.

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Medicare Hospice Payment Limits ("Caps")[35]

The inclusion of the Medicare Hospice Benefit in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) was based in large part on the premise that the new benefit would be a less costly alternative to conventional end-of-life care (Government Accountability Office 2004, Hoyer 2007). To achieve this outcome, when the Congress established the hospice benefit it included two limitations, or "caps," on payments to hospices. The June 2006 MedPAC Report to Congress's chapter on hospice care provides the following description of the two cap limits:

> "One cap limits the share of inpatient care days (either inpatient respite care or general inpatient care). An agency may provide up to 20% of its total patient care days each year. This cap [is] also intended to prevent hospice care from becoming a predominantly inpatient benefit and to preserve the delivery of hospice care in the patient's home.[36] If an agency exceeds the 20% inpatient cap, Medicare pays the routine home care rate for the days above the threshold.
>
> The second cap limits the average annual payment per patient a hospice can receive from the program.[38] The average annual payment cap is calculated for the period November 1 through October 31 each year. … If an agency's total payments divided by its total number of beneficiaries exceeds the cap amount, then the agency must repay the excess to the program. As with the 20% inpatient day cap, this cap is not a spending limit on each individual beneficiary, but is applied at the agency level. The average aggregate payment cap is adjusted annually by the medical expenditure category of the consumer price index for all urban consumers. Unlike the daily payment rates, the average aggregate payment cap is not adjusted for geographic differences in cost. As a result, an agency serving a lower wage area can provide more days of the same category of care per beneficiary before reaching the cap than an agency serving a higher wage area."

Medicare Hospice Cap Amounts (Actual Cap)	
Year	**Cap Amount**
1984	*$6,500.00*
2010	$23,874.98
2011	$24,527.69
2012	$25,377.01
2013	$26,157.50
2014	$26,725.79
2015	$27,382.63[37]

Table 7. Medicare Hospice Cap Amounts

[35] Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy (March 2010). http://www.medpac.gov/documents/reports/Mar10_EntireReport.pdf.

[36] Gage, B., C. Miller, K. Copolla, et al. 2000. Important questions for hospice in the next century. In *Synthesis and Analysis of Medicare's Hospice Benefit*. Washington, DC: Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy.

[37] Centers for Medicare and Medicaid Services, CMS-1629-F. "Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements." Display date July 31, 2015; Publication date August 6, 2015.

[38] This cap was originally conceived to be an amount that reflected the cost to the Medicare program for patients with cancer in the last six months of life. However, the average annual payment cap was ultimately set at an amount that was not based on this calculation (GAO 2004).

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To read the hospice chapter of the June 2006 MedPAC Report to Congress, click here: http://www.medpac.gov/documents/reports/Jun06_Ch03.pdf.

To read more about the Medicare Hospice Caps, click here: http://www.nhpco.org/regulatory/hospice-caps.

Margins and Medicare Expenditures

According to MedPAC data, the aggregate Medicare hospice margin was 10.1% in 2012. Yet the projected margin for 2015 was 6.6% and included effects of the sequester.[39] However, margins vary widely across hospice providers (see table 6).

Category	Percent of Hospices in 2012	2007	2008	2009	2010	2011	2012
All	**100%**	**5.8%**	**5.5%**	**7.4%**	**7.4%**	**8.7%**	**10.1%**
Freestanding	71%	8.7%	8.3%	10.2%	10.7%	11.8%	13.3%
Home health based	13%	2.3%	3.4%	5.9%	3.2%	5.0%	5.5%
Hospital based	15%	-10.9%	-11.3%	-12.2%	-16.6%	-15.9%	-16.8%
For profit (all)	59%	10.4%	10.3%	11.7%	12.3%	14.5%	15.4%
Nonprofit (all)	35%	1.6%	0.7%	3.8%	3.0%	2.5%	3.7%
Urban	73%	6.3%	5.9%	7.9%	7.7%	9.0%	10.3%
Rural	27%	1.4%	2.1%	3.7%	5.2%	6.2%	7.8%

Table 8. Hospice Medicare margins by selected characteristics, 2007–2012[40]

[39] Medicare Payment Advisory Commission. Chapter 12, Report to Congress: Medicare Payment Policy. March 2015. http://medpac.gov/documents/reports/chapter-12-hospice-services-(march-2015-report).pdf.

[40] Medicare Payment Advisory Commission. Executive Summary, Report to Congress: Medicare Payment Policy. March 2015. http://medpac.gov/documents/reports/chapter-12-hospice-services-(march-2015-report).pdf.

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Medicare spending on hospice has risen to $15.1 billion in calendar year 2013, which still comprises only about 2% of Medicare expenditures.[41] This growth in spending on hospice reflects several important factors, including greater awareness of hospice care, which has led to increased utilization of the Medicare Hospice Benefit. [42] Additionally, hospices continue to grow as they serve more patients with non-cancer terminal diagnoses such as heart disease, lung disease, and dementia.[43]

Organizational Tax Status

Hospice agencies are organized into three tax status categories:

1. Not-for-profit [charitable organization subject to 501(c)3 tax provisions]
2. For-profit (privately owned or publicly held entities)
3. Government (owned and operated by federal, state, or local municipality)

Based on analysis of CMS's Provider of Service (POS) file, 27.9% of active Medicare Provider Numbers are assigned to providers that held not-for-profit tax status and 67.8% held for-profit status in 2014. Government-owned programs comprise the smallest percentage of hospice providers (4.3% in 2014).[44]

Historical charts of the growth in number of patients served by hospice and the growth in number of hospice programs in the U.S. can be found in Appendix A.

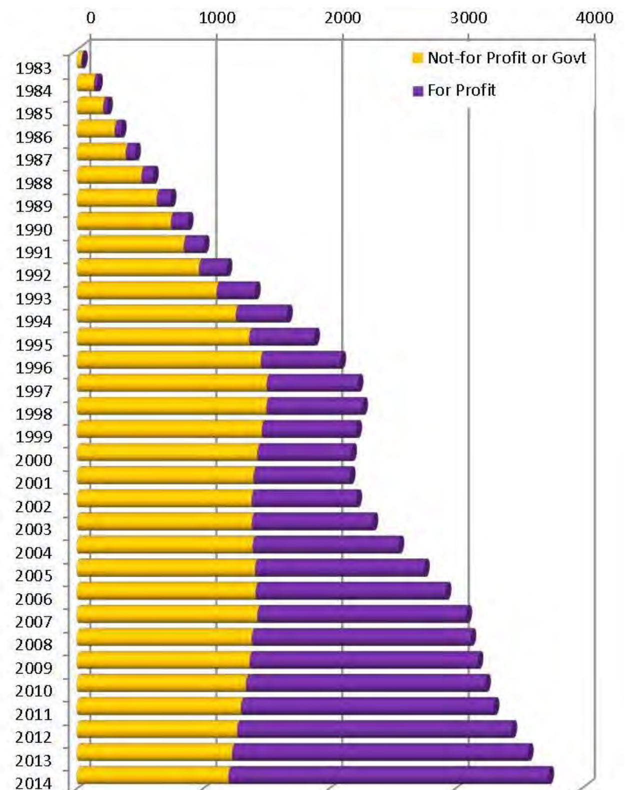

Figure 4. Number of Not-for-Profit and For Profit Hospices

Hospice and Managed Care

Medicare Advantage

Beginning in the 1970s, Medicare beneficiaries have been able to choose to receive their Medicare benefits through a private health plan instead of through the federally-managed fee-for-service program. In 2003, the Medicare Modernization Act termed this option "Medicare

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[41] Medicare Payment Advisory Commission. Executive Summary, Report to Congress: Medicare Payment Policy. March 2015. http://medpac.gov/documents/reports/chapter-12-hospice-services-(march-2015-report).pdf.

[42] Medicare Payment Advisory Commission. Chapter 11, Report to Congress: Medicare Payment Policy. March 2012. http://www.medpac.gov/documents/reports/chapter-11-hospice-services-(march-2012-report).pdf.

[43] National Hospice and Palliative Care Organization. NHPCO Facts and Figures 2015. http://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf. 2015.

[44] 1st Quarter 2015, Centers for Medicare and Medicaid Services (CMS) Provider of Service File (POS).

Advantage."[45] In 2015, 31% of Medicare beneficiaries were enrolled in a Medicare Advantage Plan, although enrollment rates vary greatly by state and locale.[46]

Medicare Advantage plans cover all services that traditional Medicare covers except for hospice and End-Stage Renal Disease (ESRD). When an individual with Medicare Advantage elects the Medicare Hospice Benefit, all Medicare-covered services they receive while in hospice care are covered by Original Medicare. This includes any Medicare-covered services for conditions unrelated to the terminal prognosis or provided by the attending physician.[47] If the Medicare Advantage Plan includes additional services not covered under Original Medicare (such as dental benefits) and the patient does not disenroll from the Medicare Advantage Plan, the Medicare Advantage Plan will continue to cover those additional services.[48]

Medicaid Managed Care (for patients not eligible for Medicare)
States have traditionally provided Medicaid benefits using a fee-for-service system. In the past 15 years, however, states have more frequently implemented a managed care delivery system for Medicaid benefits. In a managed care delivery system, beneficiaries get most or all of their Medicaid services from an organization under contract with the state. Based on 2014 data, over 43.5 million people received benefits through some form of managed care, either on a voluntary or mandatory basis.[49]

States can allow people to voluntarily enroll in a managed care program, but more frequently, states *require* residents to enroll in a managed care program. Increasing numbers of states are using Managed Long Term Services and Supports as a strategy for expanding home and community-based services, promoting community inclusion, ensuring quality and increasing efficiency.

Hospices, unlike most other providers, receive the same payment for the traditional Medicaid Hospice Benefit that they receive for the Medicare Hospice Benefit due to a provision in the Social Security Act. For states that cover the hospice benefit under their Medicaid Managed Care Plan, the Medicaid statute may not apply. Instead, states have the flexibility to require payment rates that mirror the Medicare rate or they may choose to allow Medicaid Managed Care Organizations to reimburse hospice providers at rates that are deemed by CMS as actuarially sound.

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[45] "Medicare Advantage." The Henry J. Kaiser Family Foundation. http://kff.org/medicare/fact-sheet/medicare-advantage/. June 2015.
[46] "Medicare Advantage 2015 Spotlight: Enrollment Market Update." The Henry J. Kaiser Family Foundation. http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/. June 30, 2015.
[47] Centers for Medicare and Medicaid Services. "Medicare Hospice Benefits." CMS Product No. 02154. http://www.medicare.gov/Pubs/pdf/02154.pdf. Revised August 2012.
[48] *Code of Federal Regulations*, Medicare Advantage Program, title 42, sec. 422.320; The Social Security Act, section 1853(h)(2)(B)
[49] The Expanded State of Medicaid in the United States, PwC, January 2015

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Health Insurance Plans for the Commercially Insured

Commercial payers constitute a relatively small proportion of hospice caseloads. Contractual relationships between hospice providers and health insurance plans often follow the lead of Medicare, both in form (all-inclusive, per-diem rates) and level of payment. Industry research indicates that the vast majority of health plans contract with hospices as ancillary providers. Other plans offer hospices per visit coverage for their services, following the model used with home health agencies. Some benefits may be written with low lifetime maximums for hospice care. In cases where there is no defined hospice benefit, health insurance plan case managers may be able to arrange coverage on an individualized basis or substitute other listed benefits to pay for hospice care. Decisions on how to cover hospice care are made individually by each health insurance plan, and a single plan could have dozens of coverage approaches for its different sponsoring employer groups or product lines.[50]

Accountable Care Organizations (ACOs)

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

Medicare offers several ACO programs:

- Medicare Shared Savings Program—a program that helps Medicare fee-for-service program providers becomes an ACO.
- Advance Payment ACO Model—a supplementary incentive program for selected participants in the Shared Savings Program.
- Pioneer ACO Model—a program designed for early adopters of coordinated care. (No longer accepting applications.) [51]

On October 20, 2011, CMS finalized rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through ACOs. ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program (Shared Savings Program) will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Provider participation in an ACO is purely voluntary.

The Affordable Care Act specifies that an ACO may include the following types of groups of providers and suppliers of Medicare covered services:

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[50] NHPCO Issue Brief: Managed Care and Hospice: Strengthening the Bonds, Building for the Future July 2005, Reissued December 2014.

[51] "Accountable Care Organizations" http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/.

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- ACO professionals (i.e., practitioners meeting the statutory definition) in group practice arrangements
- Networks of individual practices of professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals, or
- Other Medicare providers and suppliers as determined by the Secretary.

The ACO must have at least 5,000 beneficiaries enrolled for a period of three years.[52]

Hospice providers are now beginning to contract with ACOs to identify and provide care to terminally ill patients. With the expertise from hospice providers, ACOs should be able to identify patients earlier that are eligible for the Medicare Hospice Benefit.

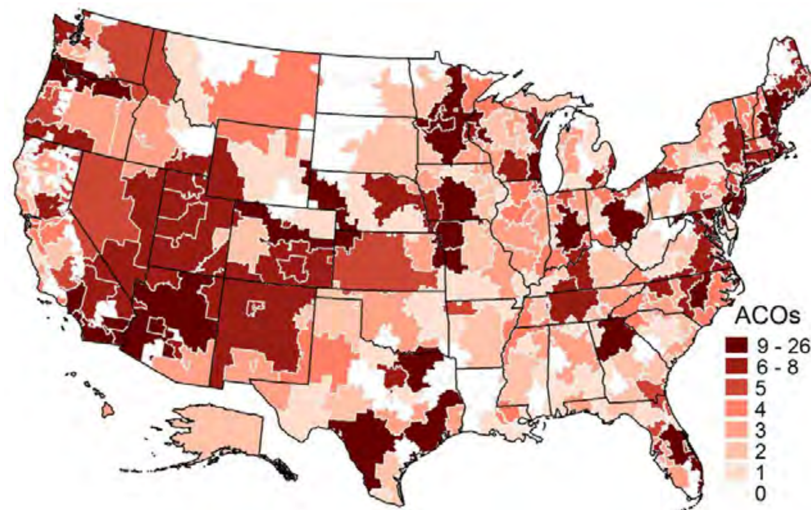

Figure 5. Number of ACOs by Hospital Referral Region, January 2015; Leavitt Partners Center for Accountable Care Intelligence, as reported in "Growth And Dispersion Of Accountable Care Organizations In 2015," Health Affairs Blog, David Muhlestein, March 31, 2015.

Care Transitions and the Continuum of Care

Hospice focuses on relieving symptoms and supporting patients with a life expectancy of months, not years. However, palliative care may be given at any time during a person's illness, and can be coupled with curative treatment. Most hospices have a set of defined services, team members, and rules and regulations. Hospice and palliative care both focus on helping a person be comfortable by addressing issues or symptoms causing physical or emotional pain or

[52] Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program, The Medicare Learning Network® (MLN), ICN 907404 November 2012.

suffering. The goals of palliative care are to improve the quality of a seriously ill person's life, and to support that person and their family during and after treatment.[53]

Cost Effectiveness of Hospice Care

Research conducted at Mount Sinai's Icahn School of Medicine, published in the March 2013 issue of *Health Affairs*, found that hospice enrollment saves money for Medicare and improves care quality for Medicare beneficiaries across a number of different lengths of services. Among the key findings are:[54]

- Medicare costs for hospice patients were lower than non-hospice Medicare beneficiaries with similar diagnoses and patient profiles,
- Hospice enrollment is associated with fewer 30-day hospital readmissions and in-hospital deaths, and
- Hospice enrollment is associated with significantly fewer hospital and ICU days.

Likewise, a 2007 study out of Duke University concluded that during the last year of life, hospice saves the Medicare program an average of $2,309 for each beneficiary served.[55] Moreover, for nursing home residents receiving the hospice care benefit, the probability of end of life hospitalization(s) is reduced.[56,57] Therefore, transitions that adversely affect residents' quality of life are reduced. The resulting improved quality of life coupled with potential Medicare savings powerfully supports the benefit's value in the nursing home setting.

Continuum of Care

When there is a seamless care continuum, providers work together to develop a coordinated plan that addresses physical, emotional, social, caregiving, spiritual, nutritional and other needs. In some communities multiple agencies work together to offer a range of services along the continuum to ensure that needs are met. The common theme throughout all models is deciding when about when and how to infuse palliative care throughout the disease trajectory.

In addition to hospice care, some programs that fall along the care continuum include:

- **Adult day programs.** Adult day service centers provide a coordinated program of professional and compassionate services for adults in a community-based group setting. Designed to provide social and some health services to adults who need supervised care

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[53] The National Consensus Project for Quality Palliative Care *Clinical Practice Guidelines for Quality Palliative Care,* 3rd ed. 2013.

[54] Kelley AS, Deb P, et al., "Hospice Enrollment Saves Money For Medicare and Improves Care Quality Across A Number of Different Lengths-Of-Stay." Health Affairs 2013; 32(3): 552-561.

[55] Taylor DH et al. 2007. What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program? *Social Science & Medicine*, 65: 1466-1478.

[56] Miller SC, Gozalo P, Mor V. 2001. Hospice Enrollment and Hospitalization of Dying Nursing Home Patients. *The American Journal of Medicine*, 111: 38-44.

[57] Miller SC, Lima JC, Looze J, Mitchell SL. 2012. Dying in US Nursing Homes with Advanced Dementia: How Does Health Care Use Differ for Residents with, versus without, End-of-Life Medicare SNF Care? *Journal of Palliative Medicine*, 15(1):43-50.

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in a safe place outside the home, adult day programs also afford caregivers respite from the demanding responsibilities of their job.[58]

- **Program of All-Inclusive Care for the Elderly (PACE).** Delivering all needed medical and supportive services, a PACE program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their home for as long as possible. Services include the following:
  - adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care;
  - medical care provided by a PACE physician familiar with the history, needs and preferences of each participant;
  - home health care and personal care;
  - all necessary prescription drugs;
  - social services;
  - medical specialties, such as audiology, dentistry, optometry, podiatry and speech therapy;
  - respite care; and
  - hospital and nursing home care when necessary.[59]

Advance Care Planning

Advance care planning consists of making decisions about the care one would want to receive if one happens to become unable to speak for one's self. Advance care planning enables the individual to make and document their decisions about end of life care based on personal values, preferences, and discussions with loved ones.

Advance care planning includes:

- Collecting information on the types of life-sustaining treatments that are available,
- Deciding what types of treatment one would or would not want should they be diagnosed with a life-limiting illness,
- Sharing personal values with loved ones, and
- Completing advance directives, POLST forms, or other appropriate documents to put into writing what types of treatment one would or would not want should he be unable to speak for them.

In 2015, CMS established Medicare coverage for two Current Procedural Terminology (CPT) codes for advance care planning, effective for use for services provided on or after January 1, 2016. These codes are billable under Medicare Part B. The advance care planning codes can be used by any physician or non-physician practitioner who is entitled to bill Part B independently, provided the services are within their scope of practice where they are licensed.

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[58] National Adult Day Services Association. About Adult Day Services. http://www.nadsa.org/learn-more/about-adult-day-services/.

[59] National PACE Association. http://www.npaonline.org/policy-advocacy/value-pace#services.

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- **99497:** Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- **99498**: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

Read more about the CPT codes for Advance Care Planning at: http://www.nhpco.org/alerts/physician-fee-schedule-final-rule-covers-acp.

Advance Directives[60]

Advance directives are legal documents that allow an individual to plan and make their end-of-life wishes known in the event that they are unable to communicate. Advance directives consist of (1) a living will and (2) a medical (healthcare) power of attorney. A living will describes the person's wishes regarding medical care. A medical power of attorney is appointed by an individual and can make healthcare decisions for that person in case the individual is no long able to make such decisions.

To learn more about advance directives, visit: http://www.caringinfo.org/files/public/brochures/Understanding_Advance_Directives.pdf.

Caring Connections provides free advance directives and instructions for each state[61] at: http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289.

POLST

Physician Orders for Life Sustaining Treatment (POLST) is a set of medical orders based on a seriously ill individual's treatment wishes. Programs are now developing in 23 states, and may have different names. This set of documents follows a patient across sites of service and provides protection for healthcare workers (e.g. EMS). It may be labeled differently in different states.

To learn more about POLST visit: http://www.polst.org.

[60] National Hospice and Palliative Care Organization and Caring Connections. "Understanding Advance Directives" http://www.caringinfo.org/files/public/brochures/What_is_Palliative_Care_Brochure.pdf. 2005.

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State Demonstrations to Integrate Care for Dual Eligible Individuals
As of August 2015 and under the State Demonstrations to Integrate Care for Dual Eligible Individuals, CMS had finalized memoranda of understanding with 13 states to implement demonstrations to better coordinate care for dual eligible individuals. Designed as three year programs, they allow states to change the care delivery systems through which beneficiaries receive their medical and long-term care services. In July 2015, CMS announced that states may extend their demonstrations for an additional two years.[62]

A longstanding barrier to coordinating care for Medicare-Medicaid enrollees has been the financial misalignment between Medicare and Medicaid. To begin to address this issue, CMS is testing two models for states to better align the financing of these two programs and integrate primary, acute, behavioral health and long term services and supports for their Medicare-Medicaid enrollees.

These two models include:

- Capitated Model: A State, CMS, and a health plan enter into a contract in which the health plan receives a prospective blended payment to provide comprehensive, coordinated care.
- Managed Fee-for-Service Model: A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

CMS is interested in testing these models across the country in programs that collectively serve up to 2 million Medicare-Medicaid enrollees. All programs will be rigorously evaluated as to their ability to improve quality and reduce costs.[63]

[62] Mesumeci, MaryBeth. “Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS”, The Henry J. Kaiser Family Foundation. http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/. September 8, 2015.
[63] “Financial Alignment Initiative” https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html

Chapter 3: Hospice Regulations and Compliance

Medicare Hospice Regulations, including the Hospice Conditions of Participation

Section 1861(dd) of the Social Security Act provides coverage for hospice care to terminally ill Medicare beneficiaries who elect to receive care from a Medicare-participating hospice. Under this section, the Secretary of the Department of Health and Human Services (HHS) established the regulations and Conditions of Participation (CoPs) that a hospice must meet to participate in Medicare and/or Medicaid, and are set forth at 42 CFR 418. The CoPs apply to a hospice as an entity as well as to the services furnished to each individual under hospice care. The Secretary is responsible for ensuring that the regulations and CoPs, and their enforcement, are adequate to protect the health and safety of individuals under hospice care. To implement this requirement, state survey agencies, or accreditation organizations that have been approved to substitute for the state survey, conduct surveys of hospices to assess their compliance with the CoPs. The hospice CoPs were originally published on December 16, 1983 (48 FR 56008) and were updated in December 2008. Each year when CMS publishes the Medicare Hospice Wage Index final rule, CMS also unveils changes to the Medicare hospice regulations. NHPCO offers members an easy-to-read version of the most updated regulations.

Patient Protection and Affordable Care Act (ACA)

In March 2010, Congress passed the Patient Protection and Affordable Care Act (ACA), which the President subsequently signed into law. The detailed chart in Appendix B outlines the provisions of the ACA that affect hospice.

Face-to-Face Requirements

The ACA requires that a hospice physician or nurse practitioner must have a face-to-face encounter with every hospice patient whose total stay across all hospices is anticipated to reach the third benefit period. The face-to-face encounter must occur prior to, but no more than 30 days prior to, the third benefit period recertification, and every benefit period (every 60 days) reconciliation thereafter, in order to gather clinical findings to determine continued eligibility for hospice care. The practitioner who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter. This policy was recommended by the Medicare Payment Advisory Commission (MedPAC) to ensure proper utilization of the benefit for long-stay patients; the provision took effect on January 1, 2011, and enforcement began April 1, 2011.

For answers to frequently asked questions about the face-to-face requirement, click here: http://www.nhpco.org/sites/default/files/public/regulatory/FAQs_Face-to-Face_v2.pdf.

Medical Review

The ACA incorporated a 2009 MedPAC recommendation that hospice programs with a high percentage of patients qualifying as long lengths of stay (more than 180 days) should have

additional oversight through medical review. The IMPACT Act of 2014 provided technical fixes to the ACA language and the provision is now ready for CMS to set the threshold, or percentage, which will trigger medical review.

Quality Reporting

Section 3004 of the ACA directs the Secretary to establish quality reporting requirements for Hospice Programs. Section 3004 requires the Secretary to publish, no later than October 1, 2012 ,the selected quality measures that must be reported by Hospice Programs. The ACA requires that CMS use measures that have been endorsed by the National Quality Forum (NQF), but also allows CMS to specify measures that are not already endorsed if a feasible and practical measure in the area determined appropriate by the Secretary has not been endorsed.

Consequently, CMS developed the Hospice Quality Reporting Program (HQRP). For initial HQRP implementation hospice providers were required to collect data on two quality measures through December 31, 2013: the structural measure, which requires participation in a quality assessment and performance improvement (QAPI) program, and NQF #0209 (the "Comfortable Dying" measure). Hospices that failed to submit data on these measures by April 1, 2014, will have their market basket update reduced by 2% in FY 2015.

Effective January 1, 2014, the structural measure and NQF #0209 data collection was discontinued. Instead, data collection related to seven other NQF endorsed quality measures was initiated on July 1, 2014 using a standardized data collection instrument (the Hospice Item Set/HIS). The current measures required for quality reporting are:

- NQF #1634: Pain Screening;
- NQF #1637: Pain Assessment;
- NQF #1638: Dyspnea Treatment;
- NQF #1639: Dyspnea Screening;
- NQF #1617: Patients Treated with an Opioid who are Given a Bowel Regimen;
- NQF #1641: Treatment Preferences;
- modified NQF #1647: Beliefs/Values Addressed.

Hospice Item Set

For all patients admitted on or after July 1, 2014, completion of a standardized Hospice Item Set (HIS) is required regardless of payer or patient age. Hospices submit HIS data online on a rolling basis within 30 days of each patient's admission and discharge. The HIS includes a set of data elements that CMS will use to calculate scores for the seven NQF endorsed quality measures described above. The HIS is not a patient assessment tool and is not intended to replace a hospice's current initial and comprehensive patient assessment. Hospices failing to report quality data via the HIS in 2014 will see their market basket reduced by 2% in FY 2016 (October 1, 2015 – September 30, 2016).[64]

[64] Centers for Medicare & Medicaid Services. FY2014 Hospice Wage Index. http://www.gpo.gov/fdsys/pkg/FR-2013-08-07/pdf/2013-18838.pdf

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Hospice programs are evaluated for purposes of the quality reporting program based on data submission, not on their performance on the required measures.

For more information on the Hospice Items Set, click here: http://www.nhpco.org/quality/hospice-item-set-his.

CAHPS® Hospice Survey

The CAHPS® Hospice Survey is a component of CMS' Hospice Quality Reporting Program that emphasizes the experiences of hospice patients and their primary caregivers listed in the hospice patients' records. The survey follows the principles used in the development of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys and joins the CAHPS® family of surveys. The CAHPS Hospice survey is administered by vendors on behalf of hospices. Hospices are required to contract with an approved survey vendor and to provide family caregiver contact information to the vendor on a monthly basis. Hospices do not provide contact information for caregivers of patients who were discharged alive or decedents who were under the age of 18; who died within 48 hours of admission to hospice care; for whom no caregiver was listed or available; for whom caregiver is a non-familial legal guardian; for whom the caregiver has a foreign (non-US or US Territory) home address; or whose caregiver requested that they not be contacted.

Hospices participated in a "dry run" of the CAHPS® Hospice survey for at least one month in the first quarter of 2015 (January 1 - March 31, 2015). Ongoing data collection began April 1, 2015 and continues through the end of 2015. Hospices that fail to report survey data will incur a 2% market basket reduction for FY 2017 (beginning October 1, 2016).

Hospices that have fewer than 50 deceased survey eligible patients in the period from January 1, 2014 through December 31, 2014 will be exempt from the CAHPS® Hospice survey data collection and reporting requirements for the FY 2017 payment determination. The hospices will be required to submit their patient counts for the period of January 1, 2014 through December 31, 2014 to CMS online via a Participation Exemption for Size Form.

New Quality Measures and Payment Penalties

Beginning with the FY 2018 payment determination, measures adopted for the HQRP beginning with a payment determination year will be automatically adopted for all subsequent years' payment determinations, unless removed, suspended, or replaced by CMS. No measures were removed or added for the FY 2017 reporting cycle.

The CAHPS® Hospice Survey continues to be a component of the CMS Hospice Quality Reporting Requirements for the FY 2018 APU and subsequent years. CMS plans to submit measures from the CAHPS® Hospice Survey to the National Quality Forum (NQF) for endorsement as hospice quality measures. The measures derived from the CAHPS® Hospice Survey include five composite measures, three single item measures, and two global measures.

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CMS has imposed data submission timeliness threshold requirements beginning with all HIS admission and discharge records that occur on or after January 1, 2016, in accordance with the following schedule:

- Beginning on or after January 1, 2016 to December 31, 2016, hospices must submit at least 70 percent of all required HIS records within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2018.
- Beginning on or after January 1, 2017 to December 31, 2017, hospices must score at least 80 percent for all HIS records received within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2019.
- Beginning on or after January 1, 2018 to December 31, 2018, hospices must score at least 90 percent for all HIS records received within the 30 day submission timeframe for the year or be subject to a 2 percentage point reduction to their market basket update for FY 2020.

For more information on the CAHPS® Hospice survey, click here: http://www.nhpco.org/quality/cahps%C2%AE-hospice-survey .

For more information on the HIS Quality Reporting requirements, click here: http://www.nhpco.org/quality/hospice-item-set-his

To view the Quality Reporting Timeline CY2013-2016, click here: http://www.nhpco.org/sites/default/files/public/quality/QualityReportingTimeline.pdf

Accreditation Organizations

CMS permits Medicare-certified hospice providers to become "accredited" by an approved national accreditation organization and to be exempt from routine surveys by state survey agencies to determine compliance with Medicare Conditions of Participation. Three national accreditation organizations are approved to accredit hospice organizations: the Joint Commission, Community Health Accreditation Partners (CHAP), and the Accreditation Commission for Health Care, Inc. (ACHC).

Office of the Inspector General (OIG)

Office of Inspector General's (OIG) mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries. The Office of Audit Services (OAS) conducts independent audits of HHS programs and/or HHS grantees and contractors. These audits examine the performance of HHS programs and/or grantees in carrying out their responsibilities and provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement, and promote economy and efficiency throughout HHS. OAS conducts audits using its own

resources and oversees audit work performed by others. OAS is the largest civilian audit agency in the Federal Government.

A summary of OIG reports on hospice care from 1995 to the present can be found here: http://www.nhpco.org/sites/default/files/public/regulatory/Summary_OIG_Reports1995-date.pdf.

OIG Workplan

The OIG Workplan for each Fiscal Year provides brief descriptions of activities that the OIG plans to initiate or continue with respect to HHS programs and operations in that fiscal year. When reports are issued, they are posted to OIG's website.

A summary of hospice issues in each OIG Workplan can be found here: http://www.nhpco.org/office-inspector-general-oig.

Compliance Programs

The OIG voluntarily promotes development and implementation of compliance programs for the health care industry. The adoption and implementation of voluntary compliance programs can significantly reduce fraud, abuse, and waste, while at the same time furthering the fundamental mission of provision of quality care to patients. Moreover, the ACA mandates that a broad range of providers, suppliers, and physicians adopt a compliance and ethics program. Congress delegated the development of the core requirements and implementation deadlines to the discretion of HHS, but dates for hospice providers have not yet been set.

In September 1999, the OIG issued guidance to assist hospices in developing effective internal controls that promote adherence to applicable Federal and State law, as well as the program requirements of Federal, State, and private health plans. In the OIG guidance, seven elements fundamental to an effective compliance program were listed:

- Implementation of written policies, procedures and standards of conduct;
- Designation of a compliance officer and compliance committee;
- Conduction of effective training and education;
- Development of effective lines of communication;
- Enforcement of standards through well-publicized disciplinary guidelines;
- Conduction of internal monitoring and auditing; and
- Prompt response to detected offenses and development of corrective action.

The OIG Compliance Guidance for Hospice Providers also listed 28 risk areas for hospice compliance. These risk areas are still valid today and should be a guide for hospices in their compliance activities. The list of risk areas can be found here: http://oig.hhs.gov/authorities/docs/hospicx.pdf.

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Regulatory and Compliance Oversight

Hospice Survey Requirement

Effective April 6, 2015, Medicare certified hospices will have mandatory surveys every 36 months, through 2025. CMS will contract with the appropriate state survey agency in each state. Surveys may also be performed by accrediting agencies with deemed status, such as the Joint Commission, CHAP, and ACHC.

CMS Medicare Administrative Contractors (MACs)

The CMS Medicare Administrative Contractors (MACs) serve as the primary point of contact for provider enrollment, Medicare coverage and billing requirements, and processing and payment of Medicare fee-for-service claims for Medicare providers. Medicare providers are assigned to the MAC based on their geographic location.

The three regional MACs for home health and hospice are CGS Administrators; National Government Services (NGS); and Palmetto, GBA. For more information about these MACs, visit: http://www.nhpco.org/billing-and-reimbursement/medicare-administrative-contractor-mac-information.

Each MAC has jurisdiction in the following states:

CGS Administrators: Colorado; Delaware; Washington, DC; Iowa; Kansas; Maryland; Missouri; Montana; Nebraska; North Dakota; Pennsylvania; South Dakota; Utah; Virginia; West Virginia; and Wyoming

National Government Services: Alaska, Arizona, California, Connecticut, Hawaii, Idaho, Maine, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, New York, Oregon, Puerto Rico, Rhode Island, Vermont Virgin Islands, Washington, Wisconsin

Palmetto, GBA: Alabama, Arkansas, Florida, Georgia, Indiana, Illinois, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas

MAC Audit Types

MACs can perform several types of audits, described below. More information about any of these types of audits can be found at http://www.nhpco.org/regulatory/fraud-and-abuse.

- Additional Documentation Request (ADR): When a Medicare Administrative Contractor (MAC) cannot make a coverage or coding determination from the information that has been provided on a claim and its attachments, they may ask for additional documentation by issuing an Additional Documentation Request (ADR). The MAC must request records related to the claim(s) being reviewed.

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- Comprehensive Error Rate Testing (CERT): The CMS CERT program measures improper payments in the Medicare fee-for-service program. The CERT program is not a measure of fraud. Since the CERT program uses random samples to select claims, reviewers are often unable to see provider billing patterns that indicate potential fraud when making payment determinations. The CERT program does not, and cannot, label a claim fraudulent.
- Payment Error Rate Measurement (PERM): The PERM measures improper payments in Medicaid and the Children's Health Insurance Program and produces error rates for each program. The error rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory, or administrative requirements.

Other Audit Types

- Medicaid Integrity Contractors (MIC): The Deficit Reduction Act of 2005 established the Medicaid Integrity Program (MIP) and MICs. A MIC ensures that paid claims were:
  - For services provided and properly documented;
  - For services billed properly, using correct and appropriate procedure codes;
  - For covered services; and
  - Paid according to Federal and State laws, regulations, and policies.
- Qualified Independent Contractors (QIC): Qualified Independent Contractors utilize a comprehensive data system to collect and share information about appeals decisions, give weight to carrier and fiscal intermediary local coverage determinations, and conduct a panel review of all medical necessity denials. A party to the redetermination may request a reconsideration if dissatisfied with the redetermination decision. A Qualified Independent Contractor (QIC) will conduct the reconsideration.
- Quality Improvement Organizations [QIO): CMS recently restructured the Quality Improvement Organization (QIO) Program to improve patient care, health outcomes, and save taxpayer resources. This restructuring included the award of contracts for two Beneficiary and Family-Centered Care (BFCC) QIO contractors who will support the program's case review and monitoring activities separate from the traditional quality improvement activities of the QIOs. These new contract awards will change the QIOs of some hospice providers and those providers will need to update the QIO information on their UPDATED - Notice of Medicare Non-Coverage (NOMNC) form. The NONMC is issued to a patient when the hospice determines the patient is no longer terminally ill. The patient has the right to appeal the decision to their QIO. The newly formed BFCC will serve that function.

For more information on the QIO restructuring and contact information for Livanta and Kepro, see the NHPCO Information Guide on "Transition of Medicare Quality Improvement Program" (July 2014) at http://www.nhpco.org/sites/default/files/public/regulatory/QIO_transition.pdf.

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Figure 5. Map of QIO Regions

- Recovery Audit Contractors (RAC): CMS has proposed the establishment of a fifth RAC contractor focused solely on DME, home health and hospice for the country. As of September 2014, all RAC contracts are on hold and there is limited new RAC activity.
- Zone Program Integrity Contractors (ZPIC): ZPICs are part of the Medicare Integrity Program and replace the former Program Safeguard Contractors. ZPICs are responsible for preventing, detecting, and deterring Medicare fraud. ZPICs complete the following functions for Medicare:
    - Prevents fraud by identifying program vulnerabilities.
    - Proactively identifies incidents of potential fraud that exist within its service area and takes appropriate action on each case.
    - Investigates (determines the factual basis of) allegations of fraud made by beneficiaries, providers, CMS, OIG, and other sources.
    - Explores all available sources of fraud leads in its jurisdiction, including the MFCU and its corporate anti-fraud unit.
    - Initiates appropriate administrative actions to deny or to suspend payments that should not be made to providers where there is reliable evidence of fraud.
    - Refers cases to the Office of the Inspector General/Office of Investigations for consideration of civil and criminal prosecution and/or application of administrative sanctions.
    - Refer any necessary provider and beneficiary outreach to the Provider Outreach and Education staff at the MAC.

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State-specific Regulatory and Compliance Information

CMS provides funding to surveyors in state agencies to inspect hospices for their compliance with the Medicare hospice Conditions of Participation. The State may also have surveyors who provide oversight for state hospice licensure regulations, in collaboration with State surveyors. Information on state-specific regulatory and compliance topics, including licensing boards, state regulations, and survey agencies, among others, can be found here: http://www.nhpco.org/regulatory/state-specific-resources.

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Chapter 4: Hospice Public Policy and Advocacy

Congressional Jurisdiction

When legislation is introduced in Congress, it is assigned to a committee that oversees legislation on a specific set of issues, including the topic of the assigned legislation. These committees are referred to as the committees of jurisdiction over the set of issues. The committees that oversee Medicare legislation, including the Medicare Hospice Benefit, are the Senate Finance Committee and the House Ways and Means Committee. Each chamber will only consider the legislation once it is passed in its Committee of Jurisdiction. However, the process by which a bill becomes law is rarely predictable and can vary significantly from bill to bill.

To learn more about the legislative process, visit: http://beta.congress.gov/legislative-process.

Senate Finance Committee website: http://www.finance.senate.gov/.
House Ways and Means Committee website: http://waysandmeans.house.gov/.

Medicare Payment Advisory Commission (MedPAC)

MedPAC is an independent Congressional agency tasked with advising Congress on issues affecting the Medicare program. The Commission's statutory mandate is broad: in addition to advising Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare. From time to time, MedPAC studies aspects of the Medicare Hospice Benefit, formulates recommended changes, and reports to Congress.

For more information on MedPAC's studies and reports on the Medicare Hospice Benefit, visit: http://www.hospiceactionnetwork.org/issues/medpac.html.

Medicare Payment Advisory Commission website: http://medpac.gov/.

Current Supported Legislation Regarding Hospice

Medicare Patient Access to Hospice Act (H.R. 1202/S.1354)
In rural and other medically under-served communities, a physician assistant (PA) may be the only primary care professionals in the community. Current Medicare rules hamper beneficiaries' access to care because the rules do not authorize PAs to provide primary care for hospice patients. This legislation fixes Medicare regulations so physician assistants can provide primary care to hospice patients. Sponsors: Representatives Lynn Jenkins (R-KS) and Mike Thompson (D-CA); Senators Michael Enzi (R-WY) and Thomas Carper (D-DE).

NHPCO Letter of Support: House/Senate

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Hospice CARE Act (H.R. 2208)
This bill will expand the types of hospice-employed professionals who can have a face-to-face encounter. Currently, a face-to-face visit can be done only by a physician employed by, or under contract with, the hospice or an NP who is employed by the hospice. This bill proposes also allowing hospice employed physician assistants or clinical nurse specialists to provide these visits. These changes will facilitate timely provision of face-to-face visits.

This bill also changes the reference to "the 180th day recertification" to "the first 60 day period" in order to make the statute consistent with CMS's interpretation. This change is simply an effort to make the statute consistent with CMS's interpretation. In the limited circumstances of a hospice newly admitting a patient who requires a face-to face encounter because of past hospice experience with a different hospice, this legislation will allow that hospices have up to 7 days after the patient elects hospice to provide a face-to-face encounter, so that admission isn't delayed. Sponsors: Representatives Tom Reed (R-NY) and Mike Thompson (D-CA).

Background
NHPCO Letter of Support

Care Planning Act (S. 1549)
The Care Planning Act is designed to give people with serious illness the freedom to make more informed choices about their care, and the power to have those choices honored. Specifically, *the Care Planning Act* (1) establishes a new Medicare benefit called Planning Services for those with advanced illness, allowing for a team-based approach of care planning discussions with doctors, nurses, and other healthcare professionals; (2) creates a pilot program for Advanced Illness Coordination Services to allow for home-based support of patients with multiple and complex chronic conditions; and (3) directs the Secretary of HHS to develop quality metrics, public educational efforts, and resource development on advance care planning. Sponsors: Senators Mark Warner (D-VA) and Johnny Isakson (R-GA).

Background
NHPCO Letter of Support

Hospice Care Access and Improvement Act (H.R. 3037)
This legislation also contains a number of program integrity provisions long-supported by the hospice community, including:

- Expanding CMS focused medical review to identify providers who have concerning results on multiple data points.
- Requiring programs to establish interventions to reduce likelihood of ER visits and hospital admissions for patients identified to be at high risk for readmissions, particularly in the first week of hospice service.
- Expanding the pre-hospice evaluation code to include additional clinical staff from the hospice interdisciplinary team.

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- Requiring, 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.

Sponsors: Representatives Tom Reed (R-NY) and Mike Thompson (D-CA)

Background

Palliative Care and Hospice Education and Training Act (H.R. 3119)
This legislation will expand opportunities for interdisciplinary education and training in palliative care, inform patients and health professionals about the benefits of palliative care and the services available to support patients with serious or life-threatening illness, and direct funding toward palliative care research to strengthen clinical practice and health care delivery. Sponsors: Representatives Eliot Engel (D-NY) and Tom Reed (R-NY).

Background
NHPCO Letter of Support

Recent Legislation Regarding Hospice

NHPCO affiliate the Hospice Action Network actively educates Congress on hospice care and advocates for legislation to address challenges hospices around the country currently face.

IMPACT Act of 2014
Hospice program integrity provisions, initially introduced in the HOSPICE Act (H.R. 5393), were passed by Congress as part of the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014* (H.R. 4994) in September 2014, and signed by President Obama on October 6, 2014. Under the new law, Medicare certified hospices will now have mandatory surveys every 36 months, through 2025. This provision builds on the provision from the HELP Hospice Act (H.R. 2302/S. 1053) that addresses mandating hospice surveys as a critically important program integrity provision. The law also makes a technical correction to allow the implementation of existing law requiring CMS to conduct a medical review of hospice programs that reach to be determined threshold of patients under care for more than 180 days. The threshold would be established by CMS. NHPCO has supported this provision since it was originally recommended by MedPAC in 2009. Finally, the IMPACT Act aligns the inflation of the hospice aggregate cap with hospice reimbursement for the 10 years, for the cap year beginning November 1, 2016/FY2017 (through the cap year ending October 31, 2025).

For more information on the IMPACT Act, click here:
http://hospiceactionnetwork.org/linked_documents/get_informed/legislation/IMPACT_Act_FAQ.pdf.

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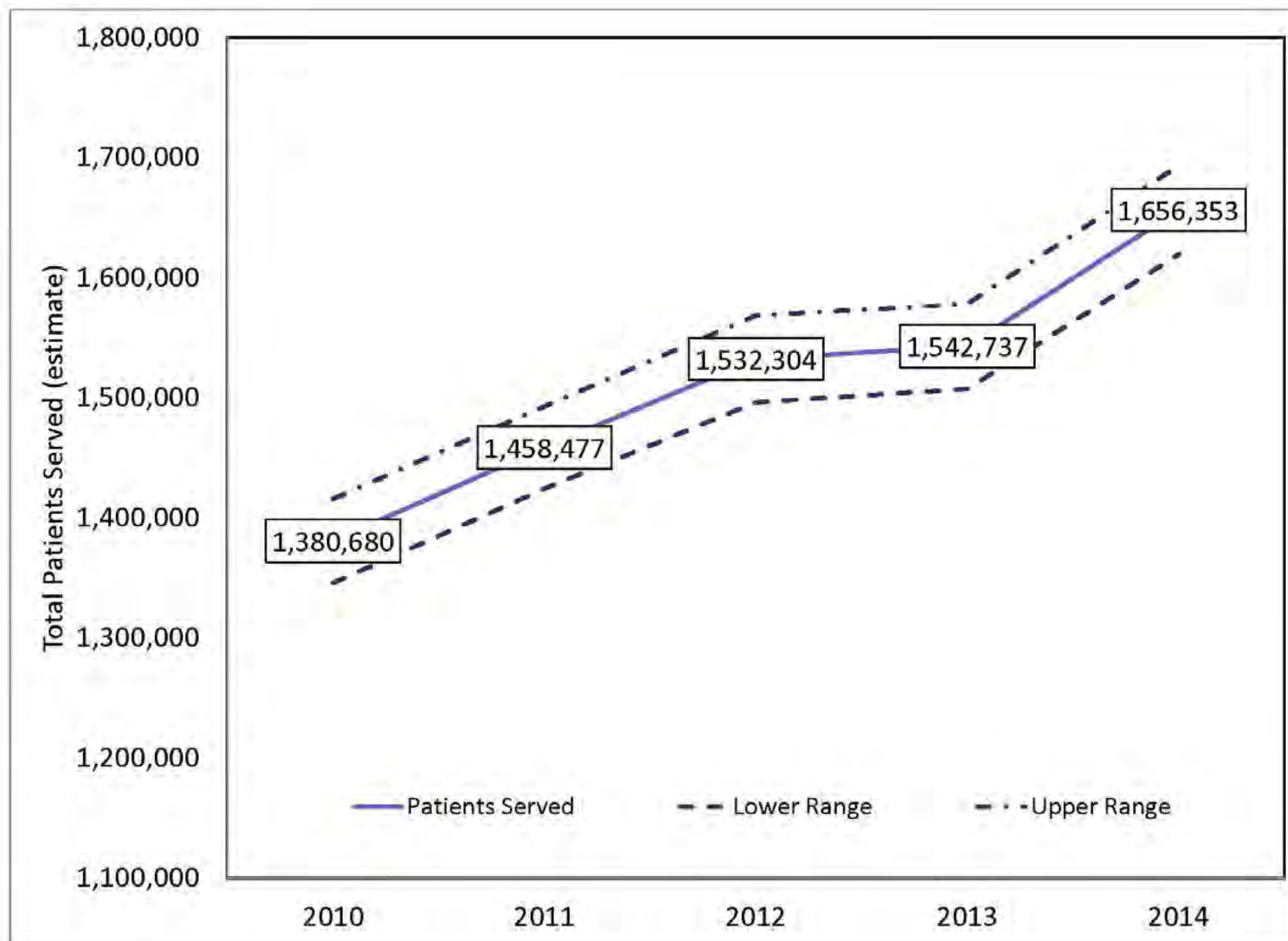
Appendix A: Growth in Patients Served by Hospice and Growth of Hospice Programs[65]



[65] 2014, NHPCO National Data Set and/or NHPCO Member Database.

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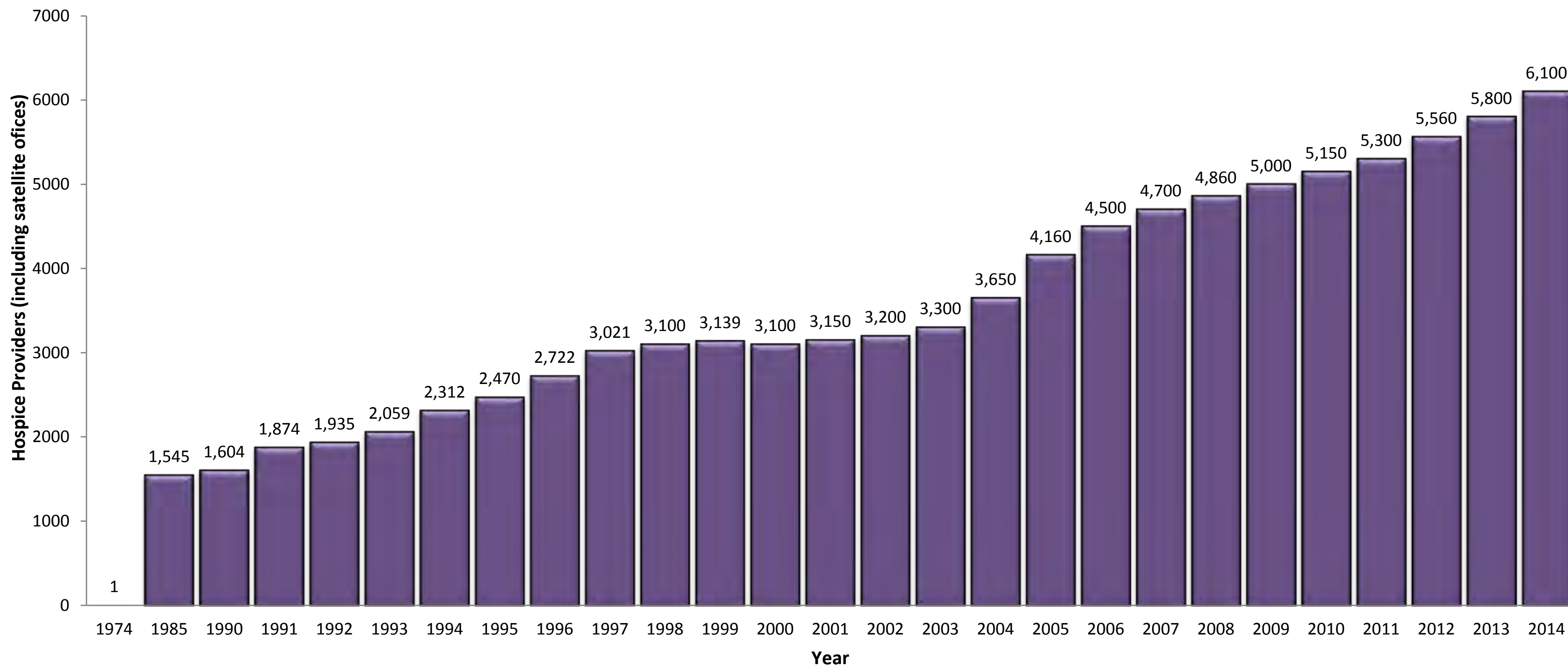

Source: National Hospice and Palliative Care Organization.
www.nhpco.org/research.

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Appendix B: Hospice Provisions in the Patient Protection and Affordable Care Act

Provision	Title	Section Number	Effective Date
Concurrent Care for Children in Medicaid and CHIP Programs	Title II – Role of Public Programs Subtitle D – Improvements to Medicaid Services	**2302**	**Immediately upon enactment – March 23, 2010.** **Action So Far:** • CMS issued a State Medicaid Director Letter on September 9, 2010 -- SMD # 10-018. • Two sets of Q&As have been posted on the NHPCO website with information from CMS, in February 2011 and again in May 2011. • States in various stages of implementation

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Quality Reporting for Hospice Programs In the Hospice Wage Index for Fiscal Year 2012 Final Rule (76 FR 47302, 47320 (August 4, 2011)), to meet the quality reporting requirements for hospices for the FY 2014 payment determination	Title III – Improving the Quality and Efficiency of Health Care Subtitle A – Transforming the Health Care Delivery System Part I – I	**3004**	10/1/2013 (FY 2014) (required that quality measures be published by 10/1/2012) Action So Far: • FY2012 Hospice Wage Index final rule confirms two measures for FY2014, with indications that the number of quality measures will increase in FY2015 and beyond • This includes data submission requirements for payment year 2014, quality measures required for hospice quality reporting for payment year FY2015 and beyond, data submission requirements for payment year FY2015, consideration of an expanded number of required measures to include additional measures endorsed by NQF for annual payment determinations beyond FY2015, and the possible implementation of a standardized data collection instrument to support quality measures.

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Hospice Reform • **Payment Reform** • **Adoption of MedPAC recommendations for:**	Title III; Subtitle B - Improving Medicare for Patients and Providers; Part III – Improving Payment Accuracy	**3132**	**Additional data collection - 1/1/2011** **Payment reform no earlier than 10/1/2013 (FY 2014)** --- **Action So Far:** • In the FY2016 Hospice Wage Index Final Rule, CMS finalized the implementation of hospice payment reform effective January 1, 2016. At that time, routine home care will be billed at two separate amounts: a higher amount for patient days 1-60, and a lower amount for days 61+. • Face-to-face encounter requirements began January 1, 2011 for patients entering their third benefit period and each subsequent period of 60 days. Regulations published as a part of the Home Health Prospective Payment Rate Change Update on November 17, 2010. • CMS granted a three month delay in enforcement so that the effective date for enforcement was April 1, 2011. • No regulatory requirements released

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Concurrent Care Demonstration Program (3 year program)	Title III(B)(III)	**3140**	**Not specified** --- **Action So Far:** • Demonstration project moved to the CMS Office of Innovations. Awaiting funding, based on CMS priorities.
Market Basket Updates and Productivity Adjustment	Title III, Subtitle E - Ensuring Medicare Sustainability	**3401(g)**	Effective 10/1/2012 (FY2013) for hospice. Amount of productivity adjustment (0.7% + 0.3% hospice specific) for hospice in FY2013 published in CR7857 on July 20, 2012.
Selected All Provider Provisions			
Background Check Requirement for Employees of LTC Facilities and Programs with Direct Patient Access	Title VI – Transparency and Program Integrity; Subtitle C – Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers;	**6201**	**Varies from State to State**

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Nursing facilities to have an effective compliance and ethics program in operation by March 23, 2013.	Title VI – Transparency and Program Integrity; Part III – Improving Staff Training; Subtitle E – Medicare, Medicaid and CHIP Program Integrity Provisions	**6401**	HHS to determine timelines for other entities at their discretion
Pilot Testing Pay-for-Performance Programs	Title X – Strengthening Quality, Affordable Health Care for All Americans; Subtitle C – Provisions Relating to Title III	**10326**	1/1/2016. A pilot for hospice providers is expected to be developed.

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U.S. Department of Health and Human Services

Office of Inspector General

Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity:

An OIG Portfolio

OEI-02-16-00570
July 2018
oig.hhs.gov

Joanne M. Chiedi
Principal Deputy
Inspector General

Portfolio in Brief
July 2018
OEI-02-16-00570

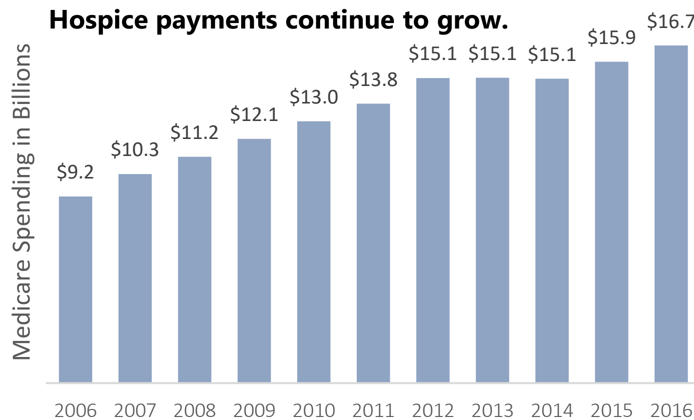
U.S. Department of Health and Human Services

Office of Inspector General

Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity

What OIG Found

Hospice care can provide great comfort to beneficiaries, families, and caregivers at the end of a beneficiary's life. Use of hospice care has grown steadily over the past decade, with Medicare paying $16.7 billion for this care in 2016. It is an increasingly important benefit for the Medicare population; 1.4 million beneficiaries received hospice care in 2016.



However, OIG has identified vulnerabilities in the program. OIG found that hospices do not always provide needed services to beneficiaries and sometimes provide poor quality care. In some cases, hospices were not able to manage effectively symptoms or medications, leaving beneficiaries in unnecessary pain for many days.

OIG also found that beneficiaries and their families and caregivers do not receive crucial information to make informed decisions about their care. Further, hospices' inappropriate billing costs Medicare hundreds of millions of dollars. This includes billing for an expensive level of care when the beneficiary does not need it. Also, a number of fraud schemes in hospice care negatively affect beneficiaries and the program. Some fraud schemes involve enrolling beneficiaries who are not eligible for hospice care, while other schemes involve billing for services never provided.

Lastly, the current payment system creates incentives for hospices to minimize their services and seek beneficiaries who have uncomplicated needs. Within each level of care, a hospice is paid for every day a beneficiary is in its care, regardless of the quantity or quality of services provided on that day. While CMS has made some changes to payments, the underlying structure of the payment system remains unchanged.

Why OIG Did This Portfolio

OIG is committed to ensuring that beneficiaries receive quality care and to safeguarding the hospice benefit. OIG has produced numerous evaluations and audits of the hospice program, including in-depth looks at specific levels of care and settings. OIG has also conducted criminal and civil investigations of hospice providers, leading to the conviction of individuals, monetary penalties, and civil False Claims Act settlements. Through this extensive work, OIG has identified vulnerabilities in the program. This portfolio highlights key vulnerabilities and presents recommendations for protecting beneficiaries and improving the program.

What Medicare Hospice Means

- Beneficiaries forgo curative care for the terminal illness and instead receive palliative care.
- Care may be provided in a variety of settings, including the home, nursing facility, hospital, and hospice inpatient unit.
- There are four levels of care, the most common of which is routine home care.
- Within each level of care, Medicare pays hospices for each day a beneficiary is in care regardless of the quantity or quality of services.

More must be done to protect Medicare beneficiaries and the integrity of the program.

What OIG Recommends and How the Agency Responded

We recommend that the Centers for Medicare & Medicaid Services (CMS) implement 15 specific actions that relate to 7 areas for improvement. CMS should strengthen the survey process—its primary tool to promote compliance—to better ensure that hospices provide beneficiaries with needed services and quality care. CMS should also seek statutory authority to establish additional remedies for hospices with poor performance. Also, CMS should develop and disseminate additional information on hospices, including complaint investigations, to help beneficiaries and their families and caregivers make informed choices about hospice care. CMS should educate beneficiaries and their families and caregivers about the hospice benefit, working with its partners to make available consumer-friendly information. CMS should promote physician involvement and accountability to ensure that beneficiaries get appropriate care.

To reduce inappropriate billing, CMS should strengthen oversight of hospices. This includes analyzing claims data to identify hospices that engage in practices that raise concerns. Lastly, CMS should take steps to tie payment to beneficiary care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs, seeking statutory authority if necessary.

In our draft report to CMS, we recommended 16 specific actions. CMS concurred with six recommendations, did not concur with nine, and neither concurred nor nonconcurred with one. We considered CMS's comments carefully, and we clarified and combined two of our recommendations. See Appendix A for a list of OIG's 15 recommendations. We remain committed to our recommendations and will continue to work with CMS to promote their implementation.

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Inappropriate billing by hospices costs Medicare hundreds of millions of dollars 10

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Seek statutory authority to establish additional remedies for hospices with poor performance 19

Develop and disseminate additional information on hospices to help beneficiaries and their families and caregivers make informed choices about their care 19

Educate beneficiaries and their families and caregivers about the hospice benefit 19

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Strengthen oversight of hospices to reduce inappropriate billing 20

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BACKGROUND

The Office of Inspector General (OIG) Portfolio presents recommendations to improve program vulnerabilities detected in prior audits, evaluations, and investigations. The Portfolio synthesizes OIG's body of work in a program area and identifies trends in payment, compliance, oversight, or fraud vulnerabilities requiring priority attention and action to protect the integrity of Department of Health and Human Services (HHS) programs and the beneficiaries they serve. This portfolio focuses on the Medicare hospice benefit.

Hospice is an increasingly important benefit for the Medicare population. It can provide great comfort to beneficiaries and their families and other caregivers at the end of a beneficiary's life. The number of hospice beneficiaries has grown every year for the past decade. In 2016, Medicare spent about $16.7 billion for hospice care for 1.4 million beneficiaries, up from $9.2 billion for fewer than 1 million beneficiaries in 2006. With this growth, OIG has identified significant vulnerabilities. OIG evaluations and audits have raised concerns about hospice billing, Federal oversight, and quality of care provided to beneficiaries. OIG investigations of fraud cases have uncovered hospices enrolling patients without the beneficiary's knowledge or under false pretenses, enrolling beneficiaries who are not terminally ill, billing for services not provided, paying kickbacks, and falsifying documentation.

This portfolio describes the growth in hospice utilization and reimbursement, and it summarizes key vulnerabilities that OIG has identified and continues to monitor. The portfolio also includes recommendations to CMS to address these vulnerabilities.

Medicare Hospice Benefit

What is hospice care? Hospice care serves terminally ill beneficiaries who decide to forgo curative treatment for the terminal illness and instead receive palliative care. Hospice care aims to make the beneficiary as physically and emotionally comfortable as possible and allow the beneficiary to remain in his or her home environment. It is an interdisciplinary approach to treatment that includes, among other things, nursing care, medical social services (services based on the patient's psychosocial assessment and the patient's and family's needs), hospice aide services, medical supplies, and physician services.

Who provides it? Medicare-certified hospices provide the care. Hospices may be for-profit, nonprofit, or government-owned. Care may be provided in various settings, including the home or other places of residence, such as an assisted living facility, skilled nursing facility, or other nursing facility.

Who is eligible? To be eligible for Medicare hospice care, a beneficiary must be entitled to Medicare Part A and be certified as having a terminal illness with a life expectancy of 6 months or less if the illness runs its normal course. Upon election of hospice care, the beneficiary waives all rights to Medicare payment for services related to the curative treatment of their terminal condition or related conditions.

How does Medicare pay? Medicare pays the hospice for each day that a beneficiary is in care, regardless of the quantity or quality of services provided on that day. Medicare pays a different daily rate for each of the four levels of hospice care: routine home care, general inpatient care, continuous home care, and inpatient respite care.

OIG's body of work covering hospice care since 2005 serves as the basis for this portfolio. This work includes in-depth looks at specific levels of care and settings. It focuses on covered hospice services such as nursing, physician, medical social, and hospice aide services. It does not focus on volunteer services. See Appendix B for a list of OIG hospice reports. The portfolio also includes descriptions of OIG investigative efforts involving hospices, which resulted in 25 criminal actions, 66 civil actions, and $143.9 million investigative receivables from fiscal year (FY) 2013 to FY 2017.

OIG recognizes that many hospices meet Medicare requirements and provide high-quality care. This portfolio focuses on vulnerabilities and possible solutions to improve the program for all hospice beneficiaries. Future OIG work will focus on quality of care in hospices, hospice billing, and compliance.

By leveraging advanced analytic techniques to detect potential vulnerabilities and fraud trends, OIG is better able to target resources at those hospices in need of oversight, leaving others free to provide care and services without unnecessary disruption.

OIG work referenced throughout this document was conducted in accordance with the professional standards applicable to audits, evaluations, and investigations.

The Four Levels of Hospice Care

Medicare pays for four levels of hospice care. Medicare-certified hospices are required to provide each of these levels when needed.[1] Hospices can provide services directly or under arrangement.

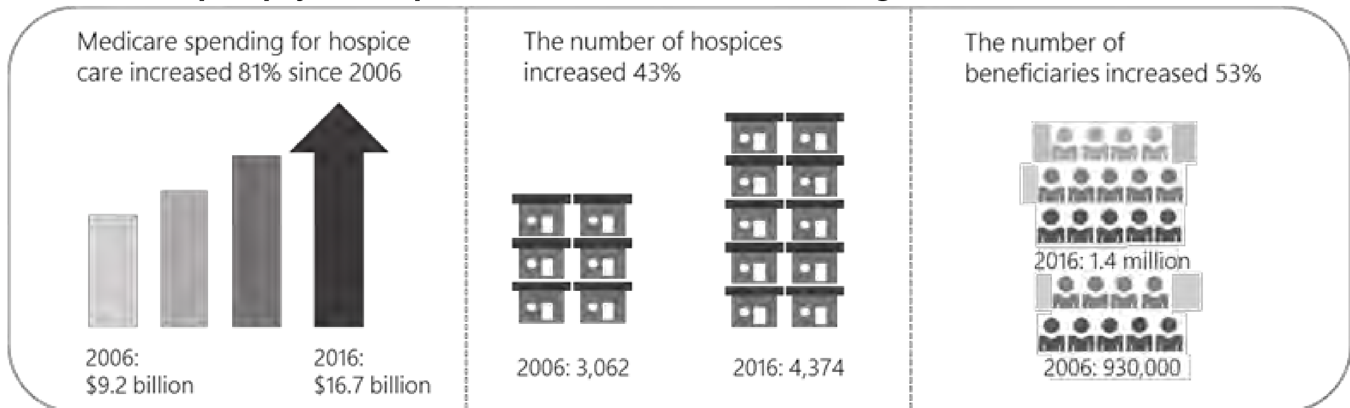
- *Routine home care* is the most commonly used. It is for any day a hospice beneficiary is at home and not receiving continuous home care, which is a more intensive level of care. Routine home care can be provided in the home or other places of residence, such as an assisted living facility or nursing facility. In FY 2017, hospices were paid $190.55 per day for days 1-60 of a beneficiary's routine home care and $149.82 per day after day 60. Before 2016, the daily rate paid to hospices did not change based on the beneficiary's time in care.[2]
- *General inpatient care* is for pain control or symptom management that cannot be managed in other settings, such as the beneficiary's home. General inpatient care is intended to be short term and may be provided in a hospice inpatient unit, a hospital, or a skilled nursing facility (SNF). In FY 2017, hospices were paid $734.94 per day for general inpatient care.
- *Continuous home care* is allowed only during brief periods of crisis and only as necessary to maintain the individual at home. In FY 2017, hospices were paid $964.63 per day for continuous home care. This is based on an hourly rate of $40.19 per hour.
- *Inpatient respite care* is short-term inpatient care provided to the beneficiary when necessary to relieve the caregiver. In FY 2017, hospices were paid $170.97 per day for inpatient respite care.

Hospice Use Has Grown Steadily Over the Past Decade

Medicare paid $16.7 billion for hospice care in 2016

Medicare paid $16.7 billion for hospice care in 2016, an increase of 81 percent since 2006. Over this period of time, the number of Medicare hospice beneficiaries increased each year. About 1.4 million beneficiaries received hospice care in 2016, an increase of 53 percent since 2006. See Exhibit 1. Increases in hospice care were greater than increases in Medicare spending and enrollment in general. From 2006 to 2016, total Medicare spending grew 66 percent, while the total number of Medicare beneficiaries grew 32 percent.[3]

Exhibit 1: Hospice payments, providers, and beneficiaries have grown.



Source: OIG analysis of CMS data, 2017.

OIG has found that patient characteristics, Medicare payments, and services provided differ among care settings and between for-profit and nonprofit hospices.

More than one-half of hospice beneficiaries—55 percent—received care in the home, and 25 percent received care in a nursing facility or SNF in 2016. Thirteen percent of hospice beneficiaries received care while residing in an assisted living facility (ALF). Compared to other settings, ALFs has had the greatest growth in hospice beneficiaries; from 2010 to 2016, the number of beneficiaries receiving care in ALFs grew 64 percent.

The number of hospices serving Medicare beneficiaries has increased every year since 2006. In 2016, a total of 4,374 hospices provided care to Medicare beneficiaries. For-profit hospices accounted for 64 percent of the total. These hospices received more than one-half of the dollars (55 percent), and served just under half (49 percent) of the beneficiaries. Of all hospices, 34 percent were small (fewer than 90 beneficiaries per year), 37 percent were medium sized (90 to 320 beneficiaries per year), and 29 percent were large (over 320 beneficiaries per year).

Hospices Do Not Always Provide Adequate Services to Beneficiaries and Sometimes Provide Poor Quality Care

Key services are sometimes lacking

When beneficiaries elect hospice care, they are choosing to receive care that will not cure their terminal illness, but should provide comfort and relief from pain. All services related to their terminal illness become the hospice's responsibility.[4] Yet hospices do not always provide the care beneficiaries need to control pain and manage symptoms.

Notably, hospices provided fewer services than outlined in the plans of care for 31 percent of claims for hospice beneficiaries residing in nursing facilities.[5] In addition, hospices did not provide adequate nursing, physician, or medical social services in 9 percent of general inpatient care stays in 2012.[6] These services are particularly important to beneficiaries in general inpatient care because they have uncontrolled symptoms requiring pain control or symptom management that cannot be provided in other settings.[7] In some cases, hospices were not able to effectively manage symptoms or medications, leaving beneficiaries in pain for many days.

Examples of Hospices Providing Poor Quality Care

- A hospice billed Medicare for serving a 101-year old beneficiary with dementia. He had uncontrolled pain throughout his 16 days in general inpatient care. The hospice did not change his pain medication until the last day and did not provide him the special mattress he needed for more than a week.[8]
- A hospice billed for 17 days of general inpatient care for a 70-year old beneficiary, but never visited him. Instead, the hospice called his family to inquire how he was doing.[9]
- An 89-year old beneficiary's respiratory symptoms were uncontrolled for 14 days during a general inpatient care stay in which the hospice rarely changed his medication dosage. The beneficiary continued to experience respiratory distress and anxiety.[10]

Hospices often do a poor job care planning

Proper care planning helps ensure that beneficiaries receive the care and attention they need and that services are coordinated effectively. Yet hospices often fall short in care planning.

Hospices are required to establish an individualized written plan of care for each beneficiary they serve and to provide services that meet the plan.[11] The plan of care must be developed by an interdisciplinary group that includes a physician, a registered nurse, a social worker, and a pastoral or other counselor. This helps ensure that the hospice team meets all of the beneficiary's needs. The plan of care must also contain a detailed statement of the scope and frequency of needed services.[12]

Plans of care play a key role

Proper care planning is crucial in providing beneficiaries the care they need. Plans must be individualized and detailed.

Hospices often fail to meet these requirements. Specifically, hospices did not meet plan of care requirements in 85 percent of general inpatient care stays in 2012.[13] An OIG study several years earlier, which focused on all levels of hospice care provided in nursing facilities, found that hospices failed to meet requirements for plan of care for 63 percent of claims.[14] Hospices often did not involve all members of the interdisciplinary group in establishing the plans or failed to include a detailed statement of the scope and frequency of needed services in the plans of care.[15]

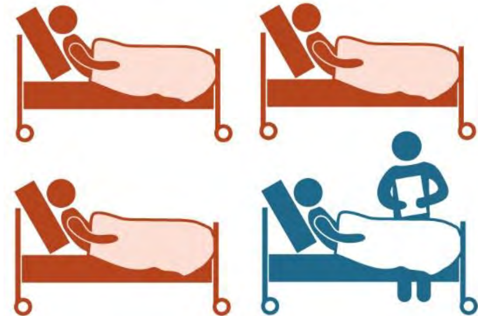
Hundreds of hospices provide only one level of care

In each year from 2006 to 2016, hundreds of hospices provided only the most basic level of care—routine home care—to all the beneficiaries they served throughout the year. In 2016, a total of 665 hospices provided only routine home care. This is an increase of nearly 55 percent from 2011, when 429 hospices did so.[16]

Medicare pays for three other levels of hospice care in addition to routine home care.[17] Hospices must provide, directly or under arrangements, these levels when needed.[18] When hospices provide just routine home care, it calls into question beneficiaries' access to needed services. It is critical that intense services, such as general inpatient care and continuous home care, be available to control the beneficiary's pain and other symptoms when needed. Respite inpatient care, which offers relief to caregivers, should also be available given the essential role that caregivers and family members play in caring for their loved ones at the end of life.

Most beneficiaries do not see a hospice physician

In each year from 2006 to 2016, about three-quarters of hospice beneficiaries did not have a visit with a hospice physician. Medicare does not require physician visits, and hospices can separately bill for them if provided.[19] Most beneficiaries do not receive visits.



This includes beneficiaries with complex needs receiving general inpatient care in hospice inpatient units. Again, physician visits are not a requirement of general inpatient care. However, it is important to note that beneficiaries are placed in this high level of care when the hospice determines that their pain or other symptoms are uncontrolled and cannot be managed at home.[20]

Common fraud schemes involve inappropriately enrolling beneficiaries

OIG has uncovered a number of fraud schemes in hospice care that negatively affect beneficiaries and their families and caregivers. Some fraud schemes involve paying recruiters to target beneficiaries who are not eligible for hospice care, while other schemes involve physicians falsely certifying beneficiaries. For example, a hospice physician inappropriately certified a beneficiary as terminally ill who just days before was determined by a hospital to be in "good shape."

Beneficiaries are put at risk when they are enrolled in hospice care inappropriately, as Medicare hospice does not pay for curative treatment for a beneficiary's terminal illness.[21] Therefore, a beneficiary who is inappropriately enrolled in hospice care might be unwittingly forgoing needed treatment. In one example, a hospice falsely told a beneficiary that she could remain on a liver transplant list even if she elected hospice care. When the beneficiary elected hospice care, she was removed from the transplant list. After the beneficiary learned of this, she stopped hospice care so she could be reinstated on the transplant list. As this example demonstrates, it is critical that beneficiaries know when they are in hospice care and what that means for their treatment options.

Examples of Fraud Schemes Affecting Beneficiaries

- An owner of a Mississippi hospice used patient recruiters to solicit beneficiaries who were not eligible for hospice care. These patients were not even aware that they were enrolled in hospice care. The owner submitted fraudulent charges and received more than $1 million from Medicare.[22] The owner was later excluded from the Medicare program.

- A Minnesota-based hospice chain agreed to pay $18 million to resolve allegations that it inappropriately billed Medicare for care provided to beneficiaries who were not eligible for hospice because they were not terminally ill. The hospice chain also allegedly discouraged physicians from discharging ineligible beneficiaries.[23]

- Two certifying physicians from one California hospice were found guilty of health care fraud for falsely certifying beneficiaries as terminally ill. Both physicians were excluded from the Medicare program. The false certifications were part of a larger fraud scheme organized by the hospice owner. The scheme involved illegal payments to patient recruiters for bringing in beneficiaries, creating fraudulent diagnoses, certifying beneficiaries as terminally ill when they were not, and altering medical records. The owner pleaded guilty to health care fraud and was sentenced to 8 years in Federal prison.[24]

Beneficiaries and Their Families and Caregivers Do Not Receive Crucial Information To Make Informed Decisions About Hospice Care

CMS provides beneficiaries little information about hospice quality

CMS does not provide comprehensive information to the public that is essential for making informed decisions about hospice care. CMS launched a compare website about hospices in August 2017 called Hospice Compare. Hospice Compare was created much later than compare websites for hospitals, nursing facilities, and home health agencies. Compare websites for each of these providers were created over a decade ago.

Hospice Compare does not include critical information about the quality of care provided by individual hospices and offers no information about complaints filed against individual hospices. This information is essential in helping beneficiaries and their families choose the hospice that would best fit their needs and provide good care.

CMS is required to develop quality measures for hospices. These measures must go through a process in which they are endorsed by a consensus-based entity, such as the National Quality Forum. Hospices review the data for these measures before they are made available to the public.[25]

Currently, Hospice Compare includes some quality measures self-reported by the hospice, such as whether the patient was checked for pain, and some quality measures from a survey of family caregivers, such as their willingness to recommend the hospice.[26] These measures do not capture a patient's full experience with hospice care.

Hospice Compare does not include any information about the number, type, and severity of problems found during surveys and complaint investigations. This information would benefit beneficiaries and their families and caregivers by alerting them to hospices found to have done a poor job caring for patients. Although this information is required to be made public,[27] CMS does not include it on Hospice Compare. Instead, some States publish this information on their websites. Gaining access to hospice survey and complaint information is difficult and time consuming, rendering it largely unhelpful. In contrast, CMS publishes survey and complaint information about nursing homes on the nursing home compare website.

Hospice Surveys

Surveyors conduct onsite reviews of hospices every 3 years to promote compliance and quality care. Surveyors observe the operations of the hospice, review clinical records, and visit patients. Surveys are also conducted in response to complaints.

Hospices often provide beneficiaries incomplete or inaccurate information about the benefit

Beneficiaries and their families and caregivers do not always get the information they need when they elect hospice care because hospices often provide incomplete or inaccurate information on election statements. The hospice election statement is an important source of information about the benefit, and hospices are required to provide it. It is written by the hospice and must be signed by a beneficiary or representative before the start of care. The statement should be complete and accurate so that beneficiaries and their caregivers understand what they are entitled to receive and what they must give up with the election of hospice care.

In 35 percent of general inpatient care stays, however, hospices' election statements lacked required information or had other vulnerabilities.[28] Most commonly, these statements neglected to specify that the beneficiary was electing the Medicare hospice benefit as opposed to Medicaid hospice or some other insurance. It is important for beneficiaries to know which benefit they are receiving, especially because eligibility criteria and election periods in some State Medicaid programs differ from those of Medicare, and private health insurance may cover hospice care differently than Medicare.

Some election statements did not mention—as required—that the beneficiary was waiving coverage of certain Medicare services by electing hospice care, or inaccurately stated which Medicare benefits were waived. Other election statements did not state—as required—that hospice care is palliative rather than curative. CMS recently developed model text that hospices can use when they write their election statements.[29] It is crucial that beneficiaries and their families and caregivers understand that when beneficiaries begin hospice care they are turning over all care for their terminal illness to the hospice.

Inappropriate Billing by Hospices Costs Medicare Hundreds of Millions of Dollars

Hospices frequently bill Medicare for a higher level of care than the beneficiary needs

Reviews of individual hospices have found improper payments ranging from $447,000 to $1.2 million for services not meeting Medicare requirements. In these cases, the hospices billed for inappropriate levels of care, lacked required certifications of terminal illness, or did not have sufficient clinical documentation.[30]

Hospices have also inappropriately billed for expensive levels of care that were not needed. Specifically, in 2012 hospices billed one-third of general inpatient care stays inappropriately, costing Medicare $268 million.[31] General inpatient care is the second most expensive level of hospice care and should only be billed when the beneficiary has uncontrolled pain or symptoms that cannot be managed at home.

Hospices often billed for general inpatient care when the beneficiary needed only routine home care. As a result, these hospices were paid $672 per day instead of $151 per day.[32] At other times, the hospice inappropriately billed for general inpatient care when the beneficiary's caregiver was not available and inpatient respite care was needed. Again, the hospices received more than they should have. By billing inappropriately, the hospices received $672 per day for general inpatient care instead of $156 per day for inpatient respite care, the level of care specifically designed to relieve caregivers.[33]

Hospices were more likely to bill inappropriately for general inpatient care provided in SNFs than general inpatient care provided in other settings. Forty-eight percent of general inpatient care stays in SNFs were inappropriate compared to 30 percent in other settings. In addition, for-profit hospices were more likely than other hospices to bill inappropriately for this level of care. For-profit hospices billed 41 percent of their general inpatient care stays inappropriately. In comparison, other hospices, including nonprofit and government-owned hospices, billed 27 percent of their general inpatient care stays inappropriately.

Examples of Hospices Billing Inappropriately

- A for-profit hospice in Mississippi inappropriately billed Medicare for a general inpatient care stay lasting over 7 weeks for a beneficiary whose symptoms were under control. She needed assistance only with personal care, eating, and the administration of medication, yet the hospice was paid almost $30,000 for general inpatient care.[34]

- A for-profit hospice inappropriately billed for a beneficiary in Florida who entered general inpatient care for symptom management. Her symptoms were managed within 2 days, yet she remained in general inpatient care for 15 additional days. Medicare paid close to $12,000 for this stay.[35]

- A hospice in New York billed for 1 month of continuous home care for dates after the beneficiary's death. The hospice improperly received at least $1,266,517 for hospice services billed on behalf of this beneficiary and others that did not comply with Medicare requirements.[36]

- A hospice in Puerto Rico billed for services after the beneficiary revoked the hospice election. The hospice received at least $453,558 in improper payments for services billed on behalf of this beneficiary and others that did not comply with Medicare requirements.[37]

Medicare sometimes pays twice for the same service

Medicare sometimes paid for drugs through Part D for hospice beneficiaries when payment for these drugs should have been covered by the daily rate paid to the hospice. Hospices are required to provide the beneficiary's drugs that are used primarily for the relief of pain and symptom control related to the terminal illness.[38] If Part D pays for them, Medicare is in effect paying twice. Also, beneficiaries may face significant copays depending on the plan and the drug.

OIG found that Part D and beneficiaries paid more than $30 million in 2009 for drugs in certain categories that potentially should have been covered under the daily rate paid to hospices. These categories include analgesic, antinausea, laxative, or antianxiety drugs, which are commonly used in hospice care.[39]

In 2012, OIG found that Part D inappropriately paid for more than 100 drugs for beneficiaries in sampled general inpatient care stays.[40] These 110 drugs were used primarily for the relief of pain and symptom control related to the hospice beneficiary's terminal illness and should have been provided by the hospice. Some of them were analgesic, antinausea, laxative, or antianxiety drugs while others were not.[41]

In addition to drugs, Medicare also paid twice for some physician services for hospice beneficiaries. OIG identified nearly $566,000 in questionable claims for physician services provided to hospice beneficiaries in 2009.[42] In

each of these cases, a service was billed under both the Part A hospice benefit and Part B even though it was from the same physician, on the same day, for the same beneficiary and terminal illness, leading OIG to suspect that the beneficiary did not receive two distinct services, but rather one service billed twice.[43]

Hospice physicians are not always meeting requirements when certifying beneficiaries for hospice care

For hospice services to be covered by Medicare, a physician must certify a beneficiary as terminally ill every election period.[44] This certification is based on the physician's clinical judgment.[45] The physician is required to compose a narrative and include an attestation in each certification of terminal illness. These requirements help to ensure that physicians are involved in determining that hospice care is appropriate for the beneficiary.

However, some hospice physicians are not meeting requirements when certifying beneficiaries. In 14 percent of general inpatient care stays in 2012, the certifying physician did not meet at least one requirement.[46] Specifically, the physicians did not explain their clinical findings or attest that their findings were based on their examination of the beneficiary or review of the medical records.

Hospice fraud schemes are growing and include kickbacks and false billing

OIG has increasingly uncovered fraud schemes that put the program at risk of improper payments. These schemes include paying kickbacks for patient referrals, billing for medically unnecessary services, upcoding, and billing for services not provided. In one case, a physician received kickbacks for recruiting beneficiaries, many of whom were not terminally ill, but were seeking opioids. OIG has taken action against a number of hospices involved in fraud schemes.

OIG Investigative Receivables for Hospice

In FY 2013, OIG investigative receivables were $15.5 million and grew to $55.8 million in FY 2017. In total, investigative receivables from FY 2013 to FY 2017 amounted to $143.9 million.

Examples of Fraud Schemes

- An Illinois-based hospice billed Medicare for medically unnecessary hospice services. The hospice paid bonuses to staff for placing patients in general inpatient care when it was not medically necessary and provided gifts and kickbacks to nursing homes for referring patients to the hospice.[47] A director of this hospice was excluded from the Medicare program.

- A former hospice owner in Alabama pleaded guilty to defrauding Medicare of more than $3 million by billing for general inpatient care but providing a lower level of hospice care.[48] In addition, the owner was excluded from the Medicare program.

- An owner of a Mississippi hospice was sentenced to almost 6 years in prison for submitting fraudulent charges to Medicare and receiving millions of dollars in Medicare funds based on alleged hospice services for patients who were not eligible for hospice care, services that were never provided, and claims based on the forged signatures of physicians. Another person involved in the scheme provided patient names and identifying information in return for kickback payments.[49] This person and the hospice's owner were excluded from the Medicare program.

The Current Payment System Creates Incentives for Hospices To Minimize Their Services and Seek Beneficiaries Who Have Uncomplicated Needs

Payments to hospices are based on the time spent in care, not services provided

A hospice is paid for every day a beneficiary is in its care regardless of how many services it provides on a particular day. The daily rate is determined by the level of care, with routine home care accounting for over 95 percent of all hospice care days.[50] The base rate is the same for all beneficiaries in routine home care, regardless of the beneficiary's needs or care setting.[51]

A hospice is paid the same rate for routine home care provided in a nursing facility as it is for routine home care provided in a beneficiary's home. However, unlike private homes, nursing facilities are staffed with professional caregivers and are required to provide personal care services. These services are similar to hospice aide services that are included in the daily rate of the hospice benefit. Therefore, the hospice is being paid for aide services when a beneficiary resides in a nursing facility even though the facility is already providing them. Furthermore, hospice payments do not include any adjustments or other payments that are tied to the quality of care provided by the hospices.

The Patient Protection and Affordable Care Act requires Medicare hospice payment reform not earlier than October 1, 2013.[52] CMS recently changed

the rate for routine home care, increasing the amount for the first 60 days and decreasing the amount thereafter; it also provides additional reimbursement if the hospice provides skilled care in the last 7 days of life.[53] However, the underlying structure of the benefit—paying for care on a daily basis regardless of the care provided—remains unchanged.

The financial incentives created by this payment system may cause hospices to seek out certain beneficiaries over others. Hospices may target beneficiaries who are likely to have long lengths of stay or fewer needs, as these beneficiaries may offer hospices the greatest financial gain. Hospices may look for these beneficiaries who have certain diagnoses or are in certain settings. When hospices target specific types of beneficiaries, it raises questions as to whether hospices are enrolling beneficiaries appropriately, whether they are serving all the beneficiaries who need care, and whether they have incentives to care for beneficiaries with greater needs. The financial incentives in the current system also could cause hospices to minimize the amount of services they provide.

Hospices typically provide less than 5 hours of visits per week

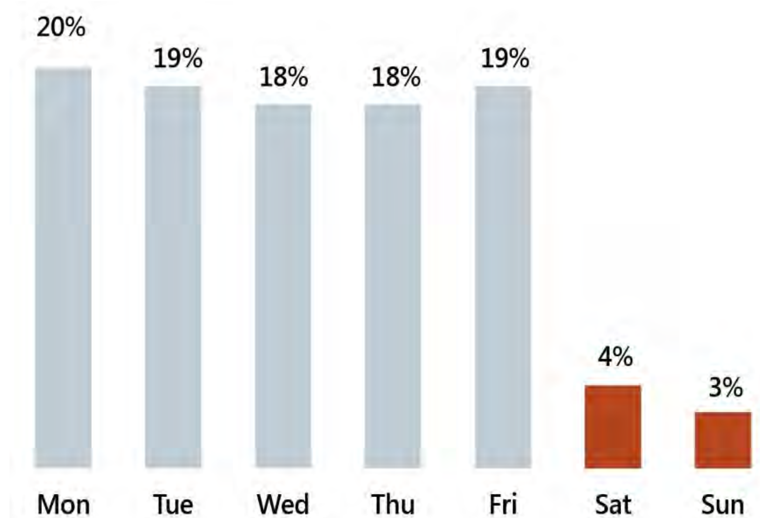
On average, hospices provided 4.8 hours of visits per week and were paid about $1,100 per week for each beneficiary receiving routine home care in an ALF in 2012.[54] Most of the visits were from aides. Of note, 25 hospices did not report making any visits to their beneficiaries receiving routine home care in ALFs in 2012. This involved 210 beneficiaries. Medicare paid these hospices a total of $2.3 million to care for these beneficiaries.

These findings are similar to earlier OIG findings regarding hospice care provided in nursing facilities.[55] Hospices provided an average of 4.2 visits per week to hospice beneficiaries in nursing facilities. This included the three most common services—nursing, hospice aide, and medical social services—combined. Again, hospice aide services were the most commonly provided.

Hospices seldom provide services on weekends

Hospices must make services available, as needed, on a 24-hour basis, 7 days a week.[56] Hospices provided fewer services on weekends, however, raising concerns about whether beneficiaries' needs are adequately served on weekends. Hospices provided the great majority of services to beneficiaries in ALFs during the workweek and rarely on weekends in 2012. Specifically, between 18 and 20 percent of hours were provided on each of the weekdays. In contrast, only 4 percent of the hours were provided on Saturdays and 3 percent on Sundays. See Exhibit 2. Hospices are paid for every day a beneficiary is under their care, and the rates are the same for every day of the week.

Exhibit 2: Hospice visits drop off on weekends.



Source: OIG analysis of CMS data, 2013.
Note: Totals do not sum to 100 percent because of rounding.

Hospices were also more likely to provide more acute care—general inpatient care level—on weekdays than weekends.[57] This level is for pain control or symptom management that cannot be managed in other settings, making it critical that beneficiaries receive it when they need it. At least 16 percent of general inpatient care stays started on each weekday, while 8 percent started on Sundays and 11 percent on Saturdays.

Hundreds of hospices target beneficiaries in certain settings who have long lengths of stay

Medicare paid $2.1 billion for hospice care provided in ALFs in 2012, an increase of 119 percent from 2007.[58] The median amount Medicare paid hospices for care for beneficiaries in ALFs was $16,195, twice as much as the median amount for beneficiaries at home.[59] The longer lengths of stay for beneficiaries in ALFs explain the higher payments, as total Medicare payments are a function of time spent in care. Over one-third of beneficiaries in ALFs received hospice care for more than 180 days.

The median stay for beneficiaries in ALFs who were served by for-profit hospices was almost 4 weeks longer than the median for nonprofit hospices. Consequently, for-profit hospices received thousands of dollars more than nonprofits per beneficiary in ALFs. See Exhibit 3.

Exhibit 3: Time in care was longer and payments were higher in for-profit hospices.

	Median time in hospice	Median Medicare payment amount
For-Profit Hospice	111 days	$18,261
Nonprofit Hospice	85 days	$13,941
Difference	26 days	$4,320

Source: OIG analysis of CMS data, 2013.

Most hospice beneficiaries in ALFs—60 percent—had diagnoses that typically require less complex care. These include ill-defined conditions, mental disorders, or Alzheimer's disease.[60] Beneficiaries in ALFs were six times more likely to have these diagnoses than a diagnosis of cancer. See Exhibit 4.

Exhibit 4: Most beneficiaries in assisted living facilities and nursing facilities had diagnoses that typically require less complex care.

Primary Setting of Hospice Care	Percentage of Beneficiaries with Diagnoses of Ill-Defined Conditions, Mental Disorder, or Alzheimer's Disease	Percentage of Beneficiaries with Diagnosis of Cancer
ALF	60%	10%
Nursing Facility	54%	13%
Skilled Nursing Facility	52%	15%
Home	27%	38%

Source: OIG analysis of CMS data, 2013.
Note: Includes beneficiaries who received care in 2012.

Beneficiaries with cancer often require complex care and receive hospice care for substantially fewer days than beneficiaries with diagnoses of ill-defined conditions, mental disorders, or Alzheimer's disease.

Almost 100 hospices stand out for their focus on ALFs. These 97 hospices received most of their Medicare hospice payments in 2012 for care provided in ALFs. All but seven of these hospices were for-profit.

Similarly, 263 hospices targeted beneficiaries in nursing facilities. For each of these hospices, two-thirds of the beneficiaries served resided in nursing facilities.[61] Almost three-quarters of the hospices were for-profit. Like beneficiaries in ALFs, beneficiaries residing in nursing facilities commonly have conditions that are associated with less complex care, longer stays, and more Medicare payments.

In addition, hospices may target beneficiaries in nursing facilities because nursing facilities are required to provide personal care services. As discussed earlier, these services are similar to the aide services that hospices

should provide under the hospice benefit and are included in the daily payment rate. OIG has recommended that hospice care provided in nursing facilities should be paid at a lower rate because of this overlap. For more information, see our prior work.[62] The Medicare Payment Advisory Commission (MedPAC) has also suggested a reduction in the payment rate for beneficiaries in nursing facilities.[63] As mentioned, CMS recently increased the rate for routine home care in all settings for the first 60 days and decreased the amount thereafter.

CONCLUSION AND RECOMMENDATIONS

Hospice is an increasingly important benefit for the Medicare population. It can provide great comfort to beneficiaries and their families and caregivers at the end of a beneficiary's life. Hospice use has grown steadily over the past decade. Medicare now pays $16.7 billion for hospice care for 1.4 million beneficiaries. Recognizing the importance of the benefit, OIG has produced numerous evaluations and audits of the hospice program, including in-depth looks at specific levels of care and settings. OIG has also conducted criminal and civil investigations of hospice providers, leading to the conviction of individuals, monetary penalties, and civil False Claims Act settlements. Through this extensive work, OIG has identified vulnerabilities in the benefit. These vulnerabilities need to be addressed to ensure that beneficiaries receive quality care and that Medicare payments to hospices are appropriate.

The following recommendations—based on OIG's body of hospice work—address these vulnerabilities. In some cases, we have expanded on recommendations that we have made in the past that remain unimplemented. We recognize that CMS continues to work on implementing past OIG recommendations, and we note where CMS has made progress in addressing specific vulnerabilities. However, more needs to be done. We look forward to more dialogue with CMS in our combined efforts to protect beneficiaries and safeguard the program. In addition, OIG will continue to conduct audits, evaluations, and investigations to identify vulnerabilities and provide recommendations to further strengthen the Medicare hospice benefit.[64]

To improve the quality of care for beneficiaries and strengthen program integrity, CMS should:

Strengthen the survey process to better ensure that hospices provide beneficiaries with needed services and quality care

Protecting beneficiaries and making sure they receive what they need from hospices at the end of their lives is paramount. CMS relies on surveyors to conduct onsite reviews of hospices as its primary tool to promote hospice compliance and quality care. Surveyors observe the operation of the hospice, review clinical records, and visit patients. Surveyors cite the hospice with a deficiency if it fails to meet a requirement needed for participating in the Medicare program. CMS has recently provided training to surveyors about care planning.

CMS should further strengthen this survey process to better ensure beneficiaries receive needed services and quality of care. Specifically, CMS should:

- **Analyze claims data to inform the survey process.** CMS should identify hospices that do not provide all levels of care, infrequently provide physician services, or rarely provide care on weekends. CMS should instruct surveyors to pay particular attention during their review of these hospices to the issues identified.

- **Analyze deficiency data to inform the survey process.** CMS should identify hospices with persistent problems (e.g., repeat deficiencies) and instruct surveyors to focus on these problem areas during their reviews of the individual hospices. The analyses of deficiency data would be in addition to the reviews of previous surveys and complaints that may be done by individual surveyors.

Seek statutory authority to establish additional remedies for hospices with poor performance

CMS does not have adequate tools to address hospices with poor performance. Currently, CMS's only recourse when a hospice is found to have serious deficiencies is to terminate the hospice from the Medicare program, a drastic step that limits CMS's ability to address performance problems. The lack of intermediate remedies undermines the survey process, as hospices have few incentives to improve performance. If CMS cannot effectively address hospices' performance problems, it cannot protect beneficiaries or the program. CMS must be able to take action against providers that do not fulfill their responsibilities to beneficiaries and the program. Specifically, CMS should:

- **Seek statutory authority to establish additional, intermediate remedies for poor hospice performance.** Such measures could include directed plans of correction, directed in-service training, denials of payment for new admissions or for all patients, civil monetary penalties, and imposition of temporary management.

Develop and disseminate additional information on hospices to help beneficiaries and their families and caregivers make informed choices about their care

Beneficiaries and their families and caregivers need reliable information about hospice performance so they can compare providers and make the best decision for their care needs. CMS has taken the positive step of launching the Hospice Compare website. At this time, however, it offers limited information. CMS is developing two claims-based quality measures, but additional information is needed. CMS should include on Hospice Compare critical data that will enable beneficiaries and their caregivers to make more informed choices and will hold hospices more accountable for the care they provide. Specifically, CMS should:

- **Develop other claims-based information and include it on Hospice Compare.** This would be in addition to the quality measures that are included on the website. Claims-based data have been previously recommended by OIG, MedPAC, hospice experts, and others. Such data could include the average number of services a hospice provides, the types of services, how often physician visits are provided, and how often a hospice provides services on weekends.

- **Include on Hospice Compare deficiency data from surveys, including information about complaints filed and resulting deficiencies**. CMS should provide the number and nature of deficiencies for each hospice as available, and report information by key categories, such as care planning and assessments. This should be provided in a consumer-friendly way to inform beneficiaries about hospices that have provided poor care.

Educate beneficiaries and their families and caregivers about the hospice benefit

The goals of hospice care are to help terminally ill beneficiaries continue life in comfort and to support beneficiaries' families and caregivers. Having complete, accurate information about hospice is crucial to achieving these goals. We support CMS's efforts to improve election statements by developing model text. In addition to these efforts, CMS should proactively educate beneficiaries and their families and

caregivers about this important benefit. This may also help protect beneficiaries from becoming victims of fraud schemes. Specifically, CMS should:

- **Work with its partners, such as hospitals and caregiver groups, to make available consumer-friendly information explaining the hospice benefit to beneficiaries and their families and caregivers.** CMS has produced brochures, which are currently available on the Medicare website. CMS has also included information such as a video explaining the benefit on Hospice Compare. In addition to these efforts, CMS should work with health care partners to ensure that these and other consumer-friendly informational resources are easily accessible to families and caregivers who may benefit from learning about the hospice benefit.

Promote physician involvement and accountability to ensure that beneficiaries get appropriate care

Physicians serve a vital role in the appropriate provision of hospice services, but our work has shown that they are not always involved in decision making. CMS has taken steps to remind hospices and physicians about the requirements for valid physician certifications and recertifications, but more needs to be done. Notably, we found that hospices did not always provide the care beneficiaries need to control pain and manage symptoms. Specifically, CMS should:

- **Ensure that a physician is involved in the decisions to start and continue general inpatient care.** CMS should implement additional strategies to increase physician involvement and accountability so that beneficiaries get appropriate care. Increased physician involvement could also help minimize the amount of time a beneficiary is in pain or has other uncontrolled symptoms.

  The interdisciplinary group, which includes the physician, is required to review and revise the patient's plan of care as frequently as the patient's condition requires. However, the care-planning process, which OIG found lacking, does not offer sufficient safeguards against inappropriate use of general inpatient care. Another safeguard could be requiring the hospice to obtain a physician's order to change the level of care to general inpatient care and including the ordering physician's National Provider Identifier on the hospice claim. The hospice could also have the physician sign off on the level of care at reasonable intervals during the general inpatient care stay. These intervals should be determined by CMS. Making the physician more accountable and requiring some record of the physician's involvement would help ensure that care is appropriate; it could also improve the quality of care.

Strengthen oversight of hospices to reduce inappropriate billing

To reduce inappropriate billing, CMS must strengthen its oversight of hospices. Our work has identified certain hospice claims that are particularly vulnerable to abuse. CMS should increase oversight of these claims, targeting them for additional reviews. Specifically, we recommend that CMS:

- **Analyze claims data to identify hospices that engage in practices or have characteristics that raise concerns.** CMS has made some progress in identifying hospices that depend heavily on nursing facility residents. CMS should continue and

expand these efforts to include hospices that target beneficiaries in ALFs, those with a high percentage of beneficiaries with diagnoses that require less complicated care, and those that do not provide all levels of hospice care.

- **Take appropriate actions to follow up with hospices that engage in practices or have characteristics that raise concerns.** That is, after these hospices are identified, CMS should initiate probe and educate reviews, provide education, conduct prepayment reviews, make referrals to law enforcement or Recovery Auditors, or take other appropriate actions.

- **Increase oversight of general inpatient care claims and focus particularly on general inpatient care provided in SNFs, given the higher rate at which these stays were inappropriate.**

- **Implement a comprehensive prepayment review strategy to address lengthy general inpatient care stays so that beneficiaries do not have to endure unnecessarily long periods of time in which their pain and symptoms are not controlled.** The prepayment reviews of lengthy general inpatient care stays that CMS contractors have conducted and plan to conduct are limited. CMS should strengthen its use of this tool by providing additional direction to their contractors to make these reviews more comprehensive and effective. This could include setting minimum thresholds to ensure that contractors review a sufficient number of hospices and include a sufficient number of claims in those reviews. The reviews should determine whether general inpatient care was appropriate for each day of the stay or if another level of care was more appropriate. The contractors should continue to use data analysis to target these reviews to stays most likely to be problematic. CMS should also set criteria for when and how contractors should take action based on the results of their reviews. Comprehensive prepayment reviews and appropriate followup will help promote effective symptom management and could reduce the time in which beneficiaries' pain and other symptoms are unmanaged.

- **Develop and execute a strategy to work directly with hospices to ensure that they are providing drugs covered under the hospice benefit as necessary and that the cost of drugs covered under the benefit are not inappropriately shifted to Part D.** CMS should target its interventions with hospices by reviewing Part D payments for drugs for hospice beneficiaries, focusing particularly on hospices that have beneficiaries with high numbers of Part D drugs or a high number of beneficiaries receiving Part D drugs. CMS described guidance it has given Part D plan sponsors to help them avoid paying claims that should be covered under the hospice benefit, which is also a helpful and important step. However, we recommend that CMS also intervene with hospices to ensure that they are providing the drugs covered under the hospice benefit as necessary so that these drugs are not inappropriately billed to Part D.

Take steps to tie payment to beneficiary care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs, seeking statutory authority if necessary

The current payment system is based on the beneficiary's time in care. It pays the hospice a daily rate regardless of how many services the beneficiary needs on a particular day. Also, the daily rate is the same regardless of where the beneficiary resides. For instance, the routine home care rate is the same for a beneficiary residing at home with no personal assistance or nursing services as it is for a beneficiary residing in an assisted living facility or nursing facility. Further, the payment system does not take into account the quality of care provided by hospices. There are no adjustments in overall payments, bonus payments, or other methods that tie quality to payment for hospices.

As a result, OIG found that the payment system creates financial incentives that raise a number of concerns, such as whether some hospices are serving only beneficiaries who offer the greatest financial gain, whether beneficiaries are being enrolled at the appropriate time, whether hospices are being paid the appropriate amount for the care they provide, and whether hospices have incentives to care for beneficiaries with greater needs.

Moreover, OIG found that some hospices have targeted certain beneficiaries who are likely to have long lengths of stay. OIG also found that some hospices typically provide less than 5 hours of visits per week and seldom provide services on weekends. These findings demonstrate that the payment system may not be aligned with beneficiaries' care needs and to providing appropriate and quality services. Opportunities exist to adjust the payment structure to promote quality of care and better ensure that beneficiaries, particularly those with greater needs, have access to appropriate care.

As discussed, CMS has made some changes to the payment system. These changes are aimed at addressing long lengths of stay and ensuring that care is provided in the last days of life. However, these changes do not address quality of care or whether payments are aligned with the beneficiary's needs outside of the last days. Specifically, CMS should:

- **Assess the current payment system to determine what changes may be needed to tie payments to beneficiaries' care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs**. As part of its assessment, CMS should determine the extent to which payments are aligned with beneficiaries' needs and not only to the services provided. It should also determine the extent to which the current payment system incentivizes hospices to provide appropriate care to beneficiaries, particularly those with greater needs, and the extent to which the payment system promotes quality care. In addition, CMS should assess the accuracy of hospice cost reports. CMS should use only reliable data sources in its analysis of the current payment system.
- **Adjust payments based on these analyses, if appropriate, to ensure that the payment system is aligned with beneficiary needs and quality of care**. CMS stated that it does not have the authority to adjust payments based on factors other than cost of services provided. Therefore, CMS may need to seek statutory authority to make adjustments to the payment system to ensure that eligible beneficiaries who choose to elect hospice care receive appropriate services.

- **Modify the payments for hospice care in nursing facilities.** Adjustments should account for setting, which may affect care needs. Notably, nursing facilities are required to provide personal care services, which are similar to hospice aide services that are paid for under the hospice benefit. Therefore, hospice beneficiaries in a nursing facility would likely need fewer hospice aide services than hospice beneficiaries at home. Also, the cost to the hospice of providing aide services to beneficiaries in nursing facilities may be less than the cost of providing these services to beneficiaries at private homes because an aide can visit multiple beneficiaries in a facility without having to travel to different locations. For these reasons, the payment rate for routine home care in nursing facilities should be reduced when appropriate. As noted earlier, CMS may need to seek statutory authority to make these changes.

Address additional recommendations contained in prior OIG reports

OIG has also made other recommendations in prior work that remain unimplemented. See Appendix C for a list of these recommendations and the related OIG reports.

AGENCY COMMENTS AND OIG RESPONSE

In our draft report to CMS, we recommended 16 specific actions. CMS concurred with six recommendations, did not concur with nine, and neither concurred nor nonconcurred with one. We considered CMS's comments carefully, and we clarified and combined two of our recommendations. We remain committed to our recommendations and will continue to work with CMS to promote their implementation.

Recommendations to strengthen the survey process

CMS did not concur with the two recommendations to strengthen the survey process. Specifically, CMS did not concur with the recommendations to analyze claims and deficiency data to inform the survey process. Regarding claims data, CMS stated that surveyors do not determine the medical necessity of the services provided and are not an extension of the audit process. Regarding deficiency data, CMS stated that surveyors review previous complaint allegations and investigations and previous survey findings and CMS does not believe additional actions are necessary.

OIG notes that the survey process is critical to promoting compliance and patient care, and we agree with CMS that surveys help ensure that hospices provide all required services and meet all conditions of participation. As we have shown in our work, claims data are key to understanding how the hospice program is working and are useful for many purposes in addition to auditing. For example, we identified hospices that do not provide all levels of care, or rarely provide care on weekends. CMS has also recognized the importance of claims data and has committed to developing claims-based quality measures. As these examples demonstrate, claims data offer a wealth of information that surveyors could use to make the survey process more effective.

In addition, we have found persistent problems in certain areas, such as care planning, that the survey process has not adequately addressed. Deficiency data give valuable insights into these persistent problems. Using deficiency data effectively to inform the survey process could promote hospice compliance, particularly in problem areas. Additionally, deficiency data are crucial to understanding how well hospices are caring for beneficiaries. Given the importance of these data, OIG is conducting further work on the nature and extent of hospice deficiencies and complaints.

Recommendation to establish additional remedies for poor performance

CMS neither concurred nor nonconcurred with the recommendation to seek statutory authority to establish additional remedies for hospices with poor performance. CMS stated that it will consider this recommendation when developing requests for the President's Budget.

Recommendations to develop and disseminate additional information on hospices

CMS concurred with the recommendation to develop other claims-based information and include it on the Hospice Compare website. CMS stated that it continues to develop claims-based quality measures, including potentially avoidable hospice care transitions and access to levels of hospice care.

CMS did not concur with the recommendation to include on Hospice Compare deficiency data from surveys, including information about complaints filed and resulting deficiencies. CMS stated that it is prohibited from publicly releasing information on any surveys performed by accrediting organizations unless the information relates to an enforcement determination. CMS further noted that the information

on this issue would therefore be skewed, and users would be selecting hospices based on lack of information that favors hospices that use accrediting organizations. CMS also stated that it has made information from surveys performed by State agencies publicly available.

OIG continues to stress the importance of providing data to consumers to help them make informed choices. We recognize the constraints in providing the data from the accrediting organizations. As a first step, however, CMS should provide publicly in a consumer-friendly and readily accessible way the data that it can release. We note that complaint information and resulting deficiencies from State surveyors—who investigate certain complaints from all hospices—are available for all hospices. Also, to address uneven data, CMS could post an explanation about why similar information is not available for certain hospices.

Recommendation to educate beneficiaries and their families and caregivers

CMS concurred with the recommendation to work with its partners to make available information explaining the hospice benefit. CMS stated that it has developed informational resources and will work to ensure that these resources are easily accessible to families and caregivers who may benefit from learning about the hospice benefit.

Recommendation to promote physician involvement and accountability

CMS did not concur with the two recommendations to promote physician involvement and accountability. Specifically, CMS did not concur with the recommendations to require that hospices obtain a physician's order to change the level of care to general inpatient care and have the physician sign off on general inpatient care at reasonable intervals. CMS stated that the hospice interdisciplinary group, which includes a physician, is required to approve general inpatient care and document this approval in the medical record.

The goal of these recommendations is to increase physician involvement and accountability to ensure appropriate care for beneficiaries. They could also help minimize the amount of time a beneficiary is in pain or has other uncontrolled symptoms. To keep the focus on this broader goal, we combined the recommendations and are open to alternative ways of achieving it. As we note in the report, the care-planning process—which OIG found to have persistent problems—does not offer sufficient safeguards against inappropriate use of general inpatient care or against poor quality care.

Recommendations to strengthen oversight of hospices

CMS concurred with four of the five recommendations to strengthen oversight of hospices. Specifically, CMS concurred with the recommendations to analyze claims data to identify hospices that engage in practices or have characteristics that raise concerns and to take appropriate actions to follow up with these hospices. CMS also concurred with the recommendation to increase oversight and focus particularly on general inpatient care provided in SNFs. In addition, CMS concurred with the recommendation to implement a comprehensive prepayment review strategy to address lengthy general inpatient care stays so that beneficiaries do not have to endure unnecessarily long periods of time in which their pain and symptoms are not controlled. CMS stated that its contractors conduct prepayment reviews of lengthy general inpatient care stays in hospices that have been found to have high amounts of these stays and recoup any overpayments found as a result of these reviews.

Regarding Part D drugs, CMS did not concur with the recommendation to develop and execute a strategy to work directly with hospices to ensure that they are providing drugs covered under the hospice benefit as necessary. CMS noted that it has directed certain plan sponsors to conduct audits for payments made

for beneficiaries who are enrolled in hospice care to ensure that payments are made appropriately. OIG notes that while working with Part D plan sponsors is an important step, working directly with hospices to ensure that they are providing the drugs covered under the hospice benefit as necessary is also a key part of oversight.

Recommendations to take steps to tie payment to beneficiary care needs and quality of care

CMS did not concur with the three recommendations about hospice payments. Specifically, CMS did not concur with the first two recommendations to assess the current payment system and to adjust payments based on these analyses, if appropriate, to ensure that the payment system is aligned with beneficiary needs and quality of care. CMS stated that it has reformed the hospice payment system to more appropriately pay hospices for the cost of providing care to beneficiaries and better align payment with beneficiary care needs during the course of a hospice stay. CMS also stated that it is required to pay hospice providers based on the costs they incur when providing care.

The current payment system is based on the beneficiary's time in care, and OIG remains concerned about whether hospices are being paid the appropriate amount for the care they provide and whether hospices are appropriately meeting beneficiaries' care needs. CMS's changes to the payment system did not link payments to the quality of care provided by hospices or to beneficiaries' care needs outside the last days of life. Opportunities exist to assess the current payment system and to make adjustments, if appropriate, to align with beneficiary needs and the quality of care; such changes may require new statutory authority.

CMS did not concur with the third recommendation to modify the payments for hospice care in nursing facilities. CMS stated that its analysis of hospice claims data demonstrated that patients residing in nursing facilities receive more visits than patients residing at home and thus the data did not support reducing the routine home care payment rate to differentiate payments based on site of service.

OIG continues to recommend that the payment rate for routine home care in nursing facilities should be reduced when appropriate. Nursing facilities are required to provide personal care services, which are similar to hospice aide services that are paid for under the hospice benefit. Therefore, hospice beneficiaries in nursing facilities would likely need fewer hospice aide services than hospice beneficiaries at home. We note that the data CMS provided also indicate that hospice visits to beneficiaries in nursing facilities were shorter than hospice visits to beneficiaries at home. Also, the cost to the hospice of providing aide services to beneficiaries in nursing facilities may be less than the cost of providing these services to beneficiaries at private homes because an aide can visit multiple beneficiaries in a facility without having to travel to different locations. CMS may need to seek statutory authority to make these changes. For the full text of CMS's comments, see Appendix D.

APPENDIX A: Key Recommendations to Improve the Medicare Hospice Program

Recommendations to CMS
Strengthen the survey process to better ensure that hospices provide beneficiaries with needed services and quality care
1. Analyze claims data to inform the survey process
2. Analyze deficiency data to inform the survey process
Seek statutory authority to establish additional remedies for hospices with poor performance
3. Seek statutory authority to establish additional, intermediate remedies for poor hospice performance
Develop and disseminate additional information on hospices to help beneficiaries and their families and caregivers make informed choices about their care
4. Develop other claims-based information and include it on Hospice Compare*
5. Include on Hospice Compare deficiency data from surveys, including information about complaints filed and resulting deficiencies
Educate beneficiaries and their families and caregivers about the hospice benefit
6. Work with its partners, such as hospitals and caregiver groups, to make available consumer-friendly information explaining the hospice benefit to beneficiaries and their families and caregivers*
Promote physician involvement and accountability to ensure that beneficiaries get appropriate care
7. Ensure that a physician is involved in the decisions to start and continue general inpatient care
Strengthen oversight of hospices to reduce inappropriate billing
8. Analyze claims data to identify hospices that engage in practices or have characteristics that raise concerns*
9. Take appropriate actions to follow up with hospices that engage in practices or have characteristics that raise concerns*
10. Increase oversight of general inpatient care claims and focus particularly on general inpatient care provided in SNFs, given the higher rate at which these stays were inappropriate*
11. Implement a comprehensive prepayment review strategy to address lengthy general inpatient care stays so that beneficiaries do not have to endure unnecessarily long periods of time in which their pain and symptoms are not controlled*
12. Develop and execute a strategy to work directly with hospices to ensure that they are providing drugs covered under the hospice benefit as necessary and that the cost of drugs covered under the benefit are not inappropriately shifted to Part D
Take steps to tie payment to beneficiary care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs, seeking statutory authority if necessary
13. Assess the current payment system to determine what changes may be needed to tie payments to beneficiaries' care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs
14. Adjust payments based on these analyses, if appropriate, to ensure that the payment system is aligned with beneficiary needs and quality of care
15. Modify the payments for hospice care in nursing facilities

* Indicates that CMS concurred.

APPENDIX B: List of Related OIG Reports

Report	Issue Date
Hospices Should Improve Their Election Statements and Certifications of Terminal Illness (OEI-02-10-00492)	September 2016
Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care (OEI-02-10-00491)	March 2016
Hospice of New York, LLC, Improperly Claimed Medicare Reimbursement for Some Hospice Services (A-02-13-01001)	June 2015
Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities (OEI-02-14-00070)	January 2015
The Community Hospice, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services (A-02-11-01016)	September 2014
Servicios Suplementarios de Salud, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services (A-02-11-01017)	August 2014
Frequency of Medicare Recertification Surveys for Hospices Is Unimproved (OEI-06-13-00130)	August 2013
Medicare Hospice: Use of General Inpatient Care (OEI-02-10-00490)	May 2013
Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice (A-06-10-00059)	June 2012
Medicare Hospices that Focus on Nursing Facility Residents (OEI-02-10-00070)	July 2011
Questionable Billing for Physician Services for Medicare Beneficiaries (OEI-02-06-00224)	September 2010
Medicare Hospice Care for Beneficiaries Residing in Nursing Homes: Compliance with Medicare Coverage Requirements (OEI-02-06-00221)	September 2009
Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities (OEI-02-06-00223)	September 2009
Hospice Beneficiaries' Use of Respite Care (OEI-02-06-00222)	March 2008
Medicare Hospice Care: Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings (OEI-02-06-00220)	December 2007
Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight (OEI-06-05-00260)	April 2007

APPENDIX C: List of Additional Recommendations from Prior Reports[*]

Provide guidance to hospices regarding the effects on beneficiaries when they revoke their election and when they are discharged from hospice care (*Hospices Should Improve Their Election Statements and Certifications of Terminal Illness*, OEI-02-10-00492). (CMS did not concur.)

Follow up on inappropriate general inpatient care stays and hospices that provided poor-quality care (*Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care*, OEI-02-10-00491). (CMS concurred.)

[*] This list does not include overpayment recovery recommendations included in some OIG reports.

APPENDIX D: Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: MAY 17 2018

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio (OEI-02-16-00570)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to ensuring that the Medicare hospice program provides quality care safe from fraud, waste, and abuse.

State agencies and national accrediting organizations are required to conduct surveys of hospices to ensure they provide all required services and meet all hospice conditions of participation before hospices are certified for participation in Medicare and at least every three years[1] thereafter. CMS has worked to strengthen and improve hospice surveys to ensure that beneficiaries receive quality care. For example, CMS regularly provides training for hospice surveyors to ensure they are familiar with certification requirements. Recent surveyor training has focused on care planning requirements in response to OIG concerns that surveyors were not adequately focusing on this issue in their surveys.

In addition, CMS has worked to follow up on hospices that OIG has referred to CMS for specific reasons by instructing state survey agencies to have their surveyors place an emphasis on election statements and certification of terminal illness at the time of the next scheduled survey. Evaluation of quality of care is the major emphasis for all hospice surveys. Although CMS is statutorily prohibited from publicly releasing information on any surveys performed by accrediting organizations unless the information relates to an enforcement determination[2], CMS has made information from surveys performed by state agencies publicly available.[3]

CMS has also focused on the integrity of the hospice benefit and strengthened its monitoring of hospice claims. CMS has initiated prepayment medical review, including targeted probe and educate reviews, of hospice services from certain providers. CMS has also enhanced monitoring

[1] 42 U.S.C. § 1395x(dd)(4)(C). The 36 month survey frequency requirement ends on September 30, 2025.
[2] 42 U.S.C. § 1395bb(b)
[3] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/2567report.html

of hospices that depend heavily on nursing facility residents and is in the process of recouping payments for inappropriate general inpatient care stays in response to OIG concerns.

CMS has taken several steps to educate beneficiaries and caregivers about the hospice benefit and help individuals choose the right hospice. CMS has developed informational resources explaining the hospice benefit and disseminated them to providers and the public.[4] In August 2017, CMS launched Hospice Compare, a website that reports information on hospices across the nation and allows patients, family members, and health care providers to get a snapshot of the quality of care each hospice provides.[5] Users can compare hospices based on a national survey that rates family members' experiences with hospice care or on important indicators of quality, like the percentage of patients checked for pain or who are asked about their preferences for life-sustaining treatment.

CMS also continues to develop claims-based quality measures, including potentially avoidable hospice care transitions and access to levels of hospice care. Potentially avoidable hospice care transitions at end of life are associated with adverse health outcomes, lower patient and family satisfaction, higher health care costs, and fragmentation of care delivery. Appropriate use of different levels of hospice care increases the likelihood of patients dying in their location of choice, decreases costs, and increases patient and caregiver satisfaction.

In addition, CMS has reformed the hospice payment system to more appropriately reimburse hospices for the cost of providing care to beneficiaries. Effective January 1, 2016, CMS implemented the creation of two routine home care rates for hospice care – a higher rate for days 1-60 and a lower rate for days 61 and beyond – as well service intensity add-on payments for registered nurse and social work visits during the last seven days of life. CMS believes these reforms will reduce the incentives for hospices to target beneficiaries likely to have long lengths of stay. CMS is required by statute to pay hospice providers based on the costs they incur when providing care and does not have authority to tie payment to quality of care.[6]

OIG's recommendations and CMS' responses are below.

OIG Recommendation
Analyze claims data to inform the survey process.

CMS Response
CMS does not concur with OIG's recommendation. Surveyors evaluate the care provided in hospice as compared to the care indicated and ordered. They do not determine the medical necessity of the services provided and are not an extension of the audit process.

OIG Recommendation
Analyze deficiency data to inform the survey process.

CMS Response

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[4] Medicare Hospice Benefits - https://www.medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF
Medicare & Hospice Benefits Getting Started – https://www.medicare.gov/Pubs/pdf/11361-Medicare-Hospice-Getting-Started.pdf
Hospice and Respite Care - https://www.medicare.gov/coverage/hospice-and-respite-care.html
How Hospice Works - https://www.medicare.gov/what-medicare-covers/part-a/how-hospice-works.html
[5] https://www.medicare.gov/hospicecompare/
[6] 42 U.S.C. § 1395f(i)

CMS does not concur with OIG's recommendation. When a surveyor cites a deficiency, the provider submits a plan for correction and the surveyor performs a visit or desk audit to ensure correction. In addition, surveyors review previous complaint allegations and investigations and previous survey findings before they begin a survey. Given the steps CMS already takes to use deficiency data to inform the survey process, CMS does not believe additional actions are necessary.

OIG Recommendation
Seek statutory authority to establish additional remedies for hospices with poor performance.

CMS Response
CMS will consider this recommendation when developing requests for the President's Budget.

OIG Recommendation
Develop other claims-based information and include it on the hospice compare website.

CMS Response
CMS concurs with OIG's recommendation. As stated above, CMS continues to develop claims-based quality measures, including potentially avoidable hospice care transitions and access to levels of hospice care.

OIG Recommendation
Include on the hospice compare website deficiency data from surveys, including information about complaints filed and resulting deficiencies.

CMS Response
CMS does not concur with OIG's recommendation. As mentioned above, CMS is statutorily prohibited from publicly releasing information on any surveys performed by accrediting organizations unless the information relates to an enforcement determination. In FY15, 40 percent of hospice surveys were performed by these organizations and could not be included on Hospice Compare. The information section on this issue would therefore be skewed, and users would be selecting hospices based on lack of information that favors hospices that use accrediting organizations. This does not accord with CMS' goals for providing useful information in a consumer-friendly manner. As stated above, CMS has made information from surveys performed by state agencies publicly available.

OIG Recommendation
Work with partners, such as hospitals and caregiver groups, to make available consumer-friendly information explaining the hospice benefit to beneficiaries and their families and caregivers.

CMS Response
CMS concurs with OIG's recommendation. As stated above, CMS has developed informational resources to educate beneficiaries and their families and caregivers about the hospice benefit. CMS will work to ensure that these resources are easily accessible to families and caregivers who may benefit from learning about the hospice benefit.

OIG Recommendation
Require that hospices obtain a physician's order to change the level of care to general inpatient care.

CMS Response
CMS does not concur with OIG's recommendation. Currently, the hospice interdisciplinary group (composed of a physician, nurse, social worker and counselor), is required to approve general inpatient care (GIP) and document this approval in the medical record.[7] This recommendation would add an additional layer of requirements without necessarily leading to increased compliance.

OIG Recommendation
Require that hospices have the physician sign off on general inpatient care at reasonable intervals that are determined by CMS.

CMS Response
CMS does not concur with OIG's recommendation. As stated above, the interdisciplinary group is required to approve GIP and document this approval in the medical record. CMS works to balance the burden placed on providers through program requirements and this recommendation would add an additional layer of requirements without necessarily leading to increased compliance.
As stated below, CMS will increase postpayment review of GIP claims and currently CMS contractors conduct prepayment reviews of lengthy GIP claims. Of note, in Fiscal Year 2016, only 1.49 percent of all hospice days were billed as GIP. Of those GIP stays, 50 percent lasted fewer than three days and 70 percent fewer than seven days.

OIG Recommendation
Analyze claims data to identify hospices that engage in practices or have characteristics that raise concerns.

CMS Response
CMS concurs with OIG's recommendation. CMS will work to identify and take appropriate actions to follow up with hospices that have raised concern.

OIG Recommendation
Take appropriate actions to follow up with hospices that engage in practices or have characteristics that raise concerns.

CMS Response
CMS concurs with OIG's recommendation. As stated above, CMS will work to identify and take appropriate actions to follow up with hospices that have raised concern.

OIG Recommendation
Increase oversight of general inpatient care claims and particularly focus on general inpatient care provided in SNFs given the higher rate at which these stays were inappropriate.

CMS Response
CMS concurs with OIG's recommendation. CMS will work to increase oversight of general inpatient care through postpayment review.

OIG Recommendation
Implement a comprehensive prepayment review strategy to address lengthy GIP stays so that beneficiaries do not have to endure unnecessarily long periods of time in which their pain and symptoms are not controlled.

[7] 42 C.F.R. § 418.56

CMS Response
CMS concurs with OIG's recommendation. CMS' contractors currently conduct prepayment reviews of lengthy GIP stays in hospices that have been found to have high amounts of these stays and recoup any overpayments found as a result of these reviews. CMS notes that CMS medical review, including prepayment review, determines whether these stays were reasonable and necessary and met payment criteria. CMS' contractors design their program integrity activities to most effectively target the highest-priority issues in their jurisdictions given their limited resources. CMS will support the program integrity activities our contractors identify that best meet CMS' goals for the program.

OIG Recommendation
Develop and execute a strategy to work directly with hospices to ensure that they are providing drugs covered under the hospice benefit as necessary and that the cost of drugs covered under the benefit are not inappropriately shifted to Part D.

CMS Response
CMS does not concur with OIG's recommendation. CMS has oversight authority over Medicare Part D plan sponsors. CMS has directed certain plan sponsors to conduct audits for payments made for beneficiaries who are enrolled in hospice care to ensure that payments are made appropriately. CMS will continue its efforts to work with plan sponsors to address this issue.

OIG Recommendation
Assess the current payment system to determine what changes may be needed to tie payments to beneficiaries' care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs.

CMS Response
CMS does not concur with OIG's recommendation. As stated above, CMS has reformed the hospice payment system to more appropriately pay hospices for the cost of providing care and better align payment with beneficiary care needs during the course of a hospice stay. CMS is required by statute to pay hospice providers based on the costs they incur when providing care.

OIG Recommendation
Adjust payments based on these analyses, if appropriate, to ensure that the payment system is aligned with beneficiary needs and quality of care.

CMS Response
CMS does not concur with OIG's recommendation. As stated above, CMS has reformed the hospice payment system to more appropriately pay hospices for the cost of providing care to beneficiaries and better align payment with beneficiary care needs during the course of a hospice stay. CMS is required by statute to pay hospice providers based on the costs they incur when providing care.

OIG Recommendation
Modify the payments for hospice care in nursing facilities.

CMS Response
CMS does not concur with OIG's recommendation. CMS has previously considered the OIG recommendation to reduce payments to Medicare hospices for beneficiaries in nursing facilities who are receiving hospice care. However, analysis of hospice claims data demonstrated that

patients residing in nursing facilities receive more visits than patients residing at home and thus the data did not support reducing the routine home care payment rate to differentiate payments based on site of service.[8] CMS has also enhanced monitoring of hospices that depend heavily on nursing facility residents.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

[8] 78 FR 48234, at 48273 (Aug. 7, 2013), Final Rule, "Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform"

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ENDNOTES

[1] Medicare has two annual caps on hospice reimbursement. The first cap limits the total number of days of inpatient care that a hospice may provide to 20 percent of the hospice's total patient care days. See Social Security Act, § 1861(dd)(2)(A)(iii); 42 CFR § 418.302(f). Inpatient care includes two of the four levels of hospice care: general inpatient care and inpatient respite care. The second cap limits the total reimbursement that a hospice may receive in a given year. The total annual payments to a hospice may not exceed a set per-patient amount multiplied by the number of beneficiaries who elected to receive hospice care from that hospice during the annual cap period. See Social Security Act, § 1814(i)(2); 42 CFR § 418.309. The 2017 cap amount is $28,404.99. See CMS, Update to Hospice Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2018, Transmittal R3828CP, Change Request 10131, August 4, 2017. Accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10131.pdf on January 31, 2018.

[2] The rates for each level of care are the unadjusted daily Medicare hospice payment rates for FY 2017. Rates are adjusted on the basis of the beneficiary's geographic location. See CMS, MLN Matters, "Updates to the Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for Fiscal Year 2017," MM9729, July 8, 2016. Accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9729.pdf on January 26, 2018.

[3] The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds*, p. 10. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf on November 22, 2017. See also, The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds*, p. 5. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2007.pdf on November 22, 2017

[4] Social Security Act, § 1861(dd); 42 CFR part 418.

[5] OIG, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance With Medicare Coverage Requirements*, OEI-02-06-00221, September 2009.

[6] OIG, *Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

[7] 42 CFR § 418.302(b)(4).

[8] OIG, *Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

[9] Ibid.

[10] Ibid.

[11] 42 CFR § 418.200.

[12] 42 CFR § 418.56(c)(2).

[13] OIG, *Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

[14] OIG, *Medicare Hospice Care for Beneficiaries In Nursing Facilities: Compliance with Medicare Coverage Requirements*, OEI-02-06-00221, September 2009.

[15] OIG, *Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

[16] OIG, *Medicare Hospice: Use of General Inpatient Care,* OEI-02-10-00490, May 2013. Updated OIG analysis, August 2017.

[17] 42 CFR § 418.302(b).

[18] Social Security Act, § 1861(dd)(1); 42 CFR §§ 418.64, 418.108 and 418.204.

[19] 42 CFR § 418.304. The daily rate paid to hospices covers general supervisory services and plan of care services by hospice physicians, not visits.

[20] 42 CFR § 418.302(b)(4).

[21] Social Security Act, §§ 1812(d)(2)(A) and 1861(dd)(1); 42 CFR § 418.24(d). CMS has developed the Medicare Care Choices Model, a demonstration program that will allow certain beneficiaries who are eligible for the hospice benefit but not enrolled to receive palliative care services from certain hospice providers while concurrently receiving services provided by their curative care providers. The model will enable CMS to study whether access to such services improves quality of life, increases patient satisfaction, and reduces Medicare expenditures. See CMS, *Medicare Care Choice Model*. Accessed at https://innovation.cms.gov/initiatives/Medicare-Care-Choices/ on January 26, 2018.

[22] Department of Justice (DOJ), "Cleveland Woman Sentenced for Hospice Fraud," December 14, 2015. Accessed at https://www.justice.gov/usao-ndms/pr/cleveland-woman-sentenced-hospice-fraud on August 28, 2017.

[23] DOJ, "Minnesota-Based Hospice Provider to Pay $18 Million for Alleged False Claims to Medicare for Patients Who Were Not Terminally Ill," July 13, 2016. Accessed at https://www.justice.gov/opa/pr/minnesota-based-hospice-provider-pay-18-million-alleged-false-claims-medicare-patients-who on August 28, 2017.

[24] DOJ, "Pasadena Doctor Sentenced to 4 Years in Prison for Falsely Certifying Patients Were Terminally Ill as Part of Healthcare Fraud Scheme," August 19, 2016. Accessed at https://www.justice.gov/usao-cdca/pr/pasadena-doctor-sentenced-4-years-prison-falsely-certifying-patients-were-terminally on December 20, 2017.

[25] Social Security Act § 1814(i)(5).

[26] CMS, *Public Reporting: Background and Announcements*. Accessed at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Public-Reporting-Background-and-Announcements.html on March 22, 2018. See also, CMS, *Current Measures*. Accessed at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html on March 21, 2018.

[27] 42 CFR §§ 401.133(a) and 401.130(b)(17).

[28] OIG, *Hospices Should Improve Their Election Statements and Certifications of Terminal Illness,* OEI-02-10-00492, September 2016. The election statements were collected for an OIG study that focused on general inpatient care, but these documents are for the hospice benefit as a whole and are not specific to any level of care.

[29] CMS, MLN Matters, "Sample Hospice Election Statement," SE1631, December 13, 2016. Accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1631.pdf on January 3, 2018.

[30] OIG, *Hospice of New York, LLC, Improperly Claimed Medicare Reimbursement for Some Hospice Services,* A-02-13-01001, June 2015; OIG, *The Community Hospice, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services,* A-02-11-01016, September 2014; OIG, *Servicios Suplementarios de Salud, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services,* A-02-11-01017, August 2014.

[31] OIG, *Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

[32] These are the unadjusted daily payment rates for FY 2012. CMS, MLN Matters, "Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and the Hospice Pricer for FY 2012," Transmittal 2260, Change Request 7518, July 29, 2011. Accessed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7518.pdf on March 25, 2015.

[33] Ibid.

[34] OIG, *Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

[35] Ibid.

[36] OIG, *Hospice of New York, LLC, Improperly Claimed Medicare Reimbursement for Some Hospice Services*, A-02-13-01001, June 2015.

[37] OIG, *Servicios Suplementarios de Salud, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services*, A-02-11-01017, August 2014.

[38] 42 CFR §418.202 (f). Drugs that are unrelated to the beneficiary's terminal illness and related conditions may be covered under Part D.

[39] OIG, *Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice*, A-06-10-00059, June 2012.

[40] OIG, *Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

[41] In recent guidance, CMS has encouraged Part D sponsors to place beneficiary-level prior authorization requirements on analgesic, antinausea, laxative, or antianxiety drugs for hospice beneficiaries because they are commonly used in hospice care and hospices are expected to provide them. See CMS, "Part D Payment for Drugs for Beneficiaries Enrolled in Medicare Hospice," July 18, 2014. Accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2014-PartD-Hospice-Guidance-Revised-Memo.pdf on September 13, 2017.

[42] OIG, *Questionable Billing for Physician Services for Hospice Beneficiaries*, OEI-02-06-00224, September 2010.

[43] Some physician services provided to hospice beneficiaries may be billed through Part B if the physician is not a hospice employee or providing services under arrangements with the hospice. If it is billed through Part B, the service should not also be billed through Part A.

[44] Social Security Act, §§ 1812(a)(4) and 1814(a)(7)(A), 42 U.S.C § 1395d(a)(4). Beneficiaries who elect hospice care are entitled to receive care for two 90-day periods, followed by an unlimited number of 60-day periods. Before 1990, hospice beneficiaries who were in hospice care for more than 210 days and still required such care were provided care by the hospice without charge to Medicare or the beneficiary.

[45] 42 CFR § 418.22(b).

[46] OIG, *Hospices Should Improve Their Election Statements and Certifications of Terminal Illness,* OEI-02-10-00492, September 2016. The certifications of terminal illness were collected for an OIG study that focused on general inpatient care, but these documents are for the hospice benefit as a whole and are not specific to any level of care.

[47] DOJ, "Director of Lisle-Based Hospice Company Convicted in Scheme to Fraudulently Bill Medicare for Medically Unnecessary Services," March 9, 2016. Accessed at https://www.justice.gov/usao-ndil/pr/director-lisle-based-hospice-company-convicted-scheme-fraudulently-bill-medicare-0 on September 29, 2017.

[48] DOJ, "Former Hospice Owner Sentenced for Health Care Fraud," February 1, 2012. Accessed at https://www.justice.gov/archive/usao/aln/News/February%202012/February%201,%202012%20Hospice.html on September 7, 2017.

[49] DOJ, "Greenwood Woman Sentenced for Millions in Hospice Fraud," December 19, 2014. Accessed at https://www.justice.gov/usao-ndms/pr/greenwood-woman-sentenced-millions-hospice-fraud on October 13, 2017. See also, DOJ, "Delta Woman Sentenced in Connection with Hospice Fraud," February 13, 2015. Accessed at https://www.justice.gov/usao-ndms/pr/delta-woman-sentenced-connection-hospice-fraud on May 26, 2016.

[50] Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Medicare Payment Policy*, March 2017, ch. 12, p. 320. Accessed at http://www.medpac.gov/docs/default-source/reports/mar17_entirereport.pdf?sfvrsn=0 on May 5, 2017.

[51] Some adjustments are made based on geography to account for differences in wage rates among markets. 42 CFR § 418.306(c).

[52] Patient Protection and Affordable Care Act, P.L. 111-148 § 3132(a).

[53] 80 Fed. Reg. 47141 (Aug. 6, 2015).

[54] OIG, *Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities,* OEI-02-14-00070, January 2015.

[55] OIG, *Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities*, OEI-02-06-00223, September 2009.

[56] 42 CFR § 418.100(c)(2).

[57] OIG, *Medicare Hospice: Use of General Inpatient Care*, OEI-02-10-00490, May 2013.

[58] OIG, *Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities,* OEI-02-14-00070, January 2015.

[59] For beneficiary's time in hospice care from 2007 to 2012.

[60] The International Classification of Diseases, 9th Revision, Clinical Modification, categorizes several diagnoses as "symptoms, signs, or ill-defined conditions." This report referred to all diagnoses listed under "symptoms, signs, or ill-defined conditions" as "ill-defined conditions."

[61] OIG, *Medicare Hospices That Focus on Nursing Facility Residents*, OEI-02-10-00070, July 2011.

[62] Ibid.

[63] MedPAC, "Hospice services," March 2017, ch. 12, p. 337. Accessed at http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch12.pdf?sfvrsn=0 on September 13, 2017.

[64] OIG, *OIG Work Plan*, 2017. Accessed at https://oig.hhs.gov/reports-and-publications/archives/workplan/2017/hhs%20oig%20work%20plan%202017.pdf on September 13, 2017.

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