

## NPHI POLICY BRIEF:

### BACKGROUND ON ISSUES WITH THE CURRENT HOSPICE PROGRAM INTEGRITY PROGRAM

*...Although physicians are expected to certify that a patient's life expectancy is 6 months or less, by no means are they expected to be certain of that time-frame. Over the years, this issue has been revisited. HCFA revised its regulations ten years ago to clarify that the physician was only expected to base this judgment on the general knowledge of the course of the illness... Bottom line, Medicare beneficiaries may live longer than 6 months and still be terminally ill and eligible for hospice. Unfortunately, the perceptions persist that this is a limited benefit and that it is fraudulent to refer a patient that may live longer. Ironically, this is the only benefit in the Medicare program to be frowned upon if it provides positive health outcomes, such as improved quality of life, ability to enjoy a day out of bed with the family, or stabilized health status.*

-Sen. Bob Dole, Special Committee on Aging Hearing, September 2000.<sup>1</sup>

#### Overview

Congress and the Centers for Medicare and Medicaid Services (CMS), by statute and regulation, make Medicare and Medicaid hospice benefits available to an individual upon a certification by two physicians that the individual is terminally ill, i.e., has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course. Such prognostication is uniformly recognized by Congress, CMS, and the courts as an inexact science for which no single criteria or set of criteria can be determinative. Rather, the certifying physicians must rely on their clinical judgment to evaluate the patient as a whole and assess whether his or her life expectancy qualifies them for the hospice benefit, i.e., whether the patient is more likely than not to die within six months. CMS has expressed numerous times in rulemaking that it does not expect physicians certifying patients as terminally ill to be correct every time in the terminal prognosis. And yet, it appears that Medicare and Medicaid audit contractors accord very little weight to the certifying physician's medical judgment.

Government contractor auditors routinely deny hospice claims based on an overly simplified and erroneous assessment of the hospice physician's complex prognostication of the individual's life expectancy. For example, in a misguided and unfounded attempt to convert the inexact science of life expectancy prognostication into a determination that is subject to simple "rules of thumb," auditors have denied claims after concluding that a patient's medical record fails to show "terminal decline," based on whatever unstated definition the auditor applies to that phrase. In doing so, the auditors elevate this undefined phrase (that does not exist in any statute or regulation) over the clinical judgment of the certifying physicians. "Rule of thumb" denials such as this are not aligned with the governing statutes or regulations and demonstrate a fundamental misapprehension of the hospice benefit by the auditors. Such denials improperly limit the scope of the hospice benefit to a degree that is inconsistent

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<sup>1</sup><https://www.aging.senate.gov/imo/media/doc/publications/9182000.pdf>

with Congress' mandate and intent and jeopardizes the availability of the hospice benefit to truly terminally ill individuals.

### Government Contractors Are Misinterpreting Hospice Core Principles

Government contractor auditors often issue claim denials with little or no explanation of the basis for the denial. When an explanation is provided, it often demonstrates the auditor's lack of familiarity with certain fundamental principles of the hospice benefit and hospice medicine including:

- **Medicare Hospice Benefit Construction:** The hospice benefit utilizes a "risk corridor" approach – therefore longer length of stay patients offset significant losses from short term patients. The hospice aggregate spending cap is applied as a ceiling of payment for every hospice in America, ensuring that there is a mechanism to address risk associated with too many long-length of stay patients. Therefore, a focus on "long length of stay" patients alone is not a fruitful approach to saving money for the Medicare Trust Fund because it is antithetical to the Congressional construct of the Medicare Hospice Benefit and because such focus redundantly addresses a category of patients that CMS already addresses through the spending cap.
- **Prognostication and Clinical Terminality:** Prognostication is not an exact science: as Senator Dole's quote underscores, both Congress and CMS have acknowledged that terminal illnesses do not have entirely predictable courses<sup>2</sup> and that medical prognostication is not an exact science.<sup>3</sup> Given this, a terminal prognosis is far from a guarantee of death within six months. Eligibility for hospice is predicated on a patient's clinical status whose prognosis is "more likely than not to result in a life expectancy of six months or less."<sup>4</sup> CMS and the HHS Office of the Inspector General (OIG) have both stated that there are not specific clinical benchmarks that are needed to certify terminal illness<sup>5</sup> – hospice admission is influenced by non-medical factors that would be indicated in the plan of care.<sup>6</sup> Patient improvement or stabilization is not a disqualifier from hospice; nor does terminality require a decline in condition. CMS has issued statements consistent with both these points.<sup>7,8</sup> Additionally, as Senator Dole said at the hearing in 2000, Medicare beneficiaries may live longer than 6 months and CMS has previously recognized that some patients have the "good fortune to live longer than

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<sup>2</sup>See, e.g., CMS, Program Memorandum Intermediaries/Carriers, AB-03-040, Hospice Care Enhances Dignity & Peace As Life Nears its End (Mar. 28, 2003); see also *State ex rel. Wall v. Vista Hospice Care, Inc.*, No. 3:07-CV-00604-M, 2016 WL 3449833 at \*2 (N.D. Texas June 20, 2016) ("CMS recognizes that prognostication is 'uncertain' and not 'an exact science.'")

<sup>3</sup>142 Cong. Rec. S9582 (daily ed. Aug. 2, 1996) (statement of Sen. Breaux).

<sup>4</sup>See Medicare Program CMS, FY 2014 Hospice Wage Index, 78 Fed. Reg. 48234, 48247 (Aug. 7, 2013) (emphasis supplied)

<sup>5</sup>See *id.* (quoting 73 Fed. Reg. 32088, 32138 (June 5, 2008)).

<sup>6</sup> Publication of the OIG Compliance Program, Guidance for Hospices, Office of Inspector General (OIG), HHS., October 5, 1999, available at: <https://www.gpo.gov/fdsys/pkg/FR-1999-10-05/html/99-25787.htm>

<sup>7</sup>Medicare Program; Hospice Wage Index for Fiscal Year 2010, 74 Fed. Reg. 39384, 39399 (Aug. 6, 2009).

<sup>8</sup>79 Fed. Reg. 50452, 50471 (Aug. 22, 2014) (emphasis added). See also 75 Fed. Reg. 70372, 70448 (Nov. 17, 2010) ("A patient's condition may temporarily improve with hospice care."); 74 Fed. Reg. 39384, 39399 (Aug. 6, 2009) ("We also acknowledge that at recertification, not all patients may show measurable decline.").

predicted by a well-intentioned physician”<sup>9</sup> and therefore, “[t]he fact that a beneficiary lives longer than expected in itself is not cause to terminate benefits.”<sup>10</sup>

- **Role of the Hospice Physician:** Physicians have broad discretion in relation to prognostication, which, in addition to the lack of certainty around medical prognostication, means that different physicians could apply their clinical judgment and could disagree about a patient’s prognosis and neither would be wrong. As a result, CMS expects only that a physician uses his or her best clinical judgment for certification and recertification, and that there is no risk to a physician that he or she believes to be terminally ill. The hospice physician’s clinical judgment is central to the hospice benefit -- CMS has acknowledged that “[i]t is the physician’s responsibility to assess the patient’s medical condition and determine if the patient can be certified as terminally ill.”<sup>11</sup> Moreover, “[t]he changes to the CMS rules and regulations over time also demonstrate the importance of the hospice physician’s clinical judgment to hospice certification.”<sup>12</sup>
- **General Inpatient Care (GIP):** Contractors are now auditing based on GIP stays that are more than five consecutive days long. Five days is an arbitrary designation – there is no statutory or regulatory limit on the length of stay or number of episodes of GIP each patient receives.<sup>13</sup> Length of stays in GIP, while intended to be short term, can vary from hours to weeks, depending on the condition of the patient. Given the variety of clinical reasons that would necessitate an appropriate GIP stay, Medicare should expect to see a natural range of GIP stays – with some very short stays and some longer than average stays. Like the hospice benefit as a whole, the inpatient portion of the benefit has a cap – i.e. there is already a safeguard against a hospice’s overutilization of GIP. Ultimately, this audit focus on GIP will disproportionately impact non-profit, community-based hospices who are more likely to have their own standalone inpatient hospice units that are also subject to rigorous state licensure and survey requirements.

### Misaligned Contractor Incentives and Disproportionate Impact on NPHI Members

Contractors’ incentives are not aligned with those of hospice beneficiaries or the Medicare Trust Fund. They are incentivized to find as many claims as possible to deny. They are not penalized for overly aggressive denials that are eventually overturned, not adhering to established timelines once an audit has been initiated, or for issuing claim denials with scant or unintelligible justifications supporting the denials. These audits, therefore, are ultimately not focused on ensuring the patient and family are getting timely, appropriate care or making sure that money is restored to the Medicare program.

Program integrity audits inordinately impact community-based, freestanding hospice providers because they often have a larger census than many newer hospices and the vast majority of hospice revenue (90%+) comes from Medicare. Hospitals and other providers that work with CMS do not have a similar payer distribution and are thus not confronted with the kind of existential threat hospices face from aggressive Medicare audit practices (particularly not-for-profit hospices). Further, when CMS assesses the effectiveness of program integrity audits, as it recently did with its report *Recovery Auditing in*

<sup>9</sup>Correspondence from Nancy-Ann Min DeParle, HCFA Administrator, date-stamped Sept. 12, 2000.

<sup>10</sup>CMS, Medicare Benefit Policy Manual (“MBPM”), CMS Pub. No. 100-02, Ch. 9, § 10.

<sup>11</sup>70 Fed. Reg. at 70539.

<sup>12</sup>*AseraCare Inc.*, 2015 WL 8486874, at \*8.

<sup>13</sup>See §418.108

*Medicare Fee-For-Service for Fiscal Year 2016*, the total cost of these audits is woefully understated. The cost to providers to withstand these audits is not taken into consideration, nor are the consequences of a 41.9% overturn rate. The impact of withholding payments from non-profit community-based, safety net hospices while unaccountable contractors conduct lengthy and error-prone audits is destructive and will result in quality providers' financial ruin and patient and family barriers to needed care.

## Conclusion

CMS and its contractors are not enforcing clear or consistent standards regarding hospice care. The "terminal decline" standard is one good example of this inappropriate oversight; another is the arbitrary application of a stay of 5-days at the general inpatient level of care. Contractors are not providing explanations for claim denials. In short, reviewers are being instructed and are issuing guidance around false standards. There is evidence that CMS contractor medical reviewers are being instructed to look for decline even though terminal decline is not a standard upon which hospice documentation should be judged.<sup>14</sup> These actions are contrary to Congress and CMS' own statements and guidance, and simultaneously undermine the authority of the treating physicians and the wishes of the beneficiaries. It is impossible for providers to operate a benefit based on arbitrary standards that are not in the statutes or regulations.

Both patients and families suffer when they fear or experience discharge from a hospice program. The stress of live discharge of a spouse or a parent from hospice is often considerable and can greatly amplify the already overwhelming challenges of providing care to a very ill family member. A live discharge often means that a very sick person and his or her caregiver must find a new DME supplier and pharmacy, including oxygen, which is a significant burden that can result in the use of more expensive care settings (i.e. ER). NPHI member hospice organizations are reporting pressure to live discharge patients based on the aggressive and unfounded claim denials issued by government contractor auditors.

Finally, innovation is and will be further chilled as a result of contractor behavior. Non-profit, community-based hospice and palliative care providers like those in NPHI are leading the innovation curve. Rather than being primarily accountable to the profit demands of shareholders, they pursue philanthropic and grant support to stand up programs that address the needs of beneficiaries with advanced illness. These include a myriad of palliative care delivery models, advanced illness management, and other strategies designed to keep beneficiaries in their own homes and out of acute care settings. Additionally, philanthropy-funded programs like specialized bereavement programs with proven results will have to be cut if those dollars are only able to cover the financial loss for basic Medicare hospice services that all providers should already be offering.

In short, the unintended consequence of excessive audits and capricious contractor behavior is that resources once used to innovate are being siphoned away to fund defenses against inappropriately denied payments – and ultimately to sustain the livelihood of our organizations.

*Please see our accompanying solutions brief for our suggestions on how Congress and CMS could more effectively implement a targeted and effective hospice program integrity program.*

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<sup>14</sup>See <https://www.palmettogba.com/palmetto/providers.nsf/vMasterDID/A3GKXA8730?OpenDocument>.