A HELP-ING HAND: HOW LEGISLATION CAN REFORM THE AFFORDABLE CARE ACT AND HOSPICE CARE TO PRIORITIZE COMFORT AND PREPARE FOR THE BABY BOOMER GENERATION

Matthew E. Misichko

The Patient Protection and Affordable Care Act (ACA) alters many phases of hospice care. Hospices today face increasing regulatory requirements for patients to keep receiving care. Estimates indicate that a majority of hospice centers will not be adequately financed to remain open. The Hospice Evaluation and Legitimate Payment (HELP) Act can smooth the transition for hospice to prepare for the Baby Boomer generation and help implement individualized, diverse hospice care. The proposed legislation strives to provide better care for less money with increased patient satisfaction.

Finally, hospice reform through the ACA requires society to rethink the social role and implications of hospice care. Implementing pay-for-performance programs, streamlining the hospice recertification process, and establishing "extreme" hospice activities inspired by the Baby Boomer generation will allow hospice care to achieve its dual goals of care and comfort.

Matthew E. Misichko is Administrative Editor 2013-2014, Member 2012-2013, The Elder Law Journal; J.D. 2014, University of Illinois, Urbana Champaign; B.S. 2011, University of Illinois, Urbana Champaign.

To Mom, Dad, and Michelle– thank you for your continuous love and support.

I. Introduction

In the next five years, hospice care will continually experience large financial and regulatory reform. The Patient Protection and Affordable Care Act (ACA) makes large financial cuts in Medicare,[1] the government program that covers over 83 percent of all hospice patients.[2] The Office of Management and Budget estimates that the new requirements to receive hospice care will decrease Medicare funding by about $100 million through 2019.[3] This reduction could push 72 percent of hospice care programs out of business within the next decade.[4]

First, the ACA delegates future changes in hospice operations and payments to the Centers for Medicare and Medicaid Services (CMS).[5] Home health care services funding, which includes hospice care, will shrink over $39.5 billion in the next seven years.[6] Increased regulatory measures as a result of the ACA shrink the potential time a

1. *See* PATRICIA A. DAVIS ET AL., CONG. RESEARCH SERV., R41196, MEDICARE PROVISIONS IN PATIENT PROTECTION AFFORDABLE CARE ACT (P.L. 111-148) 4 (2010); William B. Eck, *Home Care, Hospice Care, and the Affordable Care Act*, AHLA CONNECTIONS 16 (Nov. 2010), http://publish.healthlawyers.org/Members/PracticeGroups/LTC/Documents/LTC%20from%20AC_1011.pdf (last visited Oct. 21, 2013); NAT'L HOSPICE & PALLIATIVE CARE ORG., *The Medicare Hospice Benefit & Recent Changes Impacting the Hospice Community* 1 (2011), http://www.fourseasonscfl.org/files/dl/5b43b7b617255406d8c77cb2b066fc75 (last visited Oct. 21, 2013) [hereinafter THE MEDICARE HOSPICE BENEFIT]; *see, e.g.*, OHIO HOME, HOSPICE & PALLIATIVE CARE ADVOC. NETWORK, *Hospice Priority: Budget Neutrality Adjustment Factor (BNAF)* (2009), http://associationdatabase.com/aws/OHPCO/asset_manager/get_file/. *See generally* SOC. SEC. ADMIN., *Differences Between Medicare Parts A, B, C, and D*, http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/167/~/differences-between-medicare-parts-a,-b,-c-and-d (last updated Oct. 10, 2013, 11:42 AM).

2. NAT'L HOSPICE & PALLIATIVE CARE ORG., *NHPCO Facts and Figures: Hospice Care in America* 10 (2012), http://www.nhpco.org/sites/default/files/public/Statistics_Research/2011_Facts_Figures.pdf [hereinafter NHPCO FACTS AND FIGURES].

3. Eck, *supra* note 1, at 20.

4. Robin Stallman, *Marin Voice: Keep Hospice Care Affordable*, MARIN INDEP. J., Jul. 26, 2012, *available at* http://www.marinij.com/opinion/ci_21158677/marin-voice-hospice-is-affordable-care.

5. *See, e.g.*, CTR. FOR MEDICARE ADVOC., INC., *New Hospice Face-to-Face Requirement: Help or Hindrance?*, http://www.medicareadvocacy.org/new-hospice-face-to-face-requirement-help-or-hindrance/ (last modified Apr. 28, 2011).

6. Eck, *supra* note 1, at 16.

patient can receive hospice care, creating numerous hardships for hospice centers.[7]

These financial reductions and regulatory increases may be justified due to a familiar American ideal: dying has become big business. Today, hospice care is a $14 billion industry.[8] Bloomberg highlighted the footprint of private equity firms and "enrollment-based incentives" in hospice care.[9] Fraudulent schemes helped qualify nearly 110,000 patients not facing imminent death for hospice care eligibility, raised revenue for private firms, and created questions about whether the ultimate purpose of hospice care can be maintained if the industry as a business grows.[10]

In the last 10 years, hospice care has more than doubled.[11] In 2011, 1.65 million people in the United States, or 45 percent of those who died, received hospice care.[12] With 78 million "baby boomers"—the group of diverse, hard-working, and individualized Americans born between 1946 and 1964—growing older, the hospice care industry expects considerable future growth.[13] This growth will be seen in both the number of patients and the type of care patients expect.

Two stories outline the differences in expectations from hospice care. For some, like 85-year-old Franklin Wyman of Massachusetts, exiting with personal and familial pride is key. He stated, "it's important to me to maintain my dignity until the very end and be a good example for my family."[14] Supportive bereavement programs and "nurses or aides stroking his hand or hair in comfort, the way [his] mom would have" illustrate how the little details make hospice care unique.[15]

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7. Randy Dotinga, *Slowly Dying Patients, An Audit And A Hospice's Undoing*, KAISER HEALTH NEWS (Jan. 16, 2013), http://www.kaiserhealthnews.org/Stories/2013/January/16/san-diego-hospice.aspx.

8. *Id.*; Peter Waldman, *Aunt Midge Not Dying in Hospice Reveals $14B Market*, BLOOMBERG (Dec. 5, 2011, 11:01 PM), http://www.bloomberg.com/news/2011-12-06/hospice-care-revealed-as-14-billion-u-s-market.html.

9. Waldman, *supra* note 8.

10. *Id.*

11. Holly Ramer, *For Baby Boomers, Hospice Includes Golf, Casino Trips*, ST. J. REG., July 29, 2012, at 1, *available at* http://www.sj-r.com/features/x1054150177/For-baby-boomers-hospice-includes-golf-casino-trips; *see* NHPCO Facts and Figures, *supra* note 2, at 4–5.

12. Dotinga, *supra* note 7.

13. *See* Linda Keslar, *At Home in Hospice*, PROTO MAG. MASS. GEN. HOS. (Spring 2007), http://protomag.com/assets/at-home-in-hospice?page=1.

14. *Id.*

15. *Id.*

Conversely, Arsenia Grair, a 91-year-old hospice patient at the Hospice of the Western Reserve in Cleveland, Ohio fulfilled her final wish—playing the slot machines at the Cleveland Horseshoe Casino.[16] Casino employees greeted Grair warmly as she relived her days in Las Vegas and Atlantic City casinos but refused to reveal her playing strategy.[17] She ended the day winning $66 on a $10 bet.[18] Some hospice centers have the mindset to "do whatever we can to grant our patients' final unfulfilled wishes."[19]

Amidst recent ACA changes, the original Congressional intent of hospice care has remained the same for 30 years:[20] comfort is the core to hospice care.[21]

To address these issues, this Note will explore the possibility of improving the "triple threat": providing better care for less money with increased patient satisfaction.[22] First, the Note discusses the impact of the ACA on hospice care and what further improvements need to be made. Part II provides background on hospice, its relationship to Medicare, and the major governmental and non-governmental groups influencing hospice decisions. Part III examines five hospice changes from the ACA, including the face-to-face requirement. Financial, procedural, and policy rationales surround each provision. Part III also discusses two complex financial changes: eliminating the budget neutrality adjustment factor (BNAF) and incorporating a productivity adjustment factor in 2013 to the market basket update. Finally, Part III discusses the Hospice Evaluation and Legitimate Payment (HELP) Act,[23] evaluates its proposed changes to the ACA's

16. Pat Galbincea, *91-year-old Woman in Hospice gets Dying Wish to Play the Slots at the Horseshoe Casino*, PLAIN DEALER (May 18, 2012), http://www.cleveland.com/metro/index.ssf/2012/05/91-year-old_woman_in_hospice_g.html.

17. *Id.*

18. *Id.*

19. *Id.* (according to Laurie Henrichsen, a spokesperson for the Hospice of the Western Reserve).

20. Richard L. Fogel, *GAO/HRD-83-72*, U.S. GEN. ACCOUNTING OFFICE HUMAN RESOURCES DIVISION: COMMENTS ON THE LEGISLATIVE INTENT OF MEDICARE'S HOSPICE CARE BENEFIT 1 (1983), *available at* http://www.gao.gov/assets/210/206691.pdf.

21. Ramer, *supra* note 11, at 1.

22. *Id.*

23. THE MEDICARE HOSPICE BENEFIT, *supra* note 1, at 2; NAT'L HOSPICE & PALLIATIVE CARE ORG., *Preserve and Protect the Medicare Hospice Benefit*, http://hospiceactionnetwork.org/linked_documents/get_informed/legislation/

treatment of hospice care, and concludes with an investigation into the social role and implications of hospice care. Part IV recommends new approaches that balance the HELP Act, recertification procedures for hospice centers and patients, scaling back the booming business of hospice care, and the needs and expectations of future hospice patients.

II. Background

A. Hospice

The National Hospice and Palliative Care Organization (NHPCO) defines hospice care as providing medical, emotional, and spiritual support for those with a terminal illness.[24] In 1967, St. Christopher's Hospice in London introduced both physical and emotional relief programs for terminally ill patients.[25] Florence Ward, the dean of the Yale University Nursing School at the time, visited St. Christopher's and learned about the hospice industry.[26] Seven years later, Ward opened the Connecticut Hospice in Branford, Connecticut.[27] Since that time, a patient's hospice team has included doctors, nurses, counselors, family members, and volunteers who create a plan to cope with the patient's terminal illness.[28] A hospice doctor or nurse is on call 24 hours a day and seven days a week to provide care when needed.[29]

Hospices intend care for those that will live less than 180 days.[30] Either a hospice doctor or medical director must certify that a patient is terminally ill.[31] The doctor or medical director must include a writ-

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HELP_Hospice/HELPoverview.pdf (last visited Nov. 12, 2013) [hereinafter *Preserve and Protect the Medicare Hospice Benefit*].

24. NHPCO FACTS AND FIGURES, *supra* note 2, at 3.

25. Keslar, *supra* note 13.

26. *Id.*

27. *Id.*

28. NHPCO FACTS AND FIGURES, *supra* note 2, at 3.

29. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE HOSPICE BENEFITS 5 (2012) [hereinafter MEDICARE HOSPICE BENEFITS].

30. CTRS. FOR MEDICARE & MEDICAID SERV., HOSPICE PAYMENT SYSTEM 3 (2012), *available at* http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/hospice_pay_sys_fs.pdf [hereinafter HOSPICE PAYMENT SYSTEM]; MEDICARE HOSPICE BENEFITS, *supra* note 29, at 5.

31. HOSPICE PAYMENT SYSTEM, *supra* note 30, at 3.

ten certification in the patient's clinical record, consisting of a statement that a patient will not live more than 180 days, clinical findings supporting that conclusion, and signatures.[32] A patient can still receive hospice care longer than 180 days, also known as the "third benefit period recertification,"[33] provided that the hospice doctor or medical director recertifies the patient as terminally ill.[34] Hospice services include drugs, physical care, equipment, and other needs associated with treating a terminal illness.[35]

The previous "one-size-fits-all kind of treatment plan" that originated in hospice care has become an outdated model.[36] In 2010, 35.6 percent of hospice admissions were cancer patients.[37] The remaining 64.4 percent of hospice admissions were those with "non-cancer diagnoses," led by heart disease (14.3 percent), an unspecified disability (13 percent), dementia (13 percent), and lung disease (8.3 percent).[38] Determining when death will occur is more difficult with these non-cancer diseases.[39]

In 2006, the number of hospice patients totaled 1.3 million and the number grew to 1.58 million in 2010.[40] During that same time, the number of hospice centers increased 15 percent, and about 5,000 hospice centers exist today.[41]

B. The Major Players: Organizations Involved in Hospice

1. CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

A complex system, the CMS "provides health coverage for 100 million people through Medicare, Medicaid, and . . . [by] improving health care and ensuring coverage for all Americans."[42] The organiza-

32. *Id.*
33. *Id.*
34. MEDICARE HOSPICE BENEFITS, *supra* note 29, at 10.
35. *Id.* at 4.
36. Ramer, *supra* note 11, at 2.
37. NHPCO FACTS AND FIGURES, *supra* note 2, at 7.
38. *Id.*
39. Dotinga, *supra* note 7.
40. *See also* NHPCO FACTS AND FIGURES, *supra* note 2, at 4 (showing that from 2006–2010, the annual total of hospice patients has increased by nearly 30 percent).
41. *Id.* at 8.
42. CTRS. FOR MEDICARE & MEDICAID SERVS., *CMS Enterprise Portal*, https://portal.cms.gov (last visited Oct. 28, 2013) [hereinafter Enterprise Portal].

tion entered the hospice industry in July 2008 and compiled data on the number of visits and the cost per visit for some hospice services.[43]

The CMS provides information about the hospice services covered under Medicare Part A (defined below), hospice care availability periods, and payment rates.[44] It updates hospice data and resources for those seeking a hospice center.[45] The CMS also plays a large role in hospice care and certification requirements.[46] More specifically, it sets the minimum standards for hospice care; CMS standards outline how state agencies must certify hospice organizations and provide care.[47] With no regulation or law specifying a recertification process for hospice care *organizations*, the CMS uses an "annual budget request policy memorandum" to communicate its recertification frequency to the states.[48] For example, due to budget reductions, the CMS previously believed hospice center recertification should occur every six to eight years, a frequency much lower than recertification for hospitals and nursing homes.[49] This area will be discussed in greater detail later in this Note.

A patient enrolled in hospice and Medicare pays a daily rate to hospice agencies for each day of care.[50] For Medicare to pay the daily rate, the patient must receive care from a Medicare-approved hospice program.[51] The payment is made even if the patient does not receive care on that specific day.[52] The "daily payment rates are intended to cover costs that hospices incur in furnishing services identified in pa-

43. CTRS. FOR MEDICARE & MEDICAID SERVS., POSSIBLE FUTURE HOSPICE DATA COLLECTION 3 (2012), http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/Hospice-Data-Collection.pdf [hereinafter Possible Future Hospice Data Collection].

44. HOSPICE PAYMENT SYSTEM, *supra* note 30, at 2–4.

45. POSSIBLE FUTURE HOSPICE DATA COLLECTION, *supra* note 43.

46. *Id.*

47. DANIEL R. LEVINSON, OEI-06-05-00260, MEDICARE HOSPICES: CERTIFICATION AND CENTERS FOR MEDICARE & MEDICAID SERVICES OVERSIGHT, U.S. DEP'T OF HEALTH & HUMAN SERVS. 1 (2007).

48. *Id.*

49. *Id.*

50. MEDPAC SERVS. SYS., *Hospice Services Payment System*, Payment Basics 1 (Oct. 2012), http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_hospice.pdf [hereinafter HOSPICE SERVICES PAYMENT SYSTEM].

51. MEDICARE HOSPICE BENEFITS, *supra* note 29, at 6.

52. CTR. FOR MEDICARE ADVOC., INC., *The Medicare Hospice Benefit* (2010), http://www.medicareadvocacy.org/Print/FAQ_Hospice.htm.

tients' care plans."[53] The daily rate ranges from about $153 for routine care to $896 for non-stop care and supervision.[54]

These daily payments are divided into four different care categories: (1) routine home care (RHC), (2) continuous home care (CHC), (3) inpatient respite care (IRC), and (4) general inpatient care (GIC).[55] Location and intensity of services categorize each type of care.[56] RHC involves a patient receiving hospice care at the place he or she lives. CHC is a licensed nurse providing care where a patient lives. IRC involves a patient receiving care in an approved facility on a short-term basis so the caregiver can rest. GIC covers a patient receiving care for pain control or another issue that cannot be handled in a setting like a home.[57] RHC is the default payment rate for hospice care[58] and in 2010, 96 percent of hospice patient care days were spent in RHC.[59] Medicare usually pays the hospice provider for a patient's hospice care, but a patient on IRC must pay 5 percent of the Medicare-approved amount for his or her care.[60] Before ACA implemented changes, the annual payment rates were updated solely on a market basket index.[61]

The CMS created the market basket index, also known as a "fixed-weight index because it answers the question of how much more or less it would cost, at a later time, to purchase the same mix of goods and services that was purchased in a base period."[62] When creating a market basket, the first step is to select a time that will classify

53. *Id.*

54. Dotinga, *supra* note 7; *see also* Jordan Rau, *Growing Hospice Care Costs Bring Concerns About Misuse*, KAISER HEALTH NEWS (June 27, 2011), http://www.kaiserhealthnews.org/stories/2011/june/27/growing-hospice-care-brings-misuse-concerns.aspx (estimating Medicare payments ranging from $147 to $856 per day depending on treatment).

55. HOSPICE SERVICES PAYMENT SYSTEM, *supra* note 50, at 1; NHPCO FACTS AND FIGURES, *supra* note 2, at 11.

56. HOSPICE SERVICES PAYMENT SYSTEM, *supra* note 50, at 1.

57. NHPCO FACTS AND FIGURES, *supra* note 2, at 5.

58. HOSPICE SERVICES PAYMENT SYSTEM, *supra* note 50, at 2.

59. *Id*. at 11.

60. *See also* MEDICARE HOSPICE BENEFITS, *supra* note 29, at 8 (illustrating that "if Medicare pays $100 per day for inpatient respite care, you will pay $5 per day.").

61. HOSPICE SERVICES PAYMENT SYSTEM, *supra* note 50, at 2.

62. CTRS. FOR MEDICARE & MEDICAID SERVS., *Market Basket Definitions and General Information*, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/info.pdf (last visited Oct. 31, 2013) [hereinafter MARKET BASKET DEFINITIONS AND GENERAL INFORMATION].

as the base period.[63] Next, proportions are determined by comparing how much each expense category receives against the total amount of expenses.[64] These proportions are called "expenditure weights."[65] The CMS determines each expenditure weight and matches each expense category to an appropriate price variable, taking into account additional costs when consuming a product.[66] The resulting match is called a "price proxy."[67] Then, the CMS multiplies the price proxy and the expenditure weight for each expense category.[68] Finally, the sum of these two products gives the composite index level in the market basket for that base period.[69] No "Medicare" market basket exists because each payment system, such as the home health agency, has its own individual market basket.[70] Discussed later in this Note are the changes created by the ACA to market basket updates.

Two annual caps limit the Medicare payment a hospice center can receive annually.[71] First, the "inpatient cap" does not allow the number of inpatient care days to exceed 20 percent of the total patient care days in one year.[72] Second, the "aggregate cap"[73] determines the "average annual payment per beneficiary a hospice can receive."[74] If the total number of Medicare hospice patients multiplied by the hospice's total payments exceeds $25,377.01, which is the annual cap amount, the hospice center must repay the difference.[75]

63. *Id.*
64. *Id.*
65. *Id.*
66. *Id.*
67. *Id.*
68. *Id.*
69. *Id.*
70. *Id.*
71. HOSPICE SERVICES PAYMENT SYSTEM, *supra* note 50, at 3.
72. *Id.*
73. *Id.*
74. *Id.*
75. *Id.* If a hospice agency were to spend the maximum $896 per hospice patient, the hospice agency could support 28 hospice patients before exceeding the absolute dollar limit; if the agency spent the minimum $153 per hospice patient, the hospice agency could support 165 hospice patients before exceeding the absolute dollar limit. Agencies do not truly work in this linear fashion and have multiple payment structures depending on the needs of the hospice patient. *Id.* at 5.

2. THE MEDICARE PAYMENT ADVISORY COMMITTEE (MEDPAC)

MedPAC, an independent agency created by Congress, advises Congress on Medicare program issues.[76] This committee consists of 17 members who oversee Medicare payment structuring and analyze access to and quality of health care.[77] Public MedPAC meetings recommend policy reforms to Congress.[78] Recommendations consist of expert presentations and meetings between congressional committees and members of the CMS on a specified topic.[79] MedPAC reveals their recommendations every March and June and their recommendations are also available in the comments of reports created by the Secretary of the Department of Health and Human Services (HHS).[80]

MedPAC reiterates the hospice goal of comfort and pain relief.[81] In the 1970s, cancer patients constituted the largest percentage of hospice admissions.[82] In 1982, MedPAC responded by creating the Medicare hospice benefit (MHB) specifically tailored to terminal cancer patients.[83] After nearly 30 years, MedPAC's report from June 2008 revealed that cancer patients accounted for only a minority of those receiving MHB.[84]

3. CONGRESSIONAL BUDGET OFFICE (CBO)

The CBO analyzes economic and budgetary issues to help inform Congress in creating the budget.[85] Cost estimates, reports, and policy analyses are the essential responsibilities of this office; the CBO does not make policy recommendations.[86]

76. MEDPAC, *About Medpac* (Feb. 15, 2013), http://www.medpac.gov/about.cfm.
77. *Id.*
78. *Id.*
79. *Id.*
80. *Id.*
81. HOSPICE SERVICES PAYMENT SYSTEM, *supra* note 50, at 1.
82. NHPCO FACTS AND FIGURES, *supra* note 2, at 7.
83. POSSIBLE FUTURE HOSPICE DATA COLLECTION, *supra* note 43, at 11.
84. *Id.*
85. CONG. BUDGET OFFICE, *Overview*, http://www.cbo.gov/about/overview (last visited Nov. 1, 2013).
86. *Id.*

4. THE MORAN COMPANY

Since 1998, this research and consulting firm in Washington, D.C. has analyzed the public and private boundaries of health care.[87] The Moran Company specializes in evaluating payment systems for both the private sector and Medicare.[88] This group is known best for "scoring" the "budget impact of proposed legislation and . . . help[ing] those clients design and draft a variety of proposed policy initiatives."[89]

The Moran Company's impact on hospice care has influenced the ACA adjustments to hospice rates, MedPAC revisions to future hospice rates,[90] and the CBO's assessments of how their "score" might affect budgets of passed policies.[91] Discussed later in this Note, the Moran Company analyzed the changes in hospice margins caused by two budget cuts: the elimination of the budget neutrality adjustment factor (BNAF) and the introduction of the productivity adjustment factor."[92]

5. OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES (OIG)

The OIG helps "fight waste, fraud and abuse in Medicare, Medicaid and more than 300 other HHS programs."[93] The OIG is the largest investigative agency in the federal government with over 1,700 employees. The OIG's responsibilities include creating cost-saving recommendations from evaluations, investigations, and audits. The OIG also educates health care agencies on relevant laws and detects fraudulent activity.[94]

Previously, the OIG created compliance guidelines for hospices, audited hospice payments, and solved payment issues for people eli-

87. THE MORAN CO., *Welcome To The Moran Company*, http://www.themoran company.com/ (last visited Nov. 1, 2013).
88. *Id.*
89. *Id.*
90. *Id.*
91. Memorandum from the Moran Co. on the Summary of Profit Margin Analysis for Urban and Rural Hospices, 2009–2019, to the Office of Health Policy and the NHPCO 1 (Mar. 17, 2011), *in* THE MEDICARE HOSPICE BENEFIT, *supra* note 1.
92. *Id.*
93. OFFICE OF THE INSPECTOR GEN.: U.S. DEP'T OF HEALTH & HUMAN SERVS., *About Us*, https://oig.hhs.gov/about-oig/about-us/index.asp (last visited Nov. 1, 2013).
94. *Id.*

gible for both Medicaid and Medicare benefits.[95] The OIG 2013 Work Plan for hospice care includes two issues regarding nursing home relationships–financial responsibilities with nursing facilities and general inpatient care (GIC).[96]

C. Medicare Part A and Hospice Care

Medicare is a government health insurance program that reimburses hospitals and doctors for medical bills of people 65 years of age and older.[97] The CMS runs Medicare and it is the source for a majority of the changes and issues addressed in this Note.[98]

Over the last decade, nearly 1,000 additional hospice providers have become Medicare-certified.[99] In 2011, Medicare paid for 84 percent of MHB.[100] The number of patients using MHB has increased nearly 12 percent over the last six years.[101] Enacted by Congress in 1982,[102] MHB has four requirements for a patient seeking hospice care: (1) the patient must be eligible for Medicare Part A,[103] (2) a hospice doctor or the medical director certifies that the patient is terminally ill and has 180 days or less to live, so long as no change occurred to the illness, (3) the patient signs a statement and chooses hospice care instead of other Medicare-covered benefits to treat the terminal illness, and (4) the patient receives care from a Medicare-approved hospice program.[104] Medicare Part A pays for hospice care, inpatient hospital care, skilled nursing care, and other services.[105]

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95. OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., *Spotlight On… Medicare Hospice Care*, https://oig.hhs.gov/newsroom/news-releases/2011/hospice.asp (last visited Nov. 1, 2013).

96. Ari J. Markenson, *Hospice Activities in the OIG's 2013 Work Plan*, BENESCH, FRIEDLANDER, COPLAN & ARONOFF LLP (Oct. 8, 2012), http://www.beneschlaw.com/hospice-activities-in-the-oigs-2013-work-plan-10-08-2012/.

97. U.S. DEP'T OF HEALTH & HUMAN SERVS., *HHS FAQ: What is the Difference Between Medicare and Medicaid?*, http://answers.hhs.gov/questions/3094 (last updated Dec. 20, 2012).

98. *Id.*

99. NHPCO FACTS AND FIGURES, *supra* note 2, at 9.

100. Dotinga, *supra* note 7.

101. NHPCO FACTS AND FIGURES, *supra* note 2, at 4.

102. *Id.* at 10.

103. *See Medicare Eligibility Tool*, MEDICARE.GOV, http://www.medicare.gov/MedicareEligibility/home.asp? (last visited Nov. 1, 2013) (explaining that people receive Medicare Part A at age 65 without paying a premium so long as they receive retirement benefits from Social Security).

104. MEDICARE HOSPICE BENEFITS, *supra* note 29, at 4.

105. SOC. SEC. ADMIN., *supra* note 1.

Two types of benefit periods exist for hospice care:[106] a patient can receive "two 90-day periods followed by an unlimited number of 60-day periods."[107] For each benefit period, the hospice doctor or hospice medical director must recertify, as required by the ACA, that a patient is terminally ill and eligible for hospice care.[108]

A patient's care options and health management is discussed during a hospice consultation with either a hospice medical director or hospice doctor.[109] If hospice care becomes taxing on a patient's ordinary caregiver, Medicare covers respite care, which allows a patient to stay at an inpatient facility, hospital, or nursing home for five days and receive care while his or her usual caregiver rests.[110] This help must be used sparingly.[111]

The paradox of MHB is the tendency of hospice programs to believe that patients who "stay for a long time" show that the hospice care being provided is prolonging patients' lives.[112] This issue is addressed later in the Note.

Care, and not a cure, is the focus of hospice.[113] The ACA distorts this fundamental distinction.[114] For the majority of care, Medicare will not cover drugs, treatment, or care curing a patient's illness, nor will it cover care that a patient's hospice team does not coordinate.[115] A patient can choose to end hospice care at any time, or he or she will be taken off hospice care if his or her illness is no longer deemed terminal.[116]

The "length of service" is the total number of days a patient receives hospice care.[117] More than half of all hospice service ends before 30 days, with 35.8 percent of those patients having hospice care for less than a week.[118]

106. NHPCO FACT AND FIGURES, *supra* note 29, at 10.
107. *Id.*
108. *Id.*
109. *Id.* at 6.
110. *Id.* at 7.
111. *Id.*
112. Dotinga, *supra* note 7.
113. NHPCO FACTS AND FIGURES, *supra* note 2, at 3.
114. Paula Span, *On the Way to Hospice, Surprising Hurdles*, N.Y. TIMES BLOG: THE NEW OLD AGE (Jan. 3, 2013, 6:00 AM), http://newoldage.blogs.nytimes.com/2013/01/03/hospice-obstacles/?_4=0.
115. MEDICARE HOSPICE BENEFITS, *supra* note 29, at 7.
116. *Id.* at 10.
117. NHPCO FACTS AND FIGURES, *supra* note 2, at 5.
118. *Id.*

III. Analysis

Since its inception in 1983, Congress's intent in creating hospice care has been clear. Nearly 30 years ago, comments from the General Accounting Office about the recently enacted Medicare Hospice Care Benefit stated that the goal of hospice care was "to make the patient's remaining days as comfortable and meaningful as possible and to help the family cope with the stress."[119] The comments also discussed the "team" of hospice personnel that would provide comfort to the patient and guidance to the patient's family.[120]

However, deciding when to think about hospice care is not an easy decision. For example, 71-year-old Paul Brennan's simple outpatient surgery did not go as planned and resulted in severe medical issues.[121] To many, hospice equates to giving up. Brennan's family believed they had "been offered the hope that he might get better, and [they] didn't want to let that go."[122] A person may decide against taking "drastic efforts" that are not guaranteed to keep him or her alive.[123] Patients wrestle with the tough decision to either receive aggressive treatment or accept that their time has come and think about how they would like to die.[124] Hospice care changes from the ACA will hopefully make the decision-making process easier.

A. Overview of Hospice Care Changes from the ACA

Overall, the ACA creates a 2 percent reduction in Medicare spending.[125] These reductions are specifically linked to Medicare Part A and hospice care.[126]

1. SECTION 10326: PILOT TESTING PAY-FOR-PERFORMANCE PROGRAMS FOR HOSPICES

Section 10326 implements a pilot pay-for-performance program for hospice programs.[127] Unlike a "fee-for-service" payment structure,

119. U.S. GEN. ACCOUNTING OFFICE, *supra* note 20, at 1.
120. *Id.*
121. Span, *supra* note 114.
122. *Id.* (quoting Matt Brennan, Paul's son).
123. *See* Keslar, *supra* note 13.
124. *Id.*
125. Stallman, *supra* note 4.
126. *Id.*
127. DAVIS ET AL., *supra* note 1, at 23.

where payment is dependent on the quantity of care,[128] a pay-for-performance payment structure rewards quality and efficient health care service.[129] The Secretary of HHS will test all pay-for-performance hospice programs by January 1, 2016 and can authorize any of those tested programs through January 1, 2018.[130] The Secretary then has the discretion after January 1, 2018 to fully enact the program.[131]

Generally, hospice care is considered a Medicare Part A service and it is usually paid on a fee-for-service basis.[132] MHB, as a viable alternative to hospital care, saves Medicare $2,300 for each patient receiving hospice care.[133] In 2000, Part A services totaled $223 billion; a 2019 projection estimates that $435.2 billion will be spent on Part A services.[134] The current focus on quantity of care has led to rampant fraud in the hospice industry.

Regarding hospice care, the 2012 OIG Work Plan was concerned with how to "assess the appropriateness of hospices' general inpatient care claims."[135] Additionally, the market growth in hospice care validated MedPAC's concern of inappropriate compensation and enrollment in hospices.[136]

Private equity firms have started to dip their feet into hospice care. The hospice industry's enormous growth is attributable to many factors, including "compensation based on enrollment numbers, pay to nursing-home doctors who double as hospice medical directors, and gifts to the nursing facilities . . . ."[137]

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128. *Fee For Service*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Fee-for-Service.html (last visited Nov. 1, 2013).

129. U.S. DEP'T OF HEALTH & HUMAN SERVS., *Pay for Performance (P4P): AHRQ Resources*, http://www.ahrq.gov/qual/pay4per.htm (last updated Mar. 2012).

130. AMERIGROUP, *Value-Based Purchasing in Medicare: Sections 3001, 3006 to 3007, 10322 and 10326 of the Patient Protection and Affordable Care Act*, 3 HEALTH REFORM ISSUE BRIEFS 1 (2010), http://hcr.amerigroupcorp.com/wp-content/uploads/2011/02/Vol-3-Issue-1.pdf.

131. *Id.*

132. MEDICARE HOSPICE BENEFITS, *supra* note 29, at 13.

133. E-mail from J. Donald Schumacher, President/CEO of NHPCO, to Chairman Baucus, Ranking Member Hatch and Senators Coburn, Wyden, Grassley and Carper of the U.S. Senate Comm. on Finance (June 28, 2012) (on file with author); *see* Rau, *supra* note 54.

134. E-mail from J. Donald Schumacher, *supra* note 133.

135. *Part I: Medicare Part A and Part B*, HHS OIG WORK PLAN 12 (2012), *available at* https://oig.hhs.gov/reports-and-publications/archives/workplan/2012/WP01-Mcare_A+B.pdf.

136. *Id.* at 12.

137. Waldman, *supra* note 8.

Private equity for-profit hospices strive for the largest patient enrollment possible.[138] Over the last 10 years, Chemed Corporation and Gentiva Health Services Inc., two publicly traded companies, started hospice chains through serial takeovers.[139] An oligopoly has formed in private equity for-profit hospices, as three public companies now control more than 50 percent of the industry.[140] Larger patient enrollments attract buyers to purchase a hospice center.[141] Rae Ann Angelo, a salesperson for a Kansas hospice, explained a private equity for-profit hospice's mindset, stating "there was always pressure to get the patients census up, any way we could, to sell the company. You can't sell unless you show big growth."[142] A $75 million sale of a hospice center in 2006 eventually led to the buyer liquidating, leaving $67 million in expense write-offs and allegations of ineligible patient enrollment.[143] The way to "make a buck" is to "put everyone on hospice, don't ask questions and build!"[144]

Additionally, nursing home doctors sign treatment orders and determine a patient's condition, serving as a consultant and referring patients to a hospice center in exchange for a large cash incentive.[145] Even when a separate hospice director disapproved of a patient receiving hospice care, nursing home doctors might still certify a patient as eligible for hospice to receive cash.[146] Hospice managers may put a healthy patient on hospice because a decrease in hospice enrollment decreases the manager's salary.[147]

Finally, hospice centers bribe decision-makers with gifts. Hospice centers bankrolled a salesperson with $500 to buy gifts or food for doctors, managers, and nursing facility staff in exchange for patient referrals.[148] Vitas Healthcare determined bonuses for salespeople based on how long a patient stayed, as a longer stay meant increased

138. *Id.*
139. *Id.* at 1–2.
140. Keslar, *supra* note 13, at 3.
141. Waldman, *supra* note 8.
142. *Id.* at 2.
143. *Id.*
144. *Id.*
145. *Id.* at 10. (noting that some nursing home doctors were paid up to $4,000 for roughly four total days of consulting).
146. *Id.* at 7.
147. *Id.* at 9.
148. *Id.* at 2.

profits.[149] Other hospice center bribes to nursing facilities included gift cards, pizza parties, cash incentives, "baskets of bread, candy and other goodies at holidays, plus pens, mouse pads, calendars and hand sanitizer emblazoned with the hospice logo," and free family vacations.[150]

Statistics show how private equity firms have turned hospice care into a booming business. In the first six months of 2011, 17 hospices were acquired.[151] Large and mid-size hospice purchase prices rose nearly 50 percent in 2010.[152] In turn, a hospice patient spent on average 60 percent more time in hospice.[153] The top 10 percent of patients that "remained in hospice the longest" rose 70 percent, making the average stay at a hospice center for these patients 240 days.[154]

The 2012 OIG Work Plan and the 2009 MedPAC report illustrate the larger problem—hospices market to nursing-home patients and pay incentives to medical directors, doctors, and staff for referrals and patient enrollment.[155] The 2012 OIG Work Plan found that only 18 percent of nursing facility hospice claims complied with Medicare requirements.[156] The OIG will investigate those hospice centers heavily acquiring patients from nursing facilities.[157] The "enrollment-based incentives" explain why patients not qualified for hospice care are receiving hospice care.[158] The U.S. Department of Justice filed a civil fraud complaint, *U.S. v. Hospice Care of Kansas, LLC and Voyager Hospicecare, Inc.*, detailing the seriousness of employees receiving bonuses for signing up hospice patients who were not terminally ill and defrauding Medicare.[159]

149. *Id.* at 3.
150. *Id.* at 5.
151. *Id.* at 4.
152. *Id.* (noting that prices rose from about "one times annual revenue to as much as 1.5-times," stated Burk Lindsey, an investment banker from Raymond James & Associates).
153. *Id.*
154. *Id.*
155. *Id.*
156. *Part I: Medicare Part A and Part B*, *supra* note 135, at 12.
157. *Id.*
158. Waldman, *supra* note 8.
159. *See* United States, *ex rel.* Landis v. Hospice Care of Kan., LLC, 06-2455-CM, 2010 WL 5067614 (D. Kan. Dec. 7, 2010); *Id.*

From the period of 1994–2004, for-profit hospices increased almost 400 percent.[160] Their market share grew from 2 percent in 1990 to 30 percent in 2007.[161]

Conversely, nonprofit hospices operate on "shoestring budgets."[162] Some nonprofit hospices have six-figure debt and survive from grants, private donations, and fundraising.[163] Wayside Hospice, a center associated with Parmenter Community Health outside of Boston, had an annual operating loss of $450,000 in 2007.[164] Even worse, Wayside competes with 15 local for-profit hospices to get business.[165]

A major policy concern involves hospices reaching out to potential customers to grow their bottom line.[166] Telemarketers called an individual in Atlanta, Georgia at work and at home, vying for her parent's enrollment in their hospice center.[167] Lloyd Peeples, an Assistant U.S. Attorney who led a case against a big business hospice provider, says the demand for dying patients is "just like telephone companies fighting over whether to sell you an iPhone or a Blackberry."[168] Overall, greed has begun to creep into the business of hospice care. The individual in Atlanta said, "[h]ospice seemed like any other business. Compassion went out the window."[169]

2. SECTION 3140: MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM

Previously, Medicare prohibited funding "other Medicare covered services," or curative treatment, for those receiving hospice care.[170] Section 3140 creates a three-year demonstration program covering curative treatment for people eligible for hospice care.[171] At maximum, 15 hospice programs participate in the demonstration project as the Secretary of HHS oversees improvements to quality of life, patient care, and cost-effective hospice care.[172] This study helps de-

160. Keslar, *supra* note 13, at 31.
161. *Id.*
162. *Id.* at 1.
163. *Id.*
164. *Id.*
165. *Id.*
166. *Id.*
167. *Id.*
168. Rau, *supra* note 54.
169. Keslar, *supra* note 13, at 31.
170. DAVIS ET AL., *supra* note 1, at 45.
171. *Id.*
172. *Id.*

termine if "patients benefit when Medicare authorizes payment for receipt of concurrent curative treatment and hospice care."[173]

Section 3140 ignores hospice's original intent and requirement—before, when Medicare funded hospice care, a patient had to decline any curative benefit or treatment.[174] Today, Medicare inspects the reasoning for treatment when a patient is reviewed after receiving 180 days of hospice.[175] However, distinguishing between curative treatment and palliative, or non-curative treatment, is difficult.

A Health Affairs study states that 60 percent of hospice centers deny hospice care to patients treated with radiation, chemotherapy, or a blood transfusion because the treatment is deemed curative.[176] Some believe the distinction between curative and palliative treatment is distorted and could cause curative treatment to be hidden under a "palliative" classification.[177] Others say these treatments are entirely palliative because they improve the quality of life, reduce pain, and are not curative because they do not represent "reality for most patients today with end-stage disease."[178] Robin Stawasz, the family services director at Southern Tier Hospital and Palliative Care in upstate New York, illustrates the difficulty in distinguishing between curative and palliative treatment, saying:

> If the real focus is to help someone stay comfortable, then that's hospice, even if it's traditionally something a little bit more aggressive, such as IV antibiotics or IV diuretics or that sort of thing, or hospitalizations. So if the goal is for comfort and the treatment has a reasonable expectation to provide meaningful comfort, then that's hospice.[179]

If Medicare denies coverage because it believes care is curative, the hospice center must pay the cost of the curative treatment.[180] Most

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173. Kathy L. Cerminara, *Health Care Reform at the End of Life: Giving With One Hand But Taking With The Other*, AM. SOC'Y OF LAW, MED. & ETHICS, *available at* http://www.aslme.org/print_article.php?aid=460404&bt=ss (last visited Nov. 1, 2013).

174. *Id.*; Span, *supra* note 114.

175. Michelle Andrews, *Hospices, Wary of Costs, May Be Discouraging Patients With High Expenses*, KAISER HEALTH NEWS (Jan. 21, 2013), http://www.kaiserhealthnews.org/Features/Insuring-Your-Health/2013/012213-Michelle-Andrews-on-hospice-care.aspx.

176. Span, *supra* note 114.

177. *Id.*

178. *Id.*; *see* MEDICARE HOSPICE BENEFITS, *supra* note 29, at 9.

179. Ramer, *supra* note 11, at 1.

180. Andrews, *supra* note 175.

curative treatments are extremely expensive.[181] While large hospices, considered those with over 100 patients, can absorb costs for these treatments, smaller hospices cannot take such a risk.[182] This may explain why smaller hospices, with fewer funds, have tighter enrollment policies for hospice patients.[183] Smaller hospices cannot cover both the hospice care and potential curative treatment costs within the Medicare reimbursement.[184] Usually, costs for curative treatments are not calculated into the Medicare reimbursement.[185]

Either way, Melissa Aldridge Carlson, an assistant professor of geriatrics and palliative medicine at New York's Mount Sinai School of Medicine, helps explain the reasoning behind the demonstration program in Section 3140, stating "[i]t's a fixed, per-day cost that doesn't relate to the complexity of care provided."[186]

The demonstration program may bridge the gap between curative and palliative care, improve patient care quality, and eliminate "futile curative treatments" and high-priced "last-chance treatments."[187] Gilchrist Hospice Care in Baltimore started concurrent care and allowed patients with radiation, chemotherapy, or blood transfusion treatment to receive hospice care, so long as the 180-day hospice eligibility requirement is met.[188]

181. *Id.*; Span, *supra* note 114.
182. Andrews, *supra* note 175.
183. *Id.*
184. Span, *supra* note 114.
185. *Id.*
186. Andrews, *supra* note 175.
187. Cerminara, *supra* note 174.
188. Span, *supra* note 114.

3. SECTION 3132(A): PAYMENT REVISION FOR HOSPICE CARE

The passage of the ACA[189] required that on January 1, 2011, the Secretary of HHS would collect information and revise payment plans for hospice care.[190] Initially, Congress had the authority to reform hospice payment.[191] However, a MedPAC recommendation suggested the Secretary of HHS should have this authority.[192] The drafters of the ACA agreed and included this authority in the legislation.[193] Thus, the Secretary of HHS must consult with MedPAC about continually collecting information and preparing to establish budget-neutral adjustments.[194] The information includes "charges and payments" and "the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, benefits under part A."[195] Starting October 1, 2013, the Secretary of HHS must create budget-neutral changes to hospice care.[196] These changes could adjust per diem payments, reflect the different resources used, or increase the intensity of services provided.[197]

4. SECTION 3132(B)(2): THE FACE-TO-FACE ASSESSMENT REQUIREMENT

Section 3132 of the ACA, titled "Hospice Reform," encompasses both a financial and procedural requirement to improve hospice care.[198] Starting April 1, 2011,[199] Section 3132(b)(2)(D)(i) of the ACA places additional restrictions on the hospice care recertification process.[200] Before a patient becomes eligible for another Medicare-funded

189. H.R. Res. 3590-314, 111th Cong. (2010) (enacted) (noting the proposed hospice reform is entitled under Section 3132(a) of the ACA as a result of an amendment to Section 1814(i) of the Social Security Act (42 U.S.C. § 1395f(i)) which includes the additional data research by the Secretary).
190. DAVIS ET AL., *supra* note 1, at 40.
191. THE MEDICARE HOSPICE BENEFIT, *supra* note 1.
192. *Id.*
193. *Id.*
194. *Id.*
195. H.R. Res. 3590–312 (enacted).
196. DAVIS ET AL., *supra* note 1, at 40.
197. *Id.*; THE MEDICARE HOSPICE BENEFIT, *supra* note 1.
198. *See, e.g.*, DAVIS ET AL., *supra* note 1, at 40.
199. *New Hospice Face-to-Face Requirement: Help or Hindrance?*, *supra* note 5 (explaining that § 3132 was originally going to be implemented January 1, 2011; however, to "allow providers the opportunity to establish operational protocols necessary to comply with the face-to-face encounter requirements", and to make changes to the Code of Federal Regulations (CFR), implementation of the amendment was delayed three months).
200. Cerminara, *supra* note 173.

hospice period, the hospice director or physician recertifies that the patient is terminally ill.[201] The recertification process happens after "a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care before the 180th-day recertification and each subsequent recertification . . . ."[202] Continued eligibility for hospice care is met when the attending physician or medical director at the hospice center determines a patient has a life expectancy of less than 180 days.[203]

Although the CMS did agree with increasing documentation for certification and recertification, it did not promulgate MedPAC's requirement for specific documentation of a physician "demonstrat[ing]" that a visit with the hospice patient occurred.[204] Thus, Congress stepped in and made increased documentation a requirement.[205]

Chapter 9 of the Medicare Benefit Policy Manual details the steps to meet the face-to-face assessment requirement.[206] These include confirming an addendum—apart from the actual recertification form—with a signature and the exact date and time the face-to-face assessment occurred with the hospice patient.[207] The ACA adopts the view of MedPAC in requiring that a nurse or physician meet with every hospice patient before he or she is recertified, with the nurse or physician confirming that an assessment took place.[208]

MedPAC and the CMS worry about increased Medicare costs from those abusing or fraudulently using hospice care.[209] A concern discussed in amending Section 3132 is the "appropriate utilization of the hospice benefit."[210] MedPAC specifically believed fraud was more prevalent in for-profit hospice centers;[211] in 2010, 58 percent of free-

201. MEDICARE HOSPICE BENEFITS, *supra* note 29, at 10.
202. H.R. Res. 3590-312, 111th Cong. (2010) (enacted); *See* DAVIS ET AL., *supra* note 1, at 40 (explaining a hospice physician or nurse must talk face-to-face with a person about recertification, eligibility and confirmation that hospice care was provided); *see also* Rau, *supra* note 54.
203. DAVIS ET AL., *supra* note 1, at 40.
204. Cerminara, *supra* note 173.
205. *Id.*
206. *Chapter 9–Coverage of Hospice Services Under Hospital Insurance*, MEDICARE BENEFIT POL'Y MANUAL (2012), *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf.
207. *Id.* (describing the differences in Section 20.1(5)(b), titled "Attestation Requirements").
208. *Id.*
209. *See* Cerminara, *supra* note 173.
210. Eck, *supra* note 1, at 19.
211. Cerminara, *supra* note 173.

standing and independent hospice centers were for-profit, and future projections anticipate that the number of for-profit centers will continue to grow.[212]

Medicare's continuing concern is a combination of the increased length of stay for a hospice patient and patients receiving hospice care when death is not imminent.[213] During an audit by federal officials, agents found that the hospice "didn't always properly document that patients had six or fewer months to live . . . ."[214] Because of this, Medicare suspended reimbursements to the hospice center, causing San Diego Hospice to stop accepting new patients.[215] The CMS stated, "[w]e are working with this facility to ensure that the immediate needs of patients are being met, while actively monitoring billing to prevent abuse or fraud."[216] Kathleen Pacurar, President and CEO of San Diego Hospice, believes the reasons for decreased hospice enrollment are tighter criteria, discharging patients not within 180 days of death, and bad publicity.[217] The CMS demanded that any Medicare overpayment due to improper documentation or fraud be repaid to Medicare.[218] In 2009, MedPAC estimated 19 percent of hospice patients received hospice care for longer than 180 days.[219]

Chief Medical Director Steven Oppenheim and Chief Financial Officer Kathy Jones resigned from San Diego Hospice after the audit revealed Medicare fraud.[220] In November 2012, Pacurar still believed determining a patient's timeline is difficult, saying, "[w]e look at each patient individually. We have patients that come on service that are with us two days and we have patients that sometimes exceed that 6 month time period."[221]

In this fraudulent scheme, length of stay preempts size of enrollment. There are financial incentives tied in with a patient staying

212. NHPCO FACTS AND FIGURES, *supra* note 2, at 8.
213. Dotinga, *supra* note 7; *see* Rau, *supra* note 54.
214. Dotinga, *supra* note 7.
215. *Id.*
216. *Id.*
217. *Id.*
218. *Id.*
219. Rau, *supra* note 54.
220. Brandi Powell & R. Stickney, *Key Hospice Officials Resign After Audit Report*, NBC 7 SAN DIEGO, Nov. 13, 2012, *available at* http://www.nbcsandiego.com/news/health/San-Diego-Hospice-Medicare-Audit-Resignations-High-Level-179157531.html.
221. *Id.*

longer. Hospice centers make profits "during the intervening periods" of care when a patient requires less attention.[222] The intervening period does not come at the beginning of a patient's hospice enrollment and such periods incentivize a hospice center to keep a patient on hospice care as long as possible.[223]

Critics argue the face-to-face assessment requirement is too expensive to administer and unrealistically relies on a smaller pool of people to administer face-to-face interaction.[224] Dr. David Casarett, the chief medical officer at the University of Pennsylvania hospice, believes the face-to-face assessment requirement will shorten a patient's stay in hospice and tighten restrictions on hospice enrollment, but he remains concerned whether the correct people will be discharged from hospice.[225]

5. SECTION 3004: QUALITY REPORTING FOR HOSPICES

Previous reports from MedPAC, the CMS, and the OIG give context to the ACA and its requirement of quality reporting.

In March 2007, the OIG evaluated and recommended changes to the CMS recertification process for hospices. The OIG conducted an analysis of the actions taken by the CMS in 2006. Using certification survey results, the CMS directed state agencies to focus on the 5 percent of hospices most at risk.[226] Knowing these agencies, the CMS used its sole enforcement tactic: terminating the poorly performing hospices from Medicare.[227] The CMS resorted to this tactic because it does not include hospices in their annual surveys or reviews, does not consistently analyze performance data on hospice centers, and does not have access to information available for individual patient assessment data from each hospice center.[228] As the OIG notes, the "frequency of hospice certification is far different from the certification frequencies required for nursing homes, hospitals and home health agencies."[229]

222. *Id.*; Dotinga, *supra* note 7.
223. *Id.*; Rau, *supra* note 54.
224. *Id.*
225. *Id.*
226. LEVINSON, *supra* note 47, at 3.
227. *Id.*
228. *Id.*
229. *Id.*

The OIG recommended three types of reforms to improve oversight on Medicare hospice centers. First, the CMS should use written guidance and training to determine the "key performance indicators" of hospice care.[230] This process parallels how nursing facilities collect data and determine at-risk hospices.[231]

Second, the OIG suggested legislation to create specific hospice center certification requirements.[232] Legislation would help the CMS to both keep its recertification on schedule and increase the frequency of hospice certifications, with surveys being the most appropriate way to gather information and performance quality.[233] About 85 percent of MHB providers are not surveyed annually.[234] Currently, no legislative requirement exists regarding the frequency of surveys, possibly resulting in lower quality of care and compliance violations.[235] The CMS rejected this idea, stating they do not have the funding to increase the frequency of surveys conducted.[236] The Hospice Association of America believes hospice certification frequency, through surveys, should mirror other Medicare areas to assure compliance with regulations.[237]

Finally, the OIG suggested creating legislation to create remedies if poor performance occurs at hospice centers.[238] Since the only remedy that the CMS currently has involves terminating a hospice center, enacting less damaging penalties, such as "plans of correction, directed in-service training, denials of payment for new admissions, civil monetary penalties and imposition of temporary management" could help increase the quality of performance at hospice centers.[239]

Under Section 3004 of the ACA, the Secretary of HHS must create reporting programs for hospices by 2014. Previously, hospices were not required to report data to the CMS.[240] The Secretary was required to propose the "selected quality measures" used for the reporting programs by no later than October 1, 2012, but no date is set for

230. *Id.*
231. *Id.*
232. *Id.*
233. *Id.*
234. POSSIBLE FUTURE HOSPICE DATA COLLECTION, *supra* note 43, at 29.
235. *Id.*
236. *Id.*
237. *Id.*
238. LEVINSON, *supra* note 47, at iv.
239. *Id.*
240. DAVIS ET AL., *supra* note 1, at 20–21.

these measures and reporting programs to go public.[241] If the Secretary does not meet the reporting requirement, the market basket update reduces by two percentage points in 2014[242] and every subsequent year.[243]

B. Hospice Payment Changes under the ACA

Two financial changes implemented by the ACA's passage have already begun to negatively affect hospice care and funding.[244]

1. ELIMINATING THE BUDGET NEUTRALITY ADJUSTMENT FACTOR (BNAF) IN 2010

As previously stated, hospices are paid daily at one of the four rates for each day a Medicare patient receives hospice care.[245] The payment rates are updated each year in the Medicare statute and take into account a wage index that adjusts the Medicare payment "to reflect variations in the wages that hospices must pay their staff in different areas of the country."[246]

In 1997, a committee of CMS representatives included the Budget Neutrality Adjustment Factor (BNAF) as an element of the wage index calculation.[247] The BNAF guaranteed that the amount of total Medicare payments for hospice services would remain consistent.[248] Starting in 2010, the CMS implemented a gradual elimination of the BNAF over the next seven years.[249] A reduction of 0.4 percentage points occurred in 2010; an additional 0.6 percentage point decrease has occurred and will continue to occur annually until the BNAF is

241. DAVIS ET AL., *supra* note 1, at 21; CTRS. FOR MEDICARE & MEDICAID SERVS., *IRF Quality Reporting*, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html (last modified May 31, 2013) [hereinafter *IRF Quality Reporting*].

242. *IRF Quality Reporting*, *supra* note 241

243. *Id*.

244. THE MEDICARE HOSPICE BENEFIT, *supra* note 1.

245. *Hospice Services Payment System*, *supra* note 51, at 1.

246. HOSPICE ACTION NETWORK, *Issue Background: Hospice Payments and the Budget Neutrality Adjustment Factor*, http://hospiceactionnetwork.org/linked_documents/get_informed/issues/reimbursement/BNAF_Issue_Background.pdf (last visited Nov. 2, 2013).

247. *Id.*

248. *Id.*

249. HEALTHCARE FIRST, *Hospice Blog Series Part 1: BNAF Reductions Continue…*, HOSPICE CARE BLOG (Dec. 21, 2011), http://blog.healthcarefirst.com/hospice-care-blog/bid/80161/Hospice-Blog-Series-Part-1-BNAF-Reductions-Continue [hereinafter *Hospice Blog Series Part 1*].

eliminated in 2016.[250] Eliminating the BNAF will reduce the reimbursement rates of hospice care by about 4.2 percent,[251] and save about $2.29 billion over five years.[252] Hospice centers do not have high margins (a percentage calculated as net income divided by revenues);[253] even with the emergence of hospice care as a booming industry, a recent MedPAC study placed hospice center margins at around three percent.[254]

The BNAF reductions could put some hospice centers out of business.[255] Amazingly, two years into the gradual BNAF phase-out, the CMS has seen an increase in the number of hospice agencies.[256] However, the Hospice Association of America does not believe "the majority of hospices would be able to sustain such an overwhelming cut" and the reductions would create "a very real danger of putting community hospices out of business resulting in a lack of access to the hospice benefit . . . ."[257]

2. INCORPORATING A PRODUCTIVITY ADJUSTMENT FACTOR IN 2013 TO THE MARKET BASKET UPDATE THROUGH SECTION 3140

The ACA also changes the Medicare hospice reimbursement rate by adding a productivity adjustment factor to the market basket update analysis discussed earlier.[258] This average calculates the productivity changes in the private business economy each year[259] using various factors, including the "number, mix and level of intensity" of home health care, cost differences between providers like hospitals, for-profit organizations, and non-profit organizations, and resource

250. *Hospice Services Payment System*, *supra* note 51, at 3.
251. THE MEDICARE HOSPICE BENEFIT, *supra* note 1.
252. HOSPICE ASS'N OF AMERICA, *2012 Legislative Blueprint for Action*, http://www.congressweb.com/nahc/docfiles/12-HAA-LegBP-Inside.prf (last visited Nov. 2, 2013).
253. *Hospice Blog Series Part 1*, *supra* note 250.
254. OHIO HOME, HOSPICE & PALLIATIVE CARE ADVOCACY NETWORK, *supra* note 1.
255. NHPCO FACTS AND FIGURES, *supra* note 2, at 5.
256. *Hospice Blog Series Part 1*, *supra* note 250.
257. *2012 Legislative Blueprint for Action*, *supra* note 252, at 15.
258. *PPACA: A Closer Look: Hospice Market Basket Updates and Productivity Adjustment*, HART HEALTH STRATEGIES 1, http://www.primaryimmune.org/advocacy_center/pdfs/health_care_reform/Hospice%20Market%20Basket%20Update%20and%20Productivity%20Adjustment%20UPDATED_20100728.pdf (last updated July 28, 2010) [hereinafter *Hospice Market Basket Updates*).
259. *Id.* at 2.

costs for urban and rural providers.[260] As a result of the productivity adjustment factor, the NHPCO believes annual hospice payments will decrease by an additional 12 percent over the next ten years.[261] Section 3401 of the ACA combines the productivity adjustment factor and the market basket update to reduce the market basket update for hospice care by 0.3 percentage points as a flat rate each year from 2013–2019.[262] However, this reduction for "hospice providers is waived if in any year from 2014–2019, the previous year's total percentage of insured population (as reflected in the share of the total, non-elderly population) is more than five percentage points below CBO projections of such percentage . . . ."[263]

A "negative market basket update" will occur if the productivity adjustment factor is higher than the market basket update.[264] A negative market basket update means payment rates for the current year will be less than the payment rates from the previous year.[265] Therefore, if the market basket index factor does not increase by one percent, this will result in a negative market basket update and slow, or even stop, payments to home health agencies,[266] including hospices.[267]

The Moran Company projected a profit margin analysis with these changes in place. Overall, the financial forecast is bleak. These funding reductions will put hospices out of business. Hospice comprises only two percent of total Medicare expenditures, the lowest amount of any direct patient service that Medicare provides.[268] The Moran Company estimates profit margin losses for Medicare hospice centers in 2019 at 11 percent.[269] Hospices that serve rural or independent patients estimate a profit margin decrease of 16 percent by 2019.[270] The Moran Company report concludes that these funding reductions will increase the number of hospices with a negative profit margin by

260. Eck, *supra* note 1, at 18.
261. NHPCO FACTS AND FIGURES, *supra* note 2, at 1.
262. *Hospice Market Basket Updates, supra* note 258, at 1.
263. *Id.* at 1–2.
264. *Changes to Medicare Market Basket Updates*, HORNE LLP, http://www.horne-llp.com/industries/health-care/resources/health-care-reform--advantages--pitfalls/changes-to-medicare-market-basket-updates (last visited Nov. 2, 2013).
265. *Hospice Market Basket Updates, supra* note 258, at 1.
266. Eck, *supra* note 1, at 17.
267. NAT'L ASS'N FOR HOME CARE & HOSPICE, BASIC STATISTICS ABOUT HOME CARE 1 (2010), http://www.nahc.org/facts/10hc_stats.pdf.
268. THE MEDICARE HOSPICE BENEFIT, *supra* note 1.
269. *Id.*
270. *Id.*

nearly 50 percent, leaving little financial incentive to start a hospice center.[271]

C. Proposed Amendments to the ACA's Hospice Reform: The HELP Act

The Hospice Evaluation and Legitimate Payment (HELP) Act outlines proposed changes to the ACA and was driven by concerns over the ACA's impact on MHB, including access to services and quality patient care.[272] This bipartisan legislation has gained traction, with 16 Senate co-sponsors and about 45 House co-sponsors.[273] Additionally, the Moran Company conducted a budgetary analysis of enacting these amendments to Section 3132 of the ACA. Their mission determined how the CBO would "score" Section 3132 if it were "actively considered in the legislative process."[274]

The HELP Act outlines three goals: two amendments to the face-to-face assessment requirement, an amendment to the demonstration program under Section 3140, and increasing the frequency of hospice surveys.

1. TWO AMENDMENTS TO THE FACE-TO-FACE ASSESSMENT REQUIREMENT

The HELP Act drafters believe the face-to-face assessment requirement outlined in Section 3132(b)(2) of the ACA is troubling. To reiterate, the ACA requires a physician or nurse to meet face-to-face with a hospice patient once he or she chooses MHB.[275] This amendment requires the physician or nurse to meet with the hospice patient before the 180-day recertification period; after this period, the physi-

271. *Id.*
272. *Id.*
273. *See* Stallman, *supra* note 4 (illustrating the bipartisan nature of the bill are the legislators who helped introduce the bill: Sens. Ron Wyden (D-Oregon) and Pat Roberts (R-Kentucky), and Reps. Tom Reed (D-New York), Mike Thompson (D-Napa), and Erik Paulsen (R-Minnesota)).
274. THE MORAN CO., *Assessing the Budgetary Implications of Legislation to Amend the Hospice Payment Reform Provisions of the Affordable Care Act*, http://hospiceactionnetwork.org/linked_documents/get_informed/legislation/HELP_Hospice/Help%20ACT%20Moran%20score.pdf [hereinafter *Assessing the Budgetary Implications*].
275. *Id.*

cian or nurse must meet with the patient for each 60-day recertification that takes place.[276]

First, the HELP Act suggests expanding the category of providers who can administer the face-to-face assessment to include nurse practitioners, clinical nurse specialists, and physician assistants.[277]

Second, the HELP Act proposes that after a patient chooses MHB, a grace period of seven days is always given to complete the face-to-face assessment requirement.[278] In early 2011, the CMS created an "exceptional circumstances" modification to the ACA requirement, allowing two additional days to meet the face-to-face assessment requirement if a readmitted hospice patient was not timely scheduled for the assessment at a new hospice center or inadequate information from the CMS data system did not determine if a patient required the assessment.[279] The HELP Act proposes that seven additional days should be allowed to administer the face-to-face assessment.

Both of these HELP Act proposals speak to the same issue: Section 3132(b) of the ACA does not properly reflect the operational limitations and constraints in hospice centers.[280] Currently, the narrow timeline to conduct face-to-face assessments will force independent and rural hospices to turn potential hospice patients away.[281] Personally traveling to hospice patients in rural areas may be difficult.[282] In 2010, 60 percent of hospice care centers were independent agencies.[283]

Expanding the pool of care providers qualified to administer the face-to-face assessment increases efficiency and minimizes the chances that a patient who needs immediate hospice care must wait until a medical director or hospice doctor conducts the face-to-face assessment to receive that palliative care.[284] Also, it is impractical to ask a hospice director or physician to visit a hospice patient and "recertify a condition that is indisputable" from the patient's prior medical rec-

276. *Id.*
277. *Id*.
278. *Preserve and Protect the Medicare Hospice Benefit*, *supra* note 23.
279. POSSIBLE FUTURE HOSPICE DATA COLLECTION, *supra* note 43.
280. *Assessing the Budgetary Implications*, *supra* note 239, at 1.
281. *Preserve and Protect the Medicare Hospice Benefit*, *supra* note 23.
282. Cerminara, *supra* note 173.
283. NHPCO FACTS AND FIGURES, *supra* note 2, at 8 (The type of hospice care agencies are as follows: Independent, freestanding agencies (58 percent); Part of a hospital system (21.3 percent); Part of a Home Health Agency (19.2 percent); Part of a Nursing Home (1.4 percent).
284. POSSIBLE FUTURE HOSPICE DATA COLLECTION, *supra* note 43, at 5–6.

ords and experience.[285] Balancing the necessity of recertification with the expenses incurred for a visit to take place, the current face-to-face assessment requirement hinders the cost-cutting goals for hospice care.[286]

An email to the U.S. Senate Committee on Finance on June 28, 2012 from J. Donald Schumacher, President and CEO of the NHPCO, advocated the HELP Act proposals and reiterated the importance of expanding the category of providers administering the face-to-face assessment requirement.[287] Schumacher has similar concerns about the operational constraints of hospice centers and the delay in hospice admissions for those not satisfying the face-to-face requirement in the proper time frame.[288] Schumacher's reasons to allow the seven-day grace period for the face-to-face assessment requirement include hospice centers needing time to research the "hospice history" of each new patient.[289] The inaccessibility of CMS patient information 24 hours a day,[290] along with its inaccessibility on weekends and holidays, makes it nearly impossible to determine if a face-to-face assessment is required in only two days.[291]

Additionally, over a year has passed since the ACA adopted the face-to-face assessment requirement and minimal data is available to determine if Section 3132(b) uses hospice services more appropriately.[292] Schumacher strongly suggests measuring the impact of these ACA changes to "assess whether the face-to-face requirement has had the intended effect," citing the burdensome requirement today and the future precedent that this policy could create.[293]

Regarding the budgetary implications of the two proposals, the CBO, through the analysis of the Moran Company, hypothesizes that this provision only increases flexibility and is not a change in the recertification process; it ultimately concluded that no budgetary effect occurs.[294]

285. Cerminara, *supra* note 173.
286. *Id.*
287. Email from Donald Schumacher, *supra* note 133, at 4.
288. *Id.*
289. *Id.*
290. *2012 Legislative Blueprint for Action*, *supra* note 252, at 5.
291. Email from Donald Schumacher, *supra* note 133, at 5.
292. *Id.*
293. *Id.*
294. Memorandum from The Moran Co., *supra* note 91, at 2.

2. AMENDING THE HOSPICE PAYMENT REFORM UNDER SECTION 3132(A)

Instead of payment reform starting October 1, 2013, the HELP Act hopes to "pilot," or test, these new payment methods using a two-year program over fifteen different sites.[295] With no reliable data plan currently available, the pilot program will experiment with different payment plans to determine the most cost-effective methods for hospice service and provide the Secretary of HHS with information to implement a new payment system.[296] The pilot program will evaluate if the new payment system has "a negative impact on the delivery of high quality care in the hospice program."[297]

The CBO estimates budgets based on the language used to draft a policy.[298] With the language reviewed in Section 3132(a) of the ACA in conjunction with the HELP Act proposal, payment variations would be capped within five percent of payments under current law.[299] The Moran Company believes that the CBO would conclude, "[s]election bias associated with voluntary enrollment decisions would cause total payments to exceed what would be spent under current law."[300] Because the demonstration program period is short and a small number of hospices are involved, the Moran Company believes the overall cost to Medicare would be $3 million from 2012–2021.[301]

3. INCREASING THE FREQUENCY OF HOSPICE SURVEYS CONDUCTED

The previous report from the OIG outlines the final proposed amendment from the HELP Act.[302] Depending on resources, hospice centers were evaluated every six to eight years, a lower frequency compared to other health care agencies.[303] Also, about 15 percent of hospice centers were surveyed three years later than required.[304] More frequent hospice surveys create consistency with other Medicare pro-

295. *Preserve and Protect the Medicare Hospice Benefit*, *supra* note 23.
296. *Id.*
297. POSSIBLE FUTURE HOSPICE DATA COLLECTION, *supra* note 43, at 12.
298. *Id.*
299. *Id.* at 2.
300. *Id.*
301. *Id.*
302. *Preserve and Protect the Medicare Hospice Benefit*, *supra* note 23.
303. THE MEDICARE HOSPICE BENEFIT, *supra* note 1, at 2.
304. *Id.*

grams and aid proper oversight.[305] Although certification requirements for hospice service differ from other Medicare programs, the HELP Act proposal follows standard survey protocol.[306]

The Moran Company believes that the CBO would not find a budgetary effect because they cannot lower or increase spending from "program management activities."[307] Because the HELP Act, as drafted, does not statutorily increase expenses imposed on the CMS, the CBO does not project a cost "from the assumption that authorizing legislation changes do not bind" the CMS to increase funding in this area.[308]

D. The Social Role and Implications of Hospice Care

1. HOSPICE CARE: END-OF-LIFE VS. BRINK-OF-DEATH

Dr. Ira Byock, the director of palliative medicine at New Hampshire's Dartmouth-Hitchcock Medical Center, believes that one major problem in hospice care is the fact that hospice providers are not reaching patients in a timely manner, citing the decrease in the length of stay for a hospice patient.[309] In 2009, the median average length of hospice service was 21.1 days; in 2010, the median length of hospice service was 19.7 days.[310] Byock's issue with hospice care today is that "we're doing brink-of-death care rather than end-of-life care."[311] Schumacher points out that many patients only receive hospice care in the last week of their lives.[312]

Sometimes, the reason for delay is a family member unwilling to accept that his or her parent is dying.[313] Other reasons include misconceptions that the term "hospice" refers to a certain place the patient receives end-of-life treatment or is a treatment reserved only for

305. *Preserve and Protect the Medicare Hospice Benefit*, *supra* note 23.
306. *See id.* (discussing the required surveys for Medicare programs from accredited programs like the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)).
307. POSSIBLE FUTURE HOSPICE DATA COLLECTION, *supra* note 43, at 4.
308. *Id.*
309. *Id.;* NHPCO FACTS AND FIGURES, *supra* note 2, at 5.
310. NHPCO FACTS AND FIGURES, *supra* note 2, at 5.
311. Ramer, *supra* note 11, at 3.
312. Dotinga, *supra* note 7.
313. Paula Span, *Avoiding the Call to Hospice*, N.Y. TIMES BLOG: THE NEW OLD AGE, (May 26, 2009, 1:57 PM), http://newoldage.blogs.nytimes.com/2009/05/26/avoiding-the-call-to-hospice/.

cancer patients.[314] Schumacher believes the United States is a "death-denying society" that advocates for as much treatment as possible.[315] The result is a lose-lose situation: the parent's pain continues, families wait for the parent to rebound, yet the parent eventually dies.[316]

Intuitively, hospice care is at odds with the training and mindset of medical professionals. Since leaving medical school, a physician's end goal is always the same: do everything you can to prolong life.[317] This may make a physician or doctor unable to refer patients to hospice care.[318] Some even believe the standards for hospice admission are incorrect. Diane Meier, the head physician at New York City Mount Sinai Medical Center's palliative care program, states "[t]he criteria for admission to hospice should have much more to do with what a patient needs than about how long that person has to live."[319]

2. PREPARING FOR THE BABY BOOMER GENERATION

There are nearly 78 million "baby boomers," or those Americans born between 1946 and 1964.[320] By 2030, nearly 20 percent of the U.S. population will be age 65 or older.[321] By 2040, the annual death rate in the United States will double to about 4.1 million deaths per year.[322]

Historically, the progressive baby boomer generation pushed for natural childbirth and brought fathers into the delivery room.[323] This gives hope to those wishing for hospice reform today. An educated generation, baby boomers will expect more individualized services during their final moments of life.[324] Accordingly, some believe diversifying hospice care is essential. Dr. Byock believes America is not ready to deal with end-of-life issues within the baby boomer generation.[325] Schumacher also predicts future problems if hospice centers

314. *Id.*
315. *Id.*
316. *Id.*
317. Keslar, *supra* note 13, at 29.
318. Span, *supra* note 114.
319. Keslar, *supra* note 13, at 29.
320. Ramer, *supra* note 11, at 1.
321. Keslar, *supra* note 13, at 29.
322. *Id.*
323. *Id.*
324. *Id.* Ramer, *supra* note 11, at 3.
325. Ramer, *supra* note 11, at 2.

do not diversify their services.[326] Today, two types of diverse hospice care speak to two distinct issues. The first type can be described as the European Model, where the diversity of hospice care is small and simple for those enjoying their last days on Earth. The second type of can be referred to as Extreme Hospice—golfing trips, weekends at casinos, and dinner dates.[327]

Some believe extravagant field trips are outside the responsibility of hospice care. The European Model knows making small adjustments to current hospice care can result in substantial benefits. In the United Kingdom, simple hospice solutions have been working for some time.[328] St. Catherine's Hospice Center arranges personal and joint events for patients.[329] Personal requests range from a patient wanting Roquefort cheese and red wine to miniature bottles of whiskey passed out during Christmas.[330] Joint events include a patient's jazz band performing, afternoon tea parties to watch Wimbledon, the Queen's Jubilee, and the Olympics, two weddings, a christening, patient's Stag Night, and a birthday party for the daughter of a hospice patient.[331] The ideological mindset at St. Catherine's is to "remember our patients are individuals with families, interests and dreams and caring for someone means looking after this side of their lives too—not just their illness."[332]

St. Catherine's Hospice Center provides nursing care and advice to about 1,200 patients.[333] Nearly two-thirds of the $12.48 million needed to fund the hospice center comes from voluntary donations.[334] The 2010 NHPCO report claims that hospice in the United States "was founded by volunteers and there is a continued commitment to volunteer services."[335] 458,000 Americans volunteered over 21 million hours

326. *Id.* at 1 (adding "[i]t's a complicated time and an exciting time, but it's also, in many ways, going to be a very daunting time for hospices to try to find ways to take care of all these people.").
327. *Id.*
328. *The Surprising Side of Hospice Care*, W. SUSSEX CNTY. TIMES, Oct. 12, 2012, *available at* http://www.wscountytimes.co.uk/news/local/the-surprising-side-of-hospice-care-1-4357908.
329. *Id.*
330. *Id.*
331. *Id.*
332. *Id.*
333. *Id.*
334. *Id.*
335. NHPCO FACTS AND FIGURES, *supra* note 2, at 12.

of service.[336] However, no numbers from the NHPCO were available regarding voluntary donations.

Others believe the image of an elder person sitting in a bed in a dark room is the hospice care of the past.[337] Robin Stawasz, the family services director at Southern Tier Hospice and Palliative Care in Corning, New York, notes "[t]his is not getting ready to die. This is living—living now, living tomorrow, making the best possible life with what you have."[338] Within this idea of Extreme Hospice exists the combination of extravagant activities (including golf, trips to Florida, dinner at restaurants, and gambling at casinos) and the individualized nature of care that a baby boomer would expect.[339] Some hospice centers have started to implement this idea to prepare for the expectations of baby boomers, like Arsenia Grair's trip to a casino in Cleveland. Some hospice centers adopted the mindset to "do whatever we can to grant our patients' final unfulfilled wishes."[340]

Nonetheless, many hospice workers believe that they are ready for the baby boomer surge because of their familiarity with the "triple threat": providing better care for less money with increased patient satisfaction.[341]

How pressing is hospice care reform? The Committee on Transforming End-of-Life Care, a subcommittee of the Institute of Medicine, met on February 22–24, 2013 in Washington D.C. to discuss end-of-life care.[342] The Committee addressed the balance of increasing technology and new settings providing end-of-life care while sustaining the goals of reasonable cost, compassion, and comfort for the patient.[343] Topics at the meeting included the following: the delivery of medical care and its current effect on end-of-life care; communication of values and preferences between patient, family, and provider; and the con-

336. *Id.*
337. Ramer, *supra* note 21, at 1.
338. *Id.*
339. *Id.* at 3.
340. Galbincea, *supra* note 16 (said by Laurie Henrichsen, a spokesperson for the Hospice of the Western Reserve).
341. Ramer, *supra* note 11, at 3.
342. Sherry Boschert, *End-of-Life Care Gains Increasing Prominence*, THE ONCOLOGY REPORT 1 (Jan. 16, 2013), http://www.oncologypractice.com/oncology report/news/top-news/single-view/end-of-life-care-gains-increasing-prominence /fc6aa0e00fa036e01758d911aea59659.html; INST. OF MED. OF THE NAT'L ACADEMIES, COMM. ON TRANSFORMING END-OF-LIFE CARE, Pub. Session Agenda (2013).
343. Boschert, *supra* note 342.

tinuing education of health care to the American Academy of Hospice and Palliative Medicine, insurers, and patient advocacy groups.[344] The Committee will publish a report by 2014 addressing the goal of "coordinated, expert, compassionate care."[345]

IV. Recommendation

The hospice industry should close the gap between the average length of days a hospice patient receives care (in 2010, 19.7 days) and the eligible amount of time a hospice patient can continue receiving hospice care (180 days). The 180-day eligibility time frame leads to fraudulent activity that increases hospice profits, turning a service industry into one big business. The first financial incentive is directly correlated to enrollment size. If hospice managers and executives know that an increased hospice enrollment size will increase manager salaries and the value of the hospice center itself, they are increasingly tempted to bribe nursing homes for hospice patient referrals to create the largest enrollment possible. The second financial incentive is directly correlated to time. Improper documentation lengthens the amount of time patients are enrolled in hospice care and earns the hospice center more money. These fraudulent acts continually move hospice care away from its true, original goal of care and comfort.

The hospice industry should quickly make pay-for-performance programs the new staple of the hospice care industry. Enacting the HELP Act, shifting some financial burden on hospice centers, and understanding the exact type of care a patient wants to receive during their remaining time outline the various proposals. These proposals will help the hospice care industry become cost-effective, coherent, corruption-free, and cordial.

A. Accelerate the Timetable for Testing and Full Implementation of Pay-for-Performance Programs Under Section 10326 of the ACA

Testing pay-for-performance programs should start January 1, 2014 instead of the ACA's proposed date of January 1, 2016. Accelerating the timetable means the Secretary of HHS tests all pay-for-

344. *Id.*
345. *Id.*

performance hospice programs by January 1, 2014 and can authorize any of those tested programs through January 1, 2016. Allowing the Secretary of HHS to test pay-for-performance programs for the same allotment of time as proposed by Section 10326 should allow the Secretary enough time to gather data and make adjustments during the testing period. However, the Secretary of HHS should be able to enact the pay-for-performance program and increase the program's funding on a "rolling basis," instead of being required to wait until *after* January 1, 2016 to take these critical steps.

Waiting three years to start testing pay-for-performance programs does not accurately speak to the crisis facing hospice care. Statistics indicate that hospice care continues to develop as a big business. Profit maximization, enrollment-based incentives, and improper documentation are already taking precedence over quality of care, individualized needs of the hospice patient, and proper oversight of those qualifying for hospice care. For-profit hospice centers are starting to engulf nonprofit hospice centers. The market share of nonprofit hospice centers, albeit shrinking, is still large enough that eliminating them will create major concerns.

Another pressing need involves re-establishing the founding principle of hospice care: care and comfort. When Section 10326 of the ACA focuses on pay-for-performance programs and the *quality* of care a hospice patient receives, it implicitly speaks to the founding hospice principles of care and comfort. Still, the current timetable to implement Section 10326 is lagging.

Testing pay-for-performance programs starting January 1, 2014 provides two benefits. First, the ACA has nearly four years from its enactment to construct and analyze the pay-for-performance programs before testing them. Second, the pay-for-performance model, if implemented using this timetable, will hopefully reduce some of the projected $435 billion to be spent on Medicare Part A in 2019.

B. Decouple the Nursing Home Doctor and Nursing Home from Involvement in Medical Determinations for a Patient Contemplating Hospice Care

Although not a requirement, some patients believe choosing to enter hospice care will sever the relationship with their doctor.[346] In a medical sense, nursing home doctors should sever their relationship with a patient contemplating hospice care. The Jekyll & Hyde routine a nursing home doctor can play, from giving medical advice as a doctor to referring potential hospice patients as a businessman in exchange for personal benefits, is too rampant in the hospice industry for any gentler recommendation. The nursing home doctor must communicate to a hospice patient that the dynamic in their relationship is changing. A patient contemplating hospice care has many other things to worry about, such as researching hospice care generally and finding a hospice center most convenient for the family. However, the proper time to separate the patient's nursing home doctor and staff from the hospice care search may be a difficult determination because a patient trusts the opinions and advice of the nursing home doctor.

Still, the friendship between the nursing home doctor and the hospice patient has value. The nursing home doctor as a friend properly alters the mindset of each party. As stated previously, the goal of hospice is to provide comfort for a hospice patient's remaining days in life. The nursing home doctor, by becoming more of a friend than a medical advocate, will have a more enjoyable time with a former patient. The doctor's medical instincts to do anything to save a patient will dissipate. In turn, this will make the transition on a hospice patient easier. Seeing that his or her nursing home doctor is not providing medical advice or suggesting a curative treatment puts a patient at ease, allowing him to enjoy his remaining time. Both parties will understand that their respective roles have changed. In no way would this diminish the doctor from being a social, emotional, and comforting companion for a hospice patient.

Bribing nursing facility staff other than the nursing home doctor is troubling. Because these employees are not compensated as well as a nursing home doctor or nursing home director, hospice centers of-

346. Keslar, *supra* note 13.

fering cash incentives and personal benefits become harder to resist. If employees strategize as a group, their suggestions can influence the recommendation a nursing home doctor gives to a hospice patient. The OIG investigations of those hospice centers that heavily acquire patients from nursing facilities can limit the fraud from these employees.

C. Enact the HELP Act Payment Revision to Modify Section 3132(a) of the ACA

Enacting the HELP Act proposal to "pilot" new payment methods is financially sound. A $3 million cost is minimal and allows the industry to save more money in future years. Implementing the new payment methods for two years at 15 voluntary providers, or about 0.003 percent of all total hospices, will not disrupt current operations of the hospice industry. Concern could arise if the hospice centers volunteering have no diversity in their structure or size to see how the new payment methods affect finances and the quality of care. Still, with proper planning, the pilot program could offer important insight into the hospice industry.

D. Enact the HELP Act Proposals Regarding the Face-to-Face Assessment Requirement in Section 3132(b)

Expanding the pool of those able to recertify a hospice patient will increase administrative efficiency. If combined with the seven-day grace period, nurse practitioners, clinical nurse practitioners, or physician assistants have time to study in detail a hospice patient's medical history. This helps determine whether a hospice patient needs or does not need recertification for additional hospice care. These recertifying employees will eliminate the delay while waiting for a hospice director or doctor when an "emergency" hospice decision is needed for a person with rapidly deteriorating health.

One twist is requiring that at least two people recertify a hospice patient if one of those people is not the hospice doctor or director. Therefore, any combination of more than one nurse practitioner, clinical nurse practitioner, or physician assistant to recertify will qualify as a proper recertification. The main reason for this is the lower level of education and responsibility these positions may have. This may be difficult to implement, given the variation of staffing needs between

individual hospice facilities. If a discrepancy occurs between the opinions of the two (or three, or more) individuals recertifying a hospice patient, then a phone call can be placed to the hospice doctor or hospice director to resolve the issue.

The HELP Act proposing a seven-day grace period for recertification creates an effective and efficient process. The narrow two-day grace period puts too much pressure on rural hospices, which make up 25 percent of all hospice centers in the United States. For a rural hospice center, this narrow timeline could result in turning potential hospice patients away, as the hospice center would be unable to timely meet the face-to-face assessment requirement.

Those supporting the two-day grace period believe the small time frame helps solve the problem of ending "brink-of-death" care described by Dr. Byock. Also, allowing a seven-day grace period to become recertified is more than one third of the average hospice patient's length of stay. According to Schumacher, seven days is equal to the amount of days that 33 percent of hospice patients receive full hospice care benefits.[347]

However, operational feasibility and accurately recertifying hospice patients outweigh these arguments to enact these two HELP Act proposals.

Finally, no additional costs occur with these changes according to the CBO. Overall, the HELP Act proposals for the face-to-face assessment requirement increases flexibility, eliminates previous operational constraints, and prevents additional money spent.

347. Dotinga, *supra* note 7.

E. Implement a Medicare "Sliding Scale" Financial Model to Pass Responsibility to Hospice Centers and Help Eliminate Fraud

As stated previously, an enormous gap exists between the average length of days a hospice patient receives care and the eligible amount of time a hospice patient can continue receiving hospice care. The current national trend shows a decrease in the average length of stay, according to Dr. Byock.[348] The suggestion is not that hospice care should not change how long it initially offers hospice care to a hospice patient. The solution is a sliding scale financial model. The sliding scale financial model will apply only to large hospices (those with 100 or more patients),[349] as the primary goal of this recommendation is to eliminate the booming business and financial enlargement of the hospice industry. Instead of Medicare bearing all the cost for the entire 180 days a hospice patient receives hospice care, the hospice center itself takes on an increased financial responsibility.

The average hospice patient receiving 20 days of hospice care uses 11 percent of the total amount of hospice care available to him or her. Right now, Medicare funds nearly 90 percent of MHB.[350] Currently, the system is like a light switch: if a hospice patient receives 180 days of care, and an evaluation or audit determines that the patient did not qualify for hospice care, *only* then does the hospice center have to reimburse Medicare and become financially accountable. Hospice centers have an incentive to keep a hospice patient on hospice care for as long as possible. Medicare pays for however long a hospice patient receives care, and hospice centers keep a hospice patient on hospice care as long as possible, or at least until the "intervening periods" when the hospice center makes a profit.[351]

The sliding scale model could pass the financial burden onto the hospice center after a hospice patient receives a specific number of care days. For example, Medicare would fully fund the first 90 days of hospice care, as per usual. Then, Medicare would fund 80 percent of costs and the hospice center would fund 20 percent of the hospice care payments from day 91 to day 120 that a patient receives care. Next, Medicare would fund 70 percent and the hospice center would

348. Ramer, *supra* note 11, at 3.
349. Andrews, *supra* note 175.
350. Dotinga, *supra* note 7.
351. Rau, *supra* note 54.

fund 30 percent of payments from day 120 to day 150 that a patient receives care. Finally, Medicare would fund 60 percent and the hospice center would fund 40 percent of payments from day 150 to day 180. Because the face-to-face assessment requirement extends a hospice patient's care for only 60 more days, the sliding scale financial model, as proposed, would not apply to hospice care after day 180.

The sliding scale model will provide many benefits. First, it will discourage hospice centers from keeping patients on hospice care longer. Second, it will discourage hospice centers from keeping patients on hospice care that do not qualify for hospice care. Third, profit maximization benefitting many for-profit hospice centers will decrease, leveling the playing field for nonprofit hospice centers.

F. Enact the HELP Act Proposal Using Surveys in Determining Hospice Center Recertification

Surveys are the most appropriate way to streamline a recertification system, gather necessary information, and increase hospice center oversight at a minimal cost. Consistent with the 2007 OIG recommendations, the CMS should implement surveys as the foundation of hospice center certification and recertification requirements.

First, the CMS should increase the frequency with which these surveys are given. The CMS and state agencies have virtually ignored hospice center recertification for too long. An easy solution is to streamline the process and have hospice centers be recertified as frequently as every other home health agency. Recertification on the same continuum as other home health agencies will create consistency and encourage communication between hospice centers on becoming efficient and cost-effective. It also allows states and the federal government to see local and national trends, determine where certain types of hospices are closing, and evaluate whether proper availability for potential hospice patients is viable if some hospice centers were not recertified.

Second, states can create information storage systems about hospice centers. The economic health, average patient enrollment size, and quality of care provided may be "key performance indicators" that a hospice center must provide to a state for recertification purposes. These factors can help identify at-risk hospices, determine if smaller hospice centers have six-figure debts, and predict a hospice center's financial forecast. In no way should hospice centers need to

straddle the line of always breaking even. However, the industry should not be dominated by high profit margin hospice centers. The recertification process is helpful in assuring proper oversight to prevent fraudulent activities. The length of stay for a hospice patient would not be a metric used in the hospice center recertification process due to its subjectivity and difficulty in determining the reason. In this system, oversight is not a reactive process. Instead of the federal government and the Department of Justice filing suit and cracking down on fraudulent activity, the CMS and state agencies can evaluate hospice centers at risk before fraud or financial catastrophe occurs. Recertifying with the CMS and the state creates another check system to ensure hospice centers apply proper practices and procedures.

Survey requirements could be as structured and detail-oriented as the requirements written in Chapter 9 of the Medicare Benefit Policy Manual associated with the face-to-face assessment requirement.

G. Use Section 3004 to Compile a List of Activities Tailored to Baby Boomers

Many hospice patients are satisfied with care, special food, and time with loved ones as a simple comfort at the end of life. It would be naïve to ignore hospice's future for baby boomers needing care and having high expectations for the type of care they receive. Hospice industries should base their future hospice care on the European Model and supplement care with Extreme Hospice that is cost-effective and feasible. First, voluntary donations may be a source of income to finance activities for hospice patients. Although finding millions of dollars in funding through voluntary donations like St. Catherine's Hospice Center in the United Kingdom is difficult, organizing events to increase hospice funding is realistic. The Pasco Sheriff's Mounted Posse planned the Fifth Annual Ride for Hospice event to raise money for their local hospice in Tampa, Florida.[352] Costing $25 for adults and $15 for children ages 12 and under, participants take a two-day journey on a horseback ride through the Fair Haven Farms at Land O'Lakes.[353] New this year, a bonfire event highlights the over-

352. *Community Sports Events: Ride for Hospice, Mud Endeavor Run*, TAMPA BAY TIMES, Feb. 13, 2013, http://www.tampabay.com/news/humaninterest/community-sports-events-ride-for-hospice-mud-endeavor-run/1274968.

353. *Id.*

night camping experience.[354] Additional activities include a petting zoo, pony rides, wagon rides, and a nature walk.[355] Even though it will never reach the social and financial magnitude of the American Cancer Society and its Relay for Life events, the hospice industry should coordinate more fundraising events to finance hospice care activities. Every single dollar goes far in providing small comfort that illustrates the purpose of hospice care.

The European Model used at St. Catherine's Hospice Center assimilated cultural aspects a hospice patient enjoys, such as Roquefort cheese, Wimbledon, and the Queen's Jubilee. American hospice centers should take note of this. Board games like Monopoly, Operation, and Mouse Trap are potential solutions. Music like the Beatles, the Beach Boys, and Frank Sinatra can play in the background as hospice patients reminisce. The Magnificent Seven and Dr. No are potential movie nights for all baby boomers. Conducting research of the popular cultural aspects of the baby boomer generation allows hospice centers to be ahead of the curve once this group needs hospice care. Also, statistics show that hospice centers will provide this hospice activity to a specific hospice patient for only a short period of time.

The face-to-face assessment requirement, along with Chapter 9 of the Medicare Benefit Policy Manual, can help figure out exactly what a hospice patient wants to do with their remaining days on earth. Likewise, a hospice patient should not be pigeonholed into choosing between resting in bed in a dark room, the European Model, or Extreme Hospice. Constant communication with the hospice staff should allow a hospice patient to receive each type of care. When evaluating a hospice patient, hospice staff and doctors should be trained to include discussion about specific meals, movies, activities, or events a hospice patient would like to do during their remaining days. Within reason, a hospice center can provide one more lasting memory in a patient's life.

354. *Id.*
355. *Id.*

V. Conclusion

Hospice care reform focusing on compassion and care is essential. Congress's original intent has expanded in positive ways. The evolution of the industry correctly invited non-cancer, terminally ill patients to receive proper care at the end of life. The quality, expediency, and diversity of care today were unimaginable 30 years ago. Conversely, businesses inflate enrollment and improperly document patients, exposing the industry's flaws in oversight and recertification. The HELP Act proposals, using the ACA as a template, steer the focus of hospice care back in the proper direction and upgrade the current ACA legislation. Eliminating operational constraints, increasing survey frequency, and implementing budget-neutral payment is a start to proper hospice care for the future.

Certain sections of the ACA also cut substantial finances from the hospice industry. As private equity firms entered the hospice industry, patient enrollment increased, length of stay skyrocketed, and Medicare became the victim of fraudulent activity. Alterations to payment structures from the HELP Act proposals, with an emphasis on pay-for-performance programs, will help create logical reductions in funding and not leave the industry near insolvency. In the last two decades, the focus of hospice care has shifted from a service to a business. Reverting back to Congress's original intent for hospice care redefines and erases the misplaced mindset of using dying people to increase profit. Difficult questions still linger regarding the balance between curative and palliative care. Concurrent care demonstration programs hope to analyze and solve this complex problem.

The HELP Act proposals and individualizing hospice care will provide higher quality care, use less money, and increase patient satisfaction. Valuing human capital over financial capital is the proper context for the hospice industry. A dying patient's specific needs are the priority. Although the hospice industry faces financial cuts, the HELP Act and other reforms balance the true purpose of hospice and help prepare the industry for the future. Hope can be restored for a hospice patient to smile and enjoy his or her remaining days of life.