

CALCULATING DEATH: IMPLICATIONS OF THE SIX-MONTH PROGNOSIS CERTIFICATION REQUIREMENT FOR THE MEDICARE HOSPICE BENEFIT

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The goal of hospice organizations is to provide high quality, compassionate care for persons suffering from terminal illnesses. To achieve this goal, terminal patients must be given access to hospice care. Currently, patients face barriers in the form of requirements and regulations governing the Medicare Hospice Benefit due to an increase in Medicare fraud and abuse. Access to hospice benefits requires that the patient be diagnosed with a terminal illness and receive a physician's certification of a prognosis of death within six months. Fears of fraud allegations over the six-month certification requirement limit the willingness of physicians and nursing facilities to encourage hospice enrollment. Ms. Jacobowski recommends that new methods be developed to counteract the negative repercussions of these regulations so that patients who can benefit most from hospice care are able to gain access to the program. Ms. Jacobowski does not suggest that the six-month certification for terminal illnesses requirement be removed entirely but proposes a modification of prognosis standards. Physicians often find it difficult to predict the disease path and length of decline and, therefore, can be reluctant to certify many patients for hospice care. Ms. Jacobowski believes that modifications to prognosis standards would alleviate the fears of the majority of physicians. Proposed modifications include adjusting the prognosis requirement to an average survival of six months or a fifty percent probability of death

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within three months. With these modifications to the prognosis standards, Ms. Jacobowski believes hospice enrollment likely will increase, which would allow more patients access to the end-of-life care they deserve.

I. Introduction

In 1997, Ruth Kindred was a sixty-five-year-old widow, a grandmother, and terminally ill.¹ Suffering from diabetes, heart disease, emphysema, and metastatic lung cancer, she entered hospice, and the organization quickly became her lifeline.² In five months, hospice workers became Kindred's second family as they helped her bathe, fixed her meals, checked her vital signs, managed her medications, and tidied her room.³ In addition to physical care, hospice provided Kindred and her family with counseling and support services to help them prepare for her passing.⁴ The presence of hospice brought Kindred a solace she would not find in a hospital or nursing home.⁵ With hospice central to coping with her illness, Kindred found herself terrified when she learned that the federal government was investigating California hospices as part of Operation Restore Trust, a program that sought to combat waste, fraud, and abuse in Medicare, and that they already had ordered one hospice to repay \$2.1 million for the Medicare benefits of patients that outlived their six-month prognoses.⁶ Contemplating her own situation as a hospice patient of five months, Kindred wondered, "Good heavens! What if I don't die in six months?"⁷

Many patients and physicians shared Kindred's fears regarding the repercussions of the Operation Restore Trust audits for patients who survive past the six-month mark.⁸ In response to these fears, the

1. Beverly Beyette, *What if I Don't Die in 6 Months?; Although a Federal Probe into Medicare Fraud by Some Hospices Targets the Programs Only, Many Patients Fear They Will Be Cut Adrift if They Live Too Long*, L.A. TIMES, Apr. 18, 1997, at E1.

2. *Id.*

3. *Id.*

4. *See id.*

5. *Id.* Kindred described her distaste for nursing homes and stated that "hospice will be here to help me through to the end. I have my family, and I have hospice. That's all I need." *Id.*

6. *Id.*

7. *Id.*

8. *Id.* *See also* Robert A. Rosenblatt, *U.S. Wants Hospice to Repay Medicare Funds; Health Care: San Diego Agency Owes \$2.1 Million for 37 Patients Who Lived More Than Six Months, Auditors Say*, L.A. TIMES, Mar. 21, 1997, at A3. Hospice officials express concern over the abilities of government auditors to understand hospice issues. *Id.*

Department of Health and Human Services (HHS) acknowledged that it was a sensitive issue that required compassion.⁹ Furthermore, HHS assured the public that the audits focused on persons enrolled in hospice unnecessarily and not those legitimately requiring services.¹⁰ Even with these assurances, however, worries remained. Mary J. Labyak, executive director of a Florida hospice, shared a common concern about the “mass chilling effect” this could have on the use of hospice.¹¹ Additionally, these assurances meant little to patients already enrolled in hospice programs who feared a loss of their benefits.¹²

The specific audits performed under Operation Restore Trust no longer occur; however, investigations into hospice fraud continue.¹³ Further, access to hospice benefits continues to require a physician’s certification of a six-month prognosis.¹⁴ This Note examines the implications of the six-month certification and the effect it has on physicians, potential patients, and providers in terms of access and cost. First, Part II of the Note provides background on the Medicare Hospice Benefit. Then, in Part III(a), the Note addresses the inherent imprecision of the six-month certification process, especially when patients suffer from non-cancer conditions with unpredictable declines. Part III(b) of the Note discusses the financial costs and benefits of the Medicare Hospice Benefit. In Part III(c), the Note next addresses the prevalence and problems of Medicare fraud, as well as current methods of preventing and punishing its occurrence. The section goes on to discuss the ramifications of fraud investigations regarding the effect of the six-month certification on hospice enrollment. Finally, in Part IV, the Note recommends possible alternative approaches to the current certification requirements of the Medicare Hospice Benefit.

9. Robert A. Rosenblatt, *U.S. Targets Hospices if Patients Live Too Long; Health: Audit Is Seeking Repayment of Medicare Funds for Those Who Survived Past 6-Month Benefit Period*, L.A. TIMES, Mar. 15, 1997, at A1.

10. *Id.*

11. *Id.*

12. *Id.* One patient told hospice staff: “I just feel terrible because I am one of these people who cause the hospice trouble. I would die if I could, but God just won’t take me.” *Id.*

13. Gerald M. Morris, *Hospice Fraud and Abuse: Operation Restore Trust and Beyond*, 20 AM. J. HOSPICE & PALLIATIVE CARE 1, 6 (2003) (discussing fraud investigations that have occurred after Operation Restore Trust ended and the Healthcare Fraud and Abuse Control Program).

14. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE HOSPICE BENEFITS 4 (2010), available at <http://www.medicare.gov/publications/Pubs/pdf/02154.pdf> [hereinafter MEDICARE HOSPICE BENEFITS].

II. Background

Hospice programs provide care and support for terminally ill patients by focusing on patient comfort instead of curing the illness.¹⁵ “Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice and palliative care involve a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient’s needs and wishes.”¹⁶ The belief in the right to a pain-free death with dignity is central to hospice and palliative care.¹⁷ Additionally, hospice takes a family-centered approach to care by supporting the patient’s entire family through the end-of-life process and helping the patient achieve a dignified and peaceful death.¹⁸ Hospice provides services to patients of any age, religion, or race without limitation based on illness type.¹⁹ In most cases, hospice care occurs in the patient’s home, but it also may take place in freestanding hospice centers, hospitals, nursing homes, and other long-term care facilities.²⁰ Generally, these services include physical care, medication, medical equipment, counseling, and other supplies related to palliative care.²¹

In 2008, approximately 1.45 million patients in the United States entered into some form of hospice care, which is significantly more than the 25,000 patients in 1982 and nearly three times the number of patients only ten years ago.²² Of the 1.45 million patients, 276,000 remained living in hospice as “carryovers” who continued to receive

15. *Id.*

16. NAT’L HOSPICE & PALLIATIVE CARE ORG., *What Is Hospice and Palliative Care?*, <http://www.nhpco.org/i4a/pages/index.cfm?pageid=4648> (last visited Feb. 6, 2011).

17. *Id.*

18. *Id.*

19. *Id.*

20. *Id.*

21. MEDICARE HOSPICE BENEFITS, *supra* note 14, at 4.

22. NAT’L HOSPICE & PALLIATIVE CARE ORG., *Patients Served by Hospice in the U.S.: 1982 to 2007*, http://www.nhpco.org/files/public/statistics_research/NHPCO_graph_patientserved_by_hospice_1982to2007.pdf (depicting that the number of hospice enrollees increased from 450,000 to 540,000 between 1996 and 1998) (last visited Feb. 6, 2011); NAT’L HOSPICE & PALLIATIVE CARE ORG., *NHPCO FACTS AND FIGURES: HOSPICE CARE IN AMERICA 4* (2009), http://www.nhpco.org/files/public/statistics_research/NHPCO_facts_and_figures.pdf [hereinafter *NHPCO FACTS AND FIGURES*]. The NHPCO prepared its report based on its annual organizational level data collection and membership database, as well as Medicare Provider of Services certification data, Medicare hospice cost report data, state mandated data submission, state hospice association membership surveys, and applicable studies published in peer-reviewed journals. *Id.* at 14.

hospice benefits at the start of 2009.²³ Another 212,000 patients were “live discharges” who left the program during 2008 to pursue curative treatment or as a result of improved prognosis.²⁴ The final 963,000 passed away while receiving hospice care.²⁵ These hospice patients comprised approximately 38.5% of the 2.5 million deaths that occurred in the United States in 2008.²⁶

Focusing on decedents over the age of sixty-five who qualify for Medicare, one finds that less than one in three choose to utilize hospice services, with only thirty percent of female and twenty-seven percent of male decedents participating in hospice programs.²⁷ A typical hospice patient is a white female over age sixty-five. It is also likely that this typical patient suffers from a terminal illness other than cancer.²⁸ She most likely receives this care in her “home,” which could be her private residence, a nursing home, or a residential facility.²⁹ The typical patient will pass away at her personal residence within one month of entering hospice.³⁰

Very few hospice patients bear the burden of paying the costs associated with the care they receive while enrolled in the program.³¹ In 1982, Congress created the Medicare Hospice Benefit, which made hospice care an entitlement to persons over age sixty-five and provided the majority of hospice patients with a method of covering their costs.³² The benefit provides the patient with coverage for virtually all costs associated with hospice care,³³ although patients may have a

23. NHPCO FACTS AND FIGURES, *supra* note 22, at 4.

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.* at 7. In 2002, approximately 28.6% of older Americans opted to use hospice services. *Id.*

28. *Id.* at 6-7. In 2008, 56.6% of hospice patients were female, 83.2% were over age sixty-five, 37.8% were over age eighty-five, 81.9% were white/Caucasian, and 61.7% had a primary diagnosis other than cancer. *Id.* at 6-8.

29. *Id.* at 6. In 2008, 68.8% of patients received care in their place of residence, twenty-one percent in a hospice inpatient facility, and 10.1% in an acute care hospital. *Id.*

30. *Id.* at 5. In 2008, the median length of hospice stay was 21.3 days. *Id.*

31. *Id.* at 10. In 2008, only 0.7% of patients had to self-pay for their care, which was a decrease from the 0.9% in 2007. *Id.*

32. *Id.* In 2008, 84.3% of hospice patients utilized the benefit as their main source of payment. *Id.*

33. MEDICARE HOSPICE BENEFITS, *supra* note 14, at 6. Costs covered include doctor services, nursing care, medical equipment and supplies, drugs for symptom control or pain relief, physical therapy, social worker services, counseling, short-term inpatient care for pain and symptom management, and any other Medicare-covered services recommended by the hospice team. *Id.*

small co-payment for some services, such as inpatient hospice care or prescription drugs for pain management and symptom control.³⁴ The benefit, however, limits these co-payments to five percent of the cost for respite care and not more than five dollars for any prescription drug.³⁵ It provides no coverage for any curative treatment, including prescription drugs for purposes other than pain or symptom management, nor does it cover treatment for any health problems unrelated to the terminal illness.³⁶ Additionally, the benefit does not cover room and board or any care from a provider not approved by the patient's hospice medical team.³⁷

The Medicare Hospice Benefit also created federal regulations with which hospices must comply in order to receive reimbursement from Medicare.³⁸ For example, hospices periodically must undergo inspection to ensure that they meet regulatory standards in order to maintain their license to operate and to continue receiving Medicare reimbursements.³⁹ As of 2008, the Centers for Medicare and Medicaid Services (CMS) had certified over 3300 hospice agencies, which represented 93.5% of all hospice agencies in the United States.⁴⁰

Along with the regulations for hospice providers, Congress also imposes requirements for beneficiaries. Patients qualify for the Medicare Hospice Benefit if they are eligible for Medicare Part A, sign a statement to disenroll from Medicare in favor of hospice, receive care from a Medicare-approved hospice program, and obtain certification from their doctor and a hospice medical director that they suffer from a terminal illness with a prognosis of death within six months.⁴¹ At any time while receiving hospice care, the patient may leave the program while retaining the right to return to the standard benefits of Medicare Part A or whatever provider they carried previously.⁴²

III. Analysis

The certification of a terminal prognosis is one of the main requirements of eligibility for the Medicare Hospice Benefit and, in

34. *Id.* at 7.

35. *Id.* at 8.

36. *Id.* at 7.

37. *Id.*

38. NHPCO FACTS AND FIGURES, *supra* note 22, at 10.

39. *Id.*

40. *Id.*

41. MEDICARE HOSPICE BENEFITS, *supra* note 14, at 4.

42. *Id.*

many ways, the most difficult to satisfy.⁴³ Additionally, the failure to obtain the proper six-month certification represents one of the ways hospice programs can commit fraud.⁴⁴ Any program with the potential for abuse requires some form of fraud prevention; however, the impact on patient enrollment and costs to the program resulting from these measures also must be considered.

A. Certification of Terminal Prognosis

1. REQUIREMENTS OF CERTIFICATION

Eligibility for the Medicare Hospice Benefit requires that the patient be diagnosed with a terminal illness and receive a prognosis of six months or less.⁴⁵ This certification must be signed by two physicians—the patient’s primary care physician and the medical director of the hospice.⁴⁶ Once enrolled in hospice, the patient has a right to all care and services for two ninety-day periods.⁴⁷ If a patient continues living beyond his or her six-month prognosis, he or she can elect to leave the hospice program or apply for another sixty-day period of benefits to remain active in the program.⁴⁸ To achieve a renewal of benefits, the patient must receive a second certification from two physicians that he or she continues to suffer from a terminal illness and continues to show a functional decline.⁴⁹ Without this certification, the patient will stop receiving benefits and immediately must leave the hospice program.⁵⁰

43. See Melissa D. A. Carlson et al., *Improving Access to Hospice Care: Informing the Debate*, 11 J. PALLIATIVE MED. 438, 439 (2008).

44. See, e.g., Charles R. Babcock, *Hospices Big Business, Thanks to Medicare; Exploitation of Some Patients Is Alleged*, WASH. POST, June 14, 1998, at A1. Changes in the health care arena have led to hospice programs’ shift from largely philanthropic organizations to money-focused businesses, which for some organizations has resulted in false certification of patient prognoses. *Id.*

45. MEDICARE HOSPICE BENEFITS, *supra* note 14, at 4.

46. *Id.* The certification must be signed by two licensed physicians; nurse practitioners and other health care providers cannot provide the proper authorization. *Id.*

47. *Id.* at 10.

48. Brandon Koretz & Elizabeth Whiteman, *Hospice Eligibility*, UNIV. OF CAL. OFFICE OF THE PRESIDENT, 50, http://www.ucop.edu/agrp/docs/la_hospice.pdf (last visited Feb. 6, 2011).

49. MEDICARE HOSPICE BENEFITS, *supra* note 14, at 10.

50. *Id.*

2. THE CHANGING FACE OF THE HOSPICE PATIENT

During the early years of the Medicare Hospice Benefit, hospices mostly served patients with a primary diagnosis of cancer.⁵¹ However, in the 1990s, this started to change as more patients began to look like hospice patient Christine Kirkland.⁵² In late 1997, Kirkland entered hospice care after a series of hospitalizations caused by a heart condition.⁵³ Six months after her enrollment, she remained in hospice and continued to receive care in her home.⁵⁴ Kirkland's entry into hospice care and prolonged survival represents a common scenario of hospice patients with difficult to predict life expectancies.⁵⁵

In the 1970s, when hospice programs first appeared, cancer patients comprised the largest percentage of admissions.⁵⁶ In the past decade, however, patient composition has shifted. Today, less than forty percent of persons admitted into hospice suffer from cancer.⁵⁷ The number of cancer diagnoses has declined steadily since the 1970s, and the number of admissions for cancer dropped by three percent between 2007 and 2008 alone.⁵⁸ In fact, approximately sixty-two percent of patients admitted into hospice in 2008 suffered from non-cancer illnesses.⁵⁹ The most common diagnoses in the non-cancer category were heart disease, dementia, lung disease, and debility unspecified.⁶⁰ Other categories included stroke or coma, nephritis or renal disease, liver disease, HIV/AIDS, and Amyotrophic Lateral Sclerosis (ALS).⁶¹ Virtually all of these categories showed an increase in the number of enrollees from the previous year.⁶²

51. NHPCO FACTS AND FIGURES, *supra* note 22, at 7. The frequency of cancer patients in hospice can be traced back to the 1970s when cancer patients were the most common users of hospice programs. *Id.*

52. See Babcock, *supra* note 44, at A1.

53. *Id.* Kirkland was one of 4500 patients receiving hospice care from the Vitas Healthcare Corp., which was investigated by HHS for allegations of fraud in 1998. *Id.*

54. *Id.*

55. *Id.* (discussing how more patients suffer from non-cancer illnesses, which makes life expectancy harder to predict).

56. NHPCO FACTS AND FIGURES, *supra* note 22, at 7.

57. *Id.* In 2008, 38.3% of hospice admissions were cancer patients. *Id.*

58. *Id.* at 8. In 2007, 41.3% of hospice patients had a primary diagnosis of cancer, which decreased to 38.3% one year later. *Id.*

59. *Id.*

60. *Id.* (discussing that 11.7% were diagnosed with heart disease, 11.1% with dementia, 7.9% with lung disease, and 15.3% with debility unspecified).

61. *Id.*

62. *Id.* Those categories with no increase showed a decrease of less than one percent with liver disease admissions decreasing from two percent to 1.5% and

The reasons for the increase in non-cancer patients vary. One of the indicators is the general decrease in the prevalence of cancer deaths in America.⁶³ Although cancer remains a prominent cause of death, the overall frequency of cancer-related deaths dropped to less than twenty-five percent in recent years.⁶⁴ Advancements in cancer treatments and improvements in early detection contributed to this decrease.⁶⁵

The burden a disease places on caregivers also contributes to hospice enrollment.⁶⁶ Alzheimer's disease and other forms of dementia serve as prime examples of this, because these patients require a high level of attention from the caregiver.⁶⁷ The rise in the number of patients enrolling in hospice programs with an initial diagnosis of dementia reflects the heightened burden of care the disease requires.⁶⁸ The final indicator of patient enrollment is the ease of accurately predicting the prognosis; however, making an accurate prediction is no simple feat.

3. INHERENT PROBLEMS OF CERTIFICATION

The diagnosis of a terminal illness carries with it an implicit connotation that the patient has shifted from suffering from a condition to dying from a disease; however, the medical determination of dying remains complex.⁶⁹ Society generally expects a dying person to enter "a period of rapid, progressive illness and disability after treatment fail[s]" that includes weight loss, weakness, and other similar symptoms.⁷⁰ Despite this expectation, most diseases do not follow this typical pattern.⁷¹ Generally, cancer is the only illness that progresses through the expected course with patients suffering from weight loss,

HIV/AIDS admissions decreasing from one percent to 0.5% of total admissions into hospice. *Id.*

63. *Id.* at 7.

64. *Id.*

65. AM. CANCER SOC'Y, CANCER FACTS AND FIGURES 2010, at 2 (2010), available at <http://www.cancer.org/acs/groups/content/@nho/documents/document/acspc-024113.pdf>.

66. NHPCO FACTS AND FIGURES, *supra* note 22, at 8.

67. *Id.* at 7 (discussing the similar correlation between the level of care required of Alzheimer's malignancies, nephritis, and kidney disease).

68. *Id.* at 8.

69. See JOANNE LYNN, SICK TO DEATH AND NOT GOING TO TAKE IT ANYMORE!: REFORMING HEALTH CARE FOR THE LAST YEARS OF LIFE 20 (2004). Writings, like those of Elizabeth Kübler-Ross, created a popular understanding that the definition of dying remains difficult to apply in the medical community. *Id.*

70. *Id.* at 21.

71. *Id.* at 20-21.

decreased energy, and a progressive inability to perform daily activities during a period of less than eight weeks.⁷² With the number of deaths from cancer decreasing,⁷³ physicians less frequently must determine prognoses for illnesses that follow this shorter, more predictable trajectory.⁷⁴ In recent years, more patients suffer from life-limiting chronic illnesses and experience “long periods of diminished function” that include “multiple unpredictable and serious exacerbations of symptoms.”⁷⁵ The unpredictability of decline in these illnesses inherently conflicts with the six-month certification requirement of the Medicare Hospice Benefit.

4. METHODS OF CALCULATION

Determining the prognosis of a terminal illness requires standards that provide physicians with some form of verification beyond their personal clinical judgment. One method of calculation requires the categorization of illnesses based on their expected trajectory of decline and another involves guidelines based on the specific illnesses themselves.⁷⁶

The first method of calculation uses the trajectories of terminal diseases and divides the illnesses into three categories: (1) “short period of evident decline,” (2) “chronic illness with exacerbations and sudden dying,” and (3) “long dwindling.”⁷⁷ Patients with cancer diagnoses, some patients with HIV/AIDS, and those suffering from debilitating strokes most commonly fall into the first category.⁷⁸ These patients generally maintain their daily activities and general health after the initial diagnosis until a point when the condition worsens dramatically. At this time, the patient’s health declines rapidly, and

72. *Id.* at 20. During those eight weeks, the patient generally chooses comfort care to replace his or her daily activities and dies close to when the doctor predicted. *Id.*

73. NHPCO FACTS AND FIGURES, *supra* note 22, at 7.

74. LYNN, *supra* note 69, at 20-21.

75. *Id.* at 21.

76. *Id.* at 24-25 (proposing grouping patients by need from the health care system over time rather than conventional divisions of disease and setting of care); see, e.g., BRAD STUART ET AL., NAT’L HOSPICE ORG., MEDICAL GUIDELINES FOR DETERMINING PROGNOSIS IN SELECTED NON-CANCER DISEASES AND HOSPICE-ENROLLMENT CRITERIA FOR DEMENTIA PATIENTS A-20 (1996), available at <http://aspe.hhs.gov/daltcp/reports/impquesa.pdf> (categorizing non-oncologic terminal illnesses by their diagnoses and determining guidelines for prognosis from there).

77. LYNN, *supra* note 69, at 47-50 (depicting the pattern of decline of the three trajectories of “eventually fatal chronic illnesses”).

78. *Id.* at 47. Not all cancers fall into this category; some have trajectories that create long-term disability, such as prostate cancer. *Id.*

death occurs shortly thereafter.⁷⁹ Because the time at which the severe decline begins is clearly identifiable, the treating physician easily can determine a prognosis of less than six months for most patients in this category.⁸⁰

The second category covers chronic illnesses caused by organ system failure, such as congestive heart failure or chronic obstructive pulmonary disease (COPD).⁸¹ The prognosis for patients in this category remains much more uncertain, because the lengthy period of decline makes it difficult to delineate precisely when death will occur.⁸² In the face of this uncertainty, physicians often find it difficult to determine whether the patient has less than six months to live or simply is in the midst of a more protracted decline.⁸³

Physicians, however, find it the most difficult to accurately predict the time of death for patients that fall into the third category.⁸⁴ These “long dwindling” patients generally suffer from Alzheimer’s disease or other dementias that follow a slow decline during which patients lose the ability to care for themselves.⁸⁵ The period of severely impaired function may last for years, and without a comorbid condition, many physicians lack the professional confidence to certify a prognosis of six months or less for these patients.⁸⁶

Although trends in disease trajectories can group patients effectively, many physicians prefer guidelines specifically tailored to individual diseases. Thus, they most commonly use guidelines created by the National Hospice Organization, which specifically focus on heart disease, pulmonary disease, dementia, HIV/AIDS, liver disease, stroke and coma, renal disease, and ALS.⁸⁷ The guidelines first establish a series of general rules that apply to all terminal illnesses to help physicians determine the prognosis for certification for the Medicare

79. *Id.*

80. *Id.*

81. *Id.* at 47–48. This category also includes liver cirrhosis or disease, nephritis and renal failure, and other cardiac and pulmonary diseases. *Id.*

82. *Id.* at 48. The median chance of surviving six months is fifty percent for heart failure and forty percent for liver failure with cirrhosis, while death from COPD often cannot be predicted until the “last few days” of life. *Id.*

83. *Id.*

84. *Id.* at 49–50.

85. *Id.* at 50.

86. *Id.* “Medical personnel do not generally classify someone as ‘dying’ from dementia, Parkinson’s disease, or . . . advanced old age,” which can make them ineligible for hospice care. *Id.*

87. STUART ET AL., *supra* note 76, at A-22.

Hospice Benefit.⁸⁸ Initially, the patient must meet the basic criteria of having a life-limiting condition and choosing a course of treatment that focuses on the relief of symptoms rather than curing the illness.⁸⁹ If satisfied, then the patient must have either a “[d]ocumented recent impaired nutritional status related to the terminal process” or a “[d]ocumented clinical progression of disease.”⁹⁰

To determine nutritional status, the guidelines suggest looking at the progression of unintentional weight loss and the results of lab tests.⁹¹ Physicians can evaluate the progression of the disease by considering disease-specific criteria, the number of emergency department visits in the past six months, and assessments made by nursing staff for homebound patients.⁹² Additionally, physicians may make this determination based on the “functional decline” of patients and their own clinical judgment.⁹³ The decline must be recent and physicians should follow the Karnofsky Performance Status, which assesses the ability of patients to work and carry out daily activities.⁹⁴ Physicians also should evaluate the patient’s ability to meet three of the six “Activities of Daily Living,” which include “bathing, dressing, feeding, transfers, continence of urine and stool, and ability to ambulate independently to the bathroom.”⁹⁵ For the specific diseases, the National Hospice Organization recommends considering factors such as the number of medications taken, patient response to these medications, number and severity of symptoms specific to the disease, mental capacity and function, mobility, results of lab tests, and the presence of complicating comorbid conditions.⁹⁶ The National Hospice

88. *Id.*

89. *Id.* at A-26. “A ‘life limiting condition’ may be due to a specific diagnosis, a combination of diseases, or there may be no specific diagnosis defined.” *Id.*

90. *Id.* at A-26-27.

91. *Id.* at A-27.

92. *Id.* at A-26.

93. *Id.* Determination on this basis occurs when other documentation does not exist. *Id.*

94. Valerie Crooks et al., *The Use of the Karnofsky Performance Scale in Determining Outcomes and Risks in Geriatric Outpatients*, 46 J. GERONTOLOGY 139, 139 (1991). Developed in 1948, the Karnofsky Performance Scale serves as a functional and well-being measure for patients. It has been applied to cancer patients to determine their ability to receive chemotherapy and “has been shown to be a useful predictor of hospitalizations, survival days, living in the community, and institutionalization.” *Id.* at 139, 144.

95. STUART ET AL., *supra* note 76, at A-27.

96. *See id.* at A-26. For example, for heart disease, the physicians should look at whether the patient suffers from congestive heart failure; for pulmonary disease, they should look at response to bronchodilators; for dementia, they should consider the patient’s ability to form sentences and words. *Id.* at A-28-33.

Organization further suggests that physicians combine these guidelines with their clinical judgment in order to best predict a patient's prognosis.⁹⁷

5. LIMITATIONS ON THE METHODS OF CALCULATION

In its report, the National Hospice Organization acknowledges limitations on the application of its guidelines.⁹⁸ The study examined a large population of patients and based the guidelines on the average patient, which means that the guidelines may not apply to all patients.⁹⁹ Additionally, the National Hospice Organization based its guidelines on studies limited in terms of its pool of patients and by the stratification of patients within the research group.¹⁰⁰ For example, most studies focused on patients "who received standard medical therapy when they became acutely ill," and little information exists on the progressive outcomes of patients who receive little or no curative care upon the initial diagnosis.¹⁰¹

The National Hospice Organization also considers the fact that for many non-cancer diseases, the typical treatment often is palliative in nature.¹⁰² This means that for many chronic conditions, physicians do not focus on curing the disease, but instead focus on the treatment of symptoms, just as hospice care ensures the patient's comfort through the treatment of symptoms.¹⁰³ This remains significant to the six-month certification, because by treating the patient's pain, the symptoms may be alleviated, and the patient's life actually may be extended while in hospice care, which further challenges physicians attempting to predict prognoses accurately.¹⁰⁴

97. *Id.* at A-23.

98. *Id.* at A-23-25.

99. *Id.* at A-23-24 (acknowledging that each patient's "disease runs its own unique course").

100. *Id.* at A-24 (recognizing that many studies focused on institutionalized populations and failed to distinguish between the patients' stages of disease when determining the efficacy response to certain treatments).

101. *Id.*

102. *Id.* (recognizing that the palliative care provided is identical to the curative treatment options in some cases).

103. *Id.* at A-24-25.

104. *Id.* For example, a hospice patient suffering from congestive heart failure will receive diuretics and vasodilators to increase comfort, which also has been shown to significantly prolong the life of these patients. *Id.*

In addition to the limitations recognized by the National Hospice Organization, other studies have found fault in its guidelines.¹⁰⁵ A study of patients suffering from COPD, congestive heart failure, and end-stage liver disease found that “patients meeting various combinations of [the National Hospice Organization’s] criteria, six-month survival ranged from 53% to 70%.”¹⁰⁶ Furthermore, the study found that although the guidelines effectively “[excluded] most patients who lived longer than 6 months,” it also excluded the patients it intended to target—those “who were dead in 6 months or less.”¹⁰⁷ Looking specifically at patients suffering from Alzheimer’s disease and other forms of dementia, another study found that none of the variables in the National Hospice Organization guidelines significantly related to survival in the cohort studied.¹⁰⁸ The study argues that adherence to these faulty guidelines prevents otherwise qualifying dementia patients from accessing hospice, which would provide them with the care and benefits they deserve.¹⁰⁹

Ultimately, these studies show that the degree of accuracy required by the six-month certification creates a stringent standard that treating physicians find difficult to meet.¹¹⁰ Consequently, the six-month requirement may block some patients suffering from chronic conditions with unpredictable disease trajectories from accessing hospice care simply because a physician cannot guarantee a prognosis of less than six months and, therefore, lacks the confidence to certify the patient.

105. See, e.g., Ellen Fox et al., *Evaluation of Prognostic Criteria for Determining Hospice Eligibility in Patients with Advanced Lung, Heart, or Liver Disease*, 282 JAMA 1638, 1644 (1999) (finding the National Hospice Organization’s guidelines to be only moderately effective).

106. *Id.*

107. *Id.*

108. Ronald S. Schonwetter et al., *Predictors of Six-Month Survival Among Patients with Dementia: An Evaluation of Hospice Medicare Guidelines*, 20 AM. J. HOSPICE & PALLIATIVE CARE 105, 110 (2003) (discussing the Medicare guidelines, which mirror those of the National Hospice Organization’s guidelines).

109. *Id.*

110. Fox et al., *supra* note 105, at 1644 (noting that predicting an accurate prognosis for patients with COPD, congestive heart failure, and end-stage liver disease is difficult and unrealistic).

B. Managing the Costs

1. COST OF THE MEDICARE HOSPICE BENEFIT

The Medicare Hospice Benefit reimburses hospices for the care they provide to their patients on a per diem basis to cover all expenses associated with hospice care.¹¹¹ Since the establishment of the benefit in 1982, the number of hospice agencies and users has increased dramatically.¹¹² For example, between 1991 and 2006, “Medicare spending for hospice under the Medicare Hospice Benefit increased from \$445 million . . . to \$6.6 billion . . .”¹¹³ Numerous studies examine hospice’s effect on medical expenditures, but it remains uncertain whether hospice actually reduces costs because many of the studies yield conflicting results.¹¹⁴ Many of these conflicting studies focus on the total costs incurred by patients during their last year of life, which fails to account for the amount of time the patient actually spent in hospice while receiving the benefit and produces a skewed report of hospice costs.¹¹⁵ With these unadjusted studies, if a patient receives the Medicare Hospice Benefit for only two weeks before dying, the costs of the entire last year—including the fifty weeks during which the patient received curative treatments and not the less costly palliative care—are considered the expense of the Medicare Hospice Benefit.¹¹⁶ Thus, when studies ignore the length of hospice stays, they mask the true savings of hospice care.¹¹⁷

2. THE IMPACT OF LENGTH OF STAY ON COST

Studies show that the costs of the Medicare Hospice Benefit vary significantly based on the length of the patient’s enrollment in hos-

111. *The Medicare Hospice Benefit*, NAT’L HOSPICE & PALLIATIVE CARE ORG., <http://www.nhpco.org/files/members/MedicareHospiceBenefit.pdf> (last visited Feb. 6, 2011).

112. See Donald H. Taylor Jr. et al., *What Length of Hospice Use Maximizes Reduction in Medical Expenditures Near Death in the US Medicare Program?*, 65 SOC. SCI. & MED. 1466, 1467 (2007). Hospice costs have increased as the use of hospice “has risen dramatically, from seven percent of Medicare decedents in 1990 to approximately one-quarter by 2002.” *Id.*

113. Carlson et al., *supra* note 43, at 439 (reflecting the dramatic increase of Medicare-certified hospices since 1982).

114. Taylor et al., *supra* note 112, at 1467.

115. *Id.* at 1467–68. “Realistic cost assessments must account for patients’ actual length of benefit use” because hospices cannot “reduce third party expenditures prior to hospice use.” *Id.* at 1468.

116. *Id.* at 1468.

117. *Id.*

pice.¹¹⁸ One study found that short- to medium-length stays were the most cost-effective, whereas very short and very long stays resulted in much higher costs to Medicare.¹¹⁹ Another study found that very short stays led to high costs of care and that hospice decreased costs for cancer patients that remained in the program for long periods of time.¹²⁰ More specifically, cancer patients saw decreased costs during the first 233 days, and non-cancer patients saw a similar decrease during the first 154 days of care.¹²¹ Further, when studies control samples of decedents for the length of stay and patient diagnosis, analysis shows that “hospice saves the Medicare program around \$2300 per beneficiary who died while using hospice.”¹²²

The length of enrollment in a hospice program plays an important role in hospice expenses, because the costs of the services decrease and the savings increase when the patient spends more than a few days in hospice.¹²³ When a new patient enters a hospice program, the initial costs can be high.¹²⁴ Entry into hospice includes the creation of a care plan tailored to a patient’s individual pain management, emotional, and symptom control needs.¹²⁵ In addition, hospice provides patients with an interdisciplinary team comprised of doctors, nurses, social workers, and spiritual counselors that cater to that patient’s specific condition.¹²⁶ Further, hospice organizations must assess a new patient’s condition and stabilize him or her before any pain management or palliative care can begin.¹²⁷ Each stage of the initial entry process creates costs for health care providers, hospice programs, and patients that combine to create a disproportionate financial burden during the first few weeks of care.¹²⁸ After thirty days, however, the cost-saving strategies developed during the entry

118. David G. Stevenson & Jeffrey S. Bramson, *Hospice Care in the Nursing Home Setting: A Review of Literature*, 38 J. PAIN & SYMPTOM MGMT. 440, 445 (2009).

119. *Id.* (considering less than seven days in hospice a very short stay, eight to thirty days a short-length stay, thirty to ninety days a medium-length stay, and over ninety days a very long stay).

120. Taylor et al., *supra* note 112, at 1473–76.

121. *Id.* at 1476.

122. *Id.* at 1474.

123. Stevenson & Bramson, *supra* note 118, at 445.

124. *Id.*

125. NHPCO FACTS AND FIGURES, *supra* note 22, at 3.

126. *Id.* The team also includes volunteers, therapists, home health aides, and bereavement counselors. *Id.*

127. Stevenson & Bramson, *supra* note 118, at 445.

128. *Id.*

process take effect and the financial benefits of longer hospice stays become clearly visible.¹²⁹

Although the Medicare Hospice Benefit allows patients to receive care for a period of six months, the majority of patients do not use the full period of care, with the average length of service to be approximately sixty-nine days in 2008.¹³⁰ The statistics become more significant when considering the median length of stay. A study by the National Hospice and Palliative Care Organization found that the median length of hospice use lasted fifteen days, that twenty-five percent of patients stayed in hospice for less than six days, and that less than seven percent of patients exceeded the six-month benefit period.¹³¹ These numbers indicate that a majority of patients certified for hospice benefits suffer from terminal illnesses with prognoses that fall within the six-month requirement.¹³² These data appear to support the certification requirement, because it shows compliance with the six-month standard; however, it remains troubling that the typical hospice stay lasts less than one month given the high costs associated with short stays.¹³³

Some critics argue that the cost benefits of earlier enrollment would be negated by an increased median survival period for patients as a result of the earlier enrollment.¹³⁴ Undoubtedly, the costs of individual hospice programs would increase; however, hospices do not operate in a vacuum, but rather work within the larger Medicare system.¹³⁵ As such, the benefits of hospice appear when compared with the costs of curative care for terminal patients.¹³⁶ Thus, hospice continues to show cost benefits of early enrollment despite the potential increase in the median length of patient enrollment.

The reasons for late enrollment vary by patient, but experts find that a reluctance by patients and physicians to accept death by ending

129. *Id.*

130. NHPCO FACTS AND FIGURES, *supra* note 22, at 5. In 2008, the median length of service was 21.3 days, which means that "half of hospice patients received care for less than three weeks." *Id.*

131. Taylor et al., *supra* note 112, at 1471 (basing its statistics on 1819 hospice-using decedents, from the total sample of 11,245 decedents).

132. *Id.* (indicating that ninety-three percent of hospice beneficiaries remained in hospice for less than six months).

133. *Id.*

134. Nicholas A. Christakis & Jose J. Escarce, *Survival of Medicare Patients After Enrollment in Hospice Programs*, 335 NEW ENG. J. MED. 172, 176 (1996).

135. *See id.* (comparing costs of hospice to other Medicare programs).

136. *Id.* (finding that early hospice referrals appear to substitute the more expensive hospital care costs with the less expensive costs of hospice).

treatment, a lack of familiarity with end-of-life care options, and the “chilling effect of a federal Medicare fraud probe” all contribute.¹³⁷ Each of these factors influence hospice enrollment, but this Note focuses on the role of fraud investigations. The impact of fraud charges must be addressed, because it can increase the costs incurred by Medicare by causing beneficiaries to utilize hospice for short periods of time.¹³⁸

C. Implication of Fraud Charges

1. THE POTENTIAL FOR FRAUD

When hospice programs first developed, they grew out of charitable organizations that focused solely on providing care to terminal patients rather than earning profits.¹³⁹ Over time, the nature of these organizations underwent a philosophical shift.¹⁴⁰ In 1998, Gregory F. Grob, the deputy inspector general for HHS, described hospice organizations as experiencing a “kind of innocence lost” as they dealt with the transition from a philanthropic to profit-based focus and cases of fraud began to develop.¹⁴¹ Signs of abuse first appeared in the early 1990s when auditors discovered that seventy percent of hospice patients in Puerto Rico did not suffer from a terminal illness.¹⁴² Investigations continued, and by 1995, HHS learned that some patients enrolled in hospice lacked the requisite prognoses and information about the surrender of other Medicare benefits.¹⁴³ Additionally, they determined that some hospice organizations failed to provide patients with the services they deserved.¹⁴⁴ In response to these discoveries, the Clinton administration enacted Operation Restore Trust, a federal anti-fraud initiative that involved audits of twelve large hospice operations.¹⁴⁵ The investigation uncovered cases of fraud and set heavy

137. Judith Graham, *Hospices See Shorter Patient Stays: Many Doctors Wait Until Near Death Before Admitting Terminally Ill*, CHI. TRIB., May 12, 1999, at 3N.

138. Stevenson & Bramson, *supra* note 118, at 445; Taylor et al., *supra* note 112, at 1471.

139. Babcock, *supra* note 44, at A1. According to certain hospice managers, hospice is now “dog-eat-dog, dirty, [and] competitive” and has become a “money deal” rather than a purely non-profit service to patients. *Id.*

140. *Id.*

141. *Id.*

142. *Id.* (discussing how the hospice certified patients as terminal when the most severe condition suffered was routine, non-terminal arthritis).

143. *Id.*

144. *Id.*

145. *Id.*

penalties on organizations with patients that outlived the six-month prognosis period.¹⁴⁶

Even though Operation Restore Trust no longer remains in effect, investigations into fraud continue, and those hospice organizations found to have abused the Medicare Hospice Benefit continue to face stiff fines. Three recent examples of hospice abuse come from the organizations We Care, SouthernCare, Inc., and Odyssey HealthCare, Inc.

Based in California, the We Care hospice organization came to the attention of the state's Attorney General and HHS after an audit showed that a suspicious amount of hospice enrollees demonstrated good health and that mortality rates remained surprisingly low.¹⁴⁷ The investigation also showed that once patients enrolled in hospice, staff physicians falsely diagnosed them with terminal conditions such as COPD.¹⁴⁸ We Care staff consistently billed Medicare for procedures that either went unperformed or were not medically necessary.¹⁴⁹ The sum of these fraudulent claims reached nine million dollars.¹⁵⁰ Because of the discovery of these false billings, the organization could face criminal consequences for defrauding Medicare and Medi-Cal of nine million dollars.¹⁵¹

We Care's nine million dollar fraud pales in comparison to the amount charged to the Alabama-based hospice organization, SouthernCare. In January of 2009, SouthernCare agreed to pay \$24.7 million to the federal government for charges of falsely billing Medicare.¹⁵² An investigation by the state of Alabama revealed a "pattern and practice to falsely admit patients to hospice care," many of whom continued to live for years and clearly were not in the last stages of

146. See Beyette, *supra* note 1, at E1. An audit of a California hospice required that the organization pay the government \$2.1 million for the unwarranted Medicare benefits they received. *Id.*

147. *Brown Files Criminal Charges Against Six for Hospice Scam That Defrauded \$9 Million from Medicare and Medi-Cal*, STATES NEWS SERV., May 5, 2009. "Typically, 80% of patients die during their first six months in hospice. At We Care, only 11% of the 362 Medicare beneficiaries and 4% of the 143 Medi-Cal beneficiaries died between 2004 and 2007." *Id.*

148. *Id.* "We Care billed Medicare \$39,031 for hospice care for a patient whose medical problems only included arthritis and high blood pressure." *Id.*

149. *Id.*

150. *Id.*

151. *Id.*

152. Challen Stephens, *Medicare Fraud Case Bill: \$24.7M*, HUNTSVILLE TIMES, Jan. 16, 2009, at 6B. Commentators have said that this is the largest hospice fraud case in U.S. history. *Id.*

their lives.¹⁵³ Even with the fraud allegations and subsequent fines, SouthernCare continues to provide hospice services and remains eligible to receive funds through Medicare, Medicaid, and other federal programs.¹⁵⁴

With large hospice organizations able to continue functioning after the payment of fines, a real possibility of recurring fraudulent behaviors remains. In July 2006, Odyssey HealthCare, Inc., a Dallas-based hospice organization and one of the largest in the country, agreed to pay the federal government \$12.9 million in response to charges that it submitted false claims to Medicare.¹⁵⁵ The false claims came from allegations that Odyssey HealthCare billed Medicare for hospice patients who failed to meet the certification requirement of suffering from a terminal illness.¹⁵⁶ Three years later, Odyssey HealthCare made the news again when state fraud control units initiated a fraud investigation into their hospice services in Texas and Georgia.¹⁵⁷ Investigations in both states currently remain pending, and Odyssey HealthCare maintains that they did not commit any violation and acted in material compliance with the applicable regulations of the governmental hospice programs.¹⁵⁸ It is too soon to say what these investigations will reveal; however, they clearly reflect the real danger of hospice organizations becoming repeat offenders of fraud.

The same risks of fraud in hospice organizations exist in skilled nursing facilities and are more troubling in some respects. Namely, nursing home use in the United States has increased over the last couple of decades, and with this increase in usage comes an increase in the number of patients who will die while living in a nursing facility.¹⁵⁹ In turn, this creates an increase in the patients potentially eligi-

153. *Id.*

154. *Id.* (according to a company statement).

155. Jason Roberson, *Odyssey Healthcare Faces Inquiries on Hospice Billing*, DALLAS MORNING NEWS, Mar. 14, 2009, at 6D.

156. *Id.*

157. *Id.* (reporting that the DOJ examined patient admission and retention practices, as well as the medical records of fifty patients).

158. Odyssey HealthCare, Inc., Quarterly Report (Form 10-Q), at 14 (Nov. 6, 2009).

159. Judy Zerzan et al., *Access to Palliative Care and Hospice in Nursing Homes*, 284 JAMA 2489, 2489 (2000). "Nearly half of Americans who live to 65 years of age will enter a nursing home before they die. Two-thirds of persons who consider a nursing home their usual place of residence will remain in the nursing home until death." *Id.*

ble for hospice care.¹⁶⁰ Typically, nursing home residents suffer from chronic illnesses, and when many patients enter the late stages of their disease, they choose to forego curative measures and opt for palliative treatment.¹⁶¹ Additionally, although many people equate hospice with dying in the comfort of one's home, it has grown increasingly common for patients to receive hospice care while residing in a skilled nursing facility.¹⁶² With the aging generation of baby boomers, the demand for nursing home care and hospice services will only increase over the next few decades.¹⁶³

The nature of nursing homes and their residents provides the organization with greater opportunities to manipulate the requirements of the Medicare Hospice Benefit, which creates a heightened need to monitor for fraud and abuse in the agencies.¹⁶⁴ Although some patients enter nursing facilities for limited periods of time, many remain under the nursing home's care until their death.¹⁶⁵ With the increase in terminal patients utilizing their services, nursing homes encounter increased concerns in terms of end-of-life care.¹⁶⁶ The issues often relate to the medical, legal, and ethical considerations that arise when nursing homes face decisions regarding the withdrawal of treatment and the implementation of life-sustaining measures.¹⁶⁷

At the center of these end-of-life concerns lies hospice care. Nursing homes increasingly serve the function of providers of hospice care for their residents.¹⁶⁸ Any hospice setting creates a potential for fraud, but the risk increases in nursing homes because of the generally

160. *Id.*

161. *Id.* ("Patients . . . often prefer treatment that emphasizes pain management and supportive care for themselves and their families . . .").

162. Marshall B. Kapp, *Legal Anxieties and End-of-Life Care in Nursing Homes*, 19 ISSUES L. & MED. 111, 112 (2003).

163. Bruce Jennings et al., *Access to Hospice Care: Expanding Boundaries, Overcoming Barriers*, 33 HASTINGS CENTER REP., SPECIAL SUPPLEMENT, S3 (2003) ("One in nine baby boomers is expected to live to age 90 and by 2040, the number of Americans over age 85 will be nearly four times greater than today."); see Zerzan et al., *supra* note 159, at 2489 (noting that "by the year 2030, 23% of the population will be aged 65 years and older").

164. Kapp, *supra* note 162, at 112.

165. *Id.* Pressure to decrease health care costs combined with the growing aging population can lead to an increase in the use of nursing homes as sites for terminal care. *Id.*

166. *Id.* at 113.

167. *Id.*

168. *Id.*

insular nature of the facility.¹⁶⁹ Within the nursing home setting, the nursing facility employs all parties involved with the patient's care.¹⁷⁰ Additionally, most nursing home operators exercise complete or partial control over the hospice programs that provide services to patients.¹⁷¹ Standing alone, this organizational structure is not inherently flawed; however, the self-contained management system operates with little external scrutiny, which creates a serious potential for abuse.¹⁷² With this possibility of fraud, increased scrutiny of nursing homes when patients elect the Medicare Hospice Benefit is a necessity.

2. METHODS OF FRAUD DETECTION AND PREVENTION

The primary method of preventing abuse of the Medicare Hospice Benefit starts with the inclusion of the six-month certification requirement in the initial criteria for enrollment in the program.¹⁷³ Because hospice provides care for individuals suffering from a terminal illness, a prognosis of six months or less serves as a bright-line test for when a condition becomes terminal.¹⁷⁴

One of the first formal methods of investigating hospice fraud came in the form of Operation Restore Trust, led by the Office of the Inspector General (OIG) within HHS.¹⁷⁵ At the end of two years, the investigation identified over \$187.5 million "in unjustified Medicare and Medicaid payments potentially due to fraud and abuse."¹⁷⁶ When examining hospice agencies, Operation Restore Trust "focused on providers with longer lengths of stay, higher rates of non-cancer diagnoses, and large numbers of nursing home enrollees."¹⁷⁷ Upon the discovery of many instances of violations and abuse, the OIG went so far as to recommend the elimination of the Medicare Hospice Benefit

169. See Morris, *supra* note 13, at 3 (discussing the 1998 Special Fraud Alert, which addressed the increased potential for "improper kickbacks between hospices and nursing homes").

170. See, e.g., Kapp, *supra* note 162, at 112-13 (giving examples of nursing home care providers).

171. OFFICE OF INSPECTOR GEN., FRAUD AND ABUSE IN NURSING HOME ARRANGEMENTS WITH HOSPICES 3 (1998), available at <http://oig.hhs.gov/fraud/docs/alertsandbulletins/hospice.pdf>.

172. *Id.*

173. MEDICARE HOSPICE BENEFITS, *supra* note 14, at 4.

174. *Id.* (discussing the care and support the program provides for terminally ill patients).

175. Zerzan et al., *supra* note 159, at 2492 (describing investigations into waste, fraud, and abuse services in hospice and nursing home agencies).

176. *Id.*

177. *Id.*

for nursing homes.¹⁷⁸ Nursing homes and other critics argued that the OIG implemented a faulty methodology in identifying enrollees who met the six-month prognostic criteria.¹⁷⁹ Many hospice providers found the focus on six months inappropriate, because some patients improve when they receive good hospice care.¹⁸⁰ Critics also complained that investigators unfairly chose “the more conservative definition and scrutinized hospices with higher than average numbers of patients who lived longer than 6 months.”¹⁸¹

Although Operation Restore Trust no longer is active, hospice programs do not operate in an unregulated environment. In 1996, the Health Insurance Portability and Accountability Act established the Health Care Fraud and Abuse Control Program (HCFAC).¹⁸² The Attorney General jointly manages the program with the Secretary of HHS through the Office of the Inspector General.¹⁸³ HCFAC coordinates federal, state, and local law enforcement activities in their efforts to combat health care fraud and abuse.¹⁸⁴ According to HHS, the program has seen wide success.¹⁸⁵ During the 2008 fiscal year, it brought in nearly one billion dollars through settlements and judgments.¹⁸⁶ In terms of enforcement, HCFAC sparked 1600 criminal investigations into health care fraud and convicted over 500 defendants for fraud-related crimes in 2008.¹⁸⁷ Although these fraud investigations have not focused specifically on hospice organizations, all programs that utilize the Medicare Hospice Benefit fall under HCFAC’s regulatory umbrella.¹⁸⁸

In addition to the oversight provided by HCFAC, the Medicare Hospice Benefit requires the involvement of CMS, which has estab-

178. *Id.*

179. *Id.* (arguing that “[p]rognosis, especially in noncancer diagnoses, is of necessity imprecise”).

180. Beyette, *supra* note 1, at E1 (reporting that “hospice care often extends the lives of people with AIDS and other diseases”).

181. Zerzan et al., *supra* note 159, at 2493.

182. DEP’T OF HEALTH & HUMAN SERV. & DEP’T OF JUSTICE, HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM ANNUAL REPORT FOR FY 2008, at 1(2008), available at <http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2008.pdf>.

183. *Id.*

184. *Id.*

185. *Id.*

186. *Id.* Over \$13.1 billion have been returned to the Medicare Trust Fund through HCFAC since its establishment in 1997. *Id.*

187. *Id.* (not including the pending 1311 civil health care fraud matters).

188. *Id.* at 3 (noting that HCFAC was designed to combat fraud in both public and private health care plans).

lished a certification procedure for hospice organizations.¹⁸⁹ Individual state service agencies oversee this certification process and identify potential program participants by conducting fact-finding surveys and investigations and explaining the applicable federal requirements for participation in Medicare programs to health care providers.¹⁹⁰ CMS requires that the hospice “organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related conditions.”¹⁹¹ Additionally, it requires that a governing body manage the hospice and assume full legal responsibility and authority for “provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement.”¹⁹² Finally, hospices must keep all records and provide any reports that the Secretary of HHS finds necessary to administer the program.¹⁹³

Besides the certification and reporting requirements, hospice organizations also must comply with the regulations of other Medicare participating providers and suppliers, especially those that apply to nursing facilities. To remain active within Medicare, nursing facilities must comply with the Medicare Conditions of Participation.¹⁹⁴ These conditions must be met at the initial point of certification, and state agencies monitor them through scheduled and unscheduled surveys of the facility.¹⁹⁵ If at any point the nursing facility fails to substantially comply with the conditions, it is unable to participate in Medicare and may have its agreement terminated.¹⁹⁶ Furthermore, CMS may terminate any agreement if the nursing facility fails to supply the information necessary in determining payment deadlines and amounts, refuses to allow the examination of fiscal or medical records to verify

189. NHPCO FACTS AND FIGURES, *supra* note 22, at 10.

190. *Survey and Certification: General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/surveyscertificationgeninfo/> (last modified Sept. 21, 2010).

191. 42 C.F.R. § 418.100 (2009) (setting standards for patient care, governing bodies, services, continuation of care, professional management responsibility, multiple locations, and training).

192. *Id.*

193. 42 C.F.R. § 418.310.

194. *Survey and Certification: Enforcement*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.hhs.gov/SurveyCertificationEnforcement/01_Overview.asp (last modified Feb. 1, 2011).

195. *Id.*

196. *Id.*

the basis of claims under Medicare, or refuses the photocopying of any records needed to determine compliance with requirements.¹⁹⁷

Nursing facilities must undergo this certification procedure every fifteen months, and home health agencies require recertification every thirty-six months.¹⁹⁸ Hospice programs within these organizations face the same certification requirements; however, when a hospice program is an independent organization, CMS only requires that they undergo recertification every six years.¹⁹⁹ This lesser governmental oversight can lead to greater infractions and fraud investigations of hospice programs when they do occur.²⁰⁰

In addition to termination of the program and the implementation of administrative sanctions, individual beneficiaries and the government have other recourses to deal with cases of abuse and fraud. Individual hospice beneficiaries can file complaints under Medicare's Beneficiary Complaint Response Program.²⁰¹ Once a complaint is filed, the beneficiary receives a case manager who oversees the review process and keeps him or her informed throughout the process.²⁰² This program can provide hospice beneficiaries the relief they need in situations where they received "inadequate care or treatment by any healthcare professional" or experienced other treatment errors.²⁰³ The Beneficiary Complaint Response Program focuses on providing quality improvements for specific individual concerns that help identify system-wide issues but fails to address the problem of fraud.²⁰⁴

Further, beneficiaries and other concerned parties can seek resolution through the False Claims Act. The Act assigns liability to "any person who knowingly presents, or causes to be presented . . . a false or fraudulent claim for payment or approval."²⁰⁵ This includes instances of improper certification of patients as terminal and the filing

197. *Id.*

198. DANIEL R. LEVINSON, MEDICARE HOSPICE CARE FOR BENEFICIARIES IN NURSING FACILITIES: COMPLIANCE WITH MEDICARE COVERAGE REQUIREMENTS 5 (2009), available at <http://oig.hhs.gov/oei/reports/oei-02-06-00221.pdf> (as required between fiscal year 2000 and fiscal year 2005).

199. *Id.*

200. *See id.* at i-iii (suggesting that more frequent certification surveys would lead to better enforcement of the requirements).

201. *Beneficiary Complaint Response Program*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.hhs.gov/BeneComplaintRespProg/> (last modified Dec. 14, 2005).

202. *Id.*

203. *Id.*

204. *Id.*

205. False Claim Act, 31 U.S.C. § 3729(a)(i) (2006).

of claims for services never provided, which falls under the governance of the False Claims Act.²⁰⁶ Violations of the Act have serious consequences, especially with the passage of the 2009 amendments.²⁰⁷ Part of the Fraud Enforcement and Recovery Act of 2009 (FERA), these amendments expanded the reimbursement levels by requiring that offenders reimburse the federal government for the costs of a civil action.²⁰⁸ Additionally, FERA increases the ability of the federal government to intervene in civil actions for false claims.²⁰⁹

These regulations, along with the others discussed in this section, all place pressure on hospice organizations to comply with the qualifications of the Medicare Hospice Benefit, including the six-month certification requirement. The oversight can serve as a positive method of preventing fraud and abuse; however, each of these methods potentially creates unforeseen consequences that negatively impact hospice enrollment by eligible patients.

3. IMPACT OF FRAUD INVESTIGATIONS ON HOSPICE ENROLLMENT

When Operation Restore Trust first made headlines in the mid-1990s, many hospice providers feared the negative impact it would have on physicians as they made the decision whether to certify a patient as terminally ill and, thus, eligible for the Medicare Hospice Benefit.²¹⁰ In an effort to combat the reservations, the National Hospice Organization released a set of prognosis guidelines for physicians, but in most cases, these alone have proven inadequate, which forces physicians to rely on their own clinical judgment.²¹¹ Studies show that the difficulty in accurately determining a six-month prognosis and the fear of being subjected to a fraud investigation “plays a substantial role in limiting [the] use of hospice.”²¹² This so called “chilling” effect

206. 31 U.S.C. § 3729(a)(ii).

207. Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, 123 Stat. 1617 (2009).

208. *Id.* at 1622.

209. *Id.* at 1623.

210. See, e.g., Beyette, *supra* note 1, at E1. National Hospice Organization President, John Jay Mahoney, expressed fears that physicians “may shy away from referring to hospice, feeling ‘they can’t comfortably guarantee that they are 100% accurate with their prognosis.’” *Id.*

211. See *supra* text accompanying notes 69-75 (discussing inherent limitations to the guidelines for determining prognoses for different conditions established by the National Hospice Organization).

212. Carlson et al., *supra* note 43, at 439; see also Haiden A. Huskamp et al., *Providing Care at the End of Life: Do Medicare Rules Impede Good Care?*, 20 HEALTH AFF. 204, 204 (2001) (describing existence of anecdotal evidence that physicians choose

can lead to serious negative consequences for patients who otherwise would benefit from hospice services but for a physician's reluctance to certify their condition as terminal.²¹³

The nursing home setting amplifies fears associated with the six-month certification requirement because of higher government oversight.²¹⁴ Operation Restore Trust placed increased pressure on nursing facilities in the form of quality of care oversight, which placed an additional strain on nursing home physicians who certify terminal illnesses.²¹⁵ Some hospice directors refer to this as "an environment of fear" founded in the attention from anti-fraud efforts that focused on the patients who outlive their six-month prognosis.²¹⁶ This environment creates the danger that terminal patients suffering from illnesses with ambiguous prognostic timelines will be denied the hospice services that they and their families deserve because of misguided fears rooted in Medicare's certification requirements.²¹⁷

When a patient considers entering a hospice program, he or she begins a multifaceted decision-making process that involves a consideration of personal values balanced with medical considerations.²¹⁸ The General Accounting Office (GAO) concluded that factors other than the federal scrutiny from Operation Restore Trust caused decreases in hospice enrollment.²¹⁹ However, the GAO did not deny that the oversight of patient eligibility may have impacted the use of the hospice benefit by some patients.²²⁰ Further, they failed to identify an alternative to aggressive governmental oversight as the reason for decreased enrollment numbers.²²¹ Even if Operation Restore Trust

not to refer patients to hospice out of "fear that they will be charged with fraud if the referred patients do not die within six months"); Zerzan et al., *supra* note 159, at 2492 (discussing reluctance of physicians "to refer nursing home residents with end-stage dementia or cardiopulmonary disease to hospice care"); NHPCO FACTS AND FIGURES, *supra* note 22, at 7 (discussing the higher frequency of disease among hospice users that "make it easier for decision makers to predict the time frame of death").

213. Morris, *supra* note 13, at 5 (as advocated by providers of hospice services).

214. See Kapp, *supra* note 162, at 126 (discussing the possibility of nursing homes being targeted by state prosecutors for criminal prosecution if providing suboptimal levels of care).

215. *Id.* at 127.

216. *Id.* at 127-28.

217. *Id.* at 129.

218. Morris, *supra* note 13, at 5 (including physician preferences, individual patient circumstances, and general awareness of the benefit).

219. *Id.*

220. *Id.*

221. *Id.* at 6 (referencing a drop-off in hospice enrollment that began in 1994).

and its legacy did not solely cause the drop off in hospice enrollment, they remain a contributing factor because, accurate or not, physicians and hospice organizations remain apprehensive about certifying patients out of fear of fraud investigations.²²²

In order for a patient to even consider the hospice decision, he or she must have an awareness of the Medicare Hospice Benefit's existence.²²³ Physicians and nursing facilities play a gate-keeping role in a patient's access to medical information, which includes options for hospice care.²²⁴ Without knowledge of the programs and services available through the Medicare Hospice Benefit, many patients never would consider hospice as one of their options simply because they would not know about the availability of Medicare coverage for the costs associated with hospice.²²⁵ When physicians or nursing facilities perceive a threat of fraud investigations into their certification of a patient's terminal status, they grow hesitant to broach the subject with their patients.²²⁶ By insulating themselves from the possibility of aggressive governmental oversight, these providers act out of fear, which may result in the denial of the hospice care deserved by a needy patient.

IV. Recommendations

The goal of hospice organizations is to provide quality compassionate care for persons suffering from terminal illnesses.²²⁷ To achieve this goal, terminal patients must be given access to hospice care.²²⁸ Currently, patients face barriers in the form of requirements and regulations governing the Medicare Hospice Benefit.²²⁹ Fears of fraud allegations over the six-month certification requirement limit the willingness of physicians and nursing facilities to encourage hospice enrollment.²³⁰ New methods must be developed to counteract

222. See Huskamp et al., *supra* note 212, at 204 (discussing fears of physicians when certifying patients as terminally ill).

223. Morris, *supra* note 13, at 5.

224. See generally MEDICARE HOSPICE BENEFITS, *supra* note 14, at 10-11.

225. See Michael D. Cantor, *Making Tough Choices*, 2004 U. ILL. L. REV. 183, 191-92 (2004) (discussing significant nonfinancial barriers to adequate end-of-life care).

226. *Id.* at 189-90.

227. NHPCO FACTS AND FIGURES, *supra* note 22, at 3.

228. See, e.g., Carlson et al., *supra* note 43, at 439 (discussing the lack of access and the minimal use of the Medicare Hospice Benefit compared with actual need).

229. Zerzan et al., *supra* note 159, at 2492.

230. *Id.*

the negative repercussions of these regulations so that patients who would benefit most from hospice care gain access to the program.

The simplest approach to counteract the impact of the requirement is to take steps to educate health care providers and patients about the reality of the Medicare Hospice Benefit fraud investigations, because it would not involve any statutory changes. The benefit currently provides two ninety-day coverage periods followed by an unlimited supply of sixty-day periods, and if a patient receives proper recertification, the government will not prevent him or her from continuing to receive benefits.²³¹ Presumably, if physicians and patients are made aware of this, then hospice enrollment will increase.²³² The fact that fraud investigations continue to occur, however, reflects the limited efficacy of this approach, because headlines about multi-million dollar fines may continue to instill fear in physicians.²³³ Furthermore, past assurances that investigations would not target qualified patients who survived longer than six months were only minimally successful, as the fears of patients and physicians regarding the six-month prognosis requirement remained.²³⁴

This Note does not suggest that the six-month certification for terminal illnesses requirement be removed entirely. The potential to abuse the Medicare Hospice Benefit and commit fraud remains a serious concern, and a benchmark for entry into the program can provide protection.²³⁵ The choice of six months as the certification point, however, is not rooted strongly in science and medicine, and health care providers struggle to apply this strict guideline in practice.²³⁶ To adjust for the variations among patients, the standards for prognosis could be modified by adjusting the requirement to either “an average survival of six months” or “a 50% probability of death in three months.”²³⁷ Although determining a patient’s average survival or a fifty percent probability of death presents the same prognostic challenges as the current six-month certification, the more relaxed phrasing of either approach acknowledges the imprecision of prognoses for

231. Morris, *supra* note 13, at 2.

232. *Id.*

233. See, e.g., Roberson, *supra* note 155, at 6D (reporting a 2009 fraud investigation).

234. Rosenblatt, *supra* note 9, at A2-A3.

235. Morris, *supra* note 13, at 2.

236. Lucette Lagnado, *Rules Are Rules: Hospice's Patients Beat the Odds, So Medicare Decides to Crack Down*, WALL ST. J., June 5, 2000, at A1.

237. Christakis & Escarce, *supra* note 134, at 176.

terminal illnesses and would alleviate the fears of many physicians.²³⁸ Either option would allow the certification requirement to retain its purpose of ensuring that only truly terminal patients can access the Medicare Hospice Benefit without also creating a barrier to enrollment.

Additionally, either modification need not apply to all patients, because the certifications standards could be adjusted based on the patient's primary diagnosis. The traditional six-month requirement could remain in effect for cancer patients because of their generally predictable declines, which increases physician confidence in prognoses.²³⁹ In contrast, with non-cancer diagnoses, physicians find it more difficult to predict the disease path and length of decline and, thus, can be reluctant to certify these patients for hospice.²⁴⁰ If these patients received certification through one of the more relaxed standards outlined above, physician fears about the repercussions of prognosis error would likely decrease, which would increase early enrollment in hospice.²⁴¹ If more patients enrolled in hospice earlier in their decline, Medicare would save money on the macro level, because patients would participate in the program long enough to become cost-effective when compared with standard hospitalization.²⁴² More importantly, the modifications would allow more patients access to the end-of-life care they deserve.

Adjusting the certification requirements may raise concerns regarding fraud prevention, because any relaxation in standards may open the door for abuse of the Medicare Hospice Benefit. However, the likelihood of this having a noticeable effect on the number of false claims filed remains low. Hospice organizations charged with fraud falsely certified patients as terminally ill when they merely suffered from conditions that were chronic and not life threatening.²⁴³ These patients had prognoses that extended well beyond the six-month requirement with many surviving one year or longer.²⁴⁴ In these situa-

238. *Id.*

239. See LYNN, *supra* note 69, at 47 (discussing how most cancer patients have a prognosis that is "reliably shorter than six months").

240. *Id.*

241. See Huskamp et al., *supra* note 212, at 204 (discussing the fears many physicians have over the current six-month certification requirement).

242. Stevenson & Bramson, *supra* note 118, at 445.

243. See, e.g., *Brown Files Criminal Charges Against Six for Hospice Scam That Defrauded \$9 Million from Medicare and Medi-Cal*, *supra* note 147 (discussing when hospice certification was given for a patient with arthritis and high blood pressure).

244. *Id.*

tions, fraud occurs through the blatant false certification of unqualified patients.²⁴⁵ The motivation to submit the false claims likely would not increase following any modification to the six-month requirement, because either modification would not affect the actual certification process. Further, fraudulent hospice programs easily can certify a patient with any false prognosis, and, unfortunately, attempts to abuse the Medicare Hospice Benefit will occur regardless of what certification requirements Congress implements.

Instead of focusing their fraud prevention efforts specifically on the prognostic certification, the government could improve fraud prevention activities by increasing the frequency of hospice certification. Currently, hospices require certification every six years, and the OIG found that fourteen of these certifications were, on average, three years overdue.²⁴⁶ Additionally, in 2006, the OIG found that eighty-two percent of Medicare hospice claims failed to meet one or more coverage requirements.²⁴⁷ These faulty claims resulted in a Medicare payout of approximately \$1.8 billion.²⁴⁸ Of those claims, however, only four percent did not meet the requirements for terminal certification.²⁴⁹ This indicates that CMS can combat fraudulent Medicare expenditures by focusing on monitoring all aspects of the Medicare Hospice Benefit and not just the terminal certification requirement. Increasing the frequency of recertification for hospices would help achieve this goal, because instances of fraud could be identified and resolved more quickly.

Finally, any changes to the Medicare program and the potential changes in the national health care arena limit all of these recommendations. However, even if the current medical system undergoes significant change, the benefits of hospice programs to terminal patients will remain, as will the decreased health care costs provided by hospice, so measures to encourage timely hospice enrollment remain necessary.

245. *Id.*

246. LEVINSON, *supra* note 198, at 5.

247. *Id.* at 10.

248. *Id.*

249. *Id.* at 10 fig.1.

V. Conclusion

Many Americans approach death unprepared for the physical and emotional burden it places on themselves and their loved ones.²⁵⁰ Unaware of palliative services available through hospice programs, many terminally ill individuals die without these benefits.²⁵¹ The six-month certification of a terminal prognosis that is required by the Medicare Hospice Benefit functions as one of the barriers to access.²⁵² Medicare fraud and abuse remains a serious concern for the federal government, and measures must be taken in order to prevent it; however, this should not be done at the expense of patients. Even though the government imposes no penalties for properly certified patients who outlive their six-month prognosis, many physicians and nursing facilities remain hesitant about recommending hospice until they feel relatively certain that death is imminent.²⁵³ This delay in certification not only impacts the quality of care received by the patient but also creates increased financial costs for the program as whole.²⁵⁴ Modifications to the current system of certification are necessary to facilitate an increase in hospice enrollment, which ultimately will improve the quality of end-of-life care received by terminally ill patients.

250. Jennings et al., *supra* note 163, at 3.

251. *Id.*

252. Zerzan et al., *supra* note 159, at 2492-93.

253. *Id.*

254. Stevenson & Bramson, *supra* note 118, at 445.

