

NPHI POLICY BRIEF:

PROPOSED SOLUTIONS FOR A TARGETED & EFFECTIVE HOSPICE PROGRAM INTEGRITY PROGRAM

This brief is a companion piece to the accompanying background resource highlighting issues with the current hospice program integrity program as implemented. NPHI's immediate and most urgent policy ask is that CMS issue guidance to its contractors to stop using a "rule of thumb" coverage determination process as a means to deny payment for hospice care. It is not consistent with the statute, is creating a bigger logjam at the Administrative Law Judge (ALJ) appeals level, and is limiting access to care at a critical point in a person's trajectory of illness. Furthermore, supplying hundreds of records in support of a standard that is not consistent with the law is an unsustainable regulatory burden on hospice providers, particularly the community-based, non-profit providers represented by NPHI.

In addition to securing relief from inappropriate payment denials, NPHI is also advocating that CMS *access data it already collects in an effort to continue to target bad or unscrupulous actors in the hospice industry that pose a program integrity risk.* We ask that CMS or the Congress look at some of the following factors (in aggregate) for insight into appropriate targeting of outlier providers, as they are better indicators of potential problems than current practice and would make more suitable points of entry for medical review that could be used to target bad behavior in the hospice industry.

- Average Length of Stay > 150 days
- Median Length of Stay > 60 days
- Hospices that only utilize the routine home care level of care.
- Spending exceeding the aggregate cap¹
- Over 55% of patients with Length of Stay > 180 days
- Cancer diagnoses making up less than 20% of admitting diagnoses
- Weekend skilled visit rates substantially different than weekday skilled visits
- Overall skilled visit rates substantially different than industry averages
- Live discharges rates above 25% (excluding patient instigated revocations)²
- CAHPS scores substantially below industry averages
- Less than 30% of a hospice's patients residing in their own home
- Excessively high operating margins, such as over 20%, measured by ownership not provider number, over several years.
- Pattern of discharge from hospice before hospitalization with immediate readmission after hospital discharge

There are also other areas that are consistent with the law where wide practice variation suggests problems that could be tackled— and used for both program integrity and identifying high-quality providers. These are factors that could be calculated from claims data, cost reports, or captured in required surveys:

¹There should be a corridor approach to this – small hospices should have some leeway to go over the cap - we suggest 10%.

²CMS has the data to identify the true outliers for long length of stay. This past year's final [Hospice Wage Index update](#) contained the following paragraph:

"As part of our ongoing...efforts, we analyzed the distribution of live discharge rates among hospices with 50 or more discharges (discharged alive or deceased)... Most notably, hospices at the 95th percentile discharged 47.6 percent of their patients alive in FY 2017." If CMS is truly concerned with live discharges, it is unclear to us why the 90th and the 95th percentile are not immediate targets for concern.

- Bereavement services and use of volunteers for patient care: These are required services under the CoPs and should be enforced. Not providing bereavement services to surviving family other than sending a newsletter—with no plan or record for the bereaved, and not having sufficient volunteers to provide 5% of patient care required by the conditions of participation— are indicators of poor-quality hospice care.
- “Revoking patients” by the hospice: Only a patient may revoke the Medicare Hospice Benefit. Today, it is not uncommon to hear that hospices are “revoking” or discharging patients who need to have an expensive treatment, ER visit, or hospitalization for which the hospice does not want to pay. Currently, a patient is twice as likely to end up with a 30-day readmission to the hospital if they are served by a hospice that is for-profit vs. not-for-profit.
- Lack of sufficient 24-hour support: Hospices at times are staffing on-call nurses who live more than an hour away from a given patient, and therefore either do not make a visit when needed after hours or take an inordinate amount of time to get there.
- Medical Director hiring practices: Some hospices have been hiring physicians who are also the Medical Directors of nursing homes at an above market rate to supply referrals to the hospice. These hospices should face higher audit scrutiny.
- Limited coverage of related drugs and treatments: In order to limit financial risk, there are hospices that have practices limiting their exposure to expensive drugs. Many patients die of not just one “hospice diagnosis” but multiple. Because some pharmacies have a per diem contract structure that requires the hospice to choose a single hospice diagnosis on which to base the contract, some hospices only cover drugs needed to treat that one diagnosis. Another practice is to discharge patients who need medically indicated treatment or tests aimed at their comfort in their final months of life simply because of the expense.
- Site of service and "cherry picking" diagnoses: The business plan of some hospices centers on marketing to predominantly nursing home-dwelling patients and often bending the rules of "incentivizing" providers, marketers or physicians to reach and enroll this patient population. The MHB was designed as an aggregate, risk corridor payment system which was predicated on a case mix of diagnoses and sites of care. Overall, hospices should have a mix of sites of care. If a hospice has a disproportionate percentage of their patients in nursing homes and assisted living facilities, this is a practice that warrants CMS' attention.
- GIP in the nursing home: If GIP is being provided in the nursing home, there should be a hospice RN assigned to provide direct care on every shift.³ Alternatively, a reduced rate for GIP in the nursing home could be considered.
- Hold contractors accountable: Require contractors to provide the same calculation of interest payment (10% per annum) to hospices for overturned claims as hospices are required to pay contractors for claims that are definitively denied. Contractors should be required to adhere to the same timelines that they impose on those being audited. Finally, they should be forbidden from the use of “no decline” or examples of improved quality of life as the reason for denial of hospice care.

³See §418.110(b)(2) and See §418.112.