



AMERICAN ACADEMY OF  
HOSPICE AND PALLIATIVE MEDICINE

January 20, 2023

The Honorable Earl Blumenauer  
United States House of Representatives  
1111 Longworth House Office Building  
Washington, DC 20515

**RE: Recommendations to Improve Hospice Program Integrity**

Dear Congressman Blumenauer:

On behalf of the more than 5,500 members of the American Academy of Hospice and Palliative Medicine (AAHPM), I write to offer recommendations for improving program integrity and quality of care provided under the Medicare hospice benefit. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for patients facing serious illness, as well as their families and caregivers.

We are grateful for your longtime leadership in advancing policies to expand access to palliative care and hospice, and we appreciate your invitation to join the roundtable you recently hosted to discuss issues impacting hospice program integrity. The conversation confirmed our shared belief that ***Medicare beneficiaries nearing the end-of-life need – and deserve – all the valuable services that good hospice delivers.***

AAHPM believes we can play a key role in strengthening the hospice benefit and ensuring that scarce Medicare resources are used to provide the most help possible to patients and families, rather than lost to diversion and waste. Like you, our Academy leaders and members were distressed by recent media coverage of vulnerabilities in hospice care, including instances of outright fraud and abuse. As I noted in my [letter to the editor](#) of *The New Yorker* last month, there is no place for those who prey on the seriously ill for their own financial gain. They must be identified and held to account.

At the same time, I have the privilege to engage each day with many dedicated physicians and other health professionals who are committed to providing high-quality care to those facing serious and terminal illnesses. For these individuals and their families, the Medicare hospice benefit holds the promise of delivering life-changing relief from debilitating physical symptoms as well as providing psychological and spiritual comfort, control, dignity, and quality of life. ***AAHPM stands ready to partner with you and other policymakers to ensure that the benefit truly delivers on its promise and that Medicare beneficiaries – including those in disenfranchised, rural, and underserved communities – have access to the end-of-life care and supports they need and deserve.***

Detecting and eradicating fraud, waste, and abuse requires a different approach than efforts intended to improve the quality of care of well-intentioned but low-performing programs. As AAHPM considered policy recommendations to address the range of program integrity concerns, we identified and applied the following guiding principles:

*Policy interventions aimed at ensuring hospice program integrity and quality should:*

- *Center on the needs of hospice patients and their families to ensure optimal care experience*
- *Ensure timely and equitable access to hospice care across all geographies and communities*
- *Focus on integrity and quality indicators that impact patient care rather than technical errors, such as completion of forms*
- *Target non-operational and low-performing programs while avoiding blunt instruments that burden high-performing programs*
- *Promote education and training of hospice professionals and support the free exercise of reasonable independent judgment in clinical decisions made in good faith, including certification of terminal illness*

With these principles in mind, we offer the following recommendations for your consideration:

## **New Hospice Providers**

Recent data show a worrisome escalation of new hospices being established across just a few states, with numbers far exceeding that needed to ensure access, choice, and quality of care. In many cases, these hospices are not serving patients. Therefore, and *allowing for appropriate exceptions, we recommend that the Centers for Medicare & Medicaid Services (CMS) use its authority to limit the provision of licenses to additional hospices in counties where established hospice programs are adequate to serve the population, with targeted moratoria based on state and local data.*

CMS should establish requirements for initial capitalization, to demonstrate viability, and require administrator attestations of compliance with applicable regulations before they may open to patient care as a Medicare-certified hospice program. *Initial certification should be probationary, with new hospice providers surveyed more frequently.*

*CMS should review an initial certification application for certain “red flags” that would trigger more careful investigation prior to approval.* These might include multiple hospices located at a single address (versus a single hospice entity operating at multiple sites, which is a legitimate practice and not atypical); an administrator overseeing numerous hospices; or a history of unresolved regulatory infractions. An unannounced physical inspection should occur to confirm the legitimacy of the entity with a working office. New hospice programs should be required to disclose a history of criminal convictions by owner, consultant, or administrator, including financial crimes. This is consistent with the 2019 Medicare provider enrollment rule which, if fully implemented, would increase CMS’ authority to revoke or deny Medicare enrollment. *Where troubling indicators are identified, new hospices should be flagged as high risk, providing for enhanced survey scrutiny and/or frequency.*

*CMS should define what constitutes a “non-operational” hospice entity (e.g., programs that are not properly staffed, are unable to submit valid Medicare claims, etc.) and restrict Medicare privileges for these organizations, including voluntary termination of the provider agreement, deactivation of*

billing privileges, and revocation of Medicare enrollment. Revoking enrollment of non-operational hospices will discourage the practice of creating them for the sole purpose of selling them for profit. Frequent visits by CMS Site Visit Contractors would identify non-operational programs for which revocation is appropriate. When revocation does occur, providers should be required to disclose such on any future enrollment applications, serving to flag the need for more intensive review.

Taking this into account, ***we caution against requirements that would put new rural or frontier hospice programs at a disadvantage.*** For example, requiring a minimum number of patients before payment is permitted may pose undue burden for rural providers who are caring for a patient or two but have yet to reach an initial threshold (e.g., five or more patients). Rural and frontier areas often lack adequate access to hospice services. Care should be taken to ensure that program integrity initiatives do not inadvertently impede access to high-quality end-of-life care for patients in these communities.

## Existing Hospice Providers

AAHPM is committed to promoting health equity and eradicating disparities that leave some populations more vulnerable to predatory behaviors, such as misleading and unethical marketing of the hospice. However, the imperative to provide high-quality hospice care calls for more than simply preventing fraud and abuse. AAHPM and its members understand that ***routine and thorough review of all hospice providers is essential to ensure that terminally ill beneficiaries receive comprehensive, skilled, and compassionate care centered on their needs, values, and preferences.*** AAHPM's role in establishing a [Hospice Medical Director Certification](#) (HMDC), is an example of our commitment to leading efforts to increase quality and improve outcomes for all hospice patients. However, we believe that ***any enhanced scrutiny and policy interventions should be aimed at identifying and holding accountable the lowest-performing programs rather than applied across-the-board to all providers. Hospices with good performance indicators should not be overly burdened with responding to audits that divert limited resources from the care of their patients.*** We're hopeful that the Hospice Special Focus Program currently under development will make a difference in this regard, and we are grateful that we were provided an opportunity to nominate a member to serve on the Technical Expert Panel that has been guiding its design and implementation. In all such activities, it is also critically important to include the perspectives of patients and families.

### ***Targeting Regulatory Scrutiny and Audits***

In recent years, hospices have been subject to an excessive number of regulatory activities in the name of program integrity. Such activities divert time and resources from caring for patients. For example, if a hospice provides high-quality care to a dying patient but requisite forms are inadvertently missing a date or phone number, reimbursement for all care is denied. While some financial penalty may be in order, the current approach is disproportionate and unfair. Moreover, these ***technical denials do nothing to improve the care provided to patients and families.***

Similarly, ***the many hospice audits currently in place have no bearing on care quality, nor have they been shown to significantly curtail inappropriate organizational behavior.*** For example, while eligibility depends on a life expectancy of less than six months, even with application of sound clinical judgment, some patients will live longer than expected. Yet, current regulatory requirements put excessive focus on reviewing this group of terminally ill patients, often denying reimbursement for

their care. The struggle to balance providing appropriate care to patients that happen to live longer than expected with concern for potential downstream repayment penalty puts pressure on hospices to discharge eligible patients who happen to have long stays, often leaving them with no adequate alternative services available to meet their care needs. In many cases, the individuals conducting retrospective chart review are insufficiently expert to challenge the determination of the hospice medical director who exercised their best clinical judgment in a prospective fashion as required at the time of certification and/or recertification.

Another example of the undue consequences of broadly applied interventions can be found in the increasing scrutiny of general inpatient (GIP) level of care. GIP is a fundamental component of the Medical Hospice Benefit, enabling hospices to provide more intensive support for patients who suffer from complex pain or other acute symptoms that cannot be managed in another setting. Rather than focus on the hospices that are found not to provide this level of care (which is required of all Medicare-certified providers), current regulatory scrutiny is focused on the hospices that do, often denying coverage for the intensive symptom management that some patients need to be comfortable. This uneven application of scrutiny burdens hospices who have been willing to enroll patients with more complex care needs.

***To better focus regulatory scrutiny, AAHPM proposes that CMS develop a panel of objective indicators that aim to identify low-performing programs to improve patient safety and eliminate fraud, waste, and abuse.*** Further research is warranted but, as a start, we recommend consideration of:

- High live discharge rate
- Long average length of stay
- Unfavorable Hospice Care Index
- Poor performance on measures included in the Hospice Quality Reporting Program, and
- Condition-level deficiencies on complaint or routine surveys

We believe the above indicators are far more reliable for detecting true quality and integrity concerns than the outcomes of broad retrospective chart audits focused on questioning eligibility and recouping payment.

### ***Empowering Patients and Families***

Publicly reporting hospice quality data fulfills the Hospice Quality Reporting Program (HQRP) mandate, and CMS's Care Compare website is intended to provide a single user-friendly interface for patients and their families/caregivers to make informed decisions when selecting a hospice provider. ***In addition to data points currently available on Care Compare, CMS might consider listing current and prior hospice ownership; reporting whether a hospice has been assessed financial penalties for non-participation in HQRP; and denoting whether the hospice medical director is Board certified in Hospice and Palliative Medicine and/or holds an HMDC credential.***

The current Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey data is limited by a paucity of hospice participants and significant delays in data feedback. To boost response rates for smaller programs, CMS should test use of an abbreviated survey instrument. Likewise, as new technology emerges, CMS should test methods of capturing the patient's or family's experience of care in real time.

Consumer-focused complaint hotlines may serve to identify poor-performing or non-operational hospices. *While such hotlines are currently operated at the state level, CMS could strengthen their effectiveness by developing materials to increase awareness and promote their use to report concerns related to patient care and safety, as well as suspicions of unethical or illegal behavior that may warrant investigation.* CMS also must ensure adequate financial support for managing these hotlines and providing transparency in how calls are followed up.

Information on these tools can be highlighted in the Medicare Handbook along with relevant links online.

### ***Enhancing Hospice Surveys***

AAHPM endorsed provisions in the Consolidated Appropriations Act, 2021 (signed into law in December 2020) that established new survey requirements and enforcement procedures for Medicare-certified hospices, including to address survey frequency and the staffing and training of survey teams. Now, all hospices are surveyed at least every three years. *To best manage limited Medicare resources, AAHPM supports more frequent surveys only when targeted to new providers, those identified as poor-performing hospices, and any entities suspected of fraud or abuse.*

Current surveys might be enhanced by including information that could be used in assessing program integrity, such as the sale or transfer of hospice certification numbers; whether owners or personnel appear on the List of Excluded Individuals/Entities; and whether the provider organization has a corporate compliance plan that aligns with guidance from the HHS Office of Inspector General. Additionally, surveyors should assess whether a hospice program is able (directly or via contract) to provide all four levels of hospice care, as well as afterhours care.

### ***Elevating the Role of Hospice Professionals***

*Ensuring both administrative and clinical hospice personnel are well qualified to perform their roles is essential to protecting vulnerable patients and providing optimal end-of-life care.* To this end, minimum education and qualifications for select roles, such as hospice administrator or clinical director, could be added to the hospice conditions of participation. Background checks on owners and administrators could be added as an additional safeguard.

AAHPM particularly recognizes the value of physician-led teams. Indeed, eligibility for the hospice benefit rests on the “physician’s or medical director’s clinical judgement” in certifying a patient has a terminal illness. We believe that determining whether a patient has a life expectancy of less than six months if their disease follows its expected course is a high-order exercise of medical judgment that requires intensive training, careful consideration, and critical thinking. Only physicians have the requisite training and responsibility to make such a high-stakes determination. Thus, *AAHPM calls for all program integrity efforts to support the exercise of reasonable independent professional clinical judgment by the hospice medical director or hospice physician in determining hospice eligibility or making other medical decisions.*

Mentioned earlier, the HMDC credential signals that a hospice physician has specialized knowledge in the medical, ethical, legal, regulatory, and leadership aspects of the hospice medical director (HMD) role. We would welcome the opportunity to work with you or other policymakers to consider how to incentivize physicians working in the field to attain the HMDC credential, keeping in mind that such

additional education may not be affordable and accessible by those working in smaller hospices, especially physicians serving as a part-time HMD. In the meantime, simply reporting on Care Compare where HMDs are Board-certified in Hospice and Palliative Medicine and/or HMDC-certified will add to consumers' understanding of the expertise available within a particular hospice.

When considering professional education and training that advances the delivery of high-quality hospice care, issues for future consideration might include a requirement for any clinician working in hospice who does not hold a specialty certification relevant to hospice care to complete a minimum number of continuing education units related to hospice. It would also be prudent to consider how staffing levels impact quality of care.

\*\*\*\*\*

Thank you again for inviting AAHPM's recommendations as you consider policy interventions that can bolster hospice program integrity. We look forward to continuing to serve as a resource in this important endeavor and working together to advance our shared goal of ensuring that all patients and families who can benefit have access to high-quality hospice care. Please direct questions or requests for additional information to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at [jkocinski@aahpm.org](mailto:jkocinski@aahpm.org) or 847-375-4841.

Sincerely,



Tara C. Friedman, MD FAAHPM  
AAHPM President





AMERICAN ACADEMY OF  
HOSPICE AND PALLIATIVE MEDICINE

January 27, 2023

The Honorable Earl Blumenauer  
United States House of Representatives  
1111 Longworth House Office Building  
Washington, DC 20515

### **RE: Redesigning the Medicare Hospice Benefit**

Dear Congressman Blumenauer:

On behalf of the more than 5,500 members of the American Academy of Hospice and Palliative Medicine (AAHPM), I write to recommend guiding principles and a framework to apply as you consider options for updating the Medicare hospice benefit. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for patients facing serious illness, as well as their families and caregivers.

We appreciate your tireless dedication to advancing policies that support our nation's sickest and most vulnerable patients and expand access to high-quality serious illness care, including palliative and hospice care. We are grateful to be included in your latest efforts to examine the Medicare hospice benefit and ensure it delivers on its promise. As you or other policymakers consider the possibility of redesigning the benefit, AAHPM stands ready to be a constructive partner in assessing current inadequacies and helping to revamp the hospice benefit to ensure it meets the needs of seriously ill beneficiaries today and in the future.

### **Defining the Problem**

AAHPM shares your commitment to ensuring that Medicare beneficiaries nearing the end of life have access to all the services and supports they deserve. So, *while we believe the Medicare hospice benefit serves some patients and families well, we are concerned that others don't receive optimal care or don't ever elect the benefit.* We find that much of the reason for this can be attributed to the structure of the benefit itself.

**Requiring the choice to forgo care** — Because electing the hospice benefit means waiving access to all other Medicare services related to the terminal condition, beneficiaries and their families face a difficult choice. Too often, the desire to continue disease-directed care or certain intensive palliative treatments outside the usual scope of hospice care results in late referrals to hospice. For some, the need to make this choice means never electing hospice. Demonstrated racial and ethnic disparities in hospice use are particularly concerning. For example, studies show that for [Black patients](#), a history of discrimination, structural inequities, and substandard service delivery has resulted in a lack of trust

in the medical system associated with a reduced willingness to forgo life-sustaining care and lower enrollment in hospice. As a result of this benefit requirement, then, *many patients do not access hospice services until the last days or hours of life – or not at all – depriving them and their families/caregivers of the supportive care to which they are entitled.*

It may therefore be confusing when data shows that the average hospice length of stay is increasing. In fact, these numbers are driven by patients with the longest stays (while the number of short stays has remained steady since 2002). This points to another key issue with the current benefit design.

**Serving a population that has changed** — *The population of terminally ill patients enrolled under the Medicare hospice benefit today is very different than in 1983 when the benefit was established, and the care needs for these patients is also much different.* Forty years ago, hospices were largely caring for cancer patients who had fewer treatment options than they do today and for whom the course of illness was relatively certain. Today, patients with Alzheimer’s disease and related dementias (ADRD) represent a growing portion of hospice enrollees but their disease trajectory is less predictable, and these patients are more likely to have longer stays. While studies confirm these patients can derive significant [benefits](#) from hospice care, current policies aimed at reducing hospice misuse and long lengths of stay pose [concerns](#) for reduced utilization by patients with ADRD (whether due to late enrollment or disenrollment), which may be associated with poorer end-of-life experience and outcomes for these patients.

**Driving disparities** — As noted above, *certain aspects of the Medicare hospice benefit drive disparities in access* to vital services that can improve care and quality of life for seriously ill beneficiaries. For example, the hospice benefit was designed with the assumption that a patient has caregivers at home available to provide around-the-clock support to their loved one. However, the realities of today’s family structures and work arrangements mean such at-home care is often unavailable. Families may find it difficult to fill in the gaps for a loved one enrolled in hospice, resulting in poorer care and outcomes, and patients without family nearby or otherwise socially isolated simply may not elect the benefit. (One [analysis](#) of Medicare data showed that older adults with cancer receiving 40+ hours of unpaid care per week were twice as likely to receive hospice care at the end of life compared to those who received fewer than six hours per week.)

The payment structure of the hospice benefit is also thought to limit access for some patients. For example, hospice availability in rural areas is influenced by the lower Medicare payments made to rural providers compared to urban hospice providers. Rural hospice providers face increased costs due to travel distances and greater difficulties in maintaining staff, remaining capitalized, and overcoming economic disadvantages. This all contributes to reduced access to hospice care in rural settings. Still, while restructuring the benefit may address some of these concerns, federal efforts to support innovation and technology also might play a future role in improving access to hospice services for those in rural and frontier areas.

There are many current challenges to delivering on the promise of hospice care. We highlight here just a few of the more important concerns to consider in any redesign of the Medicare hospice benefit to ensure access to quality care near the end of life.



## Guiding Principles

Medicare beneficiaries in the later stages of serious illness deserve hospice care that meets their needs and provides the services that matter most to them. Our recommendations to update the Medicare hospice benefit are informed by the following principles:

- *Hospice eligibility should take the needs of seriously ill patients and their caregivers into account and not depend solely on estimated life expectancy*
- *Beneficiaries should have access to concurrent care and treatments while receiving hospice care*
- *Hospice care should be provided by a full interdisciplinary team that addresses physical, psychological, social, spiritual, and practical needs*
- *Hospice payment should be sufficient to support the quality and experience of care that beneficiaries deserve through the later stages of serious illness*
- *Hospice care should advance health equity and improve access, support, and outcomes for beneficiaries in underserved and low-resource communities*

Additionally, as policymakers reconsider the hospice benefit, *AAHPM strongly believes that efforts to design, establish, and implement a reformed benefit should be inclusive, transparent, and iterative*, with numerous opportunities for stakeholders across the serious illness care community – including provider organizations and patient and caregiver advocacy organizations – to weigh in and address cross-cutting and/or high-priority considerations.

## Framework for Hospice Reform

AAHPM recognizes that the guiding principles detailed above offer only a foundation for considering reforms to the Medicare hospice benefit. To build on that foundation, we suggest the following framework, which identifies the key components that must be updated to ensure the success of a reformed benefit. These include:

- Beneficiary eligibility criteria
- Care team requirements
- Covered services
- Payment
- Quality measurement and accountability

We offer additional considerations for each of these elements below.

**Beneficiary eligibility criteria** — *AAHPM believes that hospice eligibility should not be based solely on a specified prognosis or life expectancy; rather, eligibility should be based on patients' needs*, which may be associated, for example, with functional decline, high utilization of healthcare services, and lack of availability of adequate caregiver or other supports.

Prognostication is not an exact science, and physicians' ability to make accurate predictions regarding life expectancy is imperfect. Even so, a beneficiary's eligibility for the hospice benefit under current rules depends on a physician certifying a six-month life expectancy or less. Patients with an uncertain prognosis are sometimes caught in the middle and prohibited from electing hospice even when those services are clearly what they need. *AAHPM recommends that, under a reformed hospice benefit, patients with unclear prognoses should be able to access hospice services if their need is otherwise established.*

We recognize that additional work is required to further refine eligibility criteria, including to specify how need would be defined, who could certify need, and whether/how any limitations on length of service should be applied.

**Care team requirements** — *Services under a reformed Medicare hospice benefit should be furnished by a full interdisciplinary team*, with the team structure and service requirements consistent with those specified in the National Consensus Project [Clinical Practice Guidelines for Quality Palliative Care](#).

*AAHPM supports physician-led teams*, with physicians taking responsibility for patients' medical care and overseeing other care team members as they practice in accordance with their education, training, and licensure. Reliance on physician expertise can maximize patient safety and quality of care. To the extent that workforce issues exist and limit the availability of physicians with expertise in hospice and palliative medicine, AAHPM suggests that telehealth can be used to ensure the availability of physician leadership.

**Covered services** — In addition to the services currently furnished by hospice providers across the four levels of hospice care, *AAHPM recommends that a reformed Medicare hospice benefit should ensure concurrent access to disease-directed treatments, along with palliative services*. It also should address beneficiaries' social needs, as well as the needs of hospice beneficiaries' caregivers, to support high-quality, equitable care.

As noted earlier, AAHPM is concerned that requirements limiting access to concurrent disease-directed care serve as a deterrent to election of hospice care. Beneficiaries are forced to choose between supportive services provided under the hospice benefit and other related Medicare services and too often forgo hospice care until their final days. In fact, according to the National Hospice and Palliative Care Organization's [Facts and Figures Report](#), in 2020, 25 percent of patients were enrolled in hospice for only five days or less. AAHPM believes that patients deserve to have access to all the care that benefits them, when they need it, in accordance with their goals and preferences. A reformed hospice benefit should rectify this structural barrier by ensuring ongoing access to concurrent care.

Additionally, *AAHPM highlights the need to ensure attention to beneficiaries' social needs, including through assessment of social determinants of health*. By virtue of their serious illness and disease progression, hospice beneficiaries have a range of social and practical needs that do not typically get addressed through "medical" benefits. Focusing only on clinical needs would be inadequate to fully support patients during their hospice election.

Likewise, AAHPM is concerned that Medicare beneficiaries may not be able to take advantage of the full range of hospice services that may be offered due to the limited availability and/or capabilities of caregivers. For example, many caregivers are frail themselves and may have difficulty supporting hospice beneficiaries with home care needs. *A reformed hospice benefit must provide caregivers with adequate support*, for example through enhanced home health aides and services as well as facility care when needed, to ensure that hospice beneficiaries have access to the care that they deserve.

Finally, given ongoing interest in testing the carve-in of the Medicare hospice benefit into the Medicare Advantage (MA) program, **AAHPM stresses that the hospice benefit should be consistent regardless of which program or entity pays for services.** Whether under Medicare fee-for-service or MA (to the extent that responsibility for hospice services is transferred to MA plans), the quality and intensity of services should be the same.

**Payment** — For a sound hospice benefit that ensures access to services for patients across diverse geographies and communities, including rural and underserved urban communities, **payment should be adequate to support the care that patients’ needs dictate – not only their physical needs but their psychological, social, spiritual, and practical needs as well.** At the same time, the payment structure should be designed to limit incentives that increase the risk of waste, fraud, and abuse. While greater analysis is needed, we suggest that a reformed hospice benefit could utilize risk adjustment, tiering, and/or other payment adjusters (for example, based on home- or facility-based status, social needs, and caregiver resources and capabilities) to align payments with costs.

**Quality measurement and accountability** — Quality measurement needs to align with the state of the field and evolve as new measures and instruments emerge. **Accountability for quality should always focus on those aspects of care and experience that matter most to patients, families, and caregivers.**

\*\*\*\*\*

Thank you again for the opportunity to inform your consideration of potential reforms to the Medicare hospice benefit. We look forward to continuing to serve as a resource in this important endeavor and working together to update the benefit in ways that maximize equitable access, quality of care, and quality of life for seriously ill patients and their families/caregivers while minimizing the risk of waste, fraud, and abuse. Please direct questions or requests for additional information to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at [jkocinski@aaahpm.org](mailto:jkocinski@aaahpm.org) or 847-375-4841.

Sincerely,



Tara C. Friedman, MD FAAHPM  
AAHPM President