AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 714
(A-23)

Introduced by: American Academy of Hospice & Palliative Medicine

Subject: Improving Hospice Program Integrity

Referred to: Reference Committee G

Whereas, Recent investigations show disproportionate hospice growth in some states with no clear correlation to need, along with unusual billing and operational activity – including to indicate some hospices are being established primarily for the purpose of selling them for profit – suggesting willful fraud or abuse of the hospice benefit; and

Whereas, Medicare data has shown excessive geographic clustering of hospices (in one case, 120 separately licensed agencies in California are located in the same building, 75 of which are Medicare certified); and

Whereas, After a statewide moratorium on new hospice licenses was enacted in California in 2022, similar troubling activity is shown to have spread to nearby states, including Arizona, Nevada, and Texas; and

Whereas, Medicare beneficiaries nearing the end-of-life need – and deserve – all the valuable services that good hospice delivers; and

Whereas, Patients and families who engage with fraudulent hospices can suffer real and lasting consequences, including not receiving the types or level of care they need, or in some cases, any care at all; and

Whereas, The many hospice audits currently in place have no bearing on care quality, nor have they been shown to significantly curtail inappropriate organizational behavior; and

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

- Center on the needs of hospice patients and their families to ensure an 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 focusing on technical errors.
- Target non-operational and low-performing programs while avoiding blunt instruments that could unnecessarily 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; and

Whereas, Current AMA policy calls to “ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals,

hospices, and rehabilitation facilities (H-160.975, *Planning and Delivery of Health Care Services*); therefore be it

RESOLVED, That Our American Medical Association advocate that the Centers for Medicare & Medicaid Services (CMS) use its existing authority to limit certification of additional hospices in counties where growth in hospice programs is out of line with established need by implementing a temporary targeted moratorium based on federal and state data, allowing for appropriate exceptions to ensure continued access to care (Directive to Take Action); and be it further

RESOLVED, That Our AMA advocate that CMS strengthen investigation prior to approval of initial hospice certification applications and, for those new hospices approved but identified as high risk, require enhanced scrutiny and/or survey frequency (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that CMS use its existing authority to prohibit the sale or transfer of Medicare hospice certification numbers for a specified timeframe (similar to the 36-month change of ownership prohibition in the Medicare home health program), allowing for appropriate exceptions to ensure continued access to care (Directive to Take Action); and be it further

RESOLVED, That Our AMA advocate that CMS restrict Medicare privileges for non-operational hospices, including through voluntary termination of the provider agreement, deactivation of billing privileges, and revocation of Medicare enrollment (Directive to Take Action); and be it further

RESOLVED, That Our AMA advocate that CMS regulatory efforts aimed at weeding out fraud, waste, and abuse be refocused on integrity and quality indicators that impact patient care – rather than technical errors and retrospective chart audits focused on questioning eligibility – and avoid blunt instruments that burden high-performing programs, divert time and resources from patient care, and risk driving smaller providers from the market and/or putting rural or frontier hospice programs at a disadvantage. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 5/10/23

REFERENCES

1. Center for Medicare & Medicaid Services. Quality, Certifications, and Oversight Reports (QCOR) Database. https://qcor.cms.gov/main.jsp
2. "California Hospice Licensure and Oversight: The State's Weak Oversight of Hospice Agencies Has Created Opportunities for Large-Scale Fraud and Abuse." Office of the Auditor of the State of California. March 2022. https://www.auditor.ca.gov/pdfs/reports/2021-123.pdf
3. "Targeted Policy Solutions Needed to Strengthen Hospice Program Integrity." National Association for Home Care & Hospice. https://www.nahc.org/wp-content/uploads/2023/05/NAHC_Hospice-Program-Integrity-Hill-2-pager.pdf

RELEVANT AMA POLICY

Concurrent Hospice and Curative Care H-85.951
1. Our AMA supports continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent **hospice**, palliative and curative care.
2. Our AMA encourages CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services.

3. Our AMA encourages physicians to be familiar with local **hospice** and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly.
Citation: (CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18)

Hospice Care H-85.955
Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care;
(2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment;
(3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare;
(4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program;
(5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers;
(6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure; and
(7) will advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital.
Citation: (CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 212, A-19; Reaffirmation: A-22)

Hospice Coverage and Underutilization H-85.966
The policy of the AMA is that:
(1) The use of hospice care be actively utilized to provide the patient and family with appropriate physical and emotional support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying malignant disease, if the patient is showing response to such palliative therapy;
(2) The goal of terminal care is to relieve patient suffering and not necessarily to cure incurable disease;
(3) Appropriate active palliation should be a covered hospital benefit; and
(4) The initiation of hospice care may be done at the discretion of the attending physician without stopping whatever medical care is being rendered if the physician believes the patient is in the last six months of life.
Citation: (Res. 515, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18; Reaffirmed: CMS Rep. 1, I-21)

End-of-Life Care H-85.949
Our AMA supports:
(1) Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's **hospice** benefit;
(2) study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's **hospice** and skilled nursing facility (SNF) benefits for the same condition; and
(3) increased access to comprehensive interdisciplinary palliative care services by Medicare patients in skilled nursing facilities.
Citation: (CMS Rep. 1, I-21)

Planning and Delivery of Health Care Services H-160.975
(1) Planning agencies should utilize policies, educational programs and incentives to develop and maintain individual lifestyles that promote good health. The planning process should identify incentives for the providers and participants in the health care system to encourage the development and introduction of innovative and cost-effective health care services. Government at all levels, as a provider, purchaser

and consumer of health services, should play an integral role in the planning process, including the provision of adequate funding and ensuring that government policies and/or regulations facilitate and do not unduly restrict the planning process. The authority to impose sanctions on those who take actions that are inconsistent with developed plans should be separated from the planning process. Funding for the planning process should be developed by the participants.

(2) The planning process should seek to ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals, hospices, and rehabilitation facilities.

(3) Decisions concerning the use of health care services, including the selection of a health care provider or delivery mechanism, should be made by the individual.

(4) Both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing short-comings in the current public system for providing access need to be addressed.

(5) Health care facilities should have or should establish review bodies (such as hospital ethics committees) to resolve conflicts over access to scarce health care technologies. In the event that a conflict over delivery of scarce health care technologies cannot be mediated satisfactorily, individuals should be able to seek redress through appropriate appeal mechanisms.

Citation: (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: BOT Rep. 23, A-18)