

HOSPICE AND HEALTH CARE REFORM: IMPROVING CARE AT THE END OF LIFE

KATHY L. CERMINARA*

I. HOSPICE CARE AND MEDICARE COVERAGE OF IT	445
A. <i>Current Medicare Coverage Rules</i>	446
B. <i>Problems With Those Rules</i>	449
II. CONGRESSIONAL SUPPORT OF CONCURRENT CARE AS A HOSPICE MODEL.....	451
A. <i>Elimination of a False Dichotomy in the Payment Rules</i>	452
B. <i>Benefits to Both Patients and the Health Care System</i>	455
III. CONGRESSIONAL SUSPICION OF HOSPICES.....	459
A. <i>Well-Founded Suspicions</i>	459
B. <i>Possible Negative Effects of the Legislation</i>	465
C. <i>Better Ways to Address Congressional Suspicion</i>	470
IV. CONCLUSION	472

The year 2010 ushered in a new era in American health care. The Patient Protection and Affordable Care Act (the Affordable Care Act or the Act)¹ has

* Professor, Nova Southeastern University Shepard Broad Law Center. Many thanks to Christopher Brown for excellent research assistance, to Maria Albanese for valuable contributions in the home stretch, and to numerous members of the Shepard Broad Law Center “scholarship support group” for great advice.

This Article is dedicated to the memory of Professor Bruce Winick, friend and mentor, because the demonstration program it analyzes is an example of therapeutic jurisprudence. Should Congress approve Medicare payment for concurrent care as a result of that demonstration program, it would have asked and answered the question of “what legal principles are most beneficial to patient welfare and consistent with the actual experience of being sick,” then enacted the corresponding reform in the area of hospice care. Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 466 (2002). See also Kathy L. Cerminara, *Pandora’s Dismay: Eliminating Coverage-Related Barriers to Hospice Care*, 11 FLA. COASTAL L. REV. 107, 136-37 (2010) [hereinafter Cerminara, *Pandora’s Dismay*]. For more about therapeutic jurisprudence and Professor Winick’s astounding legacy, see DAVID B. WEXLER & BRUCE J. WINICK, *LAW IN A THERAPEUTIC KEY: DEVELOPMENTS IN THERAPEUTIC JURISPRUDENCE* (1996); International Network of Therapeutic Jurisprudence, ARIZONA LAW, <http://www.law.arizona.edu/depts/upr-intj/> (last visited Feb. 24, 2011); Therapeutic Jurisprudence Center, UNIVERSITY OF MIAMI SCHOOL OF LAW, <http://www.law.miami.edu/tjcenter/> (last visited Feb. 24, 2011).

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029) (to be codified as amended in scattered provisions of 42 U.S.C.). Commentators have suggested alternative popular names, including “Americare,” in an effort to better convey the true impact of this legislation on the American healthcare system through its name. See William M. Sage, *Why the Affordable Care Act Needs a Better Name: ‘Americare’*, 29 HEALTH AFF. 1496 (2010). At the time of this writing, however, the public does not seem to have latched onto one consistent name when referring to this historic legislation.

ensured that President Barack Obama will go down in history as the president who achieved health care coverage reforms on the most significant scale since President Lyndon Johnson's establishment of Medicare and Medicaid in 1965.² Approaching health care reform by focusing on health insurance,³ the Affordable Care Act should increase the number of Americans who have health care coverage and could change the way many Americans obtain that coverage.

With respect to end-of-life care, the Affordable Care Act focuses significantly on coverage of one medical specialty—hospice care. While also addressing issues of hospice quality assessment, data collection methods, and rate adjustments,⁴ the Act implicitly recognizes the value in accessing hospice care as soon as possible.⁵ Once patients have accessed hospice care, however, the Act signals Congressional suspicion about hospices and could negatively affect continued access, at least in rural areas.⁶

This Article will examine these portions of the Act, which this author has described elsewhere as illustrating how “Congress has given with one hand while taking with the other.”⁷ First, it will explain the system pursuant to

2. Jonathan Oberlander, *Long Time Coming: Why Health Reform Finally Passed*, 29 HEALTH AFF. 1112, 1112 (2010). The 907-page-long law encompasses a wide variety of subjects, with titles ranging from “Quality, Affordable Health Care for All Americans” to “Role of Public Programs” to “Improving the Quality and Efficiency of Health Care” to “Prevention of Chronic Disease and Improving Public Health” to “Health Care Workforce” to “Transparency and Program Integrity” to “Improving Access to Innovative Medical Therapies.” (Also included in the legislation, but of lesser general interest, are titles on “Class Act,” “Revenue Provisions,” and “Strengthening Quality, Affordable Health Care for All Americans.”) See Patient Protection and Affordable Care Act, 124 Stat. 119. A version of the law as passed in the senate, before reconciliation, is 906 pages, see H.R. 3590, 111th Cong. (2010), available at <http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf>.

3. The Act “focused on broadening access by means of insurance reform and not on changing the incentives driving health care treatment and overall spending.” David A. Hyman, *Follow the Money: Money Matters in Health Care, Just Like in Everything Else* 12 (U. of Ill., Law and Economics Research Paper No. LE10-008), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1604657. See also Oberlander, *supra* note 2, at 1116 (describing it as “a patchwork, reforming our complex, incoherent insurance nonsystem with a complex, somewhat coherent mix of subsidies, regulations, mandates, and public and private insurance expansions”).

4. Kenneth L. Burgess, *The Patient Protection and Affordable Care Act and Its Impact on Hospice*, THE NAT'L L. REV. (July 5, 2010), <http://www.natlawreview.com/article/patient-protection-and-affordable-care-act-and-its-impact-hospice>.

5. See Patient Protection and Affordable Care Act §§ 2302, 3104 (authorizing immediate access to concurrent care for children and a demonstration project of the concept for adults). For a more thorough discussion of the Act and hospice care, especially its focus on fraud and abuse, see *infra* Section III.A.

6. See Patient Protection and Affordable Care Act §3132; *infra* Part III.B.

7. Kathy L. Cerminara, *Health Care Reform at the End of Life: Giving With One Hand but Taking with the Other*, AM. SOC'Y OF L., MED. & ETHICS, BLOGS & FORUMS (June 7, 2010), http://www.aslme.org/Society_Scholars?post=261 [hereinafter Cerminara Blog].

which Medicare covers the cost of hospice care for patients nearing the end of life and how that payment system affects the timing of some patients' initial access to hospice care. Next, it will laud Congress for using health care reform to change that payment system in a way that promotes earlier access to hospice care for many patients. Finally, it will argue that, despite this indication that it values hospice care, Congress has over-regulated one aspect of it due to suspicion of hospices themselves. As a result, legal, regulatory, and medical professionals should carefully monitor the change Congress has made to the law governing continued care of patients already certified for hospice benefits. Without careful monitoring and calibration, the latter change could inappropriately chill hospice re-certifications.

I. HOSPICE CARE AND MEDICARE COVERAGE

Hospice care plays an important role in American health care, and Medicare plays an important role in financing hospice care. Now part of the larger field of palliative care, hospice care once was part of a countercultural movement protesting the medicalization and over-technicality of death.⁸ By 2007, 1.4 million Americans used hospice services,⁹ and 83.6% of them paid for those services through the Medicare program.¹⁰ In 2008, Medicare expenditures for hospice care exceeded eleven billion dollars, in the form of *per diem* payments to more than 3,300 hospices.¹¹ Although patients receiving hospice care historically received it through healthcare institutions,¹² most such care today involves interdisciplinary teams¹³ visiting terminally ill patients at home,¹⁴

8. See William G. Bartholome, *Physician-Assisted Suicide, Hospice, and Rituals of Withdrawal*, 24 J. L. MED. & ETHICS 233, 234 (1996) ("In large part, the emergence of hospice was a response to a systematic failure by mainstream health care professionals to deal with the problems of the dying."); see also Gary R. Vandenbos et al., *An Alternative to Traditional Medical Care for the Terminally Ill: Humanitarian, Policy, and Political Issues in Hospice Care*, 37 AM. PSYCHOLOGIST 1245, 1245 (1982) (characterizing hospice care in part as a reaction to the medical profession's "orient[ation] toward high technology and the single-minded goal of sustaining life rather than toward humane care of dying and incurable patients").

9. NAT'L HOSPICE & PALLIATIVE CARE ORG., NHPCO FACTS AND FIGURES: HOSPICE CARE IN AMERICA 4 (2009), available at http://www.nhpc.org/files/public/Statistics_Research/NHPCO_facts_and_figures.pdf [hereinafter NHPCO FACTS AND FIGURES].

10. *Id.* at 10.

11. MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 141 (2010) [hereinafter MEDPAC 2010]. Hospice payment is *per diem*, or a consistent rate paid for each day of care regardless of the level of care provided that day. See *id.* at 143. Use of the term "hospices" here includes not simply freestanding facilities in which hospice care is provided but also corporate and government entities that provide hospice care to patients at home or within hospitals. See *id.* at 149 (detailing the rise in type and number of hospices from 2001-2008).

12. See Lenora Finn Paradis & Scott B. Cummings, *The Evolution of Hospice in America Toward Organizational Homogeneity*, 27 J. HEALTH & SOC. BEHAV. 370, 371 (1986); see also Cerminara, *Pandora's Dismay*, *supra* note *, at 114-15.

13. As part of hospice care, Medicare pays for a variety of services in addition to physician and nursing care, drugs, and medical supplies; it also covers short-term inpatient and respite care, 42 C.F.R. §§ 418.202(e), 418.108(b) (2010), homemaker and home health aide

where they assist patients, patients' families, and others caring for those patients throughout the dying process.¹⁵ Currently, the rules governing Medicare coverage of hospice care ensure that only deserving patients have access to it, but also inhibit of some deserving patients from receiving it.

A. Current Medicare Coverage Rules

Whether Medicare will cover hospice care for a patient depends on the results of a three-step inquiry. First, the patient must be eligible for Medicare benefits in general.¹⁶ Second, the patient must be "terminally ill" within the meaning of the law governing Medicare benefits.¹⁷ Finally, the patient must elect Medicare coverage of hospice care by signing a statement acknowledging that "certain Medicare services . . . are waived by the election [of hospice care]."¹⁸ Specifically, a patient must waive Medicare payment for "treatment of the terminal condition . . . or a related condition,"¹⁹ and instead ask Medicare to pay "any expenses incurred for items or services . . . which are . . .

services, § 418.202(g), counseling (including social worker assistance), § 418.202(b), (d), and physical, occupational, and speech/language services as appropriate, § 418.202(h).

14. According to the National Hospice and Palliative Care Organization (NHPCO), in 2008, 68.8% of hospice care was provided at patients' places of residences, meaning "the place the patient calls 'home.'" NHPCO FACTS AND FIGURES, *supra* note 9, at 6. Most Americans wish to die at home. Cerminara, *Pandora's Dismay*, *supra* note *, at 141.

15. See 42 C.F.R. § 418.56(a)(1) (2010) (Medicare regulation requiring interdisciplinary team to "work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement").

16. 42 C.F.R. § 418.20(a); see also CTRS. FOR MEDICARE AND MEDICAID SRVS., DEP'T OF HEALTH AND HUMAN SRVS., PUB. NO. 100-01, MEDICARE GENERAL INFORMATION, ELIGIBILITY AND ENTITLEMENT ch. 1 §10.1 (2006), available at <https://www.cms.gov/manuals/downloads/ge101c01.pdf> [hereinafter MEDICARE GENERAL INFORMATION].

17. 42 C.F.R. § 418.3 (2010). Because of the fragmented nature of the law governing health care, a patient may be "terminally ill" for one purpose but not for another, since the definition of the term can and does change from setting to setting. While this is the Medicare definition, some states' advance directive statutes may define the term as "a condition . . . from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death." E.g. FLA. STAT. § 765.101(17) (2010). To take advantage of the Oregon Death With Dignity Act, a patient must be "terminally ill," defined by that state in that circumstance as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months." OR. REV. STAT. §127.800(12) (2009).

18. 42 C.F.R. § 418.24(b)(3) (2010). The statement also memorializes the patient's acknowledgment that "he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness." *Id.* § 418.24(b)(2).

19. *Id.* § 418.24(d)(2); see also CTRS. FOR MEDICARE AND MEDICAID SRVS., DEP'T OF HEALTH AND HUMAN SRVS., MEDICARE & YOU 27, (2011), available at <http://www.medicare.gov/publications/pubs/pdf/10050.pdf> [hereinafter MEDICARE & YOU].

reasonable and necessary for the palliation or management of [his or her] terminal illness.”²⁰

To be eligible for Medicare benefits generally, a patient must fall into one of three categories. The first way to qualify is to be sixty-five years of age or older and to have paid (or have a spouse who has paid) into the Social Security system for a specified amount of time.²¹ Second, a patient may qualify if he or she is under sixty-five years of age but has qualified for disability income pursuant to the Social Security Act.²² Finally, any patient with end-stage renal disease (kidney failure necessitating dialysis or a transplant) qualifies for Medicare coverage.²³

Eligibility for Medicare coverage of hospice benefits additionally requires certification of a patient as being terminally ill. To be considered “terminally ill” for purposes of Medicare hospice coverage, an individual must have “a medical prognosis that his or her life expectancy is [six] months or less if the illness runs its normal course.”²⁴ Certification of terminal illness is the responsibility of the medical director of the hospice from which the individual intends to receive hospice care, another physician associated with the hospice, or the patient’s attending physician.²⁵ A “physician” is anyone “legally authorized to practice by the State . . . who is acting within the scope of his or her license,”²⁶ which means by definition that, in addition to doctors, nurse practitioners empowered by applicable state law to make such determinations are considered to be “physicians.” “Attending physician” is the term used to refer to the physician of medicine or osteopathy whom the patient identified at the time of electing to receive hospice care as having the most significant role in his or her care,²⁷ which again can include a nurse practitioner acting within the scope of his or her practice.²⁸

The Medicare hospice benefit continues as long as the patient continues to meet the initial qualifications for eligibility for hospice.²⁹ A patient is no longer eligible for Medicare payment for hospice care if his or her condition

20. 42 U.S.C. § 1395y(a)(1)(C) (2006).

21. 42 C.F.R. § 406.10(a) (2010); MEDICARE & YOU, *supra* note 19, at 18.

22. 42 C.F.R. § 406.12 (2010); MEDICARE & YOU, *supra* note 19, at 18.

23. 42 C.F.R. § 406.13 (2010); MEDICARE & YOU, *supra* note 19, at 19.

24. 42 C.F.R. § 418.3 (2010); MEDICARE GENERAL INFORMATION, *supra* note 16, at ch. 1 §10.1.

25. 42 C.F.R. § 418.22(c) (2010); *see* 42 C.F.R. § 418.25 (2010). Initial certification requires two physicians, while later recertifications require only one physician. *See* MEDPAC 2010, *supra* note 11, at 143.

26. 42 C.F.R. § 410.20(b) (2010).

27. 42 C.F.R. § 418.3 (2010).

28. “Section 408(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173) (MMA) amended the term ‘attending physician’ at section 1861(dd)(3)(B) of the Act specifically for hospices to allow nurse practitioners to function as a patient’s attending physician if the patient identifies the nurse practitioner as such.” Medicare and Medicaid Programs: Hospice Conditions of Participation, 73 Fed. Reg. 32088, 32090 (June 5, 2008) (to be codified at 42 C.F.R. pt. 418). “We also do not believe that it is necessary to state that a nurse practitioner may act on behalf of the attending physician in the attending physician’s absence.” *Id.*

29. 42 C.F.R. § 418.24(c) (2010).

has improved so that he or she no longer meets the definition of terminally ill.³⁰ If the patient continues to meet the definition, however, he or she is eligible for two initial ninety-day periods of hospice care and an unlimited number of sixty-day periods after the initial 180 days.³¹ At the beginning of each of these periods, a physician or nurse practitioner must recertify the patient as being terminally ill³² and must ensure that documentation to that effect appears in the patient's medical record.³³ The overall effect is that physicians and nurse practitioners may recertify patients for hospice care as many times as they meet the requirements, resulting in some patients receiving hospice care for years.³⁴

The mere fact that individual patients can receive unlimited Medicare hospice benefits does not mean that Medicare spending on hospice benefits is unchecked. In an attempt to control the overall amount spent on hospice care, Congress and the Department of Health and Human Services (HHS) have established aggregate caps on benefit dollars that any one hospice can claim during a fiscal year.³⁵ One cap, which regulators state does not often affect hospices in practice, "limits the number of days of inpatient care a hospice may provide to not more than [twenty] percent of its total Medicare patient care days."³⁶ The second cap apparently is more important in operation. Each fiscal year, HHS limits the aggregate Medicare payments a hospice can receive.³⁷ If a hospice's total payments divided by the total number of Medicare beneficiaries it serves exceeds that annual cap amount, then the hospice must pay the excess back to HHS.³⁸

30. 42 C.F.R. §§ 418.26(a)(2), (c)(1) (2010); CTRS. FOR MEDICARE AND MEDICAID SRVS., DEP'T OF HEALTH AND HUMAN SERVS., PUB. NO. 100-02, MEDICARE BENEFIT POLICY MANUAL ch. 9, § 10 (2004), available at <http://www.cms.gov/manuals/downloads/bp102c09.pdf> [hereinafter MEDICARE BENEFIT POLICY MANUAL]. If a patient is no longer eligible for the hospice benefit, the Medicare program will pay for the patient's care pursuant to his original Medicare benefits. 42 C.F.R. § 418.26(c) (2010); MEDICARE BENEFIT POLICY MANUAL, *supra*, at ch. 9, § 10.

31. 42 C.F.R. § 418.21 (2010). See also MEDICARE BENEFIT POLICY MANUAL, *supra* note 30, at ch. 9, § 10.

32. 42 C.F.R. § 418.22(a). See also MEDICARE BENEFIT POLICY MANUAL, *supra* note 30, at ch. 9, § 20.1.

33. 42 C.F.R. § 418.22(d) (2010). As to written clarification, see MEDICARE BENEFIT POLICY MANUAL, *supra* note 30, at ch. 9, § 20.1. See *infra* text accompanying notes 122-23 about recent regulatory changes in what that documentation must be.

34. Cf. Stephen R. Connor et al., *Comparing Hospice and Nonhospice Patient Survival Among Patients Who Die Within a Three-Year Window*, 33 J. PAIN & SYMPTOM MGMT. 238, 242 (2007) (reporting mean numbers of days of survival in hospice as high as 514).

35. See MEDPAC 2010, *supra* note 11, at 144. Congress initially approved Medicare coverage of hospice care costs because it saw hospice care as cost-effective. See Cerminara, *Pandora's Dismay*, *supra* note *, at 132.

36. MEDPAC 2010, *supra* note 11, at 144.

37. *Id.*

38. *Id.* at 145.

B. Problems With Those Rules

Hospice care provides well-documented benefits to patients, families and caregivers when patients near the end of life.³⁹ It permits patients to exercise more control over their circumstances near the end of life, which benefits them psychologically.⁴⁰ Through a team-based, interdisciplinary approach, individual hospice care providers “act as *guides into death*, offering information, support, and guidance from the perspectives of persons who are familiar with the dying process” to patients, families, and caregivers.⁴¹ Families and caregivers can benefit from services such as counseling⁴² and respite care, which is short-term, inpatient care designed to give patients’ caregivers short breaks from the stresses of caregiving.⁴³ For patients, the psychological benefits of hospice care can result in physical benefits, such as lower blood pressure, increased efficacy of medications intended to relieve physical pain, and stronger immune systems.⁴⁴

Studies have demonstrated that healthcare professionals fail to recommend hospice care as soon as they could, at least partly because of the confusion resulting from the current payment system’s false dichotomy⁴⁵ between curative and palliative treatment. Nurses, nurse managers, and social workers treating patients with end-stage renal disease, for example, have been shown to be confused about the Medicare rules requiring patients to renounce curative treatment to receive the hospice benefit, and that confusion has affected referrals to hospice care.⁴⁶ One physician has attributed late referral to hospice

39. Cerminara, *Pandora’s Dismay*, *supra* note *, at 117-23. See Elizabeth L. Ciemins et al., *An Evaluation of the Advanced Illness Management (AIM) Program: Increasing Hospice Utilization in the San Francisco Bay Area*, 9 J. PALLIATIVE MED. 1401, 1402 (2006) (“[A]voiding the cost of hospital-based life-saving procedures is not the only issue; more importantly, invasive inpatient care often causes distress, pain and discomfort to patients and their families. Simply stated, hospice is generally a low-cost, high-benefit option.”) (footnote omitted).

40. Cerminara, *Pandora’s Dismay*, *supra* note *, at 119.

41. *Id.* at 121 (emphasis in original) (footnote omitted).

42. “Counseling” is available and reimbursable for both terminally ill patients and their families, as indicated by the inclusion of the following in the list of “covered services”:

Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.

42 C.F.R. § 418.202(d) (2010). A more specific sort of counseling, bereavement counseling, is a required hospice service but it is not reimbursable. 42 C.F.R. § 418.204(c) (2010).

43. 42 C.F.R. § 418.204(b) (2010) (“Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual.”). See also DANIEL R. LEVINSON, INSPECTOR GENERAL, DEP’T OF HEALTH AND HUMAN SERVS., OEI-02-06-00222, HOSPICE BENEFICIARIES’ USE OF RESPITE CARE 2 (2008).

44. Cerminara, *Pandora’s Dismay*, *supra* note *, at 122-23.

45. See *id.* at 111-27, 136-48 (discussing the false dichotomy).

46. Kimberly F. Thompson et al., *Hospice and ESRD: Knowledge Deficits and Underutilization of Program Benefits*, 35 NEPHROLOGY NURSING J. 461, 465 (2008).

care, in part, to the false dichotomy inherent in Medicare's payment structure as well as to "the mistaken view that patients [in hospice] must have a do-not-resuscitate order,"⁴⁷ which could be related to the requirement that patients must renounce curative treatment.

On the patient side as well, having to renounce all curative efforts before Medicare will pay for hospice care may result in patient delay in accessing hospice care even if healthcare professionals have discussed that option in a timely fashion. Elisabeth Kübler-Ross identified five stages of dying, with the final one being acceptance; yet some patients never reach acceptance at all.⁴⁸ To renounce curative treatment would require accepting impending death, so requiring patients to reach acceptance before accessing hospice care, at best, postpones their initial election of Medicare payment for such services.⁴⁹ Due to a variety of cultural influences, some Hispanic and African-American patients may never be willing to renounce curative care, even after they have accepted impending death.⁵⁰ In other words, the current Medicare payment system, which requires Medicare beneficiaries to accept the inevitability of their deaths before Medicare will pay for hospice care,⁵¹ deprives patients of

47. Gail Gazelle, *Understanding Hospice – An Underutilized Option for Life's Final Chapter*, 357 NEW ENG. J. MED. 321, 322 (2007).

48. See generally ELISABETH KÜBLER-ROSS, ON DEATH AND DYING: WHAT THE DYING HAVE TO TEACH DOCTORS, NURSES, CLERGY AND THEIR OWN FAMILIES (40th Anniversary ed., Routledge 2009) (1970) (recognizing the five stages as: denial and isolation, anger, bargaining, depression, and acceptance). See also *id.* at 32 ("Denial, at least partial denial, is used by almost all patients, not only during the first stages of illness or following confrontation, but also later on from time to time."). Of two hundred terminally ill patients Kübler-Ross studied, three attempted to deny they were dying until the very end. *Id.* "If a patient has had enough time . . . and has been given some help in working through the previously described stages, he will reach a stage during which he is neither depressed nor angry about his 'fate.'" *Id.* at 91 (emphasis added). That stage is acceptance. *Id.*

49. See Ciemins et al., *supra* note 39, at 1402 ("Although the hospice benefit can be revoked at any time, this mandatory provision deters many patients and families from electing hospice treatment."); Richard D. Brumley et al., *Effectiveness of a Home-Based Palliative Care Program for End-of-Life*, 6 J. PALLIATIVE MED. 715, 717 (2003) (studying concurrent curative and palliative care at Kaiser Permanente in Southern California). Brumley et al. envisioned the program they were studying as introducing a "hospice philosophy" . . . without the negative connotation of 'giving up' that is often associated with hospice." *Id.* Their study used the term "restorative treatment" in describing the sort of care patients could continue to receive, but in doing so they also noted that "patients do not have to forego curative care for palliative care services." *Id.*

50. See Alina M. Perez & Kathy L. Cerminara, *La Caja de Pandora: Improving Access to Hospice Care Among Hispanic and African-American Patients*, 10 HOUS. J. HEALTH L. & POL'Y 255, 271-81 (2010).

51. See Cerminara, *Pandora's Dismay*, *supra* note *, at 148. See also Brumley et al., *supra* note 49, at 717 (describing the Kaiser Palliative Care Program as introducing a "hospice philosophy" . . . without the negative connotation of 'giving up').

Rules requiring the forgoing of curative treatment to have hospice care covered tend to apply even to patients who do not qualify for Medicare, since many private insurers covering hospice care adopt the same coverage rules. Cerminara, *Pandora's Dismay*, *supra* note *, at 108-09. But see *id.* at 109 n.11 (citing OFFICE OF DISABILITY, AGING & LONG-TERM CARE POLICY,

valuable physical and psychological benefits at a time those benefits could greatly help ease the dying process.

II. CONGRESSIONAL SUPPORT OF CONCURRENT CARE AS A HOSPICE MODEL

Buried within the Affordable Care Act are two provisions that signal congressional support for significantly revising the Medicare payment system for hospice care in a way that could increase patients' access to it.⁵² Specifically, Congress immediately adopted in Medicaid, and moved toward adopting in Medicare, a model of hospice coverage it called concurrent care (also sometimes called 'open access').⁵³ Pursuant to this model, Medicaid pays, and Medicare eventually could pay, for the receipt of concurrent curative treatment and hospice care rather than requiring patients to waive payment for curative treatment to have Medicaid or Medicare pay for their hospice care.⁵⁴ In section 2302, Congress immediately permitted children receiving health care coverage through Medicaid and state Children's Health Insurance Programs to have hospice care covered without their parents waiving payment for curative treatment for their terminal illnesses.⁵⁵ In section 3140, Congress authorized a three-year Medicare hospice concurrent care demonstration program for adults.⁵⁶ At the conclusion of the demonstration program, the Secretary of HHS will provide an independent evaluation to "determine whether the demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in [it]."⁵⁷

U.S. DEP'T OF HEALTH & HUMAN SERVS., HOSPICE BENEFITS AND UTILIZATION IN THE LARGE EMPLOYER MARKET 3 (2000) (noting that only two of nine large employers with benefit plans covering hospice care researchers interviewed used a Medicare-like model)).

52. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3140(a), 2302, 124 Stat. 119, 440, 293 (2010). As previously noted, *supra* text accompanying note 4, the Act addressed hospice care in additional provisions as well. Discussion of those additional provisions, however, is beyond the scope of this Article.

53. See Alexi A. Wright & Ingrid T. Katz, *Letting Go of the Rope – Aggressive Treatment, Hospice Care, and Open Access*, 357 NEW ENG. J. MED. 324, 324 (2007).

54. Patient Protection and Affordable Care Act § 3140(a).

55. *Id.* § 2302. See also, Letter from Cindy Mann, Director, Center for Medicaid, CHIP and Survey & Certification, to State Health Officials and State Medicaid Directors (Sept. 9, 2010), available at http://www.aucd.org/docs/policy/health_care/Hospice%20Care%20for%20Children.pdf. As a joint federal-state program, administration of Medicaid is governed by state law in accordance with federal guidelines; states that cover hospice care through their Medicaid programs generally cover that care in accordance with the same rules Medicare uses. See Cerminara, *Pandora's Dismay*, *supra* note *, at 108-09.

56. Patient Protection and Affordable Care Act § 3140. See also Kevin B. O'Reilly, *Medicare to Test Allowing More Than Palliative Care in Hospice*, AMERICAN MEDICAL NEWS (May 24, 2010), <http://www.ama-assn.org/amednews/2010/05/24/prsb0524.htm>.

57. Patient Protection and Affordable Care Act § 3140(b).

A. Elimination of a False Dichotomy in the Payment Rules

Although Medicare and most private insurers do not pay for it at this time, concurrent care, or the provision of both curative and palliative care at once, is not a new concept. It is difficult to label some care as clearly “curative” rather than “palliative,” and some types of care (for example, chemotherapy and radiation) are curative in some instances and palliative in others. Therefore, providing both at once through a concurrent care model simply eliminates a false dichotomy among types of treatment existing in current law.⁵⁸ Beginning in the early 2000s, a few hospices and healthcare insurers have authorized such simultaneous coverage for both hospice care and curative treatment for terminal illnesses.⁵⁹ Their early efforts merit summary.

In 2004, Aetna developed a two-pronged approach to liberalizing access to hospice care. It “launched a comprehensive case management . . . program targeted specifically to patients with advanced illness and their families,”⁶⁰ while simultaneously “pilot[ing] a benefit design change among [thirteen] large employers that liberalized hospice and respite benefits for seriously ill patients and families.”⁶¹ Through the former program, which it called the Compassionate Care Program, nurse case managers with training in palliative care reached out to those dealing with terminal illnesses, educating patients, families, and caregivers about the disease process, advance directives, sources of community support, pain control, medication management, the possibility of care at home, and the availability of respite care.⁶² Shortly after instituting the Compassionate Care Program, Aetna also began providing expanded hospice and respite care benefits for thirteen large employers.⁶³ Whereas Aetna had only previously covered the cost of hospice care for patients within six months of death (mimicking the Medicare requirement), under this program it began covering such costs for patients within twelve months of death.⁶⁴ Additionally, it permitted “continued receipt of curative treatment while also receiving hospice services,” eliminated limits on the length of stay for inpatient hospice care and on the amount that could be spent on

58. See Cerminara, *Pandora's Dismay*, *supra* note *, at 145-46 (discussing integration of palliative care with routine care for treatment of patients with cancer).

59. See generally Claire M. Spettell et al., *A Comprehensive Case Management Program to Improve Palliative Care*, 12 J. PALLIATIVE MED. 827 (2009) (studying Aetna's comprehensive case management and concurrent benefits approach, beginning in 2004); see, e.g., Wright & Katz, *supra* note 53, at 326-27 (describing a range of such programs); Ciemins et al., *supra* note 39, at 1403 (studying “a home-based palliative care program . . . designed to provide concurrent disease-modifying and comfort care to home health patients with advanced illness in an open community-based system of care”).

60. Spettell et al., *supra* note 59, at 827.

61. *Id.* at 828.

62. *Id.*

63. *Id.*

64. *Id.*

outpatient hospice care, covered fifteen days per year of respite care to benefit patients' families, and covered bereavement services.⁶⁵

Similarly, healthcare providers have attempted to make hospice-like palliative care services available to some patients receiving curative treatment, although they cannot control what costs insurance companies will cover in the same way that an insurer such as Aetna does.⁶⁶ Such provider efforts, sometimes termed "palliative care transition programs," "create a bridge from hospitalization or home health to hospice . . . [by providing] a blended model of care combining palliative with curative practices."⁶⁷ Kaiser Permanente (Kaiser) in Southern California engaged in one of the earliest attempts to marry palliative care with the continuation of curative treatments.⁶⁸ The process was most likely aided by the fact that the same entity provides coverage and care in a staff-model health maintenance organization such as Kaiser.⁶⁹

Kaiser researchers at three medical centers in Southern California believed that "a new continuum must be developed that provides a blended model of care, introducing palliative measures into curative practices."⁷⁰ Therefore, they established what they called the Palliative Care Program to provide the psychosocial and spiritual support of hospice care without requiring patients in the program to forgo curative care.⁷¹ The Palliative Care Program also emphasized relief of physical pain and other physical symptoms associated with the patients' terminal diseases.⁷² Over two years, researchers studied 558 subjects, 210 of whom were designated in the Palliative Care Program and 348 of whom were designated in a comparison group,⁷³ in an effort to demonstrate that such a program would be effective in both satisfying patients' needs and reducing total medical services used during the last months of patients' lives.⁷⁴

At Massachusetts General Hospital in Boston, researchers were convinced that "[t]o have a meaningful effect on patients' quality of life and end-of-life care, palliative care services must be provided earlier in the course of the

65. *Id.*

66. To some extent, health care providers can control whether insurance companies will pay for services they have provided, by choosing how to identify those services when billing for them. Concerns about the patients' insurer not paying for some services they provided did not affect the providers in the Kaiser study, as Kaiser's was a "closed-system managed care organization," which means not only that it "provides an array of services across the continuum of care to its members," Brumley et al., *supra* note 49, at 722, 723, but also that it addresses questions of coverage at the time it decides whether care will be provided.

67. Ciemins et al., *supra* note 39, at 1403.

68. See generally Brumley et al., *supra* note 49.

69. Cf. Spettell et al., *supra* note 59, at 831 (explaining that "[m]anaged care organizations, with case management systems and processes that enable them to communicate directly with physicians and patients, are in a position to facilitate hospice use").

70. Brumley et al., *supra* note 49, at 716 (footnote omitted).

71. *Id.* at 717.

72. *Id.* at 718.

73. *Id.* at 719.

74. *Id.* at 716.

disease.”⁷⁵ To test this hypothesis, they studied the effect on cancer patients of providing “early palliative care integrated with standard oncologic care,” as compared with the effect on cancer patients of standard oncologic care alone.⁷⁶ They randomly assigned patients who had received lung cancer diagnoses likely to lead to death within a year to either a control group, which received standard oncological treatment, or a test group, which received consultations from a palliative care team in addition to the standard oncological treatment.⁷⁷ During the palliative care consultations, “[s]pecific attention was paid to assessing physical and psychosocial symptoms, establishing goals of care, assisting with decision making regarding treatment, and coordinating care on the basis of the individual needs of the patient[s].”⁷⁸

As a final example, health care providers in the San Francisco area created an Advanced Illness Management (AIM) program to serve as “a bridge between curative and comfort care.”⁷⁹ Patients participating in the AIM study had advanced illnesses and were receiving home care, although the majority of them were “not yet eligible or ready for hospice.”⁸⁰ Nurse case managers participating in AIM received training in a variety of palliative care and psychosocial topics⁸¹ before becoming AIM patients’ primary sources of care.⁸² Patients participating in AIM did not have to forgo curative treatment; “[i]nstead, the value of current treatment was discussed, and when appropriate, alternatives were considered.”⁸³

In sum, the concept of concurrent care is not a novel one, as insurers, healthcare providers, and other researchers have studied it, and policymakers have been advocating its use for some time.⁸⁴ The Affordable Care Act’s

75. Jennifer S. Temel et al., *Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer*, 363 *NEW ENG. J. MED.* 733, 734 (2010).

76. *Id.*

77. *Id.*

78. *Id.* (footnotes omitted).

79. Ciemins et al., *supra* note 39, at 1403. See also Harris Meyer, *Changing the Conversation in California About Care Near the End of Life*, 30 *HEALTH AFF.* 390 (2011) (describing same program).

80. Home health nurses universally indicated that they would not be surprised if those patients died within six to 12 months. Ciemins et al., *supra* note 39, at 1405.

81. Specifically, each nurse case manager received eight hours of training covering these areas: the definition and philosophy of palliative care; the AIM program itself; insurance coverage; home care regulations; hospice regulations; AIM’s interfaces with patients and with hospice; “operations, including forms, orders, [and] desired outcomes;” advance directives, advance care planning, “facilitating difficult conversations,” clinical issues regarding death and dying, ethical issues regarding death and dying, pain control and symptom management; and administrative policies relating to these issues. *Id.* at 1404.

82. *Id.*

83. *Id.*

84. See, e.g., Advance Planning and Compassionate Care Act of 2009, H.R. 2911, 111th Cong. § 226 (2009); Healthy American Act, S. Res. 334, 110th Cong. § 452 (2007); H.R. 435, 2009 Gen. Assem., Reg. Sess. (Vt. 2009), available at

authorization of coverage of concurrent care for terminally ill children and establishment of Medicare hospice benefit concurrent care demonstration programs for terminally ill adults will pave the way for the public sector to develop evidence in the same way the private sector has begun to do. Once HHS, particularly the Centers for Medicare and Medicaid Services (CMS), has such data in hand, Congress will be in a better position to consider whether it should amend the law governing the Medicare hospice benefit to cover concurrent curative and palliative care for adults.

B. Benefits to Both Patients and the Health Care System

The Act's immediate authorization of benefits for concurrent curative and palliative care for children and establishment of a concurrent care demonstration program for adults are substantial developments in health care. Eliminating the false dichotomy between curative and palliative treatment is likely very beneficial. First, it is the most efficient path to early hospice care for most patients. Second, removing the dichotomy may encourage hospice utilization among patients in racial and ethnic groups that traditionally have not embraced hospice care.⁸⁵ Moreover, the healthcare system as a whole could benefit because, although it seems paradoxical, providing both curative and palliative care at the beginning of patients' hospice care experiences can reduce overall health care spending near the end of life.⁸⁶

The AIM study⁸⁷ demonstrated that concurrent care led to earlier hospice referrals generally and resulted in a huge increase in the number of African-American patients accessing hospice care. The study included three categories of terminally ill patients: those participating in the AIM program; those receiving the usual care provided by the same pool of home healthcare workers as those providing the AIM services (the Usual Care I group); and those receiving the usual care provided by a different pool of home healthcare workers (the Usual Care II group). Sixty percent more African-American patients participating in AIM than receiving care in the Usual Care I group went into hospice care, and seventy-three percent more went into hospice care than the Usual Care II group.⁸⁸ The percentage of African-American patients in AIM who received hospice care was virtually identical to the percentage of

<http://www.leg.state.vt.us/docs/2010/bills/House/H-435.pdf> (enacted May 18, 2009). See generally Cerminara, *Pandora's Dismay*, *supra* note *, at 146-47 n.209.

85. See Perez & Cerminara, *supra* note 50, at 291; Brad Stuart et al., *CHOICES: Promoting Early Access to End-of-Life Care Through Home-Based Transition Management*, 6 J. PALLIATIVE MED. 671, 677-78 (2003); Haiden A. Huskamp et al., *Providing Care at the End of Life: Do Medicare Rules Impede Good Care?*, 20 HEALTH AFF. 204, 211 (2001).

86. "[G]enerally speaking, foregoing expensive curative treatment in favor of less-intensive hospice services will reduce overall costs." Cerminara Blog, *supra* note 7. It seems that patients who access hospice care earlier may be willing to renounce use of expensive, intensive care earlier overall. See *infra* text accompanying notes 102-114.

87. See generally *supra* text accompanying notes 79-83.

88. Cicmins et al., *supra* note 39, at 1408.

Caucasian patients in that program who received hospice care.⁸⁹ This result stands in stark contrast to general statistics demonstrating a much lower rate of hospice utilization among patients of African-American heritage than among Caucasians.⁹⁰ Whether this finding was attributable to increased knowledge about hospice as an option, or to the elimination of the requirement that curative treatment be renounced,⁹¹ it represented an increase in patient access to the positive physical and psychological benefits hospice care provides.

The Massachusetts General study⁹² showed that terminally ill patients with non-small-cell lung cancer who received early access to palliative care integrated with standard oncologic care lived longer than those who received only standard oncologic care.⁹³ The patients receiving concurrent palliative and curative treatment in that study survived approximately two months longer than did those receiving only curative treatment, even though they generally chose less aggressive care near the end of life than the other group of patients did.⁹⁴ Those patients also demonstrated “clinically meaningful improvements in quality of life and mood,” and they had their resuscitation preferences noted in their medical records more often than patients receiving standard care.⁹⁵ The researchers concluded: “Early integration of palliative care for patients with metastatic non-small-cell lung cancer is a clinically meaningful and feasible care model that has effects on survival and quality of life that are similar to the effects of first-line chemotherapy in such patients.”⁹⁶ While the study had some limitations, “the results nonetheless offer great promise for alleviating distress in patients with metastatic disease and addressing critical concerns regarding the use of health care services at the end of life.”⁹⁷

Acknowledging that there exist “concerns regarding the use of health care services at the end of life”⁹⁸ opens the door to fear about rationing care.⁹⁹ Were concerns about utilization the only rationale for concurrent care, it is

89. *Id.* at 1409.

90. See Perez & Cerminara, *supra* note 50, at 257-58 (also discussing low rates of hospice access among Hispanic patients).

91. Commentators have hypothesized both as possibilities. See Ciamins et al., *supra* note 39, at 1409.

92. See *supra* text accompanying notes 75-78.

93. Temel et al., *supra* note 75, at 739.

94. *Id.*

95. *Id.*

96. *Id.* at 741 (footnotes omitted).

97. *Id.*

98. *Id.*

99. See generally Uwe E. Reinhardt, *End-of-Life Care: Where Ethics Meet Economics*, N.Y. TIMES, ECONOMIX (Aug. 14, 2009, 6:00 AM), <http://economix.blogs.nytimes.com/2009/08/14/end-of-life-care-where-ethics-meet-economics> (describing problems that arise with the development of expensive new medical technologies, including limited accessibility and high costs).

likely that many people would protest. After all, during the debates over health care reform, the mere inclusion of a provision authorizing physician payment for time spent discussing advance directives and other end-of-life issues with patients prompted allegations that the government sought to establish “death panels” to limit care to the elderly and the terminally ill.¹⁰⁰ Nevertheless, it is appropriate to factor resource utilization data into the equation when evaluating concurrent care as a model for hospice care because when Congress originally approved Medicare funding of hospice care, it did so because that care was more cost-effective than aggressive care near the end of life.¹⁰¹

Concurrent care may advance that same goal of cost-effectiveness, as counterintuitive as that seems, for studies indicate that it could save money or at least be budget-neutral. For example, among Aetna beneficiaries participating in the Compassionate Care Program, patient use of hospice care increased greatly, and acute care and critical care utilization decreased.¹⁰² Since acute and critical care cost more than hospice care, the Aetna researchers viewed concurrent care as “financially feasible for health plan sponsors, insurers and Medicare.”¹⁰³ Patients participating in the AIM program in San Francisco¹⁰⁴ entered hospice care at greater rates than those who did not,¹⁰⁵ which is significant in terms of cost because, as noted earlier,¹⁰⁶ hospice enrollment generally correlates to a reduction in hospital expenditures.¹⁰⁷ The patients enrolled in Kaiser’s Palliative Care Program, which compared concurrent palliative and curative care with a control group, used “significantly lower” amounts of acute hospital care and emergency department services; the control group racked up “twice as many emergency department visits and four

100. See, e.g., Kate Snow et al., *Experts Debunk Health Care Reform Bill’s ‘Death Panel’ Rule*, ABC NEWS (Aug. 11, 2009), <http://abcnews.go.com/Health/Wellness/story?id=8295708> (describing the outcry over the then-pending 2009 House health care reform bill). The outcry was so great that advocates withdrew the proposal. See Christi Parsons & Andrew Zajac, *Senate Committee Scraps Healthcare Provision that Gave Rise to ‘Death Panel’ Claims*, L.A. TIMES (Aug. 14, 2009), <http://articles.latimes.com/2009/aug/14/nation/na-health-end-of-life14>. This was so although the idea of paying for such consultations was not a new one. See, e.g., Reinhardt, *supra* note 99 (noting the resemblance between section 1233 and the Medicare End-of-Life Care Planning Act of 2007). This author, for example, proposed such an idea as long ago as 1998. See Kathy L. Cerminara, *Eliciting Patient Preferences in Today’s Health Care System*, 4 PSYCHOL. PUB. POL’Y & L. 688, 696-97 (1998).

101. See Cerminara, *Pandora’s Dismay*, *supra* note *, at 132-33.

102. See Spettell et al., *supra* note 59, at 831.

103. *Id.* at 831-32.

104. See *supra* notes 79-83 and accompanying text.

105. See Ciemins et al., *supra* note 39, at 1407; see also Meyer, *supra* note 79, at 392.

106. See Donald H. Taylor, Jr. et al., *What Length of Hospice Use Maximizes Reduction in Medical Expenditures Near Death in the U.S. Medicare Program*, 65 SOC. SCI. & MED. 1466, 1470 (2007).

107. Ciemins et al., *supra* note 39, at 1402. The AIM researchers intended for further studies to establish causation, rather than correlation, and to determine the economic impact of the program. *Id.* at 1409.

times as many hospital days than the palliative care group.”¹⁰⁸ The cost of care for the patients in the control group thus was almost double that of those in the palliative care group,¹⁰⁹ while the patients in the palliative care group were significantly more satisfied with their care than were the members of the control group after sixty days of service.¹¹⁰

Similarly, an even more robust and recent study confirms that increasing length of hospice stay can decrease the cost of health care for dying patients. Taylor et al. studied more than 11,000 Medicare beneficiaries, 1,819 of whom were using hospice services at the time of their deaths.¹¹¹ They found that hospice use reduced Medicare expenditures by an average of just over \$2,300 per hospice user.¹¹² The study then took into consideration other statistics, such as the amount spent on care immediately prior to those patients’ hospice usage, and their results indicated that terminally ill cancer patients receiving hospice care for 58 to 103 days prior to death would save Medicare about \$7,000 each, while patients who are terminally ill with non-cancer diagnoses would save Medicare about \$3,500 each by receiving hospice care for 50 to 108 days prior to death.¹¹³ The results prompted these researchers to opine that “more effort should be put into increasing short [hospice] stays as opposed to focusing on shortening long ones.”¹¹⁴

In conclusion, promoting earlier initial access to hospice care is a noble goal for a variety of reasons. It facilitates additional psychological and palliative care of dying patients during stages at which such care is more meaningful and valuable than the last few days of life. Additionally, doing so serves the overall goal of cost-effectiveness. Therefore, Congress’s authorization of payment for concurrent care for children and establishment of a study of concurrent care coverage for adults are not likely to increase Medicaid and Medicare care costs overall. While funding concurrent care will increase the length of time most patients would receive hospice care, the statistics indicate that short hospice stays *should* increase, for a variety of psychosocial reasons. Finally, facilitating earlier access to hospice care in this way is likely to result in a decrease in costs associated with aggressive end-of-life interventions.

108. Brumley et al., *supra* note 49, at 721. “In addition, the palliative care group demonstrated statistically significant lower nonacute service use for skilled nursing days and physician office visits.” *Id.*

109. The average cost for the control group was \$14,570, while the average cost for the palliative care group was \$7,990. *Id.*

110. *Id.* at 720.

111. Taylor et al., *supra* note 106, at 1470.

112. *Id.* at 1471, 1474.

113. *Id.* at 1474.

114. *Id.* at 1476.

III. CONGRESSIONAL SUSPICION OF HOSPICES

Even as Congress displayed support for hospice care, it revealed some distrust of hospices in the Act. Section 3132 imposed tighter controls on hospice recertifications as of January 1, 2011; physicians and nurse practitioners may no longer rely on chart reviews, medical records, or reports from aides or others to recertify patients as being terminally ill.¹¹⁵ Rather, they must visit patients in person to recertify them as being terminally ill once those patients' initial 180 days of coverage are over.¹¹⁶ Moreover, hospices with especially high rates of recertification will be subject to 'medical review' of the care they provide to recertified patients.¹¹⁷ These provisions stem from concerns about fraud and abuse that may be valid, but their broad-brush approach could do more harm than good. A more appropriate alternative seems to exist.

A. Well-Founded Suspicions

Congress enacted section 3132 after years of concern over the rising cost of hospice care and agency-level efforts to curb such costs. The Office of Inspector General (OIG) of HHS began studying the hospice benefit in the late 1990s, investigating hospice providers as part of its statutory mission to "protect the integrity" of HHS programs such as Medicare and Medicaid.¹¹⁸ Most recently, OIG urged vigilance in guarding against fraud and abuse in the hospice setting by continuing "to recommend that CMS strengthen its

115. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3132, 124 Stat. 119, 430-32 (2010).

116. *Id.*

117. *Id.* The Secretary of HHS will determine the rate of recertification triggering review, the form of review, and the procedure to be followed during such a review. *Id.*

118. OFFICE OF INSPECTOR GEN., DEP'T OF HEALTH AND HUMAN SERVS., MEDICARE HOSPICE CARE: A COMPARISON OF BENEFICIARIES IN NURSING FACILITIES AND BENEFICIARIES IN OTHER SETTINGS (2007), available at <http://oig.hhs.gov/oei/reports/oei-02-06-00220.pdf> [hereinafter MEDICARE HOSPICE CARE]. During that time frame, the Office of Inspector General, the Health Care Financing Administration, and the Administration on Aging joined forces to "combat fraud, waste and abuse in the Medicare and Medicaid programs" through Operation Restore Trust. Office of Inspector General, Publication of the Medicare Advisory Bulletin on Hospice Benefits, 60 Fed. Reg. 55721, 55721 (November 2, 1995). For examples of the work that resulted from Operation Restore Trust, see generally OFFICE OF INSPECTOR GEN., DEP'T OF HEALTH AND HUMAN SERVS., SPECIAL FRAUD ALERT: FRAUD AND ABUSE IN NURSING HOME ARRANGEMENTS WITH HOSPICES (1998), available at <http://oig.hhs.gov/fraud/docs/alertsandbulletins/hospice.pdf>; OFFICE OF INSPECTOR GEN., DEP'T OF HEALTH AND HUMAN SERVS., MEDICARE HOSPICE BENEFICIARIES: SERVICES AND ELIGIBILITY (1998), available at <http://oig.hhs.gov/oei/reports/oei-04-93-00270.pdf>; Memorandum from June Gibbs Brown, Inspector Gen., Dep't of Health and Human Servs., to Nancy-Ann Min DeParle, Deputy Adm'r, Health Care Fin. Admin. (Nov. 4, 1997) available at <http://oig.hhs.gov/oas/reports/region5/59600023.pdf>; OFFICE OF INSPECTOR GEN., DEP'T OF HEALTH AND HUMAN SERVS., HOSPICE AND NURSING HOME CONTRACTUAL RELATIONSHIPS (1997) available at <http://oig.hhs.gov/oei/reports/oei-05-95-00251.pdf>.

monitoring practices for hospice claims,” especially in nursing facilities.¹¹⁹ The Medicare Payment Advisory Commission (MedPAC), created to advise Congress on Medicare issues,¹²⁰ has expressed similar concern, specifically regarding the potential for fraud and abuse among for-profit hospices.¹²¹ In 2008 and 2009, MedPAC recommended what John Iglehart has described as “substantial changes designed to improve the accuracy of Medicare payments to hospices, increase hospice organizations’ accountability, and ensure greater involvement by physicians in end-of-life care.”¹²²

MedPAC recommended a number of changes to the way Medicare pays for hospice care, two of which relate to increased oversight of providers certifying and recertifying patients as terminally ill, and, thus, eligible for Medicare hospice benefits. One recommendation, which CMS adopted through rulemaking in 2009, was to require physicians and nurse practitioners to provide brief narratives explaining the rationales behind certifications of patients as being terminally ill, rather than signing off on such a conclusion in patients’ medical records without explanation.¹²³ The other MedPAC recommendation, which CMS declined to incorporate into rulemaking,¹²⁴ was the face-to-face encounter requirement that Congress adopted in section 3132 of the Affordable Care Act.¹²⁵

Regulatory and legislative desire for increased accountability stems from a great increase in Medicare spending on hospice care over recent years. “Hospice became a Medicare-covered benefit in 1983 primarily because Congress saw it as cost effective,”¹²⁶ yet it requires more and more resources each year. Between 2000 and 2007, Medicare spending on hospice services increased from \$2.9 billion to about \$10 billion.¹²⁷ In 2008, MedPAC noted that “Medicare spending for hospice is expected to more than double in the next [ten] years . . . and will account for roughly 2.3 percent of overall

119. OFFICE OF INSPECTOR GEN., DEP’T OF HEALTH AND HUMAN SERVS., COMPENDIUM OF UNIMPLEMENTED OFFICE OF INSPECTOR GENERAL RECOMMENDATIONS 23 (2010) [hereinafter COMPENDIUM OF UNIMPLEMENTED RECOMMENDATIONS].

120. *About Medpac*, MEDPAC.GOV, <http://www.medpac.gov/about.cfm>. (last visited Mar. 2, 2011).

121. See Cerminara Blog, *supra* note 7.

122. John K. Iglehart, *A New Era of For-Profit Hospice Care – The Medicare Benefit*, 360 NEW ENG. J. MED. 2701, 2701 (2009) (footnote omitted). See generally Cerminara, *Pandora’s Dismay*, *supra* note *, at 134-35.

123. Medicare Program; Hospice Wage Index for Fiscal Year 2010, 74 Fed. Reg. 39384, 39398 (Aug. 6, 2009) (to be codified at 42 C.F.R. pts. 405 and 418). For background, see Cerminara, *Pandora’s Dismay*, *supra* note *, at 135-36 n.153.

124. Hospice Wage Index for Fiscal Year 2010, 74 Fed. Reg. at 39402.

125. See *supra* text accompanying notes 115-116.

126. Cerminara, *Pandora’s Dismay*, *supra* note *, at 132.

127. Iglehart, *supra* note 122, at 2701-02.

Medicare spending in FY 2009.”¹²⁸ Even if it is an economical form of care,¹²⁹ hospice care consumes a significant amount of resources.

The increasing costs are due both to the growing number of Medicare beneficiaries electing hospice care and to the increased number of days hospice beneficiaries, on average, are receiving hospice care. Between the year 2000 and the year 2008, the percentage of Medicare decedents who had received hospice care rose from twenty-three percent to forty percent.¹³⁰ The provision of hospice care to Medicare beneficiaries increased at an average rate of ten percent per year between 2000 and 2007 and still grew, but at the slower rate of five and a half percent between 2007 and 2008.¹³¹

In roughly this same time period, the number of for-profit hospices in the marketplace for hospice services has increased significantly. Between 2001 and 2008, the total number of hospices in America increased by forty-seven percent, from 2,303 to 3,389.¹³² In that time period, the number of for-profit hospices increased by 128 percent, while the number of not-for-profit hospices increased by only one percent.¹³³ In raw numbers, this translates into an increase of 983 in the number of for-profit hospices, from 765 to 1,748, compared to an increase of thirteen in not-for-profit hospices, from 1,184 to 1,197.¹³⁴

This fact becomes especially interesting when examining MedPAC’s findings about hospices that exceed the aggregate cap on Medicare payments per beneficiary each hospice may receive.¹³⁵ In each of the years between 2002 and 2005, MedPAC determined that more than eighty-four percent of the hospices exceeding the cap were for-profit.¹³⁶ This may be due to patient selection because for-profit hospices treated more patients with non-cancer terminal illness diagnoses, who typically have longer hospice stays than those with cancer diagnoses.¹³⁷ MedPAC has interpreted its data, however, as indicating that, “[a]t the extreme, some hospices may be operating a business model based on extending length of stay in hospice to maximize profitability.”¹³⁸

128. MEDICARE PAYMENT ADVISORY COMM’N, REPORT TO CONGRESS: REFORMING THE DELIVERY SYSTEM 203 (2008) [hereinafter MEDPAC 2008] (citation omitted).

129. See NHPACO Facts and Figures, *supra* note 9, at 11 (citing generally Taylor et al., *supra* note 106).

130. MEDPAC 2010, *supra* note 11, at 145.

131. *Id.* at 149.

132. *Id.*

133. *Id.* at 147. During that time period, the number of hospices owned by the government or others increased by twenty-five percent. *Id.*

134. *Id.* at 149.

135. See generally *supra* text accompanying notes 36-39.

136. MEDPAC 2008, *supra* note 128, at 212.

137. Hospices exceeding the cap treated all patients, regardless of diagnosis, for longer periods of time than hospices that were below the cap. MEDPAC 2010, *supra* note 11, at 151; MEDPAC 2008, *supra* note 128, at 214.

138. Transcript of Presentation at the Medicare Payment Advisory Commission Public Meeting: Critical Evaluation of the Medicare Hospice Benefit at 175 (Nov. 6, 2008),

Correctly or not, the mere incorporation of a hospice as a for-profit entity (at least a publicly traded one) rather than a not-for-profit one tends to raise concerns that the hospice is focused on maximizing profits, perhaps above other goals.¹³⁹ Publicly traded for-profit entities have incentives to both “maximize the wealth of their owners” (shareholders) and “mak[e] financial decisions that are tailored toward improving the highly watched fiscal quarterly earnings.”¹⁴⁰ The results of a study in 2005 “suggest[ed] that hospices owned by publicly traded companies, regardless of their size, are able to earn higher profit margins than either private, for-profit or non-profit hospices.”¹⁴¹ MedPAC has noted that hospices exceeding the cap are more likely to be for-profit, freestanding facilities than are hospices below the cap, although its data does not distinguish between publicly traded and non-publicly traded for-profit entities.¹⁴²

Hospices exceeding the cap also have attracted MedPAC attention because they discharge many patients alive. “In 2007, nearly half . . . of all discharges by above-cap hospices . . . were live discharges, compared with [sixteen] percent in below-cap hospices.”¹⁴³ Given the notorious difficulty of predicting date of death, and patients’ abilities to revoke hospice elections to return to conventional treatment, some live discharges from hospice care are normal.¹⁴⁴ Based on the “substantially higher” live discharge rates of above-cap hospices and their longer average lengths of stay, however, MedPAC has “questions about whether above-cap hospices are admitting patients before they meet the hospice eligibility criteria.”¹⁴⁵

available at <http://www.medpac.gov/transcripts/1106-1107MedPAC%20final.pdf> [hereinafter MedPAC Meeting] (statement of Dr. James E. Mathews).

139. See Barry M. Kinzbrunner, *For Profit vs. Not-for-Profit Hospice: It is the Quality that Counts*, 5 J. PALLIATIVE MED. 483, 483-84 (2002) (discussing differing interpretations of data regarding for-profit hospice providers as compared with not-for-profit hospice providers).

140. Michael J. McCue & Jon M. Thompson, *Operational and Financial Performance of Publicly Traded Hospice Companies*, 8 J. PALLIATIVE MED. 1196, 1198 (2005) (footnote omitted).

141. *Id.* at 1205. See also Emily J. Cherlin et al., *Interdisciplinary Staffing Patterns: Do For-Profit and Nonprofit Hospices Differ?*, 13 J. PALLIATIVE MED. 389, 393 (2010) (finding great variation in interdisciplinary staffing patterns by hospice ownership type but not studying the impact of such staffing differences); Sean M. O’Neill et al., *Paying the Price at the End of Life: A Consideration of Factors that Affect the Profitability of Hospice*, 11 J. PALLIATIVE MED. 1002, 1006 (2009) (finding that for-profit hospices are generally more profitable than not-for-profit hospices, although hospice profitability overall is low); Richard C. Lindrooth & Burton A. Weisbrod, *Do Religious Nonprofit and For-Profit Organizations Respond Differently to Financial Incentives? The Hospice Industry*, 26 J. HEALTH ECON. 342, 354 (2007) (demonstrating that for-profit hospices admit more patients with longer expected lengths of stay than do religious nonprofit hospices).

142. MedPAC 2010, *supra* note 11, at 151, 152 (above-cap hospices are also likely to have smaller patient loads than below-cap hospices).

143. *Id.* at 152. See also *id.* (comparing live discharges for above-cap and below-cap hospices by diagnosis in Table 2E-7).

144. *Id.* at 152.

145. *Id.*

CMS's imposition in 2009 of a narrative requirement for certifying patients as being terminally ill partially addressed MedPAC concerns about whether above-cap hospices were admitting patients before they met hospice eligibility criteria.¹⁴⁶ Requiring face-to-face recertification encounters, as Congress has done in the Affordable Care Act, seems to be intended as a gap-filler in case the narrative requirement does not succeed entirely in preventing hospice providers from admitting ineligible patients. If narrative requirements do not block all improper initial certifications, it seems that Congress believes that tighter controls on recertifications can approach the problem from the other direction, eliminating continuing coverage for patients improperly certified in the first place.

This reasoning may make sense because OIG has produced evidence that hospice providers take insufficient care in documenting certifications and recertifications. In September 2009, it reported the results of a study it undertook of Medicare-funded hospice care in nursing homes in the year 2006,¹⁴⁷ concluding that “[i]n 2006, 82 percent of Medicare hospice claims did not meet one or more coverage requirements.”¹⁴⁸

According to some representatives of the hospice industry, such noncompliance stems from lack of physician engagement.¹⁴⁹ In November 2008, MedPAC heard “anecdotal reports of some hospices never discharging patients for improved prognosis, enrolling patients who had been turned away or discharged by other hospices, disregarding the eligibility guidelines . . . , aggressively marketing to individuals likely to have long lengths of stay, . . . or marketing hospice to patients without mentioning the terminal illness requirement.”¹⁵⁰ One participant in those 2008 hearings, discussing MedPAC's proposal that initial certifications include narratives, indicated that the panelists generally supported increased accountability.¹⁵¹ Therefore, based on industry representatives themselves, it is appropriate to increase accountability by requiring more physician and nurse practitioner engagement in the certification and recertification process.

Moreover, OIG has produced evidence that noncompliance with Medicare requirements and an increase in the number of days of hospice care seem to go hand in hand, at least with respect to hospice care provided in nursing facilities. In 2007, OIG determined that, on average, Medicare beneficiaries' hospice care in nursing facilities cost the government twenty-five percent more

146. *See supra* text accompanying notes 122-25.

147. OFFICE OF INSPECTOR GEN., DEP'T OF HEALTH AND HUMAN SERVS., MEDICARE HOSPICE CARE FOR BENEFICIARIES IN NURSING FACILITIES: COMPLIANCE WITH MEDICARE COVERAGE REQUIREMENTS (2009), available at oig.hhs.gov/oci/reports/oci-02-06-00221.pdf [hereinafter MEDICARE HOSPICE CARE FOR BENEFICIARIES IN NURSING FACILITIES].

148. *Id.* at 10.

149. MedPAC Meeting, *supra* note 138, at 185 (statement of Kim Neuman).

150. *Id.* at 186.

151. The same participant also noted, however, that the panelists “didn't think much of this [improper certification] was going on, if any.” *Id.* at 200 (statement of Dr. Mark Miller).

than Medicare beneficiaries' hospice care in other settings.¹⁵² For the vast majority of patient diagnosis categories, Medicare "beneficiaries in nursing facilities had longer average lengths of stay in hospice care than beneficiaries in other settings."¹⁵³ Most strikingly, sixteen percent of beneficiaries in nursing facilities received hospice care for more than 180 days, as compared with only eleven percent in other settings.¹⁵⁴ On average, beneficiaries in nursing facilities received hospice care for eighty days, as compared with sixty-two days for beneficiaries in other settings.¹⁵⁵ Coupled with OIG's finding that eighty-two percent of claims for Medicare coverage of hospice care in nursing facilities failed to comply with Medicare requirements,¹⁵⁶ it is not a huge leap of logic to infer that longer periods of hospice care may be linked to noncompliance with requirements.

Whether such inadequate documentation stems from negligence or fraud is unclear, and it seems likely that both are present in the system. It is possible, for example, that mere negligence, perhaps due to lack of adequate staffing, underlies some failures to involve all the members of the requisite interdisciplinary team when establishing patients' plans of care.¹⁵⁷ Similarly, it is possible that incomplete plans of care are due to inadvertent errors.¹⁵⁸ More troubling, however, is OIG's finding that in nine percent of claims the election statements patients signed to receive hospice care affirmatively misrepresented the terms of that election.¹⁵⁹

In some nursing facilities, OIG even has discovered claims for payment for respite care that were clearly improper.¹⁶⁰ Medicare may not reimburse hospices for more than five consecutive days of respite care,¹⁶¹ and the vast

152. MEDICARE HOSPICE CARE, *supra* note 118, at 14 (explaining that in 2005, the average amount spent on hospice care per beneficiary in a nursing facility was \$10,631, while the average amount spent on hospice care per beneficiary in other settings was \$8,500).

153. *Id.* at 13 (finding this to be true for fourteen of fifteen diagnosis categories).

154. *Id.*

155. *Id.*

156. While not using the same data set as this one, OIG's finding to that effect was part of the same series of investigations into nursing facility practices. *See* MEDICARE HOSPICE CARE FOR BENEFICIARIES IN NURSING FACILITIES, *supra* note 147, at 2, 10.

157. *Id.* at 13 ("For 34 percent of claims, the plans of care were not established by all of the required members of the interdisciplinary groups.").

An interdisciplinary group, along with the attending physician and the medical director or physician designee, must participate in establishing each patient's hospice plan of care. 42 C.F.R. § 418.58(a) (2008). OIG found that pastoral or other counselors had not participated in establishing patients' plans of care in thirty-one percent of claims. MEDICARE HOSPICE CARE FOR BENEFICIARIES IN NURSING FACILITIES, *supra* note 147, at 13. Social workers did not participate in twenty-two percent of claims. *Id.* Registered nurses did not participate in five percent of claims, and doctors did not participate in two percent of claims. *Id.*

158. *See id.* at 14 ("For 31 percent of claims, the plans of care were missing a necessary component.").

159. *Id.* at 11-12.

160. *See supra* note 43 and accompanying text (defining respite care).

161. 42 C.F.R. § 418.204(b)(2) (2010).

majority of beneficiaries receiving it had it for a *total* of five days or less in 2005.¹⁶² Yet a small number of beneficiaries (fifty-four) received more than five consecutive days during that year, including one beneficiary whose 122 consecutive days of respite care cost the government \$16,726.¹⁶³ Another small number of beneficiaries (sixty-two) reportedly received respite care, which is supposed to be inpatient care designed to give family caregivers a break from caring for their loved ones at home, although those beneficiaries resided in nursing facilities.¹⁶⁴ If patients are in nursing facilities, however, by definition, they are not living at home with caregivers who need to send those patients for a short period of inpatient care to get a break. These claims are suspicious, to say the least, and OIG has referred these providers to CMS for further investigation.

In sum, Congress undeniably has a valid purpose for attempting to ensure that certifications and recertifications are valid. OIG investigations, testimony at MedPAC hearings, and statistics in MedPAC reports indicate that both the agencies closely scrutinizing the industry, and even some industry representatives themselves, are concerned about the potential for fraud and abuse in the present system. Especially when costs are a concern, it seems fair to impose some extra burden on those appropriately providing hospice care, as long as the burden is minimal,¹⁶⁵ to prevent wasting money by reimbursing the costs of care inappropriately provided. The result should free up more money for those appropriately providing care.

B. Possible Negative Effects of the Legislation

As the Act is implemented, legal, regulatory, and medical professionals must be on guard to ensure that efforts to rein in fraud and abuse do not inappropriately chill recertification of patients as being eligible for hospice care. Inadequate documentation and increasing overall lengths of stay may be due to any number of reasons other than fraud and abuse, and some hospices, particularly rural ones, may suffer from the face-to-face encounter requirement.

Not even CMS has found an improper motive in all the noncompliance with Medicare requirements OIG has identified. Based upon the OIG investigations of the 1990s and 2000s, MedPAC made three recommendations to CMS in March 2010. First, MedPAC recommended that CMS should

162. See LEVINSON, *supra* note 43, at 4.

163. *Id.* at 5. OIG referred these cases to CMS for investigation. *Id.* at 6 (noting that “[w]e will provide additional information about these potentially inappropriate cases to CMS in a separate memorandum”).

164. See 42 C.F.R. § 418.204(b)(1) (defining “respite care” as “short-term inpatient care provided to the individual *only* when necessary to relieve the family members or other persons caring for the individual”) (emphasis added). See also LEVINSON, *supra* note 43, at 5-6.

165. CMS, for example, considered whether the narrative requirement it added was “overly burdensome” and concluded that it was not. Medicare Program; Hospice Wage Index for Fiscal Year 2010, 74 Fed. Reg. 39384, 39399 (Aug. 6, 2009) (to be codified at 42 C.F.R. pt. 418).

“educate hospices about coverage requirements and their importance in ensuring quality of care.”¹⁶⁶ Second, MedPAC suggested that CMS “provide hospices with tools and guidance to help them properly demonstrate that coverage requirements are met.”¹⁶⁷ Finally, MedPAC suggested that CMS “strengthen monitoring practices for hospice claims.”¹⁶⁸ In response, CMS focused on education and the provision of tools and guidance, saying with regard to monitoring practices only that it would “instruct Medicare contractors to consider the coverage requirements issues . . . when prioritizing . . . medical review strategies or other interventions.”¹⁶⁹ Although MedPAC continued to press for increased monitoring,¹⁷⁰ CMS seemed to consider most of the problems to constitute negligence or to reflect lack of awareness and education rather than to signal fraud.

The reality is that there are many valid reasons for increased lengths of stay unrelated to either negligence or fraud. For example, length of stay might increase because of a change in the type of patients electing to receive hospice care. At one time, most patients receiving hospice care had terminal cancer diagnoses.¹⁷¹ Over time, however, more and more patients with a wide variety of terminal illnesses have elected to receive hospice care.¹⁷² By the year 2008, for example, patients with a wide variety of terminal illnesses were accessing hospice care, whereas the majority of hospice patients a decade previously had been cancer patients.¹⁷³ An accompanying increase in average amount of time in hospice care, from fifty-four days in the year 2000 to eighty-three days in the year 2008,¹⁷⁴ is at least partially attributable to this change in patient mix.¹⁷⁵ Patients with non-cancer diagnoses experience more acute episodes, causing peaks and valleys in the required levels of care, and thus die less predictably than those with cancer diagnoses, who experience general declines in condition requiring relatively predictable courses of care.¹⁷⁶ Not all studies compare patients of like diagnoses, as the OIG study did when studying

166. COMPENDIUM OF UNIMPLEMENTED RECOMMENDATIONS, *supra* note 119, at 23.

167. *Id.*

168. *Id.*

169. *Id.*

170. *Id.*

171. Iglehart, *supra* note 122, at 2701.

172. *Id.*

173. In 2008, sixty-nine percent of hospice patients had terminal illnesses other than cancer, while only forty-seven percent of hospice patients had non-cancer diagnoses in 1998. *See* MedPAC 2010, *supra* note 11, at 145.

174. *Id.* at 149.

175. *Id.* at 151.

176. *See, e.g.,* Brumley, *supra* note 49, at 716 (noting that “the patterns of morbidity and mortality have shifted toward chronic illness that is marked by episodic needs for higher levels of care and unpredictable disease trajectories”). *See also* MedPAC 2010, *supra* note 11, at 151 (noting that “it may be harder to predict life expectancy” for patients with non-cancer diagnoses).

hospice care in nursing facilities.¹⁷⁷ To the extent that some fail to do so, the studies may be misleading.

Additionally, the increase in for-profit hospices, while perhaps presenting public relations challenges,¹⁷⁸ does not necessarily bring with it an increase in fraudulent activity in hospice care. Even if failure to comply with Medicare requirements in patient documentation causes longer lengths of stay, for-profit hospices apparently do a better job of complying with Medicare requirements than not-for-profit hospices do.¹⁷⁹ Nearly ninety percent of the claims for payment for hospice care submitted by not-for-profit hospices failed to meet Medicare requirements in the OIG study; for-profit hospices failed to comply in a significantly smaller seventy-four percent of their submitted claims.¹⁸⁰

Finally, there exists some risk of ‘throwing the baby out with the bathwater’¹⁸¹ with the recertification requirement. Concerns about administrative burdens surfaced in the 2008 MedPAC hearings¹⁸² and in comments on the proposed regulations in 2009.¹⁸³ In particular, when CMS considered whether to require recertification visits but declined to do so, it described concerns about the lack of physician and nurse-practitioner resources in small and rural hospices.¹⁸⁴ At the time CMS began to require

177. *See supra* text accompanying notes 152-56.

178. Hospice provider VITAS Healthcare Corp., for example, is a for-profit, wholly owned subsidiary of Chemed Corp. and has been used as an example of the contrast between the traditional “image of charitable organizations bringing comfort to the dying” and “big business.” *See Chemed Corp.’s Vitas Unit Aims to Acquire*, CINCINNATI BUSINESS COURIER (July 12, 2010, 12:00 AM), <http://www.bizjournals.com/cincinnati/stories/2010/07/12/story2.html>. Chemed’s other wholly owned subsidiary is Roto-Rooter, Inc., a plumbing and drain-cleaning provider. *See Corporate Profile*, CHEMED CORP., <http://ir.chemed.com/phoenix.zhtml?c=72704&p=irol-homeProfile&t=&id=&> (last visited Mar. 4, 2011). The intermingling between the two industries prompted much laughter at a conference this author attended in June, 2010, thus also justifying the conclusion in the text that VITAS’s status might present some public relations challenges. This is true even though VITAS attempts through its press releases to emphasize its not-for-profit roots. *See Vitas Innovative Hospice Care® Signs National Agreement with American CareSource*, BUSINESSWIRE (Jan. 28, 2010), <http://www.businesswire.com/news/home/20100128006517/en/VITAS-Innovative-Hospice-Care%C2%AE-Signs-National-Agreement> (explaining that VITAS “has evolved from its founding as a volunteer organization by a United Methodist minister and a registered nurse”).

179. MEDICARE HOSPICE CARE FOR BENEFICIARIES IN NURSING FACILITIES, *supra* note 147, at 10.

180. *Id.*

181. The phrase means eliminating the good with the bad. *See* Wolfgang Mieder, “(Don’t) Throw the Baby Out with the Bathwater”: *The Americanization of a German Proverb and Proverbial Expression*, DEPROVERBIO, <http://www.deproverbio.com/DPjournal/DP,1,1,95/BABY.html> (last visited Mar. 4, 2011).

182. MedPAC Meeting, *supra* note 138, at 220-23.

183. *See* Medicare Program; Hospice Wage Scale for Fiscal Year 2010, 74 Fed. Reg. 39384, 39398 (Aug. 6, 2009) (to be codified at 42 C.F.R. § 405) (regarding initial certification narrative); *id.* at 39402-03 (regarding recertification visits).

184. *Id.* at 39403. Some of those commenting suggested that (a) resources would be better-devoted to take steps to improve quality, rather than to simply monitor recertifications more closely, and (b) required recertification visits might only be appropriate for hospices with excessively long lengths of stay, rather than across the board for all Medicare-certified hospices. *Id.*

narratives, it recognized the potential for additional paperwork to become burdensome, and sought to minimize the burden to the extent it could do so and still achieve its goal of increasing accountability with regard to initial certifications.¹⁸⁵ Congress has not similarly narrowly tailored its requirement that face-to-face encounters precede all hospice recertifications.

Rural hospices in particular may be unable to ensure face-to-face encounters for all hospice recertifications. Generally speaking, Medicare *per diem* payments already are lower for rural than for urban hospices,¹⁸⁶ leading some researchers to conclude that “many hospices, especially small rural hospices, are likely to have costs that are not adequately covered by the current Medicare payment system.”¹⁸⁷ Not only are the *per diems* lower, but, in addition, because of low volume, small rural hospices are more likely to have financial difficulty than other hospices because they have fewer patients over which to spread their fixed costs.¹⁸⁸

Staffing challenges abound for rural hospices with low patient volumes because they may not be able to fund full-time positions, and if rural hospices cover large geographic areas they may have difficulty finding staff willing to travel to remote areas.¹⁸⁹ Casey et al. suggest that hospice workers in “resource-poor rural areas” might be especially susceptible to “burnout and compassion fatigue.”¹⁹⁰ All four hospices those researchers studied “identified the distances traveled to patients’ homes as a major challenge to serving rural areas.”¹⁹¹ The hospice workers they studied traveled up to sixty miles one way to serve patients and occasionally went farther to ensure access to hospice care for patients who otherwise would have none.¹⁹² Traveling such distances costs both time and money, affecting not only the hospice worker(s) in question, but also patients whom workers could not visit while traveling to and from their distant patient(s).¹⁹³ The hospices studied also expressed concern about staff safety when traveling in isolated areas and noted that winter weather in some locations made travel more difficult.¹⁹⁴

These challenges for rural hospices counsel caution when imposing additional regulatory burdens on them, no matter how valid the concerns underlying that regulation. The field of palliative care already has experienced its share of negative, unintended consequences from efforts to eliminate

185. *Id.* at 39399-400.

186. Michelle M. Casey et al., *Providing Hospice Care in Rural Areas: Challenges and Strategies*, 22 AM. J. HOSPICE & PALLIATIVE MED. 363, 363 (2005).

187. *Id.* (footnotes omitted).

188. *Id.* at 364.

189. *Id.* at 363.

190. *Id.* The researchers indicated that this was especially likely “when the boundaries between [the hospice workers’] work and personal lives are blurred.” *Id.*

191. *Id.* at 366.

192. Casey et al., *supra* note 186 at 366.

193. *Id.*

194. *Id.*

undesirable activities, as illustrated by the struggle to balance investigation and prosecution of drug diversion with encouragement of appropriate pain relief.¹⁹⁵ Historically, physicians have under-treated pain, prompting efforts in the 1990s to encourage them to appropriately identify, calibrate, and treat it.¹⁹⁶ In the course of trying to improve patients' access to appropriate pain relief, however, those studying the problem of under-treatment of pain realized that the law contributed to the problem. Physicians under-treated pain, at least in part, because they feared prosecutorial and regulatory efforts to counter diversion of prescription pain medications to those abusing drugs.¹⁹⁷ It has taken several years for the message that physicians should do a better job of treating pain to overwhelm the negative chilling effect of much-publicized governmental efforts to eliminate drug diversion, and many physicians have not yet sufficiently overcome their fears to prescribe appropriate levels of pain medications to all patients.¹⁹⁸

With lessons from the history of pain management in mind, legal, regulatory, and medical professionals should be on guard to ensure that the recertification requirement does not chill appropriate access to continued hospice services. Just as drug diversion and abuse investigation and prosecution for years inappropriately have chilled appropriate pain management, there exists a risk that regulatory activity relating to hospice care

195. See CTR. FOR PRACTICAL BIOETHICS ET AL., BALANCE, UNIFORMITY AND FAIRNESS: EFFECTIVE STRATEGIES FOR LAW ENFORCEMENT FOR INVESTIGATING AND PROSECUTING THE DIVERSION OF PRESCRIPTION PAIN MEDICATIONS WHILE PROTECTING APPROPRIATE MEDICAL PRACTICE 3 (Feb. 2009), available at www.fsmb.org/pdf/pub_bbpi_policy_brief.pdf.

196. See generally Ben A. Rich, *The Politics of Pain: Rhetoric or Reform?*, 8 DEPAUL J. HEALTH CARE L. 519 (2005) (recounting the history and identifying policy initiatives intended to encourage appropriate pain relief).

197. See, e.g., Diane E. Hoffmann & Anita J. Tarzian, *Achieving the Right Balance in Oversight of Physician Opioid Prescribing for Pain: The Role of State Medical Boards*, 31 J. L. MED. & ETHICS 21, 25-30 (2003) (describing physicians' responses to study questions about disciplinary investigations and proceedings for over-prescribing opioids); Stephen J. Ziegler & Nicholas P. Lovrich, Jr., *Pain Relief, Prescription Drugs, and Prosecution: A Four-State Survey of Chief Prosecutors*, 31 J. L. MED. & ETHICS 75, 75-76 (2003) (describing physician responses to study questions about their reasons for under-dispensing opioids as part of a study of criminal prosecutions). For recent anecdotal evidence, see John Leland, *A Battle Against Prescription Drugs Causes Pain*, N.Y. TIMES, Oct. 3, 2010, at A22, available at http://www.nytimes.com/2010/10/03/us/03rules.html?_r=1&scp=1&sq=john%20leland%20pain&st=cse.

Concerns about such investigations and prosecutions are only partly to blame for under-treatment of pain. Many cultural factors impact pain management as well. See generally Ben A. Rich, *A Prescription for the Pain: The Emerging Standard of Care for Pain Management*, 26 WM. MITCHELL L. REV. 1 (2000) (identifying and discussing various barriers to appropriate pain management, some cultural and some related to regulatory concerns).

198. See Diane E. Hoffmann, *Treating Pain v. Reducing Drug Diversion and Abuse: Recalibrating the Balance in Our Drug Control Laws and Policies*, 1 ST. LOUIS U. J. HEALTH L. & POL'Y 231, 236 (2008) (tracing the evolution of the problem and suggesting a new standard by which to judge pain control efforts to appropriately balance "the dual goals of pain treatment and reduction of drug diversion and abuse"). See also Leland, *supra* note 197.

also could chill its provision.¹⁹⁹ CMS recognized, as it amended the requirements for initial certifications, that “at recertification, not all patients may show measurable decline.”²⁰⁰ Its statement to that effect suggests that it would agree that it should “not regulate the process such that hospices will be encouraged to discharge patients inappropriately.”²⁰¹ Given the travel challenges and staffing concerns rural hospices face, requiring face-to-face encounters may be quite difficult for that sub-set of hospice providers in particular.²⁰²

C. Better Ways to Address Congressional Suspicion

Additionally, the recertification requirement does not seem to strike at the heart of the problem. Only four percent of the year 2006 claims OIG studied failed to meet certification requirements,²⁰³ with the bulk of coverage requirement deficiencies stemming from missing plan of care requirements,²⁰⁴ improper election advice and documentation,²⁰⁵ and failures to follow plans of care.²⁰⁶ CMS already has increased accountability since that study by, in 2009, requiring narratives supporting initial certifications of patients as being terminally ill within the meaning of the Medicare regulations.²⁰⁷ Especially in

199. Some, for example, have argued that Operation Restore Trust, the OIG initiative to examine hospice referrals to combat fraud and abuse in the 1990s, had a negative, chilling effect on hospice enrollment. See Gerald M. Morris, *Hospice Fraud and Abuse: Operation Restore Trust and Beyond*, 20 AM. J. HOSPICE & PALLIATIVE CARE 1, 5 (2003).

200. Medicare Program; Hospice Wage Scale for Fiscal Year 2010, 74 Fed. Reg. 39384, 39399 (Aug. 6, 2009) (to be codified at 42 C.F.R. pts. 405 & 418).

201. *Id.*

202. It may be that rural hospice providers could convince CMS that use of technology such as Skype to confer with patients is a “face-to-face encounter,” but consideration of whether such technology-mediated communication would or should in fact satisfy the face-to-face encounter requirement is well beyond the scope of this Article. Cf. Catherine Saint Louis, *Should Surgeons Meet Patients Online?*, N.Y. TIMES, Jan. 21, 2010, at E3, available at http://www.nytimes.com/2010/01/21/fashion/21Skin.html?_r=1 (discussing virtual consultations in the plastic surgery field and noting that all the plastic surgeons interviewed noted that they also met in person with the patients in question).

203. MEDICARE HOSPICE CARE FOR BENEFICIARIES IN NURSING FACILITIES, *supra* note 147, at 16.

204. *Id.* at 12. For Medicare to fund hospice care, the hospice provider must establish a plan of care through an interdisciplinary team. Sixty-three percent of claims failed on one or more of the regulatory plan of care requirements. *Id.* at 13.

205. *Id.* at 10. Thirty-three percent of claims failed to meet election requirements. Most seriously, some election statements were misleading, suggesting that beneficiaries might revoke hospice care by exercising their rights to autonomy in treatment decisions rather than explaining that beneficiaries must affirmatively revoke elections in writing. *Id.* at 11-12.

206. *Id.* at 15. Thirty-one percent of claims provided fewer services than the patients’ plans of care had specified. *Id.*

207. Medicare Program; Hospice Wage Scale for Fiscal Year 2010, 74 Fed. Reg. 39384, 39398-39400 (Aug. 6, 2009) (to be codified at 42 C.F.R. pts. 40, 418). See *supra* text accompanying notes 123-25.

the aftermath of CMS doing so, it seems that Congress or HHS could more likely limit fraud and abuse by addressing other documentation deficiencies, rather than strengthening recertification requirements.²⁰⁸

In fact, regulators previously have proposed reforms which are more likely to help than the face-to-face encounter recertification requirement. As long ago as 2008, MedPAC proposed a payment system pursuant to which, rather than reimbursing hospices a consistent *per diem* amount, Medicare would vary them.²⁰⁹ Specifically, MedPAC proposed that Medicare pay higher *per diem* amounts at the beginning and end of patient stays, when patients consume the most resources, but reduce rates for the period in between, when hospices expend fewer resources on patient care.²¹⁰ In 2009, MedPAC again reminded HHS that it had recommended such a payment system, to “better reflect hospices’ level of effort in providing care throughout the course of a hospice episode and promote stays of a length consistent with hospice as an end-of-life benefit.”²¹¹ Such a change in payment methodology, MedPAC urged, would assure that Medicare would not merely become a “*de facto* long-term care benefit” by affecting length of stay.²¹² Specifically, “the new payment system would affect the length of stay by ensuring decisions regarding admissions to the benefit would be made at the appropriate time in the patient’s disease progression.”²¹³ In March 2010, MedPAC again reminded policymakers of that recommendation.²¹⁴ The National Hospice and Palliative Care Organization has supported such a recommendation,²¹⁵ as have scholars of medical and health care economics.²¹⁶

Rather than operating at the margins, seizing on the quick fix of requiring more paperwork at certain points along the way, this revision to the payment system could more precisely provide incentives for appropriate certification and recertification. It is too late now for Congress to adopt this recommendation rather than making recertification requirements more

208. *See generally* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

209. MedPAC Meeting, *supra* note 138, at 177-82 (explaining that while Medicare payment rates are consistent throughout long stays, hospices incur most of the costs at the beginning and end of patient stays).

210. *Id.* at 177.

211. *Report to the Congress: Medicare Payment Policy, Before the H. Subcommittee on Health, Comm. on Ways and Means*, 111th Cong. at 23 (2009), available at http://www.medpac.gov/documents/Mar09_March%20report%20testimony_WM%20FINAL.pdf (statement of Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Comm’n) [hereinafter Statement of Glenn M. Hackbarth].

212. *Id.*

213. *Id.*

214. MEDPAC 2010, *supra* note 11, at 146.

215. Press Release, Nat’l Hospice and Palliative Care Org., National End-of-Life Organizations Release Consensus Statement on Hospice, the Medicare Hospice Benefit, and Key Issues for the Future (Jan. 8, 2009), available at <http://www.nhpc.org/i4a/pages/index.cfm?pageid=5803> [hereinafter NHPCO Press Release] (expressing support for MedPAC recommendation number one).

216. *See, e.g.*, Iglehart, *supra* note 122, at 2703; Lindrooth & Weisbrod, *supra* note 141, at 355; Huskamp et al., *supra* note 85, at 210.

stringent. Instead, Congress has the option to repeal the new recertification requirement and revise Medicare's overall hospice payment structure. Alternatively, it should carefully monitor the effect of the new recertification requirement; should the requirement begin to inappropriately reduce the amount of hospice care patients receive, Congress should amend it to apply only to larger, or larger urban, hospices. Congress can also decide to repeal the recertification requirement and adopt MedPAC's proposed alternative method of achieving its goals. Congress has expressed support for hospice care by indicating that it is open to clearing patients' paths to earlier access through coverage of concurrent care. One can only hope that its desire to guard against fraud and abuse does not end up depriving some deserving patients of hospice care.

In summary, requiring face-to-face encounters not only could affect continued access to hospice care for some patients, but it also might not actually strike at the root of the problem. National hospice organizations have supported increased monitoring in the form of additional documentation because it is difficult to argue that additional oversight is unnecessary.²¹⁷ Appropriately, however, they have warned that "[s]pecial consideration should be given to the unique issues facing rural and small hospice providers in assessing the impact and implementation of such measures."²¹⁸ Other methods for addressing the problem at hand exist, and at least one other proposed method (variable *per diem* rates) would better reflect such consideration for rural and small hospices.²¹⁹

IV. CONCLUSION

The historic changes the Act made to America's healthcare system overall include some revisions to the rules governing payment for hospice care. Congress immediately expanded the number and categories of services for which Medicaid will pay in the case of terminally ill children, and it has set the stage for studies that could provide the evidence supporting Medicare's doing so for terminally ill adults. Congress also, however, revealed a certain level of suspicion about hospices, enacting into law a recertification requirement that CMS had declined to impose through regulations.²²⁰

With respect to that recertification requirement, patients are left to rely on the wisdom and strength of healthcare providers to 'do the right thing' and practice good medicine rather than becoming overcautious and refusing to recertify patients for hospice care when cases are not clear-cut. Where

217. NHPACO Press Release, *supra* note 215.

218. *Id.*

219. See MedPAC Meeting, *supra* note 138, at 177 (statement of Dr. James E. Mathews).

220. See Medicare Program; Hospice Wage Index for Fiscal Year 2010, 74 Fed. Reg. 39384, 39398-99 (Aug. 6, 2009) (to be codified at 42 C.F.R. pts. 405 & 418).

hospices already provide for in-person visits for all recertifications,²²¹ this additional official requirement will make no difference in practice. Where, however, scarce resources have mandated that personnel concentrate on other efforts, this change may affect practice a great deal.

As MedPAC has noted, “[t]he creation of the Medicare hospice benefit was more than just a change to the Medicare benefits package; it was a statement recognizing and respecting social values and patient preferences at the end of life.”²²² In this era of health care reform, regulators should take care not to lessen or eliminate the value of that statement and the effect hospice care can have on patients and their families near the end of life. Given the unpredictability of date of death and the potential effect on rural or small hospice providers, the face-to-face recertification visit requirement deserves careful watch over the next few years following its implementation. If data indicates that deserving patients are not continuing to receive hospice services because of hospice physicians’ and nurse practitioners’ inability to visit them personally to recertify terminal illness, Congress should repeal or amend this requirement, perhaps adopting MedPAC’s suggestion that hospice payments vary over the span of patient care.

221. At one meeting, a hospice physician assured this author that her hospice already did so, long before the Act was passed.

222. Statement of Glenn M. Hackbarth, *supra* note 211, at 22.

