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WHITE PAPER

Preparing For Government Audits:Hospice Services

INTRODUCTION

In the healthcare industry, the Centers for Medicare & Medicaid Services (CMS) maintains a consistent vigilance over providers and their utilization, billing, and claims practices to ensure that the services they pay for are appropriate and in compliance. This vigilance extends to providers within the entire long-term and post-acute care continuum—including hospice services.

This white paper examines hospice services in the context of how providers can stay in compliance with CMS standards and prepare for a possible visit from a RAC (Recovery Audit Contractor) official, the Office of Inspector General (OIG), or even the Department of Justice.

HOSPICE UNDER THE MICROSCOPE

The modern hospice movement came to the United States in the early 1970s, and its utilization has grown swiftly ever since. By the late-1990s, hospice was a respected part of the healthcare landscape and a multibillion dollar industry, with Medicare expenditures reaching $2.2 billion by 1998. The utilization of hospice care and the accompanying Medicare expenditures exploded over the following years—with Medicare payments for hospice service reaching $15.9 billion by 2015.

Throughout this period of dramatic growth, eligibility criteria for the Medicare hospice benefit have remained largely the same. Coverage is available to those who elect palliative treatment (i.e., care focused on pain relief and stress relief) rather than curative treatment, and who have a life expectancy of six months or less.

Patients are entitled to receive hospice care for two 90-day periods, followed by an unlimited number of 60-day periods. At the beginning of each benefit period, an attending physician must certify that the beneficiary is terminally ill, with a life expectancy of six months or less if the disease follows its normal course.

There are four levels of hospice care:

1. Routine Home Care covers basic care services, including nursing and home health services, on either an inpatient or at-home basis.
2. Respite Care is short-term inpatient care intended to relieve the patient's regular caregiver. It is meant for occasional use, and is therefore not reimbursed for more than five consecutive days.
3. General Inpatient Care takes place in a hospice inpatient unit, hospital, or skilled nursing facility (SNF); it is primarily for pain and symptom management that cannot feasibly be provided in other settings.
4. Continuous Home Care is used in times of crisis when pain relief or symptom management requires constant care. Continuous Home Care is covered as necessary to maintain the patient at home or in a nursing facility.

Hospice has been a fixture in the healthcare industry for the past 40 years. So, why have hospices now found themselves in the spotlight? The answer lies in the changing nature of hospice care itself. Hospice originally began as an alternative care setting to serve cancer patients, whose life expectancies could be estimated with a high degree of reliability due to a clear understanding of the progression of their disease. Now, though, hospice services have expanded to include patients with other terminal illnesses, but whose life expectancies cannot be well estimated due to the unpredictability of their diseases. Patients now enter hospice care with conditions such as heart disease, Alzheimer's, and chronic obstructive pulmonary disease (COPD)—and this has equated to significantly longer lengths of stay. For example, in 2013, the conditions with the longest average lengths of stay were neurologic conditions (147 days), debility (116 days), and COPD (113 days). Cancer diagnoses—the original service population for hospice—had the shortest length of stay at 53 days.

Medicare pays a scaled daily rate for hospice care, from $191 for routine care to $960 per day for continuous care

Longer lengths of stay are acceptable if the patient is recertified at the beginning of each benefit period as still likely to die within six months. What raises red flags for OIG and CMS, however, is the fact that longer lengths of stay are of greater financial benefit to the hospice provider. Medicare pays a scaled daily rate for hospice care, from $191 for routine care to $960 per day for continuous care (Base payment rate, FY 2017).

Despite the great difference in the daily payments, hospices actually make a higher profit during routine care days, when reimbursements are the lowest. When more intensive care is required, personnel and related direct costs for care are considerably higher. Thus, a much larger percentage of the Medicare reimbursement goes to offset these costs. But for a longer stay, when care is most intensive at the very beginning and at the very end of the stay, it's the days in between (when little direct care is needed and there are fewer direct costs) that hospice providers make a profit.

In its preliminary research into hospice growth and trends, OIG found evidence that the greatest growth in hospice use and related claims occurred among SNF residents. Between 2005 and 2009, Medicare saw a 70% increase in hospice expenditures among this population, while the number of SNF residents receiving hospice care increased by 40%. In 2009, OIG launched an investigation to examine the degree to which these claims met coverage requirements.

Subsequent studies conducted in 2011, 2013, and 2015, revealed additional findings in regard to hospice use that, taken together with the 2009 study, have placed hospice squarely in the sights of OIG, CMS, and the RACs.

2009: COVERAGE REQUIREMENTS FOR SNF HOSPICE CLAIMS

OIG's 2009 study revealed widespread issues with hospice claims. Not unlike the problems uncovered in their reviews of claims for atypical anti-psychotic drugs (see our white paper "Preparing and Responding to RAC Audits: Atypical Antipsychotics"), documentation was lacking in a majority of claims reviewed. Thus, most of the claims did not meet requirements for reimbursement.

The study found that:

- 82% of SNF hospice claims did not meet at least one Medicare coverage requirement.
- 33% did not meet election requirements, meaning that either the medical record included no election statement at all, that the statements did not explain hospice care is palliative, that statements did not explain that patients waived Medicare coverage of some services related to their illness, or the statements contained misleading information about the right to revoke election of hospice care.
- 63% did not meet plan of care requirements, meaning that no plan of care was included, that the plan of care was not established by an interdisciplinary group, that the plan didn't include required components (like detailed scope of service or frequency of service), or that the plan did not specify intervals for review.
- 31% of claims showed that fewer services were rendered than were outlined in the patient's plan of care, meaning either a fewer number of services were provided or services were not provided as frequently as outlined.
- 4% did not meet certification of terminal illness requirements, meaning that documentation did not specify that prognoses were for life expectancy of six months or less, that the prognoses were not supported by clinical information and documentation, or the certifications were not signed by a physician.

As with other regulatory focus areas, these findings carry the serious implication that a majority of claims are likely erroneous in terms of CMS requirements and are therefore eligible for recoupment by CMS. Worse yet, companies showing persistent errors may be suspected of fraud and abuse. As with other compliance issues, documentation failures may pose a catastrophic financial risk for providers.

2011: HOSPICE UTILIZATION IN SNFS

The 2011 study further showed that 31% of Medicare hospice beneficiaries lived in SNFs. A deeper examination into hospice use among this population raised additional concerns by revealing disparate enrollment and reimbursement trends for SNF residents, particularly among for-profit hospices.

- Industry-wide, 8% (n = 263) of hospices had two-thirds or more of their Medicare patients living in SNFs. These hospices are now known as “high-percentage hospices.”
- Among these high-percentage hospices, 72% were for-profit, while industry-wide, only 56% percent of all hospices are for-profit.
- Industry-wide, for-profit hospices were reimbursed 29% more on average per patient than non-profit providers, and 53% more than government-owned hospices.
- High-percentage hospices received an average Medicare reimbursement of $3,182 more per patient than their lower-percentage counterparts.
- High-percentage hospice patients’ median length of stay was three weeks longer than the median length of stay for typical hospice patients.
- 51% of high-percentage hospice patients had ill-defined conditions, such as Alzheimer’s disease, mental disorders, or COPD as their primary diagnosis, compared to 32% of all other hospice patients.

The OIG's findings raised concern that the high-percentage hospices may be purposely targeting SNF residents with diagnoses that require longer lengths of stay but less complex care—which equates to longer-term Medicare reimbursements and greater profits over time.

2013: HOSPICE INPATIENT UNITS

A May 2013 report also shared information on additional disparities identified by OIG. This time, those disparities involved hospice inpatient units and claims for General Inpatient Care (GIP). GIP is the second most expensive level of care, and is intended to be short-term to manage pain and symptoms when palliation cannot be achieved in other settings.

However, the report shares that length of GIP stays was notably longer in hospice inpatient units than in other settings, including SNFs:

- GIP stays were 50% longer in hospice inpatient units than in hospitals and 20% longer than in SNFs. Hospice inpatient GIP stays averaged 6.1 days, while hospitals had an average GIP stay of 4.1 days, and SNFs had a 4.8 day average.
- 58% of all GIP provided to Medicare beneficiaries occurred in hospice inpatient units; hospitals provided 33% and SNFs provided 8%.
- 35% of Medicare beneficiaries at hospices with inpatient units received GIP, compared to 12% for hospices without inpatient units.

Taken together, the findings of the 2009, 2011, and 2013 studies raise plenty of concerns for OIG and CMS about how hospice care is being delivered, by whom, and to whom.

2015: HOSPICE MISUSE OF GENERAL INPATIENT CARE

A number of instances where Medicare was inappropriately billed by hospices for hospice general inpatient care were discovered during this investigation.

Using data from a medical record review of a stratified random sample of all GIP stays in 2012, the office of the OIG found hospices billed one-third of GIP studies inappropriately. Findings showed care was billed but not provided and some beneficiaries received care they did not need. GIP is the second most expensive level of hospice care; the billing errors cost Medicare $268 million.

- 31% of GIP stays were inappropriate.
- 20% No need for GIP at all during their stay.
- 10% No need for GIP for part of their stay.
- 1% No evidence beneficiary elected hospice or was diagnosed with terminal disease.
- 48% of inappropriate GIP stays were in Skilled Nursing Facilities.
- 9% No need for GIP at all during their stay.
- 31% No need for GIP for part of their stay.

CLAMPING DOWN: OIG RECOMMENDATIONS & IMPLICATIONS

It's not hard to understand why hospices have become a focal point for CMS. In response to its 2009 study, OIG recommended that CMS conduct targeted medical reviews to urge provider compliance with Medicare requirements. The 2011 study provided further guidance on claims that should be targeted by CMS: those from high-percentage hospices and patients with diagnoses related to long stays and less complex care. And the 2013 and 2015 studies shed additional light on concerns from CMS itself that GIP was being misused.

In November 2011, select RACs began reviewing test claims to assess compliance with requirements. OIG work plans from subsequent years continue to include review of hospice issues including inpatient claims, as well as claims for those receiving hospice care in SNFs. In preparation for Fiscal Year 2018, the Department of Health and Human Services (HHS) OIG compiled a list of the top 25 unimplemented OIG recommendations to determine those which would prove most beneficial to HHS in terms of reducing costs while improving program effectiveness, efficiency, and quality.

Recommendations from that list will be a priority for OIG and includes a change in hospice payments to minimize the incentive for hospice agencies to target beneficiaries with particular diagnoses and expected lengthy stays. This was based on the OIG finding that hospices may be targeting beneficiaries that provide the greatest financial incentive. OIG encouraged CMS to consider options that tied specific beneficiary needs to payment rates and improve oversight in areas where billing incentives exist.

DOCUMENT PROACTIVELY

It should come as no surprise that proper documentation is a critical aspect to preventing audits as well as ensuring a successful audit. Since auditors are known to look back three years at cases, it's a good idea to adopt policies and practices around documentation that all staff can comply with.

The best way to initiate something like this is to conduct an assessment of patient records so that you can identify where you are and where you are not meeting CMS requirements. Here are some items to ponder with regard to documentation: Does it fully support the decision for hospice care? Does it clearly outline patient eligibility? Are care plans and evaluations recorded on a consistent basis?

When assessing the appropriateness of hospice services, the RACs and CMS are generally assessing whether:

- Hospice services are reasonable and necessary for the management of the pain and symptoms of the terminal illness.
- The individual elected hospice care.
- A plan of care is established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary groups (IDGs) of the hospice program.
- The plan of care is established before hospice care is provided.
- A certification of the individual's terminal prognosis is completed.

Consider reviewing whether some or all of the following election requirements have been met, including whether:

- A signed election statement is on file;
- The election statement explains that hospice care is palliative, not curative;
- A complete explanation that the beneficiary has waived Medicare coverage of certain services related to their terminal illness; and
- The election statement includes clear language about the beneficiary's right to revoke election of hospice care.

If plan of care requirements have been met, determine whether:

- A plan of care is present;
- The plan of care was established by an IDG whose work with the patient is documented in the medical record;
- The plan of care contains all necessary components, including a detailed description of the services to be provided (including management of discomfort and symptom relief), and scope and frequency of services needed to meet the patient's and family's needs; and
- The plan of care specifies frequency of review by the IDG.

If services requirements have been met, determine whether:

- The hospice provided the number of services described in the plan of care;
- The hospice provided services as frequently as described in the plan of care;
- The medical record contains documentation of all visits for providers of each discipline and for each particular service; and
- The plan of care specifies frequency of review by the IDG.

If certification requirements have been met, determine whether they include:

- Certification that the individual's prognosis is for life expectancy of six months or less, if the illness follows its normal course;
- Clinical information and documentation in the medical record that supports the prognosis; and
- The signature of the attending physician and/or hospice director.

(*Adapted from the National Hospice and Palliative Care Organization's OIG Compliance Audit Tool.*)

CONCLUSION

In general, and for the foreseeable future, OIG and CMS consistently question whether hospices are too broadly applying the concept of "end of life." The reason why: The longer a patient is in hospice care, the better the financial returns for providers. While this may simply be a fact of life in mathematical terms, it has caused both agencies to examine how hospice is being used.

One of the most important ways to avoid audits and undue scrutiny is to assess procedures now and make a commitment to engaging appropriate, dedicated, and knowledgeable consultants and partners that can help you identify what you're doing right and where you may need improvement.

Not to put too fine a point on it, but among the most important things you can do to ward off auditors and ensure appropriate stays is to document, document, document.

Excelas can help you manage your regulatory challenges. Contact us for a quick, no-obligation conversation.

RESOURCES

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