HOSPICE: NO ONE IS SAFE FROM AUDITS

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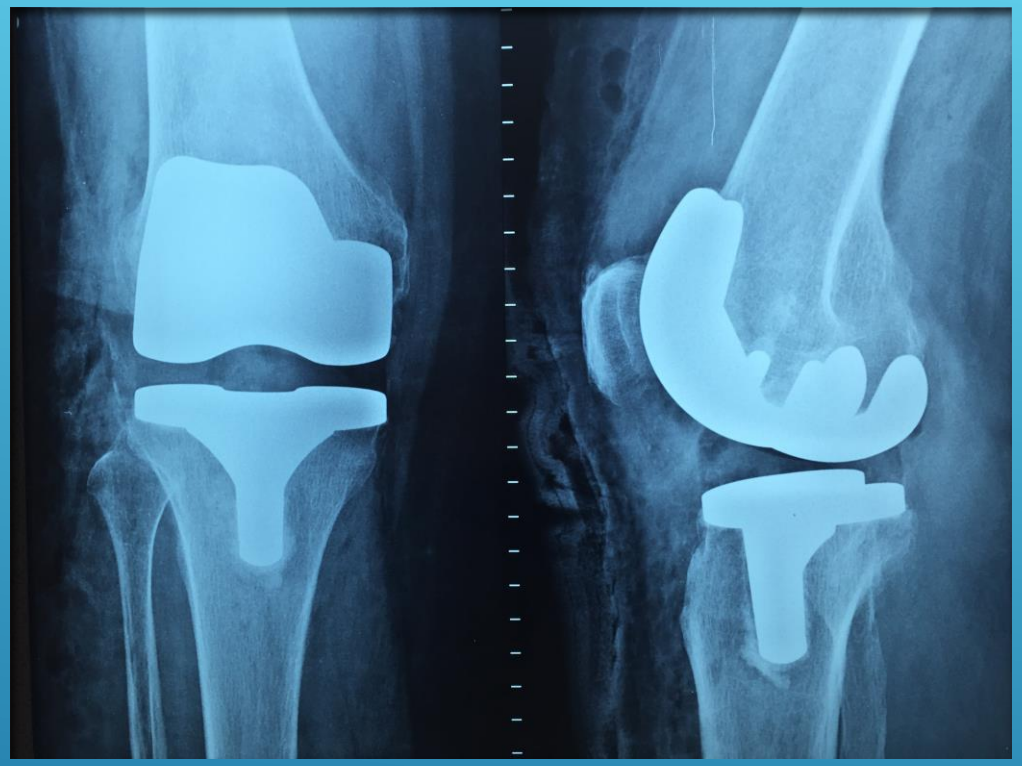


DISCLOSURES

- I have no actual or potential conflict of interest in relation to this presentation.
- Disclosures
  - Consultant: My husband, Matthew Plante, MD, is an orthopedic surgeon consultant for Mitek, a division of Johnson and Johnson
  - His involvement with Johnson and Johnson did not influence this presentation

GOALS

To review the Medicare hospice benefit

- What does it cover?
- Who is eligible?

To highlight the current state of CMS oversight to the program

- As we go through the next 10 slides, note the areas that you think would be most likely to be audited by CMS . . .

WHAT IS HOSPICE?

- Patient-centered, comprehensive, team-based care focused on quality of life
- MEDICARE BENEFIT
  - "Palliative care" is not
- Life expectancy of six months or less if the disease follows its natural course
- Usually goals of care are to focus on comfort and not on life-prolonging treatments.
  - Disease-modifying treatments are no longer beneficial
  - Burdens of disease-modifying treatments outweigh their benefits
- Usually occurs in the patient's home (can be nursing home or assisted living)

HISTORY OF HOSPICE

- Dame Cicely Saunders in England began working with persons at end of life in 1948 and established St. Christopher's Hospice in London in 1967
- 1969 Dr. Elisabeth Kubler-Ross wrote, *On Death and Dying*, in which she advocated for home care at end of life.
- 1972 Dr. Elisabeth Kubler-Ross testified in front of the US Senate Special Committee on Aging
  - "We isolate both the dying and the old, and it serves a purpose. They are reminders of our own mortality. We should not institutionalize people. We can give families more help with home care and visiting nurses, giving the families and patients spiritual, emotional, and financial help in order to facilitate the final care at home"

HISTORY OF HOSPICE

- 1983 United States Medicare hospice benefit was authorized
- Currently hospice services in the United States are reimbursed by most commercial insurance plans, Medicaid, and Medicare
- Hospice programs currently in all 50 states
  - Variable sizes, ranging from only a few patients to over 1500 patient daily censuses
  - Some are free standing; some are affiliated with a hospital system
  - 68% for profit, 28% not for profit, 4% government owned
- 85% of hospice patients have Medicare
- Hospice is only 2-3% of total Medicare expenditures

www.NHPCO.org

- Medicare part A
  - US citizens or legal residents who are eligible for social security
  - Over 65 years or under 65 years but with long term disability for 2 years or greater (with some exceptions, such as ESRD on HD)
- Hospice agency must be Medicare-certified (93% are certified)
- Election statement signed by the patient or Power of Attorney
- Certification by 2 physicians—usually PCP or oncologist/specialist and the hospice medical director
  - Life expectancy is less than 6 months if the disease runs its natural course
  - Must choose a terminal diagnosis (i.e., what you would put on the death certificate)

MEDICARE BENEFIT: WHO QUALIFIES FOR HOSPICE?

MEDICARE HOSPICE BENEFIT

- "Carve out" benefit
  - Patient waives traditional Part A and Part D
- Hospices are paid a *per diem* capitated rate
  - Hospice gets a fixed dollar amount per day per patient
    - Routine hospice care
      - About $193 for hospice days 1-60
      - About $151 for hospice days >60
    - GIP level of care
      - About $744
    - Respite care
      - $173
    - Continuous care
      - $976 (or about $40 per hour)
- https://www.cgsmedicare.com/hhh/claims/fees/hospice_rates.html

HOSPICE: LEVELS OF CARE

- General Inpatient Hospice (GIP)
  - Short term intensified services with **acute** care needs, such as uncontrolled symptoms and/or extensive wound care
  - Depending on local contracts, can be at a hospital, in an inpatient hospice facility, or in a nursing home that has 24 hour skilled nursing
- Continuous care
  - Crisis management
  - Short term increased support in the home setting provided by the hospice team (usually RN) with the goal of keeping the patient at home
  - 8-24 hours in a day
- Respite care
  - Short-term inpatient care to relieve the family/caregiver, such as for travel
  - Limited to 5 days
  - Provided in settings that have contracted with the hospice agency, such as nursing homes, hospitals, hospice facilities
  - Patient liable for 5% copayment if the hospice program chooses to charge for it.

MEDICARE REIMBURSEMENT

- Regular Medicare reimbursement is allowed for medical expenses NOT RELATED to the terminal diagnosis
  - Hospice medical director determines “relatedness”
  - Gray area
- Hospices usually have medication formularies

BENEFITS TO HOSPICE: INTERDISCIPLINARY TEAM

- Hospice nurse
  - Case manager
- Hospice physician
- Primary attending physician
- Social worker
- Chaplain
- Home health aides (limited hours)
- Dietary counseling, PT, OT, speech therapy as deemed appropriate
- Bereavement counselors
- Volunteers

HOSPICE BENEFITS: MEDICARE REQUIREMENTS

- Medical equipment and supplies
  - Oxygen, specialized beds, wound care supplies
- Medications related to the terminal illness
  - Analgesics, anxiolytics, antiemetics, laxatives, etc.
  - Most hospices do not charge copayment but it is allowable by CMS
- 24-hour access to on call nurses and clinicians, 7 days per week
- Bereavement services to families at a minimum of 13 months after the patient has died.

HOSPICE USAGE IS GROWING . . .

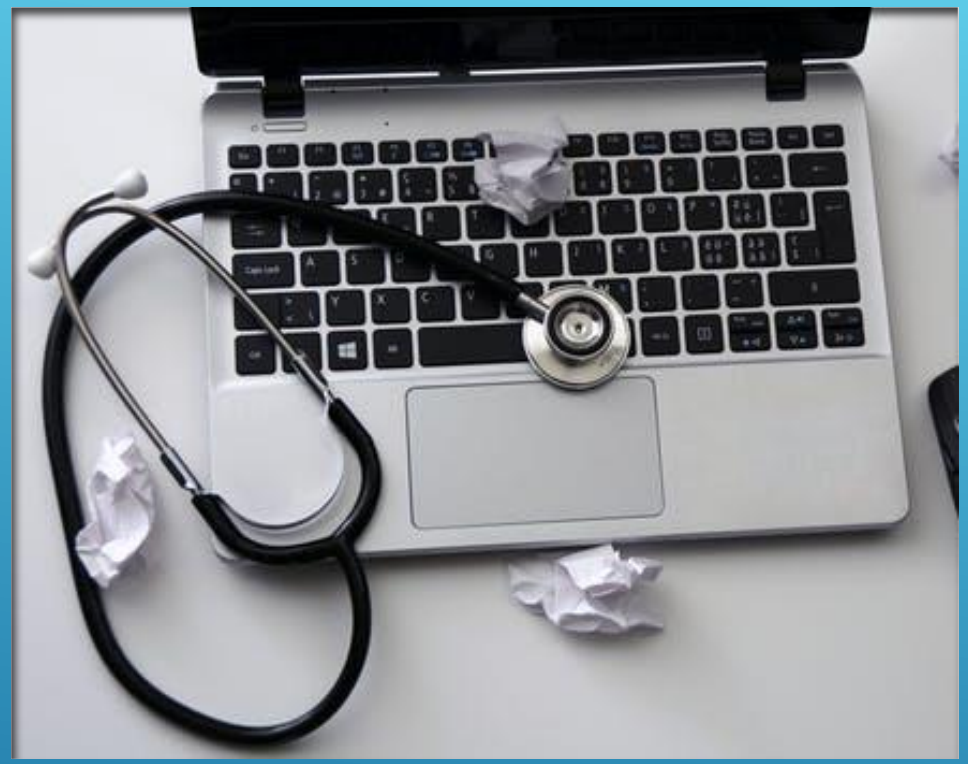
- 2014: 6,100 hospice programs serving 1.6-1.7 million Americans annually
- 2009: 40% of all Medicare decedents used the hospice benefit at some point in their lives
  - 2000: only 23% used the hospice benefit
- 2010: 41.9% of all deaths in the United States were under the care of hospice
  - 1992: 8% of deaths were patients on hospice*

- **INCREASED CMS SCRUTINY AND AUDITS**

*www.NHPCO.org

WHO IS AUDITING?

- The usual alphabet soup of organizations:
  - MAC/ZPICs/RAC/OIG/OAS/UPICs/CERTS
    - MAC: pre payment monitoring
    - Zone Program Integrity Contractors (ZPICs): (gulp) looking for fraud. Pre or post payment. Could issue a 100% prepayment review of claims without notice.
- Same process, same levels of care of audits for level of care



- Face to Face Encounters
- 2011 Affordable Care Act
  - section 1814(a)(7) of the Social Security Act
  - A **hospice physician or nurse practitioner (NP)** must have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient **prior to the 180-day recertification, and prior to each subsequent recertification.**
    - Entering the 2(90) benefit period (180 days on service)
    - Entering each subsequent 60-day benefit period
  - The hospice physician must also attest that such a visit took place and write a brief narrative statement
- Easy area to audit

INCREASED CLINICAL DOCUMENTATION REQUIREMENTS

IMPACT ACT

- Improving Post-Acute Care Transformation (HR 4994)
- Bipartisan bill passed on September 18, 2014 and signed into law by President Obama on October 6, 2014
- Mostly addresses home health agencies, nursing homes, and rehabs
- New hospice rules buried within the legislation

- From NHPCO:
  - "The IMPACT Act, H.R. 4994 moved under a rarely used path, reserved for noncontroversial legislation, in both chambers of Congress. In the House, it was considered 'Under Suspension of the Rules' meaning the bill was raised on the House Floor and if anyone had objected it would have required 2/3 of the House to vote in favor of it to pass. No Member objected, so it passed without a roll call vote. The Senate moved the House bill, H.R. 4994, through "Unanimous Consent." Senators were given advance notice of the bill and if a single Senator had objected, the bill would not have been moved to the Senate Floor for consideration. No Senator objected, so the bill went to the floor for consideration, and was also passed without a roll call vote. Since there was not a roll call vote, you will not know if your Members supported the bill.

- Mandates all Medicare-certified hospices be surveyed at least every 3 years
- Prior to this, mandate was every 6 years
- 2013 OIG found that greater than 15% of hospices were due for their 6 year survey

- Note: hospices also have voluntary accreditation organizations, such as the Joint Commission, ACHC, CHAP, etc.

IMPACT ACT: CMS OVERSIGHT

IMPACT ACT

- Budgeted $70 million over ten years for increased hospice agency supervision
- Suggested that hospices (esp for-profit) were "gaming" the system
  - Highest cost for patient care is right after admission and right before death
  - Suggested that hospices were discharging patients so that the agency would not have to pay for the "costly death"
  - Simultaneously suggested that patients with a long length of stay are not eligible for the hospice benefit

- Organizations with a "high" percentage of patients who have been on service for greater than 180 days will be reviewed.
  - Focus of audits on patients who are recertified.
- CMS sets the threshold, or percentage, that will trigger the medical review.
- PEPPER report
  - Gives the percentage long length of stay patients (either live discharges or deaths)

IMPACT ACT: LONG LENGTH OF STAY

LONG LENGTH OF STAY PATIENTS

- Prognostication is HARD
- LCDs (Local Coverage Determination) for some disease states
  - Need to be sure you are using your state's LCD
    - RI is NGS
  - Some LCDs are out of date
  - Ultimately physician judgment

EXAMPLE LCD FOR DEMENTIAS

- FAST score
  - Fast 7: unable to ambulate, unable to dress or bathe independently, incontinence, no consistently meaningful speech (6 or fewer intelligible words)
- Occurrence of one of the following in the year prior:
  - Aspiration pneumonia
  - Pyelonephritis
  - Septicemia
  - Multiple decubitus ulcers stage 3 or greater
  - Recurrent fever after antibiotics
  - Inability to maintain sufficient fluid and calorie intake with a 10% weight loss during the past 6 months

- Hospice income is related to patient volume
  - Patient volume relies on referrals to hospice
- Area of audit: Financial relationships between hospices and nursing homes/facilities/ALFs
  - Can't pay organizations to send patients to hospice
- Even physicians or members of the hospice's own staff who can influence admissions or recertifications are being scrutinized

HOSPICE AREAS OF RISK: ANTI KICKBACK/REFERRALS

HOSPICE AREAS OF RISK: GIP LEVEL OF CARE

- "HOSPICES INAPPROPRIATELY BILLED MEDICARE OVER $250 MILLION FOR GENERAL INPATIENT CARE" March 2016
- Report by Daniel Levinson, Inspector General from the Dept of Health and Human Services (https://oig.hhs.gov/oei/reports/oei-02-10-00491.pdf)
  - "GIP is the second most expensive level of hospice care and is intended to be short-term inpatient care for symptom management and pain control that cannot be handled in other settings."
  - "We found that hospices billed one-third of GIP stays inappropriately, costing Medicare $268 million in 2012. Hospices commonly billed for GIP when the beneficiary did not have uncontrolled pain or unmanaged symptoms."
  - "Hospices were more likely to inappropriately bill for GIP provided in skilled nursing facilities than GIP provided in other settings. For-profit hospices were more likely than other hospices to inappropriately bill for GIP."
  - "Further, hospices did not meet all care planning requirements for 85 percent of GIP stays and sometimes provided poor-quality care."

HOSPICE AREAS OF RISK: PART D PAYMENT

- We also found that Medicare sometimes paid twice for drugs because they were paid for under Part D when they should have been provided by the hospice and covered under the hospice daily payment rate.

HOSPICE AREAS OF RISK: GIP LOC AND PART D

- WHAT WE RECOMMEND
  - The findings in this report make clear the need to address the misuse of GIP and hold hospices accountable when they bill inappropriately or provide poor-quality care. We recommend that the Centers for Medicare & Medicaid Services (CMS)
  - (1) increase its oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries;
  - (2) ensure that a physician is involved in the decision to use GIP;
  - (3) conduct prepayment reviews for lengthy GIP stays;
  - (4) increase surveyor efforts to ensure that hospices meet care planning requirements;
  - (5) establish additional enforcement remedies for poor hospice performance; and
  - (6) follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor quality care.
  - CMS concurred with all six recommendations.

PART D PAYMENT

- 2012 OIG memo: Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice
  - Hospice covers prescription drugs related to beneficiaries terminal illnesses (covered in the per diem payments), not Part D
  - Analgesics, anti nauseants, laxatives, and antianxiety drugs
  - Also reviewed specifically COPD and ALS
  - Summary: 198.543 beneficiaries received 677,022 prescription drugs through Part D that "should" have been covered by hospice
  - Totaled $33,638,137 in Part D payments and $3,835,557 in copayments
  - Recommended: education, oversight, and requirement of sponsors to develop controls that prevent Part D from paying for drugs that are already covered under the per diem payments
- www.Oig.hhs.gov

- Live discharges
  - Revocation
  - No longer terminally ill
- Long length of stay
- Continuous care
- Routine home care by place of care
  - ALF
  - Nursing facility
  - SNF
- Claims with a single diagnosis coded
- No GIP or continuous home care
- Long GIP stays

OTHER POTENTIAL AREAS OF RISK: PEPPER REPORT

TARGETED PROBE AND EDUCATE

- **October 1, 2017**
- CMS expanded its targeted probe and educate (TPE) program.
- MAC selects providers to submit 20-40 claims for review.
  - If these claims are found to have errors or improper billing and payments, the provider will have the opportunity to correct those issues with the next round of new claims selected for targeted probe and review.
  - Each round of review is called a probe, and providers can be probed up to three times before CMS may take other action, including the potential for 100% prepay review.
- MAC provides education through probes.

EXAMPLES OF AUDITS

- Hospicio Toque de Amor in Puerto Rico
  - May 2016 ZPIC audit (post payment audit)
  - Hospice put on full payment suspension due to findings on FIVE patients due to lack of "medical necessity"
  - Did not have a life expectancy of less than 6 months
    - 3/5 had Alzheimer's disease as an admitting diagnosis
    - 2 had stage 7 Alzheimer's disease but "remained stable"

SAN DIEGO HOSPICE

- Huge hospice that served up to 1000 patients daily
- National founder and leader of hospice care
- Audit in 2012 of charts from 2009-2010
- Alleged to owe the government over $110 million
  - Mostly due to enrolling patients who did not have a 6-month life expectancy
  - Board was told by the CEO that the final would be close to $50 million
- Filed for bankruptcy and closed its doors in 2013
  - DOJ testified in bankruptcy court that the hospice owed $112 million
- Final audit results released in 2014 (a year after bankruptcy) and alleged only $10 million

SUMMARY

- Hospices are not safe from audits
- Areas of risk are related to
  - Eligibility
  - Documentation (Face to Face Encounters)
  - Long Length of Stays
  - Live Discharges
  - General Inpatient Care (GIP)
  - Continuous Home Care (CHC)