

CMS Focuses on OIG Hospice Reports
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On June 8, 2010, The Centers for Medicare and Medicaid Services (“CMS”) held a second in a series of three national outreach sessions to “educate providers and suppliers of specific vulnerabilities that exists in DME, Part A, Part B, and Home Health and Hospice settings related to [Office of Inspector General “OIG” Reports].” In this session, CMS discussed two OIG reports addressing the provision of hospice services to beneficiaries residing in nursing facilities. Brief summaries of these two reports are provided below.

Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements (“Compliance Report”). (OEI-02-06-0021).

The Compliance Report was published by the OIG in September, 2009 and determined the extent to which hospice claims for services provided to hospice beneficiaries residing in nursing facilities in 2006 met the Medicare hospice coverage requirements. The conclusions in this study were alarming and found, in part, that approximately 82% of claims for hospice services provided to nursing facility residents failed to meet one or more Medicare coverage requirements. Citing these findings, CMS said, “[t]he extent to which hospices did not meet coverage requirements raises concerns about the services that Medicare is paying for and the quality of care that hospices are providing to beneficiaries during the last months of life. The results of our review also indicate that CMS’s current oversight procedures are inadequate and that it must do more to ensure that hospices deliver care that meets Medicare requirements. Given the nature of hospices’ non-compliance - *which does not appear to be related to the beneficiaries setting* - these concerns extend to all Medicare beneficiaries receiving hospice care.” *Compliance Report, Pg. 17.*

More specifically, the Compliance Report found:

- 63% of claims did not meet one or more care plan requirements, most commonly being the plans of care were not established by all of the required members of the interdisciplinary group (“IDG”); were missing a necessary component, such as the scope and frequency of services; and/or fewer services were provided than outlined in the hospice plan of care.
- 33% of the claims did not meet one or more election requirements, most commonly being that the election statements failed to adequately explain that hospice is palliative in nature and/or the beneficiaries waived certain other Medicare coverage upon election of the hospice benefit.
- 4% of the claims failed to meet one or more certification requirements, most commonly being the certifications did not specify that the beneficiaries’ prognoses were for life expectancies of 6 months or less if the illness ran its normal course, were not supported by clinical information in the medical record and/or were not signed by the physicians.

As a result of these findings, the OIG made several recommendations to CMS:

1. Educate hospices about the Medicare coverage requirements and their importance in ensuring quality of care, particularly for election statements, plans of care and certifications of terminal illness;
2. Provide tools and guidance to hospices to help them meet the coverage requirements; and
3. Strengthen its monitoring practices regarding hospice claims especially with respect to establishing plans of care, providing services consistent with those plans of care and more frequent certification surveys as a means to enforce these requirements.

CMS agreed with all of the OIG recommendations and further indicated that it would share the Compliance Report with the Recovery Audit Contractors to determine if this is an area that they may wish to conduct claims review.

Memorandum Report: “Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities” (“Memorandum Report”). (OEI -02-06-00223).

Unlike the Compliance Report, the Memorandum Report published by the OIG did not include recommendations. The Memorandum Report provided an updated evaluation of the percentage of Medicare hospice beneficiaries residing in nursing facilities as well as the extent to which certain hospice services were provided. The OIG said, “[t]he results of this memorandum report can help CMS and other decision makers determine whether the types and frequencies of hospice services provided to beneficiaries in nursing facilities meet the goals of the hospice benefit and whether current payment rates are aligned with the hospice services being provided.” *Memorandum Report, Pg. 2.*

The Memorandum Report found, in part, that the percentage of Medicare hospice beneficiaries residing in nursing facilities increased from 28% in 2005 to 31% in 2006 and also cited an earlier OIG report that found that such beneficiaries were more than twice as likely as beneficiaries in other settings to have ill-defined conditions or mental disorders as their terminal diagnosis. The Memorandum Report also reported that 91% of hospice claims for services provided in nursing facilities were for routine home care and 3% for general inpatient care only.

In addition, hospices most commonly provided nursing, hospice aide and medical social services to nursing facility residents and provided an average of 4.2 visits per week for these three services combined. Hospice aide services were furnished for a higher percentage of claims by for-profit hospices than from non-profit hospices, 79% compared to 67%, respectively, while non-profit hospices furnished more volunteer and miscellaneous services than for-profit hospices.

The Compliance Report and the Memorandum Report, in conjunction with the June 8th, 2010 outreach session, illustrate CMS’ and the OIG’s increased scrutiny of the Medicare hospice benefit, particularly the provision of hospice services to residents of nursing facilities, and the significance of the data collected in regards to pending payment reform, quality measures, accountability and the need for additional data collection.

Hospice Outreach Session

CMS discussed the Compliance Report and Memorandum Report (collectively referred to as “Reports”) in its June 8th outreach session (“Hospice Outreach Session”). The outreach sessions in general are a new approach to medical review education by CMS. The ultimate goal of the outreach sessions is to reduce the Medicare payment error rate. This was a listening session only and CMS did not take questions on the call. However, CMS provided a mailbox for listeners to submit questions after the call. CMS said that it will respond to questions either on its website, through its contractors, or directly to the provider that asked the question.

The Hospice Outreach Session started with a brief overview of the Reports by OIG staff followed by CMS clinical staff providing their perspective of how the Reports impact CMS medical review and the implementation of Medicare policies. Nancy Harrison, the OIG Team Leader for Hospice Studies, provided the hospice overview as outlined in the Report summaries above. Ms. Harrison acknowledged the “extreme importance” of hospice services as well as the increasing costs to Medicare for the provision of such services. She also said that she found the results of the Compliance Report “troubling”, not only

in terms of the extent to which the hospice coverage requirements were not met, but also because hospice providers often failed to meet their own standards by not providing services in accordance with the hospice plan of care.

Dr. Jim Cope, a Medical Director with the Medicare Comprehensive Error Rate Testing (“CERT”) program highlighted the continued concerns of both the OIG and CMS regarding the “profusion” of hospice beneficiaries residing in nursing facilities. Dr. Cope said that particular attention will be given to hospice services in these settings. Dr. Cope also pointed out that the Compliance Report looked only at the “technical” issues surrounding hospice care and did not evaluate the eligibility aspect of hospice, which remains “untouched”.

Dr. Cope agreed with the Ms. Harrison that the findings in the Compliance Report are very concerning and how much of the overall failure to meet coverage requirements is related to lack of documentation as opposed to “delinquency” in enforcing CMS regulations is unclear. He is hopeful that many of the adverse findings the Compliance Report are currently being addressed by hospices in light of the new Conditions of Participation. However, Dr. Cope said that the hospice industry will continue to gather “much scrutiny from CMS and the OIG”.

Summary

We can expect to see increased regulatory oversight and scrutiny of the hospice industry for hospice services provided to residents of nursing facilities as well as in all other settings. If you have not already done so, this would be a good time to carefully review your policies and procedures to make sure they are consistent with hospice regulatory requirements and ensure that you carefully and accurately document that your services are being provided in accordance with the Conditions of Participation, Conditions of Coverage and applicable State licensure requirements. Otherwise, you may be jeopardizing your largest revenue stream. You may also want to review your contracts with nursing facilities to ensure that your agreements comply with all state and federal laws and regulations.

Because the facts in each situation may vary, the legal precedents noted herein may not be applicable to individual circumstances. For more information, please contact Michael Hale at 919-761-7078 or mike@michaelhalelaw.com.