Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medicare Hospice Beneficiaries: Services and Eligibility

JUNE GIBBS BROWN
Inspector General

APRIL 1998
OEI-04-93-00270

OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To describe services for and eligibility status of Medicare hospice beneficiaries.

BACKGROUND

Hospice is an approach to caring for a person who is diagnosed as terminally ill. Hospice services are intended to provide comfort and relief from pain, as opposed to curative care. To elect hospice care under Medicare, a beneficiary must be eligible for Part A Medicare. Beneficiaries must also be certified by a physician as being terminally ill, with a life expectancy of 6 months or less if an illness runs its normal course.

Medicare payments for hospice care are based on a capitated amount per day. In 1994, Medicare hospice payments to 1,445 hospice agencies totaled over $1.3 billion. In 1995, 1,726 Medicare-certified hospice agencies received $1.8 billion--a 38 percent increase in funding and a 19 percent increase in agencies. Prior Office of Inspector General (OIG) studies indicated that some hospice agencies may be enrolling beneficiaries who do not meet Medicare's eligibility requirements at the time they are enrolled in hospice.

FINDINGS

Hospice agencies seemed to plan for and provide appropriate services

The hospice agencies that treated the beneficiaries we sampled had developed formal plans of care for 96 percent of the beneficiaries and 93 percent of beneficiary families. In 99 percent of the patient records examined by our medical reviewer, the documentation showed that beneficiaries and their families received services as indicated by the plans of care. Hospice services for both the patient and their family were provided continuously, allowing agency personnel to remain close to a beneficiary and the family on a regular basis throughout the entire course of treatment.

A significant portion of hospice patients in nursing homes were ineligible

We found a significant association between living in a nursing home and being ineligible for the hospice benefit. Twenty-nine percent of sampled hospice beneficiaries in nursing homes were ineligible. However, only 2 percent of beneficiaries not residing in nursing homes were ineligible.

Overall, 7 percent of beneficiaries in our sample were ineligible for hospice care, and 81 percent were eligible. We could not determine eligibility for 12 percent of the beneficiaries.

CONCLUSION

Overall, the Medicare hospice program seems to be working as intended. However, recent OIG work indicated problems regarding eligibility of beneficiaries in specific hospices and raised questions more generally about hospice provided to nursing home beneficiaries. This study adds to our concern about the Medicare hospice program in the nursing home setting. We have no further recommendations to make at this time, but refer the reader to our other reports, which are mentioned in the background section.

AGENCY COMMENTS

The HCFA Administrator reviewed our draft report, and agreed that problems exist with the hospice benefit provided to beneficiaries in nursing homes. She stated that HCFA staff are currently studying the issues involved and working to identify appropriate ways to correct the problems.

The President of the National Hospice Association (NHO) and the Executive Director of the Hospice Association of America (HAA) also commented on our draft report. Both agreed with our finding that, overall, the program seemed to be working well, but some problems exist with hospice care in nursing home settings.

The NHO President expressed concern about the study's description of patients as being ineligible when our reviewers and the patient's attending physician differed in their medical opinions about prognosis of death. He was also concerned that, as a result of continuing OIG scrutiny, hospice services may be underutilized, and hospices may not be enrolling eligible beneficiaries. While we recognize the difficulty of making prognosis of death, we believe that, overall, our study correctly describes both the general success of hospices in service delivery and the program vuneralability in the nursing home area. We certainly do not condone depriving any beneficiary of services to which they are entitled.

The HAA Executive Director requested that we compare the findings of this report to previous OIG audits. Previous OIG audits focused on specific providers. Such results cannot be used to make national projections, and hence cannot be compared to those of our nationally representative sample. However, all previous OIG work has noted special problems with hospice care in nursing homes.

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INTRODUCTION

PURPOSE

To describe services for and eligibility status of Medicare hospice beneficiaries.

BACKGROUND

Hospice Care

Hospice is an approach to caring for a person who is diagnosed as terminally ill. Hospice services are intended to provide comfort and relief from pain, as opposed to curative care. Services are usually rendered in a beneficiary's home.

To elect hospice care under Medicare, a beneficiary must be eligible for Part A Medicare. Beneficiaries must also be certified by a physician as being terminally ill, and have a life expectancy of 6 months or less should a disease runs its normal course. A Medicare hospice beneficiary waives the right to receive curative treatment for their terminal illness, and elects to receive palliative care. A beneficiary selects a Medicare-approved hospice agency to provide medical care and social services. The beneficiary signs a statement choosing hospice benefits in lieu of fee-for-service Medicare benefits. Medicare payments for hospice care is based on a capitated amount per day.

Services provided by hospice agencies include (1) physician services, (2) nursing care, (3) medical appliances, (4) medical supplies, (5) drugs for symptom management and pain relief, (6) short-term inpatient care, (7) home health aide and homemaker services, (8) physical and occupational therapy (9) speech pathology services, (10) medical social services, (11) counseling, (12) bereavement services, and (13) volunteer services. Interdisciplinary teams at hospice agencies plan and monitor beneficiary plans of care. That team typically includes a physician, nurse, home health aide, social worker, and a pastoral counselor.

In 1994, Medicare hospice payments to 1,445 hospice agencies totaled about $1.3 billion. In 1995, 1,726 Medicare-certified hospice agencies received $1.8 billion--a 38 percent increase in funding and 19 percent increase in agencies.

Hospice Benefit Periods, Revocation, and Resumption

Hospice eligibility is divided into benefit periods. The first two benefit periods are 90-days each. Effective with the Medicare Hospice Benefit Amendments of 1997, signed into law on August 5, 1997, the first two benefit periods are followed by an unlimited number of 60-day periods. After each benefit period, a hospice physician assesses a beneficiary's condition to determine if hospice care is still appropriate.

Beneficiaries can revoke their hospice benefits at any time, and return to curative treatment. A hospice agency may discharge a beneficiary if they determine that a beneficiary's condition has stabilized or improved, and the eligibility criteria are no longer met.

Beneficiaries who leave hospice care, by their decision or an agency's decision, and later wish to return to hospice care are admitted into the benefit period following the one they were in at revocation or discharge. For example, beneficiaries who leave in the second benefit period are admitted into the third period if they return to hospice care.

Prior Office of Inspector General Work

In 1994, the Office of Inspector General (OIG) examined medical records of hospice beneficiaries in Puerto Rico to determine eligibility for hospice. We found significantly high eligibility errors. Based on this, the audit effort was expanded to in-depth audits of 12 selected large hospice providers in the Continental United States who had higher than average numbers of long-term patients. The audits found high ineligibility rates among the long-term patients. A disproportionate number of these ineligible patients resided in nursing homes. Findings of those audits are contained in a summary report (A-05-96-00023).

In conjunction with those targeted hospice reviews, additional OIG studies have been conducted in an effort to obtain national data concerning the hospice benefit. One such study examined eligibility, services, and growth in the number of hospice patients living in nursing homes (OEI-05-95-00250). Another report examines contractual relationships between hospices and nursing homes (OEI-05-95-00251). Both studies revealed problems related to hospice care in nursing homes.

METHODOLOGY

Medical Review

We contracted with a medical consulting agency with hospice experience to review medical records of 236 beneficiaries who were enrolled in hospice on June 14, 1996.

First, we used a stratified cluster sample to select 36 hospice agencies. We identified hospices that were Medicare-certified before July 1, 1995. We eliminated hospices from our universe where there was continuing OIG work. In selecting the 36 hospice agencies, we used six strata. One stratum was created for each of the five Operation Restore Trust States[1]. The sixth stratum contained all of the remaining States. From each stratum, we selected six hospice agencies.

[1]In 1995 and 1996, a joint initiative referred to as Operation Restore Trust (ORT) was conducted between OIG, the Health Care Financing Administration (HCFA) and the Administration on Aging. Among its objectives, Project ORT sought to identify vulnerabilities in the Medicare program and develop solutions that would reduce Medicare's exposure to fraud, abuse and waste. Project ORT targeted five States (California, Florida, Illinois, New York and Texas) that account for approximately 40 percent of Medicare expenditures and beneficiaries. ORT projects focused on home health care, nursing home care, durable medical equipment and hospice care.

We asked each of the 36 agencies in our sample for their enrollment roster for June 14, 1996, which was a date approximately 2 weeks prior to our request. From those rosters, we randomly selected the names of up to seven beneficiaries per agency. Some agencies did not have seven beneficiaries enrolled on the specified day. In such instances, we selected all beneficiaries enrolled. Cumulatively, we selected and collected copies of medical records for 243 selected beneficiaries. All agencies responded to our request. However, one agency sent their seven records too late to be reviewed by our medical contractor. Thus, our contractor reviewed a total of 236 records.

The contractor's registered nurses reviewed the 236 records for evidence of the existence of plans of care, of services provided to beneficiaries and their families, continuity of care, and for eligibility and appropriateness of services. The nurses referred 102 of the 236 records for the contractor's physician to review. Those were for beneficiaries that were either in nursing homes or the reviewing nurses had questions about their eligibility.

The physicians examined the services provided, comparing them to the plans of care, and reviewed the medical information to determine if patients were eligible for hospice benefits. To determine eligibility for patients with non-cancer diseases, our contractor used guidelines developed by the National Hospice Organization. The guidelines are to help hospice agencies determine if a non-cancer illness has progressed to within 6 months of death.

We sent the medical records of beneficiaries that the contractor determined ineligible to Regional Home Health Intermediaries (RHHIs) for a second medical opinion on hospice eligibility. RHHIs process Medicare claims for hospice. In this report, we counted as ineligible only those cases where the RHHI agreed with the medical contractor's decision that the patient was ineligible.

All percentages in the report were properly weighted according to each hospice agency's proportion to the universe. Appendix A shows the variance, confidence intervals, and chi-square values. Appendix B shows the unweighted numbers of beneficiaries.

Site Visits

We conducted site visits at 13 of the 36 randomly selected hospice agencies. The agencies were chosen because of their location and ownership. We selected agencies in close proximity to facilitate visiting as many as possible. We also selected a sample of both for-profit and not-for-profit agencies. We visited agencies in each of the five ORT States.

During the site visits, we used a standardized questionnaire. We interviewed hospice directors and other staff about operating practices, staffing, referral sources, and marketing strategies.

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

HOSPICE AGENCIES SEEMED TO PLAN FOR AND PROVIDE APPROPRIATE SERVICES

Hospices Made Plans of Care for Both Beneficiaries and Families

Our medical contractor found formal plans of care developed by the hospices for 96 percent of the beneficiaries and 93 percent of the families.

Typically, when a patient enrolls in hospice, the hospice agency assigns a team of individuals to provide care required by the terminal condition. After a preliminary examination of a patient by a nurse, all members of the team meet to outline a plan of care to specifically meet the physical, emotional, spiritual, and other needs that a patient or family may require.

Services Provided Were Consistent With Plans of Care

In 99 percent of the patient records reviewed by the contractor's physician, there was documentation that showed beneficiaries and their families received services as indicated by the plans of care. The medical contractor's review also showed that in 92 percent of all the sample cases, there was documentation of a periodic re-evaluation of the patient's plan of care by hospice agencies' multidisciplinary teams. In 61 percent of those cases, beneficiary needs did change. In every case except one, the hospice team responded appropriately to the change. The medical reviewers were unable to determine from the other record if the hospice team responded appropriately to the change.

Most Services Were Provided on a Continuing Basis

Hospice regulations require that care to beneficiaries and their families be continuous, or uninterrupted. This requirement recognizes the need for agency personnel to remain close to a beneficiary and the family on a regular basis throughout the entire course of treatment. The medical contractor's review found that hospice agencies provided most services on a continuing basis. However, some beneficiaries do not want all services offered by the hospice agency. For example, a beneficiary who has his own minister may decline spiritual counseling.

A SIGNIFICANT PORTION OF HOSPICE PATIENTS IN NURSING HOMES WERE INELIGIBLE FOR THE MEDICARE HOSPICE BENEFIT

We found a significant association between living in a nursing home and being ineligible for the hospice benefit.[2] Of the 19 beneficiaries found to be ineligible, 10 resided in nursing homes. Of all sampled beneficiaries in nursing homes, 29 percent were ineligible. However, only 2 percent of

[2]Appendix A contains details about statistical tests used.

beneficiaries not in nursing homes were ineligible. The chi-square test shows this difference to be statistically significant. (See appendix A for the confidence intervals.)

Another OIG report (OEI-05-95-000250) discusses in more detail eligibility, services, and growth in the number of hospice patients living in nursing homes. In that study, we found the eligibility error rate for hospice patients in nursing homes to be 19 percent. The confidence intervals of that estimate overlap those of this study, thus confirming a substantial error rate for those patients.

Our medical contractor's physician reviewed records of all 39 beneficiaries in our sample who were living in nursing homes. Table 1 shows the primary diagnosis of each of the 10 ineligible beneficiaries living in a nursing home.

Table 1
INELIGIBLE BENEFICIARIES IN NURSING HOMES

Patient	Primary Diagnosis
1	Paget's Disease (Chronic Inflammation of Bones)
2	Senile Dementia
3	Prostate Cancer
4	Lung Cancer
5	Lung Cancer
6	Anemia, Dementia
7	Congestive Heart Failure
8	Heart Disease
9	Alzheimer
10	Cognitive Dementia

Patient records showed that, overall, 7 percent of beneficiaries were ineligible. Based on 2 different medical reviews, 19 patients, or 7 percent of the beneficiaries in our sample, were ineligible. Our medical contractor found that 81 percent of the beneficiaries were eligible, i.e. had terminal illnesses, and it was reasonable to expect they would die within 6 months. Eligibility for the remaining 12 percent of the beneficiaries could not be determined because beneficiary records did not have sufficient documentation to determine eligibility.

Directors of the hospices we visited said their patients are referred to them by hospitals, physicians, and beneficiary family members. None of the hospices had sales staff, and the hospice directors told us they do not solicit patients. To advertise their services, they have booths at health fairs, and they visit or write hospitals and physicians--primarily oncologists.

CONCLUSION

Overall, the Medicare hospice program seems to be working as intended. However, recent OIG work indicated problems regarding eligibility of beneficiaries in specific hospices and raised questions more generally about hospice provided to nursing home beneficiaries. This study adds to our concern about the Medicare hospice program in the nursing home setting. We have no further recommendations to make at this time, but refer the reader to our other reports, which are mentioned in the background section.

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The HCFA Administrator reviewed our draft report, and agreed that problems exist with the hospice benefit provided to beneficiaries in nursing homes. She stated that HCFA staff are currently studying the issues involved and working to identify appropriate ways to correct the problems.

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The NHO President expressed concern about the study's description of patients as being ineligible when our reviewers and the patient's attending physician differed in their medical opinions about prognosis of death. He was also concerned that, as a result of continuing OIG scrutiny, hospice services may be underutilized, and hospices may not be enrolling eligible beneficiaries. While we recognize the difficulty of making prognosis of death, we believe that, overall, our study correctly describes both the general success of hospices in service delivery and the program vuneralability in the nursing home area. We certainly do not condone depriving any beneficiary of services to which they are entitled.

The HAA Executive Director requested that we compare the findings of this report to previous OIG audits. Previous OIG audits focused on specific providers. Such results cannot be used to make national projections, and hence cannot be compared to those of our nationally representative sample. However, all previous OIG work has noted special problems with hospice care in nursing homes.

We have made the technical changes suggested by HCFA, NHO, and HAA. The full text of their comments can be found in appendix C.

APPENDIX A

VARIANCE, CONFIDENCE INTERVALS

AND CHI-SQUARE VALUES

VARIANCE AND CONFIDENCE INTERVALS

The tables below contain estimates, corresponding standard error, and 90 percent confidence intervals for the findings section of this report.

Hospices Made Plans of Care for Both Beneficiaries and Families

Description	Estimate	Standard Error	Boundaries for 90% Confidence Intervals
Formal Plans of Care developed for beneficiaries	95.61%	3.24	+/- 5.32%
Formal Plans of Care developed for families	93.46%	3.16	+/- 5.20%

Services Provided Were Consistent With Plans of Care

Description	Estimate	Standard Error	Boundaries for 90% Confidence Intervals
Beneficiaries received services as indicated in plan of care	98.72%	.91	+/- 1.50%
Documentation of periodic re-evaluation of plan of care	92.09%	2.77	+/- 4.56%
Beneficiary needs changed during hospice care	61.25%	4.99	+/- 8.21%

Most Services Were Provided on a Continuing Basis

To Patients--

Description	Estimate			Standard Error			Boundaries for 90% Confidence Intervals		
	Yes	No	UTD*	Yes	No	UTD*	Yes	No	UTD
Nursing	94.87%	4.17%	.96%	3.02	3.29	1.04	+/- 4.97%	+/- 5.41%	+/- 1.71%
Aide	84.29%	6.99%	8.73%	8.39	4.48	4.40	+/- 13.80%	+/- 7.37%	+/- 7.24%
Social Work	92.34%	5.69%	1.97%	2.91	3.30	1.33	+/- 4.79%	+/- 5.43%	+/- 2.19%
Spiritual	83.27%	7.11%	9.62%	5.88	3.23	3.31	+/- 9.67%	+/- 5.31	+/- 5.44%
Grief Counseling	70.44%	10.82%	18.74%	3.27	5.54	5.45	+/- 5.38%	+/- 9.11%	+/- 8.97%

*Unable to Determine

To Families--

Description	Estimate			Standard Error			Boundaries for 90% Confidence Intervals		
	Yes	No	UTD*	Yes	No	UTD	Yes	No	UTD
Nursing	92.73%	4.88%	2.39%	2.78	3.22	1.53	+/- 4.57%	+/- 5.30%	+/- 2.52%
Aide	82.01%	8.78%	9.21%	8.29	4.57	4.40	+/- 13.64%	+/- 7.52%	+/- 7.24%
Social Work	91.84%	5.99%	2.17%	2.86	3.31	1.40	+/- 4.70%	+/- 5.44%	+/- 2.30%
Spiritual	83.29%	7.61%	9.09%	5.78	3.12	3.25	+/- 9.51%	+/- 5.13%	+/- 5.35%
Grief Counseling	75.76%	9.03%	15.22%	4.35	5.24	4.88	+/- 7.16%	+/- 8.62%	+/-8.03%

*Unable to Determine

Ineligibles Likely to Reside in Nursing Homes

Description	Estimate	Standard Error	Boundaries for 90% Confidence Interval
Eligible	**80.89%**	**4.92**	**+/- 8.09%**
Ineligible - Overall	**7.21%**	**3.81**	**+/- 6.27%**
- In Nursing Home	29.31%	9.93	+/- 16.33%
- Not in Nursing Home	2.01%	1.30	+/- 2.14%
Could Not Be Determined	**12.10%**	**2.47**	**+/- 4.06%**

CHI-SQUARE VALUES

We computed chi-square values to determine if there was a significant association between living in a nursing home and being ineligible for the hospice benefit. The chi-square values in the table below show that the association between living in a nursing home and ineligibility was significant at the 92 percent confidence level.

Confidence Level	Degrees of Freedom	Chi-Square
92%	2	5.42

APPENDIX B

UNWEIGHTED NUMBERS AND WEIGHTED PERCENTAGES

Numbers and percentages are based on number of responses to each question.

Description	Number of Beneficiaries	Weighted Percent
Formal Plans of Care		
Beneficiary:		
Yes	233	96.51
No	2	4.39
Unable to Determine	0	
Family:		
Yes	223	93.46
No	5	5.50
Unable to Determine	2	1.03
Services Documented in Record[3]		
Yes	99	98.72
No	1	.31
Unable to Determine	2	.97
Periodic Review Documented		
Yes	215	92.09
No	11	7.02
Unable to Determine	3	.89
Change in Patient's Needs		
Yes	137	61.25
No	91	37.34
Unable to Determine	5	1.41

[3]This question was only asked about cases that went to the contractor's physician.

Description	Number of Beneficiaries	Weighted Percent
Overall Eligibility of Beneficiaries		
Eligible	196	80.69
Ineligible	19	7.21
Unable to Determine	21	12.10
Beneficiaries in Nursing Homes		
Eligible	23	45.21
Ineligible	10	29.31
Unable to Determine	6	25.48
Beneficiaries Not in Nursing Homes		
Eligible	169	86.65
Ineligible	9	2.01
Unable to Determine	19	11.33

APPENDIX C

AGENCY COMMENTS

- HCFA
- National Hospice Organization
- Hospice Association of America

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAR 23 1998

IG ✓
EAIG
SAIG
PDIG ✓
DIG-AS
DIG-EC
DIG-EI ✓
DIG-OI
DIG-MP
AIG-LC
OGC/IG
ExecSec
Date Sent 3/25/98

DATE:

TO: June Gibbs Brown
Inspector General

FROM: Administrator
Health Care Financing Administration

SUBJECT: Office of Inspector General (OIG) Draft Report, "Medicare Hospice Beneficiaries: Services and Eligibility," (OEI-04-93-00270)

We reviewed the subject draft report on services and eligibility of Medicare hospice beneficiaries. We recognize the problems with the Medicare hospice benefit provided to beneficiaries in nursing homes discussed in this and several other OIG reports. The Health Care Financing Administration (HCFA) is currently studying the issues involved and we are working to identify the most appropriate way to address these concerns.

We would like to take this opportunity to provide several technical comments:

- In your report, you state that 29 percent of all hospice beneficiaries in nursing homes were in fact ineligible for the benefit. Based on the discussion on page 6, it seems you found 29 percent of those hospice beneficiaries in nursing homes included in the study to be ineligible, as opposed to 29 percent of the entire Medicare hospice population residing in nursing homes. If this is the case, it is not clear in the Executive Summary. We would ask that you provide clarification of this statistic in the Executive Summary.

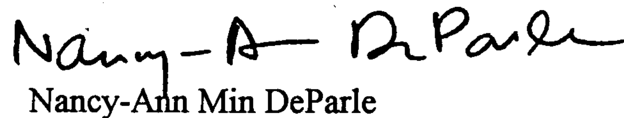
- Current Federal regulations at 42 CFR 418.3 define terminally ill as meaning that the individual has a medical prognosis that his or her life expectancy is 6 months or less should the illness run its normal course. Please make this clarification in the second paragraph under the section entitled, "Hospice Care" on page 1.

- Also, page 1 of the report lists a minister as typically being a member of the interdisciplinary team. We note that other types of counselors can participate in the interdisciplinary team. Federal regulations, at 42 CFR 418.68, require that

either a pastoral or other counselor be a member of the interdisciplinary team. Please clarify that either a pastoral or other counselor is required to participate on the interdisciplinary team.

- On page 2, second paragraph, please add the phrase, "or discharge." at the end of the first sentence.

Thank you for the opportunity to provide comments on this draft report.



Nancy-Ann Min DeParle

January 29, 1998

The Honorable June Gibbs Brown
Inspector General
Department of Health and Human Services
330 Independence Ave., S.W., Room 5246
Washington, DC 20201-0001

Dear Inspector General Brown:

Thank you for the opportunity to review and respond to a draft of the Office of the Inspector General report, *Medicare Hospice Beneficiaries: Services and Eligibility* as developed by the Office of Evaluation and Inspections (OEI). We would also like to express our appreciation for the cooperative efforts of OEI staff provided our office during the development of this report.

The National Hospice Organization (NHO) is pleased that after almost four years of audits and evaluations of hospice care in the United States the Office of the Inspector General has concluded that: "Overall, the Medicare hospice program seems to be working as intended."

NHO is encouraged by the findings that suggest that hospices plan for and provide appropriate services, and was also pleased to see the OIG report that the services provided by hospices were consistent with the plan of care, and that hospices responded appropriately when the patient's condition changed.

NHO was also encouraged by findings showing that hospice services were provided on a continuing basis. Such findings suggest that hospices are establishing close and ongoing relationships with patients and families which can be critical to the transition process that patients and families experience when coping with terminal illness. This finding also strongly suggests that hospices continue to provide appropriate levels of services regardless of the financial incentives to provide fewer or less expensive services.

The National Hospice Organization, however, continues to be distressed by the OIG's characterization of patients being ineligible for the Medicare hospice benefit where differences in medical opinion related to the prognosis of a patient exist between OIG reviewers and the patient's attending physician and hospice medical director. The well-regarded Institute of Medicine has very clearly warned the OIG not to draw conclusions about the veracity of hospice programs based on these differences of medical opinion.

The National Hospice Organization encourages all hospice programs, the physicians working with them as medical directors and attending physicians to establish the most accurate prognosis possible, and to not accept patients into the Medicare hospice benefit who clearly have a prognosis of six months or more if the prognosis runs its normal course. However, NHO will not, as advocates for the needs of the terminally ill, encourage hospices and

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physicians to aspire to a standard where they admit only those patients who they can be 100 percent certain will die within six months. To do so will create an environment in which tens of thousands of people will be denied for days and weeks the care they require and are entitled to as Medicare beneficiaries, and NHO will resist attempts to create such an environment.

NHO believes that an unintentional consequence of the OIG's intense scrutiny of hospices over the past few years, together with an ever-changing and chaotic health care environment has resulted in an underutilization of hospice care. As such, terminally ill Medicare beneficiaries are not receiving the hospice services they need and are entitled to as well as increasing costs to the Medicare Trust Fund. NHO was disappointed that the OIG report did not use this opportunity to comment on the underutilization of hospice care and its harmful impact on beneficiaries and the Trust Fund. As noted in the report: "The mission of the Office of the Inspector General, as mandated by Public Law 95-452, is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them." Surely, this mandate must extend to assisting beneficiaries to identify and receive the services they need, because to do otherwise only serves to diminish their health and welfare.

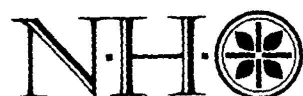
NHO recommends that the industry, the OIG and HCFA work together to determine a methodology for identifying truly aberrant behavior on the part of hospices and physicians in establishing eligibility for the Medicare hospice benefit, and to vigorously pursue any wrongdoers. In this way, the important goal of ferreting out fraud, abuse and waste in the Medicare system can be achieved, but the concern raised by the OIG can be more correctly focused on those that would abuse the system rather than on differences in medical opinion.

The National Hospice Organization also makes the following specific comments:

- As noted, NHO is generally encouraged by the report's findings; however, it must be stated that while the findings may be representative of the population, the reader of this and previous OIG reports should be cautioned to resist accepting the findings of these very limited studies as a perfectly accurate portrayal of the hospice community and expanding the conclusions of these reports to a broader population should be done with an understanding of those limitations.

- In the *Executive Summary* under "Background" the statement should reflect that "Beneficiaries must also be certified by a physician as being terminally ill, and have a life expectancy of 6 months or less if the disease runs its normal course."

- In the *Introduction* section under Services provided...volunteers should be added as a covered service. Number (11) should be changed to "counseling" as dietary counseling is



only one of the required counseling services. The team typically includes a "pastoral counselor" rather than a "minister."

- The statement is made regarding the growth of hospice care in a manner that leaves the impression that such growth is not appropriate. On the contrary, such growth is not only appropriate, it should be expected in a still emerging benefit program. According to HCFA data the increase in expenditures related to this program are being driven primarily by the increase in patients served, not by increased cost per patient. Additionally, this report suggests that hospice patients are generally eligible for the benefits they are receiving and that hospices deliver the services they are obligated to provide.

- In the same introductory section of the report the statement is made that a hospice agency can also revoke care by determining that a beneficiary's condition stabilizes or improves, and hospice care is no longer appropriate. This statement is not altogether accurate. The hospice may discharge a patient from the Medicare hospice benefit if eligibility criteria are no longer met.

- Table 1 of the report identifies the ten ineligible beneficiaries living in nursing homes, and their primary diagnoses. From the report's findings we are unable to determine if comorbidities were considered when the medical contractor determined prognosis. The absence of consideration of these additional factors could have an impact on final determinations of prognosis.

- The final paragraph of the report on page 8 states: "None of the hospices had sales staff, and the hospice directors told us they do not solicit patients. To advertise their services, they have booths at health fairs, and they visit or write hospitals and physicians—primarily oncologists." NHO would object to this statement if it is meant to imply that a "good hospice" is one that limits services to patients with cancer or does not make all reasonable and appropriate efforts to respond to its community's need for access to hospice care.

Responding to issues raised by previous OIG reports, NHO has taken the following actions to improve the delivery of hospice care:

- In the absence of a government or medical community initiative NHO has spent significant resources developing guidelines for establishing terminal prognoses to encourage the referral of patients to hospice care, and to provide attending physicians and hospice physicians the tools to increase their certainty that only appropriate patients are admitted to hospice care.

- NHO has also spent considerable resources and almost a decade in an effort to improve the quality of hospice care provided in the nursing home, and to improve the relationship between the hospice and the nursing home while minimizing the potential for abusive behavior. These efforts have been made with minimal government assistance to clarify the rules governing these relationships.

- NHO has established a Nursing Home Task Force that continues to identify problems and solutions to this complex issue.

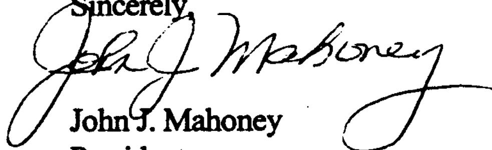
- Despite our differences, NHO has worked closely with the OIG to identify problems and to communicate these issues to hospices.

- NHO is also working closely with HCFA to develop new Medicare Conditions of Participation, including new provisions concerning hospice care provided in the nursing home. We have worked with HCFA and the Regional Home Health Intermediaries on focused medical review, and we are also working with the RHHI Medical Directors to design "Local Medical Review Policies."

- NHO is working with HCFA to develop new cost reports for hospices, and we are hopeful that these new tools will assist the hospice community and the government in making sound policy decisions about the future of the Medicare hospice benefit.

NHO thanks you for your consideration of our comments, and we look forward to working with your office in the furtherance of our common goals.

Sincerely,



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Date Sent 2/10/98

February 10, 1998

The Honorable June Gibbs Brown
Inspector General
Department of Health and Human Services
330 Independence Ave., SW
Room 5246
Washington, DC 20201-0001

Dear Inspector General Brown:

The Hospice Association of America would like to thank you for the opportunity to comment on the draft report, "Medicare Hospice Beneficiaries: Services and Eligibility." We appreciate the positive tone of the report and believe that it is a fair reflection of the hospice industry. We concur that hospices are doing a good job. We also appreciate what appears to be a growing understanding by the Office of the Inspector General (OIG) of the unique constellation of hospice services and how they are delivered; the need to have these services audited by experienced and skilled hospice professionals; and the advisability of selecting and auditing patient records with tools that had been developed and are being used by the industry.

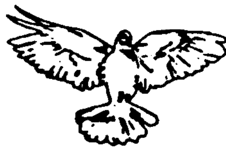
INTRODUCTION
Overall, this draft inspection report accurately describes what we believe to be true about the hospice industry: the "error rate" for determining eligibility for the Medicare hospice benefit is low; hospice agencies plan for and provide appropriate services; and there are problems with the eligibility of hospice patients residing in nursing homes. We commend the OIG for its perseverance in improving the methodology for conducting hospice audits. The industry looks forward to working together with OIG in the development of a model hospice corporate compliance plan that will hopefully eliminate the need for future audits such as ORT. Our comments will focus on the conclusions drawn by this draft report in comparison to previous reports issued by OIG since the reader is referred to those reports for recommendations.

REVIEW OF HOSPICE INDUSTRY RESPONSE TO FRAUD, WASTE, AND ABUSE
The examination of hospices began in 1994 in Puerto Rico and soon expanded into focused medical review (FMR) by the Regional Home Health Intermediaries (RHHI), followed by Operation Restore Trust (ORT), a joint initiative of OIG, the Health Care Financing Administration (HCFA), and the Administration on Aging. Throughout this period of time the hospice industry responded quickly and vigorously by emphasizing policies of zero tolerance for fraud, abuse, and waste; developing and expanding a set of medical guidelines for non-cancer diagnoses (*Medical Guidelines for Determining Prognoses in Selected Non-Cancer Diseases*); providing national, regional, and local educational programming; and working in cooperation with OIG, HCFA, RHHIs, and state surveyors. At the present time RHHIs are in the process of implementing hospice local medical review policies (LMRP), which were developed by HCFA and based on the industry's *Medical Guidelines*. The purpose of the LMRP is to assist RHHIs in claims review as well as provide guidance for hospice programs in appropriately enrolling and recertifying patients. In addition the two national organizations representing hospice providers, HAA and the National Hospice Organization (NHO) are developing a model hospice corporate compliance plan (CCP) in conjunction with OIG.

COMMENTS
Auditing of hospices under ORT began in early 1995 and examined medical records between the period January 1993 and the first quarter of 1996. Problems of hospice programs identified in earlier reports included: determining eligibility for enrollment in the Medicare hospice benefit; nursing home patients receiving hospice services; marketing strategies; and weak internal controls in the areas of physician certifications, claims processing, and medical and cap report reviews at the RHHI. There were specific recommendations addressing these identified problems, including:

- Reinforcing the six-month prognosis requirement;
- Prohibiting hospices from paying nursing homes more for room and board than the hospices receive from Medicaid;
- Ensuring that hospice marketing materials prominently feature Medicare eligibility requirements; monitoring the use of sales commissions as incentives for patient recruiting;
- Requiring physician certification forms contain a statement concerning the penalties for false claims;
- Requiring RHHIs to place more focus on front-end reviews and nontraditional, suspect, or exceedingly vague diagnoses;
- Seeking legislative change to the hospice cap; requiring RHHIs to establish audit procedures for cap reports; and
- Seeking legislative amendment to change the reimbursement for dually eligible hospice nursing home patients.

This draft report, "Medicare Hospice Beneficiaries: Services and Eligibility," which reviewed medical records of beneficiaries who were enrolled in hospice on June 14, 1996, reflects an apparent increased sophistication on the part of hospices in terms of enrollment practices, documentation, and provision of services. It would be helpful for the report to comment on the earlier concern of high eligibility errors for hospice patients not living in nursing homes and if OIG believes this continues to be problematic.



An analysis of the difference in eligibility errors between the reports would help direct future activities regarding OIG recommendations that would: require HCFA to reinforce the six-month prognosis; modify physician certification forms; require RHHIs to place more focus on front-end reviews and nontraditional, suspect, or exceedingly vague diagnoses; and seek legislative changes for the hospice cap amount. These recommendations may no longer be appropriate given the operational improvements within the hospice industry.

The report indicates that all of the hospice patients and their families, including patients residing in nursing homes, had formal plans of care and received appropriate services, all of which were appropriately documented in the patient's medical record. It would be helpful for the report to comment on the differences between the results of this audit and earlier ones, particularly in light of an OIG recommendation to seek a legislative amendment to reduce the payment for dually eligible hospice patients residing in nursing homes.

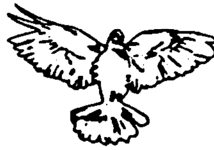
The report does corroborate the problems previously identified with nursing home residents enrolled in hospice programs as they relate to eligibility errors. Reinforcing the recommendations regarding marketing materials and prohibiting the practice of paying nursing facilities more for room and board than hospices receive from Medicaid would seem to be appropriate actions to combat this problem. As an alternative to prohibiting excessive payments for room and board, we recommend that federal statute be changed to require Medicaid room and board payments be made directly to the nursing facility rather than passing through the hospice.

CONCLUSION

HAA, along with the hospice industry, commends OIG for the work it has done in helping eliminate fraud, waste, and abuse from Medicare and Medicaid programs. We are particularly pleased that this report helps to "set the record straight" and paints a more realistic picture of what hospice looks like in the US. Regarding concerns about hospice services provided in nursing homes, we reiterate what we have said in previous correspondence with OIG: hospice services should not be denied to eligible nursing home residents, regardless of income status. We do support the idea of further study and analysis for the development of a reimbursement formula that accurately reflects the costs of hospice services provided to hospice patients residing in nursing homes.

HAA is committed to establishing a national hospice financial data base. To this end we conducted a pilot study in 1997 using HAA's *Hospice Financial Record Keeping Manual*, which is a hospice cost report that has been distributed to several hundred hospices around the country. We are now preparing to launch the second study in mid-1998. The number of participating hospices will be increased, and the cost report will be updated to allow hospices to track their nursing home program costs. This tool will give hospices the ability to compare their nursing home costs with home-based costs within their own programs as well as benchmark with national data. We believe that this information will help hospices ensure that they are providing appropriate services across all sites of care, including services provided to hospice patients residing in nursing facilities.

On another, more global note, we would like to comment on the statutory requirement for a six-month prognosis.



The hospice industry, along with hundreds of other interested organizations, foundations, and individuals, are committed to continuing the quest of improving care at the end of life. The Medicare hospice benefit by statute can only provide services for those who have a certifiable prognosis of six months or less, which in reality translates to the last few days or weeks of life. Hospice care is therefore a relatively small part of the continuum of care required by seriously ill people to ensure that the last chapter of their lives is free from pain and can be lived to its fullest.

The latest HCFA statistics report the national average length of stay for a Medicare beneficiary has dropped and is now under 54 days. Our experience of the last few years tells us that the "art" and "science" of prognostication are not exact and prone to a high rate of error. It would seem to be unwise and even inhumane to support a system that focuses on error-free prognoses of six months or less to allow access to the holistic, patient and family-centered care hospice provides. We are striving to find a better indicator to trigger hospice care and at the same time find ways to work with other providers so that those in need of end-of-life care will not be lost. We will also continue to educate hospices about the law as it exists today, encourage the implementation of CCPs, and work to eliminate fraud, waste, and abuse.

Thank you again for allowing HAA to comment on this draft report. We look forward to continuing our work with your office.

Sincerely,

Diane H. Jones
Executive Director

DHJ:lj

cc: George F. Grob
Deputy Inspector General
Office of Evaluations and Inspections