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## CLIENT ADVISORY

### September 2009 Findings on Hospice Claims in Nursing Facilities Meeting Medicare Coverage Requirements and Changes That Could Be On the Way

#### Background

The hospice benefit allows a Medicare beneficiary with a terminal illness to forgo curative treatment for the illness and instead receive palliative care.<sup>1</sup> The number of Medicare beneficiaries receiving hospice care has risen dramatically from 580,000 in 2001 to 939,000 in 2006.<sup>2</sup> In response, Medicare spending on hospice care nearly tripled over that time to from \$3.6 billion in 2001 to \$9.2 billion in 2006.<sup>3</sup>

Some studies suggest that the use of hospice care has grown most rapidly in nursing facilities.<sup>4</sup> Questions have also been raised about the hospice benefit for nursing home residents, with suggestions that payment levels for hospice care in nursing homes may be excessive.<sup>5</sup> In response to such a rapid increase in hospice care payments by Medicare and the particular concerns with the payments going to nursing homes, the Department of Health and Human Services (DHHS) conducted a study, finalized in September 2009, to determine the extent to which hospice claims for Medicare beneficiaries in nursing facilities in 2006 met Medicare coverage requirements.<sup>6</sup> Contained in the report are DHHS's findings along with specific recommendations to the Centers for Medicare & Medicaid Services (CMS) for how to deal with the compliance problems highlighted by the study. Contained in the report are DHHS's findings along with specific recommendations to the Centers for Medicare & Medicaid Services (CMS) for how to deal with the compliance problems highlighted by the study.

#### Findings of the Study

<sup>1</sup> OIG, "Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements," OEI-02-06-00221, September 2009, at 1 [hereinafter "OIG Report"].

<sup>2</sup> *Id.* at 1.

<sup>3</sup> Centers for Medicare & Medicaid Services (CMS), "Medicare Hospice Expenditures and Units of Care," available online at [http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/downloads/FY05update\\_hospice\\_expenditures\\_and\\_units\\_of\\_care.pdf](http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/downloads/FY05update_hospice_expenditures_and_units_of_care.pdf). Accessed October 1, 2009; CMS analysis of Medicare Health Care Information System data for calendar year 2006 claims. Provided by CMS on May 5, 2009.

<sup>4</sup> Government Accountability Office (GAO), "Medicare Hospice Care: Modifications to Payment Methodology May Be Warranted," GAO-05-42, October 15, 2004, pp. 4 and 20; Office of the Assistant Secretary for Planning and Evaluation (ASPE), "Synthesis and Analysis of Medicare's Hospice Benefit," March 2000.

<sup>5</sup> See OIG, "Hospice Patients in Nursing Homes," OEI-05-95-00250, September 1997 (suggesting that 1995 payments levels for hospice care in nursing homes may have been excessive).

<sup>6</sup> See OIG Report.

The study revealed some rather startling findings regarding how well nursing facilities complied with Medicare coverage requirements when they submitted hospice claims for fiscal year 2006. Overall, 82 percent of Medicare hospice claims did not meet one or more coverage requirements, and payments for those claims totaled \$1.8 billion, over 19 percent of Medicare's total payments for hospice care.<sup>7</sup> There were four key areas where DHHS found that hospice claims failed to meet requirements:

- **Election Requirements:** 33 percent of claims failed to meet one or more election requirements.<sup>8</sup> Election requirements help ensure that beneficiaries understand the types of services they will be receiving as well as forgoing under the hospice benefit.<sup>9</sup> For 4 percent of claims, there were no election statements.<sup>10</sup> For the other 29 percent of claims, regulatory violations most commonly included a failure to explain that hospice care was palliative rather than curative, a failure to explain that beneficiaries waived Medicare coverage of certain services related to their terminal illnesses, or that the statements were not signed by the beneficiaries.<sup>11</sup> Nine percent of election statements contained misleading language.<sup>12</sup>
- **Plan of Care Requirements:** 63 percent of claims did not meet one or more plan of care requirements.<sup>13</sup> A plan of care helps ensure that those involved in hospice care know precisely “what is supposed to be done, by whom, at what time, and for what purpose.”<sup>14</sup> For 1 percent of claims, hospices failed to establish plans of care altogether.<sup>15</sup> For the other 62 percent, the plans did not meet at least one requirement: they were not established by an interdisciplinary group (34 percent); they were missing a necessary component (31 percent); or they did not specify intervals for review (22 percent).<sup>16</sup>
- **Provision of Services Outlined in Plans of Care:** For 31 percent of claims, hospices provided fewer services than outlined in beneficiaries' plans of care.<sup>17</sup> Most often, hospices provided the services outlined in the plans of care, but not as frequently as they were supposed to.<sup>18</sup>
- **Terminal Illness Certification:** 4 percent of claims failed to meet one or more requirements to certify beneficiaries' conditions as terminal illnesses.<sup>19</sup> Common mistakes included a failure to specify that the beneficiaries' prognoses were for

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<sup>7</sup> OIG Report, at 10.

<sup>8</sup> *Id.* at 11-12

<sup>9</sup> *Id.* at 11.

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> *Id.* at 11-12

<sup>13</sup> *Id.* at 12-15

<sup>14</sup> 73 Fed. Reg. 32088, 32115 (June 5, 2008).

<sup>15</sup> OIG Report, at 12.

<sup>16</sup> *Id.* at 12-13.

<sup>17</sup> *Id.* at 15-16.

<sup>18</sup> *Id.* at 15.

<sup>19</sup> *Id.* at 16.

life expectancies of 6 months or less if the terminal illness ran its normal course, a lack of supporting clinical information or other documentation in the medical record, or the lack of physicians' signatures.<sup>20</sup>

### **Recommendations**

In response to these findings, DHHS made three recommendations to CMS that it should implement, all of which CMS is in agreement with. CMS should:

- **Educate Hospices About the Coverage Requirements and Their Importance in Ensuring Quality of Care:** these include presentations at industry conferences and other hospice association events, training broadcasts for State surveyors which are available to hospice providers, and education about the new Conditions of Participation.<sup>21</sup>
- **Provide Tools and Guidance to Hospices To Help Them Meet the Coverage Requirements:** these include model text for election statements, a checklist of items that must be in the plans of care, and guidance on complying with the certification of terminal illness regulations.<sup>22</sup>
- **Strengthen Its Monitoring Practices Regarding Hospice Claims:** this includes using targeted medical reviews and other oversight mechanisms, along with more frequent certification surveys of hospices.<sup>23</sup> CMS is also going to share the report and relevant claim information with the Recovery Audit Contractors (RACs).<sup>24</sup> RACs will undoubtedly pay much closer attention to the Medicare hospice care claims submitted by nursing facilities in the future. Future noncompliance with the requirements could lead to nonpayment and penalties.

### **Impact on Hospice Claims at Nursing Facilities**

CMS has already begun implementing the recommendations made by DHHS in an effort to ensure greater compliance with the Medicare hospice care regulations. Nursing home facilities that provide hospice care funded by Medicare should take advantage of the tools and educational opportunities CMS will provide as well as pay particular attention to the areas the DHHS study found deficient. By paying dutiful attention to the Medicare hospice care requirements, nursing facilities can ensure future payment and certification.

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<sup>20</sup> *Id.*

<sup>21</sup> *Id.* at 17-18.

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> *Id.* at 18.