

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE HOSPICE CARE  
FOR BENEFICIARIES  
IN NURSING FACILITIES:  
COMPLIANCE WITH MEDICARE  
COVERAGE REQUIREMENTS**



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Inspector General

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# *Office of Inspector General*

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## OBJECTIVES

To determine the extent to which hospice claims for beneficiaries in nursing facilities in 2006 met Medicare coverage requirements.

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## BACKGROUND

The Medicare hospice benefit allows a beneficiary with a terminal illness to forgo curative treatment for the illness and instead receive palliative care. The number of beneficiaries receiving hospice care has increased significantly in recent years, and some studies suggest that the use of hospice care has grown most rapidly in nursing facilities. In addition, previous Office of Inspector General work has raised questions about the hospice benefit for nursing home residents. However, little subsequent research has been done to examine hospice care for these beneficiaries, and almost no beneficiary-specific data exist.

This report determines the extent to which hospice claims for beneficiaries in nursing facilities in 2006 met Medicare coverage requirements. We based this study on data from a medical record review of a stratified random sample of hospice claims for beneficiaries in nursing facilities in 2006. A companion report, “Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities,” determines the nature and extent of hospice services provided to beneficiaries in nursing facilities.

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## FINDINGS

### **Eighty-two percent of hospice claims for beneficiaries in nursing facilities did not meet at least one Medicare coverage requirement.**

Eighty-one percent of claims did not meet at least one Medicare coverage requirement pertaining to election statements, plans of care, services, or certifications of terminal illness. An additional 1 percent of claims were undocumented. Medicare paid approximately \$1.8 billion for these claims.

Claims from not-for-profit hospices were less likely to meet Medicare coverage requirements than those from for-profit hospices. Specifically, 89 percent of claims from not-for-profit hospices did not meet Medicare requirements, compared to 74 percent of claims from for-profit hospices.

**Thirty-three percent of claims did not meet election requirements.**

For 4 percent of claims, there were no election statements. For another 29 percent of claims, the election statements did not meet one or more regulations. Most commonly, the statements did not explain that hospice care was palliative rather than curative or that the beneficiaries waived Medicare coverage of certain services related to their terminal illnesses.

For another 9 percent of claims, the election statements contained misleading language about the beneficiaries' right to revoke the election of hospice care.

**Sixty-three percent of claims did not meet plan of care requirements.**

For 1 percent of claims, the hospices did not establish plans of care for the beneficiaries. For another 62 percent of claims, the plans did not meet at least one Federal requirement. These plans of care were not established by an interdisciplinary group; they did not include necessary components, such as a detailed description of the scope and frequency of services; or they did not specify intervals for review, as required.

**For 31 percent of claims, hospices provided fewer services than outlined in beneficiaries' plans of care.** For 31 percent of claims, the hospices did not provide the number of services outlined in the plans of care that they established. Most commonly, the hospices provided services to the beneficiaries but not as frequently as called for in the plans of care. In the most extreme cases, there was no documentation in the medical records of any visits for a particular service.

**Four percent of claims did not meet certification of terminal illness requirements.** For 4 percent of claims, the certifications were missing or did not meet one or more Federal requirements. For these claims, the certifications did not specify that the individuals' prognoses were for life expectancies of 6 months or less if the terminal illness ran its normal course; they were not supported by clinical information and other documentation in the medical records; or they were not signed by physicians.

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## RECOMMENDATIONS

Based on the findings in this report, we recommend that the Centers for Medicare & Medicaid Services (CMS):

**Educate hospices about the coverage requirements and their importance in ensuring quality of care.** CMS should educate hospices about the coverage requirements, particularly for election statements, plans of care and their review, and certifications of terminal illness. It should pay particular attention to not-for-profit hospices, given the higher rate at which their claims did not meet requirements.

**Provide tools and guidance to hospices to help them meet the coverage requirements.** These tools should include clear and specific instructions, such as 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.

**Strengthen its monitoring practices regarding hospice claims.** CMS should effectively use targeted medical reviews and other oversight mechanisms to improve hospice performance and compliance with Medicare requirements, especially with respect to establishing plans of care and providing services that are consistent with these plans of care. Additionally, as we recommended in a previous report, CMS should conduct more frequent certification surveys of hospices as a way to enforce the requirements.

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## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all three of our recommendations. In response to our first recommendation, CMS stated that it has made presentations at industry conferences and participated in other events with hospice associations. CMS also noted that its Web site has a training broadcast for State surveyors that is available to hospice providers. CMS stated that it has educated providers about the requirements of the new Conditions of Participation (CoP), issued June 5, 2008. These CoPs address patient care planning and the care of patients who reside in nursing facilities.

In response to our second recommendation, CMS stated that it has issued new Hospice Program Interpretive Guidance, a tool used by providers and State Survey agencies to determine compliance with the CoPs. CMS

## E X E C U T I V E   S U M M A R Y

also stated that it held three satellite training sessions to educate stakeholders on the new requirements. We encourage CMS to continue educating providers and to give them detailed instructions that encompass the new requirements as well as existing requirements that have not been revised but are equally important. We also encourage CMS to augment these efforts with specific tools that address the problems outlined in this report, such as model text for election statements.

In response to our third recommendation, CMS stated that it will instruct Medicare contractors to consider the issues in this report when prioritizing its medical review strategies or other interventions. CMS also stated that it will share this report and relevant claim information from OIG with the Recovery Audit Contractors.

We have made changes to the final report based on CMS's technical comments, as appropriate.



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## OBJECTIVE

To determine the extent to which hospice claims for beneficiaries in nursing facilities in 2006 met Medicare coverage requirements.

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## BACKGROUND

The Medicare hospice benefit allows a beneficiary with a terminal illness to forgo curative treatment for the illness and instead receive palliative care, which is the relief of pain and other uncomfortable symptoms. The number of beneficiaries receiving hospice care has increased significantly in recent years. In fiscal year 2001, 580,000 Medicare beneficiaries received hospice care. In 2006, this number increased by 62 percent to 939,000 beneficiaries. Medicare spending on hospice care rose from \$3.6 billion in 2001 to \$9.2 billion in 2006.<sup>1</sup>

Some studies suggest that the use of hospice care has grown most rapidly in nursing facilities.<sup>2</sup> In addition, previous Office of Inspector General (OIG) work has raised questions about the hospice benefit for nursing home residents. For example, OIG reported that in 1995, payment levels for hospice care in nursing homes may have been excessive.<sup>3</sup> However, little subsequent research has been done to examine hospice care for these beneficiaries, and almost no beneficiary-specific data exist.<sup>4</sup>

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<sup>1</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 on March 27, 2009. CMS analysis of Medicare Health Care Information System data for calendar year 2006 claims. Provided by CMS on May 5, 2009.

<sup>2</sup> Office of the Assistant Secretary for Planning and Evaluation (ASPE), "Use of Medicare's Hospice Benefit by Nursing Facility Residents," March 2000; Medicare Payment Advisory Commission, "Report to the Congress: Medicare Beneficiaries' Access to Hospice," May 2002, p. 5.

<sup>3</sup> OIG, "Hospice Patients in Nursing Homes," OEI-05-95-00250, September 1997.

<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; ASPE, "Synthesis and Analysis of Medicare's Hospice Benefit," March 2000.

This report is one in a series of four reports conducted by OIG that examine the hospice benefit for nursing facility residents. This report determines the extent to which hospice claims for beneficiaries in nursing facilities met Medicare coverage requirements. A companion report determines the nature and extent of hospice services provided to beneficiaries in nursing facilities.<sup>5</sup>

An earlier report in this series found that 28 percent of Medicare hospice beneficiaries resided in nursing facilities for at least some time while they received hospice care in 2005.<sup>6</sup> These beneficiaries were more than twice as likely as beneficiaries in other settings to have terminal diagnoses of ill-defined conditions, mental disorders, or Alzheimer's disease. Finally, another report in the series found a number of cases in which the use of respite care for nursing facility beneficiaries may have been inappropriate; these cases were referred to CMS for corrective action.<sup>7</sup>

### **The Medicare Hospice Benefit**

The Tax Equity and Fiscal Responsibility Act of 1982 created the Medicare hospice benefit for eligible beneficiaries under Medicare Part A.<sup>8</sup> The goals of hospice care are to help terminally ill beneficiaries continue life with minimal disruption and to support beneficiaries' families and other caregivers throughout the process. The care may be provided to individuals and their families in the home or other places of residence, such as a skilled or other nursing facility. The care provided to families and other caregivers includes counseling, training to provide care for the individual, and bereavement counseling.

To be eligible for Medicare hospice care, a beneficiary must be entitled to Part A of Medicare and be certified as having a terminal prognosis with a life expectancy of 6 months or less if the disease runs its normal course. Upon a beneficiary's election of hospice care, the hospice agency

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<sup>5</sup> OIG, "Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities," OEI-02-06-00223.

<sup>6</sup> OIG, "Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings," OEI-02-06-00220, December 2007.

<sup>7</sup> OIG, "Hospice Beneficiaries' Use of Respite Care," OEI-02-06-00222, March 2008.

<sup>8</sup> The Tax Equity and Fiscal Responsibility Act of 1982, § 122, P.L. No. 97-248 § 122, 96 Stat. 324, 356, 42 U.S.C. § 1395x(dd).

assumes the responsibility for medical care related to the beneficiary's terminal illness and related conditions. This care is palliative, rather than curative. The beneficiary waives all rights to Medicare payment for services related to the treatment of the terminal condition or a related condition but retains rights to Medicare payment for services to treat conditions unrelated to the terminal illness.<sup>9</sup>

Beneficiaries are entitled to receive hospice care for two 90-day periods and unlimited 60-day election periods.<sup>10</sup> The periods need not be consecutive.<sup>11</sup> At the start of each period of care, a physician must certify that the beneficiary is terminally ill and has a life expectancy of 6 months or less.<sup>12</sup> Beneficiaries may revoke their election of hospice care and return to standard Medicare coverage at any time.<sup>13</sup> Hospice care is provided by Medicare-certified hospice agencies, hereinafter referred to as hospices.

*Medicare coverage requirements for hospice services.* Pursuant to regulations, hospice services must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. Hospice services must also meet the following requirements to be covered by Medicare:<sup>14</sup>

- The individual must elect hospice care in accordance with regulations.
- A plan of care must be established as set forth in regulation before services are provided.
- The services must be consistent with the plan of care.
- A certification that the individual is terminally ill must be completed as set forth in regulation.

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<sup>9</sup> 42 CFR § 418.24.

<sup>10</sup> Before 1990, hospice beneficiaries who were in hospice care for more than 210 days and still required such care were provided care by the hospices without charge to Medicare or the beneficiaries.

<sup>11</sup> 42 CFR § 418.21.

<sup>12</sup> 42 CFR § 418.22.

<sup>13</sup> 42 CFR § 418.28.

<sup>14</sup> 42 CFR § 418.200.

The election statement must explain the palliative rather than curative nature of hospice care, acknowledge that coverage of certain Medicare services are waived with the election, and include the signature of the beneficiary or representative.<sup>15</sup> The plan of care must include an assessment of the patient's needs, address the management of discomfort and symptom relief, and state in detail the scope and frequency of services needed. The plan must be established by the attending physician, the medical director or physician designee, and an interdisciplinary group and be reviewed and updated at intervals specified in the plan.<sup>16</sup> In addition, the services provided to the hospice beneficiary must be consistent with the plan. Finally, the certification of terminal illness must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course, must be supported by clinical information and other documentation in the medical record, and must be signed by a physician.<sup>17</sup>

**Hospice services.** The Medicare hospice benefit covers nursing care, medical social services, home health aide and homemaker services, physician services, counseling, physical therapy, occupational therapy, and speech-language pathology services. It also includes short-term inpatient care, medical supplies (including drugs and biologicals), and the use of medical appliances. In addition, the hospice benefit covers any other service that is specified in the plan of care as reasonable and necessary for the palliation and management of the terminal illness and related conditions and for which payment may otherwise be made under Medicare.<sup>18</sup>

**Levels of care.** The Medicare hospice benefit has four levels of care, and each level has an all-inclusive, prospectively determined daily rate. The rate is paid to the hospice for each day that a beneficiary is in hospice care, regardless of the number of services furnished. The four levels of care are: routine home care, continuous home care, respite care, and general inpatient care. Routine home care is the most common level of

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<sup>15</sup> 42 CFR § 418.24(b).

<sup>16</sup> 42 CFR § 418.200.

<sup>17</sup> 42 CFR § 418.22.

<sup>18</sup> 42 CFR § 418.202(i).

care and includes, but is not limited to, nursing and home health aide services. Appendix A provides detailed information on the four levels of care and the payment rates.

*Hospice care in nursing facilities.* When a beneficiary resides in a nursing facility, the hospice is responsible for providing the hospice services to the beneficiary. The nursing facility provides room and board and care unrelated to the terminal illness. Medicare reimburses the hospice according to the level of care provided, and the beneficiary or a third party payer pays the nursing facility for room and board costs.<sup>19</sup> In the case of a nursing facility resident who is eligible for Medicaid, Medicaid pays the hospice, and the hospice pays the nursing facility.

#### **Related Work**

A 2007 OIG report reviewed the hospice survey and certification process.<sup>20</sup> It found that Federal oversight of hospices was limited. Between FY 2000 and FY 2005, CMS required that hospices undergo certification every 6 years. By contrast, nursing facilities and home health agencies must undergo certification at least every 15 months and 36 months, respectively. OIG determined that State agencies certified 86 percent of hospices within the required timeframe, while 14 percent averaged 3 years past due. In addition, 46 percent of hospices surveyed were cited with health deficiencies, a substantial proportion of which related to patient care planning and quality issues. The report also found that CMS and State agencies rarely used methods other than certification surveys and complaint investigations to monitor or enforce hospice performance.

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## METHODOLOGY

We based this study on data from a medical record review of a stratified random sample of hospice claims for beneficiaries in nursing facilities.

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<sup>19</sup> CMS, “Medicare Benefit Policy Manual,” Pub. No. 100-02, ch. 9, § 20.3. Available online at <http://www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf>. Accessed on February 10, 2009.

<sup>20</sup> OIG, “Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight,” OEI-06-05-00260, April 2007.

**Sample Selection**

Using the National Claims History file, we extracted all Medicare hospice claims that had service dates in 2006 and were received through December 2006. Hospice claims typically cover a 1-month period but could be for shorter periods of time. We matched the claims data to the Medicare Enrollment Database by health insurance claim number to identify the Social Security number for each beneficiary.

Because hospice claims in 2006 did not include place of service, we used the Minimum Data Set (MDS) to identify nursing facility stay dates. The MDS includes assessments on all residents in Medicare- or Medicaid-certified nursing facilities. We used the MDS assessments received from January 2004 through December 2006 to create a record for each beneficiary of the dates when he or she resided in a nursing facility.

We matched the hospice claims to these nursing facility stay dates by the beneficiaries' Social Security numbers to identify claims for beneficiaries while they resided in nursing facilities. We created a file that included all hospice claims that corresponded to beneficiaries' nursing facility stays. This file included 812,668 hospice claims for 231,978 beneficiaries.

We selected a stratified random sample of 470 hospice claims from this file. We stratified the sample to ensure that we included claims for beneficiaries who had high-dollar amount claims and had received hospice care while in nursing facilities for an extended period of time. This stratum comprised all claims for hospice beneficiaries with an average hospice reimbursement of \$400 or more per day for at least 60 days while in nursing facilities during 2006. The other two strata comprised claims for all remaining beneficiaries who received hospice care while in nursing facilities: one stratum included all claims for beneficiaries with maximum claim amounts of \$3,000 or less, and the other included all claims for beneficiaries with maximum claim amounts of more than \$3,000. We then selected a random sample of claims from each stratum. See Table 1 for more details.

<b>Table 1: Sample Selection</b>			
<b>Description of Strata</b>	<b>Population</b>	<b>Initial Sample</b>	<b>Final Sample</b>
Claims for beneficiaries with high average daily claim amounts and extended nursing home stays	1,441	35	33
Claims for all other beneficiaries with nursing home stays	Maximum claim amount $\leq$ \$3,000	85	82
	Maximum claim amount $>$ \$3,000	350	335
<b>Total claims</b>	<b>812,668</b>	<b>470</b>	<b>450</b>

We excluded 12 claims from our sample because the hospices were currently under investigation by OIG. We excluded an additional claim because the beneficiary’s nursing facility stay information was incomplete and an additional three claims because we were unable to locate the hospices.<sup>21</sup> We also excluded another four claims because the contractor erred in record collection.<sup>22</sup> Our final sample included 450 claims.

As a last step, we identified the names and addresses of the hospices associated with each sampled claim by using the Online Survey and Certification Reporting System (OSCAR). We matched the hospice provider numbers in the claims file with the OSCAR data. We also identified hospices that were for-profit and those that were not-for-profit using a variable that indicated the type of provider ownership. In total, 43 percent of claims were from not-for-profit hospices and 53 percent of claims were from for-profit hospices. The remaining 4 percent were for services provided by government hospices.

**Medical Record Review**

We used a contractor to collect and review the medical records associated with each sampled claim. For each claim, we requested that the hospice provide the relevant hospice election statement, plan(s) of

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<sup>21</sup> The hospices’ telephone numbers were disconnected and the hospices could not be reached by certified mail. We have referred these cases to CMS for appropriate action.

<sup>22</sup> The contractor collected records for the wrong claim period in three cases and contacted the wrong provider in one case.

care,<sup>23</sup> record of services provided (including those furnished under arrangement or contract with the hospice), certification(s) of terminal illness, and clinical information and other documentation that supported the medical prognosis. Hospices are required to keep all of this information in the clinical record that they establish for every individual receiving care and services.<sup>24</sup> We requested these records for the claim period and, if possible, for the 30 days preceding and the 30 days following the claim period.

The contracted reviewers included two registered nurses, each of whom had experience with hospice care. For each claim, they used a standardized instrument to review the beneficiary's plan(s) of care, the services provided by the hospice, and the beneficiary's certification(s) of terminal illness. As part of their review, they recorded the scope and frequency of the services outlined in the plan of care, identified the members of the interdisciplinary group who signed the plan, and noted the intervals for review specified in the plan. Using the medical records, the reviewers also recorded all hospice services provided to the beneficiary during the claim period, with the exception of physician services.<sup>25</sup> Finally, the reviewers determined whether the certification of terminal illness specified a prognosis for a life expectancy of 6 months or less, whether it was signed by a physician, and whether clinical information and other documentation in the record supported the medical prognosis.

The contractor reviewed a total of 447 claims. For the other three claims, the hospices did not provide any documentation to review.<sup>26</sup> We included these three claims when determining the total percentage of claims that did not meet at least one Medicare coverage requirement. We did not include them when determining the percentages of claims that failed to meet each specific coverage requirement.

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<sup>23</sup> Although only one plan of care is in effect at any given time, some beneficiaries had more than one plan of care during the claim period.

<sup>24</sup> 42 CFR § 418.74, Condition of Participation – Central Clinical Records.

<sup>25</sup> Services provided by the beneficiary's attending physician are not always included in the hospice record.

<sup>26</sup> We contacted the hospices by telephone and certified mail, but they did not provide the requested records. We have referred these cases to CMS for appropriate action.

**Analysis**

Based on the results of the medical record review, we determined whether the frequency of hospice services provided to the beneficiary was consistent with the frequency called for in the plan of care. If the record indicated that services were missing because the beneficiary refused treatment, we considered the frequency of services provided to be consistent with the plan of care.

We reviewed the hospice election statements associated with the sample claims. We determined whether the statements addressed the palliative rather than curative nature of hospice care and whether certain Medicare services were waived by election. We also determined whether the beneficiary or representative signed the statement.

We compared the percentages of claims from not-for-profit and for-profit hospices that met the Medicare coverage requirements for election statements, plans of care, services, and certifications of terminal illness. We tested for statistically significant differences and noted in our findings when these differences occurred.

See Appendixes B and C for the results of our statistical tests.

**Limitations**

This review determined whether hospice claims for beneficiaries in nursing facilities met key Medicare coverage requirements. We did not determine whether the claims met every requirement. For example, we did not analyze whether plans of care were reviewed within specified timeframes. Also, we did not report on specific levels of care, such as general inpatient, because the results could not be projected to the universe.

In addition, as part of the study, medical record reviewers determined whether each beneficiary associated with the sample claims had a certification of terminal illness and documentation supporting the medical prognosis in his or her medical record. The reviewers did not assess eligibility status for the hospice benefit or independently verify the beneficiary's prognosis for a life expectancy of 6 months or less.

**Standards**

This study was conducted in accordance with the "Quality Standards for Inspections" approved by the Council of the Inspectors General on Integrity and Efficiency.

## ► FINDINGS

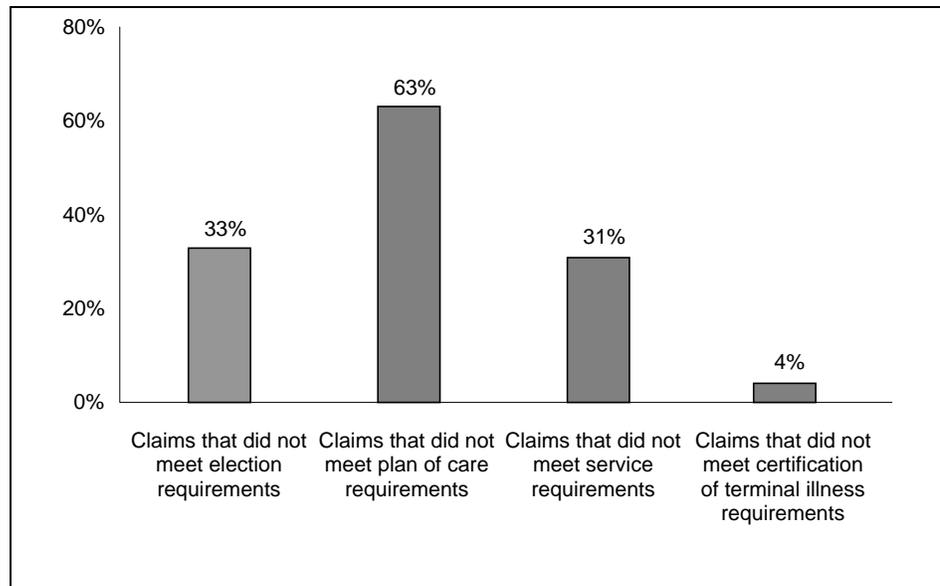
### **Eighty-two percent of hospice claims for beneficiaries in nursing facilities did not meet at least one Medicare coverage requirement**

Hospices must meet certain Federal requirements for their services to be covered by Medicare. In 2006, 82 percent of Medicare

hospice claims did not meet one or more coverage requirements. Medicare paid approximately \$1.8 billion for these claims.

Eighty-one percent of claims did not meet at least one Medicare coverage requirement pertaining to election statements, plans of care, services, or certifications of terminal illness. An additional 1 percent of claims were undocumented. For these claims, the hospices did not submit any records to support the claims, as required. Figure 1 and the following findings address the percentage of claims that did not meet each of the coverage requirements.

FIGURE 1:  
Percentage of Hospice Claims That Did Not Meet Specific Medicare Coverage Requirements



Source: OIG analysis of medical record review results, 2008.

Note: Percentages are not mutually exclusive.

Claims from not-for-profit hospices were less likely to meet Medicare coverage requirements than those from for-profit hospices. Specifically, 89 percent of claims from not-for-profit hospices did not meet Medicare requirements, compared to 74 percent of claims from for-profit hospices. This difference was statistically significant at the 95-percent confidence level.

**Thirty-three percent of claims did not meet election requirements**

Individuals who are terminally ill and entitled to Medicare Part A may elect hospice care by

filing election statements.<sup>27</sup> For hospice services to be covered by Medicare, election statements must meet certain Federal regulations.<sup>28</sup> These regulations help to ensure that beneficiaries understand the types of services they will be receiving as well as forgoing under the hospice benefit. Ensuring informed consent for hospice election is especially important as beneficiaries may be forgoing potentially life-saving therapies.

For 4 percent of claims, there were no election statements. For another 29 percent of claims, the election statements did not comply with one or more regulations. Most commonly, the statements did not explain that hospice care was palliative rather than curative or that the beneficiaries waived Medicare coverage of certain services related to their terminal illnesses. In a few instances, the election statements were not signed by the beneficiaries or representatives.

In addition, a greater percentage of claims from not-for-profit hospices did not meet election requirements compared to claims from for-profit hospices. Thirty-nine percent of claims from not-for-profit hospices did not meet election requirements, compared to 25 percent of claims from for-profit hospices. This difference was statistically significant at the 95-percent confidence level.

**Some election statements misrepresented regulations**

For another 9 percent of claims, the election statements contained misleading language. The following excerpts provide examples of such language:

“If I choose care or treatment that has not been preauthorized by the hospice team or included in the plan, I understand that I have removed myself from the hospice benefit effective immediately upon my action.”

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<sup>27</sup> 42 CFR 418.24(a). Physically or mentally incapacitated individuals may have their representatives file the election statements.

<sup>28</sup> 42 CFR §§ 418.200 and 418.24.

## F I N D I N G S

“If I choose to be admitted to a hospital that does not have a contract with [named hospice], that admission will be considered a decision to revoke my Medicare/Medicaid hospice benefit election.”

Pursuant to Federal regulations, a beneficiary does not revoke the hospice benefit simply by entering a hospital without authorization from his or her hospice. Rather, the individual must file a signed statement with the hospice that revokes the election for the remainder of that election period.<sup>29</sup> Further, to discharge a patient for cause, the hospice must follow a number of steps outlined in Federal regulations, which include making a serious effort to resolve the problem.<sup>30</sup>

### **Sixty-three percent of claims did not meet plan of care requirements**

For hospice services to be covered by Medicare, a plan of care must be established pursuant to Federal regulations for each hospice beneficiary.<sup>31</sup> The plan of care helps to 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>32</sup>

For 1 percent of claims, the hospices did not establish plans of care for the beneficiaries. For another 62 percent of claims, the plans did not meet at least one Federal requirement. As discussed in more detail below, these plans of care were not established by interdisciplinary groups; they did not include necessary components, such as detailed descriptions of the scope and frequency of services; or they did not specify intervals for review, as required. See Table 2.

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<sup>29</sup> 42 CFR § 418.28.

<sup>30</sup> 42 CFR § 418.26.

<sup>31</sup> 42 CFR § 418.200.

<sup>32</sup> 73 Fed. Reg. 32088, 32115 (June 5, 2008).

**Table 2: Percentage of Claims That Did Not Meet Plan of Care Requirements**

	Percentage of Claims*
Hospice did not establish plan of care	1%
Plan of care was not established by an interdisciplinary group	34%
Plan of care was missing a necessary component	31%
Plan of care did not specify intervals for review	22%
<b>Plan of care did not meet at least one requirement listed above</b>	<b>63%</b>

Source: OIG analysis of medical record review results, 2008.

\*Percentages are not mutually exclusive.

In addition, a higher percentage of claims from not-for-profit hospices did not meet plan of care requirements compared to claims from for-profit hospices. Seventy-five percent of claims from not-for-profit hospices did not meet plan of care requirements, compared to 52 percent of claims from for-profit hospices. This difference was statistically significant at the 95-percent confidence level.

**For 34 percent of claims, the plans of care were not established by interdisciplinary groups**

Federal regulations require that the plan of care be established by the attending physician, the medical director or physician designee, and an interdisciplinary group prior to providing care.<sup>33</sup> The interdisciplinary group must include at least a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor.<sup>34</sup>

For 34 percent of claims, the plans of care were not established by all of the required members of the interdisciplinary groups. Most commonly, pastoral or other counselors and social workers did not participate in the plans' establishment (for 31 percent and 22 percent of claims, respectively). Registered nurses did not participate for 5 percent of claims and physicians for 2 percent of claims.

<sup>33</sup> 42 CFR § 418.58(a).

<sup>34</sup> 42 CFR § 418.68(a).

**For 31 percent of claims, the plans of care were missing a necessary component**

The plan of care must include an assessment of the patient's needs; identification of services, including the management of discomfort and symptom relief; and a detailed statement of the scope and frequency of needed services.<sup>35</sup>

For 1 percent of claims, the plans of care were missing assessments of the patients' needs; for 1 percent of claims, the plans were missing the management of discomfort and symptom relief; for 29 percent of claims, the plans were missing the scope of at least one service; and for 1 percent of claims, the plans were missing the frequency of at least one service.<sup>36</sup>

Most commonly, plans of care were missing the scope of services for home health aide and nursing services. For 24 percent of claims, the plans of care called for home health aide services but did not include any details about the scope of this care. Plans that provided the scope listed specific home health aide tasks, such as feeding and bathing the patient, helping with ambulation, and changing incontinence pads. Similarly, for 17 percent of claims, the plans of care called for nursing services but did not include any information about their scope. Plans that included the scope described particular nursing duties, such as assessing and monitoring patients for various issues, including depression, anxiety, neuro-sensory status, pain type, and respiratory status.

As noted earlier, the plans of care were missing the frequency of services for 1 percent of claims. Other plans of care included frequencies but were somewhat vague. For example, they called for certain services to be provided as needed or included a range as wide as one to seven visits per week or zero to five visits per month.<sup>37</sup>

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<sup>35</sup> 42 CFR § 418.58(c).

<sup>36</sup> These percentages are not mutually exclusive.

<sup>37</sup> For 8 percent of claims, the plans of care called for services to be provided as needed.

**For 22 percent of claims, the plans of care did not specify intervals for review**

The plan of care must be reviewed and updated at intervals specified in the plan.<sup>38</sup> Frequent reviews and updates are especially important among the terminally ill population, given the potential for rapid changes in their conditions.

Length of Intervals	Percentage of Claims*
7 days	<1%
14 days	20%
60 days	17%
90 days	37%
Other intervals	1%
No interval specified	22%
No plan of care	1%

Source: OIG analysis of medical record review results, 2008.

\*Percentages do not sum to 100 percent because of rounding.

However, for 22 percent of the claims, the plans of care did not include any such interval. See Table 3. For another 37 percent of claims, the plans specified an interval of 90 days. It should be noted that hospice beneficiaries are expected to live for 6 months or less. Therefore, beneficiaries who have plans with 90-day intervals could anticipate only one review during their expected time in hospice care.

For 21 percent of claims, the plans of care had an interval of 14 or fewer days. These would be the only claims that would comply with a new rule, effective December 2008, mandating that the plan

be reviewed and revised as frequently as the patient’s condition requires, but no less than every 15 days.<sup>39</sup>

**For 31 percent of claims, hospices provided fewer services than outlined in beneficiaries’ plans of care**

To be covered by Medicare, hospice services must be consistent with the plan of

care.<sup>40</sup> For 31 percent of claims, the hospices did not provide the number of services outlined in the plans of care they established. Most commonly, the hospices provided services to the beneficiaries but not as frequently as called for in the plans of care. In the most extreme cases, there was no documentation of any visits for a particular service.

Failure to provide home health aide services was the most frequent error, but nursing and medical social services were also not provided as

<sup>38</sup> 42 CFR § 418.58(b).

<sup>39</sup> 73 Fed. Reg. 32088, 32206 (June 5, 2008).

<sup>40</sup> 42 CFR § 418.200.

often as the plans of care specified. For 8 percent of claims, the plans called for home health aide services, but no services were documented during the claim period. For another 12 percent of claims, the hospices provided fewer home health aide services than specified in the plans. For 9 percent of claims, the hospices provided fewer nursing services than called for in the plans, and for 7 percent of claims, they provided fewer medical social services. As mentioned earlier, hospices set their own standards for the number of services that beneficiaries needed, and these standards were, at times, quite broad.

**Four percent of claims did not meet certification of terminal illness requirements**

A certification that the individual is terminally ill must be completed pursuant

to regulations in order for hospice services to be covered by Medicare.<sup>41</sup> For 4 percent of claims, the certifications were missing or did not meet one or more Federal requirements. For these claims, the certifications did not specify that the individuals' prognoses were for life expectancies of 6 months or less if the terminal illness ran its normal course, they were not supported by clinical information and other documentation in the medical record, or they were not signed by physicians.

A greater percentage of claims from not-for-profit hospices failed to meet certification of terminal illness requirements compared to claims from for-profit hospices. Six percent of claims from not-for-profit hospices failed to meet these requirements, compared to 2 percent of claims from for-profit hospices. This difference was statistically significant at the 95-percent confidence level.

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<sup>41</sup> 42 CFR § 418.200.



## R E C O M M E N D A T I O N S

We found that 82 percent of hospice claims for beneficiaries in nursing facilities in 2006 did not meet Medicare coverage requirements. Medicare paid approximately \$1.8 billion for these claims. The 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 their 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' noncompliance—which does not appear to be related to the beneficiaries' setting—these concerns extend to all Medicare beneficiaries receiving hospice care.

Based on the findings in this report, we recommend that CMS:

### **Educate Hospices About the Coverage Requirements and Their Importance in Ensuring Quality of Care**

Our findings raise questions about whether hospices are providing accurate information to individuals about the benefit upon election and whether they are furnishing needed services to beneficiaries at an especially vulnerable time in their lives. CMS should educate hospices about the coverage requirements, particularly for election statements, plans of care and their review, and certifications of terminal illness. It should pay particular attention to not-for-profit hospices, given the higher rate at which their claims did not meet requirements.

### **Provide Tools and Guidance to Hospices To Help Them Meet the Coverage Requirements**

These tools should include clear and specific instructions, such as 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.

### **Strengthen Its Monitoring Practices Regarding Hospice Claims**

CMS should effectively use targeted medical reviews and other oversight mechanisms to improve hospice performance and compliance with Medicare requirements, especially with respect to establishing plans of care and providing services that are consistent with these plans of care. Additionally, as we recommended in a previous report, CMS should conduct more frequent certification surveys of hospices as a way to enforce the requirements.

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## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all three of our recommendations. In response to our first recommendation, CMS stated that it has made presentations at industry conferences and participated in other events with hospice associations. CMS also noted that its Web site has a training broadcast for State surveyors that is available to hospice providers. CMS stated that it has educated providers about the requirements of the new Conditions of Participation (CoP), issued June 5, 2008. These CoPs address patient care planning and the care of patients who reside in nursing facilities.

In response to our second recommendation, CMS stated that it has issued new Hospice Program Interpretive Guidance, a tool used by providers and State Survey agencies to determine compliance with the CoPs. CMS also stated that it held three satellite training sessions to educate stakeholders on the new requirements. We encourage CMS to continue educating providers and to give them detailed instructions that encompass the new requirements as well as existing requirements that have not been revised but are equally important. We also encourage CMS to augment these efforts with specific tools that address the problems outlined in this report, such as model text for election statements.

In response to our third recommendation, CMS stated that it will instruct Medicare contractors to consider the issues in this report when prioritizing its medical review strategies or other interventions. CMS also stated that it will share this report and relevant claim information from OIG with the Recovery Audit Contractors.

We have made changes to the final report based on CMS's technical comments, as appropriate. For the full text of CMS's comments, see Appendix D.

### Hospice Payment Rates

The Centers for Medicare & Medicaid Services (CMS) publishes general hospice payment rates annually to be used for each level of care.<sup>42</sup> The rates are adjusted based on the beneficiaries' geographic locations. The levels of care and the fiscal year 2006 Medicare unadjusted daily rates for each are as follows:

- Routine Home Care (\$126.49): The routine home care rate is paid to the hospice for each day that the beneficiary is under the care of the hospice and is not receiving one of the other categories of care. Routine home care includes, but is not limited to, nursing and home health aide services. Routine home care may be provided in the home or other places of residence, such as a nursing facility.
- Continuous Home Care (\$738.26): Continuous home care is allowed only during periods of crisis in which a beneficiary requires continuous care to achieve palliation or management of acute medical symptoms. It is covered only as necessary to maintain the terminally ill beneficiary at home. The care must be predominantly nursing care. Continuous home care may be provided in the home or other places of residence, such as a nursing facility. The continuous home care rate is divided by 24 hours to determine an hourly rate. A minimum of 8 hours must be provided.
- Respite Care (\$130.85): Respite care is short-term inpatient care provided to the beneficiary when necessary to relieve the beneficiary's caregiver(s). Respite care may be provided only on an occasional basis and is not reimbursed for more than 5 consecutive days. Respite care may be provided in a Medicare- or Medicaid-certified hospice inpatient facility, hospital, skilled nursing facility, or nursing facility.

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<sup>42</sup> CMS, "Medicare Claims Processing Manual," Pub. No. 100-04, ch. 11, Transmittal 663, Change Request 3977. Available online at <http://www.cms.hhs.gov/transmittals/downloads/R663CP.pdf>. Accessed on February 10, 2009.

## A P P E N D I X ~ A

- **General Inpatient Care (\$562.69):** General inpatient care is for pain control and symptom management that cannot feasibly be provided in other settings. General inpatient care may be provided in a Medicare- or Medicaid-certified hospice inpatient facility, hospital, or skilled nursing facility.



## A P P E N D I X ~ B

### Confidence Intervals for Selected Estimates

Estimate Description	n	Point Estimate	95-Percent Confidence Interval
Percentage of hospice claims that did not meet Medicare coverage requirements	450	82%	77% – 85%
Dollar amount paid by Medicare for claims that did not meet Medicare coverage requirements	450	\$1.8 billion	\$1.7 billion – \$1.9 billion
Percentage of undocumented claims	450	0.6%	0.2% – 1.8%
Percentage of claims that did not meet at least one Medicare coverage requirement pertaining to election statements, plans of care, services, or certifications of terminal illness	450	81%	77% – 85%
Percentage of claims that did not meet election requirements	447	33%	28% – 38%
Percentage of claims that did not meet plan of care requirements	447	63%	58% – 68%
Percentage of claims for which interdisciplinary groups did not establish the plans of care	447	34%	29% – 39%
Percentage of claims for which the plans of care were missing a necessary component	447	31%	27% – 36%
Percentage of claims for which the plans of care did not specify the interval for review	447	22%	18% – 27%
Percentage of claims for which the hospices provided fewer services than outlined in the plans of care	447	31%	26% – 36%
Percentage of claims that did not meet certification of terminal illness requirements	447	4%	2% – 6%

Source: Office of Inspector General analysis of medical record review results, 2008.



## A P P E N D I X ~ C

### Weighted Chi-Square Test Comparing Not-For-Profit and For-Profit Hospices

	Percentage of Claims From Not-For-Profit Hospices	Percentage of Claims From For-Profit Hospices	P-Value
Percentage of claims that did not meet Federal requirements*	89%	74%	0.0002
Percentage of claims that did not meet election requirements*	39%	25%	0.009
Percentage of claims that did not meet plan of care requirements*	75%	52%	<0.0001
Percentage of claims for which the hospices provided fewer services than outlined in the plans of care	31%	32%	0.91
Percentage of claims that did not meet certification of terminal illness requirements*	6%	2%	0.007

Source: Office of Inspector General analysis of medical record review results, 2008.

\*Differences between percentages of claims from not-for-profit hospices and those from for-profit hospices were statistically significant at the 95-percent confidence level.

► A P P E N D I X ~ D

**Agency Comments**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington, DC 20201

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OFFICE OF  
INSPECTOR GENERAL

**DATE:** AUG 06 2009

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** Charlene Frizzerá  
Acting Administrator

**SUBJECT:** Office of Inspector General's Draft Report: "Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements" (OEI-02-06-00221)

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report entitled, "Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements."

The objective of the report was to determine the extent to which hospice claims for beneficiaries in nursing facilities in 2006 met Medicare coverage requirements. As noted in the report, the number of Medicare beneficiaries receiving hospice care has increased significantly in recent years and some studies suggest that the number of beneficiaries receiving hospice care while residing in a nursing facility is also growing rapidly. This report found that 82 percent of hospice claims for beneficiaries in nursing facilities in 2006 did not meet at least one Medicare scope of benefit or coverage requirement pertaining to election statements, plans of care, provision of services, and certification of terminal illness.

**OIG Recommendation**

Educate hospices about the coverage requirements and their importance in ensuring quality of care.

**CMS Response**

The Centers for Medicare & Medicaid Services (CMS) concurs with this recommendation. When electing the Medicare hospice benefit, a Medicare beneficiary waives his/her right to have Medicare pay for services related to the treatment of the terminal condition for which hospice was elected (or a related condition), except when provided or arranged for by the Medicare hospice. Therefore, it is critically important that Medicare beneficiaries are certified appropriately and understand the implications of electing to receive hospice care.

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Additionally, the Medicare Hospice Conditions of Participation (CoPs) require that an interdisciplinary team of hospice professionals work with the beneficiary and the beneficiary's family to develop an individualized plan of care that reflects the patient and family goals and includes all services necessary for the palliation and management of the terminal illness and related conditions. On June 5, 2008, CMS issued revised CoPs. The revised CoPs focus on the care delivered to patients and their families by hospice and the outcome of that care. The revised requirements continue to reflect the unique interdisciplinary view of patient care and are an integral part of an overarching effort to achieve broad based improvements in the quality of health care. Following publication of the final CoPs, CMS conducted extensive provider outreach to educate the hospice community on the new requirements.

Also, CMS participated in 6 industry-sponsored, live audience and live Webcast presentations for more than 500 attendees; 5 90-minute teleconferences with major hospice associations and newsletters; and presented at several industry conferences. Furthermore, CMS filmed a three-part training broadcast for State surveyors that is freely available to the provider community on the CMS Web site. CMS also established a new requirement within the CoPs whose sole focus is governing the coordinated provision of care to hospice patients who reside in long-term care facilities. We have stressed the flexible, patient-centered nature of the plan of care requirements. CMS has actively collaborated with the hospice provider community through a variety of mediums and forums to educate them about the requirements of the new CoPs, including those related to patient care planning and the care of patients who reside in long-term care facilities.

**OIG Recommendation**

Provide tools and guidance to hospices to help them meet the coverage requirements.

**CMS Response**

The CMS concurs with this recommendation. CMS issued new Hospice Program Interpretative Guidance, sub-regulatory guidance for implementing the Hospice CoPs, on January 2. This guidance is a tool used by both providers and State Survey agencies to determine compliance with the Hospice CoPs. CMS also held three satellite training sessions beginning January 22, to educate all stakeholders on the new requirements. The trainings advised hospices about the Medicare hospice eligibility requirements, election statements, plans of care, and certification if terminal illness. CMS will continue to consider additional types of outreach such as open door forum presentations and Medlearn articles to ensure that hospice providers understand current requirements for election statements, certification or terminal illness, and plans of care, particularly for hospice patients residing in nursing homes.

**OIG Recommendation**

Strengthen its monitoring practices regarding hospice claims.

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**CMS Response**

The CMS concurs with this recommendation. CMS will share the OIG report and any additional claim information received from the OIG with the Medicare claims processors and will instruct the Medicare contractors to consider the issues identified in this report and the additional claim information when prioritizing their medical review strategies or other interventions. This information will also be provided to the Recovery Audit Contractors to determine if this is an area they wish to conduct review for claims on or after October 1, 2007.

**Technical Comments**

- We recommend that throughout this document, the OIG replace “Medicare coverage requirements” with “Medicare eligibility requirements” since the focus of this study was to assess the extent to which hospice patients in nursing homes met certain eligibility requirements.
- Page 3: We suggest a reference to 42 CFR 418.22 after the bullet describing the certification of terminal illness requirement.
- Page 5: In the case of a nursing home (NH) resident who is eligible for Medicaid, Medicaid pays the hospice, and the hospice pays the NH.
- Page 6: The report describes that the sample studied included a stratum for claims where the average reimbursement was greater than or equal to \$400 per day for at least 60 days, indicating that the patients were receiving Continuous Home Care (CHC) or General Inpatient Care (GIP). We recommend that the OIG further qualify their results to also reflect percentages based on the different strata described on page 7. Because the GIP and CHC levels of hospice care are intended for short term, crisis situations only, we recommend that the OIG describe whether or not their medical review focused at all on the appropriateness of the use of the GIP and/or CHC levels of care for these long periods of time.
- We recommend that the OIG further describe the significance in the samples which differentiated claim amounts greater than \$3,000 and those less than \$3,000.
- Page 11: We recommend the footnote be changed to 42 CFR 418.24.
- Page 12: We recommend the OIG describe the new CoPs requirements which became effective in 2008, and also reference the training and outreach efforts associated with these new requirements.
- Pages 13 and 15: We recommend adding 42 CFR 418.200 as an additional footnote.
- Page 17: We recommend that there be a mention that review of the plan of care (POC) is a Medicare requirement as well.

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- Finally, we suggest that the OIG may want to consider recommending more frequent surveys as a way to better enforce the POC requirements.

In closing, CMS thanks the OIG for the opportunity to review and comment on this report. The report provides additional insight into the practices of hospice care in nursing facilities. We look forward to continuing to work closely with the OIG on this growing area of the Medicare hospice benefit.



## A C K N O W L E D G M E N T S

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Meridith Seife, Deputy Regional Inspector General.

Nancy Harrison served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the New York regional office who contributed to the report include Olivia Herman, Michelle McInnis, and Bailey Orshan; central office staff who contributed include Rob Gibbons and Sandy Khoury.