Memorandum

Date NOV 4 1997

From June Gibbs Brown
Inspector General

Subject Enhanced Controls Needed to Assure Validity of Medicare Hospice Enrollments
(A-05-96-00023)

To Nancy-Ann Min DeParle
Deputy Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled "Enhanced Controls Needed to Assure Validity of Medicare Hospice Enrollments." The objective of this report was to consolidate and present issues disclosed by our ongoing Project Operation Restore Trust (ORT) audits of Medicare hospice services. Some of the hospices which we have audited and referred to in this report are also the subject of continuing Office of Inspector General (OIG) review.

The Medicare hospice program, while highly respected and successful in its mission, is a program which has experienced a substantial number of ineligible enrollments as identified in our audits. The reviews focused on determining whether the beneficiaries met the Medicare definition of "terminally ill" at the time of enrollment in the hospice program. The audits covered 12 large hospices located in 4 ORT States (Illinois, Florida, Texas, and California). Working with us, physicians from Medicare Peer Review Organizations (PRO's) reviewed the medical files of all 2,109 long-term beneficiaries in those hospices that had been in care over 210 days, or that had been discharged from hospice at some point after reaching the 210 day threshold. The PRO physicians concluded that 1,373 of the selected beneficiaries were ineligible for hospice because, at the time of initial diagnosis, they were not terminally ill as defined by Medicare regulations, i.e., having a life expectancy of 6 months or less (we hereinafter use the phrase "terminally ill" as defined in Medicare regulations).

To date, we have issued 5 individual reports to the Health Care Financing Administration (HCFA) recommending that the Regional Home Health Intermediaries' (RHHI) recover about $17.2 million for ineligible payments made to these hospices. The remaining seven hospices are pending further OIG review of their activities. Combining the findings on all 12 hospices, Medicare paid about $83 million on behalf of the 1,373 ineligible beneficiaries. Payments for some of these beneficiaries could be continuing today. For 262 additional beneficiaries reviewed, eligibility could not be established because medical evidence was missing from patient files or was incomplete. Medicare payments applicable to these 262 patients totaled about $14 million.

These ORT reviews followed a more limited audit of hospices in Puerto Rico which noted large numbers of ineligible beneficiaries. An island-wide statistical sample in Puerto Rico disclosed that about $20 million was paid by Medicare for beneficiaries who were not terminally ill at the time of diagnosis. This amount, together with our results at the selected hospices in ORT States, brings the total of identified Medicare payments for ineligible recipients to more than $100 million. We recommended to HCFA that it recover about $37.2 million for ineligible payments made to these hospices.

We have identified several underlying factors which we believe contributed to the problems we noted in our hospices audits.

- There has been less rigorous enforcement of the 6-month prognosis requirement by the hospice industry, especially for various noncancer diagnosed patients. This softening is most apparent in the enrollment of nursing facility residents that have chronic medical problems common to an elderly population. About 60 percent of the 1,373 ineligible beneficiaries identified during our reviews were nursing facility patients.

- Hospice regulations applicable to nursing home residents are complex. The regulations prohibit Medicare payments for hospice care on behalf of beneficiaries receiving Medicare funded services in skilled nursing facilities. Paradoxically, Medicare payments for hospice care are permissible when the beneficiary is receiving Medicaid funded services in a nursing facility. The joint funding by the Medicare and Medicaid programs for these nursing home residents open the possibility for abusive practices.

- A nationwide chain of hospices paid an amount in excess of the usual Medicaid reimbursement to nursing facilities and used marketing materials which downplayed or ignored the 6-month prognosis requirement. In addition, the chain had a large sales staff which was paid commissions in amounts based on the length of a patient's stay. These practices created a climate conducive to enrollment of hospice patients who were not terminally ill.

- Internal controls are weak in the areas of physician certifications of terminal illness, claims processing, and medical review at the RHHI, audit procedures at the RHHIs for "cap" report reviews, and the overall design of the reimbursement "cap" system--the method of paying hospices a maximum amount of Medicare funds based on a census count of beneficiaries enrolled.

To date, we have issued 5 individual reports to HCFA recommending that the RHHIs recover $17.2 million for payments made for ineligible beneficiaries. The remaining 7 hospices representing ineligible payments totaling $65.8 million are pending additional OIG review of their activities. In this report, we are making broader recommendations for HCFA

to consider that, in our opinion, will prevent various problems or abusive practices we have identified in the hospice program from reoccurring. Our recommendations include:

- Reinforcing the "6-month prognosis" requirement through a direct bulletin or memorandum from HCFA to industry advocacy groups for dissemination to all hospices.

- Prohibiting the practice of hospices paying nursing facilities more for "room and board" than the hospices receive from the State Medicaid agencies on behalf of dually eligible beneficiaries.

- Informing hospices that marketing materials should prominently feature Medicare eligibility requirements and monitoring the use of sales commissions as incentives for patient recruiting.

- Making hospice physicians more accountable for their certifications of terminal prognosis by requiring that the certification/recertification forms signed by these physicians contain a statement concerning the penalties for false claims.

- Strengthening claims processing controls at the RHHIs with more focus on front-end reviews and nontraditional, suspect, or exceedingly vague diagnoses.

- Seeking legislative change for a more meaningful "cap" or maximum amount for hospice payments and instructing the RHHIs to establish standard audit procedures for these "cap" reports submitted by hospices.

- Proposing legislation to restructure the use of benefit periods so that individuals who do not need or no longer need hospice care could be discharged without prejudice to eligibility during a defined hold harmless period of program adjustments.

- Seeking a legislative amendment to make changes to the existing payment methodology for dually eligible nursing facility residents, by reducing to the lowest level necessary, the Medicare hospice payment for these nursing facility patients.

The Balanced Budget Act of 1997, enacted after publication of our draft report, resulted in numerous modifications of Medicare's hospice benefit. These modifications included allowing hospices to discharge patients whose conditions improved without loss of future benefits to the hospice beneficiary (which addressed one of the above recommendations) and a new requirement for more frequent certifications of eligibility after 180 days of hospice care.

The HCFA generally concurred with the recommendations in our draft report. They noted, however, that from their readings, the art of accurate predictions about terminal prognoses is

not exact. Although they do not believe this negates the findings overall (giving recognition to the PROs that reviewed our cases), they noted there could be some degree of inaccuracy in some of the individual cases found ineligible. We appreciate the state of the art, but we have no reason to dispute the medical opinion of the PRO reviewers, who determined that 1,373 beneficiaries were not terminally ill as defined by HCFA.

We have paraphrased HCFA's response after each recommendation in the Results of Review section of this report and have added our additional comments, where appropriate. The full text of HCFA's response is attached as an appendix.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions or need clarification on the report, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-05-96-00023 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ENHANCED CONTROLS NEEDED TO ASSURE VALIDITY OF MEDICARE HOSPICE ENROLLMENTS

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1997
A-05-96-00023

EXECUTIVE SUMMARY

OBJECTIVE

The objective of this report was to consolidate and present issues disclosed by our ongoing Project Operation Restore Trust (ORT) audits of Medicare hospice services. Some of the hospices which we have audited and referred to in this report are also the subject of continuing Office of Inspector General (OIG) review.

SUMMARY OF RESULTS

The Medicare hospice program, while highly respected and successful in its mission, is a program which has experienced a substantial number of ineligible enrollments as identified in our audits. The reviews focused on determining whether the beneficiaries met the Medicare definition of "terminally ill" at the time of enrollment in the hospice program. The audits covered 12 large hospices located in 4 ORT States (Illinois, Florida, Texas, and California). Working with us, physicians from Medicare Peer Review Organizations (PRO's) reviewed the medical files of all 2,109 long-term beneficiaries in those hospices that had been in care over 210 days, or that had been discharged from hospice at some point after reaching the 210 day threshold. The PRO physicians concluded that 1,373 of the selected beneficiaries were ineligible for hospice because, at the time of initial diagnosis, they were not terminally ill as defined by Medicare regulations, i.e., having a life expectancy of 6 months or less (we hereinafter use the phrase "terminally ill" as defined in Medicare regulations).

> The hospice program has experienced a substantial number of ineligible enrollments.

To date, we have issued 5 individual reports to the Health Care Financing Administration (HCFA) recommending that the Regional Home Health Intermediaries (RHHI) recover about $17.2 million for ineligible payments made to these hospices. The remaining seven hospices are pending further OIG review of their activities. Combining the findings on all 12 hospices, Medicare paid about $83 million on behalf of the 1,373 ineligible beneficiaries. Payments for some of these beneficiaries could be continuing today. For 262 additional beneficiaries reviewed, eligibility could not be established because medical evidence was missing from patient files or was incomplete. Medicare payments applicable to these 262 patients totaled about-$14 million.

> At 12 large hospices, our audits found Medicare paid about $83 million for long-term patients not terminally ill. To date, recommendations were made to HCFA to recover $17.2 million at 5 hospices.

Although our audits covered only 12 large hospices and were focused only on long-term

patients, analysis of the HCFA data base for hospice beneficiaries showed evidence of numerous long-term beneficiaries in other hospices across the country. Significant growth in the number of long-term patients admitted by hospices occurred after hospice regulations were modified to add a fourth, indefinite length, period of care for reimbursement purposes. As of February 1996, over 11,000 beneficiaries (about 14 percent of hospice beneficiaries nationwide) had been in care for more than 210 days.

These ORT reviews followed a more limited audit of hospices in Puerto Rico which noted large numbers of ineligible beneficiaries. An island-wide statistical sample in Puerto Rico disclosed that about $20 million was paid by Medicare for beneficiaries who were not terminally ill at the time of diagnosis. This amount together with our results at the selected hospices in ORT States brings the total of identified Medicare payments for ineligible recipients to more than $100 million. We recommended to HCFA that it recover about $37.2 for ineligible payments made to these hospices.

We have identified several underlying factors which we believe contributed to the problems we noted in our hospices audits.

- There has been less rigorous enforcement of the 6-month prognosis requirement by the hospice industry, especially for various noncancer diagnosed patients. This softening is most apparent in the enrollment of nursing facility residents that have chronic medical problems common to an elderly population. About 60 percent of the 1,373 ineligible beneficiaries identified during our reviews were nursing facility patients.

- Hospice regulations applicable to nursing home residents are complex. The regulations prohibit Medicare payments for hospice care on behalf of beneficiaries receiving Medicare funded services in skilled nursing facilities. Paradoxically, Medicare payments for hospice care are permissible when the beneficiary is receiving Medicaid funded services in a nursing facility. The joint funding by the Medicare and Medicaid programs for these nursing home residents open the possibility for abusive practices.

- A nationwide chain of hospices paid an amount in excess of the usual Medicaid reimbursement to nursing facilities and used marketing materials which downplayed or ignored the 6-month prognosis requirement. In addition, the chain had a large sales staff which was paid commissions in amounts based on the length of a patient's stay. These practices created a climate conducive to enrollment of hospice patients who were not terminally ill.

- Internal controls are weak in the areas of physician certifications of terminal illness, claims processing, and medical review at the RHHI, audit procedures at the RHHIs for "cap" report reviews, and the overall design of the reimbursement "cap" system--the method of paying hospices a maximum amount of Medicare funds based on a census count of beneficiaries enrolled.

Some of the problems noted in this report are longstanding and have been pointed out by others. A recent article in *The New England Journal of Medicine* concluded that patients in large and for-profit hospices have relatively long survival periods after enrollment and suggested that such hospices may encourage early enrollments to recoup the high up-front costs associated with admissions. Other questions were posed in the article regarding whether such hospices have efficient "outreach" programs or place fewer "barriers to enrollment." We believe the results of our audits as detailed in this report will help HCFA respond to these questions. Other recently issued OIG reports have highlighted vulnerabilities in the Medicare program for hospice beneficiaries residing in nursing homes.

RECOMMENDATIONS

To date, we have issued 5 individual reports to HCFA recommending that the RHHIs recover $17.2 million for payments made for ineligible beneficiaries. The remaining 7 hospices representing ineligible payments totaling $65.8 million are pending additional OIG review of their activities. In this report, we are making broader recommendations for HCFA to consider that, in our opinion, will prevent various problems or abusive practices we have identified in the hospice program from reoccurring. Our recommendations include:

- Reinforcing the "6-month prognosis" requirement through a direct bulletin or memorandum from HCFA to industry advocacy groups for dissemination to all hospices.

- Prohibiting the practice of hospices paying nursing facilities more for "room and board" than the hospices receive from the State Medicaid agencies on behalf of dually eligible beneficiaries.

- Informing hospices that marketing materials should prominently feature Medicare eligibility requirements and monitoring the use of sales commissions as incentives for patient recruiting.

- Making hospice physicians more accountable for their certifications of terminal prognosis by requiring that the certification/recertification forms signed by these physicians contain a statement concerning the penalties for false claims.

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- Seeking a legislative amendment to make changes to the existing payment methodology for dually eligible nursing facility residents, by reducing to the lowest level necessary the Medicare hospice payment for these nursing facility patients.

The Balanced Budget Act of 1997, enacted after publication of our draft report, resulted in numerous modifications of Medicare's hospice benefit. These modifications included allowing hospices to discharge patients whose conditions improved without loss of future benefits to the hospice beneficiary (which addressed one of the above recommendations) and a new requirement for more frequent certifications of eligibility after 180 days of hospice care.

The HCFA generally concurred with the recommendations in our draft report. They noted, however, that from their readings the art of accurate predictions about terminal prognoses is not exact. Although they do not believe this negates the findings overall (giving recognition to the PROs that reviewed our cases), they noted there could be some degree of inaccuracy in some of the individual cases found ineligible. We appreciate the state of the art, but we have no reason to dispute the medical opinion of the PRO reviewers who determined that 1,373 beneficiaries were not terminally ill as defined by HCFA.

We have paraphrased HCFA's response after each recommendation in the Results of Review section of this report and have added our additional comments, where appropriate. The full text of HCFA's response is attached as an appendix.

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INTRODUCTION

PROGRAM HISTORY AND REGULATIONS

The hospice benefit was established by the Congress as a discrete Medicare benefit available to terminally ill beneficiaries effective November 1, 1983. An initial goal of the hospice benefit was to help terminally ill individuals continue life with minimal disruption in normal activities while remaining primarily in the home environment. As such, hospice services related to terminal illnesses are palliative in nature (pain control and symptom management). Through this emphasis on palliative rather than curative services, individuals have a choice whenever conventional approaches for medical treatment may no longer be appropriate.

To elect hospice services, a beneficiary must be entitled to Part A of Medicare and be certified as being terminally ill. According to Medicare hospice regulations, "terminally ill" means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

For the hospice program, Medicare defines "terminally ill" as life expectancy of 6 months or less.

A beneficiary who elects to enroll in a hospice program waives rights to regular Medicare coverage of all services for treatment of the terminal illness, other than those services furnished by his/her nonhospice attending physician. Services for conditions not related to the terminal condition, however, remain covered under Part A and Part B of Medicare.

The services necessary for the palliation or management of the terminal illness must be provided by a hospice in accordance with a written plan of care. The plan of care must be established by the attending physician, the medical director or physician designee, and interdisciplinary group prior to the provision of care.

Hospices must establish and maintain a clinical record for each beneficiary receiving services. Requirements state that the records must be complete, promptly and accurately documented, readily accessible, and systematically organized to facilitate retrieval. Each beneficiary's record must contain (1) the initial and subsequent assessments; (2) the plan of care; (3) identification data; (4) consent and authorization and election forms; (5) pertinent medical history; and (6) complete documentation of all services and events (including evaluations, treatments, progress notes, etc.).

Inclusion in a hospice program is voluntary and can be revoked at any time by the beneficiary. During the period of our review, the beneficiary had four election periods for hospice care and had to be certified as terminally ill for each of those periods. The first and second periods were 90 days each, the third period is 30 days, and the fourth and last period had an indefinite duration. The first three election periods total 210 days. The "indefinite" fourth period was added by the Congress effective January 1, 1990. Subsequent to our audit period, the Balanced

Budget Act of 1997 enacted a new requirement for more frequent certifications of eligibility after 180 days of hospice care.

The initial election of hospice benefit requires a certification of the terminal illness by both the hospice physician and the beneficiary's attending physician if the patient had an attending physician. For subsequent periods, the certification may be made solely by the hospice physician.

HOSPICE PAYMENTS AND FISCAL ADMINISTRATION

When a beneficiary is receiving hospice care, the hospice is normally paid a predetermined rate for each day during the length of care, no matter how much care the hospice actually provides. This rate, referred to as the routine home care rate, is currently about $94 per day. If a beneficiary requires continuous home care or inpatient hospitalization, higher rates are paid. These predetermined rates include the reimbursement for all care provided by or through the hospice, except for direct patient care rendered by physician employees of the hospice, or for patient care by physicians under arrangements with the hospice, for which separate or additional payments are made.

Medicare payments to hospices are made through eight regional contractors designated by HCFA as RHHIs. The RHHIs also have responsibilities for medical and utilization review and administrative duties such as communicating to the hospices any information and instructions from HCFA.

Although the hospice benefit is still a relatively small portion of total Medicare Part A benefit payments (about 1.5 percent), it has grown considerably over the past several years. According to HCFA's published statistics, Medicare hospice payments increased from about $958 million for Fiscal Year (FY) 1993 to over $1.8 billion for FY 1995.

> Medicare payments for hospice benefits have grown considerably over the past several years.

PREVIOUS OIG REVIEWS IN PUERTO RICO

In 1994, our office conducted studies to assess the accuracy of beneficiary medical eligibility determinations at two hospice facilities in Puerto Rico. Our assessments were made based on reviews of medical records by physicians from the Medicare PRO in Puerto Rico. The PRO physicians determined whether medical evidence supported the initial determination that a beneficiary's life expectancy was six months or less. These efforts concentrated on cases that had been active for over 210 days and on cases where the beneficiaries had been discharged for reasons other than death.

Over 70 percent of the cases reviewed were found to be medically ineligible long-term beneficiaries. Medicare payments to the two hospices on behalf of the ineligible beneficiaries exceeded $2.6 million. Due to these findings, the work was later expanded to obtain an island-wide assessment of eligibility, through review of a statistical sample. Based on the results of this sample review, we estimated that $19.7 million was improperly paid to 37 hospice providers in Puerto Rico on behalf of ineligible beneficiaries.

OPERATION RESTORE TRUST

In March 1995, a joint initiative referred to as Operation Restore Trust (ORT) was established between the Office of Inspector General (OIG), HCFA, and the Administration on Aging. Among its objectives, ORT seeks to identify vulnerabilities in the Medicare program and pursue ways to reduce Medicare's exposure to fraud, waste, and abuse. Projects under ORT initially targeted the five largest States in terms of Medicare spending (New York, Florida, Illinois, Texas, and California) and focused on home health care, nursing home care, durable medical equipment, and hospice care.

With knowledge from our reviews in Puerto Rico, we began an ORT project in July 1995 to assess medical eligibility for hospice services in the five ORT States. We initially made a computer analysis of HCFA's Common Working File (CWF) to identify those hospices having the highest number of long-term cases. We defined long-term cases as (1) active cases that had received hospice services for over 210 days and (2) closed cases that were discharged for reasons other than death after 210 days of hospice service. Through this analysis, we selected hospices for on-site reviews. Our on-site reviews were made with assistance from PRO physicians through arrangements with HCFA.

> This ORT project was designed to review hospices having the highest number of "long-term" cases.

Also, as part of ORT, we initiated other studies of Medicare hospice care, with a special focus on how those services are provided in a nursing home setting.

RECENT LEGISLATION

The Balanced Budget Act of 1997, enacted after publication of our draft report, resulted in numerous modifications of Medicare's hospice benefit. These modifications included allowing hospices to discharge patients whose conditions improved without loss of future benefits and a new requirement for more frequent certifications of eligibility after 180 days of hospice care.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our objective was to present the results of our reviews to date of hospice eligibility in a summary report by consolidating the results of audits in the ORT States and by identifying common causes and trends that contributed to the problems identified. The reviews focused on determining whether the beneficiaries met the Medicare definition of "terminally ill" at the time of enrollment in the hospice benefit program. Although our reviews of hospices under ORT are continuing and further reporting will be made, our conclusions, suggestions, and recommendations are provided at this time for early consideration by HCFA program officials.

> Reviews focused on whether long-term beneficiaries at 12 hospices met the Medicare definition of terminally ill.

Based on analysis of data extracted from the CWF, we selected 12 hospices in 4 of the 5 ORT States for initial reviews: 3 in Illinois, 4 in Florida, 4 in Texas, and 1 in California. No hospices were selected in New York at this time.

At four of the hospices covered early in our review, we selected beneficiaries for review only if CWF data processed in April 1995 indicated that they met our 210-day "long-term" selection criteria. At the other eight hospices, we added beneficiaries that had reached the 210-day threshold at the date of our on-site review. Six of the 12 hospices were part of a large national chain.

Through arrangements with HCFA, the States' Medicare PROs provided technical assistance in reviewing the medical records of the selected beneficiaries. A different team of PRO physicians assisted us in each State. For each selected beneficiary, a PRO physician reviewed the beneficiary's clinical record and made the assessment whether the hospice's initial determination of "6-month" terminal prognosis was reasonable.

> Physicians from Medicare PROs made the eligibility assessments by reviewing the beneficiaries' clinical records.

A beneficiary was deemed ineligible if the clinical evidence of the patient's condition, contained in the medical record, indicated that at the time of initial certification the beneficiary had a prognosis of living greater than six months. A beneficiary's case was deemed inadequately documented if there was insufficient clinical evidence to support a prognosis of death within six months or less. In making the determination, the PRO physician considered the diagnosis and other factors contained in the medical file, such as: certification of terminal illness, hospital and laboratory reports, and the hospice physician's and nurses' notes.

Our field work and the medical reviews by the PRO physicians were made during FY 1996. Individual reports on the results of our reviews will be issued to each hospice's RHHI. These reports are currently in varying stages of completion. For seven individual hospices, OIG work continues in review of their activities.

RESULTS OF REVIEW

Our reviews at selected hospices have uncovered problems with beneficiary eligibility that lead us to conclude that the problems first discovered in Puerto Rico are widespread. Our latest estimate of the magnitude of these problems in Puerto Rico is about $20 million in ineligible payments for long-term beneficiaries. Payments on behalf of ineligible beneficiaries at the 12 selected hospices in ORT States have totaled about $83 million. Five individual hospice reports were issued to HCFA recommending that the RHHIs recover $17.2 million. The remaining 7 hospices representing ineligible payments totaling $65.8 million are pending additional OIG review of their activities. There are over 1,800 hospices participating nationwide in Medicare.

Details concerning the number and location of ineligible and undocumented beneficiaries, factors which contributed to improper payments, financial and program effects, and our recommendations are presented in the following report sections.

MEDICAL ELIGIBILITY OF BENEFICIARIES

Our review was limited to a review of hospice beneficiaries with over 210 days of hospice coverage as of specific dates, and who were still active in hospice or had been discharged for reasons other than death later than January 1, 1993. For the 12 hospices completed, the PRO physicians reviewed medical records of 2,109 long-term Medicare beneficiaries, finding 1,373 (65.1 percent) to be ineligible. Of the remaining 736 beneficiaries, 474 were determined to be eligible. Medical records for 262 beneficiaries were insufficiently documented for the PRO physicians to make an eligibility determination. Results by hospice are shown below:

Hospice	Cases Reviewed	Number and (%) Ineligible		Number Eligible	Could Not Determine
A	106	85	(80.2%)	21	-
B	101	86	(85.1%)	12	3
C	224	213	(95.1%)	6	5
D	215	163	(75.8%)	21	31
E	247	176	(71.3%)	42	29
F*	364	176	(48.4%)	70	118
G*	147	71	(48.3%)	31	45
H	210	140	(66.7%)	54	16
I	276	165	(59.8%)	106	5
J*	60	20	(33.3%)	38	2
K*	81	29	(35.8%)	52	-
L*	78	49	(62.8%)	21	8
Total	2,109	1,373	(65.1%)	474	262

*Reports issued to HCFA

Medical Conditions of Ineligible Beneficiaries

Although medical evidence for some of the 1,373 ineligible beneficiaries showed that they may have been eligible for home health care (for homebound beneficiaries) or for nursing facility care under Medicaid (for more chronically-ill, dually eligible beneficiaries), the evidence did not support life expectancies of 6 months or less. We noted that about 60 percent of the ineligible beneficiaries were nursing facility residents who were also receiving hospice benefits.

About 60 percent of the ineligible beneficiaries were nursing facility residents receiving hospice benefits.

Eligibility for hospice care is based on a beneficiary's prognosis. The prognosis of life expectancy, in turn, is based upon the diagnosis, which identifies the beneficiary's medical condition. Certain major categories of diagnoses had higher rates of ineligibility than others. Rankings by percent ineligible follow:

SUMMARY OF RESULTS OF MAJOR CATEGORIES OF DIAGNOSES IN HOSPICES REVIEWED

Category	Number Reviewed	Number Ineligible	Percent Ineligible
Debility Unspecified	117	102	87.2%
Dementia/Senility	85	73	85.9%
Vascular	184	153	83.2%
Alzheimer's Disease	204	151	74.0%
Cardiac	429	313	73.0%
Parkinson's Disease	63	46	73.0%
Renal	27	19	70.4%
Pulmonary	213	119	55.9%
Cancer	593	268	45.2%
All Other	194	129	66.5%
Total	2,109	1,373	65.1%

These categories represent the general groupings of the individual primary diagnoses shown on hospice certification forms.

The categories with the highest levels of ineligibility were diagnoses very common among an elderly population of nursing home residents. Over 200 of the 2,109 beneficiaries had been certified by the hospice physicians as "terminal" with diagnoses of debility unspecified, dementia, and senility. Taken as a group, these diagnoses had an ineligibility rate of about 87 percent. Nursing facility residents with various cardiac and vascular problems and Alzheimer's disease patients were also often found to be ineligible by the PRO physicians.

> Highest levels of ineligibility were for diagnoses common among an elderly population of nursing home residents.

Beneficiaries with Undetermined Medical Eligibility

Medical documentation was insufficient for the PRO physicians to make a determination of eligibility for 262 of the 2,109 beneficiaries (12.4 percent). Evidence crucial to a prognosis of a life expectancy of 6 months or less, such as reports on physical examinations, consultations, and lab tests, was not included in the hospices' files for many of these beneficiaries. For other beneficiaries, the medical evidence present in the files was inconclusive.

> For 262 beneficiaries, information crucial to the terminal prognosis was missing or inconclusive.

With regard to medical documentation, 42 CFR 418.74 provides that the hospice must establish and maintain a clinical record for every individual receiving care and services. According to the regulation, the record must include several items, including the "plan of care", "pertinent medical history", and "complete documentation of all services and events".

We found that the extent of the problem with missing or incomplete medical documentation varied among the 12 hospices that we visited. Lack of documentation was not a problem at two of the hospices visited where the medical records for all selected beneficiaries were sufficient for the PRO physicians to make their determinations. The hospice with the greatest medical documentation problem was a hospice in Florida where medical evidence was missing or incomplete for 118 beneficiaries. This represented over 32 percent of the total 364 beneficiaries included in our review at this hospice. The hospice indicated that additional information from outside sources could be obtained for each case but was not included in the medical records. At another hospice, we were informed that medical information was sometimes obtained over the telephone, but not documented in the files.

In the absence of the required medical documentation, doubt is cast on hospice eligibility for the 262 beneficiaries. We are obtaining Medicare claims data from the servicing RHHIs to determine the amounts paid to the hospices on behalf of the 262 beneficiaries. We estimate that these amounts will total about $14 million.

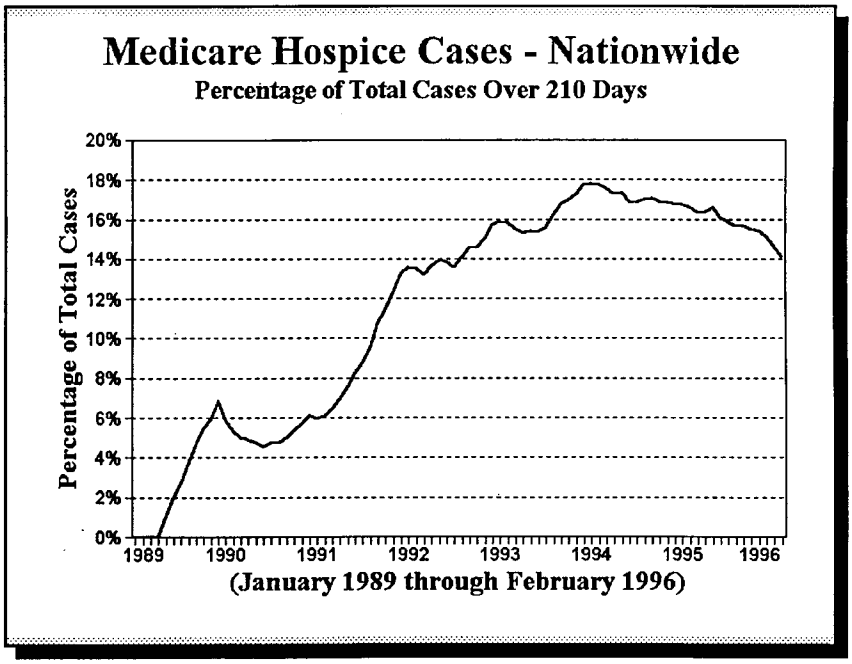
NUMBER OF LONG-TERM CASES NATIONWIDE

The Balanced Budget Act of 1997, enacted after we issued our draft report, begins to address some of the concerns about potential abuses in the fourth benefit period. The new legislation requires that a hospice medical director recertify a patient's eligibility every 60 days once a patient has been in hospice care for more than 180 days.

As previously stated, our review targeted only long-term hospice cases (beneficiaries who were in hospice care for over 210 days). Before January 1990, when the fourth "indefinite" election period was added to the hospice benefit, Medicare did not pay for hospice care beyond 210 days. Nonetheless, hospices were required to continue providing services--without Medicare funding--for any beneficiaries who outlived this 210-day (7 month) threshold. This policy was an effective control which prevented intentional early or unnecessary admissions to hospice.

To determine what effect adding the fourth, indefinite benefit period had on the number of cases exceeding a 210-day length of stay, we analyzed HCFA's data base for hospices. Our analysis of this nationwide data clearly showed a dramatic rise in the percentage of cases exceeding 210 days over the years after this benefit period was added.

Long-term cases increased from less than 6 percent of active cases in January 1990 (1,071 of 18,176 cases) to almost 18 percent of active cases in January 1994 (10,201 of 57,278 cases). The percentage has fallen in recent months, a development which staff at one RHHI attributed to the sentinel effect of our ORT activities.



As of February 1996 (the most recent month for which we analyzed the data), over 11,000 beneficiaries (about 14 percent) had been in hospice care for more than 210 days.

The high number of long-term cases emphasizes the seriousness of the problem of ineligible beneficiaries since over 65 percent of the long-term cases covered by our reviews were found to be ineligible for hospice care. Although these reviews covered 2,109 long-term beneficiaries, at hospices having the largest numbers of such cases, HCFA's data base indicates there are about

11,000 such beneficiaries active nationwide. In addition, an undetermined number were discharged alive after 210 days. The following paragraphs outline what we believe are contributing factors to these problematic cases.

CONTRIBUTING FACTORS

Certain underlying factors are contributing to the hospices' certification of beneficiaries who do not have "terminal illnesses" as defined by Medicare regulations. These factors can be classified in three major issue categories: hospice coverage in nursing facilities, hospice marketing and sales techniques, and internal controls.

> Major issues include coverage in nursing facilities, marketing and sales techniques, and internal controls.

Hospice Coverage in Nursing Facilities

As previously stated, nearly 60 percent of the 1,373 beneficiaries, whose medical conditions were determined by the PRO physicians to be non-terminal illnesses, were residents of nursing facilities (823 beneficiaries). These beneficiaries represented some of the longest-stay hospice patients included in our reviews. The numbers reflect problems in the general area of hospice eligibility for nursing facility patients.

Hospice regulations are inconsistent in that the hospice benefit is prohibited for some nursing home patients and available to others. Although payment for hospice benefits is prohibited on behalf of a beneficiary receiving skilled nursing facility (SNF) services under Medicare, current law permits the hospice payments when the beneficiary is receiving nursing facility services funded by Medicaid in medical institutions or intermediate care facilities. In these situations, Medicare and Medicaid will simultaneously pay for hospice and nursing facility benefits. As the number of nursing facility residents enrolled in hospice programs continues to rise, this provision in the requirements becomes more and more costly to the Government.

History of Coverage Although the original hospice benefit statute was silent as to whether the Congress intended for the Medicare hospice benefit program to apply to beneficiaries in nursing homes, the Congress later enacted provisions in Title XIX of the Social Security Act (Medicaid) that allow residents of Medicaid nursing facilities to elect the Medicare hospice benefit.

An early obstacle to hospice enrollments by nursing facility patients was the lack of a national policy governing conditions under which the States' Medicaid programs would cover the cost of nursing facility services on behalf of dually eligible (Medicare/Medicaid) beneficiaries who elect hospice services. Since a hospice beneficiary must waive traditional Medicare services for the terminal illness when electing the hospice benefit, Medicare does not simultaneously pay for hospice care and SNF care. For dually eligible beneficiaries residing in Medicaid nursing

facilities, each State's Medicaid program would have needed special State plan provisions to cover reimbursement of nursing care when Medicare hospice coverage was elected.

The obstacle to hospice coverage of Medicaid nursing facility beneficiaries was removed by the passage of P.L. 99-509 in October 1986. The new law amended title XIX to require a State to pay the hospice for the nursing facility's "room and board" services provided on behalf of a dually eligible beneficiary who was residing in a nursing facility and elected to receive the Medicare hospice benefit. The hospice was then responsible for paying the nursing facility under a written agreement with the facility.

"Room and board" was defined in section 1902(a)(13)(D) as:

> "...performance of personal care services, including assistance in activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies..."

This section was later amended by the Omnibus Budget Reconciliation Act of 1989 to provide that the payment shall:

> "...take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual..."

Initially, nursing facilities were hesitant to enter into written agreements with hospices due to uncertainties as to how hospice enrollments would affect survey and certification procedures. For example, in August 1991, HCFA responded to a request by the State of Oregon to clarify if nursing facilities were obligated to meet the same physician visit requirements for hospice inpatients that they must meet for other residents. Although clarification was given by HCFA, it noted that written interpretive guidelines were needed. The HCFA's Office of Survey and Certification issued a policy memorandum in November 1993 that included guidelines for hospice care in nursing facilities.

The guidelines addressed joint and individual responsibilities of the hospice and the nursing facility in the provision of care. For example, concerning the plan of care, HCFA clarified that the hospice and the nursing facility must coordinate, establish, and agree upon one plan of care for both providers.

Consequences of Coverage Finalizing the survey and certification guidelines may have been the last step needed for wider acceptance of hospice by nursing facility providers. Although HCFA did not publish statistics on the

The number and proportion of total hospice patients in nursing facilities has significantly increased since 1992.

number of Medicare hospice patients residing in nursing facilities, our reviews have confirmed that the numbers and the proportion of total hospice patients in nursing facilities have significantly increased since 1992. We also noted that nursing facilities are a popular source for hospice recruitment of new patients. Some observations:

Increasing Numbers: Admission records of the six locations we audited that were part of a national hospice chain showed significant increases in the total number of enrollments of nursing facility patients over the last few years. Overall, for these 6 hospices, nursing facility enrollments increased from about 300 in 1992 (about 3 percent of total enrollments), to about 2,300 in 1994 (about 19 percent of total enrollments). Some of the hospices had more significant increases than others. For an Illinois site, only 37 of the 1,044 enrollments in 1992 were nursing facility patients (about 3.5 percent). In 1994, 493 of its 1,307 enrollments lived in nursing facilities (37.7 percent).

We did not perform a similar review of admissions records at the nonchain hospices. However, we noted that one independent Illinois hospice included in our audits had recruited virtually all of its patients from nursing facilities.

Increasing Costs: Many, if not most, of the nursing home patients that enroll for Medicare hospice coverage are dually eligible beneficiaries. For these beneficiaries, the State Medicaid agencies pay the hospices at least 95 percent of the nursing facility rates, while the hospices, in turn, pay the nursing facilities. On top of this reimbursement is Medicare's payments to the hospices.

We believe there is no reasonable need for this two-tier payment system. The hospice daily payment for routine home care under the Medicare hospice benefit is currently more than the average Medicaid daily payment to nursing facilities even though the latter payment is designed to cover all the daily needs of a patient. During FY 1993, the daily hospice rate for routine home care was about $87. According to statistics published by HCFA, the Medicaid program spent $34.3 billion in FY 1993 for 416.2 million days of nursing home services. These payments averaged about $82 per day--$5 less than the daily hospice rate.

> The hospice daily payment for routine home care is more than the average Medicaid daily payment designed to cover all the needs of a patient.

Potential for Conflicts of Interest: Enrollments of nursing home patients with hospices is attractive to the nursing homes because hospice staff often relieve the nursing homes of several duties and responsibilities creating the potential for the homes to cut their costs. The potential for conflict of interest would be even greater if a nursing home provider also became certified as a Medicare hospice provider. The current reimbursement methodology would permit the provider to virtually double its revenue with little, if any, incremental costs.

In addition, we found that the chain hospices we reviewed, although receiving only 95 percent of the nursing facilities' rates from State Medicaid agencies, were paying the nursing facilities the full amount that they had received before hospice enrollments. This practice puts other hospices, paying nursing facilities at the 95 percent level, at a competitive disadvantage when recruiting patients.

Potential for Patient Neglect: Under the current system, hospices could enroll nursing facility patients and then provide little or no additional care. Under a separate project, we are reviewing a random sample of hospice patients in nursing facilities to establish what additional services, if any, the hospices are providing to the patients. When completed, a report on the results of this inspection will be issued separately.

Medical Guide for Non-Cancer Diagnoses In November 1995, HCFA distributed a medical guide entitled "Medical Guidelines for Determining Prognosis in Selected Non-cancer Diseases" to its regional offices. The guide, developed by an industry group, addressed heart disease, pulmonary disease, and dementia. The HCFA instructed its Regional Administrators to distribute copies of the guide to the RHHIs along with written instructions for their use. In its instructions, HCFA advised that work is continuing on refining and expanding the guidelines and that the guide should be used by the RHHIs, along with all other available documentation, when performing medical reviews on claims from aberrant hospice providers.

Since these guidelines pertain to illnesses that are common among elderly nursing home patients (a population of beneficiaries that our reviews have shown to be prone to incorrect life expectancy prognoses by hospice physicians), we believe that HCFA should ensure that they are based on scientifically sound conclusions. We discussed the guide with medical staff at one RHHI and shared it with one PRO that participated in our review. The RHHI believed that the guide was "vague," while the PRO raised concerns about the validity of medical studies listed in the guide as data sources. Although these comments do not lead us to conclude that the guide is inappropriate, they do point out the need for HCFA to assure that the guidelines are considered in development of policies that will be used to adjudicate hospice claims.

> The HCFA needs to assure that the medical policies are based on scientifically sound conclusions.

Changes are Needed Problems with hospice coverage for nursing facility patients are complex and will be difficult for HCFA to solve. However, unless there are changes, the hospice program will continue moving toward covering all chronically ill individuals. Significant amounts are currently being spent under the Medicare hospice program on behalf of beneficiaries in nursing facilities who are not

> Amounts are also spent unwisely through simultaneous Medicare and Medicaid payments for nursing home patients who are terminally ill.

terminally ill. Additional amounts being spent through simultaneous Medicare and Medicaid payments on behalf of those beneficiaries in nursing homes who are terminally ill may also be unwise.

The HCFA needs to begin reviewing its options for changes to coverage for beneficiaries in nursing facilities. It could begin to seek an amendment to the law that would reduce to the lowest level the Medicare hospice payments for nursing facility patients or give these patients a choice between nursing home care or hospice care. If the hospice benefit for nursing facility patients was reduced to a proper level, terminally ill patients could still receive palliative services from the nursing facilities.

Another possibility would be legislative changes to the reimbursement methodology for hospice and nursing care involving dually eligible beneficiaries. The results of our ongoing inspection should be helpful to HCFA in inventorying the services currently provided. These results might also demonstrate the need for either reducing the daily hospice payment or the amount paid by the Medicaid State agencies.

Marketing Techniques

The significant increases since 1992 in the number of nursing facility residents enrolled at selected locations of the national chain we reviewed may be attributable to marketing strategies that emphasized the recruitment of long-term care patients. These strategies included the distribution of written promotional literature and the payment of sales commissions to sales staff.

Promotional Literature This chain hospice's marketing staff used written promotional literature for sales presentations and for distribution to the public, physicians, nursing homes, and others. Although this material was comprehensive and generally reflected hospice program requirements, it placed considerable emphasis on the availability of hospice benefits for long-term care patients while downplaying or ignoring the 6-month prognosis requirement. The literature stressed the "availability of care in the most comfortable, appropriate environment: in the home, a nursing home, or a home-like inpatient hospice setting." One promotional segment, titled "A Partnership of Care: (Corporate name) and the Long Term Care Facility," conveyed the message that hospice services were supplemental to nursing home services and more specifically that "services do not substitute for those already provided under existing reimbursement."

This chain hospice's promotional material additionally stated that "individual patients may receive hospice services for periods beyond six months" and that "after 210 days, the hospice periodically continues to recertify the patients' six month terminal prognosis." These statements create the perception that the initial terminal prognosis was of limited importance and that hospice benefits may almost routinely be provided over an indefinite time period.

We believe that another promotional item was misleading in defining who may be appropriate for hospice services. This item was a laminated pocket-sized reference card distributed to physicians. The card included a scale, known as the "Karnofsky scale," for assigning points to a patient's general physical condition. According to the card, a patient scoring 50 or less points was a candidate for referral to the hospice. The card indicated that this included patients who "require considerable assistance from others and frequent medical care." Physicians might, therefore, incorrectly conclude that their referrals could be based solely on the Karnofsky scale, without regard to other medical evidence in support of a prognosis of a life expectancy of six months or less. The original source for the Karnofsky scale was Appendix A of the "Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases" also referred to on page 13 of this report.

> The literature was misleading and created the perception that terminal prognosis was of limited importance.

Sales Commissions The national chain's marketing staff responsible for patient recruiting were paid commissions under incentive compensation plans. Since the amounts of the commissions were directly tied to the length of a patient's stay, we believe this marketing tactic encouraged the recruitment of long-term patients, many of whom our review found ineligible for hospice benefits.

> Commissions were directly tied to the length of a patient's stay, encouraging recruitment of long-term patients.

The marketing staff was divided into two primary groups. The first group, referred to as "Sales Representatives," was assigned responsibilities that included direct contacts with attending physicians. According to job descriptions, the representatives developed early and appropriate referrals by creating and sustaining business partnerships with referral sources. The second group, known as "Long Term Care Liaisons," had responsibilities similar to the Sales Representatives but dealt primarily with long-term care facilities, usually nursing homes, and long-term care physicians. Each Sales Representative and Long Term Care Liaison was assigned a geographic "territory" within which referral sources were located.

Commission payments for these two groups, under incentive compensation plans that covered FY 1995, were calculated as follows:

Sales Representatives: Commissions were paid in addition to a base salary. The amounts were determined by multiplying the total number of days of hospice patient care (patient-days) within the representative's territory by a factor which reflected the level of achievement of assigned sales performance objectives. This factor ranged between $.26 and $1.69 per day of care for each patient. Commission payments were limited only by the actual number of patient-days realized.

Long Term Care Liaisons: Commissions were based on performance-driven incentives ranging between 5 percent and 25 percent of the liaison's base salary. The percent was determined by measuring the average daily census of hospice patients living in long-term care facilities in the liaison's territory against pre-established marketing objectives. Since the base salary limit for a liaison was about $46,000, the commissions generally could not exceed about $11,500 annually.

The use of commissions as incentives for patient recruiting has been a significant part of this chain's marketing strategy. During FYs 1994 and 1995, about 100 commissioned sales staff worked throughout this nationwide chain of hospices. The total amount of commission payments exceeded $1 million in each of these years. On an individual basis, when considering commission payments totaling over $30,000 each, several of the "top" sales representatives received annual compensation of between $80,000 and $100,000.

We recognize that effective marketing techniques are essential to health care providers that compete with one another for business. Commission payment systems such as the one used by this chain, however, promote a revenue enhancement mentality at the sales staff level which is contrary to the best interests of the beneficiaries and the Medicare program.

A recent article in *The New England Journal of Medicine* raises additional concerns.[1] Addressing the relatively long survival of patients after enrollment in large and for-profit hospices, the article suggested that the hospices may encourage the early enrollment of patients as a way to recoup the high up-front costs associated with admission. It also posed the questions:

> "Do such hospices have efficient outreach programs or place fewer barriers to enrollment?"
>
> "Do they offer care in such a way that patients, families, and physicians are willing to consider earlier enrollment?"
>
> "Or do they inappropriately admit patients they expect to live many months after enrollment?"

Internal Controls

The hospice program has control features intended to prevent or, at least, limit the payment of Medicare funds on behalf of beneficiaries who are not terminally ill. Our beneficiary eligibility reviews have shown, however, that these controls should be enhanced to achieve greater effectiveness as program safeguards. The control areas needing improvement include

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Christakis, N.A., "Survival of Medicare Patients After Enrollment in Hospice Programs," *The New England Journal of Medicine*, 335: pp. 172-178.

(1) physician certifications and recertifications, (2) RHHI claims processing edits and medical reviews, and (3) the "cap" on overall reimbursement.

Certifications/Recertifications The primary control to ensure that a beneficiary qualifies for hospice services on the basis of a prognosis of a six month or less life expectancy is the physician certification and recertification of terminal illness. According to the hospice regulations, the initial certification must be made by both the beneficiary's attending physician, if one exists, and the hospice physician, while the recertifications of terminal illness can be made by the hospice physician only.

The hospices included in our review had designed their own forms for documenting the physician "certifications/recertifications." For example, each of the six hospices in the national chain that we reviewed used a form for the initial certification, signed by the attending physician and hospice physician, that included the pre-printed statement:

> "Based upon my clinical expertise, and in consultation with the primary physician and Hospice Interdisciplinary Care Team, I certify that the above-named patient is suffering from a terminal illness and has a prognosis of 6 months or less."

The form used by a nonchain Illinois hospice was also signed by the attending physician and the hospice physician. However, it simply included a section where one of three options could be marked to reflect the prognosis. The options were (1) less than 1 month, (2) 1 to 4 months, or (3) 4 to 6 months.

None of these forms included a section which explained the responsibility of the physicians to assure the accuracy of the prognosis data they certified. Since the hospice physician's certification of terminal illness is required in order for the hospice to receive Medicare payments, we believe that the certification/recertification forms should include statements similar to the warning statements included on Medicare claims forms. For example, a hard-copy Medicare claim form includes the following notice:

> Certification forms need a warning statement so hospice physicians can be held more accountable for their actions.

> "This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws."

If a similar notice were used on all hospice certification and recertification forms, we believe that the physicians, especially the hospice physicians, would be constantly reminded about their responsibilities for authorizing Medicare payments.

The need to establish accountability for hospice physicians can best be illustrated with examples. Although these physicians certified and recertified patients for hospice, we found numerous instances where their own notes in patient files indicated they were unsure of the prognosis. A few examples from patient files at hospices follow:

> "No laboratory studies are on the medical record...it is difficult to decide what her long term prognosis might be..." (discharged alive after 9 months - Medicare paid $25,143)
>
> "Knowing the diagnosis (Alzheimer's) I do not consider this patient at end stage...but...it is difficult to assess the life span of this patient..." (discharged alive after 10 months - Medicare paid $27,661)
>
> "...the life span is very difficult to determine...maybe less than a year or so." (discharged alive after 1 year 9 months - Medicare paid $72,718)
>
> "At the present time she looks very stable. No signs of congestive heart failure..." (discharged alive after 8 months - Medicare paid $26,774)
>
> "I do not think that she is appropriate at this time for hospice and I will make recommendations accordingly." (died in hospice after 4 years 9 months - Medicare paid $163,149)

Had these hospice physicians been constantly aware of the potential for penalties and/or prosecution, they may have been reluctant to sign the certification forms.

RHHI Edits and Reviews Controls over hospice payments also include pre-payment claims processing edits and focused medical review activities of the RHHIs. We believe that these controls could be made more effective as tools to halt hospice spending on ineligible beneficiaries. The controls need to focus on early detection of problems in order to prevent hospices from certifying beneficiaries who do not have terminal medical conditions.

> Controls should focus on the early detection of problems through front-end edits and other activities.

As we pointed out in our March 21, 1996 report entitled "Review of Medicare Hospice Beneficiary Eligibility in the Commonwealth of Puerto Rico" (CIN: A-02-94-01035), HCFA's instructions to the RHHIs have been silent concerning the implementation of any "front-end" hospice eligibility computer edits. Although several pre-payment edits unique to hospice claims are in use for claims processing, the edits pertain to payment screens unrelated to medical eligibility. Examples include screens for tracking hospice election periods, limiting the number of respite inpatient hospitalization days, and controlling the number of transfers between hospices. Furthermore, our visits to RHHIs servicing hospices covered in this summary report

confirmed that focused medical reviews have not been used to identify and recover payments on behalf of ineligible beneficiaries.

As recommended in the Puerto Rico report, we believe that claims processing controls for hospices could be improved by instituting a "front-end" diagnosis-based edit to identify suspect claims for medical review. Such a control would certainly be appropriate for such diagnoses as debility unspecified, dementia, senility, and others correlated with high rates of ineligibility.

Another option for consideration is a requirement for pre-enrollment approval by the servicing RHHI for all hospice admissions. This could be done on a trial basis or until "incorrect terminal prognosis" becomes less of a problem. We noted that private insurance companies often require prior approval for hospice benefit coverage.

A final suggestion for improvement in control activities of RHHIs is the implementation of a quality control program for hospice medical eligibility. We believe that medical reviews of random samples, selected periodically from new hospice certifications, could help detect and control inappropriate hospice admissions. Quality control programs have proven to be successful under the Medicaid program.

Cap on Overall Reimbursement The "cap" report system, an existing control aimed at limiting the amount of annual Medicare payments to hospices, has been ineffective in curbing hospice spending for long-term beneficiaries. This control places a "cap amount" on the overall aggregate payments made to a hospice. The manner in which the cap amount is calculated, however, allows hospices to offset long-term cases, such as those included in our review, with short-term cases. It also encourages hospices with long- term cases to continue to find large numbers of new admissions each year in order to avoid reaching the reimbursement ceiling. Further reducing the cap's effectiveness as a control was the general lack of review and verification of cap reports by the RHHIs.

> The cap system allows hospices to offset long-term cases, such as those in our review, with short-term cases.

The hospice cap system was established by law under section 1814(I)(2) of title XVIII of the Act. According to the implementing regulation at 42 CFR 418.309, a cap period runs from November 1st of each year through October 31st of the next year. The cap amount is calculated essentially as follows:

> *Number of Medicare beneficiaries who have not been included in any previous cap calculation and who have filed an election to receive hospice care during the*

period beginning 35 days before the beginning of the cap period through 35 days before the end of the cap period.

...TIMES...

Individual "per beneficiary" cap amount. This amount is adjusted each year for inflation or deflation. (For the cap period ending October 31, 1995, the amount was $13,469.)

...EQUALS...

Hospice's cap amount. This is the ceiling on reimbursement for the cap period.

The hospice's cap amount is compared to the total payments made for hospice services furnished to all Medicare beneficiaries during the cap period, regardless of when they filed elections to receive hospice care. Any payments in excess of the cap amount must be refunded by the hospice.

Our review disclosed that the cap was generally ineffective as a control to limit overall Medicare reimbursement to hospices. Although each of the hospices included in our review had certified large numbers of long-term beneficiaries, none had filed a cap report that showed a refund was due the Medicare program. Specifically, the cap system was not working because:

- Hospices could demonstrate compliance through a mix of long-term cases, such as nonterminal nursing home patients, with short term cases, patients whose deaths were imminent. For example, in 1995 when the cap amount per beneficiary was $13,469, the daily rate paid for routine home care was about $90. Therefore, for a beneficiary receiving only routine home care, the cap would be theoretically attained in about 150 days (13,469/90), or about 5 months. However, since the overall cap amount is computed in the aggregate, a 300-day stay (twice the above 150 days) could be offset by a single beneficiary that had a 1-day stay.

- Since the cap amount is based only on the number of beneficiaries newly electing to receive hospice services during the cap period, the cap system encourages hospices with large numbers of long-term cases, especially cases having stays in excess of 1 year, to continue to find new enrollments in order to avoid reaching the cap amount.

- Although cap reports were filed by the hospices with their servicing RHHIs, the RHHIs often did not verify the reported data or review the reports in a timely manner.

Our review of cap reports filed by the six hospices in the national chain showed that although 29 percent to 57 percent of the active caseloads of the hospices had been active for more than 210 days, cap amounts were not exceeded because the hospices also provided services to large numbers of very short-term beneficiaries. For a Texas hospice, 267 of the 1,419 beneficiaries admitted during the 1994 cap period died within 5 days. Eighty-one died in 1 day or less. The hospice was apparently able to enroll these patients on such short notice because of its arrangements with hospitals and nursing homes. Without these 81 enrollments, the hospice would have exceeded its cap amount by about $200,000.

> The hospice was apparently able to enroll patients on short notice because of its arrangements with hospitals and nursing homes.

The effect of short term enrollments on the cap amount is also apparent for an Illinois hospice. On its cap report for the 1995 cap period, the hospice reported 633 beneficiaries as having elected hospice services. Of the 633 beneficiaries, 75 had died in 2 days or less. Without these 75 enrollments, the hospice would have exceeded its cap amount by over $500,000. We also noted that 170 of the 633 beneficiaries had died within 5 days of their enrollments. Without the 170 enrollments, the hospice would have been required to repay about $1.8 million of the total $8.1 million that it received from Medicare during the 1995 cap period.

Unlike the chain related hospices, some hospices may not have networks for locating and enrolling large numbers of beneficiaries a short time before their deaths. Such was apparently the case for another hospice in Illinois. This company is currently under investigation by the FBI for reporting fictitious numbers of beneficiaries on its cap report.

We believe that HCFA needs to seek legislation for a more meaningful cap on hospice reimbursement. Under the current system, equal weight is given to each beneficiary enrollment. The HCFA may want to consider including a factor that would give long-term cases more weight in the calculations, thereby eliminating the ability to offset long-term cases with short-term cases on a one-for-one basis.

Problems with the mechanics of the cap calculation were compounded by a lack of emphasis on the need for an independent review of the cap reports by the RHHIs. We noted that some RHHIs were not verifying the number of reported hospice enrollments with their own computer records. At one RHHI, employees responsible for approving cap reports were unaware of important cap requirements and cap reports filed by hospices for periods after the 1992 year had not been approved.

EFFECTS OF INELIGIBLE ENROLLMENTS

While the 1,373 cases found to be ineligible in our reviews may represent a small number of the total beneficiary enrollments over the last several years at the 12 hospices, they represent a

significant amount of the Medicare payments. To date, we issued five individual reports to HCFA recommending recovery of about $17.2 million for ineligible payments made to these hospices. About $83 million had been paid to the 12 hospices on behalf of the 1,373 beneficiaries through the latter part of Calendar Year 1995. This amount does not include the monthly Medicare payments that have continued in 1996 for those beneficiaries who are still enrolled. It also does not include about $14 million that has been paid on behalf of the 262 beneficiaries for whom the PRO physicians were unable to determine eligibility. When the $20 million applicable to Puerto Rico is considered, the impact of ineligible hospice enrollments that we have identified has exceeded $103 million. The HCFA was notified to recover about $37.2 million for ineligible payments made to these hospices.

Although misspent dollars are a major concern, the programmatic effect on beneficiaries was also important. Prior to the passage of the Balanced Budget Act of 1997, beneficiaries who were discharged as nonterminal in their fourth (final) election period lost their entitlement to future hospice coverage. The law now allows hospices to discharge patients whose conditions improved without loss of future benefits to the hospice beneficiary. This change addressed one of our recommendations in this report. Quality of care issues present additional concerns when beneficiaries with nonterminal illnesses receive palliative, rather than curative treatment.

Financial Effect

Several of the 12 covered hospices referred us to statistics showing that the number of beneficiaries included in our reviews represented only a small portion of the total number of beneficiaries that had been enrolled. They also pointed out that their "average lengths of stay" were well within reason.

Over time, long-term cases (over 210 days) tend to accumulate and become a disproportionate share of the active caseload. While these cases represent a small part of the total number of hospice enrollments, they represent an increasingly large part of the active caseload and of Medicare payments. For example, at one Florida hospice, the active caseload in November 1995 of 422 cases had accumulated over a 4-year period. Of the 422 active cases, 153 cases (36 percent) had been active for over 210 days. Our review of the 153 cases found that 112 (73 percent) were ineligible. Assuming a minimum of $90 a day for routine care, the hospice was receiving approximately $300,000 monthly ($90 times 112 times 30 days) in unallowable Medicare payments. Similar situations existed at other

(Enrollments at One Florida Hospice)

Year	Total Enrollments	Still Active (as of Nov 1995)
1992	2,217	15
1993	2,205	38
1994	2,210	56
1995 (thru Nov)	2,143	313
Total	8,775	422

hospices. For the six hospices in the national chain that we reviewed, we found that long-term cases represented between 29 percent and 57 percent of the active caseloads. Active caseload is the total number of patients enrolled in a hospice at a given point in time. In our opinion, the percentage of ineligible beneficiaries in the active caseload represents a more meaningful measure than the percentage of total enrollments.

Many of the beneficiaries included in our reviews had received hospice services for years. For the 6 hospices in the national chain, 473 of the beneficiaries found to be ineligible were still active at the time of our site visits. Of the 473 beneficiaries, 84 had been receiving Medicare-reimbursed hospice care since 1992 or earlier. As of October 1995, the Medicare payments made on behalf of only these 84 cases totaled $10.4 million.

> Many beneficiaries in our review had received hospice services for years.

Also, as we described on page 21, some of the hospices were enrolling large numbers of beneficiaries that had very short lengths of stay. A single beneficiary enrolled for 1 year (365 days) can generate the same Medicare revenue for routine care as 73 beneficiaries enrolled for 5 days each (73 x 5 days = 365 days). These short-term enrollments significantly affect the "average length of stay" but such enrollments generate only a negligible portion of Medicare reimbursement received by the hospices.

Programmatic Effect on Beneficiaries

An unfortunate consequence for beneficiaries who were inappropriately enrolled and subsequently discharged alive from these hospices is the possible loss of eligibility for future hospice coverage. According to section 210 of HCFA's Hospice Manual, a hospice may discharge a patient if it discovers that the patient is not terminally ill. However, if a beneficiary's hospice benefit is revoked during the fourth benefit period, the Medicare hospice benefit is exhausted, and the beneficiary is not eligible for future hospice coverage. As previously mentioned, this provision was changed by the Balanced Budget Act of 1997. However, according to 42 CFR 418.24, a beneficiary also waives all rights to Medicare payments for the duration of the election of hospice care for any Medicare services that are related to the treatment of the terminal condition, except for services provided by the hospice, another hospice under arrangement, or by the individual's attending physician. Since 1,373 beneficiaries in our reviews were determined by the PRO physicians to not have terminal medical conditions, questions arise as to the appropriateness of the care that they received. Hospice may provide only palliative care and curative treatment may still have been needed.

> Questions arise as to the appropriateness of care given to beneficiaries who were not terminal.

Although the medical reviews were not designed to address "quality of care" issues, we discussed this area with a few of the PRO physicians. We were told that even if curative treatment is not recommended, pain management may also not always be in a "nonterminal" patient's best interests. The cited example involved the use of narcotic drugs in pain management that may be contraindicated for patients requiring oxygen therapy.

IMPACT OF ATTENTION GIVEN TO HOSPICE PROBLEMS

As shown graphically on page 9, the percentage of long-term hospice cases peaked in 1994 when about 18 percent of all active cases had been in hospice care for over 210 days. This percentage then began to fall slightly, with a more noticeable decline during 1995 and into 1996. At the end of February 1996, it had fallen to about 14 percent. Staff at one RHHI attributed this decline in long-term cases to the attention being given to the potential problems identified in the hospice program.

As our and HCFA's attention to the hospice problems identified conditions that needed to be addressed, beginning in Puerto Rico in 1994 and expanding with ORT in 1995, general awareness increased throughout the hospice industry about the importance of complying with the program's medical eligibility requirements. For example, in October 1995 we issued a Medicare Advisory Bulletin to consumers, health care professionals, and health care associations titled "Questionable Practices Affecting the Hospice Benefit." This bulletin was later published in the Federal Register of November 2, 1995 for more widespread distribution. The bulletin explained the purposes of hospice care and highlighted several practices used by providers for maximizing Medicare reimbursements, including the making of incorrect determinations of a person's life expectancy.

Actions taken by hospices to subsequently modify their eligibility caseloads can be illustrated through statistics that we obtained for providers in one State. The number of beneficiaries discharged from these hospices for reasons other than death normally averaged about 600 per month. These discharges were attributable to several reasons, including voluntary elections by beneficiaries, transfers to other hospices, and medical determinations that terminal prognoses do not exist. We noted that during the month of December 1995--immediately following the release of our advisory bulletin--over 5,200 beneficiaries were discharged by these hospices for reasons "other than death." In January 1996, the number of such discharges returned to about 500 (near its previous level). We did not obtain similar statistics for hospices in other states, but we do know that from 1994 through February 1996 a 4 percent drop (from 18 percent to 14 percent) was realized in the percentage of active cases that were in hospice care for more than 210 days.

CONCLUSIONS AND RECOMMENDATIONS

Several studies have been made on the cost effectiveness to the Government of the hospice program. Some of these studies compared the cost of traditional Medicare services to the cost of hospice services for terminally ill beneficiaries. A study made for HCFA in 1988 by a consultant group is still quoted by the hospice industry in support of the program's cost effectiveness. The study concluded that Medicare saved $1.26 for each $1.00 spent on hospice care. This study, however, was made during times when hospice care was generally not provided to nursing home residents--and when hospice patients were more commonly cancer patients.

The Balanced Budget Act of 1997, enacted after publication of our draft report, resulted in numerous modifications of Medicare's hospice benefit. These modifications included allowing hospices to discharge patients whose conditions improved without loss of future benefits to the hospice beneficiary (which addressed one of the above recommendations) and a new requirement for more frequent certifications of eligibility after 180 days of hospice care.

We identified $83 million of Medicare payments made to hospices for the ineligible beneficiaries identified by our audits. We will also be recommending that the RHHIs conduct medical reviews of the cases with insufficient medical evidence to determine hospice eligibility, and recover amounts subsequently determined to be overpayments. We have issued 5 reports to HCFA recommending that the RHHIs recover $17.2 million. The remaining 7 hospices representing ineligible payments totaling $65.8 million are pending additional OIG review of their activities.

Systemic problems detailed in this report require direct action by HCFA rather than the RHHIs alone. Accordingly, we are making the following recommendations.

We recommend that HCFA consider:

1. Reinforcing requirements that certification of the terminal illness be based on the HCFA requirement of a "6-month prognosis." A direct bulletin or memorandum from HCFA should be sent to the industry advocacy groups for dissemination to all hospices.

HCFA's Response: The HCFA indicated that the Balanced Budget Act of 1997 included a provision applicable to physician certifications for hospice and that it is considering reinforcing the "6-month prognosis" when issuing operational instructions for the statutory change.

OIG's Comments: The proposed action would comply with the intent of our recommendation.

2. Prohibiting the practice of hospices paying nursing facilities more for "room and board" than the hospices receive from the State Medicaid agencies on behalf of dually eligible beneficiaries.

HCFA's Response: The HCFA agreed that hospices should not pay nursing facilities for more services than they have arranged to purchase under their contracts with facilities and indicated that it would more fully address this issue when responding to our OEI report entitled "Hospice and Nursing Homes: Contractual Relationships."

3. Informing hospices that marketing materials and sales techniques should prominently include discussion of hospice eligibility requirements under Medicare so that beneficiaries and their attending physicians are not misled.

HCFA's Response: The HCFA concurred.

4. Monitoring the use of sales commissions by hospices as incentives for patient recruiting that could result in improper Medicare hospice payments.

HCFA's Response: The HCFA agreed that the use of sales commissions by hospices may be inappropriate and report such practices to the extent that they are able to identify them to the Office of Inspector General.

5. Adding a warning statement to hospice certification forms to make hospice physicians more accountable when making certifications of terminal illnesses.

HCFA's Response: Although HCFA concurred with the intent of the recommendation, it did not agree with a warning statement. Instead, it indicated that a more affirmative flavor to the wording of the hospice certification would achieve the desired results.

OIG's Comments: We continue to believe a "warning" statement is appropriate based on the numbers of ineligible admissions disclosed in this report.

6. Strengthening claims processing controls of the RHHIs, to include:

a) instituting a "front-end" diagnosis-based edit to identify suspect claims for subsequent medical review,

b) establishing a targeting technique for hospice admissions that will identify aberrant practices for early payment review, and

c) implementing a quality control program for hospice medical eligibility based on reviews of random samples, selected periodically from new hospice admissions.

HCFA's Response: The HCFA stated that it agreed with the intent of the recommendation but does not support a full prepayment review of all claims involving particular diagnoses such as dementia/senility, debility unspecified and/or Alzheimer's disease, etc. However, HCFA agrees to target certain hospice admissions of beneficiaries based on trends they uncover using a more program-wide quality control priority process.

OIG's Comments: We are encouraged by HCFA's interest in targeting problematic diagnosis of beneficiaries admitted to the hospice program. We continue to believe that certain diagnoses as outlined in our report result in a large number of ineligible hospice claims. However, the above recommendations have been modified from the draft report to recognize HCFA's need for flexibility in targeting certain hospice admissions for payment review.

7. Proposing legislative change for a more meaningful "cap" on hospice payments by giving more weight to long-term cases than under the present system.

HCFA's Response: The HCFA agreed with the need to further review the cap methodology; however, it believes that it is too early in the process to commit to a legislative proposal.

OIG's Comments: After HCFA performs further analysis, it may agree that a legislative change is needed. We would be pleased to participate in additional discussion or to furnish technical advice on this matter.

8. Requiring the RHHIs to make timely reviews of hospice cap reports and to verify the reported numbers to their computer records.

HCFA's Response: The HCFA concurred with the recommendation.

9. Seeking legislation that would restructure the use of benefit periods so that individuals who did not need or who no longer need hospice care could be discharged without prejudice to eligibility, during a defined hold harmless period of program adjustments.

HCFA's Response: The HCFA agreed and stated that provisions of the Balanced Budget Act of 1997 address our recommendation.

10. Seeking an amendment to the law that would change the reimbursement methodology for concurrent hospice and nursing facility care involving dually eligible beneficiaries. These changes should include a reduction in the amount of Medicare and Medicaid funds paid a hospice for dually eligible nursing home patients to the lowest level necessary.

HCFA's Response: The HCFA concurred with the recommendation and stated that it is developing a legislative proposal to address this issue.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: AUG 22 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Hospice-A Program at Risk," (A-05-96-00023)

We received the above-referenced report that discloses results of audits of Medicare hospice services.

Our detailed comments on the report recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report.

IG
EAIG
SAIG
PDIG
DIG-AS
DIG-EC
DIG-EI
DIG-OI
DIG-MP
AIG-LC
OGC/IG
ExecSec
Date Sent 8/26

Comments of the Health Care Financing Administration (HCFA) on
Office of Inspector General (OIG) Draft Report:
"Hospice - A Program At Risk," (A-05-96-00023)

Overall Comments

One area which we believe needs to be mentioned in the report is the state of the art of making medical prognoses. We do not dispute that the physicians who were engaged to do the reviews were well educated and appropriately briefed; however, we also know from our readings that the art of accurate predictions about terminal prognosis is not exact. As a result, we also know that the findings of the hospice physicians and the HCFA Peer Review Organization reviewers could reflect some degree of inaccuracy. We do not believe that this negates the findings overall but do believe that it should be acknowledged generally in the report."

We are pleased to report that the Balanced Budget Act of 1995 included a hospice provisions that addresses some of the concerns raised in this report. The 4th, and final, benefit period has been eliminated and replaced with an unlimited number of 60 day benefit periods. We expect this change to address concerns that many hospices faced with a terminally ill beneficiary who has gone into remission in the 4th benefit period and no longer meets the Medicare hospice eligibility criteria. Previously in this situation, hospices were required to discharge this beneficiary, who would then lose any future hospice eligibility. With this legislative change, the beneficiary can be discharged and then readmitted if the terminal illness becomes severe enough to justify a prognosis of 6 months or less to live should the illness run its normal course. Now hospices will be required to recertify a beneficiary's eligibility for hospice care more frequently as a result of this change. We are hopeful that this change will eliminate industry concern with discharging beneficiaries whose condition may be stabilized only temporarily during the 4th benefit period and that we will begin to see the number of individuals remaining on the hospice benefit for an inappropriate number of consecutive days decrease.

OIG Recommendation 1

Reinforce requirements that certification of the terminal illness be based on the HCFA requirement of a "6 month prognosis." A direct bulletin or memorandum from HCFA should be sent to the industry advocacy groups for dissemination to all hospices.

HCFA Response

The Balanced Budget Act of 1997 included a hospice provision specific to physician certification of an individual's terminal illness. We will consider reinforcing the requirement of physician certification of terminality with a life expectancy of 6 months or less should the illness run its normal course when issuing operational instructions for this statutory change.

HCFA did send a memo to all Regional Home Health Intermediaries (RHHI's) as a reminder that all hospice patients must meet the "6 month prognosis" requirement in order to be eligible for Medicare reimbursement in November 1995. With this memo we also sent a copy of National Hospice Organization (NHO's) "Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases." RHHIs were informed at that time that these guidelines could be used as a tool to assist in the claims process, but that decisions were to be made based on the medical records and medical judgement. It is our intention for these guidelines to assist physicians in making as accurate a prognosis as possible, but we realize that the guidelines will need to be subject to continual development and review.

OIG Recommendation 2

Prohibit the practice of hospices paying nursing facilities more for "room and board" than the hospices receive from the State Medicaid agencies on behalf of dually eligible beneficiaries.

HCFA Response

We agree that hospices ought not to pay nursing facilities for more services than they have arranged to purchase under their contracts with the facilities. Accordingly, we believe that such contracts should reflect the full range of services being purchased, including the price to be paid in consideration for them. We sent you a May 28 memorandum commenting on "Hospice and Nursing Homes: Contractual Relationships" which contained at item 6 a discussion of the factors that affect the hospice's payments to skilled nursing facilities or nursing facilities. We believe that this issue should be more fully dealt with in the context of that report; however, we also agree fully that any undocumented excess payments could well (and should) trigger an investigation by OIG under the anti-kickback statutes.

OIG Recommendation 3

Establish standards for marketing materials and techniques to ensure that beneficiaries and their attending physicians are not misled about hospice eligibility requirements.

HCFA Response

We agree that inappropriate marketing practices should be prohibited. We would support issuing some type of letter reminding hospices that they could be targeted for an OIG audit if they use marketing materials and techniques that mislead beneficiaries, and their attending physicians, about hospice eligibility. In terms of this report, we suggest that you reword your recommendation to read, "Inform hospices that marketing materials and techniques should include discussions of Medicare hospice eligibility requirements."

OIG Recommendation 4

Eliminate or otherwise monitor the use of sales commissions by hospices as incentives for patient recruiting.

HCFA Response

We agree that abuse of the anti-kickback statutes by hospices is inappropriate. To the extent that these practices occur, we believe that hospices should be targeted for OIG investigations. We will report such practices to the extent that we are able to identify them.

OIG Recommendation 5

Add a warning statement to hospice certification forms to make hospice physicians more accountable when making certifications of terminal illnesses.

HCFA Response

We concur with the objective of the OIG's recommendation; however, we would recommend a different wording for the recommendation that reflects a more affirmative flavor to the response. We would revise the recommendation to read, " Add a statement to hospice certification forms to advise hospice physicians that they are certifying to their belief that the patient's medical prognosis at the time of certification is 6 months or less if the disease follows its ordinary course." We believe that this achieves the results desired by OIG.

OIG Recommendation 6

Strengthen claims processing controls of the RHHIs, to include: (a) instituting a "front-end" diagnosis-based edit to identify suspect claims for subsequent medical review, (b) establishing a pre-enrollment approval process for hospice admissions on a trial basis or until "incorrect terminal prognosis" becomes less serious a problem, and © implementing a quality control program for hospice medical eligibility based on reviews of random samples, selected periodically from new hospice certifications.

HCFA Response

We agree with the intent of the recommendation; however, in the interests of flexibility and the most effective use of intermediary claims processing dollars, we believe that parts (b) and (c) of the recommendation should be more general so that, for example, an intermediary could target certain hospices cases at admission for post-payment review and so that quality control priorities can be set program-wide based on cost-effectiveness criteria.

OIG Recommendation 7

Propose legislative change for a more meaningful "cap" on hospice payments by giving more weight to long term cases than under the present system.

HCFA Response

We agree with the need to look at whether there is a way to revise the cap methodology to deal with potentially inappropriate incentives to offset expensive long stays with very short stays; however, we believe it is too early in the process to commit to a legislative proposal. We would prefer a recommendation to perform the analysis and decide upon a course of action.

OIG Recommendation 8

Require the RHHIs to make timely reviews of hospice cap reports and to verify the reported numbers to their computer records.

HCFA Response

We concur. Resources for reviews are limited and we rely on our RHHIs to set priorities for review of home health and hospice services. Our approach to review encourages contractors to address those issues they find to be the most problematic. We will share these findings with our contractors.

OIG Recommendation 9

Seek legislation that would permit hospices to discharge ineligible beneficiaries who are in the final election period, without loss of future hospice eligibility for the beneficiaries, during a defined hold harmless period of program adjustments.

HCFA Response

We agree that the concern over loss of future hospice benefits for those beneficiaries in the 4th benefit period may have contributed to some of the concerns raised in this report. We believe that the provision restructuring the Medicare hospice benefit periods included in the Balanced Budget Act of 1997 will address the intent of this recommendation. With the new benefit period structure, hospices may now discharge a beneficiary who no longer meets the Medicare hospice eligibility criteria without the fear of losing all future hospice eligibility.

OIG Recommendation 10

Seek an amendment to the law that changes the reimbursement methodology for concurrent hospice and nursing facility care involving dually eligible beneficiaries. These changes could range from elimination of the hospice benefit for these nursing facility patients to a reduction in the amount of Medicare and Medicaid funds paic a hospice for dually eligible nursing home patients.

HCFA Response

We concur. Although there have not been any amendments to this part of the hospice law included in recent congressional action, HCFA will continue to work to develop a legislative proposal to address this issue.