

**Memorandum**

Date JUN 9 1995

From June Gibbs Brown
Inspector General *June G Brown*

Subject Review of Hospice Beneficiary Eligibility At Hospicio Del Oeste, Inc. (A-02-94-01029)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum alerts you to the issuance on June 13, 1995 of our final audit report on "**REVIEW OF HOSPICE BENEFICIARY ELIGIBILITY AT HOSPICIO DEL OESTE, INC.**" A copy is attached.

The purpose of this review, which covered the period November 10, 1992 through July 31, 1994, was to assess the accuracy of Hospicio Del Oeste, Inc.'s (HDO) beneficiary eligibility determinations and resultant Medicare reimbursements. Our review, which included a medical evaluation of HDO's eligibility determinations for a limited universe of 127 beneficiaries, showed that 97 (77 percent) of those eligibility determinations were incorrect. As a result, HDO claimed and improperly received Medicare reimbursements totaling about \$1.1 million. Although we did not find a reasonable explanation for HDO's high rate of error in eligibility determinations, we did determine that for the majority of the time period covered by our review, claims processing controls at the Medicare fiscal intermediary (FI), United Government Services (UGS) were not entirely adequate.

We are recommending that UGS improve its claims processing controls through the incorporation of more focused edits to detect and prevent payments on behalf of ineligible hospice beneficiaries. Regarding the \$1.1 million of improper Medicare reimbursements, we have referred this matter to the Office of Inspector General's Office of Investigations (OIG-OI) for possible investigative or other actions. Accordingly, UGS should coordinate with the OIG-OI prior to initiating recovery of the \$1.1 million of identified overpayments.

On March 14, 1995, UGS responded to a draft of this audit report. The UGS' written comments did not directly address our findings and recommendations but did provide valuable background information regarding the rapid growth of the hospice program in Puerto Rico, UGS' attempts to institute claims processing controls, and the controls

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currently in place. Subsequently, a UGS official verbally concurred that additional claims processing controls are warranted subject to the Health Care Financing Administration's approval.

For further information, contact:

John Tournour
Regional Inspector General
for Audit Services, Region II
(212) 264-4620

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HOSPICE BENEFICIARY
ELIGIBILITY AT
HOSPICIO DEL OESTE, INC.
SAN GERMAN, PUERTO RICO**



**JUNE GIBBS BROWN
Inspector General**

**JUNE 1995
A-02-94-01029**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Our Reference: Common Identification Number A-02-94-01029

Ms. Marva King
Director of Government Programs
United Government Services
1515 North River Center Drive
Milwaukee, Wisconsin 53212-3953

Dear Ms. King:

This report provides you with the results of our **"REVIEW OF HOSPICE BENEFICIARY ELIGIBILITY AT HOSPICIO DEL OESTE, INC."** Our review covered the period from the date that Hospicio Del Oeste, Inc. (HDO) was initially certified as a hospice facility, November 10, 1992, through July 31, 1994. The purpose of this review was to assess the accuracy of HDO's beneficiary eligibility determinations and resultant Medicare reimbursements.

Our review, which included a medical evaluation of HDO's eligibility determinations for a limited universe of 127 beneficiaries, showed that 97 (77 percent) of those eligibility determinations were incorrect. As a result, HDO claimed and improperly received Medicare reimbursements totaling about \$1.1 million during the period November 10, 1992 through July 31, 1994. Although we did not find a reasonable explanation for HDO's high rate of error in eligibility determinations, we did determine that for the majority of the time period covered by our review, claims processing controls at the Medicare fiscal intermediary (FI), United Government Services (UGS) were not entirely adequate.

We are recommending that UGS improve its claims processing controls through the incorporation of more focused edits to detect and prevent payments on behalf of ineligible hospice beneficiaries. Regarding the \$1.1 million of improper Medicare reimbursements claimed and received by HDO as a result of HDO's incorrect eligibility determinations, we have referred this matter to the Office of Inspector General's Office of Investigations (OIG-OI) for possible investigative or other actions. Accordingly, UGS should coordinate with the OIG-OI prior to initiating recovery of the \$1.1 million identified overpayment.

On March 14, 1995, UGS responded to a draft of this audit report. The UGS' written comments did not directly address our findings and recommendations but did provide valuable background information regarding the rapid growth of the hospice program in Puerto Rico, UGS' attempts to institute claims processing controls, and the controls currently in place. Subsequently, a UGS official verbally concurred that additional claims processing controls are warranted subject to the Health Care Financing Administration's (HCFA) approval. The UGS' written comments to our draft report have been summarized after the recommendations section of this report and have been included as an Appendix to this report.

INTRODUCTION

Background

Title XVIII of the Social Security Act, section 1861(dd) establishes the provisions for hospice care. Hospice is an approach to treatment that recognizes that the impending death of an individual warrants a change in focus from curative care to palliative care. The goal of hospice care is to help terminally ill individuals continue life with minimal disruption in normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, social, psychological, emotional, and spiritual services through the use of a broad spectrum of professional and other caregivers with the goal of making the individual as physically and emotionally comfortable as possible.

In order to be eligible for hospice care under Medicare, an individual must be entitled to Part A of Medicare, and be certified as terminally ill by the hospice medical director (or staff physician) and, where applicable, the beneficiary's attending physician. For purposes of the hospice program, a beneficiary is deemed to be terminally ill if the medical prognosis is that the patient's life expectancy is 6 months or less if the terminal illness runs its normal course. A Medicare beneficiary's inclusion in the hospice program is voluntary and can be revoked at any time by the beneficiary. The beneficiary has four election periods for hospice care and must be certified as terminally ill by the hospice medical staff for each of those periods. The first and second election periods have a duration of 90 days each, the third election period has a duration of 30 days and the fourth and last election period has an indefinite duration. The first three election periods total 210 days of service.

The HDO, which is located in San German, Puerto Rico, was certified by HCFA as a Medicare hospice provider (provider number 40-1520) on November 10, 1992. At the time of that certification, HDO was incorporated as a not for profit corporation under the laws of the Commonwealth of Puerto Rico. On April 6, 1994, The HDO amended its

certificate of incorporation and became a for profit corporation. During the period covered by this review, November 10, 1992 through July 31, 1994, HDO enrolled 265 beneficiaries in its hospice program and received Medicare reimbursements of \$2,203,800.

Claims for Medicare reimbursement for hospice services in Puerto Rico are processed by UGS as the regional Medicare FI under contract with the HCFA.

Scope of Review Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to assess the accuracy of HDO's eligibility determinations for beneficiaries who elected hospice coverage and to determine the amount and causes of any improper payments made to HDO for ineligible beneficiaries. The period covered by our review was from November 10, 1992 to July 31, 1994.

Our review of internal controls included a review of policies and procedures related to the creation and safekeeping of medical records. We found that HDO did not have any written policies and procedures for the creation and safekeeping of medical records, however, we found that there were certain procedures instituted and followed.

During the period November 10, 1992 through July 31, 1994, HDO enrolled 265 beneficiaries in its hospice program. Our review of HDO's beneficiary eligibility determinations was limited to 127 of the 265 determinations based on our assessment of potential risk of inaccurate determinations. In that regard, since the program was designed to benefit the terminally ill with a life expectancy prognosis of 6 months or less, eligibility determinations for beneficiaries in their fourth election period (enrolled for over 210 days) and beneficiaries discharged for reasons other than death, were presumed to have the highest risk of being inaccurate. The 127 reviewed included all determinations for active patients that had over 210 days of service (44 patients) and all determinations for patients that had been discharged for reasons other than death (83 patients).

To perform our review, we obtained the medical records for the selected beneficiaries from HDO. Our assessment of beneficiary eligibility was based on medical reviews of the beneficiaries' medical records by a physician contracted by the Puerto Rico peer review organization (PRO). Our determination of the amount of payments made on behalf of ineligible beneficiaries was based on payment history data obtained from the UGS. Due to time constraints, we did not perform procedures to validate the accuracy of the computer data furnished to us by UGS. Additionally, our review of claims processing controls at UGS was limited to correspondence made available to us and discussions with UGS officials.

Our field work was performed at HDO's offices in San German, Puerto Rico and at our offices in San Juan, Puerto Rico during the period June 1994 through October 1994.

RESULTS OF REVIEW

Our review, which included a medical evaluation of HDO's eligibility determinations for a limited universe of 127 beneficiaries, showed that 97 (77 percent) of those eligibility determinations were incorrect. As a result, HDO improperly claimed and received Medicare reimbursements totaling about \$1.1 million during the period November 10, 1992 through July 31, 1994. Although we did not find a reasonable explanation for HDO's high rate of error in eligibility determinations, we did determine that the reimbursement claims for ineligible beneficiaries were improperly paid because claims processing controls at the Medicare FI, UGS were not entirely adequate. The results of our review are summarized below.

| <u>PRO PHYSICIAN'S ELIGIBILITY DETERMINATION</u> | <u>NUMBER REVIEWED</u> | <u>PERCENT</u> | <u>TOTAL MEDICARE PAYMENTS</u> | <u>PERCENT</u> |
|--|----------------------------|----------------|--|----------------|
| Ineligible | | | | |
| - Payments Made | 83 | | \$1,070,814 | 73% |
| - No Payments Made | <u>14</u> * | | <u>-0-</u> | |
| Total Ineligible | <u>97</u> | 77% | <u>\$1,070,814</u> | |
| Eligible | | | | |
| - Payments Made | 20 | | \$ 303,484 | 21% |
| - No Payments Made | <u>2</u> * | | <u>-0-</u> | |
| Total Eligible | <u>22</u> | 17% | <u>\$ 303,484</u> | |
| Undetermined | 8 | 6% | 97,182 | 6% |
| Total | <u>127</u> | <u>100%</u> | <u>\$1,471,480</u> | <u>100%</u> |

* Note: There were no payments made to HDO for 16 beneficiaries included in our review. For these patients either UGS had suspended the related payment or HDO had not yet submitted a claim for reimbursement.

Accuracy of Eligibility Determinations

Our review showed that 97 (77 percent) of the 127 eligibility determinations reviewed were incorrect based on the clinical evidence included in the beneficiaries' medical records. A beneficiary was deemed ineligible if the clinical evidence at the time of the initial certification, did not support a life expectancy prognosis of 6 months or less.

In order to be eligible for hospice care, a beneficiary must be entitled to Medicare Part A benefits and be certified by a physician as terminally ill, with a life expectancy of 6 months or less if the terminal illness runs its normal course (42 CFR 418.20 and 418.22). The certification and other clinical evidence supporting the hospice's determination of beneficiary eligibility for hospice care are contained in the beneficiary's medical record maintained by the hospice.

Our review of beneficiary eligibility determinations at HDO was limited to 127 of 265 patients which HDO serviced during the period November 10, 1992 through July 31, 1994. The 127 eligibility determinations reviewed included active patients that had more than 210 days of service (fourth election period) and all patients that had been discharged from the hospice for reasons other than death. When we initiated our review in June 1994, HDO was providing hospice services to 80 beneficiaries, 44 of whom had more than 210 days of service and were included in our review. The balance of the beneficiaries (83) included in our review had been discharged for reasons other than death.

At our request, HCFA arranged for the PRO to provide us technical assistance in reviewing the medical records. Based on the information contained in the beneficiary medical records, a PRO contracted physician reviewed the patients' clinical records and determined whether the hospices' initial determination of beneficiary eligibility was correct. In that regard, a beneficiary was deemed ineligible if the clinical evidence of the patient's condition contained in the medical record did not support that, at the time of initial certification, the beneficiary had a life expectancy prognosis of 6 months or less. In making the determination the PRO physician considered the diagnosis and other medical factors included on documents such as, the certification of terminal illness, the hospice physicians' notes, and the nurses' notes.

The PRO physician determined that 97 (77 percent) of the 127 eligibility determinations reviewed were incorrect and that those beneficiaries were ineligible for hospice care at the time of initial certification. Additionally, for eight beneficiaries (6 percent), the physician was unable to make a determination regarding the beneficiaries' eligibility because the medical records were incomplete. For the remaining 22 (17 percent) eligibility determinations reviewed, the physician found that the beneficiaries were eligible for hospice care at the time of the initial certification.

Although eligibility for hospice care is based on a beneficiary's prognosis, the diagnosis, which identifies the beneficiary's medical condition, is one of the primary considerations in determining the beneficiary's life expectancy or prognosis. In that regard, although the diagnosis for each of the 97 beneficiaries found to be ineligible indicated a serious medical condition, the PRO physician did not find any justification in the diagnosis and other information contained in the medical record for HDO's determination that the condition would result in a life expectancy prognosis of 6 months or less.

The following is a summary of the primary diagnoses for the 97 cases found to be ineligible.

| <u>DIAGNOSES</u> | <u>NO. OF INELIGIBLE BENEFICIARIES</u> |
|---|--|
| Cerebral Vascular Accident | 21 |
| Congestive Heart Failure | 18 |
| Arteriosclerosis | 12 |
| Alzheimer Disease | 11 |
| Chronic Obstructive Pulmonary Disease | 7 |
| Cancer: (Colon; Skin; Prostate) | 4 |
| Parkinson Disease | 3 |
| Brain Disease | 3 |
| Arthritis | 2 |
| Myocardial Infarction | 2 |
| Other: (ASHD; Dementia; Foot Gangrene; Flaccid Hemipleg; Hepatitis; Peripheral Vascular Disease; Transient Ischemic Cerebral Attack; Tympanic Membrane Disease; Post Infarct Dementia; Hydrocephalus; Paralysis; Senility; Chronic Renal Disease) | <u>14</u> |
| Total | <u>97</u> |

The amount of Medicare payments HDO received on behalf of the 127 beneficiaries included in our review was ascertained from Medicare payment history files provided by the FI (UGS). According to the payment data included on those files, which included all payments through July 31, 1994, HDO had received a total of \$1,471,480 on behalf of 111 beneficiaries included in our review. The \$1,471,480 was comprised of \$1,070,814 relating to 83 ineligible beneficiaries, \$97,182 relating to 8 beneficiaries who the PRO physician was unable to determine the beneficiaries' eligibility, and \$303,484 paid on behalf of 20 beneficiaries determined to be eligible. For the remaining 16 beneficiaries included in our review (14 were found to be ineligible and 2 were found to be eligible), either UGS had suspended the related payment or HDO had not yet submitted a claim for reimbursement.

Medicare Claims Processing Controls

Our review of hospice claims processing controls at UGS, which was limited to available correspondence and discussions with UGS and HCFA personnel, disclosed apparent weaknesses in FI oversight, computer edits, and medical review. We found that for most of the period covered by our review, UGS did not have computer edits to identify claims submitted for potentially ineligible beneficiaries. We also found that until early 1994, UGS did not subject hospice claims to focused medical reviews which should have disclosed HDO's aberrant billing practices. Additionally, it appears that UGS did not provide adequate oversight due to cost and logistical problems resulting from UGS' location in Wisconsin and its lack of a sufficient number of bilingual medical review staff.

In response to our inquiry regarding the lack of medical review procedures and computer edits to identify potentially ineligible beneficiaries' hospice claims, UGS officials asserted that they were verbally instructed by HCFA personnel not to perform medical reviews of hospice claims. However, contrary to UGS' assertions, section 3901 of the Medicare Intermediary Manual includes instructions for medical review of hospice claims. Accordingly, irrespective of any asserted verbal instructions it may have received from HCFA, UGS should have established adequate procedures in its claims processing to identify hospice claims for potentially ineligible beneficiaries.

In early 1994, UGS, with the approval of HCFA, stepped up its monitoring and hospice claim review activities for all hospices located in Puerto Rico. Those actions were in response to numerous allegations of improprieties and a noticeable rapid increase in the number of facilities and claims over the last several years. As a result, most of the claims submitted by many hospice facilities in Puerto Rico, including HDO, for services rendered during 1994 have either been denied or related payments have been suspended. Those actions are commendable. However, this recent claims review activity by UGS, which is comprised predominately of focused medical reviews of providers with aberrant billings, may not adequately detect and prevent payments to other providers on behalf of ineligible beneficiaries. To alleviate that problem, we believe that UGS should further develop claims processing edits to identify claims submitted on behalf of potentially ineligible beneficiaries. In that regard, one type of edit UGS should continue to explore is one which is based on suspect diagnoses. Although claims submitted do not contain information to support a prognosis, which is the primary eligibility criteria for hospice services, they do contain a diagnosis code. Based on its past experience, UGS may be able to develop a claims processing edit which identifies claims with suspect diagnoses. Those claims could then be referred to UGS' medical review staff for further review.

Recommendations

We are recommending that UGS:

- ... Continue to improve its claims processing controls through the incorporation of focused edits to detect and prevent payments on behalf of ineligible hospice beneficiaries.
- ... Coordinate with the OIG-OI on the recovery of the \$1,070,814 of improper payments made to HDO on behalf of ineligible beneficiaries.

UGS' Comments to Draft Report

On March 14, 1995, UGS responded to a draft of this audit report. The UGS' comments did not directly address our findings and recommendations. However, UGS' comments did provide valuable insight, from a historical prospective, regarding the rapid growth of the hospice program in Puerto Rico and UGS' attempts to initiate corrective action. The UGS' response is summarized below and is included as an Appendix to this report.

In its response, UGS asserted that it had acted diligently in alerting HCFA regarding the need for initiatives to identify improper payments on behalf of ineligible beneficiaries in Puerto Rico. In that regard, UGS stated that on several occasions, starting in January 1991, UGS requested HCFA's permission to take action to identify aberrant billings and to perform medical reviews of eligibility, but those requests were not approved by HCFA until December 1993. After receiving HCFA's approval, UGS "immediately began suspending for development and review 100 percent of claims from providers and their related organizations where our previous sampling had detected difficulties." Additionally, UGS indicated that focused medical review criteria were established and installed on January 21, 1994. As a result of actions taken, UGS indicated that during the period April 1994 through December 1994, they denied 5,705 claims, totaling \$9,559,526 from all hospice providers in Puerto Rico. The UGS officials also indicated that they were recently directed by HCFA not to change claims processing controls.

OIG's Response

We recognize and commend UGS' efforts to establish claims processing controls. However, we do not believe that the controls currently in place, which are comprised primarily of focused medical reviews of claims submitted by providers previously identified as aberrant, are sufficient to effectively identify and deny unallowable claims submitted by all providers. More effective claims processing controls may require the

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use of additional edits, which would identify for further medical review potentially improper claims submitted by providers. In that regard, subsequent to receiving UGS' comments, we were informed by a UGS official involved in preparing UGS' comments, that UGS generally agrees with our proposal but maintains that it is currently prohibited by HCFA from instituting it.

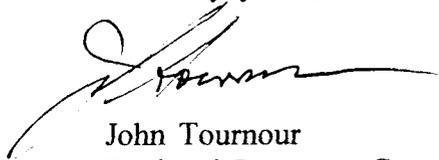
We shared UGS' comments with HCFA central office staff and were informed that UGS and all regional Medicare FIs who process hospice claims are allowed by HCFA to look behind a physician's certification of terminal illness and that data analysis and edits have been authorized since December 1993. Accordingly, our recommendations to improve claims processing edits and to coordinate with the OIG-OI on recovery of the identified overpayments, remain unchanged. We plan to assess the effectiveness of FIs monitoring of hospice eligibility determination in a future review.

The HCFA action official will contact you to resolve the issues in the report. Any additional comments or information you believe may have a bearing on the resolution of the audit may be presented at that time.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5).

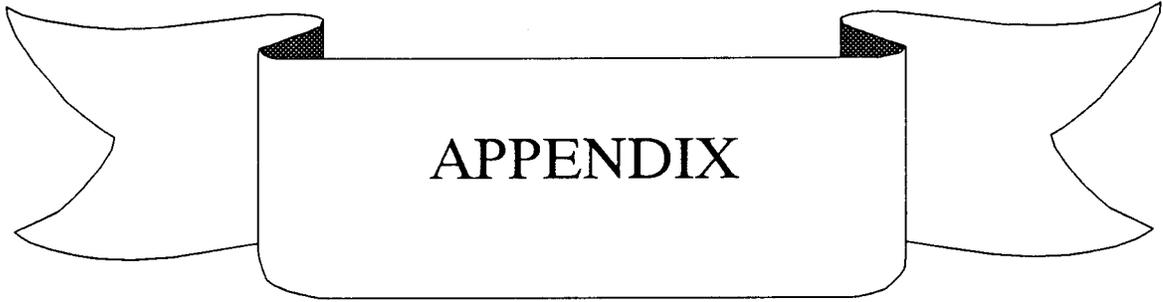
To facilitate identification, please refer to the above Common Identification Number in all correspondence relating to this report.

Sincerely yours,



John Tournour
Regional Inspector General
for Audit Services

Attachments



APPENDIX

UNITED
GOVERNMENT
SERVICES

March 14, 1995

Mr. John Tournour
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services - Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Re: Common Identification Numbers A-02-94-01029 and A-02-94-01030

Dear Mr. Tournour,

Thank you for your correspondence on the Office of Inspector General's draft report findings and recommendations concerning two (2) of Puerto Rico's Medicare-certified hospices, Hospicio en el Hogar De Manati and Hospicio Del Oeste. We appreciate the opportunity to respond to these reports.

Enclosed you will find a summary report which describes United Government Services' experiences, findings, conclusions, and recommendations we wish to have you consider for inclusion in your final report. However, before you review our report, we believe that there is crucial background information of which you may be unaware. In order to fully understand our findings and conclusions, we ask that you first review the following information to acquaint you with the unique background circumstances pertinent to the Medicare Hospice Benefit, UGS, and the Puerto Rico Hospice Providers.

One of the specific benefits established in the *Health Insurance for the Aged and Disabled Act, Title XVIII of the Social Security Act* (Section 1861 dd), is the Hospice Benefit. Hospice care is a unique type of care for people who are terminally ill. The primary goal of hospice care is to help terminally ill patients continue with their normal activities of daily living, as comfortably as possible, while remaining primarily in a home environment. Thus, to achieve this goal, hospices provide a wide range of medical, social, and emotional supportive services.

MEDICARE

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Under the Medicare Hospice Benefit, Medicare pays for hospice treatment if an individual is entitled to Part A of Medicare, he or she chooses to receive care from a hospice instead of standard Medicare benefits for the terminal illness, and the medical director of the hospice (or one of the hospice's staff physicians and, when applicable, the individual's attending physician) certifies that the patient is terminally ill. Medicare considers an individual as terminally ill only if that person has a medical prognosis that his or her life expectancy is 6 months or less if the terminal illness runs its normal course.

Aside from these initial prerequisites regarding basic Medicare program and hospice benefit eligibility, the hospice benefit unlike most other benefits of the Medicare program, is not highly regulated. This latitude, we believe, is deliberate in order to help providers fulfill a variety of patient needs. The Medicare guidelines regarding this benefit are flexible and open to interpretation by providers.

Consequently, the mix of patients utilizing the Medicare hospice benefit has changed over time. Initially when the benefit was first introduced, hospice care was used primarily by terminal cancer patients. Over time, however, the mix of patients utilizing this benefit has changed significantly and today many patients with other, non-cancer diagnoses utilize this benefit. Not surprisingly, the average "length-of-stay" of hospice patients has also shifted over time, from an initial value of merely 17 days to over 50 days.

Similarly as more individuals learned about the hospice benefit, the demand for hospice benefits and growth in the number of hospices increased over time, especially in geographic regions where local regulatory safeguards do not exist (e.g. Puerto Rico hospice providers are not required to file a "Certificate of Need" to prove that there exists a genuine medical necessity for additional hospice services in a given locale).

United Government Services (UGS) assumed responsibility from Prudential for administering the Medicare Program for hospice care for Puerto Rico in October of 1988. At that time, there were only 2 hospice agencies in Puerto Rico. As knowledge of this benefit became more widespread, the demand for hospice benefits increased and the growth in the number of Puerto Rican hospices increased dramatically to a height of 40 hospice agencies in 1994.

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Aside from this increased demand for hospice benefits, the growth in the number of Puerto Rican hospices was also fueled by a number of preconditions specific to Puerto Rico. These preconditions included: an absence of "Certificate of Need" requirements for hospice agencies; a lack of Skilled Nursing Facilities to provide long-term care; the absence of a state-run Medicaid program; and cultural/language barriers faced by many Puerto Rican providers in interpreting Medicare guidelines.

In conclusion, we believe that these circumstances, along with the enclosed facts, will provide the OIG with vital information which was not identified in the draft findings. We believe that the additional facts will assist your office in revising its recommendations to provide definitive solutions to this issue.

If you wish to discuss our response prior to the issuance of your final report, please contact me directly at (414) 226-5160. Thank you for your time and efforts in this matter.

Sincerely,



Marva King
Director
Federal Programs

Enclosure

UNITED GOVERNMENT SERVICES



The Puerto Rico Hospice Experience

1988 to 1994

UNITED GOVERNMENT SERVICES

UGS ACTIVITIES

In March 1990, UGS received new criteria for review of continuous care. The Intermediary Manual was revised to drop the 10% review requirement and all funding for hospice review was eliminated. Then, in January of 1991, managers at UGS requested permission from HCFA's Central Office in Baltimore to conduct post-pay compliance on-site audits to support our analysis of aberrant patterns of care. Our request was denied. We believe that HCFA's decision was based upon a perception that the Medicare Hospice Benefit was being utilized properly and that, based upon the provisions of this benefit (i.e. terminal prognosis requirements, life-expectancy of 6 months or less, etc.), there appeared to be no urgency to pursue an investigation into a benefit designed to be limited in duration and reimbursement.

Subsequently, we began in-house post-payment reviews during Fiscal Year 1992. Less than six (6) months into the effort, on February 14, 1992, we received notification from our Regional Office to discontinue all planned post-payment audits of hospices in our region, including Puerto Rican hospices, and were instructed to reverse any denials.

As the number of Puerto Rico Hospices continued to grow in 1992 and early 1993, our Fraud and Abuse (F&A) Department began to receive sporadic contacts from concerned individuals about inappropriate admissions, including admissions for non-terminal prognosis. During this period, at one of the RHHI Advisory meetings in Milwaukee, we also received complaints from Puerto Rican home health agencies regarding hospices. Without proper authorization from HCFA, however, we were still effectively disallowed from performing medical reviews of Puerto Rican hospice agencies.

In March of 1993 as the number of complaints against hospices in Puerto Rico increased, the UGS F&A Department established an internal task force to examine the Puerto Rican hospice situation. At this point, in order to determine the extent of alleged abuse of the hospice benefit and substantiate allegations made against Puerto Rican hospice agencies, UGS F&A undertook a more intensive analysis of the various beneficiary and provider complaints.

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It appeared to us, based upon all indicators received thus far, that the hospice benefit was not being utilized properly as it was initially intended by HCFA. In addition, three (3) key indicators appeared to have provided the incentive for this improper utilization:

1. Effective January 1, 1990, federal legislation eliminated the 210-day cap on hospice services by adding an open-ended fourth benefit period. With the sudden prospect for provider reimbursements over a longer term, the incentive for creating new hospices was established.
2. Lack of a "Certificate of Need" in Puerto Rico. States have official review organizations which verify the "need" for new provider services. No such review exists in the Commonwealth of Puerto Rico.
3. Lack of Skilled Nursing Facilities (SNF's) in Puerto Rico. SNF's provide long-term care with Medicare coverage in all states except Puerto Rico.

We believe that the legislative changes, along with the lack of certification controls and lack of alternative medical care, fueled an unprecedented growth of hospice providers which could not have been anticipated.

Initially, UGS investigators were concerned that perhaps some providers were simply failing to understand the Medicare benefit for hospice. To address this concern, UGS prepared and published (in May 1993) a Medicare Bulletin to all hospice providers served by UGS (including Puerto Rico). This bulletin detailed the hospice benefit and reviewed certain hospice billing issues.

At the same time, UGS F&A began a detailed investigation of three (3) hospice providers in Puerto Rico. These particular providers were selected for investigation because of specific beneficiary and provider complaints. To further substantiate claims against these hospice providers, UGS compiled statistics concerning diagnosis patterns for HCFA Region II during June 1993. These statistics, combined with UGS's own data on Puerto Rican hospice agencies, indicated a clear aberration from the norm.

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Although UGS Medical Review participated on the internal task force and assisted in the analysis of sample cases from targeted providers, UGS still was not authorized at this point to formally review Hospice cases as part of its routine workload. In addition, no RHHI, including UGS, had the mechanics to deny a claim for lack of a terminal prognosis.

With the results of its analysis in hand, UGS participated in a Payor/Provider round table in Puerto Rico on August 20, 1993. Attendees included: UGS, the Puerto Rico Medical Foundation, the Puerto Rico Hospital Association, COSVI - the Medicare Part A Intermediary for non-RHHI activity, SSS - the Medicare Part B Carrier, the Puerto Rico Home Health and Hospice Association, the HCFA Chicago Regional Office, and the HCFA New York Regional Office (Assistant Regional Administrator for Puerto Rico). Invited but missing, was the local HCFA Survey & Certification Branch.

At this meeting, UGS presented statistics which showed that Puerto Rican hospice bills did not reflect diagnoses proportionate to conventional hospice terminal illnesses. Hospital representatives also raised their concerns regarding the failure of many new hospice agencies to assume proper financial liability for contracted hospital inpatient services. In addition, representatives from home health agencies complained that their patient's were being "recruited" by the local hospices despite the fact that the appropriate care choice was home care. All of the discussion participants voiced concerns regarding physician certifications of patient terminal illnesses despite a lack thereof.

After this meeting, the Puerto Rico Home Health and Hospice Association representatives agreed to communicate these issues with their member agencies. This communication occurred in a subsequent hospice association meeting on August 24 in which admission standards, diagnosis, patient's rights, function of the physician in the hospice program, and fraud and abuse issues were all discussed.

A follow-up conference call was held on September 22, 1993, with the HCFA regions II and V, COSVI, SSS, and UGS. UGS was then given the support of both Regional offices to pursue the authority to medically review hospice claims. A letter was drafted to this effect and was sent to the HCFA Chicago Regional office on October 13, 1993 for forwarding to HCFA Central. This letter summarized the concerns of the organizations at the August meeting, reviewed the statistics from our previous analyses, presented a strategy for correcting the problems, and contained the following excerpt:

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"Through our current expanded review and analysis of complaints, we are noticing similar patterns of abuse as we did in 1990 and 1992. The results strongly direct us to again request permission to perform Medical Review of hospice bills. Our review would encompass physician certification and Notice of Election forms and therefore, authority to disallow hospice benefits for non-terminally ill beneficiaries. Also we would like permission to medically review level of care determinations and authority to adjust payment to the appropriate level."

While waiting for HCFA's response, UGS proceeded with other assignments from the round table meeting. On November 4, 1993, we established an "800" phone number for beneficiary use in Puerto Rico. The number was published in Puerto Rico telephone books and is answered by UGS bilingual staff. We also drafted yet another hospice bulletin on critical issues and published it in both English and Spanish.

Carol Walton, Director of HCFA's Program Operations Branch, immediately responded to the request and on December 3, 1993, we received permission to begin our medical review of Puerto Rico hospice claims. UGS Medical Review immediately began suspending for development and review 100% of claims from providers and their related organizations where our previous sampling had detected difficulties. FMR (Focused Medical Review) criteria for all Puerto Rico Hospices were established in conjunction with UGS F&A and were installed on January 21, 1994. These edits were further enhanced in March 1994.

Although a number of coverage denial reasons existed, the greatest number were for lack of terminal prognosis. As the Medical Review sections of the Intermediary Manual did not specifically cover denials for this reason, UGS sought clarification from HCFA on our authority to deny claims in this category. We received the clarification on January 6, 1994 in a memo to both Region V RHHIs which stated that we did have the necessary authority and supplied BPD (Bureau of Policy Development) guidelines to be followed when questioning physician certification (of the terminal prognosis).

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The next hurdle was the lack of specific denial language in the Manual for this type of denial. UGS developed language, shared it with provider representatives for their input, received clearance from the Regional Office to use it, and distributed it to other RHHs for their use as well.

In addition to lacking terminal prognosis, the primary reasons for Medical Review denials were incomplete Beneficiary election forms (failing to meet statutory/regulatory requirements identified in the Hospice Manual, Section 204, 210) and incomplete Physician certifications (failing to meet statutory/regulatory requirements identified in the Hospice Manual, Section 201). Medical Review findings on Puerto Rico Hospice claims were significant and a summary for the last three quarters is as follows:

| Puerto Rico Hospice | Total Claims Reviewed | Total Claims Denied | Total Charges Reviewed | Total Charges Denied | Rate of Charges Denied |
|---------------------|-----------------------|---------------------|------------------------|----------------------|------------------------|
| 94Q3 (Apr-Jun) | 1065 | 710 | \$1,624,027.05 | \$1,091,278.32 | 67% |
| 94Q4 (Jul-Sep) | 3497 | 2501 | \$5,778,982.24 | \$4,110,598.35 | 71% |
| 95Q1 (Oct-Dec) | 3473 | 2494 | \$6,050,908.93 | \$4,357,649.75 | 72% |

CONCLUSIONS

Although UGS has been criticized for deficiencies in its oversight, computer edits, and medical review of the Puerto Rico hospice program, officials at UGS have actively pursued measures to efficiently and effectively administer the hospice benefit. At the same time, we have strived to protect the integrity of the hospice program, especially in Puerto Rico, within our scope of authority (as evidenced by an excess of \$25 million benefit savings in FY1994). We have a history of effectively serving providers throughout the country which we endeavor to maintain and enhance.

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From the beginning of our Puerto Rico experience, UGS has consistently employed bilingual staff sufficient for the task at hand. In fact, UGS aided the HCFA Region II Office of Survey and Certification Branch in New York by supplying this office with a bilingual RN/Fraud Investigator to help conduct on-site reviews of agencies in Puerto Rico.

In addition, UGS coordinated and cooperated fully with the OIG on recovery issues resulting from OIG audits of Puerto Rico hospices. To facilitate such efforts, UGS provided a bilingual RN/Fraud Investigator to the OIG for the on-site OIG audits of both Manati and Del Oeste. The UGS investigator supplied the OIG staff with complaint data and review protocol. UGS assisted further by helping to categorize 500 beneficiaries at the audit sites as either eligible, not eligible, or not able to determine. Upon returning to Wisconsin, the investigator continued this effort on behalf of the OIG by categorizing an additional 8,718 beneficiaries.

Again, UGS endeavored to effectively monitor and administer the hospice program. This effort includes numerous requests for authorization to place internal controls to prevent abuse of the hospice benefit. Unfortunately, a number of UGS's requests for authorization were denied.

Attached is a February 3, 1995, written communication to UGS from the HCFA Chicago Regional Office. It mentions an agreement between HCFA BPO (Bureau of Program Operations) and the National Hospice Organization to not review or deny hospice care, except in UGS and South Carolina jurisdictions, where edits/reviews/denials were underway and based on aberrant practices prior to the BPO/NHO agreement. "UGS and SC are not to change edits". Based on this document from HCFA, UGS cannot change its edits, beyond those already in place, to "improve its claims processing controls through the incorporation of edits to detect and prevent payments on behalf of ineligible hospice beneficiaries" as recommended by the OIG.

In closing, UGS has developed specific recommendations which we believe will assist the OIG and HCFA in implementing realistic remedies to this matter. These recommendations were designed to provide both immediate and long term solutions to this situation. Because the Medicare Hospice Benefit lacks many of the controls found in other benefits, and with the extensive research, training, and problem-solving activities already accomplished by UGS, the following recommendations are presented for application to all hospice activities and to ensure the integrity of the Medicare Hospice Benefit.

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RECOMMENDATIONS

1. UGS must be permitted to utilize the full scope of our Focused Medical Review developed for Puerto Rico hospices until there is a sufficient degree of evidence that eligibility requirements by medical review standards are being met.
2. Authorization to continue efforts in Puerto Rico beneficiary outreach programs is needed, to facilitate understanding with beneficiaries and enable us to stay abreast of changes in program utilization.
3. The lack of "Certificate of Need" for hospices in Puerto Rico needs to be addressed along with possible legislative authority for such action. We recommend mandated reviews by Survey and Certification personnel (Puerto Rico Dept. of Health and HCFA Regional Office).
4. The potential for program abuse is present in the administration of the aggregate caps on hospice services to beneficiaries based on provider numbers and HIC numbers. The current system permits agencies to "transfer" beneficiaries to another hospice location within their organization to circumvent to aggregate cap limitation. A mechanism to prevent such circumvention of the aggregate cap is needed.
5. In an effort to ensure and audit fiscal responsibility of hospices receiving substantial Medicare dollars, we recommend hospices be required to file cost reports, as do other Part A providers.
6. The Puerto Rico Hospice Association should be encouraged to initiate programs to educate physicians and providers about the hospice benefit, and to help address the special bilingual and cultural needs of hospice care providers and beneficiaries, in an effort to provide safeguards and facilitate understanding so that beneficiaries who truly qualify get the care that the hospice benefit was designed to provide.