DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandu

Date AUG 16 1996

From for June Gibbs Brown
Inspector General

Subject OPERATION RESTORE TRUST--Review of Hospice Eligibility at the Hospice of the Florida Suncoast, Inc. (CIN: A-04-95-02111)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on August 19, 1996 of our final report. A copy is attached.

The objective of our review was to evaluate hospice eligibility determinations for beneficiaries that remained in hospice care for more than 210 days. We also determined the amount of payments made to the Hospice of the Florida Suncoast, Inc. (Suncoast) for those Medicare beneficiaries that did not meet the Medicare reimbursement requirements.

Our review included a medical evaluation of Suncoast's eligibility determinations for 364 beneficiaries who had been in hospice care for more than 210 days. Of the 364 cases, 237 were active in hospice at the time of our review and represented 26 percent of the total active Medicare hospice beneficiaries at Suncoast as of April 30, 1995. The review showed that:

- 176 of the beneficiaries were not eligible for hospice coverage; and,
- for 118 beneficiaries, we were unable to conclusively determine their terminal illness.

Our medical determinations were made by physicians employed by or under contract with the Medicare peer review organization (PRO) for Florida. In addition, 30 cases reviewed by the PRO were also reviewed by fiscal intermediary (FI) Medical staff as part of their initial review of all the cases. The FI agreed with all 30 of the PRO's decisions.

We believe the identified problems occurred for the 176 beneficiaries because hospice physicians made inaccurate prognoses of life expectancy based on the medical evidence in the patients' files. For the 118 beneficiaries, the evidence in the patient's medical files was not sufficient to determine that the beneficiary was terminally ill.

Suncoast received improper Medicare payments totaling $8.9 million for the 176 ineligible beneficiaries and $5.9 million relating to 118 beneficiaries for whom we were unable to determine that a terminal illness existed at the time of admission to the hospice.

We are recommending the intermediary:

- Recover payments of $8.9 million for the 176 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of these beneficiaries still enrolled in hospice care after December 31, 1995.

- Conduct medical reviews of the 118 cases, for which the hospice received $5.9 million, that we were unable to conclusively determine that the beneficiary was terminally ill. Based on the results of these reviews, take appropriate action to recover amounts determined to be overpayments.

- Coordinate with the Health Care Financing Administration (HCFA) in providing training to hospice providers and physicians on eligibility requirements for hospice beneficiaries, particularly the requirement for a 6-month prognosis.

- Analyze utilization trends to identify hospices with large increases in claims for beneficiaries with over 210 days of hospice coverage and conduct medical reviews on a sample of their claims.

- Conduct periodic reviews of hospice claims to ensure the hospices are obtaining sufficient medical information to make valid eligibility determinations.

The intermediary responded on April 5, 1996 to a draft of this audit report. Aetna generally agreed with our recommendations and stated it is committed to working closely with HCFA to strengthen program procedures and controls to ensure proper payment of hospice claims.

Suncoast provided written comments that generally disagreed with the findings in the report. The comments stated that they were in compliance with the HCFA guidance on hospice admissions.

For further information, contact:

Charles J. Curtis
Regional Inspector General
for Audit Services
Region IV
(404) 331-2446

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OPERATION RESTORE TRUST

REVIEW OF HOSPICE ELIGIBILITY AT THE HOSPICE OF THE FLORIDA SUNCOAST, INC.

JUNE GIBBS BROWN
Inspector General

AUGUST 1996
A-04-95-02111

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
P.O. BOX 2047
ATLANTA, GEORGIA 30301

Common Identification Number: A-04-95-02111

Mr. Reginald R. Williams
Vice President
AHP-Medicare Administration
151 Farmington Avenue, MAA8
Hartford, Connecticut 06156

Dear Mr. Williams:

This report provides you with the results of our audit of Medicare hospice beneficiary eligibility determinations at the Hospice of the Florida Suncoast, Inc. (Suncoast) in Largo, Florida. This audit was part of a joint initiative among various Department of Health and Human Services components called Operation Restore Trust (ORT). The ORT seeks to identify specific vulnerabilities in the Medicare program and pursue ways to reduce Medicare exposure to abusive practices. The hospice audits focussed on Medicare beneficiaries in hospice care for at least 210 days.

EXECUTIVE SUMMARY

The objective of our review was to evaluate hospice eligibility determinations for beneficiaries in hospice care for more than 210 days. We also determined the amount of payments made to Suncoast for those Medicare beneficiaries that did not meet the Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Our review included a medical evaluation of Suncoast's eligibility determinations for 364 beneficiaries who had been in hospice care for more than 210 days. The evaluations of the medical records showed that:

- 176 of the beneficiaries were not eligible for hospice coverage; and
- for 118 beneficiaries, we were unable to conclusively determine their terminal illness.

Medicare regulations state that an individual must be terminally ill with a life expectancy of 6 months or less in order to be eligible for hospice benefits. The regulations also require

that the clinical records for each individual contain assessment information, a plan of care, pertinent medical histories, and complete documentation of all services and events.

Our audit was a limited review of the Suncoast hospice operation. We did not review the hospice eligibility determinations for all Medicare beneficiaries who were or had been in the Suncoast program. We limited our review to hospice beneficiaries with over 210 days of hospice coverage as of April 30, 1995 and who were still active in hospice or had been discharged for reasons other than death between the period January 1, 1993 and April 30, 1995. We offer no opinion nor have any conclusion on the accuracy of payments made to Suncoast outside the scope of our audit.

We identified 364 Medicare beneficiaries who met the criteria of our audit scope. To place the scope of our audit (364 cases) in perspective, we offer the following comparisons:

- There were 913 Medicare beneficiaries active in Suncoast hospice as of April 30, 1995. We found that 237 (26 percent) of these had been in hospice care beyond 210 days (7 months).

- Medicare length of stays in Suncoast hospice care averaged 92 days compared to 68 days for non-Medicare hospice stays for Fiscal Year (FY) 1994. The national average length of stay for all Medicare hospice beneficiaries for FY 1994 was 59 days.

- Medicare payments made to Suncoast totaled $113 million during the period October 1, 1990 through December 31, 1995. Our review showed that $14.8 million (13 percent) of this total related to beneficiaries that our review showed were ineligible for hospice care or for those that we were unable to determine that they were terminally ill.

Our medical determinations were made by physicians who were employed by or under contract to Florida Quality Assurance Inc., the Florida Medicare Peer Review Organization (PRO).

We believe the identified problems with the 176 beneficiaries occurred due to inaccurate prognoses of life expectancy by hospice physicians based on the medical evidence in the patients' files. For the 118 beneficiaries, we do not believe that sufficient evidence was present in the medical files to support the fact that the beneficiaries had a terminal illness.

We believe these cases need to be further reviewed by the fiscal intermediary to ensure that providing Medicare hospice payments to Suncoast is appropriate. Suncoast received Medicare payments totaling $8.9 million for the 176 ineligible beneficiaries and $5.9 million relating to 118 beneficiaries placed in the questionable category.

Based on our audit work, we recommend the intermediary:

- Recover payments of $8.9 million for the 176 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of these beneficiaries still enrolled in hospice care after December 31, 1995.

- Conduct medical reviews of the 118 cases, for which the hospice received $5.9 million, that we were unable to conclusively determine that the beneficiary was terminally ill. Based on the results of these reviews, take appropriate action to recover amounts determined to be overpayments.

- Coordinate with the Health Care Financing Administration (HCFA) in providing training to hospice providers and physicians on eligibility requirements for hospice beneficiaries, particularly the requirement for a 6-month prognosis.

- Analyze utilization trends to identify hospices with large increases in claims for beneficiaries with over 210 days of hospice coverage and conduct medical reviews on a sample of their claims.

- Conduct periodic reviews of hospice claims to ensure the hospices are obtaining sufficient medical information to make valid eligibility determinations.

On April 5, 1996, the intermediary responded to a draft of this audit report. Aetna stated that in general, it agreed that strong procedural controls and review activities would ensure hospice benefits are properly paid, has historically included hospice claims in program safeguard activities, has worked with HCFA in an effort to prevent inappropriate payments, and is committed to working closely with HCFA to strengthen program procedures and controls to ensure proper payment of hospice claims. The intermediary's written comments in their entirety are included as Appendix B to this report.

On April 29, 1996, Suncoast provided us some written comments on our audit results. They essentially disagreed with the findings and recommendations. Suncoast's comments have been incorporated in the appropriate sections of the report and are included as Appendix C for Aetna's use in acting on our recommendations.

BACKGROUND

Hospice of the Florida Suncoast

Suncoast was founded in 1977. It is a community-based nonprofit agency located in and serving Pinellas County, Florida. Suncoast serves Medicare beneficiaries under the provisions of a certificate of need issued by the State of Florida. From October 1, 1990 to August 31, 1995, Suncoast admitted 15,426 patients including Medicare and non-Medicare patients. The hospice estimated the average daily census at the time of our review was 1,168 patients. Care is delivered by 600 full-time health care professionals and more than 1,300 volunteers.

Regulations

Title XVIII, section 1861(dd) of the Social Security Act set forth 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 care-givers 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 benefits and be certified as terminally ill by a hospice 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 of the patient's life expectancy is 6 months or less if the terminal illness runs its normal course. Federal regulations require that medical records be maintained for every individual receiving hospice care and services.

A Medicare beneficiary's inclusion in the hospice program is voluntary and can be revoked at any time by the beneficiary. A hospice may discharge a patient if it concludes the patient no longer meets the definition of terminally ill. The beneficiary has four election periods for hospice care and must be certified as terminally ill for each of those periods. The first and second election periods are 90 days each, the third election period is 30 days, and the fourth and last election period has an indefinite duration. The first three election periods total 210 days of service.

Intermediary Responsibilities

The HCFA has designated eight regional intermediaries to service hospices. Aetna Life and Casualty (Aetna) in Clearwater, Florida is the Intermediary that serves Suncoast. The intermediary is responsible for administrative duties including making payments to providers and serving as a center for and communicating to providers, any information or instructions furnished by HCFA.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to evaluate hospice eligibility determinations for beneficiaries in hospice care for more than 210 days and who were either active in hospice as of April 30, 1995 or had been discharged for reasons other than death from January 1, 1993 to April 30, 1995. We also determined the amount of payments made to Suncoast for those Medicare beneficiaries that did not meet the Medicare reimbursement requirements.

Scope

Our review was conducted in accordance with generally accepted government auditing standards. We limited our review to hospice beneficiaries with over 210 days of hospice coverage as of April 30, 1995 and who were still active in hospice or had been discharged for reasons other than death later than January 1, 1993. These beneficiaries were selected from the Medicare Enrollment Database maintained by HCFA's Bureau of Data Management and Strategy. A total of 364 Medicare beneficiaries met our selection criteria and were included in the review. Of the 364, 237 were active hospice Medicare beneficiaries and 127 had been discharged for reasons other than death. Suncoast's Medicare census on April 30, 1995 was 913; thus, the 237 active hospice beneficiaries that were included in our review represented 26 percent of the total active Medicare beneficiaries at that time.

We did not review the overall internal control structure at the intermediary or hospice. Our internal control review was limited to obtaining an understanding of the hospice's admission and recertification procedures and the intermediary's procedures for reviewing claims and provider audit activities. We did not test the internal controls because the objective of our review was accomplished through substantive testing. Field work was conducted from September to December 1995 at the offices of Suncoast in Largo, Florida.

Methodology

The HCFA arranged for the PRO to provide us medical review assistance. Either a PRO physician or a PRO contracted physician reviewed the patients' clinical records and determined whether the hospice's initial determinations of beneficiary eligibility were correct. A beneficiary was deemed ineligible if the clinical evidence of the patient's condition contained in the medical record indicated at the time of initial certification, that the beneficiary had a life expectancy of greater than 6 months. If there was insufficient clinical evidence to support a prognosis of 6 months or less, the PRO physician made no determination of eligibility, but included those cases in a "could not determine" category. As part of the medical review, the PRO physician considered the terminal diagnosis and other factors contained in the medical file such as the certification of terminal illness, the plan of care, the beneficiary's medical history, hospital and lab reports, and the hospice physician's and nurses' notes.

Our calculation of the payments made on behalf of ineligible beneficiaries or beneficiaries whose medical records did not contain sufficient information to make a determination of terminal illness was based on payment history data obtained from Aetna.

Thirty cases, which the PRO physician determined were ineligible or lacking sufficient evidence to make a determination, were reviewed by medical staff from Aetna. In all 30 cases, the PRO determination was affirmed.

DETAILED RESULTS OF REVIEW

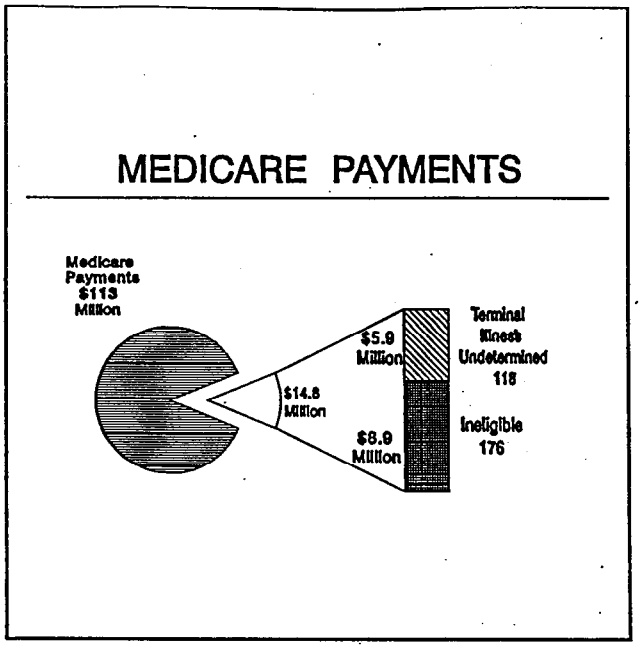
Our review, which included a medical evaluation of Suncoast's eligibility determinations, showed that:

- the medical records for 176 of the beneficiaries did not support a determination that the beneficiary had an illness that would have been terminal within 6 months if the illness followed a normal course; and

- the medical records for 118 beneficiaries did not contain sufficient medical information to determine the terminal illness of the beneficiary.

The medical determinations were made by physicians who were employed by or under contract with the PRO.

We believe the identified problems occurred due to inaccurate prognoses of life expectancy by hospice physicians based on the medical evidence in the patients' files or because the hospice physicians certified beneficiaries as terminal based on insufficient clinical data.



The amount of Medicare payments Suncoast received on behalf of the 294 beneficiaries was ascertained from payment files provided by Aetna. According to the payment data included on those files through December 31, 1995, Suncoast received $8.9 million for the 176 ineligible beneficiaries and $5.9 million relating to 118 beneficiaries for whom the PRO physicians were unable to determine that they were terminally ill based on the medical records maintained by Suncoast. These payments represented 13 percent of total Medicare payments of $113 million that Suncoast received between October 1, 1990 and December 31, 1995. Some of these beneficiaries were active at the time of our review and Suncoast may still be receiving payments on behalf of these beneficiaries.

Of the 364 beneficiaries selected for review, 237 were still active as of April 30, 1995. The 237 beneficiaries still active as of April 30, 1995, represented 26 percent of the actual Medicare patient census of 913 as of that date.

Criteria for Certification of Hospice Services

The Code of Federal Regulations (CFR), 42 section 418.20 stipulates that, in order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and certified as being terminally ill in accordance with section 418.22. The initial certification must include the statement that the individual's medical prognosis is that his or her life expectancy is 6 months or less and be signed by a hospice physician and the individual's attending physician if the individual has an attending physician. The hospice must certify that the beneficiary is terminally ill for each of the three subsequent periods of hospice coverage, including the fourth indefinite period.

The periods are (1) an initial 90-day period, (2) a subsequent 90-day period, (3) a subsequent 30-day period, and (4) a subsequent extension period of unlimited duration during the individual's lifetime.

The CFR 42, section 418.58 provides that a written plan of care must be established and maintained for each individual admitted to a hospice program prior to providing care, and the care provided to an individual must be in accordance with the plan.

In commenting on a draft of this report, Suncoast stated that the only published requirements regarding eligibility for hospice care under Medicare are that an individual must be entitled to Part A benefits and be certified as terminally ill by a hospice physician and, when applicable, the beneficiary's attending physician and that no regulations exist mandating additional documentation in the hospice record to support the certification decision.

In responding to a draft of this report, Suncoast officials correctly noted that there were no minimal requirement of documentation necessary to be maintained to support a determination of eligibility. This final report separates our results into cases our medical professionals believe are persons ineligible for the hospice benefit (i.e. the patient did not have a terminal illness) and those for which we were not able to determine if the patient was terminally ill (and these cases are being referred to the Regional Home Health Intermediary for their further review). Thus, we have not determined any person to be ineligible because of a lack of medical records supporting their terminal illness. Rather, our medical professionals used all the data that was in the Suncoast files to arrive at a decision on the beneficiaries eligibility. And, in fact concluded that documentation in the Suncoast files provided clinical evidence that the patient did not have a terminal illness.

The data our medical professionals used were those contained in the medical records as required by Medicare as a condition of participation in CFR 42, section 418.74. This requirement has been in effect since November 1983. These records must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. Each individual'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 histories; and (6) complete documentation of all services and events (including evaluations, treatments, progress notes, etc.). Presuming care begins (or should begin) upon admission to the hospice, the condition of participation requirements for medical information should have been available for use by the hospice medical staff to assist them in ensuring that their decision of terminal illness was correct.

Analysis of Cases Reviewed

We analyzed 364 admissions and the corresponding length of service as of August 31, 1995. We found the average length of service for these admissions was 19 months. Twenty-two beneficiaries were in over 36 consecutive months. Two were in for 51 months. These beneficiaries had all been certified and recertified as having a life expectancy of 6 months or less.

We also analyzed the diagnoses for both the ineligible beneficiaries and those whose records did not support a terminal illness determination. The following is a summary of the primary diagnosis areas for those 294 cases found to be ineligible or lacking sufficient documentation to make a determination.

Disease Area	No. of Beneficiaries
Cancer	117
Cardiac	41
Pulmonary	30
Alzheimer	22
AIDS	14
Dementia	10
Renal	9
Vascular	8
Other	43
Total	294

Although the diagnoses for the 294 beneficiaries indicated serious medical conditions, the PRO physicians did not find adequate justification in the medical records for Suncoast's determinations that the conditions would result in a life expectancy of 6 months or less. For 176 of the cases, the PRO physician concluded that the individual was not eligible for hospice services; for 118 of the cases, the documentation was not sufficient to evaluate the life expectancy of the individual. Suncoast indicated additional information from outside sources could be obtained for each of the 118 cases.

Hospice officials stated that they did not admit patients that were not eligible for hospice. They also believe that they identified and discharged patients that improved to the point that they were expected to live longer than 6 months. They stated that the fact that a number of their patients lived longer than 6 months is evidence of quality care rather than service to ineligible beneficiaries. They stand by their decisions to recertify eligibility for the above patients because they felt at each review that they were not going to live another 6 months.

Suncoast officials also stated that eligibility determinations are subject to medical opinions of physicians which may and do vary. Hospice staff expressed that it is difficult to know for certain whether or not a patient will die within 6 months considering the variables such as the introduction of hospice care into the patient's routine.

We recognize that in some cases, the beneficiary will exceed the 6-month life expectancy. However, the certification of an individual as terminally ill must be based on medical evidence that supports a life expectancy of 6 months or less. In the cases reviewed, the medical records either contradicted life expectancy of 6 months or less or the medical documentation was inadequate to determine life expectancy.

Medical review staff at the intermediary examined 30 of the 294 cases that were determined to be either ineligible or a terminal illness could not be verified by the PRO physician reviewers. They also concluded that all of the 30 either did not meet Medicare guidelines of eligibility or had inadequate support for the certification. Eventually, all of the cases included in our audit will be provided to the intermediary staff for their adjudication.

Cause of Incorrect Eligibility Determinations

We believe the identified problems occurred due to inaccurate prognosis of life expectancy by hospice physicians based on the medical evidence in the patients' files. Hospice staff

expressed that in some cases, the personal (referring) physician's experience with the patient and, therefore, their prognosis of the patient may be relied upon in determining the patient's appropriateness for hospice.

We found that hospice physicians, at times, did rely partly on the referring physicians. For example, in response to our finding on one case, a hospice physician stated "...Family physician who has known and followed patient was in best position to know the significance of this decline in the patient's overall outlook." In response to another finding, a hospice physician stated, "...End stage heart disease as a diagnosis must be deferred to referring physician's judgement as far as prognosis. We must count on his knowledge of the patient and of medicine - Clearly, no one can "guarantee" the patient will succumb in 6 months."

Although the referring physician's opinion can and should be considered as part of the decision making process, the final determination of hospice eligibility is the responsibility of the hospice physician. We believe that in the cases the PRO physician determined were ineligible, the clinical evidence did not support either the referring physician's prognosis or the hospice physician's certification.

Intermediary Activity

The intermediary's Medical Review staff conducted a review on the medical necessity of hospice inpatient services in 1991. As a result, Aetna originally denied approximately 500 claims overall for several providers that were later overturned by HCFA. Specifically, 55 out of 59 original denials for 1 provider were overturned. Since that time, there was minimal intermediary oversight of the medical necessity of hospice services or of documentation supporting the certifications until Fiscal Year 1995.

In July 1995, the intermediary conducted a focused medical review based on admitting diagnoses. Ultimately, a total of 50 claims from 17 providers were scrutinized under this review. Suncoast was not one of the 17 providers. Out of those 50 cases, 26 were denied. Aetna found 22 did not have documentation supporting a life expectancy of 6 months or less, 3 did not have sufficient documentation of inpatient days and physician visits and 1 routine day was billed outside the billing period. Providers were notified of the results of the review and were advised to review the June 12, 1995 correspondence from the Regional Administrator of HCFA that was sent to all hospice providers serviced by Aetna-Florida and Palmetto Government Benefit Administrators. This letter generally reiterated Medicare eligibility guidelines, documentation standards, and communicated that the intermediaries are increasing emphasis on hospice medical reviews.

Intermediary officials attributed the minimal review activity to a lack of support for hospice claim denials and weak review guidelines for their use from HCFA. Medical guidelines for determining prognosis in selected non-cancer diseases were published by the National Hospice Organization but these have not been formally adopted by HCFA.

RECOMMENDATIONS

We recommend the intermediary:

- Recover payments of $8.9 million for the 176 beneficiaries who were not eligible for Medicare hospice benefits. Recover payments made on behalf of these beneficiaries still enrolled in hospice care after December 31, 1995.

- Conduct medical reviews of the 118 cases, for which the hospice received $5.9 million, that we were unable to determine terminal illness. Based on the results of these reviews, take appropriate action to recover amounts determined to be overpayments.

- Coordinate with HCFA in providing training to hospice providers and physicians on eligibility requirements for hospice beneficiaries, particularly the requirement for a 6-month prognosis.

- Analyze utilization trends to identify hospices with large increases in claims for beneficiaries with over 210 days of hospice coverage and conduct medical reviews on a sample of their claims.

- Conduct periodic reviews of hospice claims to ensure the hospices are obtaining sufficient medical information to make valid eligibility determinations.

INTERMEDIARY'S RESPONSE

On April 5, 1996, the intermediary responded to a draft of this audit report. Aetna stated that in general, it agreed that strong procedural controls and review activities would ensure hospice benefits are properly paid and has historically included hospice claims in program safeguard activities. Aetna has worked with HCFA in an effort to prevent inappropriate payments, and is committed to working closely with HCFA to strengthen program procedures and controls to ensure proper payment of hospice claims.

The full text of Aetna's response is found in Appendix B. With regard to the specific recommendation,s Aetna made the following comments:

- Regarding recovery of payments made for beneficiaries who did not meet Medicare hospice guidelines, Aetna stated that hospices are reimbursed on a prospective payment system and do not file cost reports. Payments would, therefore, be recovered on an individual claim-by-claim basis through the adjustment process and several issues would need to be addressed. Among these are the form of notification to beneficiaries and providers, the determination of whether providers or beneficiaries are held responsible for the overpayments, and the possible need for any review of the determinations made by the Florida

PRO. Aetna will be happy to discuss these issues with HCFA and the Office of Inspector General (OIG) to determine specific guidelines to be followed.

- With regard to educating hospice physicians and hospice in-service training, Aetna stated that hospice in-services are provided to hospice providers on an "as needed" basis. In 1995, the Hospice Quad State Committee was formed with Aetna and representatives from the Florida, Alabama, Georgia, and Mississippi hospice associations. Minutes of these meetings are distributed to all hospices and Aetna believes that all Regional Home Health Intermediaries should perform aggressive education to ensure consistency of the instructions given to providers. Aetna stated it would be happy to have HCFA representatives join in Quad State Committee meetings and would welcome the opportunity to work with HCFA to develop a strong education program for hospice physicians and providers.

- Regarding analyzing trends and conducting medical necessity reviews, Aetna stated its Limited-On-Line Access process was used to analyze utilization trend data for hospice providers who had a high number of beneficiaries that had both a non-cancer diagnosis and were in their fourth benefit period. The Clearwater Medical Review Unit is currently in the process of completing post-payment sample reviews of the top 10 hospice providers.

- In regard to conducting periodic medical documentation reviews, Aetna stated that the Clearwater Medical Review Unit has performed data analysis of hospice claims and is currently performing a prepayment review on samples of hospice admissions to determine if the beneficiaries meet the hospice eligibility requirements for services. The full text of Aetna's response is found in Appendix B.

On April 29, 1996, Suncoast responded to a draft of this report and, in general, disagreed with the findings and recommendations contained in the report. Suncoast's comments have been incorporated into the appropriate sections of the report and their written comments, in their entirety, are included in Appendix C to this report.

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Final determinations as to the actions to be taken on all matters reported will be made by the Department of Health and Human Services official identified below. An action official representative will contact you in the near future. This report includes your response to the findings, however, you may want to update or provide any additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, 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)

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

HHS Action Official
Associate Regional Administrator
Division of Medicare
Health Care Financing Administration, Region IV
101 Marietta Tower, Suite 702
Atlanta, Georgia 30323

APPENDICES

APPENDIX A

MAJOR CONTRIBUTORS TO THIS REPORT

From HHS OIG OAS Region IV:	Gerald Dunham, HCFA Audit Manager (404) 331-2446, ext. 107 Vincent Imbriani, Senior Auditor Kimberly Henderson, Auditor in Charge Mervyn Carrington, Auditor
From HHS OIG OAS Region V:	Robert Wiedeman, Senior Auditor Tom Tucker, Auditor
From HCF Audits Division:	Ben Jackson, Audit Manager Rich Warczynski, Senior Auditor
From the Florida PRO:	Robert Turkel, MD Felix LoCicero, MD Ferdinand Richards, MD
From the Regional Home Health Intermediary:	Barbara Jenkins, RN, BS Karen McCall, LPN Terri Ginetti, RN Trudy Wood

151 Farmington Avenue
Hartford, CT 06156

Janet M. Kalas
Medicare Administration, MAA8
Aetna Health Plans
(203) 636-5667
Fax: (203) 636-1659

April 5, 1996

Gerald Dunham, Audit Manager
PO Box 2047
Atlanta, Georgia 30301-2047

Dear Mr. Dunham:

Re: Common Identification #A-04-95-02111

Thank you for the opportunity to comment on the draft report entitled Review of Hospice Eligibility at the Hospice of Florida Suncoast, Inc. dated March 5, 1996. In general we agree that strong procedural controls and review activities would ensure hospice benefits are properly paid. Aetna has historically included hospice claims in its program safeguard activities and has worked with HCFA in an effort to prevent inappropriate payments.

With regard to the specific recommendations in your report, we offer the following comments.

Recover payments of $14.8 million made for beneficiaries that did not meet Medicare hospice eligibility guidelines. Recover payments made on behalf of beneficiaries still enrolled in hospice after December 31, 1995.

Hospices are reimbursed on a prospective payment system and do not file cost reports. Payments would therefore be recovered on an individual claim-by-claim basis through the adjustment process and several issues would need to be addressed. Among these are, the form of notification to beneficiaries and providers, the determination of whether providers or beneficiaries are held responsible for the overpayment, possible need for any review of the determinations made by the Florida PRO. Aetna will be happy to discuss these issues with HCFA and the OIG to determine specific procedures to be followed.

Educate hospice physicians and providers on hospice appropriate patients and, encourage hospices to take advantage of in-service training to ensure consistency in application of guidelines.

Hospice in-services are provided to hospice providers on an "as needed" basis. In 1995, the Hospice Quad State Committee was formed with Aetna and representatives from the Florida, Alabama, Georgia, and Mississippi hospice associations.

Minutes of these meetings are distributed to all hospices. We would recommend that all Regional Home Health Intermediaries perform aggressive education to ensure consistency of the instructions given to providers. Aetna would be happy to have HCFA representatives join in Quad State Committee meetings and would welcome the opportunity to work with HCFA to develop a strong education program for hospice physician and providers.

Analyze utilization trends to identify hospices that have had unusually large increases in claims or an unusually large number of beneficiaries in their fourth benefit period and conduct medical necessity reviews on a sample of their claims.

Aetna's Limited On-Line Access process (LOLA) was used to analyze utilization trend data for hospice providers who had a high number of beneficiaries that had both a non-cancer diagnosis and were in their fourth benefit period. The Clearwater Medical Review Unit is currently in the process of completing post-payment sample reviews of the top 10 hospice providers.

Conduct periodic documentation reviews of hospice claims to ensure the hospices are obtaining adequate medical documentation to make valid assessments of patients.

The Clearwater Medical Review Unit has performed data analysis of hospice claims and is currently performing a prepayment review on samples of hospice admissions to determine if the beneficiaries meet the hospice eligibility requirements for services.

In summary, Aetna is committed to working closely with HCFA to strengthen program procedures and controls to ensure proper payment of hospice claims.

Sincerely,

Janet M. Kalas
Aetna Life Insurance Company

THE HOSPICE
OF THE FLORIDA SUNCOAST

April 29, 1996

Mr. Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV
P.O. Box 2047
Atlanta, GA 30301

Dear Mr. Curtis:

Thank you for this opportunity to provide comments of the draft report entitled "Review of Hospice Eligibility at The Hospice of the Florida Suncoast, Inc." Thank you as well for the courtesies extended by your auditors during this process and the opportunity for extensive dialogue during the formal exit conference.

In general, let me say we continue to be perplexed by this situation. The mission of our hospice has always been to serve our community well. We see ourselves as a health care provider certainly, but also as a mental health service, a volunteer program, a community service, a community charity, and a community trust. We have depended on community support and volunteers to accomplish our goals. Further, we have always sought to abide by any regulation as it has become known to us.

Based on the comments of others, we believe our hospice has been a leader in the hospice movement and an example of quality hospice care. Suddenly, these very tenets are shaken. In this era of cost containment in health care, an aging population and the real possibility of physician assisted suicide, we are astonished at the OIG's apparent desire to restrict the availability of hospice across America.

Our average length of stay for Medicare patients in Fy 1995 was 106 days, with a median length of stay of 47 days. For the first 6 months of 1996, the average length of stay is 98 days, and the median length of stay was 40 days. In our hospice and many others, these numbers are falling every month, as hospices and their referring physicians learn that the continued existence of the hospice could be threatened if the physician is mistaken in his prognosis.

Research has shown that Medicare saves more than $1.50 for every dollar spent on hospice care. If you succeed in restricting use of hospice care to the period after there is no possibility that the patient will survive more than 6 months, the inevitable result will be that many more Medicare beneficiaries will receive more expensive, less appropriate care until they die or are referred to hospice care days or hours before death. This outcome would reverse years of progress made by this hospice and others around the country. The Board of Directors of The Hospice of the Florida Suncoast, Inc., is gravely concerned and will aggressively pursue this issue.

Given our fundamental objection to the premise of your report, i.e., that large numbers of ineligible Medicare patients were cared for by this hospice over a 5-year period, we believe that the report should be withdrawn. Nevertheless, the hospice staff and counsel have prepared page-by-page suggestions for improving the tone and the substance of the document. A copy of those suggestions is attached.

In addition, I would like to make the following comments on the draft report:

1. At the exit conference it was clearly stated that there was no finding of fraud or abuse but, rather, a "difference of medical opinion". Please consider making this distinction in the report.

2. As you know, the only published requirements regarding eligibility for hospice care under Medicare are that an individual must be a) entitled to Part A benefits; and b) certified as terminally ill by a Hospice physician and, where applicable, the beneficiary's attending physician. These conditions were met in 100% of the cases reviewed by the OIG audit staff.. No regulations exist mandating additional documentation in the hospice record to support the certification decision as contrasted with the provision of services. We have been routinely surveyed for certification and work regularly with our fiscal intermediary.. No such standards were ever intimated. This hospice is being held to a standard entirely different and higher than nearly all other hospices. We had no way whatsoever of knowing that such documentation would be required, and we would have certainly met such standard if it had existed. We know our practice to be consistent with the standards of good hospices across America.

3. As you know, HCFA has set out instructions regarding documenting terminal illness certifications in mid-1995. Immediately upon receiving this information, the hospice began research and program modifications to comply. The National Hospice Organization also set up a process to develop diagnosis-based guidelines for prognostication. The report's reference to these state-of-the-art guidelines is a single sentence suggesting that the intermediary has "reservations" about their effectiveness.

4. The sampling process itself selected persons with lengths of stay much longer than the norm. Based on sampling methodology alone, one would expect to see only exceptional situations in the sample.

5. The sample is small; 364 records from 15,426 admissions; and it could not be construed to be representative. Please consider reflecting this in the Executive Summary as well as in the body of the report.

6. As documented in numerous medical publications, prognosis of terminal illness is difficult to establish, further complicated by very advanced age as is characteristic of the community this Hospice serves. Yet, prognosis was "correctly" established in a very high percentage of patients cared for by this hospice. Average length of stay and cost of care are far below the aggregate limits in the hospice Medicare benefit. Reference articles were offered during the audit. Data was also furnished regarding our length of stay, non-admissions and practice patterns.

7 The review process itself was very vague. There were no standards or criteria utilized by which to measure our practice. There were simply Works Sheets of paper on which the reviewing physicians wrote narrative comments regarding their clinical impressions of the appropriateness of hospice admissions. Our understanding is that these PRO physicians were not trained in hospice and had little or no experience in terminal care or establishing a terminal prognosis.

8. Many of the patients deemed inappropriate died under the care of hospice, yet it was stated that this is no indication they were terminally ill.

With respect to a large percentage of the cases reviewed, you concluded that you were "unable to determine whether the beneficiary was eligible." All met regulatory requirements for eligibility, and yet you recommend recoupment of all Medicare funds paid for their care.

If the fiscal intermediary did, in fact, recoup the $14.8 million in alleged over-payments, as recommended in your draft report, it is likely the very existence of this hospice would be threatened. We intend to appeal any attempt to recoup these payments, but recoupment would likely threaten our financial existence before appeals could be heard.

We implore you to consider the broad ramifications of this report. It is our firm belief that a broad retrospective application of new documentation requirements would close many hospice programs and force many dying American to die in pain, alone and without the benefit of appropriate cost-effective care. Again, thank you for this opportunity to comment.

Sincerely yours,

The Very Reverend Barry R. Howe
Chairperson, Board of Directors

BRH/ejs
Attachment

cc: Ann Morgan Vickery
Hogan & Hartson L.L.P.

ATTACHMENT

Specific Suggestions from The Hospice of the Florida Suncoast, Inc.
On Draft OIG Report

Page 1, paragraph 3:
Redraft first two sentences under "Findings" to read: "Our review included a medical evaluation of Suncoast's eligibility determinations for 364 patients who had been in the hospice program more than 210 days or had been discharged alive. These 364 long-stay outlier cases represented about 2 percent of patients cared for by Suncoast during the relevant period. We found that....

Page 2, paragraph 2:
Delete this sentence, as it cannot be supported by the facts before you. As you point out on page 7, Suncoast indicated that additional information underlying the certification decisions could be obtained from other sources. Since there was no regulatory requirement to keep this information in the hospice medial record, no conclusions should be drawn from its absence there.

Page 2, paragraph 3:
Delete references to "improper" payments. No finding has been made that any of the payments were improperly made.

Page 2, paragraph 4:
Delete the first bullet point under "Recommendations." In second bullet, clarify reference to"guidelines." Does this refer to the NHO Guidelines distributed by HCFA to fiscal intermediaries for use in prospective medical review activities? We are aware of no other relevant guidelines. In fourth bullet point, change second reference to "documentation" to read " information." Assessments are not made on the basis of documentation alone.

Page 3, after paragraph 4:
Insert new heading "Documentation Requirements" and new paragraph as follows: "Hospice regulations require that the certifications of terminal illness be kept on file. Until May of 1995, there was no notice given by HCFA to hospices of the need to keep additional documentation supporting the certification decision."

Page 7, after partial sentence at top of page, add:
"(This regulatory requirement does not clearly apply to decisions which predate the provision of care. With respect to certification and recertification decisions, the Hospice Manual and the Intermediary Manual require only that the certifications be retained.)"

Page 7, paragraph 4:
Delete "contend that they" in the first sentence and "also believe that they" in the second sentence. The tone of this paragraph is snide.

Page 8, paragraphs 1-4 are inconceivable in that they suggest that the hospice physician is required to examine a prospective patient and make an independent decision regarding prognosis, without consulting with the attending physician. This is not, never has been and hopefully never will be the Medicare policy. The only suggestion that comes to mind is to add at the end of paragraph 4 and additional sentence: "This fundamental misunderstanding about the imprecise nature of prognosis decisions and the relationship between the attending physician and the hospice physician is likely a major contributing factor the failure of this audit to produce useful results."

Page 9, paragraph 4:
Delete first bullet point. See comments above regarding other points.