Memorandum

Date FEB 26 1998

From June Gibbs Brown
Inspector General

Subject Audit of Beneficiary Hospice Eligibility at Samaritan Care, Inc., Lansing, Illinois (A-05-96-00024)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of the U.S. Department of Health and Human Services, Office of Inspector General's report entitled "Audit of Beneficiary Hospice Eligibility at Samaritan Care, Inc., Lansing, Illinois" (A-05-96-00024). Our initial audit work covering the eligibility of Medicare hospice beneficiaries and further assistance we provided in the investigative actions were completed in Fiscal Year 1997.

The financial findings reported herein are included in criminal and civil cases brought against Samaritan Care's (Samaritan) previous owner by the Department of Justice in October 1997. Because of the pending criminal and civil action, the Health Care Financing Administration (HCFA) should take no action to independently recoup the $10.4 million in identified overpayments at this time. We do however want to reemphasize previous recommendations we made in our roll-up report on our national hospice audits entitled, "Enhanced Controls Needed to Assure Validity of Medicare Hospice Enrollments," (A-05-96-00023) issued on November 4, 1997. In that report we highlighted problems we found with the "cap" reports used as part of the hospice reimbursement process. The problems noted at Samaritan provide HCFA with specifics on how the cap reports can be manipulated. We therefore believe that HCFA should give serious attention to making the "cap" report system less vulnerable to manipulation, and to more timely reviews of the hospice "cap" reports including the verification of reported numbers. Without these improved controls, abusive or fraudulent practices may go undetected for extended periods, as shown with Samaritan.

The audit was part of the joint initiative by various HHS components called Operation Restore Trust (ORT). The hospice audits under ORT have focused on determining whether the Medicare beneficiaries met the Medicare definition of "terminally ill" at the time of enrollment in the hospice program.

As this report contains no new recommendations, no response is necessary. However if you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number (A-05-96-00024) in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF BENEFICIARY HOSPICE ELIGIBILITY AT SAMARITAN CARE, INC., LANSING, ILLINOIS

JUNE GIBBS BROWN
Inspector General

FEBRUARY 1998
A-05-96-00024

Memorandum

Date FEB 26 1998

From June Gibbs Brown
Inspector General

Subject Beneficiary Hospice Eligibility at Samaritan Care, Inc., Lansing, Illinois (A-05-96-00024)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This report provides you with the results of our audit covering the eligibility of Medicare hospice beneficiaries at Samaritan Care, Inc. (Samaritan), Lansing, Illinois. The financial findings reported herein are included in criminal and civil cases brought against Samaritan's previous owner by the Department of Justice (DOJ) in October 1997. We therefore are not making a recommendation for the Health Care Financing Administration (HCFA) to independently recoup over $10 million in identified overpayments. We do however want to reemphasize previous recommendations we made in our roll-up report on our national hospice audits (A-05-96-00023) issued on November 4, 1997. In that report we highlighted problems we found with the "cap" reports used as part of the hospice reimbursement process. The problems noted at Samaritan provide HCFA with specifics on how the cap reports can be manipulated. We therefore believe that HCFA should give serious attention to their proposed analysis of making the cap reporting system less susceptible to gaming to determine if a legislative change should be forthcoming and ensure that the regional home health intermediaries (RHHI) audit the patient counts on the cap reports.

The audit was part of the joint initiative by various Department of Health and Human Services components called Operation Restore Trust. The hospice audits focused on determining whether the Medicare beneficiaries met the Medicare definition of "terminally ill" at the time of enrollment in the hospice program.

EXECUTIVE SUMMARY

The objective of our review was to evaluate hospice eligibility determinations applicable to beneficiaries in their final authorization period for benefits. We also determined the amount of payments made to Samaritan for those beneficiaries that did not meet Medicare eligibility requirements. Medicare regulations state that an individual must be terminally ill with a life expectancy of six months or less 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 history, and complete documentation of all services and events.

Our review included a medical evaluation of Samaritan's eligibility determinations for 224 beneficiaries who had been in hospice care for more than 210 days. The evaluation of the medical records pertaining to the 224 beneficiaries showed that:

- 213 beneficiaries were not eligible for hospice coverage. Overpayments of Medicare funds amounted to over $10.4 million for these beneficiaries.

- for 5 beneficiaries, medical eligibility could not be conclusively determined. Medicare hospice expenditures for these five individuals totaled $231,000.

We did not review hospice eligibility for all Medicare beneficiaries who were or had been in the Samaritan hospice. We limited our review to 224 beneficiaries, admitted to Samaritan's hospice program under its original ownership (prior to December 9, 1994), that were in hospice care more than 210 days. Of the 224 beneficiaries, 221 had been discharged and 3 were still active at the time of our review in January 1996. Of the 221 discharged beneficiaries, 90 had been discharged by the current owners following medical reviews of cases that had been previously certified as eligible under the original ownership. To place the scope of our review in perspective:

- For service periods under the original ownership, Samaritan received about $12 million in Medicare payments for its total enrollment of 650 patients.

- The 224 beneficiaries covered by our review represented 268 (some enrolled more than once) or 40 percent of the 650 enrollments.

- Medicare payments applicable to the 224 beneficiaries we reviewed were about $8 million, or 67 percent of the $12 million in total payments for service periods under Samaritan's original ownership.

Our medical determinations were made by physicians under contract to the Illinois Medicare peer review organization (PRO). The 213 beneficiaries were found to be ineligible because the medical evidence in the files showed that the beneficiaries did not have terminal conditions resulting in life expectancies of 6 months or less. Nonetheless, the hospice physicians had certified the beneficiaries as meeting the requirements. For the five beneficiaries, sufficient medical documentation was not present to support a terminal illness. We offer no opinion nor have we drawn any conclusion on the accuracy of payments made to the hospice outside the scope of our audit of the 224 beneficiaries noted above.

BACKGROUND

Samaritan Care, Inc.

Samaritan began its operation as a Medicare hospice provider on June 3, 1992 (the effective date of its Medicare provider number). This operation continued under the original

ownership until December 9, 1994 when it was purchased by Integrated Health Services, Inc. For dates of service from June 3, 1992 through November 1994, Samaritan received Medicare hospice payments of about $12 million for 650 total enrollments. The number of beneficiaries was somewhat less than 650 since several beneficiaries were enrolled more than once.

Regulations

Title XVIII, section 1861(dd) of the Social Security Act sets 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. Federal regulations require that medical records be maintained for every individual receiving hospice care and services.

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.

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. During the period of our review, the beneficiary had four election periods for hospice care and must have been certified as terminally ill for each of those periods. The first and second election periods were 90 days each, the third election period was 30 days, and the fourth and last election period had an indefinite duration. The first 3 election periods totaled 210 days of service.

Through the passage of the Balanced Budget Act of 1997, numerous modifications were made to the hospice benefit. These modifications included allowing hospices to discharge beneficiaries whose conditions improve without loss of future benefits to the hospice beneficiary and a new requirement for more frequent certifications of eligibility after 180 days of hospice care.

Intermediary Responsibilities

The HCFA has designated eight regional intermediaries to service hospices. Health Care Service Corporation (HCSC) is the RHHI that served Samaritan. The intermediary is responsible for administrative duties including making payments to providers and communicating to providers information or instructions furnished by HCFA.

OBJECTIVE, SCOPE, & METHODOLOGY

Objective

The objective of our review was to evaluate eligibility determinations for beneficiaries enrolled in hospice care at Samaritan for more than 210 days and who either were active in hospice or were discharged for reasons other than death. We also determined the amount of payments made 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 did not review the hospice eligibility determinations for all Medicare beneficiaries who were or had been in Samaritan's program. We limited our review only to beneficiaries who had been enrolled for hospice care under the original ownership. We also limited our review to those beneficiaries who received over 210 days of hospice coverage and who either were still active in hospice or were discharged for reasons other than death.

A total of 224 Medicare beneficiaries met our selection criteria and were included in the review. Of the 224 beneficiaries, 221 had been discharged and 3 were still active at the time of our review in January 1996. Of the 221 discharged beneficiaries, 90 had been discharged under the current ownership following internal medical reviews of cases previously certified as eligible under the original ownership.

We also performed a limited review of HCSC's claims processing procedures and medical review policies relating to hospice beneficiaries. We offer no opinion nor have any conclusion on the accuracy of Medicare payments made to Samaritan outside the scope of our audit.

We did not review the overall internal control structure at Samaritan or at HCSC. Our internal control review was limited to obtaining an understanding of the intermediary's procedures for reviewing claims and performing medical reviews. Our initial audit work and further assistance we provided in the investigative actions were completed in Fiscal Year 1997.

Methodology

We initially made a computer analysis of HCFA's Common Working File to identify those hospices having the highest number of long-term cases. We defined long-term cases as (1) active cases that had received hospice services for over 210 days and (2) closed cases that were discharged for reasons other than death after 210 days of hospice service. Through this analysis of data processed in April 1995, Samaritan was identified as having 152 long-term cases, the highest number of long-term hospice cases among all hospices in Illinois.

The 224 beneficiaries covered by our review included these 152 beneficiaries (enrolled under the original ownership), plus 72 additional beneficiaries, also enrolled under the original ownership, who had reached the 210-day threshold at the date of our on-site review in January 1996.

The HCFA arranged for the PRO to provide medical review assistance. The PRO physicians reviewed the patients' clinical records and determined if Samaritan's determinations of beneficiary eligibility were correct. A beneficiary was deemed ineligible if the clinical evidence indicated 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 HCSC.

DETAILED RESULTS OF REVIEW

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

- the medical records for 213 of the beneficiaries (95 percent of the 224 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;

- the medical records for five beneficiaries did not contain sufficient medical information to determine the terminal illness of the beneficiary; and

- the medical records for six beneficiaries supported a determination that the beneficiary had an illness that would have been terminal within 6 months if the illness followed a normal course.

The 213 beneficiaries were found to be ineligible because the medical evidence in the files showed that they did not have terminal illnesses with life expectancies of 6 months or less. Although this medical evidence showed otherwise, the hospice physicians nonetheless certified the beneficiaries as meeting the requirements.

Our audit showed that Samaritan had received Medicare payments totaling $10,431,533 for the 213 ineligible beneficiaries and $231,445 for the 5 beneficiaries whose medical records did not contain sufficient information to make a determination of eligibility. Three of the

ineligible beneficiaries continued to receive care after our audit period and Medicare may have been billed for the care.

Criteria for Certification of Hospice Services

The CFR Title 42, section 418.20 stipulates that 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 six months or less if the terminal illness runs its normal course and be signed by a hospice physician and the individual's attending physician, if the individual has an attending physician. During the period of our audit, the hospice was required to certify that the beneficiary was terminally ill for each of the three subsequent periods of hospice coverage, including the fourth indefinite period.

The periods were (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. Following our audit period, the Balanced Budget Act of 1997 enacted changes to this criterion by requiring more frequent certifications of eligibility after the first 180 days of hospice care.

The CFR Title 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.

The CFR Title 42, section 418.74, specifies that the hospice must establish and maintain a clinical record for every individual receiving care and services. The 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 history; and (6) complete documentation of all services and events (including evaluations, treatments, progress notes, etc.). Ensuring that all of the above data is present in the medical records provides adequate support for decisions on the terminal illness of beneficiaries.

Analysis of Cases Reviewed

All of the 213 ineligible beneficiaries were nursing home residents who had been certified by Samaritan's hospice physicians as having terminal illnesses with life expectancies of 6 months or less. Thirty-eight of these beneficiaries had been discharged, primarily for curative treatment (usually for inpatient hospitalization), and later readmitted to the hospice. Four of the thirty-eight beneficiaries had been discharged and readmitted on more than one occasion.

For the 38 beneficiaries with multiple admissions, the PRO physicians reviewed the appropriateness of each admission and concluded that the beneficiaries remained ineligible.

We analyzed the diagnoses for the 213 ineligible beneficiaries. The following is a summary of their primary diagnoses:

Diagnoses	No. of Beneficiaries
Cardiac	50
Vascular	39
Alzheimer's Disease	38
Cancer	23
Dementia	23
Neurological	10
Parkinson's Disease	10
Pulmonary	7
Debility Unspecified	4
Other	9
Total	213

The diagnoses indicated that the beneficiaries had medical conditions that were common among nursing home residents. Although these beneficiaries may have qualified for nursing home care, the PRO physicians did not find adequate justification in the medical records for Samaritan's determinations that the conditions would result in a life expectancy of 6 months or less.

Intermediary Activity

We were told by HCSC officials that Samaritan has not been the subject of any medical reviews by the intermediary. Prior to 1996, the only medical reviews it made of hospice services involved the appropriateness of inpatient hospital stays of selected hospice beneficiaries. These reviews were made to verify the medical necessity of the hospitalizations under the Medicare hospice requirements. Affected hospices did not include Samaritan.

In June 1996, HCSC implemented certain prepayment screens designed to detect potentially ineligible cases that had been in hospice over 210 days. These screens, based on several diagnostic codes, have resulted in about 500 claims being suspended each quarter with almost half of the claims being denied. The screens have also led to two recent audits of hospices that resulted in about $200,000 in recoveries.

DOJ Actions

In October 1997, Samaritan's previous owner was indicted on criminal charges of alleged fraud schemes. A civil suit was also filed by the DOJ seeking restitution and damages under the False Claims Act. The civil suit relates to preparation of false certifications of terminal illness as detailed in this report and asks for treble damages pertaining to the amount of $10.4 million questioned by our audit. The indictment involves several alleged crimes, including the submission of fraudulent reimbursement "cap" reports.

According to the indictment, the previous owner of Samaritan avoided repaying about $4 million to Medicare by grossly inflating the number of patients on Medicare cap reports in two consecutive years. Under Medicare's cap report system, a reimbursement ceiling or limit is placed on total annual payments to a hospice. The ceiling is calculated for any given year by multiplying the number of new Medicare beneficiaries that enroll in a hospice by a "per beneficiary" cap amount. The product of this calculation becomes the total reimbursement cap which is compared with total interim payments to determine whether the hospice was paid amounts that exceeded the reimbursement ceiling.

Conclusions

Because of pending criminal and civil actions, the HCFA should take no action to independently recoup the $10.4 million in identified overpayments at this time. We do, however, want to reemphasize previous recommendations we made in our roll-up report on our national hospice audits (A-05-96-00023) issued November 4, 1997, in particular, our recommendations for improved controls over the "cap" report system. Based on these recommendations we believe that the HCFA should give serious attention to making the "cap" report system less vulnerable to manipulation, to the need for timely reviews of the hospice "cap" reports, and to the verification of reported numbers. Without these improved controls, abusive or fraudulent practices may go undetected for extended periods, as shown with Samaritan.