DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date SEP 1 1 1998

From June Gibbs Brown
Inspector General

Subject Beneficiary Hospice Eligibility at Samaritan Care, Inc., Southfield, Michigan (A-05-97-000 15)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached is our final report entitled *Beneficiary Hospice Eligibility at Samaritan Care, Inc., Southfield, Michigan.* The objective of our audit was to evaluate Medicare eligibility determinations of terminal illness for beneficiaries enrolled in hospice care at Samaritan Care, Inc. (Samaritan). Working with us, physicians from the Michigan Medicare Peer Review Organization reviewed the medical files for 180 beneficiaries and determined that 130 beneficiaries were not eligible for hospice coverage. Overpayments of Medicare funds amounted to approximately $2.6 million for these beneficiaries.

These financial findings are included in a civil complaint filed by the Department of Justice (DOJ) in February 1998 against Samaritan's initial owners. The suit seeks penalties and treble damages under the False Claims Act. We, therefore, are not making a recommendation for the Health Care Financing Administration (HCFA) to independently recoup the $2.6 million in identified overpayments.

Our audit was made at the request of the DOJ following audits that we made at other hospices under Operation Restore Trust. One of these audits was of Samaritan Care, Inc., Lansing, Illinois (A-05-96-00024). The owner of this hospice was also a part owner of Samaritan (covered by this report). The owner was criminally indicted in Illinois last October and a civil suit was filed simultaneously for treble damages on $10.4 million identified by our audit.

We want to again call your attention to recommendations that we made in our roll-up report on our national hospice audits (A-05-96-00023) issued November 4, 1997. In particular, we discussed problems with hospice coverage in nursing facilities. These problems are further highlighted by conditions found at Samaritan where about 98 percent of the 130 ineligible beneficiaries were residents of nursing facilities. We consequently believe that HCFA should give a high priority to its work in developing a legislative proposal to address this issue.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. 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 (4 10) 786-7 104.

To facilitate identification, please refer to Common Identification Number A-05-97-0001 5 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

BENEFICIARY HOSPICE ELIGIBILITY AT SAMARITAN CARE, INC., SOUTHFIELD, MICHIGAN

JUNE GIBBS BROWN
Inspector General

SEPTEMBER 1998
A-05-97-00015

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date · SEP 1 1 1998

From June Gibbs Brown
Inspector General /s/ June G. Brown

Subject Beneficiary Hospice Eligibility at Samaritan Care, Inc., Southfield, Michigan (A-05-97-000 15)

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), Southfield, Michigan. The financial findings reported herein are included in a civil case brought against Samaritan's previous owners by the Department of Justice (DOJ) in February 1998. We, therefore, are not making a recommendation for the Health Care Financing Administration (HCFA) to independently recoup the approximate $2.6 million in identified overpayments. We do, however, want to reemphasize previous recommendations made in our roll-up report on our national hospice audits (A-05-96-00023) issued on November 4, 1997. In that report, we identified problems with hospice coverage in nursing facilities as an underlying factor that contributed to high levels of beneficiary ineligibility. These problems are further highlighted from the conditions found at Samaritan, where about 98 percent of the 130 ineligible beneficiaries were residents of nursing facilities. We consequently believe that HCFA should give a high priority to its work in developing a legislative proposal to address this issue.

The audit was made at the request of the DOJ following audits that we made at other hospices under the joint initiative called Operation Restore Trust (ORT). One of these audits was of Samaritan Care, Inc., Lansing, Illinois (A-05-96-00024). The owner of this hospice, also a part owner of Samaritan, was criminally indicted in Illinois last October and a civil suit was filed simultaneously for treble damages on $10.4 million identified by our audit.

Unlike our previous audits under ORT where we focused our review on Medicare beneficiaries in hospice care for at least 210 days, our audit of Samaritan (at the request of the DOJ) covered all Medicare beneficiaries who received services during the period of the initial owners' tenure, regardless of the length of time the beneficiaries were in hospice.

EXECUTIVE SUMMARY

The objective of our review was to evaluate hospice eligibility determinations applicable to all beneficiaries who had received hospice care during the tenure of Samaritan's initial owners. We also determined the amount of payments made to Samaritan for those beneficiaries who

did not meet Medicare eligibility requirements. Medicare regulations state that an individual must be terminally ill with a life expectancy of 6 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 180 beneficiaries who had been in hospice care between November 1, 1993 and March 3 1, 1995. The evaluation of the medical records pertaining to the 180 beneficiaries showed that:

- 130 beneficiaries (72 percent of the 180 beneficiaries) were not eligible for hospice coverage. Overpayments of Medicare funds for hospice care amounted to approximately $2.6 million for these beneficiaries.

- for 2 beneficiaries, medical eligibility could not be conclusively determined. Medicare hospice expenditures for these two individuals totaled about $17,000.

We limited our review to Medicare beneficiaries who had been certified for hospice care under the original ownership of Samaritan. On this basis, we identified 180 beneficiaries.

Our medical determinations were made by physicians under contract to the Michigan Medicare peer review organization (PRO). The 130 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 two 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 180 beneficiaries noted above.

BACKGROUND

Samaritan Care, Inc.

Samaritan began its operation as a Medicare hospice provider on November 1, 1993 (the effective date of its Medicare provider number). This operation continued under the original ownership until March 3 1, 1995 when it was purchased by Integrated Health Services, Inc.

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. United Government Services (UGS) is the regional home health intermediary that served Samaritan. The intermediary is responsible for administrative dutics 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 all beneficiaries enrolled in hospice care at Samaritan between November 1, 1993 and March 3 1, 1995. 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 limited our review only to beneficiaries who had been enrolled for hospice care under the original ownership, between November 1, 1993 and March 3 1, 1995. Previous hospice audits that we made under ORT were limited to those beneficiaries who received over 210 days of hospice coverage and who were either still active in hospice or had been discharged for reasons other than death. However, for this review, in order to assist the DOJ in its investigation, we reviewed the hospice eligibility determinations for all Medicare beneficiaries who were in Samaritan's program during the period in question, regardless of the length of stay.

A total of 180 Medicare beneficiaries met our selection criteria and were included in the review. None of the 180 beneficiaries was still active in hospice care at the time of our review in January 1997. Twenty-nine of the beneficiaries had been discharged under the new ownership.

We also performed a limited review of UGS'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 UGS. 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 in the investigative actions were completed in Fiscal Year 1997.

Methodology

Under previous ORT initiatives involving audits of beneficiary eligibility for hospice services, we limited our scope to Medicare beneficiaries who had been in hospice over 210 days and who were either still active, or were discharged for reasons other than death. For our audit of Samaritan, at the request of the DOJ, we included all Medicare beneficiaries admitted under the original ownership, regardless of the length of the beneficiaries' stay in hospice care. A total of 180 beneficiaries were reviewed. Of the 180 beneficiaries, 38 beneficiaries had been in hospice care more than 2 10 days.

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 UGS.

DETAILED RESULTS OF REVIEW

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

- the medical records for 130 of the beneficiaries (72 percent of the 180 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 two beneficiaries did not contain sufficient medical information to determine the terminal illness of the beneficiary; and

- the medical records for 48 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 130 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 $2,573,723 for the 130 ineligible beneficiaries and $16,670 for the 2 beneficiaries whose medical records did not contain sufficient information to make a determination of eligibility. None of the ineligible beneficiaries was receiving care at the time of our review,

Criteria for Certification of Hospice Services

The CFR Title 42, section 4 18.20 stipulates that to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be 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 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

Length of Stay The average length of stay for the 180 beneficiaries included in the review was approximately 153 days. For the 130 ineligible beneficiaries, the length of stay averaged almost 200 days.

Nursing Home Cases About 98 percent of the ineligible beneficiaries (127 of 130) were nursing home residents.

Beneficiaries in Hospice Care Over 210 Days Of the total 180 beneficiaries, 38 beneficiaries had received hospice care for periods in excess of 210 days. Of the 38 beneficiaries, 21 had been in Samaritan's program for over a year. The average length of stay for these 38 beneficiaries was 427 days. All 38 beneficiaries were found to be ineligible.

Diagnoses An analysis of the diagnoses for the 130 ineligible beneficiaries revealed that they had medical conditions that were common among nursing home residents:

Primary Diagnoses	Number of Ineligible Beneficiaries
Cardiac	67
Vascular	15
Alzheimer's Disease	11
Cancer	10
Pulmonary	5
Debility Unspecified	5
Renal Failure	4
Dementia	3
Neurological	3
Other	7
Total	130

As shown, many of the ineligible beneficiaries were diagnosed with heart-related illnesses, as well as Alzheimer's disease. 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 initial determinations that the conditions would result in a life expectancy of 6 months or less.

Intermediary Activity

We were told by UGS officials that Samaritan has not been the subject of any medical reviews by the intermediary. The UGS does not use prepayment screens (edits) for hospice claims, however, various post-payment activities are being used to identify potentially abusive hospice providers. In 1997, focused medical reviews resulted in audits of two hospices. The audits identified Medicare overpayments totaling about $1.7 million that were made for services provided to ineligible beneficiaries. Most of the overpayments occurred because the medical documentation did not substantiate a terminal prognosis of 6 months or less from the start of care.

DOJ Actions

In February 1998, the DOJ filed a civil complaint against Samaritan's initial owners seeking penalties and damages under the False Claims Act. The civil suit includes counts related to the preparation of false certifications of terminal illness as detailed in this report, and asks for

treble damages pertaining to the amount of $2.6 million questioned by our audit. (One of these initial owners had earlier been indicted in Illinois on criminal charges of alleged fraud schemes involving Samaritan Care, Inc., Lansing, Illinois.) On August 26, 1998, a medical director of Samaritan pleaded guilty to four counts of mail fraud and kickbacks.

Conclusions

Because of the pending civil actions, the HCFA should take no action to independently recoup the $2.6 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 changes to reimbursement methodology for concurrent hospice and nursing facility care involving dually eligible beneficiaries. In the roll-up report, we identified problems with hospice coverage in nursing facilities as an underlying factor that contributed to high levels of beneficiary ineligibility. For Samaritan, about 98 percent of the 130 ineligible beneficiaries were nursing facility residents. Many of these beneficiaries were diagnosed with medical conditions common for long-term care patients, such as cardiac and vascular illnesses, and Alzheimer's disease. We, therefore, believe that HCFA should give a high priority to its work in developing a legislative proposal to address this issue.