

# REFORMING HOSPICE AUDITS

## PROPOSED SOLUTIONS FOR A TARGETED AND EFFECTIVE HOSPICE PROGRAM INTEGRITY STRUCTURE

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# INTRODUCTION

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CMS's Program Integrity structure plays an important role in protecting hospice patients and their families, providers, and the Medicare hospice benefit. Congress created the Medicare hospice benefit in 1982 to provide terminally ill patients more appropriate care than continued medical treatment. The statute bases eligibility for the hospice benefit on the clinical judgment of two physicians who must certify that the patient's illness may, if it follows the normal course, lead to death in six months. The statute further provides for extensions of the benefit in circumstances where beneficiaries are stabilizing or improving while receiving care yet have a reasonable expectation of continued decline over a subsequent six-month period. The relevant statutes, regulations, and agency guidance all acknowledge that individual experiences will vary and that determining eligibility is not an exact science.

NPHI believes strongly that the current standards and processes for audit and recovery that are applied in the field by CMS and its contractors are not aligned with the statutory or regulatory intent for the benefit. Audit denials and recovery of payments on the basis of arbitrary and inconsistently applied rules of thumb do not reflect clinical realities and do interfere with the effective delivery of clinically appropriate care, harming patients and families and threatening the financial viability of regulatory-compliant hospice providers.

NPHI also recognizes that the design of the Medicare hospice benefit includes several features that can invite inappropriate or excessive utilization. These exploitive patterns and practices by certain providers should be the subject of CMS audit activity rather than imposing arbitrary rules of thumb on the entire hospice community.

NPHI recommends that CMS and its contractors take immediate action to modify the current audit and compliance regime with the goal of protecting the right of Medicare beneficiaries and their families to a comprehensive end-of-life hospice experience while protecting the ability of well-intentioned hospice organizations to continue providing the highest quality hospice care possible.

Toward this end, we offer three sets of recommendations to:

- 1 Target exploitive patterns or practices by certain providers;**
- 2 Align audit standards and definitions with statute and regulation; and**
- 3 Modify the audit, recovery, and appeals processes to reduce their impacts on beneficiaries and hospice providers.**



# RECOMMENDATIONS

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## 1 Target Exploitive Patterns or Practices

In 2012, CMS made its Program for Evaluating Payment Patterns Electronic Report (PEPPER) available to hospice providers as a way to help them identify and avoid potential areas of improper billings. PEPPER targets 12 patterns of claims activity on which it provides individualized quarterly reports to hospices. Each hospice is ranked in relation to its peers, with each target area in which a hospice scores in the 80th or higher percentile identified as a potential area in need of correction. While PEPPER can alert providers to areas that might be subject to an audit, hospices do not experience a connection between PEPPER-identified targets and the focus of program integrity audits.

CMS should ensure that its Medicare program integrity contractor target patterns and practices that are characteristic of providers that aim to minimize or avoid therapeutic care and supportive services that are part of the hospice model and are fully reimbursed through the per diem payment, rather than relying on simplified algorithms and other rule-of-thumb methodologies. The following patterns and practices should raise flags for audit and compliance attention.

- **High rates of revoking/discharging patients:** Only a patient may revoke their hospice election. It is not uncommon for those in need of expensive treatments or hospitalizations to be discharged in a manner that enables the hospice to elude financial responsibility. Thus, a high live discharge or revocation rate (while legitimately appropriate in some circumstances such as the beneficiary moving out of the service area) may be a sign that a provider is discharging high-cost patients to hospitals or nursing homes. CMS should consider examining outlier scores on the new Hospice Care Index (HCI) Burdensome Transitions measure as an indicator of activity that could merit an audit.

- **Lack of sufficient 24-hour support:** Some hospices are staffing on-call nurses that are not geographically or otherwise appropriate and available to deliver after-hours visits as required by the CoPs. Despite staffing shortages which may impact their response time, CMS should determine whether this is a general provider practice or the result of current circumstances. Provider practices should be scrutinized to ensure that visits at the end of life are appropriately provided for and prioritized.
- **Hiring nursing home medical directors:** Hospices hiring physicians at above market rates who also serve as nursing home medical directors should be scrutinized for possible inappropriate referral incentives. These physicians should face additional audit scrutiny to ensure they are not reimbursed twice for the same patient by serving as both the attending physician and hospice physician.
- **Limiting coverage of related drugs and treatment:** Hospices that limit coverage of drugs that treat a patient's single terminal diagnosis and exclude coverage of drugs needed for a patient's related conditions for financial reasons (e.g. Chemotherapy).
- **Preferring specific settings of service:** Hospices that focus primarily or exclusively on providing services to patients in nursing homes or assisted living facilities (ALFs) while providing little or no care in other settings should be reviewed to avoid duplication of services. This is important because the Medicare hospice payment is calculated based on the assumption that providers are caring for patients in a mix of care settings. Furthermore, hospice providers engaging in this behavior may be incentivizing referrals from these organizations or their providers.
- **Preferring specific diagnoses:** Hospices that have a high percentage of patients with a particular set of diagnoses may be "cherry picking" patients with relatively low-cost, long-term illnesses (e.g., dementia). Hospice per diem rates are designed as an aggregate, risk corridor payment predicated on an assumed mix of patient diagnoses.

- **GIP in hospitals or nursing homes:** Some hospices provide most or all of their inpatient care in hospital units or or skilled nursing facilities (SNFs) in lieu of operating their own inpatient unit (IPU). CMS should monitor inpatient hospice care provided in hospital or nursing facilities to ensure that they are providing the higher level of care required when billing at the GIP-level, including providing RN level of staffing for every shift.
- **Failure to provide genuine bereavement services:** These are required services under the Conditions of Participation (CoPs) and should be enforced. For instance, some hospices do not provide bereavement services to surviving family other than sending a newsletter or card –with no plan or record of services for the bereaved.
- **Insufficient use of volunteers:** Some hospices are not meeting the CoPs requirement that at least 5% of patient care be provided by volunteers or are meeting the minimum but not providing volunteers throughout the service area – (allowing for insufficient volunteer engagement that may result from the current public health emergency (PHE)).

## 2

### **Align Audit Standards and Definitions with Statute and Regulation**

CMS should develop clear definitions, standards, and algorithms as the basis for program integrity audits and should make these transparent to providers so that performance and expectations are mutually understood and respected. Contractors should be prohibited from deviating from these algorithms or applying their own rules of thumb.

- **Provide standardized definitions for hospice eligibility:** CMS should adopt definitions in regulatory and sub-regulatory guidance of terminal illness and eligibility for inpatient care that would negate current local coverage decisions (LCDs) and rules-of-thumb adopted by and applied inconsistently by MACs.
  - Reaffirm that the statutory determination of eligibility relies solely on the clinical judgment of the physician and acknowledge the natural variation in the course of illness which belies use of a uniform pattern of decline as a review standard.



- Develop clearly stated review criteria emphasizing the medical judgment of the hospice and attending physicians rather than relying on the application of a blanket standard to judge the clinical records of the course of the patient's illness.
  - Evaluate the appropriateness of billing for GIP care in terms of the patient's total episode of care, rather than denying payment for an interval of quiescence when a patient's overall condition is not controlled. Halt the practice of using rule-of-thumbs for maximum length of GIP stays (e.g., 7 days).
  - To reduce incentives driving increasing lengths of stay, CMS should urge Congress to adopt the Medicare Payment Advisory Commission (MedPAC) recommendations to reduce and index the dollar amount of the cap on a hospice program's aggregate Medicare payments.
- **Ensure audits are conducted on a consistent basis:** Structure the framework for audit activity so that, in any particular audit, all contractors focus on the same exploitive practice, using a standard algorithm to conduct the audit and abiding by the same timelines for notification, response, reconciliation, and adjudication.
    - Develop a standardized methodology by which all contractors would be obligated to audit. Include requirements that must be used to define an eligible population and uniform audit procedures and criteria.
    - Require standard training, competency determination, credentialing, supervision and ongoing education of auditors to ensure consistency.
    - Prepare and educate auditors to understand the nuances of medication management so that they understand that all dosages given via different routes of administration are not equal.
    - Require MACs, SMRCs, and other auditors to audit individual auditor performance to improve interrater reliability among auditors.
    - Eliminate the ability for the individual auditors to expand the scope of their audits beyond the initially defined target to avoid scope creep which may dilute the findings of an audit.

### 3

## **Modify the Audit, Recovery, and Appeals Processes to Reduce Impact on Hospice Providers and Beneficiaries**

The current protracted, multi-step appeals and adjudication process, which places an enormous burden on hospice staff and often recoups and holds substantial financial assets for years, should be streamlined and consolidated. Recoupment of payments should be delayed until programs have had the opportunity to correct audit errors and appeal claims denials. Amounts that are currently recouped and held until a denial is reversed by an Administrative Law Judge (ALJ) should be repaid with interest. CMS should also provide greater transparency into the conduct and outcomes of its audits.

- **Improve the audit process:** Manage the timing of audits by adding controls into the structure of the audit process that would prevent providers from being subjected to multiple audits on the same or different issues occurring simultaneously or sequentially by the same or different contractors.
  - Place the emphasis in Targeted Probe and Educate (TPE) audits on education, preparing auditors with contemporary best practices to close performance gaps and enabling them to present information clearly to providers.
  - Compel all contractors to respond to providers within prescribed timeframes.
  - Compile and publish data on the number of hospice program audits and proportion with successful outcomes, the number of prepayment and post-payment denials, the amount of payments denied or recovered, the number and amount of recovered payments that are restored to the hospice after reconsideration, the number of appeals to the ALJ and number of decisions overturned by the ALJ and total amount and dollar value of payments restored to hospices by the ALJs.

- **Improve recovery and appeals processes:** Modify the drawn-out, multi-step process that hospices go through to return a disputed amount by directing appeals to mediation first. Seek recovery only after the appeals process has been exhausted.
  - Require audit contractors to reopen denial decisions when the hospice provider alleges a clear error by the auditor, such as a denial reason not based on the CoPs or a failure to acknowledge a document that was included in the originally submitted records.
  - Create a Demonstration Project to test the potential of an initial face-to-face mediation of denials with auditors to reduce costs, backlogs, and delays associated with the lengthy appeals process. The mediation would enable providers to correct audit errors and oversights before initiating a lengthy and expensive appeals process.
  - Empower the Administrative Law Judges (ALJs) to determine the outcome of the hearing based on the information presented and prohibit the practice of simply relying on the MACs' Local Coverage Decisions (LCDs) to rule in a prescribed fashion.
  - If recoupment of an alleged overpayment is initiated early in the process, ensure that providers who ultimately prevail in appeals decisions are paid back their claims with interest – using the same rate that is charged hospices on claims denied.
  - Hospice agencies receiving a successful outcome from an audit (an error rate below the specified threshold) should be exempt from further audits on the same issue from all auditors for a period of two years.

## CONCLUSION

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In the wake of the pandemic, America's hospice programs are struggling to continue providing the highest quality care to Medicare beneficiaries who choose hospice for their end-of-life care. Along with challenges arising from staffing shortages and COVID-19 protocols, hospices are experiencing an increase in CMS audit activity and the associated administrative and financial burden of complying with these audits. We urge CMS to consider the recommended changes we offer to the audit and compliance process in the interest of reducing the burden on well-intentioned hospices and the inadvertent harm to beneficiaries and their families while achieving greater compliance for the Medicare hospice program.

# OTHER PAPERS ON THE MEDICARE HOSPICE BENEFIT

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NPHI is developing recommendations for changes in the Medicare hospice benefit and in hospice operations to address the challenges and barriers detailed above, and to sustain the viability of non-profit, community-based providers.

- [Reforming the Medicare Hospice Benefit: The Case for Modernization](#)

## ABOUT NPHI

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**The National Partnership for Healthcare and Hospice Innovation (NPHI)** is a collaborative of 80+ not-for-profit, community-integrated hospice and palliative care providers dedicated to ensuring patients and their families have access to care that reflects their individual goals, values and preferences. Representing providers from 31 states and the District of Columbia, NPHI and its members help design more innovative and effective models of care, advocate for comprehensive and community-integrated care customized to meet each person's unique needs, and build collaboration between national thought leaders, decision-makers, and other healthcare stakeholders to improve hospice care. [www.nphi.info](http://www.nphi.info)

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