Improving CMS' Targeting of Hospice Audits

The hospice community is unified in our support for high-quality, regulatorily compliant providers. As such, we continue to advocate for enhanced and targeted program integrity oversight of outright fraudulent providers engaged in exploitation of the Medicare Hospice Benefit. This activity, however, is distinctly different from the actions of legitimate providers who nevertheless engage in activities that benefit their margins and produce positive revenue. Although we recognize and appreciate that audits of Medicare-certified hospices are necessary to safeguard the integrity of the Medicare hospice benefit, we are proposing that the Centers for Medicare and Medicaid (CMS) focus on patterns and practices, revealed through claims-based measures, that are suggestive of profiteering behaviour and malfeasance as opposed to the current focus on recouping payment for inadvertent billing and technical errors.

It is important to note that no single indicator should be considered in isolation when identifying which hospices are appropriate for auditing. A variety of factors, including health equity and geographic considerations, can impact the case mix and care provision of any single provider. Moreover, the existence of indicators should be assessed over a period of time to determine whether they demonstrate a pattern of intentionally wasteful or abusive practices. Note that some hospices with small censuses may appear as outliers on one or more measures as the result of a small number of instances among a small number of patients. However, due to the large number of small providers, CMS should consider:

1. Creating a small provider data set
2. Removing all exceptions/exclusions related to size for quality and data collection
3. Reviewing a small hospice's performance on a variety of measures in selecting them as an outlier hospice for further review or audit.

In other words, hospices should be selected for potential Medicare audits based on multiple criteria, that when taken together, suggest an increased likelihood that the hospice is purposefully engaging in fraud, waste or abuse. This approach necessitates an exercise in weighting of different metrics which is not fully discussed in this document. The hospice community stands ready, however, to engage collaboratively with CMS to determine both the appropriate mix of criteria and how those individual metrics are compared to each other.

Adopting such a matrix-style targeting approach would more accurately identify fraudulent, wasteful, and abusive providers, and result in a more tailored and efficient auditing program that better protects the integrity of the hospice benefit while minimizing burdens for providers by reducing claim denial appeals (and subsequent reversals) and reducing Medicare expenditures. Ultimately, CMS has limited resources to ensure proper

payment for hospices services and the hospice provider community seeks to ensure those resources are appropriately targeted at bad actors seeking to subvert the intent of the benefit.

Several existing indicators or data points available to CMS could be useful in searching for outliers engaged in abusive and wasteful patterns and practices as well as others, which could be indicative of poor patient care and abuse of the Medicare Hospice Benefit for monetary gain.

Exclusion from Quality Data Reporting and PEPPER

Small hospices make up a significant percent of the providers in the United States. According to the most recent data available from CMS in 2020, 34 precent of hospices have an average daily census below 50. Large numbers of hospices do not have quality scores and are excluded from the Program for Evaluating Payment Patterns Electronic Reports (PEPPER). There are valid reasons for excluding hospices from quality reporting in aggregate, especially when they have a small census that would make calculating measures less statistically accurate. However, this same statistical anomaly can occur in multiple subsets of providers across the industry (for-profit, nonprofit, providers with in-patient units and those without, hospices with census above 1,000 vs all others). It is important to note that more than a fifth (22%) of hospices do not have a Hospice Care Index (HCI) score, and more than half (52%) do not participate in Hospice CAHPS or report data. An unknown number are excluded from PEPPER reports. This should raise serious concerns that hospices are intentionally minimizing census size in order to avoid reporting requirement thresholds.

Claims from hospices that are excluded due to size from participating in quality reporting – from either a selection of excluded hospices that are in geographic areas at heightened risk of fraud or an annual random sample of all excluded hospices – should be reviewed to ensure that hospices are not intentionally organizing their business to remain just small enough to avoid scrutiny for the quality of services provided. This should be compared against the other indicators listed below.

Live Discharge Rates

Live discharges occur for a variety of reasons – some patient-initiated and some provider-initiated – not all of which are problematic – but which are often disruptive for the patient and family. Hospices with a high live discharge rate that are near or exceed the aggregate cap may indicate a pattern of bringing patients on services who may not meet eligibility requirements. A high rate of live discharges between 61 to 179 days on service may indicate a provider's effort to maximize revenue by keeping patients only for the first 60 days when the Routine Home Care (RHC) level of care is paid at a higher rate than subsequent days on service. A high rate of burdensome transitions, defined by HCI indicators, could indicate a pattern of inappropriate provider-initiated discharges of patients. While of all hospices work to reduce burdensome transitions, no legitimate hospice has none or close to zero burdensome transitions and those that do could indicate abuse of the benefit and denial of patient's rights to disenroll or access other needed services. Similarly, a high rate of hospice benefit revocations could suggest either a high level of patient and family dissatisfaction with the quality of services.

In all cases, a higher threshold should be considered for hospices that serve a high proportion of socially and economically disadvantaged individuals (SEDI) since those populations are more likely to revoke a hospice election to seek additional medical care or hospital care.

The measures below should be considered by CMS as indicators that additional scrutiny is warranted:

- Live discharges no longer terminally ill (PEPPER)
- Percent of live discharges on or after 180 days (HCI)
- Revocations (PEPPER)
- Live discharges with LOS 61-179 days (PEPPER)
- Burdensome Transitions Type 1 (HCI) (Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission)
    - % of readmissions to a different hospice after hospitalization
- Burdensome Transitions Type 2 (HCI) (Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital)
    - % of patients with certain diagnoses

High Percentage of Low-Cost Patients with Long Lengths of Stay (LLOS)

Providers with a notably high percentage of LLOS patients could be enrolling a high percentage of patients who are not eligible for hospice and may be preferred by the provider as more likely to be lower acuity (and lower cost) and more likely to have longer stays on service. Additionally, hospices with these LLOS patients could be discharging them to avoid billing for payments that could exceed the aggregate cap. In addition, providers who are selecting low-cost, long-stay patients may be an indicator that beneficiaries are not receiving the full hospice benefit.

In particular, the measures below should be considered by CMS:

- High percentage (outlier) of patients with a terminal diagnosis of ADRD (claims data).
- High average number of patient days for decedents or patients discharged in last year (claims data)
- Gaps in skilled nursing visits (HCI)
    - % of patients residing in congregate settings
- Nurse care minutes per routine home care day (HCI)
    - % of patients residing in congregate settings
- Per-Beneficiary Medicare Spending (HCI)
- Average cost of care per patient inverse with the average reimbursement per patient and relationship to the aggregate cap.

Billing for Care Unrelated to the Terminal Diagnosis

Hospice providers typically have no control over and are frequently unaware of care unrelated to the terminal condition that is billed by other providers to Medicare Part B or D for beneficiaries in hospice care. It would generally not be appropriate to audit hospice providers for care they are

unaware of that is billed by other providers. However, CMS does have the authority to audit Part B and D billers through other oversight contractors.

However, hospice providers serving beneficiaries for whom there are an abnormally high number of Part B or D claims may be involved in arrangements with medical providers to provide hospice benefits to patients who are continuing to undergo curative treatment. Often omission of co-occurring diagnoses could limit services and items covered through the hospice per diem and enable these services and items to be provided and billed separately to Part B and D. An abnormally high number of Part B or D claims may also indicate erroneous or fraudulent billing by DME vendors, pharmacies, or other entities for items and services that should be covered by hospice, possibly with knowledge of the hospice in order to avoid exceeding the aggregate cap.

Specifically, the measures below should be considered by CMS:

- Average number of Part B claims for beneficiaries residing at home (PEPPER)
- Average number of Part B claims for beneficiaries residing in a facility (PEPPER)
- Average number of Part D claims for beneficiaries residing at home (PEPPER)
- Average number of Part D claims for beneficiaries residing in an ALF (PEPPER)
- Average number of Part D claims for beneficiaries residing in a NF (PEPPER)
- Claims with a single diagnosis coded (PEPPER)

Each of these measures should be cross-referenced and matrixed with the ownership of the hospice provider to ensure there is no collusion between hospices and Part B and D billers owned in common.

Hospice Patients by Setting

Some hospices provide a high percentage of their hospice services in congregant living settings. There are high quality hospices who predominantly serve nursing homes (SNF/NF) and assisted living settings because they are part of a specific Life Plan Community or Continuing Care Retirement Community that provides a continuum of services including hospice and skilled nursing care. But if a hospice has a pattern of never or rarely taking referrals from hospitals or other community sources, this indicator should be considered in combination with others as a potential flag to review for waste and abuse. Hospices with a very high percentage services in one of these settings may be attempting to maximize revenue by serving a single site and combined with the other indicators above may be manipulating enrolment to avoid the aggregate cap.

The outlier measures below should be considered by CMS:

- Continuous Home Care Provided in an Assisted Living Facility (PEPPER)
- Routine Home Care Provided in an Assisted Living Facility (PEPPER)
- Routine Home Care Provided in a Skilled Nursing Facility (PEPPER)
- Routine Home Care Provided in a Nursing Facility (PEPPER)
- Low volume of referrals from acute care settings (new claims-based measure needed)

- High volume of referrals to a specific hospice coming from a co-owned skilled nursing facility/nursing facility and a high percentage of a hospice's patients' resident in a co-owned SNF/NF (new measure needed)
    - Also, referrals between SNF/NF and hospice with shared administrative and/or professional staff (with an exception for rural providers in areas where staffing shortages may necessitate shared staffing)

Each of these measures should be cross referenced and matrixed with the average length of stay and the homogeneity of a hospice's patients' terminal diagnoses to focus in on patterns that are consistent with cherry-picking and underserving.

Lack of Non-RHC Levels of Care Days

It is a requirement of the Hospice Conditions of Participation (CoP) to provide all four levels of hospice care: routine home care (RHC), general inpatient care (GIP), continuous home care (CHC), and respite care (RC). Lack of billing for these services may indicate a hospices' effort to maximize profit while skirting federal requirements. For example, hospices that do not bill GIP service days may suggest that providers do not enroll patients with complex care needs that could require more expensive care or may simply be avoiding that higher cost of care despite patient needs to skirt the aggregate cap.

Some hospices may transfer patients that need the GIP level of care to other hospices that do provide this care through their own inpatient unit (IPU) or through arrangements with hospitals. Some allowance should be made for hospices without IPUs that may not be able to establish GIP contracts with area hospitals or SNFs. However, hospices that make no genuine effort to provide GIP or CHC are failing to comply with Hospice CoPs. CMS could look for a pattern of live discharges to hospital Emergency Departments from hospices that report no GIP or CHC.

The measures below should be considered by CMS:

- No GIP or CHC (PEPPER)
- High % Burdensome Transitions Type 1 and 2 (HCI)
- High % Revocations (PEPPER)