

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**HOSPICES SHOULD IMPROVE  
THEIR ELECTION STATEMENTS  
AND CERTIFICATIONS OF  
TERMINAL ILLNESS**



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## Report in Brief

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### Why OIG Did This Review

Medicare hospice care is intended to help terminally ill beneficiaries continue life with minimal disruptions and to support beneficiaries' families. Two key requirements of the benefit are for the beneficiary to sign an election statement and for a physician to certify the beneficiary as terminally ill. These requirements provide critical safeguards to ensure that the beneficiary understands the benefit and that the physician is involved in determining whether the beneficiary is appropriate for hospice care.

Previous OIG work has raised concerns that some election statements used by hospices are misleading and that physicians are sometimes not involved in care planning and may rarely see beneficiaries. Also, OIG has investigated numerous cases in which hospices submitted fraudulent claims for patients who were not appropriate for hospice care.

### How OIG Did This Review

We based this study on a review of hospice election statements and certifications of terminal illness from a stratified random sample of hospice general inpatient (GIP) stays in 2012. Although the election statements and certifications of terminal illness were collected for a previous OIG study that focused on GIP, these documents are for the hospice benefit as a whole and are not specific to any one level of care.

## Hospices Should Improve Their Election Statements and Certifications of Terminal Illness

### What OIG Found

We found that hospice election statements lacked required information or had other vulnerabilities in more than one-third of general inpatient care (GIP) stays. Notably, they did not always mention—as required—that the beneficiary was waiving coverage of certain Medicare services by electing hospice care or that hospice care is palliative rather than curative. Further, in 14 percent of GIP stays, the physician did not meet requirements—such as composing a narrative—when certifying that the beneficiary was terminally ill and appeared to have limited involvement in determining that the beneficiary was appropriate for hospice care.

### What OIG Recommends and Agency Response

The findings in this report make clear that hospices should improve their election statements and ensure that physicians meet requirements when certifying beneficiaries for hospice care.

We recommend that the Centers for Medicare & Medicaid Services (CMS) (1) develop and disseminate model text for election statements, (2) instruct surveyors to strengthen their review of election statements and certifications of terminal illness, (3) educate hospices about election statements and certifications of terminal illness, and (4) provide guidance to hospices regarding the effects on beneficiaries when they revoke their election and when they are discharged from hospice care.

CMS concurred with three of our recommendations and neither concurred nor nonconcurred with the fourth recommendation.

### Key Takeaway

**It is important that hospices provide complete and accurate information in election statements so that beneficiaries and caregivers can make informed care choices. It is also critical that physicians fulfill their role and complete certifications of terminal illness as required. These certifications are an important safeguard in ensuring that beneficiaries are appropriately receiving hospice care.**

**However, we identified concerns with election statements in more than one-third of hospice GIP stays and, in 14 percent of stays, the physician did not meet requirements when certifying.**

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## OBJECTIVES

1. To determine the extent to which hospice election statements lack required information or have other vulnerabilities.
2. To determine the extent to which physicians meet requirements when certifying beneficiaries for hospice care.

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## BACKGROUND

The goals of hospice care are to help terminally ill beneficiaries continue life with minimal disruption and to support their families and other caregivers. In 2013, Medicare paid \$15.1 billion for hospice care for 1.3 million beneficiaries.<sup>1</sup>

Two key requirements of the Medicare hospice benefit are for the beneficiary to elect hospice care and for a physician to certify that the beneficiary is terminally ill. When electing hospice care, the beneficiary signs an election statement that is written by the hospice. The election statement is intended to ensure that the beneficiary understands the hospice benefit—particularly that hospice care is palliative, not curative—and that the beneficiary waives the right to Medicare payment for treatment of the terminal illness except for services provided by the hospice.<sup>2</sup> At the beginning of care and at set intervals thereafter, a physician completes a certification of terminal illness, which is intended to ensure that the physician is involved in determining whether the beneficiary is appropriate for hospice care.

Previous OIG work has raised concerns that some election statements used by hospices are misleading and that physicians are sometimes not involved in care planning and may rarely visit beneficiaries.<sup>3</sup> In addition, OIG has investigated a number of recent hospice fraud cases that illustrate the need to focus on program integrity. For example, in one case, the owner of a hospice in Mississippi used patient recruiters and submitted fraudulent

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<sup>1</sup> Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Medicare Payment Policy*, March 2015, ch. 12, p. 285. Accessed at [http://medpac.gov/documents/reports/mar2015\\_entirereport\\_revised.pdf?sfvrsn=0](http://medpac.gov/documents/reports/mar2015_entirereport_revised.pdf?sfvrsn=0) on May 11, 2015.

<sup>2</sup> 42 CFR § 418.24. Services may be made under arrangements by the hospice or provided by the beneficiary's attending physician.

<sup>3</sup> For concerns about election statements, see OIG, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance With Medicare Coverage Requirements* (OEI-02-06-000221), September 2009. For concerns about physician involvement see OIG, *Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities* (OEI-02-14-00070), January 2015; and OIG, *Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care* (OEI-02-10-00491), March 2016.

claims to Medicare for patients who were not appropriate for hospice. According to investigators, these beneficiaries had no idea they were in hospice care. The owner was sentenced to 3 years in prison and ordered to pay \$1.1 million in restitution to Medicare.<sup>4</sup>

In another case, a hospice in Philadelphia submitted false claims to Medicare and altered patient records to make patients appear to be eligible for hospice services when they were not. To increase enrollment, the hospice owner also paid health care professionals for referring patients to his hospice even though they were not appropriate for hospice care. The owner was found guilty of health care fraud and sentenced to more than 14 years in prison and ordered to pay \$16.2 million in restitution to Medicare.<sup>5</sup>

Also in Pennsylvania, a hospice's former chief operating officer admitted that she caused her staff to put patients in hospice care who were not appropriate for the benefit. She faces a possible 10-year sentence for health care fraud.<sup>6</sup>

These cases demonstrate the importance of having key safeguards in place that keep beneficiaries well informed and help ensure that the hospice care provided to beneficiaries is appropriate.

### **The Medicare Hospice Benefit**

To be eligible for Medicare hospice care, a beneficiary must be entitled to Part A of Medicare and be certified as having a terminal illness with a life expectancy of 6 months or less if the disease runs its normal course.<sup>7</sup> Upon a beneficiary's election of hospice care, the hospice agency is responsible for medical care related to the beneficiary's terminal illness and related conditions. Beneficiaries who elect hospice care are entitled to receive care for two 90-day periods, followed by an unlimited number of 60-day

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<sup>4</sup> Department of Justice (DOJ), "Cleveland Woman Sentenced for Hospice Fraud," December 4, 2015. Accessed at <https://www.justice.gov/usao-ndms/pr/cleveland-woman-sentenced-hospice-fraud> on June 17, 2016.

<sup>5</sup> DOJ, "Hospice Owner Sentenced To More Than 14 Years For Health Care Fraud Scheme," May 27, 2014. Accessed at <https://www.justice.gov/usao-edpa/pr/hospice-owner-sentenced-more-14-years-health-care-fraud-scheme> on June 17, 2016.

<sup>6</sup> DOJ, "Former Horizons Hospice Chief Operating Officer Pleads Guilty to Health Care Fraud," June 2, 2016. Accessed at <https://www.justice.gov/usao-wdpa/pr/former-horizons-hospice-chief-operating-officer-pleads-guilty-health-care-fraud> on June 17, 2016.

<sup>7</sup> Social Security Act, §§ 1814(a)(7)(A) and 1861(dd)(3)(A), 42 U.S.C. §§ 1395f(a)(7)(A) and 1395x(dd)(3)(A); 42 CFR §§ 418.20 and 418.22. Certification is based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness.

periods.<sup>8</sup> These periods are known as “election periods” and need not be consecutive.

Hospice care includes nursing care, medical social services, medical supplies (including drugs and biologicals), and physician services, among other things. By electing hospice care, the beneficiary waives all rights to Medicare payment for services related to the treatment of the terminal illness and related conditions except for services provided by or arranged for by the hospice. The beneficiary retains rights to Medicare payment for services to treat conditions unrelated to the terminal illness.<sup>9</sup>

The Medicare hospice benefit has four levels of care, which are paid at different rates. The levels are routine home care, general inpatient care (GIP), continuous home care, and inpatient respite care.<sup>10</sup> GIP is the second most expensive and, next to routine home care, is the most commonly used. GIP is provided in a hospice inpatient unit, a hospital, or a skilled nursing facility for symptom management or pain control that cannot be managed in other settings.<sup>11</sup> See Appendix A for descriptions of the levels of care and payment rates.

### **Election of Hospice Care**

A beneficiary choosing Medicare hospice care must file an election statement with a hospice. This statement is designed by the hospice and signed by the beneficiary. Regulations require that the election statement include information on key features of the hospice benefit. Specifically, the election statement must include acknowledgments that the beneficiary (1) has been given a full understanding of the palliative rather than curative nature of hospice care and (2) is waiving all rights to Medicare payment for certain services—such as treatment of the terminal illness and related conditions—when not provided by or arranged for by the beneficiary’s designated hospice.<sup>12</sup>

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<sup>8</sup> Social Security Act, § 1812(a)(4), 42 U.S.C. § 1395d(a)(4). Prior to 1990, Medicare provided hospice coverage for a maximum of 210 days.

<sup>9</sup> Social Security Act, §§ 1812(d)(2)(A) and 1861(dd)(1), 42 U.S.C. §§ 1395d(d)(2)(A) and 1395x(dd)(1); 42 CFR § 418.24(d). CMS has developed the Medicare Care Choices Model, a demonstration program that will allow certain beneficiaries to receive palliative care services from certain hospice providers while concurrently receiving services provided by their curative care providers. The model will enable CMS to study whether access to such services improves quality of life, increases patient satisfaction, and reduces Medicare expenditures. See CMS, *Medicare Care Choice Model*. Accessed at <http://innovation.cms.gov/initiatives/Medicare-Care-Choices/> on January 26, 2016.

<sup>10</sup> 42 CFR § 418.302.

<sup>11</sup> 42 CFR §§ 418.108(a) and 418.302(b)(4).

<sup>12</sup> 42 CFR § 418.24(b) and (d). Other requirements include the identification of the hospice, the effective date of election, and the signature of the individual or representative.

A beneficiary may revoke his or her election of hospice care and return to standard Medicare coverage at any time. To do so, the beneficiary must provide the hospice with a signed statement.<sup>13</sup>

A hospice may discharge a beneficiary if the beneficiary moves out of the hospice's service area, transfers to another hospice, or is no longer terminally ill. A hospice can also discharge a beneficiary for cause.<sup>14</sup>

### **Certification of Terminal Illness**

At the beginning of each election period, at least one physician must certify that the beneficiary is terminally ill with a life expectancy of 6 months or less.<sup>15</sup> The certification of terminal illness must be based on the physician's clinical judgment regarding the normal course of the beneficiary's illness and must be supported by clinical information in the medical record.

The physician must include a narrative in the certification that explains the clinical findings. It must reflect the beneficiary's individual clinical circumstances and cannot include checkboxes or standard language used for all patients.<sup>16</sup> The narrative must include an attestation confirming that the physician wrote the narrative based on either an examination of the patient or a review of the clinical record.<sup>17</sup> For the third and subsequent periods, the beneficiary must be examined face-to-face by either a physician or a nurse practitioner.<sup>18</sup>

### **CMS Oversight**

Hospices must be certified to participate in the Medicare program.<sup>19</sup> In 2013, there were 3,925 Medicare hospices. Of these, 2,411 were for-profit, 1,314 were nonprofit, and 200 were government-owned.<sup>20</sup>

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<sup>13</sup> Social Security Act, § 1812(d)(2)(B), 42 U.S.C. § 1395d(d)(2)(B); 42 CFR § 418.28.

<sup>14</sup> A hospice can discharge a beneficiary for cause if a beneficiary's behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the beneficiary or the ability of the hospice to operate effectively is seriously impaired. See 42 CFR § 418.26(a).

<sup>15</sup> The initial certification must be done by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the beneficiary's attending physician, if the beneficiary has one. Subsequent certifications can be done by one physician. See 42 CFR § 418.22(c). The attending physician is a physician or nurse practitioner identified by the beneficiary as having the most significant role in the beneficiary's medical care. See 42 CFR § 418.3.

<sup>16</sup> 42 CFR § 418.22(b)(3)(iv).

<sup>17</sup> 42 CFR § 418.22(b)(3)(iii).

<sup>18</sup> 42 CFR § 418.22(a)(4).

<sup>19</sup> Social Security Act, §§ 1814(a) and 1866, 42 U.S.C. §§ 1395f(a) and 1395cc.

<sup>20</sup> Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Medicare Payment Policy*, March 2015, ch. 12, p. 296. Accessed at [http://medpac.gov/documents/reports/mar2015\\_entirereport\\_revised.pdf?sfvrsn=0](http://medpac.gov/documents/reports/mar2015_entirereport_revised.pdf?sfvrsn=0) on May 11, 2015.

CMS contracts with State survey and certification agencies to conduct onsite surveys of hospices at the time of initial hospice certification, for recertification, and in response to complaints. These surveys determine whether the hospice meets Medicare requirements.<sup>21</sup> Surveyors review a sample of beneficiaries' records during this process, including the election statements and certifications of terminal illness.<sup>22</sup> Surveyors must cite deficiencies when hospices fail to meet requirements.

### **Related Work**

This report is part of a larger body of OIG work examining the delivery of hospice care to Medicare beneficiaries. A recent OIG report found that hospices billed one-third of GIP stays inappropriately, costing Medicare \$268 million in 2012.<sup>23</sup> Hospices sometimes provided poor-quality care and often did not provide intense services. Another OIG report found that hospices typically provided fewer than 5 hours of visits per week and were paid about \$1,100 per week for each beneficiary receiving routine home care in assisted living facilities.<sup>24</sup> It also found that hospice physicians rarely saw beneficiaries who received care in assisted living facilities.

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## **METHODOLOGY**

We based this study on a review of hospice election statements and certifications of terminal illness from a stratified random sample of 565 GIP stays in 2012. The sample was selected for another OIG study, which focused on the use of GIP.<sup>25</sup> However, the election statements and certifications of terminal illness that hospices use are for the hospice benefit as a whole and are not specific to any one level of care.

We reviewed the election statements for key required features, such as information about the palliative nature of hospice care and the waiver of coverage for certain services. We also noted when statements contained inaccurate information and when they contained information beyond what is required. We reviewed the certifications of terminal illness for key information, focusing on the physician narratives and attestations.

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<sup>21</sup> National accreditation organizations may perform the certification and recertification process for some hospices in accordance with section 1865 of the Social Security Act.

<sup>22</sup> CMS, *State Operations Manual, Appendix M - Guidance to Surveyors: Hospice*, Accessed at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap\\_m\\_hospice.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_m_hospice.pdf) on June 19, 2015.

<sup>23</sup> OIG, *Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care* (OEI-02-10-00491), March 2016.

<sup>24</sup> OIG, *Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities* (OEI-02-14-00070), January 2015.

<sup>25</sup> OIG, *Hospice Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care* (OEI-02-10-00491), March 2016.



See Appendix B for more detailed information about the methodology. See Appendix C for all statistical estimates and 95-percent confidence intervals.

### **Limitations**

For this study, we reviewed the content of hospice election statements and certifications of terminal illness. We did not independently verify the beneficiary's prognosis for a life expectancy of 6 months or less.

### **Standards**

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

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## FINDINGS

### **In more than one-third of GIP stays, hospice election statements lacked required information or had other vulnerabilities**

Before receiving hospice care, a beneficiary signs an election statement that has been written by the hospice. Complete and accurate election statements are an important safeguard to ensure that beneficiaries and their caregivers can make informed decisions about their care and understand what they are getting and what they are giving up when they elect hospice care. However, in 35 percent of GIP stays, hospices used election statements that were missing required information or had other vulnerabilities. See Table 1.

**Table 1: Percentage of GIP Stays With Election Statements That Lacked Required Information or Had Other Vulnerabilities**

<b>Vulnerability With Election Statement *</b>	<b>Percentage of GIP Stays</b>
Did not specify Medicare	19%
Required waiver information was missing or was stated inaccurately	12%
Required information about palliative care was missing	9%
Revocation or discharge information was inaccurate or unclear	4%

\*Categories are not mutually exclusive.

Source: OIG analysis of election statements, 2015.

In 19 percent of GIP stays, the election statements did not specify that the hospice benefit that the beneficiary was electing was Medicare hospice. These statements either referred to Medicaid hospice or referred to another hospice benefit in addition to Medicare, such as private health insurance, and did not indicate which hospice benefit the beneficiary was electing. Statements that do not make clear that the election is for Medicare hospice care are depriving beneficiaries of critical information. It is important for beneficiaries to know which benefit they are receiving, especially because eligibility criteria and election periods in some State Medicaid programs differ from those in Medicare, and private health insurance may cover hospice care very differently than Medicare.

In 12 percent of stays, the election statements did not mention—as required—that the beneficiary was waiving coverage of certain Medicare services by electing hospice care, or inaccurately stated what Medicare benefits were waived. For example, some election statements stated that the beneficiary waived the right to *all* other benefits under the Medicare program while receiving hospice benefits. This is not accurate. A beneficiary who

elects hospice care retains rights to Medicare payment for services to treat conditions unrelated to the terminal illness.

In 9 percent of stays, the election statements did not state—as required—that hospice care is palliative, rather than curative. Palliative care means patient- and family-centered care that optimizes the quality of life by anticipating, preventing, and treating suffering.<sup>26</sup> Election statements must include the beneficiary’s acknowledgment that he or she has been given a full understanding of this type of care.

In 4 percent of stays, the election statements included inaccurate or unclear information about how a beneficiary may revoke the election of hospice care or how the hospice may discharge a beneficiary. See the example of such a statement in the box on the following page. Information on revocation and discharge is not a required feature of election statements, but hospices may include such information. Beneficiaries who are given inaccurate or unclear information may not understand their rights and might be at a disadvantage if disagreements arise with their hospices.

In addition, hospices provided inconsistent information about the effect of revocation and discharge on the beneficiary. While some election statements explained that both revocation and discharge result in the beneficiary's losing the remaining days in the election period, others said this only about revocation. Also, many election statements did not say when a beneficiary who is eligible can again elect the hospice benefit after revocation or discharge.

Hospices’ inconsistencies in their election statements may stem from the way revocation and discharge are discussed in statute, regulations, and the CMS manual. The three sources note that upon revocation, a beneficiary is no longer covered under the Medicare hospice benefit for the remainder of the election period.<sup>27</sup> They also mention that the beneficiary may elect to receive hospice coverage in another election period.<sup>28</sup> However, it is unclear

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<sup>26</sup> 42 CFR § 418.3.

<sup>27</sup> Social Security Act, § 1812(d)(2)(B)(i), 42 U.S.C. § 1395d(d)(2)(B)(i); 42 CFR § 418.28(c)(1); CMS, *Medicare Benefit Policy Manual*, ch. 9, § 20.2.2 (Rev. 209, effective 10/1/14).

<sup>28</sup> Social Security Act, § 1812(d)(2)(B)(ii), 42 U.S.C. § 1395d(d)(2)(B)(ii); 42 CFR §§ 418.24(e) and 418.28(c)(3); CMS, *Medicare Benefit Policy Manual*, ch. 9, § 20.2.2 (Rev. 209, effective 10/1/14).

whether the beneficiary can start a subsequent election period immediately or only after the remaining days of the election period have passed.<sup>29</sup>

In addition, the regulations and manual discuss discharge differently. The manual explicitly states that upon discharge, the beneficiary loses the remaining days in the election period; the regulations do not address whether the beneficiary loses the remaining days in the election period.<sup>30</sup> As with revocation, it is unclear when a beneficiary can again obtain hospice coverage after discharge. The regulations and manual do not clarify whether the beneficiary can reelect hospice immediately or only once the remaining days in the current election period have passed.

### **Example of Inaccurate Information Contained in Election Statements**

*“If I choose care or treatment that has not been preauthorized by the hospice team or included in the plan, I understand that I have removed myself from the hospice benefit effective immediately.”*

- Contrary to this statement, a beneficiary does not revoke the hospice election or get automatically discharged simply by choosing care without authorization. To revoke the election, the beneficiary must provide the hospice with a signed statement.<sup>31</sup> A hospice may discharge a beneficiary if the beneficiary moves out of the service area or transfers to another hospice, if the hospice determines that the beneficiary is no longer terminally ill, or for cause. To discharge a beneficiary for cause, the hospice must follow a number of steps, including informing the beneficiary that he or she might be discharged and making a serious effort to resolve the problem.<sup>32</sup>

Some election statements had other features that might confuse beneficiaries. For instance, some hospices included the election statement within a much longer and more complex document or labeled the election statement something other than “election,” such as “Admission Service Agreement” or “Financial Agreement.” Other hospices used small print for the text explaining the palliative nature of hospice care, which may make it difficult for some beneficiaries and caregivers to read.

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<sup>29</sup> Election periods are a set number of days consistently defined as two initial periods of 90 days each and an unlimited number of subsequent periods of 60 days each. Social Security Act, §§ 1812(a)(4) and 1812(d)(1), 42 U.S.C. §§ 1395d(a)(4) and 1395d(d)(1); 42 CFR § 418.21; and CMS, *Medicare Benefit Policy Manual*, ch. 9, § 10 (Rev. 188, effective 8/4/14).

<sup>30</sup> 42 § CFR 418.26(c); CMS, *Medicare Benefit Policy Manual*, ch. 9, § 20.2.3 (Rev. 209, effective 10/1/14). The Social Security Act does not mention discharge at all.

<sup>31</sup> 42 CFR §§ 418.28(b).

<sup>32</sup> 42 CFR § 418.26(a)(3).

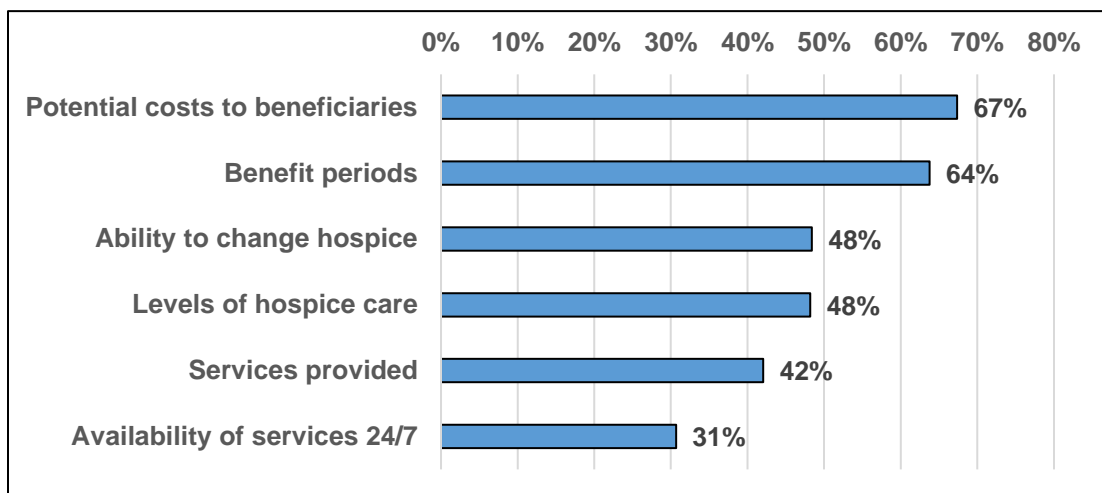
## In many cases, hospices included information in election statements that is not required

Although they are not required to do so, many hospices added detailed information to their election statements that explained key parts of the hospice benefit. For example, information about potential costs to the beneficiary—such as coinsurance payments for drugs or for the inpatient respite level of care—was included in the election statements for approximately two-thirds of GIP stays.

Information about the lengths of hospice election periods was included in the election statements for almost two-thirds of GIP stays. In addition, election statements for almost half of GIP stays noted that the beneficiary can change hospice providers, although not all of the statements explained that it could be done just once per election period. Some statements included other information, such as the levels of hospice care available and specific services that the hospice provides, such as nursing and hospice aide services.

Election statements for almost a third of stays noted that hospice services were available 24 hours a day, 7 days a week. This may be especially important because previous OIG work found that hospices often provided far fewer services on weekends than on weekdays, and beneficiaries and their caregivers may not know that hospices are required to make needed services available on a 24-hour basis.<sup>33</sup> A few statements also included a 24-hour phone number to call with any questions. See Figure 1.

**Figure 1: Percentage of GIP Stays with Election Statements That Contained Selected Additional Information**



Source: OIG analysis of election statements, 2015.

<sup>33</sup> OIG, *Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities* (OEI-02-14-00070), January 2015. See also 42 CFR § 418.100(c)(2).

Other features that were not as commonly found, but may be helpful, included text in large print sizes; instructions directing the beneficiary or representative to initial the sections of the statement that contain important facts about the benefit; contact information for Medicare; and information on how to make a complaint.

### **In 14 percent of GIP stays, the physician did not meet requirements when certifying and appeared to have limited involvement in determining that the beneficiary was appropriate for hospice care**

To be eligible for hospice care, a beneficiary must be certified as terminally ill with a life expectancy of 6 months or less. This is done by a physician for every election period and is based on the physician's clinical judgment.<sup>34</sup> Certifying physicians are required to compose a narrative and include an attestation in each certification of terminal illness. These requirements help to ensure that physicians are involved in determining that the beneficiary has a life expectancy of 6 months or less and is appropriate for hospice care.

However, in 14 percent of GIP stays, the certifying physician did not meet at least one of these requirements. Specifically, in 10 percent of stays, the certifying physician did not include a narrative at all or included only the beneficiary's diagnosis. This means that the certifying physician did not explain the clinical findings that support a life expectancy for the beneficiary of 6 months or less. In one example, the physician merely wrote, "resp. failure dying." This is in sharp contrast to other narratives that provided details about the beneficiary's condition, such as the beneficiary's activities of daily living, weight loss, moods, body mass index, and changes in scores on the palliative performance scale.

In 5 percent of GIP stays, the certifying physician did not include an attestation.<sup>35</sup> That is, the physician did not attest that the narrative was based on his or her examination of the beneficiary or review of the medical records. Composing a narrative and attesting that the narrative was based on an examination or record review are important safeguards to ensure that certifying physicians fulfill their role and demonstrate active involvement in the certifying process.

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<sup>34</sup> 42 CFR § 418.22(b).

<sup>35</sup> Some election statements lacked both a narrative and an attestation.

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## CONCLUSION AND RECOMMENDATIONS

This report looks at two key coverage requirements for the Medicare hospice benefit: election statements and certifications of terminal illness. It is part of a larger body of work that has revealed numerous vulnerabilities and raised serious questions about how the benefit is administered, such as whether Medicare is paying appropriately for hospice care and whether beneficiaries are receiving the services they need in their last months of life. These questions highlight both the need to protect the integrity of the hospice benefit and the need to protect beneficiaries.

The findings in this report make clear that hospices should improve their election statements and ensure that physicians meet requirements when certifying beneficiaries for hospice care. In 35 percent of GIP stays, hospices' election statements lacked required information or had other vulnerabilities. It is essential that hospices provide beneficiaries and their caregivers with accurate and complete information, especially about the palliative nature of hospice care and the benefits they are waiving. This is critical to ensuring that beneficiaries and their caregivers make informed care choices, especially because beneficiaries who elect hospice care are—in essence—turning over all care for their terminal illness to the hospice.

In 14 percent of GIP stays, the certifying physician did not meet requirements and appeared to have limited involvement in determining that the beneficiary was appropriate for hospice care. It is essential that physicians fulfill their role and complete certifications as required, as these certifications are a critical safeguard in ensuring that beneficiaries are appropriately receiving hospice care.

We recommend that CMS:

### **Develop and disseminate model text for election statements**

CMS should develop model text that hospices could use in crafting their election statements. This might be done through CMS contractors, such as the Medicare Administrative Contractors that oversee the hospice benefit. Model text will help ensure that hospice election statements are clear and complete and that they contain accurate information about the Medicare hospice benefit.

The model text should clearly identify the benefit as Medicare, as we found numerous instances in which the election statement does not. Medicare can have different rules than other payers, so it is important for beneficiaries to know that Medicare, as opposed to other payers, is covering their care. This is a fundamental program integrity safeguard. The statement must clearly communicate to beneficiaries and their families which program is paying for beneficiaries' care, especially so that they know which program to contact if

they experience problems with the hospice or have any questions about which services they are entitled to receive.

The model text should also accurately explain what the beneficiary is waiving and describe the palliative nature of hospice care. In addition, the model text should include helpful information about the hospice benefit, so that hospices can choose to add this information to their election statements. Specifically, the model text should include information about services being available 24 hours a day, an explanation of services included in the benefit, and contact information for the hospice.

### **Instruct surveyors to strengthen their review of election statements and certifications of terminal illness**

CMS should instruct surveyors to—as a part of the survey and certification process—increase their attention to the requirements for election statements. Surveyors should determine whether election statements contain all the required information and that this information is accurate. If not, surveyors should cite deficiencies. Likewise, surveyors should strengthen their review of certifications of terminal illness to ensure that certifying physicians are meeting the requirements. Surveyors should cite deficiencies when they find certifications that are not complete. Surveyors should strengthen their reviews of all hospices but should particularly focus on the hospices we found to have election statements that lacked required information or had other vulnerabilities and on the hospices that had certifications for which the physician did not meet requirements. We will provide a list of these hospices to CMS in a separate memorandum.

### **Educate hospices about election statements and certifications of terminal illness**

CMS should provide training to hospice providers about the requirements for election statements. The model text that we recommend be developed could serve as a basis for part of this training. The training should reiterate the requirements and ensure that hospices are reviewing and revising their election statements as appropriate. CMS should also provide training to hospices about the requirements for certifications of terminal illness. In addition, CMS should work with hospices to educate physicians about their responsibilities in determining and documenting their clinical findings for certifying terminal illness, given the important role that certifying physicians play in ensuring the appropriate use of hospice care. As part of this effort, CMS could develop educational materials that hospices can share with physicians. CMS should educate all hospices but should particularly focus on the hospices we found to have election statements that lacked required information or had other vulnerabilities and on the hospices that had certifications for which the physician did not meet requirements. We will provide a list of these hospices to CMS in a separate memorandum.



**Provide guidance to hospices regarding the effects on beneficiaries when they revoke their election and when they are discharged from hospice care**

CMS should provide guidance to hospices that clarifies the effects of revocation and discharge on the beneficiary. This guidance should explicitly address (1) whether remaining days of the election period are lost and (2) when, after revocation or discharge, a new election period can begin for beneficiaries who are eligible. Hospices should have a clear understanding of the effects of revocation and discharge so that they can consistently implement policies and accurately inform beneficiaries.

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## **AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

CMS concurred with three of our recommendations and neither concurred nor nonconcurred with the fourth recommendation.

CMS concurred with our first recommendation to develop and disseminate model text for election statements. CMS stated that it will develop model text that satisfies the regulatory requirements, which could be used by hospices when designing their own election statements.

CMS concurred with our second recommendation to instruct surveyors to strengthen their review of election statements and certifications of terminal illness. CMS stated that it will revise the Basic Hospice Training provided to surveyors to place appropriate emphasis on election statements and certifications of terminal illness. CMS will also include these topics during yearly training and webinars with surveyors.

CMS concurred with our third recommendation to educate hospices about election statements and certifications of terminal illness. CMS stated that, together with the Medicare Administrative Contractors, it will work to issue guidance to providers on election statements and certifications of terminal illness. CMS will also continue to use the Medicare Learning Network, weekly electronic newsletters and quarterly compliance newsletters to educate providers on avoiding common errors.

CMS neither concurred nor nonconcurred with our fourth recommendation to provide guidance to hospices regarding the effects on beneficiaries when they revoke their election and when they are discharged from hospice care. CMS stated that it will monitor patient revocations and discharges and provide additional guidance to hospices, if needed. OIG reiterates the need for clearer guidance regarding the effects of revocation and discharge, as hospices have provided inconsistent information about the effect of revocation and discharge on the beneficiary. The statute, regulations, and the CMS manual note that upon revocation, a beneficiary is no longer covered under the Medicare hospice benefit for the remainder of the election period. They also mention that the beneficiary may elect to receive hospice coverage in another election period. However, it is unclear whether the beneficiary can start a subsequent election period immediately or only after the remaining days of the election period have passed. Similarly, it is unclear when a beneficiary can again obtain hospice coverage after discharge. The regulations and CMS manual do not clarify whether the beneficiary can reelect hospice immediately or only once the remaining days in the current election period have passed.

For the full text of CMS's comments, see Appendix D.

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## APPENDIX A

### Levels of Care and Payment Rates

The Medicare hospice benefit has four levels of care: routine home care, general inpatient care (GIP), continuous home care, and inpatient respite care. Routine home care is the most commonly used, followed by GIP. GIP is provided in a hospice inpatient unit, a hospital, or a skilled nursing facility.<sup>36</sup> It is for pain control or symptom management that cannot be managed in other settings, such as the beneficiary's home.<sup>37</sup> Continuous home care is allowed only during brief periods of crisis and only as necessary to maintain the individual at home.<sup>38</sup> Inpatient respite care is short-term inpatient care provided to the beneficiary when necessary to relieve the beneficiary's caregiver.<sup>39</sup>

Medicare pays hospices a daily rate from the day a beneficiary elects hospice care to the day of discharge. Each level of hospice care has an all-inclusive daily rate that is paid through Part A.<sup>40</sup> The daily rate is paid to the hospice for each day that a beneficiary is in hospice care, regardless of the amount of services furnished on a particular day. The rates are adjusted on the basis of the beneficiary's geographic location. See Table A-1 for the unadjusted payment rates for each level of care in fiscal year (FY) 2015. Beneficiaries generally do not pay coinsurance for hospice care.<sup>41</sup>

**Table A-1: Unadjusted Daily Medicare Hospice Payment Rates by Level of Care, FY 2015**

Routine Home Care	\$159.34
Continuous Home Care	\$929.91
General Inpatient Care	\$708.77
Inpatient Respite Care	\$164.81

Source: CMS, *Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, Quality Reporting Program and the Hospice Pricer for FY 2015*, Transmittal R3023CP, Change Request 8876, October 1, 2014.

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<sup>36</sup> 42 CFR § 418.108(a).

<sup>37</sup> 42 CFR § 418.302(b)(4).

<sup>38</sup> 42 CFR § 418.302(b)(2); 42 CFR § 418.204(a)(defining "periods of crisis"); and CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 11, § 30.1.

<sup>39</sup> 42 CFR § 418.302(b)(3).

<sup>40</sup> For continuous home care, the hospice is paid an hourly rate based on the number of hours of continuous care furnished to the beneficiary on that day. The daily continuous home care rate is divided by 24 hours to determine an hourly rate. A minimum of 8 hours of predominantly nursing care must be provided. CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 11, § 30.1.

<sup>41</sup> Hospices may charge beneficiaries a 5-percent coinsurance for inpatient respite care. Hospices also may charge beneficiaries a coinsurance payment, not exceeding \$5, for each palliative drug and biological prescription. See 42 CFR § 418.400.

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## APPENDIX B

### Detailed Methodology

#### Selection of Statistical Sample

We based this study on a review of election statements and certifications of terminal illness from a stratified random sample of GIP stays. The sample was selected for another OIG study, which focused on the use of GIP.<sup>42</sup> As part of that study, we collected the election statements and certifications of terminal illness for the beneficiary in each stay.

To select the sample of GIP stays, we performed the following steps. Using CMS's National Claims History file, we extracted all Medicare Part A hospice claims that had service dates in 2012 and were received through December 2012. Each claim included information about the level of hospice care, such as GIP, and the setting, such as a SNF. We combined the claims to identify all GIP stays. We considered a GIP stay to be one or more claims for GIP for the same beneficiary in the same setting, from the same hospice, for which the claims represented consecutive periods. We considered the periods to be consecutive if the first claim's ending date was either the same day as or the day before the starting date of the subsequent claim, and so on. We identified 282,225 GIP stays in 2012 for 252,759 beneficiaries.

We selected a stratified simple random sample of 570 GIP stays from this file. We did not contact the hospices that billed for five of the stays in our sample because these hospices were under investigation by OIG. Our final sample included 565 stays.

We used a contractor to collect the election statements and all certifications of terminal illness associated with each sampled stay. We had response rates of 100 percent for election statements and 99 percent for certifications of terminal illness.

#### Review of Election Statements and Certifications of Terminal Illness

For each GIP stay, we used a standardized instrument based on Medicare coverage requirements and CMS guidance to review the beneficiary's election statement and certifications of terminal illness.

*Election Statements.* We reviewed the election statements to determine the extent to which they lacked required information or had other vulnerabilities. Specifically, we determined whether the statement specified that the election was for the Medicare hospice benefit; included

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<sup>42</sup> For a detailed description of the sample see OIG, *Hospice Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care* (OEI-02-10-00491), March 2016.

the information that the beneficiary waives certain Medicare services by electing hospice care; and included information about the palliative rather than curative nature of hospice care, as it related to the individual's terminal illness. We also reviewed information in the statements about revocation and discharge. We further noted whether the hospice included any additional information in the election statements, such as the potential costs to beneficiaries, the length of Medicare hospice election periods, the levels of hospice care, and the services the hospice provides.

*Certifications of Terminal Illness.* We reviewed the certifications to determine the extent to which the physician met requirements that demonstrate involvement in the certification process. Specifically, we determined whether a physician signed the document; whether it stated that the beneficiary's prognosis was for a life expectancy of 6 months or less if the terminal illness were to run its normal course, if it contained a narrative and, if so, whether the narrative reflected the beneficiary's clinical circumstances. We also determined whether the certifying physician attested to basing the narrative on a review of the beneficiary's medical record and/or an examination of the beneficiary.

### **Analysis**

We analyzed the results of the reviews of election statements to estimate the percentage of GIP stays for which the election statement lacked the required information or had other vulnerabilities. We estimated the percentage of GIP stays for which the election statement included additional information that was beyond what was required. We also analyzed the results of the reviews of the certifications to estimate the percentage of GIP stays for which the physician did not meet requirements when certifying and appeared to have limited involvement in determining that the beneficiary was appropriate for hospice care.

## APPENDIX C

### Statistical Estimates and Confidence Intervals

#### Sample Sizes, Point Estimates, and Confidence Intervals

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower Limit	Upper Limit
<b>Election Statements</b>				
Percentage of GIP stays for which the hospice election statement lacked required information or had other vulnerabilities	563	34.9%	30.0%	40.2%
Percentage of GIP stays for which the election statement did not specify that the hospice benefit that the beneficiary was electing was Medicare hospice	563	19.4%	15.5%	23.9%
Percentage of GIP stays for which the election statement did not mention that the beneficiary was waiving coverage of certain Medicare services by electing hospice care, or inaccurately stated what Medicare benefits were waived	563	11.6%	8.4%	15.8%
Percentage of GIP stays for which the election statement did not state that hospice care is palliative rather than curative	563	9.5% <sup>1</sup>	6.7%	13.2%
Percentage of GIP stays for which the election statement included inaccurate or unclear information about how a beneficiary may revoke the election of hospice care or how the hospice may discharge a beneficiary	563	3.6%	2.1%	6.2%
Percentage of GIP stays for which the election statement mentioned potential costs to the beneficiary	563	67.4%	62.2%	72.2%
Percentage of GIP stays for which the election statement mentioned the length of periods	563	63.8%	58.4%	68.8%
Percentage of GIP stays for which the election statement noted that the beneficiary can change hospice providers	563	48.4%	43.0%	53.8%
Percentage of GIP stays for which the election statement included information on the levels of hospice care available	563	48.2%	42.8%	53.6%
Percentage of GIP stays for which the election statement included information on specific services that the hospice provides	563	42.0%	36.9%	47.4%

continued on the next page

### Sample Sizes, Point Estimates, and Confidence Intervals (Continued)

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower Limit	Upper Limit
<b>Election Statements</b>				
Percentage of GIP stays for which the election statement noted that hospice services were available 24/7	563	30.7%	26.0%	35.8%
<b>Certifications of Terminal Illness</b>				
Percentage of GIP stays for which the physician did not meet requirements when certifying and appeared to have limited involvement in determining that the beneficiary was appropriate for hospice care	562	14.1%	10.6%	18.5%
Percentage of GIP stays for which the certifying physician did not include a narrative at all or included only the beneficiary's diagnosis	562	10.5% <sup>2</sup>	7.5%	14.5%
Percentage of GIP stays for which the certifying physician did not include an attestation	562	4.6%	2.7%	7.5%

<sup>1</sup> The point estimate was 9.47 percent, which rounded to 9 percent as a whole number in the text.

<sup>2</sup> The point estimate was 10.49 percent, which rounded to 10 percent as a whole number in the text.

Source: OIG analysis of hospice election statements and certifications of terminal illness, 2015.

## APPENDIX D

### Agency Comments



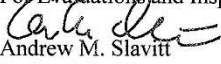
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW  
Washington, DC 20201

AUG 19 2016

**To:** Daniel Levinson  
Deputy Inspector General  
For Evaluations and Inspections

**From:**   
Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services

**Subject:** Hospices Should Improve Their Election Statements and Certifications of Terminal Illness (OEI-02-10-00492)

The Centers for Medicare & Medicaid Services (CMS) appreciates your continued work on hospice and the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS strives to provide Medicare beneficiaries with access to high quality health care while protecting taxpayer dollars.

CMS recognizes the importance of continuing to provide Medicare beneficiaries with access to hospice services and, at the same time, is also working to improve appropriate use. CMS has made significant changes in hospice payment policy in recent years to reward providers that offer higher quality care and reduce improper payments. The Affordable Care Act (ACA) gave CMS the authority to reform hospice payment policies, and established a quality reporting program for hospices. In accordance with the ACA, starting in fiscal year (FY) 2014, hospices that fail to meet quality reporting requirements may receive a reduction to their overall payment. The ACA also authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and to reform how Medicare pays for hospice services.

In the FY 2015 Hospice Wage Index and Payment Rate Update final rule (79 FR 50452), CMS finalized requirements for timelier filing of notices of election and termination/revocation. CMS also revised requirements for the election statement to include the patient's choice of attending physician, and to indicate that if a patient (or representative) wants to change his or her designated attending physician, he or she will have to follow a procedure similar to that which currently exists for changing the designated hospice. We believe that such changes will help ensure that any changes the attending physician will be the result of the patient's freedom of choice. CMS also implemented the requirement in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) that Medicare-certified hospices have mandatory surveys every 36 months to ensure that they meet the health, safety and quality of care standards in the Hospice Conditions of Participation. In addition, CMS now requires hospices to report and share standardized assessment data, which allows providers to facilitate more coordinated care, with the goal of improving Medicare beneficiary outcomes.



CMS will monitor the effects of recent policy changes and will continue to work with the hospice community in order to safeguard the Medicare hospice benefit while maintaining beneficiary access to care.

**OIG Recommendation**

OIG recommends that CMS develop and disseminate model text for election statements.

**CMS Response**

CMS concurs with this recommendation. Hospices are allowed to design their own election statements as long as they contain certain content outlined in regulation. While the content requirements pertaining to the hospice election statement are clearly articulated in regulation and the Medicare Benefit Policy Manual, CMS will develop model text that satisfies the regulatory requirements, which could be used by hospices when designing their own election statements.

**OIG Recommendation**

OIG recommends that CMS instruct surveyors to strengthen their review of election statements and certification of terminal illness.

**CMS Response**

CMS concurs with this recommendation. CMS will revise the Basic Hospice Training provided to surveyors to place appropriate emphasis on election statements and certification of terminal illness. CMS will also include these topics during yearly training and webinars with surveyors.

**OIG Recommendation**

OIG recommends that CMS educate hospices about election statements and certifications of terminal illness.

**CMS Response**

CMS concurs with this recommendation. CMS and the Medicare Administrative Contractors will work to issue guidance to providers on election statements and certifications of terminal illness. CMS also continues to use the Medicare Learning Network, weekly electronic newsletters and quarterly compliance newsletters to educate providers on avoiding common errors.

**OIG Recommendation**

OIG recommends that CMS provide guidance to hospices regarding the effects on beneficiaries when they revoke their election and when they are discharged from hospice care.

**CMS Response**

CMS will monitor patient revocations and discharges and provide additional guidance to hospices, if needed. CMS recognizes that the decision to elect the Medicare hospice benefit can be difficult and strives to maintain access to this important benefit. Section 1812(d)(2) of the Social Security Act, allows patients to stop receiving hospice care, at any time, and for any reason and re-elect the hospice benefit for any other benefit period for which he or she is eligible.

The regulations are consistent in that for discharges and revocations, the patient is no longer covered under Medicare hospice care; however, the patient may at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive. The Medicare hospice benefit does not limit the number of election periods that a beneficiary can receive, as long as the beneficiary continues to meet the hospice eligibility criteria.

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## **ACKNOWLEDGMENTS**

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Nancy Harrison and Jenell Clarke-Whyte served as team leaders for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Lauren A. Haynes, Jennifer Karr, and Casey Lyons. Central office staff who provided support include Evan Godfrey, Kevin Farber, Christine Moritz, and Berivan Demir Neubert.

# Office of Inspector General

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