OIG Continues its Focus on GIP Abuse: What Hospice Providers Need to Know

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On March 31, 2016, the U.S. Department of Health and Human Services' Office of Inspector General (OIG) issued a report on hospice billing for general inpatient care (GIP).[1] According to the OIG, hospices billed Medicare for GIP inappropriately in one-third of stays in 2012, costing Medicare $268 million. The report reflects the OIG's continuing focus on GIP costs, and the OIG's recommendations to the Centers for Medicare and Medicaid Services (CMS) offer guidance to hospice providers on upcoming enforcement trends.

Background

The Medicare hospice benefit covers four levels of care: routine home care, continuous home care, GIP, and inpatient respite care. GIP, which is used to provide pain control or symptom management care that can be provided only in a hospice inpatient unit, hospital, or skilled nursing facility (SNF). A physician's order is not required to initiate GIP, and it is intended to be short-term. GIP is the second most expensive, and the second most commonly utilized, type of hospice care. Thus, while the Medicare daily rate for routine hospice home care, the most commonly utilized type of care, is $151, the daily rate for hospice GIP care is $672.

The cost of drugs for the palliation and management of terminal illness is included in the hospice daily rate. Since Medicare beneficiaries can also elect to receive the Medicare Part D drug benefit, drugs related to the beneficiary's terminal illness and covered under the hospice benefit, are excluded from Part D. CMS has issued guidance to Part D sponsors that focuses on eliminating double payments for hospice drugs.

Findings

The OIG, which based its findings on a stratified random sample of 565 GIP stays in 2012, as well as Medicare Part D data, found that in 20 percent of GIP stays, the beneficiary did not need GIP at all. In an additional 10 percent of GIP stays, the OIG found that the beneficiary did not need GIP for the entire stay, but the hospice continued to bill for GIP even after the beneficiary's symptoms were under control. The OIG concluded that, in many of the inappropriate GIP stays, less expensive routine home care would have been appropriate. Furthermore, where patients received GIP because their caregiver was overwhelmed, respite care, which is reimbursed at a lower rate, should have been provided instead.

The OIG also noted that certain states and hospice settings had higher levels of inappropriate GIP stays, with Florida, Ohio, and Arizona each having disproportionately high numbers of inappropriate stays. According to the report, hospices were more likely to bill inappropriately for GIP in SNFs than in hospitals and hospice inpatient units, while 41 percent of GIP stays in for-profit hospices were billed inappropriately, compared with 27 percent of stays in nonprofit and government-owned hospices.

1 Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care, DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL, March 2016, available at http://oig.hhs.gov/oei/reports/oei-02-10-00491.pdf

What Hospice Providers Need to Know

In light of these findings, OIG has offered recommendations to CMS to "hold hospices accountable":

- **Increase oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries**

The OIG recommended that CMS contractors institute more medical reviews of GIP claims, with particular emphasis on GIP care provided in SNFs and by for-profit hospices. The OIG further recommended that CMS identify hospices serving beneficiaries with high numbers of Part D drugs and "target" these hospices for further review. CMS, which concurred with the recommendations, is currently procuring a national Durable Medical Equipment (DME) and Home Health/Hospice Recovery Audit Contractor to review applicable claims and work with CMS and MACs to recoup overpayments and pay underpayments.

OIG and CMS have put providers on notice that they will be increasing audits of hospice claims. We recommend that hospice providers self-audit claims submitted now to prepare for increased scrutiny of these claims during CMS review.

- **Ensure that a physician is involved in the decision to use GIP**

The OIG recommended that CMS require a physician's order to change the hospice level of care to GIP. Although CMS stated that it will "work with the hospice community to explore other options for expanding physician involvement," it expressed concern that requiring a physician's order could delay access to GIP care for patients who need it.

We anticipate further developments, whether in the form of government commentary, rule-making, or legal decisions, in this area. The recent *Aseracare* decision,[2] which held that one medical expert's opinion alone could not prove the falsity of hospice claims submitted to the government, has generated discussion on how to determine when hospice care is appropriate. While the OIG identified situations where GIP was not needed, hospice providers are well-aware that patient assessments are not always clear-cut. Healthcare professionals may have differing opinions on whether a patient is eligible for hospice or what level of care is appropriate. Thus, we expect greater emphasis on who decides if GIP is appropriate and greater scrutiny of the decision.

- **Conduct prepayment reviews for lengthy GIP stays**

The OIG and CMS agreed that "lengthy" GIP stays should be reviewed prepayment. Because there is no set number of days for a "lengthy" stay, the OIG suggested that CMS conduct prepayment reviews for GIP stays "exceeding a reasonable threshold, such as 7 days," but that the threshold be determined by consulting hospice and palliative care experts and analyzing data. Since CMS agreed that prepayment review is needed, we recommend that providers continually review the level of care needed for individual patients, especially for GIP stays approaching the one-week mark.

- **Increase surveyor efforts to ensure that hospices meet care planning requirements**

The OIG found that hospices did not meet care planning requirements for 85 percent of GIP stays. Common errors were omission of the frequency or scope of at least one type of service (i.e. physician, nursing or medical social services), or developing the care plan without the involvement of required parties (e.g. a pastoral or other counselor, physician, or nurse). CMS will be revising its hospice training for surveyors to increase emphasis on care planning review.

- **Establish additional enforcement remedies for poor hospice performance**

The OIG has again recommended that CMS establish intermediate enforcement measures, like directed plans of correction, directed in-service training, denials of payment for new admissions, civil monetary penalties, and imposition

2 *See* District Court Deals Blow to DOJ in False Claims Act Case, Alan Horowitz, available at http://www.agg.com/files/Publication/f22a421d-4f0a-46e9-8de8-eafdabdc13ec/Presentation/PublicationAttachment/1dcc85f1-1002-4e69-92b6-f7aa50804042/Horowitz-Lord-District-Court-Deals-Blow-to-DOJ-in-False-Claims-Act-Case.pdf

of temporary management, for hospices. Though the FY 2016 budget does not include a proposal to seek authority to establish these remedies, CMS stated that it "will consider submitting this proposal in the future as part of the budget process." CMS has shown a willingness to expand intermediate sanctions to SNFs and Home Health Agencies, and we see hospice as a logical next area for added enforcement mechanisms.

- **Follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor-quality care**

The OIG will provide CMS with a list of hospices providing poor-quality care and submitting claims for inappropriate GIP stays. Based on this analysis, CMS will review a number of these claims.

OIG and CMS have offered a guide for hospice providers on how they plan to focus enforcement efforts. As the government sharpens its focus on hospice GIP stays, we recommend that providers do the same to prepare for increased scrutiny.

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