

Hospice Toolkit

Program Integrity—An Overview for Medicaid Hospice Providers





Content Summary

This booklet discusses the Medicaid hospice benefit and the importance of provider documentation to support medical necessity and proper level of care; provides examples of fraud, waste, and abuse; reviews new practices to improve communication, documentation, and quality of care; and discusses what hospice providers and other stakeholders can do to help reduce improper payments and improve the services offered. Finally, additional resources are listed in the booklet for providers to understand anti-fraud efforts and the training they should provide to their staff. Contact information is provided to report potential fraud.

Introduction

The Centers for Medicare & Medicaid Services (CMS), Center for Program Integrity (CPI), and the States are providing educational resources to hospice providers and other stakeholders to enhance awareness of the Medicaid hospice benefit and to engage providers in efforts to prevent fraud, waste, and abuse in the Medicaid program.

CMS uses two comprehensive strategies to protect the integrity of Medicaid. The first strategy is the Medicaid Integrity Program (MIP) established under section 1936 of the Social Security Act (SSA), which gives CMS two broad responsibilities:

1. Effectively assist and support the efforts of the States to combat Medicaid provider fraud and abuse; and
2. Review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.[1]

The second strategy was established by Executive Order 13520 which requires assurances that major programs administered by the Federal government intensify efforts to eliminate payment error, waste, fraud, and abuse in high risk or vulnerable areas.[2]



Definition of Hospice Care

The SSA (“the Act” in this paragraph) defines hospice care as a “comprehensive set of services described in [Section] 1861(dd)(1) of the Act, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.”[3, 4, 5] Under the authority of sections 1905(a)(18) and (o) of the Act, hospice benefits are services provided by a Medicaid-participating hospice program. The hospice program is a public or private organization that meets the requirements as defined under Section 1861(dd)(2) of the Act. The hospice provider must have an interdisciplinary group of personnel that includes at least one physician, one registered professional nurse, and one social worker that provides or supervises the provision of hospice care and services and that establishes policies governing the provision of such care and services.[6] The participant’s attending physician, along with the hospice interdisciplinary team, establishes and periodically reviews the participant’s care plan.[7, 8]

Palliative care can help manage the pain and symptoms of illness, whether the illness is terminal or not. Palliative care is distinct from curative care, which seeks a cure for a disease or medical condition. Palliative care can go hand-in-hand with hospice care for the patient who has chosen to end or forgo curative treatment, unless he or she is 21 years of age or younger.[9] However, a patient does not have to be in hospice or at the end of life to receive palliative care.



Results of Hospice Audits

Recent State and U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) audits of Medicaid hospice providers uncovered a trend of overpayments made for claims submitted for hospice services provided to Medicaid participants that lacked documentation supporting life expectancy of 6 months or less. Specifically, claims were denied because:

- Medical records did not support a terminal illness with a life expectancy of 6 months or less, or did not support patient status generally;[10, 11]
- Certification was not provided in a timely manner;[12, 13]
- Hospice employees were not properly vetted or licensed;[14, 15, 16]
- Documentation supported long-term or custodial care rather than hospice care;[17, 18] and
- The principal hospice diagnoses on the claims were adult failure to thrive, dementia, and debility.[19, 20]

Federal regulations for the Medicaid hospice benefit defer to Medicare hospice benefit regulations for definitions of hospice care and a hospice program.[21] Therefore, Medicaid hospice programs often follow Medicare rules and regulations for determination of eligibility and benefits provided. CMS issued final rules on August 7, 2013, that specifically addressed the Medicare diagnoses related to eligibility for the hospice benefit. The rules clarify that nonspecific symptom diagnoses, such as adult failure to thrive, dementia, and debility, may no longer be considered the principal diagnosis for determining eligibility under the Medicare hospice program. Nonspecific symptom diagnoses listed as principal diagnoses will be identified as questionable encounters and will be returned to the provider for a more definitive principal diagnosis.[22] Check with your State Medicaid agency (SMA) to see if this rule applies in your State.

This booklet provides an overview of the Medicaid hospice benefit; examples of fraud, waste, and abuse; new practices for improvement in communication, documentation, and quality of care; and actions hospice providers and other stakeholders can take to help reduce improper payments and to improve the services offered.

Medicaid Hospice Benefit Overview

The Medicaid programs in almost all 50 States and the District of Columbia currently designate hospice as a covered benefit.[23] However, hospice service is an optional benefit that allows each State some flexibility as long as the hospice benefit complies with minimum Federal requirements.[24] For example, prior authorization may be required for specific procedures or services; life expectancy requirements may be longer; a copayment may be required; or the benefit may only be available to specific eligibility groups.[25]

Upon election of the hospice benefit, treatment to cure the terminal illness usually ceases. An exception is provided under Section 2302 of the Affordable Care Act, which allows participants younger than 21 who are eligible for the Children’s Health Insurance Program (CHIP) and Medicaid to enroll in a hospice program and receive Medicaid-covered services to treat their terminal illness.[26, 27]

Services covered under hospice must be provided by a participating hospice program that meets Medicare certification requirements and has a valid provider agreement. Hospice benefits covered under Medicaid and Medicare are often very similar. Providers should check their SMA provider manual for specific definitions, applicable Medicare local coverage determinations (LCDs), and benefits available.

The benefits listed below are examples of the minimum services available through hospice care:

- Physician services furnished by hospice-employed physicians and nurse practitioners, or by other physicians under arrangement with the hospice;
- Nursing care;
- Medical equipment;
- Medical supplies;
- Drugs for symptom control and pain relief;
- Hospice aide and homemaker services;
- Physical therapy;
- Occupational therapy;
- Speech-language pathology services;
- Social worker services;
- Dietary counseling; and
- Short-term inpatient care for pain control and symptom management, and for respite care.[28]

Hospice services are designed to be provided in the participant’s home, but for purposes of the Medicaid hospice benefit, a nursing facility may be considered a participant’s home.[29] In these cases, an additional payment is made to the hospice for nursing facility services that covers both room and board and ancillary services. Contact your SMA for other facilities that may be considered a Medicaid participant’s home under the Medicaid hospice benefit.

Medicaid hospice benefits can also include anything else needed to manage terminal illness and related conditions normally covered by Medicare. Nursing care, physicians’ services, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted for during periods of peak patient loads and to obtain physician specialty services.[30]



Eligibility

Eligibility for hospice care under Medicaid requires physician certification that the participant is terminally ill.[31] Each State's definition of "terminal illness" includes a medical prognosis with a limited life expectancy; however, the length of the life expectancy may differ from State to State. Some States, including Kentucky[32] and Texas,[33] use the Medicare definition of "terminal illness" as a medical prognosis with a life expectancy of 6 months or less if the illness runs its normal course.[34, 35] States have the option to provide longer life expectancy criteria for determining hospice eligibility through an amendment to their Medicaid State plan. For example, the State of New York requires a prognosis of life expectancy of 12 months or less for hospice eligibility.[36] As a Medicaid provider, you are responsible for knowing the waivers to eligibility requirements for your State. The terminal prognosis also must be supported by clinical information and other documentation in the medical record.[37, 38]

Participants must elect hospice benefits by completing an election of hospice benefits form with a particular hospice.[39] The election form must contain:

- Identification of the particular hospice that will provide care;
- The participant's or representative's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the participant's terminal illness;
- Acknowledgement that certain Medicare and Medicaid services are waived by the election;[40]
- The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement;
- The name of the participant's designated attending physician (if any). Information identifying the attending physician recorded on the election statement should provide enough detail so that it is clear which physician or nurse practitioner was designated as the attending physician. This information can include, but is not limited to, the attending physician's name and National Provider Identifier (NPI).
- The participant's acknowledgment that the designated attending physician was the participant's or representative's choice; and
- The signature of the participant or representative.[41]

Election of Benefits

The election of benefits stays in effect as long as the participant remains in hospice, does not revoke the election, and is not discharged from hospice for other reasons.[42] Reasons for discharge may include: the participant is no longer considered terminally ill, the participant transfers to another hospice, the participant moves out of the hospice service area, or the participant is not receiving the required or expected care from the hospice provider. A participant may also be discharged “for cause” if the hospice determines the participant’s behavior is disruptive or otherwise prevents effective delivery of care and attempts to resolve the situation have not been successful. A participant may not be discharged simply for using necessary hospice services.[43]

States are required to offer at least 210 days of hospice coverage that may be subdivided into two or more time periods, typically two 90-day periods and a 30-day period.[44] The Medicare benefit is divided into two 90-day periods and an unlimited number of 60-day periods.[45] Although States are not required to adopt Medicare guidelines for benefit periods, many do for coordination of care. Ultimately, duration for Medicaid coverage is up to each State, so check with your SMA for policies about benefit periods for hospice coverage.

After an eligible participant elects hospice care, the hospice must receive physician certification within 2 days of the written or verbal initiation of hospice care. If the certification is given verbally, the written certification must be completed within 8 days.[46] Benefits may continue for each subsequent period if the participant does not revoke the benefit and if the required certifications are made, and as long as the hospice follows each State’s policies.[47] Recertification must be made no later than 2 days after the effective date of a subsequent period.[48]

If a hospice participant’s stay is anticipated to reach the third benefit period, and the participant is eligible for both Medicaid and Medicare, the hospice physician or nurse practitioner must have a face-to-face visit with the participant not more than 30 calendar days before certification for the third period to determine clinical findings and continued eligibility for hospice care.[49] A participant may revoke the hospice benefit at any time by filing a signed statement that includes the effective date of revocation with the hospice. A participant may change hospice agencies once in each benefit period.[50]

Levels of Care

There are four different categories or levels of care for hospice payment. These categories or levels include:

1. Routine home care—a participant is at home and is not receiving continuous care;
2. Continuous home care—a participant is not in an inpatient facility and receives hospice on a continuous basis at home (consists predominantly of nursing care during a brief period of crisis only as necessary to maintain the terminally ill patient at home);
3. Inpatient respite care—a participant receives care in an approved facility on a short-term basis for respite; and
4. General inpatient care—a participant receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed at home.[51] In this situation, at home can mean a participant’s personal home, an assisted living facility, or a nursing home.



Proper documentation is required to support medical necessity and proper level of care. A provider who bills Medicaid for hospice care delivered to an ineligible participant or bills for services at a higher level of care than were actually provided or than were necessary could be subject to civil liability under the False Claims Act.[52] For example, in 2013, the U.S. Attorney's Office for the Middle District of Florida announced that a hospice in Florida agreed to pay a \$1 million settlement for submitting false claims to Medicaid and Medicare from 2005 to 2010. The government alleged that false claims were submitted for hospice participants who did not need end-of-life care, that ineligible participants were admitted to hospice, and that staff members were discouraged from discharging participants who did not need hospice. The settlement also resolved claims that the facility billed at a higher rate than it was entitled to.[53]

Documentation

Determination of medical necessity for hospice services and the level of hospice care is dependent on the certifying hospice provider's documentation. As part of the medical record, the physician must include a brief explanation of the clinical findings[54] that support a terminal illness as defined by your SMA. The explanation must be included as a part of, or as an addendum to, the certification and recertification forms.[55] Recent audits identified situations in which the certification and recertification forms with physicians' clinical findings supported eligibility; however, the daily progress notes and related medical documentation behind the certifications and recertifications did not support the necessity of hospice services.

The purpose for the initial and subsequent certifications is to ensure that the participant is, at the time of the initial certification and upon subsequent certification, terminally ill with a life expectancy of (generally) 6 months or less, depending on the State.[56]

The certification must meet these requirements:

- The certification must specify that the participant has a medical prognosis of a limited life expectancy if the terminal illness runs its normal course. States have the option to provide longer life expectancy criteria for determining hospice eligibility through an amendment to their Medicaid State plan; and
- The certification must be signed by the physician.[57]

A plan of care must be established by a member of the basic interdisciplinary team and a nurse or physician before services can be provided. At least two other basic members of the interdisciplinary team must review and provide input on the plan of care.[58]

Resources, including Medicare LCDs, are available that provide guidance for determining whether the participant is “terminally ill.” LCDs are regional coverage decisions made by a Medicare administrative contractor that describe the clinical circumstances under which an item or service is considered to be reasonable and necessary.[59] These resources may assist a provider in determining the participant’s eligibility using generally accepted assessment tools, including:

- Palliative Performance Scale (PPS);
- Reisberg Functional Assessment Staging Scale (FAST);
- Mid-arm circumference;
- Body Mass Index (BMI);
- Pain Scale Index; and
- New York Heart Association (NYHA) heart failure classification.

To support eligibility, it may be necessary to obtain additional sources of medical information and the associated documentation. For example, the participant may have had conditions up to 12 months prior to the initial election of hospice benefits. Therefore, it may be necessary to obtain additional sources of medical documentation such as diagnostic magnetic resonance imaging (MRI) results to confirm the presence of cancer. This information helps to support the participant’s eligibility status.

Quality of Care

Section 3004 of the Affordable Care Act amended the SSA to authorize a quality reporting program for hospices.[60, 61] Under the Hospice Quality Reporting Program (HQRP), all Medicare-certified hospices must submit their quality data to CMS. CMS cycles the quality measures from year to year using the rulemaking process.[62] For current information on the HQRP current measures, visit <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting> and <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html> on the CMS website.

The National Quality Forum lists the general principles that should guide the provision of high-quality palliative and hospice care as follows:

- Care is participant-centered, family-centered, and provided by trained and skilled members of a coordinated interdisciplinary team;
- Well-trained and qualified staff provide information for and support decision-making to ensure that the participant’s and family’s spiritual, cultural, and social values and preferences are treated with respect;
- Care addresses the total needs of participants, including symptom control, psychosocial distress, spiritual issues, and the social, practical, financial, and legal ramifications of their conditions;
- Equal access to care is available regardless of age, prognoses, patient populations, health care settings, geographical areas, race, ethnicity, sexual orientation, or ability to pay;



- Processes are regularly and systematically evaluated, and outcomes data are measured using validated instruments or tools that assess structure, process, outcomes, and patient perceptions of care;
- Palliative and hospice professionals act as advocates when addressing regulatory, legal, and legislative issues affecting the delivery of high-quality palliative care;
- Palliative and hospice care programs for unique populations (for example, those in Intermediate Care Facilities for the Mentally Retarded [ICFMR], the physically disabled, and those with dual diagnoses) assess any need for specialized services and have the capability of delivering services or knowledge of how to access specialized services in a timely manner; and
- Research and education are supported to promote preferred practices in the delivery of palliative and end-of-life care.[63]

For detailed reporting information and training, review the CMS Clinical Standards and Quality website.[64]

Having well-trained medical directors increases quality of care and compliance, which reduces their risk of being subject to penalties for violating regulations. Likewise, having staff members who are trained and educated about the issues facing patients during end of life greatly improves quality of care and quality of life for patients and their families.

Hospice Benefit and Nursing Facilities

In September 2009, HHS-OIG released a four-part report on hospice care in nursing homes. A part of that report was a comparison of participants receiving hospice care in nursing facilities with those receiving hospice services in the home. The report revealed that during 2006, 31 percent of Medicare participants enrolled in hospice programs were residents of nursing facilities and 82 percent of the hospice claims for those participants did not meet Medicare coverage requirements.[65] A 2010 study examining the growth of Medicare-certified hospices providing services in nursing facilities found that the proportion of nursing facility decedents who received hospice care increased from 18.8 percent in 2001 to 30.1 percent in 2007.[66] The Centers for Disease Control and Prevention (CDC) reported that in 2013 there were 2.6 million deaths in the United States,[67] and approximately 1.2 million of those deaths were individuals were under the care of a hospice program.[68] The OIG 2016 work plan will focus on whether hospices are billing for appropriate levels of care, especially general inpatient care claims, and continue to audit for payments in compliance with Medicare requirements.[69]

On June 27, 2013, CMS issued a final rule requiring Medicare skilled nursing facilities and Medicaid nursing facilities to coordinate care with hospice providers.[70] When a patient lives in a Medicaid nursing facility, he or she may receive Medicaid hospice services. The nursing facility may arrange for hospice services or may assist in transferring the patient to a facility that provides hospice services. If the nursing facility arranges that the patient will receive hospice services at the nursing facility, there must be a written agreement with each hospice provider. The agreement must be signed by an authorized representative of the hospice and an authorized representative of the nursing facility and must be executed prior to hospice services being furnished. The agreement between the nursing home and hospice provider must include:

- The services that the hospice will provide;
- The responsibilities of the hospice for determining the appropriate plan of care;
- The service the nursing home will continue to provide, based on each resident's plan of care;
- A communication process, including how the communication will be documented between the nursing home and the hospice provider to ensure that the needs of the resident are addressed and met 24 hours per day;
- A provision that the nursing facility immediately notify the hospice about certain occurrences, such as clinical complications or the need to transfer the resident;
- A provision that the hospice assumes responsibility for determining the appropriate course of hospice care;
- A provision that the nursing facility must furnish 24-hour room-and-board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriate based on the resident's needs;
- A delineation of the hospice's responsibilities, including, but not limited to, providing medical direction and management of the resident, medical equipment, and counseling;
- A provision that when the nursing facility personnel are responsible for administration of prescribed therapies, the personnel may administer the therapies where permitted by State law and as specified by the nursing home;
- A provision that the nursing facility must immediately report all alleged violations to the hospice administrator when it becomes aware of an alleged violation; and
- A delineation of the responsibilities of the hospice and the nursing home to provide bereavement services to nursing home staff.[71]



The regulation also states that the Medicare or Medicaid long-term care facility must designate a member of the interdisciplinary team to work with hospice representatives and to coordinate care. The specified member's duties also include:

- Collaborating with hospice representatives and coordinating nursing home staff participation in the hospice care planning process;
- Communicating with hospice representatives and providers assigned by the hospice to provide care for the resident to ensure quality of care for the resident and their family;
- Ensuring that the nursing facility communicates with the hospice medical director, the resident's attending physician, and other practitioners participating in the provision of care as needed to coordinate the hospice care with the medical care provided by other physicians;
- Obtaining information from the hospice, including, but not limited to, the most recent hospice plan of care specific to each resident, the hospice election form, and hospice medication information specific to each resident; and
- Ensuring that nursing facility staff members provide an orientation in the policies and procedures of the nursing home—including patient rights—and appropriate forms and record-keeping requirements to hospice staff who are furnishing care to the resident.[72]

Additional provisions regarding communication include requiring the nursing home to notify the hospice provider of the following:

- Significant changes in the resident's physical or emotional status;
- Clinical complications that suggest a need to alter the resident's plan of care;
- A need to transfer the resident from the facility for any condition; and
- The resident's death.[73]

Communication is important, not only between the nursing home and hospice provider, but also with family members. In February 2013, “The Journal of the American Medical Association” published a study that found hospice use had almost doubled during the time frame of the study and that the number of decedents using hospice for 3 days or less increased from 22.2 percent in 2000 to 28.4 percent in 2009. The study concluded that awareness of the hospice benefit has increased, but patients and families are opting for more aggressive curative treatment before transitioning to hospice care. By waiting to have a discussion on election of hospice care, many participants and families may be missing out on the full scope of the benefit.[74]

What Providers Can Do to Help

Hospice providers can take certain measures to help prevent fraud, waste, and abuse and reduce improper payments in the Medicaid program. Those measures include:

- Make sure the patient meets the eligibility criteria for hospice benefits (including a medical prognosis for life expectancy that is within the time frames established through an amendment to the Medicaid State plan);
- Make sure that documentation in the medical record, such as the daily progress notes, supports that the patient is “terminally ill”;
- Make sure the principal diagnosis and all additional diagnoses contributing to a life expectancy of 6 months or less are reported on the claim to more clearly describe the patient’s condition;
- Make sure to provide and bill for the appropriate level of care provided; and
- Report potential fraud to your State Medicaid Fraud Control Unit (MFCU) or SMA.

Providers should make sure staff members understand anti-fraud efforts and should provide proper training regarding the False Claims Act. Section 1902(a)(68) of the SSA states that “any entity that receives or makes annual payments under the State plan of at least \$5,000,000 ... shall establish written policies” regarding false claims and fraud, waste, and abuse for all employees, contractors, and agents. The policies shall provide detailed information about the administrative and civil false claims provisions, and whistleblower protections, found in Title 31 of the United States Code, as well as applicable State laws establishing civil or criminal penalties for false claims or protections for whistleblowers. Any existing employee handbook must include a discussion of these laws.[75]

New Long-Term Care Facility Staffing Requirements

Hospice providers will be affected by new requirements for long-term care facilities. On July 1, 2016, new requirements at 42 C.F.R. § 483.75(u) take effect for reporting long-term care facility staffing information to CMS for direct care staff on a quarterly basis. Long-term care facilities will have to electronically submit staffing information based on payroll data. This data must include each direct care staff member’s category of work, direct care staff tenure and turnover, and hours of care for each category of direct care staff per resident per day. The facility must also report resident census data. The staffing information must also distinguish between facility-employed staff and contracted staff.[76]



Conclusion

Hospice care is a comprehensive set of services provided to assist a participant in managing a terminal prognosis as guided by a specific plan of care. Upon election of the hospice benefit, treatment to cure the terminal illness must cease, unless the patient is younger than age 21. For a patient under age 21, the Affordable Care Act permits curative treatment, even when the patient has been diagnosed with medical conditions expected to limit life expectancy to 6 months or less if the illness runs its normal course.

Eligibility for hospice care under both Medicare and Medicaid requires physician certification that the participant is terminally ill. Each State's definition of terminal illness includes a medical prognosis with a limited life expectancy; however, the length of the life expectancy may differ from State to State. Some States use the Medicare definition of terminal illness as a medical prognosis with a life expectancy of 6 months or less if the illness runs its normal course.[77] States have the option to provide longer life expectancy criteria for determining hospice eligibility through an amendment to their Medicaid State plan. As a Medicaid provider, you are responsible for knowing the waivers to eligibility requirements for your State. The election of benefits remains in effect as long as the participant remains in hospice care, does not revoke the election, and is not discharged from hospice for other reasons.

Recent audits of Medicaid hospice providers conducted by the Audit Medicaid Integrity Contractors (MIC) identified overpayments for claims submitted for hospice services provided to Medicaid participants. In addition, recent HHS-OIG audits of Medicaid hospice providers identified common claim errors that resulted in overpayments.

Hospice providers can take steps to prevent fraud, waste, and abuse and reduce improper payments in the Medicaid program. Staff should be trained in areas including hospice eligibility, medical necessity, and proper documentation of the case record to avoid any undue penalties or sanctions. The next section provides additional resources available to providers.

Additional Resources

CMS oversees other anti-fraud efforts through its CPI. Efforts include tracking medical identity theft; using a remediation process for the victims of medical identity theft; using predictive modeling to identify suspect claims before payment; screening providers at enrollment; suspending payments upon a finding of a credible allegation of fraud; and terminating providers if they are found to have been terminated for cause from Medicare or any State's Medicaid program.[78]

People who have been excluded from the Medicaid program or prohibited from participating in Federal contracts under the Federal debarment regulations cannot receive Medicaid payments, and the organizations they are part of cannot be reimbursed by Federal health care programs for the work they do.[79] Therefore CMS recommends that all providers conduct employee exclusion searches on a monthly basis to determine whether the provider's employees and contractors have been excluded. An individual or entity that has been excluded is reported on the List of Excluded Individuals/Entities (LEIE) database, which is available at <https://exclusions.oig.hhs.gov/> on the HHS-OIG website. An individual or entity that is debarred is reported on the Excluded Parties List System, which is available at <https://www.sam.gov> on the System for Award Management (SAM) website, maintained by the General Services Administration (GSA).

Report potential fraud to your State MFCU or SMA. A link to a list of their contact information is available at http://www.cms.gov/medicare-medicare-coordination/fraud-prevention/fraudabuseforconsumers/report_fraud_and_suspected_fraud.html on the CMS website.

You may also contact HHS-OIG:

Office of Inspector General
U.S. Department of Health and Human Services
ATTN: Hotline
P.O. Box 23489
Washington, D.C. 20026
Phone: 1-800-HHS-TIPS (1-800-447-8477)
TTY: 1-800-377-4950
Fax: 1-800-223-8164
Email: HHSTips@oig.hhs.gov
Website: <https://forms.oig.hhs.gov/hotlineoperations/>

The CMS CPI has posted a checklist that provides a list of criteria that must be met prior to a participant's enrollment in hospice. Providers may use this checklist in combination with other SMA requirements to ensure appropriate enrollment in hospice.

To see the electronic version of this booklet and the other products included in the "Hospice Care" Toolkit, visit the Medicaid Program Integrity Education page at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html> on the CMS website.

Follow us on Twitter  [#MedicaidIntegrity](https://twitter.com/MedicaidIntegrity)

References

- 1 Centers for Medicare & Medicaid Services. Medicaid Integrity Program—General Information. (2015, April 28). Retrieved December 9, 2015, from <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/index.html?redirect=/MedicaidIntegrityProgram/>
- 2 Reducing Improper Payments and Eliminating Waste in Federal Programs. (2009, November 23). 74 Fed. Reg. 62201. Executive Order 13520. Retrieved December 9, 2015, from <https://www.gpo.gov/fdsys/pkg/FR-2009-11-25/pdf/E9-28493.pdf>
- 3 Definitions, 42 C.F.R. § 418.3. Retrieved November 23, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=009d7a8f47e1232ab64f843034cf7275&rgn=div5&view=text&node=42:3.0.1.1.5&idno=42#se42.3.418_13
- 4 Social Security Act § 1861(dd)(1). Retrieved November 23, 2015, from https://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm
- 5 Centers for Medicare & Medicaid Services. (1999). State Medicaid Manual. Chapter 4: Services, § 4305 Hospice Services. Retrieved December 9, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 6 Social Security Act § 1861(dd)(2)(B). Retrieved December 9, 2015, from https://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm
- 7 Social Security Act § 1861(dd)(1). Retrieved December 9, 2015, from https://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm
- 8 Social Security Act § 1905(a)(18) and § 1905(o). Retrieved December 9, 2015, from https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
- 9 Social Security Act § 1905(o)(1)(C). Retrieved December 9, 2015, from https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
- 10 U.S. Department of Health and Human Services. Office of Inspector General. (2015, April). New Jersey Claimed Medicaid Hospice Services That Were Not in Compliance With Federal and State Requirements. Retrieved December 9, 2015, from <http://oig.hhs.gov/oas/reports/region2/21101014.pdf>
- 11 The United States Attorney's Office. Middle District of Florida. (2013, July 22). HPH Hospice to Pay \$1 Million to Resolve False Claims Act Allegations. Retrieved December 9, 2015, from http://www.justice.gov/usao/flm/press/2013/july/20130722_HPH.html
- 12 Illinois Department of Healthcare and Family Services. (2014, April 7). Hospice Audit Findings and New Notification of Election Form [Informational Notice]. Retrieved December 9, 2015, from <http://www.hfs.illinois.gov/html/040714n.html>
- 13 U.S. Department of Health and Human Services. Office of Inspector General. (2014, May). Ohio Did Not Always Properly Claim Medicaid Reimbursement for Hospice Claims. Retrieved December 9, 2015, from <http://oig.hhs.gov/oas/reports/region5/51200087.pdf>
- 14 U.S. Department of Health and Human Services. Office of Inspector General. (2014, June). CMS's Reliance on Illinois Licensure Requirements Could Not Ensure the Quality of Care Provided to Medicaid Hospice Beneficiaries. Retrieved December 9, 2015, from <http://oig.hhs.gov/oas/reports/region5/51200028.pdf>
- 15 U.S. Department of Health and Human Services. Office of Inspector General. (2014, September). CMS's Reliance on Ohio Licensure Requirements Did Not Always Ensure the Quality of Care Provided to Medicaid Hospice Beneficiaries. Retrieved December 9, 2015, from <http://oig.hhs.gov/oas/reports/region5/51200086.pdf>

- 16 U.S. Department of Health and Human Services. Office of Inspector General. (2015, June). CMS's Reliance on Ohio Licensure Requirements Could Not Ensure the Quality of Care Provided to Medicaid Hospice Beneficiaries. Retrieved December 9, 2015, from <http://oig.hhs.gov/oas/reports/region2/21101024.pdf>
- 17 U.S. Department of Health and Human Services. Office of Inspector General. (2013, September). Medicaid Hospice General Inpatient Payments to Home and Hospice Care of Rhode Island Did Not Always Meet Federal and State Requirements. Retrieved December 9, 2015, from <http://oig.hhs.gov/oas/reports/region1/11300002.pdf>
- 18 U.S. Department of Health and Human Services. Office of Inspector General. (2012, August). Rhode Island Hospice General Inpatient Claims and Payments Did Not Always Meet Federal and State Requirements. Retrieved December 9, 2015, from <http://oig.hhs.gov/oas/reports/region1/11200002.pdf>
- 19 Centers for Medicare & Medicaid Services. (2013, August 7). Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform; Final Rule. 78 Fed. Reg. 48239. Retrieved December 9, 2015, from <http://www.gpo.gov/fdsys/pkg/FR-2013-08-07/pdf/2013-18838.pdf>
- 20 U.S. Department of Health and Human Services. Office of Inspector General. (2015, January). Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities. Retrieved December 9, 2015, from <http://oig.hhs.gov/oei/reports/oei-02-14-00070.pdf>
- 21 Social Security Act § 1905(o)(1)(A). Retrieved December 9, 2015, from https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
- 22 Centers for Medicare & Medicaid Services. (2013, August 7). Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform; Final Rule. 78 Fed. Reg. 48239. Retrieved December 9, 2015, from <http://www.gpo.gov/fdsys/pkg/FR-2013-08-07/pdf/2013-18838.pdf>
- 23 The Henry J. Kaiser Family Foundation. Medicaid Benefits: Hospice Care. (2012). Retrieved December 10, 2015, from <http://kff.org/medicaid/state-indicator/hospice-care/>
- 24 U.S. Department of Health and Human Services. Office of Inspector General. (2011, September 23). Review of Medicaid Hospice Payments to Evercare Hospice & Palliative Care for State Fiscal Years 2007 Through 2009. [A-01-10-00012]. Retrieved December 10, 2015, from <http://oig.hhs.gov/oas/reports/region10/11000012.pdf>
- 25 The Henry J. Kaiser Family Foundation. Medicaid Benefits: Hospice Care. (2012). Retrieved December 10, 2015, from <http://kff.org/medicaid/state-indicator/hospice-care/>
- 26 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2302. 124 Stat. 119, 293. (2010, March 23). Retrieved December 10, 2015, from <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>
- 27 Centers for Medicare & Medicaid Services. Center for Medicaid, CHIP and Survey & Certification. (2010, September 9). State Medicaid Director Letter No. 10-018. Hospice Care for Children in Medicaid and CHIP. Retrieved December 10, 2015, from <https://www.cms.gov/smdl/downloads/SMD10018.pdf>
- 28 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305.5. Covered Services. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 29 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305.2, para. 3. Hospice Services. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>

- 30 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305.5. Hospice Services. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 31 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305. Physician Certification. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 32 Kentucky Cabinet for Health and Family Services. Hospice Services. Eligibility Information. (2014). Retrieved December 10, 2015, from <http://chfs.ky.gov/dms/hospice.htm>
- 33 Texas Department of Aging and Disability Services. (2014, April). Texas Medicaid Hospice Program Standards Handbook Revision: 08-1. Retrieved December 10, 2015, from <http://www.dads.state.tx.us/handbooks/mhps/30.htm>
- 34 Definitions, 42 C.F.R. § 418.3. Retrieved December 10, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=009d7a8f47e1232ab64f843034cf7275&rgn=div5&view=text&node=42:3.0.1.1.5&idno=42#se42.3.418_13
- 35 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305. Hospice Services. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 36 Centers for Medicare & Medicaid Services. (2014, January 29). Medicaid State Resource Center. State Plan Amendments–New York. Retrieved December 10, 2015, from <http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NY/2014/NY-11-89.pdf>
- 37 Certification of Terminal Illness, 42 C.F.R. § 418.22(b)(1). Retrieved December 10, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=009d7a8f47e1232ab64f843034cf7275&rgn=div5&view=text&node=42:3.0.1.1.5&idno=42#se42.3.418_122
- 38 Social Security Act §1902(a)(27). Retrieved December 10, 2015, from https://www.ssa.gov/OP_Home/ssact/title19/1902.htm
- 39 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305.2. Election Procedures. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 40 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305.3. Election Procedures. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 41 Election of Hospice Care, 42 C.F.R. § 418.24(b)(5). Retrieved December 10, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=009d7a8f47e1232ab64f843034cf7275&rgn=div5&view=text&node=42:3.0.1.1.5&idno=42#se42.3.418_124
- 42 Election of Hospice Care, 42 C.F.R. § 418.24(c). Retrieved December 10, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=009d7a8f47e1232ab64f843034cf7275&rgn=div5&view=text&node=42:3.0.1.1.5&idno=42#se42.3.418_124
- 43 Reasons for Discharge, 42 C.F.R. § 418.26(a)–(b). Retrieved December 10, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=009d7a8f47e1232ab64f843034cf7275&rgn=div5&view=text&node=42:3.0.1.1.5&idno=42#se42.3.418_126
- 44 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305. Hospice Services. Retrieved October December 10, 2015/24, 2014, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>

- 45 Duration of Hospice Care Coverage—Election Periods, 42 C.F.R. § 418.21(a)(3). Retrieved December 10, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?SID=7d495050c7d9ed758b3fb0e78d7777e4&mc=true&node=se42.3.418_121&rgn=div8
- 46 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305. Hospice Services. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 47 Social Security Act § 1905(o)(2). Retrieved December 10, 2015, from https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
- 48 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305.1. Election Procedures. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 49 Certification of Terminal Illness, 42 C.F.R. § 418.22(a)(4). Retrieved December 10, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=009d7a8f47e1232ab64f843034cf7275&rgn=div5&view=text&node=42:3.0.1.1.5&idno=42#se42.3.418_122
- 50 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305.3. Revocation, Change of Hospice. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 51 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4306. Hospice Reimbursement. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 52 False, Fictitious or Fraudulent Claims, 18 U.S.C. § 287. Retrieved December 10, 2015, from <http://www.gpo.gov/fdsys/pkg/USCODE-2011-title18/pdf/USCODE-2011-title18-partI-chap15-sec287.pdf>
- 53 The United States Attorney’s Office. Middle District of Florida. (2013, July 22). HPH Hospice to Pay \$1 Million to Resolve False Claims Act Allegations. Retrieved December 10, 2015, from http://www.justice.gov/usao/flm/press/2013/july/20130722_HPH.html
- 54 Social Security Act §1902(a)(27). Retrieved December 10, 2015, from https://www.ssa.gov/OP_Home/ssact/title19/1902.htm
- 55 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305.1. Physician Certification. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 56 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305.1. Physician Certification. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 57 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305.1. Physician Certification. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 58 Centers for Medicare & Medicaid Services. (2000, July 31). State Medicaid Manual. Chapter 4 § 4305.4. Requirements for Coverage. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>
- 59 Centers for Medicare & Medicaid Services. (2014, April 11). Medicare Program Integrity Manual: Chapter 13—Local Coverage Determinations. Section 13.1.3. Retrieved December 10, 2015, from <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c13.pdf>

- 60 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3004. (2010, March 23). Retrieved November 24, 2015, from <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>
- 61 Quality Measures. Social Security Act § 1814(i)(5)(D). Retrieved December 10, 2015, from https://www.ssa.gov/OP_Home/ssact/title18/1814.htm
- 62 Centers for Medicare & Medicaid Services. (2013, August). User Guide for Hospice Quality Reporting Data Collection. Retrieved December 10, 2015, from <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/User-Guide-for-Data-Collection-FY2015-Reporting-Cycle.pdf>
- 63 National Quality Forum. (2006, December). A National Framework and Preferred Practices for Palliative and Hospice Care Quality. (2006, December 1). Retrieved December 10, 2015, from http://www.qualityforum.org/Publications/2006/12/A_National_Framework_and_PREFERRED_Practices_for_Palliative_and_Hospice_Care_Quality.aspx
- 64 Centers for Medicare & Medicaid Services. Hospice Quality Reporting. Retrieved December 10, 2015, from <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html>
- 65 U.S. Department of Health and Human Services. Office of Inspector General. (2009, September 4). Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities (p. 2). [OEI-02-06-00223]. Retrieved December 10, 2015, from <https://oig.hhs.gov/oei/reports/oei-02-06-00223.pdf>
- 66 National Hospice and Palliative Care Organization. (2012). NHPCO's Facts and Figures: Hospice Care in America (p. 4). Retrieved December 10, 2015, from http://www.nhpc.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf
- 67 Centers for Disease Control and Prevention. (2014). 2013 Mortality Multiple Cause Micro-data Files, Table 1. Retrieved December 10, 2015, from http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf
- 68 National Hospice and Palliative Care Organization. (2012). NHPCO's Facts and Figures: Hospice Care in America (p. 4). Retrieved December 10, 2015, from http://www.nhpc.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf
- 69 U.S. Department of Health and Human Services. Office of Inspector General. Work Plan Fiscal Year 2016 (p. 12). Retrieved December 10, 2015, from <http://oig.hhs.gov/reports-and-publications/archives/workplan/2016/oig-work-plan-2016.pdf>
- 70 Centers for Medicare & Medicaid Services. (2013, June 27). Medicare and Medicaid Programs; Requirements for Long Term Care Facilities; Hospice Services. Final Rule. 78 Fed. Reg. 38594. Retrieved December 10, 2015, from <http://www.gpo.gov/fdsys/pkg/FR-2013-06-27/pdf/2013-15313.pdf>
- 71 42 C.F.R. § 483.75(t). Retrieved December 10, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?SID=ba210419f6ef2bcf4e874732de9ac8ed&node=pt42.5.483&rgn=div5#se42.5.483_175
- 72 42 C.F.R. § 483.75(t)(3). Retrieved December 10, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?SID=ba210419f6ef2bcf4e874732de9ac8ed&node=pt42.5.483&rgn=div5#se42.5.483_175
- 73 42 C.F.R. § 483.75(t)(2)(ii)(E). Retrieved December 10, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?SID=ba210419f6ef2bcf4e874732de9ac8ed&node=pt42.5.483&rgn=div5#se42.5.483_175
- 74 Teno, J., Gozalo, P., Bynum, J., Leland, N., Miller, S., Morden, N., . . . Mor, V. (2013, February 6). Change in End-of-Life Care for Medicare Beneficiaries: Site of Death, Place of Care, and Health Care Transitions in 2000, 2005, and 2009. *The Journal of the American Medical Association*, 309(5), 470–477. [Results]. Retrieved November 24, 2015, from <http://jama.jamanetwork.com/article.aspx?articleid=1568250#METHODS>

75 Social Security Act § 1902(a)(68). Retrieved December 10, 2015, from https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

76 Administration (Amendment). (2015, August 4). 42 C.F.R. 483.75(u) [80 F.R.46477]. Retrieved December 10, 2015, from <http://www.ecfr.gov/cgi-bin/text-idx?SID=8382cea1456f0806cac125fa3faa9d93&mc=true&node=20150804y1.10>

77 Definitions, 42 C.F.R. § 418.3. Retrieved December 10, 2015, from http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=009d7a8f47e1232ab64f843034cf7275&rgn=div5&view=text&node=42:3.0.1.1.5&idno=42#se42.3.418_13

78 Centers for Medicare & Medicaid Services. Center for Program Integrity. (2011, November 3). New Strategic Direction and Key Antifraud Activities (pp. 4–6). Retrieved December 10, 2015, from <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/downloads/cpiinitiatives.pdf>

79 U.S. Department of Health and Human Services. Office of Inspector General. (2013, May 9). Updated Special Advisory Bulletin on the Effect of Exclusion From Federal Health Care Programs. Retrieved December 10, 2015, from <https://oig.hhs.gov/exclusions/files/sab-05092013.pdf>

Disclaimer

This booklet was current at the time it was published or uploaded onto the web. Medicaid and Medicare policies change frequently so links to the source documents have been provided within the document for your reference.

This booklet was prepared as a service to the public and is not intended to grant rights or impose obligations. This booklet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. Use of this material is voluntary. Inclusion of a link does not constitute CMS endorsement of the material. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

February 2016



February 2016