Be Aware of...

OIG FY 2014 Work Plan

HOSPICE FUNDAMENTALS SUBSCRIBER EMAILS -- Feb. 4, 2014

The Least You Need to Know:

On January 31, the Office of the Inspector General (OIG) released its 2014 work plan. Slimmer than usual, this year's plan includes a continuation of one of the FY 2013 hospice projects – general inpatient care (GIP) services - and a brand new one looking at hospice care provided in assisted living facilities (ALFs). Although not all hospices will likely be impacted by the continued focus on use of general inpatient care (GIP), it's a rare hospice that does not have patients in the ALF setting.

Additional Information:

The OIG said that they would release the 2014 work plan in January and they took it right down to the wire – the e-mail announcing its release arrived in mailboxes right around 5:00 p.m. on January 31st.

Two projects in the hospice section and, unlike the last few years, nothing hospice related in other provider sections.

Links to Other Material:

The 2014 OIG Workplan:
https://oig.hhs.gov/reports-and-publications/workplan/index.asp#current

Work Plan Basics

This annual publication contains short descriptions of all projects – both new and underway – that the OIG is planning on working on during the upcoming year. The individual areas are concise, clear and give health care providers direction into areas they should consider focusing auditing and/or monitoring resources.

The plan is broken down into provider groups – and naturally each provider immediately goes first to its own section. It's both interesting and important, however, to take a few minutes to review some of other provider's areas that are of interest to the OIG, particularly any with which we interact.

At the end of each project is a parenthetical set of information that gives readers information on which section of the OIG is doing the work, the project number, whether it is new or work in progress and the expected issue date for the report.

THE SECTIONS

OEI: The Office of Evaluation and Inspections conducts national evaluations of Health and Human Services (HHS) programs with an eye towards improving the efficiency and effectiveness with a focus on preventing fraud, waste and abuse. If the OEI is in charge of a work item, one might assume that the area has already been determined to be problematic. ***Note that both of the items in the 2014 work plan are run by the OEI.***

OAS: The Office of Audit Services conducts independent audits of HHS programs, examines the performance of programs in carrying out their responsibilities, and provides independent assessments of HHS programs and operations. If the OAS is in charge of a work item, one might assume that the OIG is interested in getting the "lay of the land" of the area.

The plan has two changes to its customary format:

1. Projects are assigned to one of three categories:
- **a.** Policies and Practices
- **b.** Billings and Payments
- **c.** Quality of Care and Safety

2. Each project description includes a context section that expands on why the project was undertaken.

1. Hospice in assisted living facilities (new)

From the OIG Work Plan:

Policies and Practices. We will review the extent to which hospices serve Medicare beneficiaries who reside in assisted living facilities (ALFs). We will determine the length of stay, levels of care received, and common terminal illnesses of beneficiaries who receive hospice care in ALFs.

Context—Pursuant to the Affordable Care Act, § 3132, CMS must reform the hospice payment system, collect data relevant to revising hospice payments, and develop quality measures for hospices. Our work is intended to provide HHS with information relevant to these requirements. Medicare covers hospice services for eligible beneficiaries under Medicare Part A. *(Social Security Act, § 1812(a).)* Hospice care may be provided to individuals and their families in various settings, including the beneficiary's place of residence, such as an ALF. ALF residents have the longest lengths of stay in hospice care. The Medicare Payment Advisory Commission has said that these long stays bear further monitoring and examination. *(OEI; 02-14-00070; expected issue date: FY 2014; work in progress; Affordable Care Act)*

HF translation: ***For the first time ever, hospice in the ALF steps out of the shadow of hospice in the nursing home and takes its place in the sun. How did that happen? By continuing to be the setting with the longest average lengths of stay.***

From MedPAC's March 2013 Report to Congress *(Table 12-5)*
Hospice Average length of stay among decedents *(in days)*

Main Location of Care	2009	2010	2011
Home	87	87	88
Nursing Facility	107	111	111
ALF	143	148	149
Hospice facility or hospital	14	14	15

Thanks to Cordt Kassner at Hospice Analytics www.hospiceanalytics.com, we can see that the 2012 Medicare claims data demonstrate that not only does the ALF setting continue to have the longest length of stay; it also is the setting that has the highest % of live discharges. Both are potential problem areas.

Measure	Unskilled NF	Skilled NF	ALF	National
Beneficiaries Served	18%	9%	10%	100%
Utilization Days	19%	5%	17% KY=2%; AZ=33%	100%
Mean LOS	102 Days	55 Days	155 Days	71 Days
Median LOS	35 Days	14 Days	73 Days	25 Days
% Discharged Alive	18%	18%	25%	13%
% Days @ RHC	99.4%	97.2%	99.6%	97.5%

2. Hospice general inpatient care

From the OIG Work Plan:

Quality of Care and Safety. We will review the use of hospice general inpatient care. We will assess the appropriateness of hospices' general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care. We will also review hospice medical records to address concerns that this level of hospice care is being misused.

Context—Hospice care is palliative rather than curative. When a beneficiary elects hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary's terminal illness and related conditions. Federal regulations address Medicare conditions of participation for hospices. *(42 CFR Part 418.)* Beneficiaries may revoke their election of hospice care and return to standard Medicare coverage at any time. *(42 CFR § 418.28.) (OEI; 02-10-00491; 02-10-00492; expected issue date: FY 2014; work in progress)*

HF translation: ***GIP holds its place in the work plan for the third year running. The wording has remained almost the same each year; only the year designation has changed. The first time it specified years 2005 – 2010, the second time 2011, and now this third time the period is unspecified which we take to mean from 2012 through real time. The only thing that surprises us is that it was assigned to the Quality of Care and Safety category.***

Actions of a Prudent Hospice™

ONE. Consider the OIG work plan information and determine if you need to incorporate it into this year's auditing and monitoring schedule.

TWO. **Hospice in ALFs**

- **a.** Each state has its own definition of assisted living (as well as its own licensing rules); CMS says "as defined by the State in which the beneficiary is located."
- **b.** How does your data measure up to 2012 data above?
- **c.** Consider a focused audit on those patients with the longest length of stay to determine how well the documentation supports their eligibility.

THREE. **GIP Documentation** (or, more correctly, the lack thereof) leads to the potential of tremendous pay-backs. For any GIP claim, does documentation review clearly demonstrate

- **a.** The precipitating event requiring more intensive interventions that made the GIP admission necessary
- **b.** The interventions that were put in place to try to manage the symptoms in the beneficiary's routine home care setting or for those direct hospital admissions, why they need the continued higher level of care.
- **c.** Once in the GIP setting, daily documentation should clearly demonstrate
  - **i.** Why GIP is still necessary – if admitting symptoms have been resolved, what justifies continued stay at GIP?
  - **ii.** What is being done to get patient back to lower level of care
- **d.** For patients residing in a NF whose level of care is changed to GIP, what does the NF do differently to support the higher level of care that you are paying them to provide? Are they increasing the frequency of their documentation to capture the interventions? Do you get a discharge summary (or at least a copy of the care provided while GIP) and copy of the medication profile to support the higher level of care? In a 2012 OIG project looking at GIP provided in an SNF, almost all of the reviewed claims were denied because, from record review, the OIG could not see that anything had changed.

FOUR. Learn more about the OIG and the work plan in the February subscriber webinar. 1pm EST on Friday, February 14th. Call-in details and handouts will arrive on February 12th.