How to Avoid Risk while Meeting Care Needs: Getting Hospice GIP and Continuous Care Right

Rich Chesney, President and Founder, Healthcare Market Resources
Susan Garcia Strauss, Chief Compliance Officer, HopeHealth
Katie Wehri, CHC, CHPC, Hospice Specialist, NAHC
Objectives

- Review the CMS regulations for the GIP and CHC levels of care
- Identify patient eligibility criteria and expected documentation for each level of care
- Discuss barriers to the use of GIP and CHC
- Share applicable scenarios for utilizing each level of care
The Concerns

ARE PROVIDERS OFFERING THE FULL RANGE OF SERVICES?

ARE PROVIDERS INAPPROPRIATELY ADMINISTERING THE BENEFIT?

Referrals to S & C, Program Integrity
What Does This Mean for Providers?

• Review PEPPER results
  – MAC
  – State
  – National

• Reasons for no GIP
  – Patient characteristics
  – Hospital/SNF relationships
What Does This Mean for Providers?

• Review PEPPER results
  – MAC
  – State
  – National

• Reasons for no CHC
  – Patient characteristics
  – Staffing
  – Hospice inpatient unit
  – Relationship with hospital/SNF
## GIP & CHC Utilization

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<td>1.7%</td>
<td>.3%</td>
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<td>by hospice</td>
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- 890 hospices offered neither service
- Top 20% of hospices in GIP % have 92.5% of GIP days
- Top 10% of hospices in Cont Care % have 93.3% of Cont Care Days
- 7 hospices exceeded the 20% inpatient cap, but three of them were start-
Focus on GIP

Oversight focus on GIP

Oversight focus on proper use of the levels of care
Two OIG Reports

2013
Medicare Hospice: Use of General Inpatient Care

2016
Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care
The Facts

OIG Report 2013 – Medicare Hospice: Use of General Inpatient Care

• Based on GIP care provided in 2010 and 2011
• Majority of GIP care provided in hospice inpatient units
• Hospices with inpatient units provided GIP care to more of their beneficiaries and for longer periods of time
• Some hospices did not provide any GIP
• Eight percent of all Medicare hospice dollars were for GIP care
  • 67% of this was for GIP care provided in hospice inpatient units
The Facts

OIG Report 2013 – Medicare Hospice: Use of General Inpatient Care

• One third of GIP stays had length of stay (LOS) >5 days
  • 11% LOS 10 days or more

• A total of 23% of hospice beneficiaries received GIP care in 2011
  • 71% of these patients received GIP care at the beginning of their hospice election
The Facts

OIG Report 2013 – Medicare Hospice: Use of General Inpatient Care

• OIG recommended:
  • Further review of long GIP stays and GIP in inpatient units
  • CMS should focus on hospices that do not provide GIP care and ensure that these hospices are providing beneficiaries access to needed levels of care at the end of their lives
  • Suggested adopting a quality measure regarding hospices’ ability to provide all hospice services
OIG Report 2016 – Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care

- Hospices billed one-third of GIP stays inappropriately
- Hospices commonly billed for GIP when the beneficiary did not have uncontrolled pain or unmanaged symptoms
- Ohio had many inappropriate GIP stays
- Hospices billed inappropriately for about half of GIP stays in SNFs
- Medicare sometimes paid twice for drugs for beneficiaries receiving GIP
- Hospices did not meet care planning requirements for 85 percent of GIP stays
- Hospices sometimes provided poor quality care and often did not provide intense services
The Facts

OIG Report 2016 – Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care

Recommendations

• CMS increase its oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries
• CMS should ensure that a physician is involved in the decision to use GIP
• CMS conduct prepayment reviews for lengthy GIP stays
• CMS increase surveyor efforts to ensure that hospices meet care planning requirements
• CMS establish additional enforcement remedies for poor hospice performance
The Concerns

ARE PROVIDERS OFFERING THE FULL RANGE OF SERVICES?

ARE PROVIDERS INAPPROPRIATELY ADMINISTERING THE BENEFIT?

Referrals to S & C, Program Integrity
Definitions

• **In-patient care** or services is defined as *short term*, general in-patient care provided directly by a hospice program in their own in-patient facility, through a contract arrangement with a licensed Medicare certified long term care facility, or hospital to *provide pain and symptom management that cannot be accomplished in another setting*.

• **Continuous Home Care** is provided in a patient’s home during *periods of crisis*. A period of crisis is defined as a period in which a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms.
Regulations: General In-Patient CoP 418.108

- In-patient level of care must be made available for pain and symptom management as well as respite level of care in a participating Medicare or Medicaid facility.

- A hospice providing in-patient care directly must meet regulation specified in CoP 418.110.

- A hospice providing in-patient care under an arrangement agreement within a hospital or SNF must meet regulation specified in CoP 418.110(b) and (e) regarding 24 hour nursing and patient areas.
Service Level: In-Patient

- Hospices that provide in-patient care directly must provide 24 hour nursing services that are sufficient to meet the total needs of the patient in accordance with the patient’s plan of care.

- Each shift must include a registered nurse that provides direct patient care.

- The medical director or his/her designee may conduct regular on-site visits including daily visits if necessary.
In-Patient Eligibility

• General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in home settings.

• GIP under the hospice benefit is NOT equivalent to a hospital level of care.

• Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting.
In-Patient Eligibility

Pain Requiring:

• Delivery of medication which may require skilled nursing care for calibration, tubing change or site care/adjustment due to the complexity, nature of the medication and it’s delivery system.

• Frequent evaluation/assessments by nurse or physician.

• Aggressive treatment to control pain that cannot be accomplished within the home setting.

• Frequent medication adjustments.
In-Patient Eligibility

Symptom changes:

- Sudden deterioration requiring intensive nursing intervention.
- Uncontrolled nausea or vomiting.
- Pathological fractures.
- Respiratory distress that becomes unmanageable.
- Transfusions for relief of symptoms.
- Traction and frequent re-positioning requiring more than one staff member.
- Severe agitated delirium or anxiety or depression secondary to end-stage disease process.
In-Patient Eligibility

Imminent death alone is not the criterion for the GIP level of care!

- Symptom management that requires frequent skilled nursing intervention as evidenced by mottling, change in respiratory status and level of consciousness, etc.

- Symptoms related to imminent death which cannot be managed in the home setting.
When GIP Is NOT Billable

- Caregiver breakdown, unless patient need meets criteria
- Patient admitted to hospice while in a hospital, SNF, or hospice inpatient unit, unless patient need meets criteria
- Unsafe/unclean home situation
- While awaiting nursing home placement
- Actively dying and not meeting the criteria for symptoms that cannot be managed in another setting
Criteria for Continued In-Patient Eligibility

• Hospice is working aggressively to develop a plan for safe discharge.

• Pain continues to require active treatment and frequent assessment.

• Symptoms such as N/V, respiratory distress, open lesions, or ongoing deterioration require active treatment and frequent assessment.

• Ongoing mental status changes that require active treatment and frequent assessment.

• Acute symptoms have stabilized but death is imminent within a short period of time as evidence by mottling, change in respiratory status and level of consciousness. Frequent skill nursing intervention is needed to help family that is unable to cope.
Requirements While Patient Receiving GIP

- IDG determines the level of care
- Patient does not need to change attending physicians
- Hospice inpatient cap
  - Hospice-specific limitation
  - Inpatient days billed to Medicare cannot exceed 20 percent of the total hospice days billed to Medicare
In-Patient Discharge Eligibility

- Reason for admission stabilized.
- Re-established family support system.
- Appropriate safe discharge plan has been developed.
- Transfer to another level of care (i.e. respite).
- All of these reasons should be reviewed as a whole and not separately.
In-Patient Documentation Tips

Do

• Discharging planning begins on the first day of in-patient level of care and continues throughout the in-patient level stay.

• Document the team’s effort to resolve patient problems at the lowest level of care.

• Address discharge plans and why patient remains eligible for in-patient level of care.

• Explain why care must be provided in the in-patient setting and not at home e.g. “patient requires frequent RN/NP/MD assessment and titration of medication to control pain”.
In-Patient Documentation Tips

**Do**

- Describe services provided. Think of your note as a bill to Medicare. Each note must stand alone.

- Document the context and the events that led to the in-patient level of care.

- Document the failed attempts to control/manage symptoms prior to in-patient level of care admission.

- Document care that caregivers cannot manage at home. (frequent changes in medication/medication titration etc.)
In-Patient Documentation Tips

Do

• Document specific symptoms that are being addressed (uncontrolled n/v, new agitation/delirium). Describe failed attempts to manage these at home.

• Document progress/context/changes including: “symptomatic imminent death that cannot be managed at home or in SNF”.

• Document patient response to interventions provided on the in-patient level of care (Were they effective? Are they still effective?).
**In-Patient Documentation Tips**

**Don’t**

- Don’t use “patient is dying”, “end-of-life care”, “general decline” or “medication adjustment” to justify in-patient level of care unless you also document why these actions cannot take place in the home.

- Don’t document resolution of the precipitating events that led to in-patient level of care without further documenting eligibility that maintains in-patient level of care status or, alternatively, documentation describing efforts to move the patient to a more appropriate setting, i.e., SNF or home.
Continuous Home Care
**Periods of crisis.** Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide (also known as hospice aide) services or both may be covered on a 24-hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation and management of acute medical symptoms.
Regulations: Continuous Home Care CoP 418.204

Hospice inpatient unit – Q5006
Hospital – Q5005
SNF – Q5004

Nursing facility – Q5003
ALF – Q5002
Regulations: Continuous Home Care CoP 418.204

• A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances.

• Continuous care is not a highly specialized service, because while time intensive, it does not require highly specialized nursing skills.
Requirements For Continuous Home Care

• The hospice must provide a minimum of 8 hours of care during a 24-hour day, which begins and ends at midnight.

• This care need not be continuous, e.g., 4 hours could be provided in the morning and another 4 hours in the evening.

• The care must be predominately nursing care provided by either an RN, an LPN, or an LVN.

• This means that more than half of the hours of care are provided by an RN, LPN, or LVN. Homemaker or hospice aide services may be provided to supplement the nursing care.

• Disciplines such as medical social workers or pastoral counselors are not included in the statutory definition of continuous care and are not counted towards total hours of continuous care.
Continuous Care Eligibility

- Need for care and or monitoring must be constant; remember a minimum of 8 hours in a 24 hour period.
- 51% of the continuous care hours must be skilled care.
  - MSW and Pastoral Counselor visits may not be included as continuous care hours.
- Continuous care is an effort to de-escalate the immediate crises and possibly avoid hospitalization.
- Continuous care is covered only as necessary to maintain the terminally ill individual at home.
Continuous Care Eligibility

**Symptom Management:**

- Seizures
- Nausea/vomiting
- Uncontrolled pain

**Collapse of family structure:**

- Caregiver has been providing *skilled* care and change in patient condition *warrants nursing intervention* as caregiver no longer can and/or wishes to provide care.
When Continuous Care Is Not Allowed

- Actively dying and not meeting the criteria for symptoms that cannot be managed in another setting
- Caregiver breakdown, unless patient need meets criteria
- Unsafe home situation
- To maintain the patient in their own home
- While awaiting nursing home placement
Continuous Care Documentation Tips

**Do**

- Document the team’s effort to resolve patient problems at the lowest level of care.
- Document specific symptoms that need to be controlled.
- Document what care needs are not being met and why they require acute medical care.
- Documentation should reflect that patient is at risk for hospitalization if symptoms and or care needs are not managed and or met.
- Document at least hourly
Continuous Care Documentation Tips

**Don’t**

- Include documentation time, hospice aide supervision, care plan changes in continuous care hours calculation
- Include non-allowed discipline time in continuous care hours calculation
- Discount aide hours
Create a “snapshot” that will paint a picture of the patient’s needs and what the care needs entail. The picture you paint is the picture Medicare will use to determine whether this level of care is appropriate and reimbursable.
References

- Hospice & Palliative Care Federation of Massachusetts (2008), *The Hospice General In-Patient Level of Care; Criteria, Guidelines, Reimbursement and Contracting*
Questions, comments?  
Katie@nahc.org