OIG, DOJ put hospice providers under a microscope

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OIG Report

The Office of Inspector General's (OIG) recent report, "Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio," calls out a number of areas where the OIG identified room for improvement in the Medicare hospice program. The OIG report calls on the Centers for Medicare & Medicaid Services (CMS) to increase its oversight of hospices and strengthen its process for surveying hospices. It also recommends other changes to protect both Medicare beneficiaries and the integrity of the hospice program. The OIG identified vulnerabilities in the Medicare hospice program, including the following:

- Key services, including adequate pain control and management of symptoms, are sometimes lacking. The OIG notes that hospices provided fewer services than outlined in plans of care 31 percent of the time for hospice beneficiaries in nursing facilities. The OIG also notes that many hospices only provided routine home care, calling into question whether beneficiaries have access to all needed services.
- The OIG notes that about three-fourths of all hospice beneficiaries – including patients receiving general inpatient care – did not receive a visit from a hospice physician. While Medicare does not require physician visits, this finding left the OIG questioning how hospice patients with complex needs receiving general inpatient care in hospice inpatient units can be placed in that level of care without seeing a hospice physician.
- CMS offers little information to beneficiaries about hospice quality. The OIG noted that the online Hospice Compare service lacks critical information about the quality of care provided by individual hospices and has no information about

complaints filed against providers.

- Hospices often provide incomplete or inaccurate information about the hospice benefit to beneficiaries, including the use of election statements with incorrect language.
- The OIG identifies instances of inappropriate billing by hospices, including billing for a higher level of care than the beneficiary needed.
- Medicare sometimes pays twice for the same service, such as drugs paid for under Part D that are already included in the daily rate paid to the hospice and paying for physician services under both the Part A and Part B benefits.
- Hospice physicians often not explaining their clinical findings or attesting that their findings were based on their examination of the beneficiary or review of medical records in accordance with the requirements to certify beneficiaries for hospice care.
- The OIG report notes that the current payment system creates incentives for hospices to minimize their services and seek beneficiaries with uncomplicated needs.
    - Payments are based on time spent in care, not services provided. The base rate is the same for all beneficiaries in routine home care, regardless of the beneficiary's needs.
    - Hospices typically provide less than five hours of visits per week (and are paid about $1,100 for the week for a beneficiary receiving routine home care) with most visits being made by hospice aides.
    - Hospices seldom provide services on weekends, even though they are required to make services available, as needed, on a 24 /7 basis. This raises concerns as to whether beneficiaries are adequately served on weekends.
    - Hospices seem to target beneficiaries in assisted living facilities (ALFs) who tend to have long lengths of stay. The OIG report notes that during the timeframe of their review, over one-third of beneficiaries in ALFs received hospice care for more than 180 days. The OIG report also notes that beneficiaries living in ALFs tended to have diagnoses that required less complex care, such as mental disorders, Alzheimer's disease, and other "ill-defined" conditions. Additionally, the OIG observed that beneficiaries in ALFs were six times more likely to have these conditions than cancer.

The OIG report also notes that OIG investigative efforts involving hospices have resulted in 25 criminal actions, 66 civil actions and $143.9 million in investigative receivables during the fiscal years 2013 to 2017.

OIG settlements

This OIG report comes on the heels of several recent settlements with hospices involving allegations that the hospices submitted false claims for hospice services provided to patients who were not terminally ill and, thus, not eligible for the hospice benefit:

- May 2018 - Health and Palliative Services of the Treasure Coast and two of its businesses paid $2.5 million to resolve fraud allegations brought by two physicians formerly employed by the hospice organization.
- February 2018 - Horizons Hospice and its CEO agreed to pay $1.24 million to resolve allegations in two separate whistleblower lawsuits.
- October 2017 - Chemed Corporation, which owns Vitas Hospice Services and Vitas Healthcare, agreed to pay $75 million to resolve fraud allegations stemming from three separate whistleblower lawsuits filed against it.

OIG Work Plan

The OIG's July 2018 report is not the only evidence that the OIG has its eye on hospices. A check of the OIG's active work plan shows six active matters relating to hospice and the hospice benefit:

- Medicare Payments Made Outside of the Hospice Benefit
- Duplicate Drug Claims for Hospice Beneficiaries
- Trends in Hospice Deficiencies and Complaints
- Hospice Home Care - Frequency of Nurse On-Site Visits to Assess Quality of Care and Services
- Review of Hospices' Compliance with Medicare Requirements

- Medicare Payments for Chronic Care Management

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