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Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio

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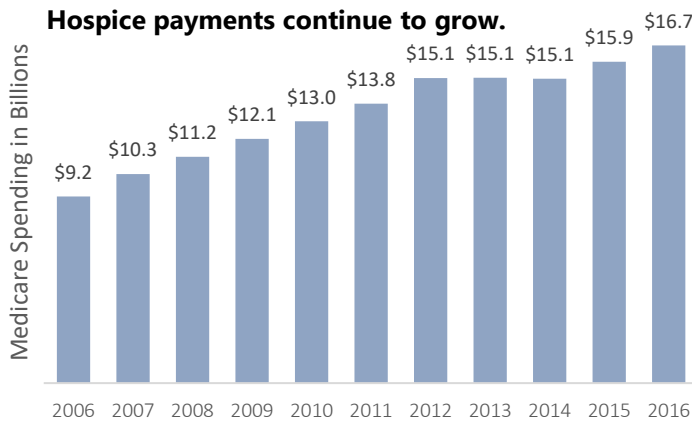


Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity

What OIG Found

Hospice care can provide great comfort to beneficiaries, families, and caregivers at the end of a beneficiary's life. Use of hospice care has grown steadily over the past decade, with Medicare paying \$16.7 billion for this care in 2016. It is

an increasingly important benefit for the Medicare population; 1.4 million beneficiaries received hospice care in 2016.



However, OIG has identified vulnerabilities in the program. OIG found that hospices do not always provide needed services to beneficiaries and sometimes provide poor quality care. In some cases, hospices were not able to manage effectively symptoms or medications, leaving beneficiaries in unnecessary pain for many days.

OIG also found that beneficiaries and their families and caregivers do not receive crucial information to make informed decisions about their care. Further, hospices' inappropriate billing costs Medicare hundreds of millions of dollars. This includes billing for an expensive level of care when the beneficiary does not need it. Also, a number of fraud schemes in hospice care negatively affect beneficiaries and the program. Some fraud schemes involve enrolling beneficiaries who are not eligible for hospice care, while other schemes involve billing for services never provided.

Lastly, the current payment system creates incentives for hospices to minimize their services and seek beneficiaries who have uncomplicated needs. Within each level of care, a hospice is paid for every day a beneficiary is in its care, regardless of the quantity or quality of services provided on that day. While CMS has made some changes to payments, the underlying structure of the payment system remains unchanged.

Why OIG Did This Portfolio

OIG is committed to ensuring that beneficiaries receive quality care and to safeguarding the hospice benefit. OIG has produced numerous evaluations and audits of the hospice program, including in-depth looks at specific levels of care and settings. OIG has also conducted criminal and civil investigations of hospice providers, leading to the conviction of individuals, monetary penalties, and civil False Claims Act settlements. Through this extensive work, OIG has identified vulnerabilities in the program. This portfolio highlights key vulnerabilities and presents recommendations for protecting beneficiaries and improving the program.

What Medicare Hospice Means

- Beneficiaries forgo curative care for the terminal illness and instead receive palliative care.
- Care may be provided in a variety of settings, including the home, nursing facility, hospital, and hospice inpatient unit.
- There are four levels of care, the most common of which is routine home care.
- Within each level of care, Medicare pays hospices for each day a beneficiary is in care regardless of the quantity or quality of services.

More must be done to protect Medicare beneficiaries and the integrity of the program.

What OIG Recommends and How the Agency Responded

We recommend that the Centers for Medicare & Medicaid Services (CMS) implement 15 specific actions that relate to 7 areas for improvement. CMS should strengthen the survey process—its primary tool to promote compliance—to better ensure that hospices provide beneficiaries with needed services and quality care. CMS should also seek statutory

authority to establish additional remedies for hospices with poor performance. Also, CMS should develop and disseminate additional information on hospices, including complaint investigations, to help beneficiaries and their families and caregivers make informed choices about hospice care. CMS should educate beneficiaries and their families and caregivers about the hospice benefit, working with its partners to make available consumer-friendly information. CMS should promote physician involvement and accountability to ensure that beneficiaries get appropriate care.

To reduce inappropriate billing, CMS should strengthen oversight of hospices. This includes analyzing claims data to identify hospices that engage in practices that raise concerns. Lastly, CMS should take steps to tie payment to beneficiary care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs, seeking statutory authority if necessary.

In our draft report to CMS, we recommended 16 specific actions. CMS concurred with six recommendations, did not concur with nine, and neither concurred nor nonconcurred with one. We considered CMS's comments carefully, and we clarified and combined two of our recommendations. See Appendix A for a list of OIG's 15 recommendations. We remain committed to our recommendations and will continue to work with CMS to promote their implementation.

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BACKGROUND

The Office of Inspector General (OIG) Portfolio presents recommendations to improve program vulnerabilities detected in prior audits, evaluations, and investigations. The Portfolio synthesizes OIG's body of work in a program area and identifies trends in payment, compliance, oversight, or fraud vulnerabilities requiring priority attention and action to protect the integrity of Department of Health and Human Services (HHS) programs and the beneficiaries they serve. This portfolio focuses on the Medicare hospice benefit.

Hospice is an increasingly important benefit for the Medicare population. It can provide great comfort to beneficiaries and their families and other caregivers at the end of a beneficiary's life. The number of hospice beneficiaries has grown every year for the past decade. In 2016, Medicare spent about \$16.7 billion for hospice care for 1.4 million beneficiaries, up from \$9.2 billion for fewer than 1 million beneficiaries in 2006. With this growth, OIG has identified significant vulnerabilities. OIG evaluations and audits have raised concerns about hospice billing, Federal oversight, and quality of care provided to beneficiaries. OIG investigations of fraud cases have uncovered hospices enrolling patients without the beneficiary's knowledge or under false pretenses, enrolling beneficiaries who are not terminally ill, billing for services not provided, paying kickbacks, and falsifying documentation.

This portfolio describes the growth in hospice utilization and reimbursement, and it summarizes key vulnerabilities that OIG has identified and continues to monitor. The portfolio also includes recommendations to CMS to address these vulnerabilities.

OIG's body of work covering hospice care since 2005 serves as the basis for this portfolio. This work includes in-depth looks at specific levels of care and settings. It focuses on covered hospice services such as nursing, physician, medical social, and hospice aide services. It does not focus on volunteer services. See Appendix B for a list of OIG hospice reports. The portfolio also includes descriptions of OIG investigative efforts involving hospices, which resulted in 25 criminal actions, 66 civil actions, and \$143.9 million investigative receivables from fiscal year (FY) 2013 to FY 2017.

Medicare Hospice Benefit

What is hospice care? Hospice care serves terminally ill beneficiaries who decide to forgo curative treatment for the terminal illness and instead receive palliative care. Hospice care aims to make the beneficiary as physically and emotionally comfortable as possible and allow the beneficiary to remain in his or her home environment. It is an interdisciplinary approach to treatment that includes, among other things, nursing care, medical social services (services based on the patient's psychosocial assessment and the patient's and family's needs), hospice aide services, medical supplies, and physician services.

Who provides it? Medicare-certified hospices provide the care. Hospices may be for-profit, nonprofit, or government-owned. Care may be provided in various settings, including the home or other places of residence, such as an assisted living facility, skilled nursing facility, or other nursing facility.

Who is eligible? To be eligible for Medicare hospice care, a beneficiary must be entitled to Medicare Part A and be certified as having a terminal illness with a life expectancy of 6 months or less if the illness runs its normal course. Upon election of hospice care, the beneficiary waives all rights to Medicare payment for services related to the curative treatment of their terminal condition or related conditions.

How does Medicare pay? Medicare pays the hospice for each day that a beneficiary is in care, regardless of the quantity or quality of services provided on that day. Medicare pays a different daily rate for each of the four levels of hospice care: routine home care, general inpatient care, continuous home care, and inpatient respite care.

OIG recognizes that many hospices meet Medicare requirements and provide high-quality care. This portfolio focuses on vulnerabilities and possible solutions to improve the program for all hospice beneficiaries. Future OIG work will focus on quality of care in hospices, hospice billing, and compliance.

By leveraging advanced analytic techniques to detect potential vulnerabilities and fraud trends, OIG is better able to target resources at those hospices in need of oversight, leaving others free to provide care and services without unnecessary disruption.

OIG work referenced throughout this document was conducted in accordance with the professional standards applicable to audits, evaluations, and investigations.

The Four Levels of Hospice Care

Medicare pays for four levels of hospice care. Medicare-certified hospices are required to provide each of these levels when needed.¹ Hospices can provide services directly or under arrangement.

- *Routine home care* is the most commonly used. It is for any day a hospice beneficiary is at home and not receiving continuous home care, which is a more intensive level of care. Routine home care can be provided in the home or other places of residence, such as an assisted living facility or nursing facility. In FY 2017, hospices were paid \$190.55 per day for days 1-60 of a beneficiary's routine home care and \$149.82 per day after day 60. Before 2016, the daily rate paid to hospices did not change based on the beneficiary's time in care.²
- *General inpatient care* is for pain control or symptom management that cannot be managed in other settings, such as the beneficiary's home. General inpatient care is intended to be short term and may be provided in a hospice inpatient unit, a hospital, or a skilled nursing facility (SNF). In FY 2017, hospices were paid \$734.94 per day for general inpatient care.
- *Continuous home care* is allowed only during brief periods of crisis and only as necessary to maintain the individual at home. In FY 2017, hospices were paid \$964.63 per day for continuous home care. This is based on an hourly rate of \$40.19 per hour.
- *Inpatient respite care* is short-term inpatient care provided to the beneficiary when necessary to relieve the caregiver. In FY 2017, hospices were paid \$170.97 per day for inpatient respite care.

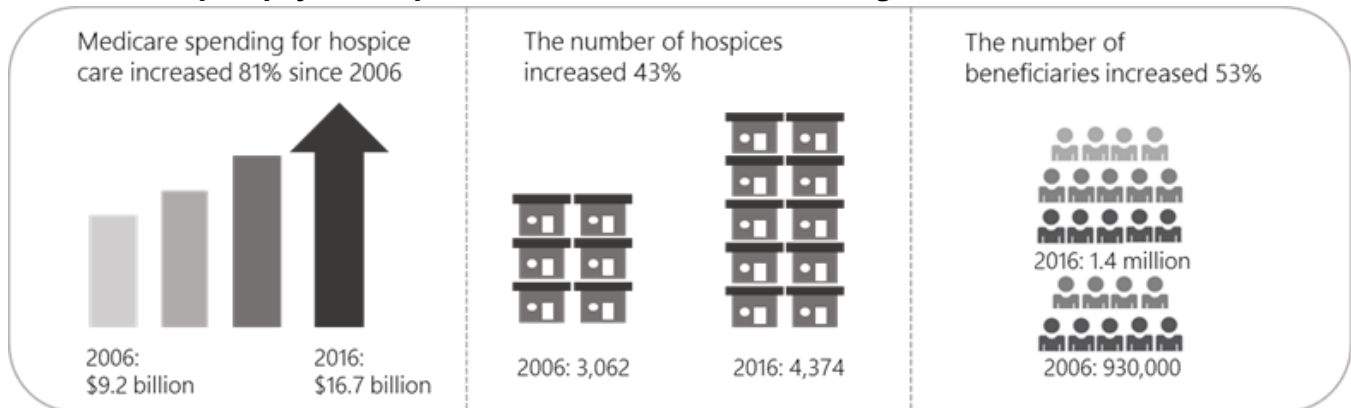
FINDINGS: TRENDS IN MEDICARE HOSPICE

Hospice Use Has Grown Steadily Over the Past Decade

Medicare paid \$16.7 billion for hospice care in 2016

Medicare paid \$16.7 billion for hospice care in 2016, an increase of 81 percent since 2006. Over this period of time, the number of Medicare hospice beneficiaries increased each year. About 1.4 million beneficiaries received hospice care in 2016, an increase of 53 percent since 2006. See Exhibit 1. Increases in hospice care were greater than increases in Medicare spending and enrollment in general. From 2006 to 2016, total Medicare spending grew 66 percent, while the total number of Medicare beneficiaries grew 32 percent.³

Exhibit 1: Hospice payments, providers, and beneficiaries have grown.



Source: OIG analysis of CMS data, 2017.

OIG has found that patient characteristics, Medicare payments, and services provided differ among care settings and between for-profit and nonprofit hospices.

More than one-half of hospice beneficiaries—55 percent—received care in the home, and 25 percent received care in a nursing facility or SNF in 2016. Thirteen percent of hospice beneficiaries received care while residing in an assisted living facility (ALF). Compared to other settings, ALFs has had the greatest growth in hospice beneficiaries; from 2010 to 2016, the number of beneficiaries receiving care in ALFs grew 64 percent.

The number of hospices serving Medicare beneficiaries has increased every year since 2006. In 2016, a total of 4,374 hospices provided care to Medicare beneficiaries. For-profit hospices accounted for 64 percent of the total. These hospices received more than one-half of the dollars (55 percent), and served just under half (49 percent) of the beneficiaries. Of all hospices, 34 percent were small (fewer than 90 beneficiaries per year), 37 percent were medium sized (90 to 320 beneficiaries per year), and 29 percent were large (over 320 beneficiaries per year).

FINDINGS: ENSURING BENEFICIARIES RECEIVE APPROPRIATE HOSPICE

Hospices Do Not Always Provide Adequate Services to Beneficiaries and Sometimes Provide Poor Quality Care

Key services are sometimes lacking

When beneficiaries elect hospice care, they are choosing to receive care that will not cure their terminal illness, but should provide comfort and relief from pain. All services related to their terminal illness become the hospice's responsibility.⁴ Yet hospices do not always provide the care beneficiaries need to control pain and manage symptoms.

Notably, hospices provided fewer services than outlined in the plans of care for 31 percent of claims for hospice beneficiaries residing in nursing facilities.⁵ In addition, hospices did not provide adequate nursing, physician, or medical social services in 9 percent of general inpatient care stays in 2012.⁶ These services are particularly important to beneficiaries in general inpatient care because they have uncontrolled symptoms requiring pain control or symptom management that cannot be provided in other settings.⁷ In some cases, hospices were not able to effectively manage symptoms or medications, leaving beneficiaries in pain for many days.



Examples of Hospices Providing Poor Quality Care

- A hospice billed Medicare for serving a 101-year old beneficiary with dementia. He had uncontrolled pain throughout his 16 days in general inpatient care. The hospice did not change his pain medication until the last day and did not provide him the special mattress he needed for more than a week.⁸
- A hospice billed for 17 days of general inpatient care for a 70-year old beneficiary, but never visited him. Instead, the hospice called his family to inquire how he was doing.⁹
- An 89-year old beneficiary's respiratory symptoms were uncontrolled for 14 days during a general inpatient care stay in which the hospice rarely changed his medication dosage. The beneficiary continued to experience respiratory distress and anxiety.¹⁰

Hospices often do a poor job care planning

Proper care planning helps ensure that beneficiaries receive the care and attention they need and that services are coordinated effectively. Yet hospices often fall short in care planning.

Hospices are required to establish an individualized written plan of care for each beneficiary they serve and to provide services that meet the plan.¹¹

The plan of care must be developed by an interdisciplinary group that includes a physician, a registered nurse, a social worker, and a pastoral or other counselor. This helps ensure that the hospice team meets all of the beneficiary's needs. The plan of care must also contain a detailed

statement of the scope and frequency of needed services.¹²

Plans of care play a key role

Proper care planning is crucial in providing beneficiaries the care they need. Plans must be individualized and detailed.

Hospices often fail to meet these requirements. Specifically, hospices did not meet plan of care requirements in 85 percent of general inpatient care stays in 2012.¹³ An OIG study several years earlier, which focused on all levels of hospice care provided in nursing facilities, found that hospices failed to meet requirements for plan of care for 63 percent of claims.¹⁴ Hospices often did not involve all members of the interdisciplinary group in establishing the plans or failed to include a detailed statement of the scope and frequency of needed services in the plans of care.¹⁵

Hundreds of hospices provide only one level of care

In each year from 2006 to 2016, hundreds of hospices provided only the most basic level of care—routine home care—to all the beneficiaries they served throughout the year. In 2016, a total of 665 hospices provided only routine home care. This is an increase of nearly 55 percent from 2011, when 429 hospices did so.¹⁶

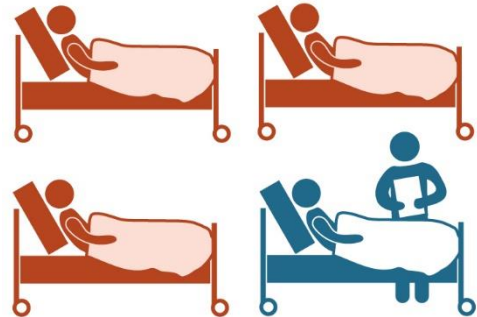
Medicare pays for three other levels of hospice care in addition to routine home care.¹⁷ Hospices must provide, directly or under arrangements, these levels when needed.¹⁸ When hospices provide just routine home care, it calls into question beneficiaries' access to needed services. It is critical that intense services, such as general inpatient care and continuous home care, be available to control the beneficiary's pain and other symptoms when needed. Respite inpatient care, which offers relief to caregivers, should also be available given the essential role that caregivers and family members play in caring for their loved ones at the end of life.

Most beneficiaries do not see a hospice physician

In each year from 2006 to 2016, about three-quarters of hospice beneficiaries did not have a visit with a hospice physician. Medicare does not require physician visits, and hospices can separately bill for them if provided.¹⁹ Most beneficiaries do not receive visits.

This includes beneficiaries with complex needs receiving general inpatient care in hospice inpatient units. Again, physician visits are not a requirement of general inpatient care. However, it is important to note that beneficiaries are placed in this high level of care when the hospice determines that their pain or other symptoms are uncontrolled and cannot be managed at home.²⁰

3 of 4 hospice beneficiaries did not receive a visit from a hospice physician



Common fraud schemes involve inappropriately enrolling beneficiaries

OIG has uncovered a number of fraud schemes in hospice care that negatively affect beneficiaries and their families and caregivers. Some fraud schemes involve paying recruiters to target beneficiaries who are not eligible for hospice care, while other schemes involve physicians falsely certifying beneficiaries. For example, a hospice physician inappropriately certified a beneficiary as terminally ill who just days before was determined by a hospital to be in “good shape.”

Beneficiaries are put at risk when they are enrolled in hospice care inappropriately, as Medicare hospice does not pay for curative treatment for a beneficiary’s terminal illness.²¹ Therefore, a beneficiary who is inappropriately enrolled in hospice care might be unwittingly forgoing needed treatment. In one example, a hospice falsely told a beneficiary that she could remain on a liver transplant list even if she elected hospice care. When the beneficiary elected hospice care, she was removed from the transplant list. After the beneficiary learned of this, she stopped hospice care so she could be reinstated on the transplant list. As this example demonstrates, it is critical that beneficiaries know when they are in hospice care and what that means for their treatment options.

Examples of Fraud Schemes Affecting Beneficiaries

- An owner of a Mississippi hospice used patient recruiters to solicit beneficiaries who were not eligible for hospice care. These patients were not even aware that they were enrolled in hospice care. The owner submitted fraudulent charges and received more than \$1 million from Medicare.²² The owner was later excluded from the Medicare program.
- A Minnesota-based hospice chain agreed to pay \$18 million to resolve allegations that it inappropriately billed Medicare for care provided to beneficiaries who were not eligible for hospice because they were not terminally ill. The hospice chain also allegedly discouraged physicians from discharging ineligible beneficiaries.²³
- Two certifying physicians from one California hospice were found guilty of health care fraud for falsely certifying beneficiaries as terminally ill. Both physicians were excluded from the Medicare program. The false certifications were part of a larger fraud scheme organized by the hospice owner. The scheme involved illegal payments to patient recruiters for bringing in beneficiaries, creating fraudulent diagnoses, certifying beneficiaries as terminally ill when they were not, and altering medical records. The owner pleaded guilty to health care fraud and was sentenced to 8 years in Federal prison.²⁴

Beneficiaries and Their Families and Caregivers Do Not Receive Crucial Information To Make Informed Decisions About Hospice Care

CMS provides beneficiaries little information about hospice quality

CMS does not provide comprehensive information to the public that is essential for making informed decisions about hospice care. CMS launched a compare website about hospices in August 2017 called Hospice Compare. Hospice Compare was created much later than compare websites for hospitals, nursing facilities, and home health agencies. Compare websites for each of these providers were created over a decade ago.

Hospice Compare does not include critical information about the quality of care provided by individual hospices and offers no information about complaints filed against individual hospices. This information is essential in helping beneficiaries and their families choose the hospice that would best fit their needs and provide good care.

CMS is required to develop quality measures for hospices. These measures must go through a process in which they are endorsed by a consensus-based entity, such as the National Quality Forum. Hospices review the data for these measures before they are made available to the public.²⁵

Currently, Hospice Compare includes some quality measures self-reported by the hospice, such as whether the patient was checked for pain, and some quality measures from a survey of family caregivers, such as their willingness to recommend the hospice.²⁶ These measures do not capture a patient's full experience with hospice care.

Hospice Compare does not include any information about the number, type, and severity of problems found during surveys and complaint investigations. This information

would benefit beneficiaries and their families and caregivers by alerting them to hospices found to have done a poor job caring for patients.

Although this information is required to be made public,²⁷ CMS does not include it on Hospice Compare.

Instead, some States publish this information on their websites.

Gaining access to hospice survey and complaint information is difficult and time consuming, rendering it largely unhelpful. In contrast, CMS publishes survey and complaint information

about nursing homes on the nursing home compare website.

Hospice Surveys

Surveyors conduct onsite reviews of hospices every 3 years to promote compliance and quality care. Surveyors observe the operations of the hospice, review clinical records, and visit patients. Surveys are also conducted in response to complaints.

Hospices often provide beneficiaries incomplete or inaccurate information about the benefit

Beneficiaries and their families and caregivers do not always get the information they need when they elect hospice care because hospices often provide incomplete or inaccurate information on election statements. The hospice election statement is an important source of information about the benefit, and hospices are required to provide it. It is written by the hospice and must be signed by a beneficiary or representative before the start of care. The statement should be complete and accurate so that beneficiaries and their caregivers understand what they are entitled to receive and what they must give up with the election of hospice care.

In 35 percent of general inpatient care stays, however, hospices' election statements lacked required information or had other vulnerabilities.²⁸ Most commonly, these statements neglected to specify that the beneficiary was electing the Medicare hospice benefit as opposed to Medicaid hospice or some other insurance. It is important for beneficiaries to know which benefit they are receiving, especially because eligibility criteria and election periods in some State Medicaid programs differ from those of Medicare, and private health insurance may cover hospice care differently than Medicare.

Some election statements did not mention—as required—that the beneficiary was waiving coverage of certain Medicare services by electing hospice care, or inaccurately stated which Medicare benefits were waived. Other election statements did not state—as required—that hospice care is palliative rather than curative. CMS recently developed model text that hospices can use when they write their election statements.²⁹ It is crucial that beneficiaries and their families and caregivers understand that when beneficiaries begin hospice care they are turning over all care for their terminal illness to the hospice.

FINDINGS: PROTECTING THE MEDICARE HOSPICE PROGRAM

Inappropriate Billing by Hospices Costs Medicare Hundreds of Millions of Dollars

Hospices frequently bill Medicare for a higher level of care than the beneficiary needs

Reviews of individual hospices have found improper payments ranging from \$447,000 to \$1.2 million for services not meeting Medicare requirements. In these cases, the hospices billed for inappropriate levels of care, lacked required certifications of terminal illness, or did not have sufficient clinical documentation.³⁰

Hospices have also inappropriately billed for expensive levels of care that were not needed. Specifically, in 2012 hospices billed one-third of general inpatient care stays inappropriately, costing Medicare \$268 million.³¹ General inpatient care is the second most expensive level of hospice care and should only be billed when the beneficiary has uncontrolled pain or symptoms that cannot be managed at home.

Hospices often billed for general inpatient care when the beneficiary needed only routine home care. As a result, these hospices were paid \$672 per day instead of \$151 per day.³² At other times, the hospice inappropriately billed for general inpatient care when the beneficiary's caregiver was not available and inpatient respite care was needed. Again, the hospices received more than they should have. By billing inappropriately, the hospices received \$672 per day for general inpatient care instead of \$156 per day for inpatient respite care, the level of care specifically designed to relieve caregivers.³³

Hospices were more likely to bill inappropriately for general inpatient care provided in SNFs than general inpatient care provided in other settings. Forty-eight percent of general inpatient care stays in SNFs were inappropriate compared to 30 percent in other settings. In addition, for-profit hospices were more likely than other hospices to bill inappropriately for this level of care. For-profit hospices billed 41 percent of their general inpatient care stays inappropriately. In comparison, other hospices, including nonprofit and government-owned hospices, billed 27 percent of their general inpatient care stays inappropriately.

Examples of Hospices Billing Inappropriately

- A for-profit hospice in Mississippi inappropriately billed Medicare for a general inpatient care stay lasting over 7 weeks for a beneficiary whose symptoms were under control. She needed assistance only with personal care, eating, and the administration of medication, yet the hospice was paid almost \$30,000 for general inpatient care.³⁴
- A for-profit hospice inappropriately billed for a beneficiary in Florida who entered general inpatient care for symptom management. Her symptoms were managed within 2 days, yet she remained in general inpatient care for 15 additional days. Medicare paid close to \$12,000 for this stay.³⁵
- A hospice in New York billed for 1 month of continuous home care for dates after the beneficiary's death. The hospice improperly received at least \$1,266,517 for hospice services billed on behalf of this beneficiary and others that did not comply with Medicare requirements.³⁶
- A hospice in Puerto Rico billed for services after the beneficiary revoked the hospice election. The hospice received at least \$453,558 in improper payments for services billed on behalf of this beneficiary and others that did not comply with Medicare requirements.³⁷

Medicare sometimes pays twice for the same service

Medicare sometimes paid for drugs through Part D for hospice beneficiaries when payment for these drugs should have been covered by the daily rate paid to the hospice. Hospices are required to provide the beneficiary's drugs that are used primarily for the relief of pain and symptom control related to the terminal illness.³⁸ If Part D pays for them, Medicare is in effect paying twice. Also, beneficiaries may face significant copays depending on the plan and the drug.

OIG found that Part D and beneficiaries paid more than \$30 million in 2009 for drugs in certain categories that potentially should have been covered under the daily rate paid to hospices. These categories include analgesic, antinausea, laxative, or antianxiety drugs, which are commonly used in hospice care.³⁹

In 2012, OIG found that Part D inappropriately paid for more than 100 drugs for beneficiaries in sampled general inpatient care stays.⁴⁰ These 110 drugs were used primarily for the relief of pain and symptom control related to the hospice beneficiary's terminal illness and should have been provided by the hospice. Some of them were analgesic, antinausea, laxative, or antianxiety drugs while others were not.⁴¹

In addition to drugs, Medicare also paid twice for some physician services for hospice beneficiaries. OIG identified nearly \$566,000 in questionable claims for physician services provided to hospice beneficiaries in 2009.⁴² In

each of these cases, a service was billed under both the Part A hospice benefit and Part B even though it was from the same physician, on the same day, for the same beneficiary and terminal illness, leading OIG to suspect that the beneficiary did not receive two distinct services, but rather one service billed twice.⁴³

Hospice physicians are not always meeting requirements when certifying beneficiaries for hospice care

For hospice services to be covered by Medicare, a physician must certify a beneficiary as terminally ill every election period.⁴⁴ This certification is based on the physician's clinical judgment.⁴⁵ The physician is required to compose a narrative and include an attestation in each certification of terminal illness. These requirements help to ensure that physicians are involved in determining that hospice care is appropriate for the beneficiary.

However, some hospice physicians are not meeting requirements when certifying beneficiaries. In 14 percent of general inpatient care stays in 2012, the certifying physician did not meet at least one requirement.⁴⁶ Specifically, the physicians did not explain their clinical findings or attest that their findings were based on their examination of the beneficiary or review of the medical records.

Hospice fraud schemes are growing and include kickbacks and false billing

OIG has increasingly uncovered fraud schemes that put the program at risk of improper payments. These schemes include paying kickbacks for patient referrals, billing for medically unnecessary services, upcoding, and billing for services not provided. In one case, a physician received kickbacks for recruiting beneficiaries, many of whom were not terminally ill, but were seeking opioids. OIG has taken action against a number of hospices involved in fraud schemes.

OIG Investigative Receivables for Hospice

In FY 2013, OIG investigative receivables were \$15.5 million and grew to \$55.8 million in FY 2017. In total, investigative receivables from FY 2013 to FY 2017 amounted to \$143.9 million.

Examples of Fraud Schemes

- An Illinois-based hospice billed Medicare for medically unnecessary hospice services. The hospice paid bonuses to staff for placing patients in general inpatient care when it was not medically necessary and provided gifts and kickbacks to nursing homes for referring patients to the hospice.⁴⁷ A director of this hospice was excluded from the Medicare program.
- A former hospice owner in Alabama pleaded guilty to defrauding Medicare of more than \$3 million by billing for general inpatient care but providing a lower level of hospice care.⁴⁸ In addition, the owner was excluded from the Medicare program.
- An owner of a Mississippi hospice was sentenced to almost 6 years in prison for submitting fraudulent charges to Medicare and receiving millions of dollars in Medicare funds based on alleged hospice services for patients who were not eligible for hospice care, services that were never provided, and claims based on the forged signatures of physicians. Another person involved in the scheme provided patient names and identifying information in return for kickback payments.⁴⁹ This person and the hospice's owner were excluded from the Medicare program.

The Current Payment System Creates Incentives for Hospices To Minimize Their Services and Seek Beneficiaries Who Have Uncomplicated Needs

Payments to hospices are based on the time spent in care, not services provided

A hospice is paid for every day a beneficiary is in its care regardless of how many services it provides on a particular day. The daily rate is determined by the level of care, with routine home care accounting for over 95 percent of all hospice care days.⁵⁰ The base rate is the same for all beneficiaries in routine home care, regardless of the beneficiary's needs or care setting.⁵¹

A hospice is paid the same rate for routine home care provided in a nursing facility as it is for routine home care provided in a beneficiary's home. However, unlike private homes, nursing facilities are staffed with professional caregivers and are required to provide personal care services. These services are similar to hospice aide services that are included in the daily rate of the hospice benefit. Therefore, the hospice is being paid for aide services when a beneficiary resides in a nursing facility even though the facility is already providing them. Furthermore, hospice payments do not include any adjustments or other payments that are tied to the quality of care provided by the hospices.

The Patient Protection and Affordable Care Act requires Medicare hospice payment reform not earlier than October 1, 2013.⁵² CMS recently changed

the rate for routine home care, increasing the amount for the first 60 days and decreasing the amount thereafter; it also provides additional reimbursement if the hospice provides skilled care in the last 7 days of life.⁵³ However, the underlying structure of the benefit—paying for care on a daily basis regardless of the care provided—remains unchanged.

The financial incentives created by this payment system may cause hospices to seek out certain beneficiaries over others. Hospices may target beneficiaries who are likely to have long lengths of stay or fewer needs, as these beneficiaries may offer hospices the greatest financial gain. Hospices may look for these beneficiaries who have certain diagnoses or are in certain settings. When hospices target specific types of beneficiaries, it raises questions as to whether hospices are enrolling beneficiaries appropriately, whether they are serving all the beneficiaries who need care, and whether they have incentives to care for beneficiaries with greater needs. The financial incentives in the current system also could cause hospices to minimize the amount of services they provide.

Hospices typically provide less than 5 hours of visits per week

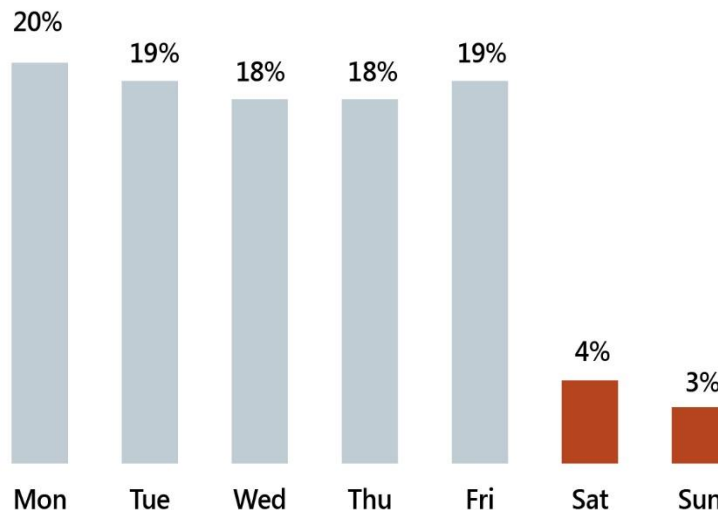
On average, hospices provided 4.8 hours of visits per week and were paid about \$1,100 per week for each beneficiary receiving routine home care in an ALF in 2012.⁵⁴ Most of the visits were from aides. Of note, 25 hospices did not report making any visits to their beneficiaries receiving routine home care in ALFs in 2012. This involved 210 beneficiaries. Medicare paid these hospices a total of \$2.3 million to care for these beneficiaries.

These findings are similar to earlier OIG findings regarding hospice care provided in nursing facilities.⁵⁵ Hospices provided an average of 4.2 visits per week to hospice beneficiaries in nursing facilities. This included the three most common services—nursing, hospice aide, and medical social services—combined. Again, hospice aide services were the most commonly provided.

Hospices seldom provide services on weekends

Hospices must make services available, as needed, on a 24-hour basis, 7 days a week.⁵⁶ Hospices provided fewer services on weekends, however, raising concerns about whether beneficiaries' needs are adequately served on weekends. Hospices provided the great majority of services to beneficiaries in ALFs during the workweek and rarely on weekends in 2012. Specifically, between 18 and 20 percent of hours were provided on each of the weekdays. In contrast, only 4 percent of the hours were provided on Saturdays and 3 percent on Sundays. See Exhibit 2. Hospices are paid for every day a beneficiary is under their care, and the rates are the same for every day of the week.

Exhibit 2: Hospice visits drop off on weekends.



Source: OIG analysis of CMS data, 2013.

Note: Totals do not sum to 100 percent because of rounding.

Hospices were also more likely to provide more acute care—general inpatient care level—on weekdays than weekends.⁵⁷ This level is for pain control or symptom management that cannot be managed in other settings, making it critical that beneficiaries receive it when they need it. At least 16 percent of general inpatient care stays started on each weekday, while 8 percent started on Sundays and 11 percent on Saturdays.

Hundreds of hospices target beneficiaries in certain settings who have long lengths of stay

Medicare paid \$2.1 billion for hospice care provided in ALFs in 2012, an increase of 119 percent from 2007.⁵⁸ The median amount Medicare paid hospices for care for beneficiaries in ALFs was \$16,195, twice as much as the median amount for beneficiaries at home.⁵⁹ The longer lengths of stay for beneficiaries in ALFs explain the higher payments, as total Medicare payments are a function of time spent in care. Over one-third of beneficiaries in ALFs received hospice care for more than 180 days.

The median stay for beneficiaries in ALFs who were served by for-profit hospices was almost 4 weeks longer than the median for nonprofit hospices. Consequently, for-profit hospices received thousands of dollars more than nonprofits per beneficiary in ALFs. See Exhibit 3.

Exhibit 3: Time in care was longer and payments were higher in for-profit hospices.

	Median time in hospice	Median Medicare payment amount
For-Profit Hospice	111 days	\$18,261
Nonprofit Hospice	85 days	\$13,941
Difference	26 days	\$4,320

Source: OIG analysis of CMS data, 2013.

Most hospice beneficiaries in ALFs—60 percent—had diagnoses that typically require less complex care. These include ill-defined conditions, mental disorders, or Alzheimer’s disease.⁶⁰ Beneficiaries in ALFs were six times more likely to have these diagnoses than a diagnosis of cancer. See Exhibit 4.

Exhibit 4: Most beneficiaries in assisted living facilities and nursing facilities had diagnoses that typically require less complex care.

Primary Setting of Hospice Care	Percentage of Beneficiaries with Diagnoses of Ill-Defined Conditions, Mental Disorder, or Alzheimer’s Disease	Percentage of Beneficiaries with Diagnosis of Cancer
ALF	60%	10%
Nursing Facility	54%	13%
Skilled Nursing Facility	52%	15%
Home	27%	38%

Source: OIG analysis of CMS data, 2013.

Note: Includes beneficiaries who received care in 2012.

Beneficiaries with cancer often require complex care and receive hospice care for substantially fewer days than beneficiaries with diagnoses of ill-defined conditions, mental disorders, or Alzheimer’s disease.

Almost 100 hospices stand out for their focus on ALFs. These 97 hospices received most of their Medicare hospice payments in 2012 for care provided in ALFs. All but seven of these hospices were for-profit.

Similarly, 263 hospices targeted beneficiaries in nursing facilities. For each of these hospices, two-thirds of the beneficiaries served resided in nursing facilities.⁶¹ Almost three-quarters of the hospices were for-profit. Like beneficiaries in ALFs, beneficiaries residing in nursing facilities commonly have conditions that are associated with less complex care, longer stays, and more Medicare payments.

In addition, hospices may target beneficiaries in nursing facilities because nursing facilities are required to provide personal care services. As discussed earlier, these services are similar to the aide services that hospices

should provide under the hospice benefit and are included in the daily payment rate. OIG has recommended that hospice care provided in nursing facilities should be paid at a lower rate because of this overlap. For more information, see our prior work.⁶² The Medicare Payment Advisory Commission (MedPAC) has also suggested a reduction in the payment rate for beneficiaries in nursing facilities.⁶³ As mentioned, CMS recently increased the rate for routine home care in all settings for the first 60 days and decreased the amount thereafter.

CONCLUSION AND RECOMMENDATIONS

Hospice is an increasingly important benefit for the Medicare population. It can provide great comfort to beneficiaries and their families and caregivers at the end of a beneficiary's life. Hospice use has grown steadily over the past decade. Medicare now pays \$16.7 billion for hospice care for 1.4 million beneficiaries. Recognizing the importance of the benefit, OIG has produced numerous evaluations and audits of the hospice program, including in-depth looks at specific levels of care and settings. OIG has also conducted criminal and civil investigations of hospice providers, leading to the conviction of individuals, monetary penalties, and civil False Claims Act settlements. Through this extensive work, OIG has identified vulnerabilities in the benefit. These vulnerabilities need to be addressed to ensure that beneficiaries receive quality care and that Medicare payments to hospices are appropriate.

The following recommendations—based on OIG's body of hospice work—address these vulnerabilities. In some cases, we have expanded on recommendations that we have made in the past that remain unimplemented. We recognize that CMS continues to work on implementing past OIG recommendations, and we note where CMS has made progress in addressing specific vulnerabilities. However, more needs to be done. We look forward to more dialogue with CMS in our combined efforts to protect beneficiaries and safeguard the program. In addition, OIG will continue to conduct audits, evaluations, and investigations to identify vulnerabilities and provide recommendations to further strengthen the Medicare hospice benefit.⁶⁴

To improve the quality of care for beneficiaries and strengthen program integrity, CMS should:

Strengthen the survey process to better ensure that hospices provide beneficiaries with needed services and quality care

Protecting beneficiaries and making sure they receive what they need from hospices at the end of their lives is paramount. CMS relies on surveyors to conduct onsite reviews of hospices as its primary tool to promote hospice compliance and quality care. Surveyors observe the operation of the hospice, review clinical records, and visit patients. Surveyors cite the hospice with a deficiency if it fails to meet a requirement needed for participating in the Medicare program. CMS has recently provided training to surveyors about care planning.

CMS should further strengthen this survey process to better ensure beneficiaries receive needed services and quality of care. Specifically, CMS should:

- **Analyze claims data to inform the survey process.** CMS should identify hospices that do not provide all levels of care, infrequently provide physician services, or rarely provide care on weekends. CMS should instruct surveyors to pay particular attention during their review of these hospices to the issues identified.
- **Analyze deficiency data to inform the survey process.** CMS should identify hospices with persistent problems (e.g., repeat deficiencies) and instruct surveyors to focus on these problem areas during their reviews of the individual hospices. The analyses of deficiency data would be in addition to the reviews of previous surveys and complaints that may be done by individual surveyors.

Seek statutory authority to establish additional remedies for hospices with poor performance

CMS does not have adequate tools to address hospices with poor performance. Currently, CMS's only recourse when a hospice is found to have serious deficiencies is to terminate the hospice from the Medicare program, a drastic step that limits CMS's ability to address performance problems. The lack of intermediate remedies undermines the survey process, as hospices have few incentives to improve performance. If CMS cannot effectively address hospices' performance problems, it cannot protect beneficiaries or the program. CMS must be able to take action against providers that do not fulfill their responsibilities to beneficiaries and the program. Specifically, CMS should:

- **Seek statutory authority to establish additional, intermediate remedies for poor hospice performance.** Such measures could include directed plans of correction, directed in-service training, denials of payment for new admissions or for all patients, civil monetary penalties, and imposition of temporary management.

Develop and disseminate additional information on hospices to help beneficiaries and their families and caregivers make informed choices about their care

Beneficiaries and their families and caregivers need reliable information about hospice performance so they can compare providers and make the best decision for their care needs. CMS has taken the positive step of launching the Hospice Compare website. At this time, however, it offers limited information. CMS is developing two claims-based quality measures, but additional information is needed. CMS should include on Hospice Compare critical data that will enable beneficiaries and their caregivers to make more informed choices and will hold hospices more accountable for the care they provide. Specifically, CMS should:

- **Develop other claims-based information and include it on Hospice Compare.** This would be in addition to the quality measures that are included on the website. Claims-based data have been previously recommended by OIG, MedPAC, hospice experts, and others. Such data could include the average number of services a hospice provides, the types of services, how often physician visits are provided, and how often a hospice provides services on weekends.
- **Include on Hospice Compare deficiency data from surveys, including information about complaints filed and resulting deficiencies.** CMS should provide the number and nature of deficiencies for each hospice as available, and report information by key categories, such as care planning and assessments. This should be provided in a consumer-friendly way to inform beneficiaries about hospices that have provided poor care.

Educate beneficiaries and their families and caregivers about the hospice benefit

The goals of hospice care are to help terminally ill beneficiaries continue life in comfort and to support beneficiaries' families and caregivers. Having complete, accurate information about hospice is crucial to achieving these goals. We support CMS's efforts to improve election statements by developing model text. In addition to these efforts, CMS should proactively educate beneficiaries and their families and

caregivers about this important benefit. This may also help protect beneficiaries from becoming victims of fraud schemes. Specifically, CMS should:

- **Work with its partners, such as hospitals and caregiver groups, to make available consumer-friendly information explaining the hospice benefit to beneficiaries and their families and caregivers.** CMS has produced brochures, which are currently available on the Medicare website. CMS has also included information such as a video explaining the benefit on Hospice Compare. In addition to these efforts, CMS should work with health care partners to ensure that these and other consumer-friendly informational resources are easily accessible to families and caregivers who may benefit from learning about the hospice benefit.

Promote physician involvement and accountability to ensure that beneficiaries get appropriate care

Physicians serve a vital role in the appropriate provision of hospice services, but our work has shown that they are not always involved in decision making. CMS has taken steps to remind hospices and physicians about the requirements for valid physician certifications and recertifications, but more needs to be done. Notably, we found that hospices did not always provide the care beneficiaries need to control pain and manage symptoms. Specifically, CMS should:

- **Ensure that a physician is involved in the decisions to start and continue general inpatient care.** CMS should implement additional strategies to increase physician involvement and accountability so that beneficiaries get appropriate care. Increased physician involvement could also help minimize the amount of time a beneficiary is in pain or has other uncontrolled symptoms.

The interdisciplinary group, which includes the physician, is required to review and revise the patient's plan of care as frequently as the patient's condition requires. However, the care-planning process, which OIG found lacking, does not offer sufficient safeguards against inappropriate use of general inpatient care. Another safeguard could be requiring the hospice to obtain a physician's order to change the level of care to general inpatient care and including the ordering physician's National Provider Identifier on the hospice claim. The hospice could also have the physician sign off on the level of care at reasonable intervals during the general inpatient care stay. These intervals should be determined by CMS. Making the physician more accountable and requiring some record of the physician's involvement would help ensure that care is appropriate; it could also improve the quality of care.

Strengthen oversight of hospices to reduce inappropriate billing

To reduce inappropriate billing, CMS must strengthen its oversight of hospices. Our work has identified certain hospice claims that are particularly vulnerable to abuse. CMS should increase oversight of these claims, targeting them for additional reviews. Specifically, we recommend that CMS:

- **Analyze claims data to identify hospices that engage in practices or have characteristics that raise concerns.** CMS has made some progress in identifying hospices that depend heavily on nursing facility residents. CMS should continue and

expand these efforts to include hospices that target beneficiaries in ALFs, those with a high percentage of beneficiaries with diagnoses that require less complicated care, and those that do not provide all levels of hospice care.

- **Take appropriate actions to follow up with hospices that engage in practices or have characteristics that raise concerns.** That is, after these hospices are identified, CMS should initiate probe and educate reviews, provide education, conduct prepayment reviews, make referrals to law enforcement or Recovery Auditors, or take other appropriate actions.
- **Increase oversight of general inpatient care claims and focus particularly on general inpatient care provided in SNFs, given the higher rate at which these stays were inappropriate.**
- **Implement a comprehensive prepayment review strategy to address lengthy general inpatient care stays so that beneficiaries do not have to endure unnecessarily long periods of time in which their pain and symptoms are not controlled.** The prepayment reviews of lengthy general inpatient care stays that CMS contractors have conducted and plan to conduct are limited. CMS should strengthen its use of this tool by providing additional direction to their contractors to make these reviews more comprehensive and effective. This could include setting minimum thresholds to ensure that contractors review a sufficient number of hospices and include a sufficient number of claims in those reviews. The reviews should determine whether general inpatient care was appropriate for each day of the stay or if another level of care was more appropriate. The contractors should continue to use data analysis to target these reviews to stays most likely to be problematic. CMS should also set criteria for when and how contractors should take action based on the results of their reviews. Comprehensive prepayment reviews and appropriate followup will help promote effective symptom management and could reduce the time in which beneficiaries' pain and other symptoms are unmanaged.
- **Develop and execute a strategy to work directly with hospices to ensure that they are providing drugs covered under the hospice benefit as necessary and that the cost of drugs covered under the benefit are not inappropriately shifted to Part D.** CMS should target its interventions with hospices by reviewing Part D payments for drugs for hospice beneficiaries, focusing particularly on hospices that have beneficiaries with high numbers of Part D drugs or a high number of beneficiaries receiving Part D drugs. CMS described guidance it has given Part D plan sponsors to help them avoid paying claims that should be covered under the hospice benefit, which is also a helpful and important step. However, we recommend that CMS also intervene with hospices to ensure that they are providing the drugs covered under the hospice benefit as necessary so that these drugs are not inappropriately billed to Part D.

Take steps to tie payment to beneficiary care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs, seeking statutory authority if necessary

The current payment system is based on the beneficiary's time in care. It pays the hospice a daily rate regardless of how many services the beneficiary needs on a particular day. Also, the daily rate is the same regardless of where the beneficiary resides. For instance, the routine home care rate is the same for a beneficiary residing at home with no personal assistance or nursing services as it is for a beneficiary residing in an assisted living facility or nursing facility. Further, the payment system does not take into account the quality of care provided by hospices. There are no adjustments in overall payments, bonus payments, or other methods that tie quality to payment for hospices.

As a result, OIG found that the payment system creates financial incentives that raise a number of concerns, such as whether some hospices are serving only beneficiaries who offer the greatest financial gain, whether beneficiaries are being enrolled at the appropriate time, whether hospices are being paid the appropriate amount for the care they provide, and whether hospices have incentives to care for beneficiaries with greater needs.

Moreover, OIG found that some hospices have targeted certain beneficiaries who are likely to have long lengths of stay. OIG also found that some hospices typically provide less than 5 hours of visits per week and seldom provide services on weekends. These findings demonstrate that the payment system may not be aligned with beneficiaries' care needs and to providing appropriate and quality services. Opportunities exist to adjust the payment structure to promote quality of care and better ensure that beneficiaries, particularly those with greater needs, have access to appropriate care.

As discussed, CMS has made some changes to the payment system. These changes are aimed at addressing long lengths of stay and ensuring that care is provided in the last days of life. However, these changes do not address quality of care or whether payments are aligned with the beneficiary's needs outside of the last days. Specifically, CMS should:

- **Assess the current payment system to determine what changes may be needed to tie payments to beneficiaries' care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs.** As part of its assessment, CMS should determine the extent to which payments are aligned with beneficiaries' needs and not only to the services provided. It should also determine the extent to which the current payment system incentivizes hospices to provide appropriate care to beneficiaries, particularly those with greater needs, and the extent to which the payment system promotes quality care. In addition, CMS should assess the accuracy of hospice cost reports. CMS should use only reliable data sources in its analysis of the current payment system.
- **Adjust payments based on these analyses, if appropriate, to ensure that the payment system is aligned with beneficiary needs and quality of care.** CMS stated that it does not have the authority to adjust payments based on factors other than cost of services provided. Therefore, CMS may need to seek statutory authority to make adjustments to the payment system to ensure that eligible beneficiaries who choose to elect hospice care receive appropriate services.

-
- **Modify the payments for hospice care in nursing facilities.** Adjustments should account for setting, which may affect care needs. Notably, nursing facilities are required to provide personal care services, which are similar to hospice aide services that are paid for under the hospice benefit. Therefore, hospice beneficiaries in a nursing facility would likely need fewer hospice aide services than hospice beneficiaries at home. Also, the cost to the hospice of providing aide services to beneficiaries in nursing facilities may be less than the cost of providing these services to beneficiaries at private homes because an aide can visit multiple beneficiaries in a facility without having to travel to different locations. For these reasons, the payment rate for routine home care in nursing facilities should be reduced when appropriate. As noted earlier, CMS may need to seek statutory authority to make these changes.

Address additional recommendations contained in prior OIG reports

OIG has also made other recommendations in prior work that remain unimplemented. See Appendix C for a list of these recommendations and the related OIG reports.

AGENCY COMMENTS AND OIG RESPONSE

In our draft report to CMS, we recommended 16 specific actions. CMS concurred with six recommendations, did not concur with nine, and neither concurred nor nonconcurred with one. We considered CMS's comments carefully, and we clarified and combined two of our recommendations. We remain committed to our recommendations and will continue to work with CMS to promote their implementation.

Recommendations to strengthen the survey process

CMS did not concur with the two recommendations to strengthen the survey process. Specifically, CMS did not concur with the recommendations to analyze claims and deficiency data to inform the survey process. Regarding claims data, CMS stated that surveyors do not determine the medical necessity of the services provided and are not an extension of the audit process. Regarding deficiency data, CMS stated that surveyors review previous complaint allegations and investigations and previous survey findings and CMS does not believe additional actions are necessary.

OIG notes that the survey process is critical to promoting compliance and patient care, and we agree with CMS that surveys help ensure that hospices provide all required services and meet all conditions of participation. As we have shown in our work, claims data are key to understanding how the hospice program is working and are useful for many purposes in addition to auditing. For example, we identified hospices that do not provide all levels of care, or rarely provide care on weekends. CMS has also recognized the importance of claims data and has committed to developing claims-based quality measures. As these examples demonstrate, claims data offer a wealth of information that surveyors could use to make the survey process more effective.

In addition, we have found persistent problems in certain areas, such as care planning, that the survey process has not adequately addressed. Deficiency data give valuable insights into these persistent problems. Using deficiency data effectively to inform the survey process could promote hospice compliance, particularly in problem areas. Additionally, deficiency data are crucial to understanding how well hospices are caring for beneficiaries. Given the importance of these data, OIG is conducting further work on the nature and extent of hospice deficiencies and complaints.

Recommendation to establish additional remedies for poor performance

CMS neither concurred nor nonconcurred with the recommendation to seek statutory authority to establish additional remedies for hospices with poor performance. CMS stated that it will consider this recommendation when developing requests for the President's Budget.

Recommendations to develop and disseminate additional information on hospices

CMS concurred with the recommendation to develop other claims-based information and include it on the Hospice Compare website. CMS stated that it continues to develop claims-based quality measures, including potentially avoidable hospice care transitions and access to levels of hospice care.

CMS did not concur with the recommendation to include on Hospice Compare deficiency data from surveys, including information about complaints filed and resulting deficiencies. CMS stated that it is prohibited from publicly releasing information on any surveys performed by accrediting organizations unless the information relates to an enforcement determination. CMS further noted that the information

on this issue would therefore be skewed, and users would be selecting hospices based on lack of information that favors hospices that use accrediting organizations. CMS also stated that it has made information from surveys performed by State agencies publicly available.

OIG continues to stress the importance of providing data to consumers to help them make informed choices. We recognize the constraints in providing the data from the accrediting organizations. As a first step, however, CMS should provide publicly in a consumer-friendly and readily accessible way the data that it can release. We note that complaint information and resulting deficiencies from State surveyors—who investigate certain complaints from all hospices—are available for all hospices. Also, to address uneven data, CMS could post an explanation about why similar information is not available for certain hospices.

Recommendation to educate beneficiaries and their families and caregivers

CMS concurred with the recommendation to work with its partners to make available information explaining the hospice benefit. CMS stated that it has developed informational resources and will work to ensure that these resources are easily accessible to families and caregivers who may benefit from learning about the hospice benefit.

Recommendation to promote physician involvement and accountability

CMS did not concur with the two recommendations to promote physician involvement and accountability. Specifically, CMS did not concur with the recommendations to require that hospices obtain a physician's order to change the level of care to general inpatient care and have the physician sign off on general inpatient care at reasonable intervals. CMS stated that the hospice interdisciplinary group, which includes a physician, is required to approve general inpatient care and document this approval in the medical record.

The goal of these recommendations is to increase physician involvement and accountability to ensure appropriate care for beneficiaries. They could also help minimize the amount of time a beneficiary is in pain or has other uncontrolled symptoms. To keep the focus on this broader goal, we combined the recommendations and are open to alternative ways of achieving it. As we note in the report, the care-planning process—which OIG found to have persistent problems—does not offer sufficient safeguards against inappropriate use of general inpatient care or against poor quality care.

Recommendations to strengthen oversight of hospices

CMS concurred with four of the five recommendations to strengthen oversight of hospices. Specifically, CMS concurred with the recommendations to analyze claims data to identify hospices that engage in practices or have characteristics that raise concerns and to take appropriate actions to follow up with these hospices. CMS also concurred with the recommendation to increase oversight and focus particularly on general inpatient care provided in SNFs. In addition, CMS concurred with the recommendation to implement a comprehensive prepayment review strategy to address lengthy general inpatient care stays so that beneficiaries do not have to endure unnecessarily long periods of time in which their pain and symptoms are not controlled. CMS stated that its contractors conduct prepayment reviews of lengthy general inpatient care stays in hospices that have been found to have high amounts of these stays and recoup any overpayments found as a result of these reviews.

Regarding Part D drugs, CMS did not concur with the recommendation to develop and execute a strategy to work directly with hospices to ensure that they are providing drugs covered under the hospice benefit as necessary. CMS noted that it has directed certain plan sponsors to conduct audits for payments made

for beneficiaries who are enrolled in hospice care to ensure that payments are made appropriately. OIG notes that while working with Part D plan sponsors is an important step, working directly with hospices to ensure that they are providing the drugs covered under the hospice benefit as necessary is also a key part of oversight.

Recommendations to take steps to tie payment to beneficiary care needs and quality of care

CMS did not concur with the three recommendations about hospice payments. Specifically, CMS did not concur with the first two recommendations to assess the current payment system and to adjust payments based on these analyses, if appropriate, to ensure that the payment system is aligned with beneficiary needs and quality of care. CMS stated that it has reformed the hospice payment system to more appropriately pay hospices for the cost of providing care to beneficiaries and better align payment with beneficiary care needs during the course of a hospice stay. CMS also stated that it is required to pay hospice providers based on the costs they incur when providing care.

The current payment system is based on the beneficiary's time in care, and OIG remains concerned about whether hospices are being paid the appropriate amount for the care they provide and whether hospices are appropriately meeting beneficiaries' care needs. CMS's changes to the payment system did not link payments to the quality of care provided by hospices or to beneficiaries' care needs outside the last days of life. Opportunities exist to assess the current payment system and to make adjustments, if appropriate, to align with beneficiary needs and the quality of care; such changes may require new statutory authority.

CMS did not concur with the third recommendation to modify the payments for hospice care in nursing facilities. CMS stated that its analysis of hospice claims data demonstrated that patients residing in nursing facilities receive more visits than patients residing at home and thus the data did not support reducing the routine home care payment rate to differentiate payments based on site of service.

OIG continues to recommend that the payment rate for routine home care in nursing facilities should be reduced when appropriate. Nursing facilities are required to provide personal care services, which are similar to hospice aide services that are paid for under the hospice benefit. Therefore, hospice beneficiaries in nursing facilities would likely need fewer hospice aide services than hospice beneficiaries at home. We note that the data CMS provided also indicate that hospice visits to beneficiaries in nursing facilities were shorter than hospice visits to beneficiaries at home. Also, the cost to the hospice of providing aide services to beneficiaries in nursing facilities may be less than the cost of providing these services to beneficiaries at private homes because an aide can visit multiple beneficiaries in a facility without having to travel to different locations. CMS may need to seek statutory authority to make these changes. For the full text of CMS's comments, see Appendix D.

APPENDIX A: Key Recommendations to Improve the Medicare Hospice Program

Recommendations to CMS	
Strengthen the survey process to better ensure that hospices provide beneficiaries with needed services and quality care	
1. Analyze claims data to inform the survey process	
2. Analyze deficiency data to inform the survey process	
Seek statutory authority to establish additional remedies for hospices with poor performance	
3. Seek statutory authority to establish additional, intermediate remedies for poor hospice performance	
Develop and disseminate additional information on hospices to help beneficiaries and their families and caregivers make informed choices about their care	
4. Develop other claims-based information and include it on Hospice Compare*	
5. Include on Hospice Compare deficiency data from surveys, including information about complaints filed and resulting deficiencies	
Educate beneficiaries and their families and caregivers about the hospice benefit	
6. Work with its partners, such as hospitals and caregiver groups, to make available consumer-friendly information explaining the hospice benefit to beneficiaries and their families and caregivers*	
Promote physician involvement and accountability to ensure that beneficiaries get appropriate care	
7. Ensure that a physician is involved in the decisions to start and continue general inpatient care	
Strengthen oversight of hospices to reduce inappropriate billing	
8. Analyze claims data to identify hospices that engage in practices or have characteristics that raise concerns*	
9. Take appropriate actions to follow up with hospices that engage in practices or have characteristics that raise concerns*	
10. Increase oversight of general inpatient care claims and focus particularly on general inpatient care provided in SNFs, given the higher rate at which these stays were inappropriate*	
11. Implement a comprehensive prepayment review strategy to address lengthy general inpatient care stays so that beneficiaries do not have to endure unnecessarily long periods of time in which their pain and symptoms are not controlled*	
12. Develop and execute a strategy to work directly with hospices to ensure that they are providing drugs covered under the hospice benefit as necessary and that the cost of drugs covered under the benefit are not inappropriately shifted to Part D	
Take steps to tie payment to beneficiary care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs, seeking statutory authority if necessary	
13. Assess the current payment system to determine what changes may be needed to tie payments to beneficiaries' care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs	
14. Adjust payments based on these analyses, if appropriate, to ensure that the payment system is aligned with beneficiary needs and quality of care	
15. Modify the payments for hospice care in nursing facilities	

* Indicates that CMS concurred.

APPENDIX B: List of Related OIG Reports

Report	Issue Date
Hospices Should Improve Their Election Statements and Certifications of Terminal Illness (OEI-02-10-00492)	September 2016
Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care (OEI-02-10-00491)	March 2016
Hospice of New York, LLC, Improperly Claimed Medicare Reimbursement for Some Hospice Services (A-02-13-01001)	June 2015
Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities (OEI-02-14-00070)	January 2015
The Community Hospice, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services (A-02-11-01016)	September 2014
Servicios Suplementarios de Salud, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services (A-02-11-01017)	August 2014
Frequency of Medicare Recertification Surveys for Hospices Is Unimproved (OEI-06-13-00130)	August 2013
Medicare Hospice: Use of General Inpatient Care (OEI-02-10-00490)	May 2013
Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice (A-06-10-00059)	June 2012
Medicare Hospices that Focus on Nursing Facility Residents (OEI-02-10-00070)	July 2011
Questionable Billing for Physician Services for Medicare Beneficiaries (OEI-02-06-00224)	September 2010
Medicare Hospice Care for Beneficiaries Residing in Nursing Homes: Compliance with Medicare Coverage Requirements (OEI-02-06-00221)	September 2009
Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities (OEI-02-06-00223)	September 2009
Hospice Beneficiaries' Use of Respite Care (OEI-02-06-00222)	March 2008
Medicare Hospice Care: Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings (OEI-02-06-00220)	December 2007
Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight (OEI-06-05-00260)	April 2007

APPENDIX C: List of Additional Recommendations from Prior Reports*

Provide guidance to hospices regarding the effects on beneficiaries when they revoke their election and when they are discharged from hospice care (*Hospices Should Improve Their Election Statements and Certifications of Terminal Illness*, [OEI-02-10-00492](#)). (CMS did not concur.)

Follow up on inappropriate general inpatient care stays and hospices that provided poor-quality care (*Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care*, [OEI-02-10-00491](#)). (CMS concurred.)

* This list does not include overpayment recovery recommendations included in some OIG reports.

APPENDIX D: Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: MAY 17 2018

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verna
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio (OEI-02-16-00570)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to ensuring that the Medicare hospice program provides quality care safe from fraud, waste, and abuse.

State agencies and national accrediting organizations are required to conduct surveys of hospices to ensure they provide all required services and meet all hospice conditions of participation before hospices are certified for participation in Medicare and at least every three years¹ thereafter. CMS has worked to strengthen and improve hospice surveys to ensure that beneficiaries receive quality care. For example, CMS regularly provides training for hospice surveyors to ensure they are familiar with certification requirements. Recent surveyor training has focused on care planning requirements in response to OIG concerns that surveyors were not adequately focusing on this issue in their surveys.

In addition, CMS has worked to follow up on hospices that OIG has referred to CMS for specific reasons by instructing state survey agencies to have their surveyors place an emphasis on election statements and certification of terminal illness at the time of the next scheduled survey. Evaluation of quality of care is the major emphasis for all hospice surveys. Although CMS is statutorily prohibited from publicly releasing information on any surveys performed by accrediting organizations unless the information relates to an enforcement determination², CMS has made information from surveys performed by state agencies publicly available.³

CMS has also focused on the integrity of the hospice benefit and strengthened its monitoring of hospice claims. CMS has initiated prepayment medical review, including targeted probe and educate reviews, of hospice services from certain providers. CMS has also enhanced monitoring

¹ 42 U.S.C. § 1395x(dd)(4)(C). The 36 month survey frequency requirement ends on September 30, 2025.

² 42 U.S.C. § 1395bb(b)

³ <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/2567report.html>

of hospices that depend heavily on nursing facility residents and is in the process of recouping payments for inappropriate general inpatient care stays in response to OIG concerns.

CMS has taken several steps to educate beneficiaries and caregivers about the hospice benefit and help individuals choose the right hospice. CMS has developed informational resources explaining the hospice benefit and disseminated them to providers and the public.⁴ In August 2017, CMS launched Hospice Compare, a website that reports information on hospices across the nation and allows patients, family members, and health care providers to get a snapshot of the quality of care each hospice provides.⁵ Users can compare hospices based on a national survey that rates family members' experiences with hospice care or on important indicators of quality, like the percentage of patients checked for pain or who are asked about their preferences for life-sustaining treatment.

CMS also continues to develop claims-based quality measures, including potentially avoidable hospice care transitions and access to levels of hospice care. Potentially avoidable hospice care transitions at end of life are associated with adverse health outcomes, lower patient and family satisfaction, higher health care costs, and fragmentation of care delivery. Appropriate use of different levels of hospice care increases the likelihood of patients dying in their location of choice, decreases costs, and increases patient and caregiver satisfaction.

In addition, CMS has reformed the hospice payment system to more appropriately reimburse hospices for the cost of providing care to beneficiaries. Effective January 1, 2016, CMS implemented the creation of two routine home care rates for hospice care – a higher rate for days 1-60 and a lower rate for days 61 and beyond – as well service intensity add-on payments for registered nurse and social work visits during the last seven days of life. CMS believes these reforms will reduce the incentives for hospices to target beneficiaries likely to have long lengths of stay. CMS is required by statute to pay hospice providers based on the costs they incur when providing care and does not have authority to tie payment to quality of care.⁶

OIG's recommendations and CMS' responses are below.

OIG Recommendation

Analyze claims data to inform the survey process.

CMS Response

CMS does not concur with OIG's recommendation. Surveyors evaluate the care provided in hospice as compared to the care indicated and ordered. They do not determine the medical necessity of the services provided and are not an extension of the audit process.

OIG Recommendation

Analyze deficiency data to inform the survey process.

CMS Response

⁴ Medicare Hospice Benefits - <https://www.medicare.gov/Pubs/pdf/002154-Medicare-Hospice-Benefits.PDF>
Medicare & Hospice Benefits Getting Started - <https://www.medicare.gov/Pubs/pdf/11361-Medicare-Hospice-Getting-Started.pdf>

Hospice and Respite Care - <https://www.medicare.gov/coverage/hospice-and-respite-care.html>

How Hospice Works - <https://www.medicare.gov/what-medicare-covers/part-a/how-hospice-works.html>

⁵ <https://www.medicare.gov/hospicecompare/>

⁶ 42 U.S.C. § 1395f(i)

CMS does not concur with OIG's recommendation. When a surveyor cites a deficiency, the provider submits a plan for correction and the surveyor performs a visit or desk audit to ensure correction. In addition, surveyors review previous complaint allegations and investigations and previous survey findings before they begin a survey. Given the steps CMS already takes to use deficiency data to inform the survey process, CMS does not believe additional actions are necessary.

OIG Recommendation

Seek statutory authority to establish additional remedies for hospices with poor performance.

CMS Response

CMS will consider this recommendation when developing requests for the President's Budget.

OIG Recommendation

Develop other claims-based information and include it on the hospice compare website.

CMS Response

CMS concurs with OIG's recommendation. As stated above, CMS continues to develop claims-based quality measures, including potentially avoidable hospice care transitions and access to levels of hospice care.

OIG Recommendation

Include on the hospice compare website deficiency data from surveys, including information about complaints filed and resulting deficiencies.

CMS Response

CMS does not concur with OIG's recommendation. As mentioned above, CMS is statutorily prohibited from publicly releasing information on any surveys performed by accrediting organizations unless the information relates to an enforcement determination. In FY15, 40 percent of hospice surveys were performed by these organizations and could not be included on Hospice Compare. The information section on this issue would therefore be skewed, and users would be selecting hospices based on lack of information that favors hospices that use accrediting organizations. This does not accord with CMS' goals for providing useful information in a consumer-friendly manner. As stated above, CMS has made information from surveys performed by state agencies publicly available.

OIG Recommendation

Work with partners, such as hospitals and caregiver groups, to make available consumer-friendly information explaining the hospice benefit to beneficiaries and their families and caregivers.

CMS Response

CMS concurs with OIG's recommendation. As stated above, CMS has developed informational resources to educate beneficiaries and their families and caregivers about the hospice benefit. CMS will work to ensure that these resources are easily accessible to families and caregivers who may benefit from learning about the hospice benefit.

OIG Recommendation

Require that hospices obtain a physician's order to change the level of care to general inpatient care.

CMS Response

CMS does not concur with OIG's recommendation. Currently, the hospice interdisciplinary group (composed of a physician, nurse, social worker and counselor), is required to approve general inpatient care (GIP) and document this approval in the medical record.⁷ This recommendation would add an additional layer of requirements without necessarily leading to increased compliance.

OIG Recommendation

Require that hospices have the physician sign off on general inpatient care at reasonable intervals that are determined by CMS.

CMS Response

CMS does not concur with OIG's recommendation. As stated above, the interdisciplinary group is required to approve GIP and document this approval in the medical record. CMS works to balance the burden placed on providers through program requirements and this recommendation would add an additional layer of requirements without necessarily leading to increased compliance.

As stated below, CMS will increase postpayment review of GIP claims and currently CMS contractors conduct prepayment reviews of lengthy GIP claims. Of note, in Fiscal Year 2016, only 1.49 percent of all hospice days were billed as GIP. Of those GIP stays, 50 percent lasted fewer than three days and 70 percent fewer than seven days.

OIG Recommendation

Analyze claims data to identify hospices that engage in practices or have characteristics that raise concerns.

CMS Response

CMS concurs with OIG's recommendation. CMS will work to identify and take appropriate actions to follow up with hospices that have raised concern.

OIG Recommendation

Take appropriate actions to follow up with hospices that engage in practices or have characteristics that raise concerns.

CMS Response

CMS concurs with OIG's recommendation. As stated above, CMS will work to identify and take appropriate actions to follow up with hospices that have raised concern.

OIG Recommendation

Increase oversight of general inpatient care claims and particularly focus on general inpatient care provided in SNFs given the higher rate at which these stays were inappropriate.

CMS Response

CMS concurs with OIG's recommendation. CMS will work to increase oversight of general inpatient care through postpayment review.

OIG Recommendation

Implement a comprehensive prepayment review strategy to address lengthy GIP stays so that beneficiaries do not have to endure unnecessarily long periods of time in which their pain and symptoms are not controlled.

⁷ 42 C.F.R. § 418.56

CMS Response

CMS concurs with OIG's recommendation. CMS' contractors currently conduct prepayment reviews of lengthy GIP stays in hospices that have been found to have high amounts of these stays and recoup any overpayments found as a result of these reviews. CMS notes that CMS medical review, including prepayment review, determines whether these stays were reasonable and necessary and met payment criteria. CMS' contractors design their program integrity activities to most effectively target the highest-priority issues in their jurisdictions given their limited resources. CMS will support the program integrity activities our contractors identify that best meet CMS' goals for the program.

OIG Recommendation

Develop and execute a strategy to work directly with hospices to ensure that they are providing drugs covered under the hospice benefit as necessary and that the cost of drugs covered under the benefit are not inappropriately shifted to Part D.

CMS Response

CMS does not concur with OIG's recommendation. CMS has oversight authority over Medicare Part D plan sponsors. CMS has directed certain plan sponsors to conduct audits for payments made for beneficiaries who are enrolled in hospice care to ensure that payments are made appropriately. CMS will continue its efforts to work with plan sponsors to address this issue.

OIG Recommendation

Assess the current payment system to determine what changes may be needed to tie payments to beneficiaries' care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs.

CMS Response

CMS does not concur with OIG's recommendation. As stated above, CMS has reformed the hospice payment system to more appropriately pay hospices for the cost of providing care and better align payment with beneficiary care needs during the course of a hospice stay. CMS is required by statute to pay hospice providers based on the costs they incur when providing care.

OIG Recommendation

Adjust payments based on these analyses, if appropriate, to ensure that the payment system is aligned with beneficiary needs and quality of care.

CMS Response

CMS does not concur with OIG's recommendation. As stated above, CMS has reformed the hospice payment system to more appropriately pay hospices for the cost of providing care to beneficiaries and better align payment with beneficiary care needs during the course of a hospice stay. CMS is required by statute to pay hospice providers based on the costs they incur when providing care.

OIG Recommendation

Modify the payments for hospice care in nursing facilities.

CMS Response

CMS does not concur with OIG's recommendation. CMS has previously considered the OIG recommendation to reduce payments to Medicare hospices for beneficiaries in nursing facilities who are receiving hospice care. However, analysis of hospice claims data demonstrated that

patients residing in nursing facilities receive more visits than patients residing at home and thus the data did not support reducing the routine home care payment rate to differentiate payments based on site of service.⁸ CMS has also enhanced monitoring of hospices that depend heavily on nursing facility residents.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

⁸ 78 FR 48234, at 48273 (Aug. 7, 2013), Final Rule, "Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform"

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To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

ENDNOTES

¹ Medicare has two annual caps on hospice reimbursement. The first cap limits the total number of days of inpatient care that a hospice may provide to 20 percent of the hospice's total patient care days. See Social Security Act, § 1861(dd)(2)(A)(iii); 42 CFR § 418.302(f). Inpatient care includes two of the four levels of hospice care: general inpatient care and inpatient respite care. The second cap limits the total reimbursement that a hospice may receive in a given year. The total annual payments to a hospice may not exceed a set per-patient amount multiplied by the number of beneficiaries who elected to receive hospice care from that hospice during the annual cap period. See Social Security Act, § 1814(i)(2); 42 CFR § 418.309. The 2017 cap amount is \$28,404.99. See CMS, Update to Hospice Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2018, Transmittal R3828CP, Change Request 10131, August 4, 2017. Accessed at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10131.pdf> on January 31, 2018.

² The rates for each level of care are the unadjusted daily Medicare hospice payment rates for FY 2017. Rates are adjusted on the basis of the beneficiary's geographic location. See CMS, MLN Matters, "Updates to the Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for Fiscal Year 2017," MM9729, July 8, 2016. Accessed at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9729.pdf> on January 26, 2018.

³ The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds*, p. 10. Accessed at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf> on November 22, 2017. See also, The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds*, p. 5. Accessed at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2007.pdf> on November 22, 2017.

⁴ Social Security Act, § 1861(dd); 42 CFR part 418.

⁵ OIG, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance With Medicare Coverage Requirements*, OEI-02-06-00221, September 2009.

⁶ OIG, *Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

⁷ 42 CFR § 418.302(b)(4).

⁸ OIG, *Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

⁹ *Ibid.*

¹⁰ *Ibid.*

¹¹ 42 CFR § 418.200.

¹² 42 CFR § 418.56(c)(2).

¹³ OIG, *Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

¹⁴ OIG, *Medicare Hospice Care for Beneficiaries In Nursing Facilities: Compliance with Medicare Coverage Requirements*, OEI-02-06-00221, September 2009.

¹⁵ OIG, *Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

¹⁶ OIG, *Medicare Hospice: Use of General Inpatient Care*, OEI-02-10-00490, May 2013. Updated OIG analysis, August 2017.

¹⁷ 42 CFR § 418.302(b).

¹⁸ Social Security Act, § 1861(dd)(1); 42 CFR §§ 418.64, 418.108 and 418.204.

¹⁹ 42 CFR § 418.304. The daily rate paid to hospices covers general supervisory services and plan of care services by hospice physicians, not visits.

²⁰ 42 CFR § 418.302(b)(4).

²¹ Social Security Act, §§ 1812(d)(2)(A) and 1861(dd)(1); 42 CFR § 418.24(d). CMS has developed the Medicare Care Choices Model, a demonstration program that will allow certain beneficiaries who are eligible for the hospice benefit but not enrolled to receive palliative care services from certain hospice providers while concurrently receiving services provided by their curative care providers. The model will enable CMS to study whether access to such services improves quality of life, increases patient satisfaction, and reduces Medicare expenditures. See CMS, *Medicare Care Choice Model*. Accessed at <https://innovation.cms.gov/initiatives/Medicare-Care-Choices/> on January 26, 2018.

²² Department of Justice (DOJ), “Cleveland Woman Sentenced for Hospice Fraud,” December 14, 2015. Accessed at <https://www.justice.gov/usao-ndms/pr/cleveland-woman-sentenced-hospice-fraud> on August 28, 2017.

²³ DOJ, “Minnesota-Based Hospice Provider to Pay \$18 Million for Alleged False Claims to Medicare for Patients Who Were Not Terminally Ill,” July 13, 2016. Accessed at <https://www.justice.gov/opa/pr/minnesota-based-hospice-provider-pay-18-million-alleged-false-claims-medicare-patients-who> on August 28, 2017.

²⁴ DOJ, “Pasadena Doctor Sentenced to 4 Years in Prison for Falsely Certifying Patients Were Terminally Ill as Part of Healthcare Fraud Scheme,” August 19, 2016. Accessed at <https://www.justice.gov/usao-cdca/pr/pasadena-doctor-sentenced-4-years-prison-falsely-certifying-patients-were-terminally> on December 20, 2017.

²⁵ Social Security Act § 1814(i)(5).

²⁶ CMS, *Public Reporting: Background and Announcements*. Accessed at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Public-Reporting-Background-and-Announcements.html> on March 22, 2018. See also, CMS, *Current Measures*. Accessed at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html> on March 21, 2018.

²⁷ 42 CFR §§ 401.133(a) and 401.130(b)(17).

²⁸ OIG, *Hospices Should Improve Their Election Statements and Certifications of Terminal Illness*, OEI-02-10-00492, September 2016. The election statements were collected for an OIG study that focused on general inpatient care, but these documents are for the hospice benefit as a whole and are not specific to any level of care.

²⁹ CMS, MLN Matters, “Sample Hospice Election Statement,” SE1631, December 13, 2016. Accessed at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1631.pdf> on January 3, 2018.

³⁰ OIG, *Hospice of New York, LLC, Improperly Claimed Medicare Reimbursement for Some Hospice Services*, A-02-13-01001, June 2015; OIG, *The Community Hospice, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services*, A-02-11-01016, September 2014; OIG, *Servicios Suplementarios de Salud, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services*, A-02-11-01017, August 2014.

³¹ OIG, *Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

³² These are the unadjusted daily payment rates for FY 2012. CMS, MLN Matters, “Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and the Hospice Pricer for FY 2012,” Transmittal 2260, Change Request 7518, July 29, 2011. Accessed at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7518.pdf> on March 25, 2015.

³³ Ibid.

³⁴ OIG, *Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

³⁵ Ibid.

³⁶ OIG, *Hospice of New York, LLC, Improperly Claimed Medicare Reimbursement for Some Hospice Services*, A-02-13-01001, June 2015.

³⁷ OIG, *Servicios Suplementarios de Salud, Inc., Improperly Claimed Medicare Reimbursement for Some Hospice Services*, A-02-11-01017, August 2014.

³⁸ 42 CFR §418.202 (f). Drugs that are unrelated to the beneficiary’s terminal illness and related conditions may be covered under Part D.

³⁹ OIG, *Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice*, A-06-10-00059, June 2012.

⁴⁰ OIG, *Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care*, OEI-02-10-00491, March 2016.

⁴¹ In recent guidance, CMS has encouraged Part D sponsors to place beneficiary-level prior authorization requirements on analgesic, anti-nausea, laxative, or anti-anxiety drugs for hospice beneficiaries because they are commonly used in hospice care and hospices are expected to provide them. See CMS, "Part D Payment for Drugs for Beneficiaries Enrolled in Medicare Hospice," July 18, 2014. Accessed at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2014-PartD-Hospice-Guidance-Revised-Memo.pdf> on September 13, 2017.

⁴² OIG, *Questionable Billing for Physician Services for Hospice Beneficiaries*, OEI-02-06-00224, September 2010.

⁴³ Some physician services provided to hospice beneficiaries may be billed through Part B if the physician is not a hospice employee or providing services under arrangements with the hospice. If it is billed through Part B, the service should not also be billed through Part A.

⁴⁴ Social Security Act, §§ 1812(a)(4) and 1814(a)(7)(A), 42 U.S.C § 1395d(a)(4). Beneficiaries who elect hospice care are entitled to receive care for two 90-day periods, followed by an unlimited number of 60-day periods. Before 1990, hospice beneficiaries who were in hospice care for more than 210 days and still required such care were provided care by the hospice without charge to Medicare or the beneficiary.

⁴⁵ 42 CFR § 418.22(b).

⁴⁶ OIG, *Hospices Should Improve Their Election Statements and Certifications of Terminal Illness*, OEI-02-10-00492, September 2016. The certifications of terminal illness were collected for an OIG study that focused on general inpatient care, but these documents are for the hospice benefit as a whole and are not specific to any level of care.

⁴⁷ DOJ, "Director of Lisle-Based Hospice Company Convicted in Scheme to Fraudulently Bill Medicare for Medically Unnecessary Services," March 9, 2016. Accessed at <https://www.justice.gov/usao-ndil/pr/director-lisle-based-hospice-company-convicted-scheme-fraudulently-bill-medicare-0> on September 29, 2017.

⁴⁸ DOJ, "Former Hospice Owner Sentenced for Health Care Fraud," February 1, 2012. Accessed at <https://www.justice.gov/archive/usao/aln/News/February%202012/February%201.%202012%20Hospice.html> on September 7, 2017.

⁴⁹ DOJ, "Greenwood Woman Sentenced for Millions in Hospice Fraud," December 19, 2014. Accessed at <https://www.justice.gov/usao-ndms/pr/greenwood-woman-sentenced-millions-hospice-fraud> on October 13, 2017. See also, DOJ, "Delta Woman Sentenced in Connection with Hospice Fraud," February 13, 2015. Accessed at <https://www.justice.gov/usao-ndms/pr/delta-woman-sentenced-connection-hospice-fraud> on May 26, 2016.

⁵⁰ Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Medicare Payment Policy*, March 2017, ch. 12, p. 320. Accessed at http://www.medpac.gov/docs/default-source/reports/mar17_entirereport.pdf?sfvrsn=0 on May 5, 2017.

⁵¹ Some adjustments are made based on geography to account for differences in wage rates among markets. 42 CFR § 418.306(c).

⁵² Patient Protection and Affordable Care Act, P.L. 111-148 § 3132(a).

⁵³ 80 Fed. Reg. 47141 (Aug. 6, 2015).

⁵⁴ OIG, *Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities*, OEI-02-14-00070, January 2015.

⁵⁵ OIG, *Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities*, OEI-02-06-00223, September 2009.

⁵⁶ 42 CFR § 418.100(c)(2).

⁵⁷ OIG, *Medicare Hospice: Use of General Inpatient Care*, OEI-02-10-00490, May 2013.

⁵⁸ OIG, *Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities*, OEI-02-14-00070, January 2015.

⁵⁹ For beneficiary's time in hospice care from 2007 to 2012.

⁶⁰ The International Classification of Diseases, 9th Revision, Clinical Modification, categorizes several diagnoses as "symptoms, signs, or ill-defined conditions." This report referred to all diagnoses listed under "symptoms, signs, or ill-defined conditions" as "ill-defined conditions."

⁶¹ OIG, *Medicare Hospices That Focus on Nursing Facility Residents*, OEI-02-10-00070, July 2011.

⁶² Ibid.

⁶³ MedPAC, "Hospice services," March 2017, ch. 12, p. 337. Accessed at http://www.medpac.gov/docs/default-source/reports/mar17_medpac_ch12.pdf?sfvrsn=0 on September 13, 2017.

⁶⁴ OIG, *OIG Work Plan*, 2017. Accessed at <https://oig.hhs.gov/reports-and-publications/archives/workplan/2017/hhs%20oig%20work%20plan%202017.pdf> on September 13, 2017.

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