OIG Portfolio Highlights Hospice Fraud and Quality-of-Care Concerns

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On July 31, 2018, the Office of Inspector General (“OIG”) of the U.S. Department of Health and Human Services released a portfolio titled “Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity” (“Portfolio”).

The Portfolio provides 15 recommendations to the Centers for Medicare & Medicaid Services (“CMS”) regarding hospice oversight based on a review of the Medicare hospice benefit and hospice care generally since 2005. Notably, the Office of Evaluation and Inspections conducted the study, as opposed to the Office of Audit Services, indicating that the study was a broad, investigative look into the hospice industry rather than a more focused review typical of an OIG audit assessment. The study examined prior OIG evaluations and audits of billing and quality of care, as well as investigations of hospice-related fraud cases.

The Portfolio highlights the growth of hospice utilization and reimbursement over the last decade, and describes OIG’s findings with respect to the adequacy and quality of hospice services provided to Medicare beneficiaries. The Portfolio also highlights the importance of providing adequate education to hospice patients and their families and caregivers about the CMS hospice benefit. While OIG acknowledges that not all hospice care facilities have the vulnerabilities identified in this Portfolio, it is important for stakeholders to review the concerns and recommendations expressed by OIG in the Portfolio in order to get a full picture of the government’s stance and to evaluate their services for any of the identified deficiencies that may subject them to enforcement risk.

This Client Alert provides key considerations that hospice stakeholders should take away from the Portfolio with respect to compliance, enforcement, and quality considerations.

1 A copy of the Portfolio is available at https://oig.hhs.gov/oei/reports/oei-02-16-00570.pdf.
Compliance and Enforcement Considerations

The Portfolio demonstrates continued scrutiny of hospice services by the government and represents a trend toward ongoing government enforcement against the hospice industry. Therefore, to mitigate risk, it is important that the hospice industry consider the government’s current focus, as outlined below, and incorporate mitigation efforts into corporate compliance programs. The key risk areas include the following:

Specific Service Considerations

The Portfolio focuses on the provision of, and billing for, varying levels of care as well as evaluation of the care setting. The Portfolio indicates that hospice providers performing solely routine services are under more intense scrutiny than hospice providers providing other levels of care. OIG highlights that between 2006 and 2016, hundreds of hospices provided only routine home care, the most basic level of care, to all of their beneficiaries served throughout the year. This trend is increasing over time. In 2016, over 650 hospices provided only routine home care, which is a 55 percent increase from 2011. When a hospice provider’s services are limited to routine home care, the government is concerned that beneficiaries might not have access to the more intensive services they need despite the obligation that hospice facilities provide all services necessary for the management of the patient’s illness and related conditions. The Portfolio emphasizes that it is critical that hospice providers also provide general inpatient care and continuous home care when patients need more intensive services. A failure to provide all levels of care to beneficiaries, as well as respite inpatient care to caregivers, could be problematic from the government’s perspective. Providers should incorporate awareness of the case mix into their compliance efforts.

OIG also identified significant inappropriate billing by hospices for services not meeting Medicare requirements for the level of care billed. Some hospices billed for inappropriate levels of care and for expensive levels of care that the patient did not need. Specifically, the Portfolio indicates that in 2012, hospices billed one-third of all general inpatient care stays inappropriately, costing Medicare over $250 million. General inpatient care is the second most expensive level of care, and hospices often billed for it when the beneficiary needed only routine home care. Hospices received an unadjusted daily fixed payment rate of $672 a day for inpatient care instead of $151 a day for routine home care.

A major takeaway from the Portfolio is OIG’s particular focus on for-profit hospices providing care to patients in skilled nursing facilities (“SNFs”) or assisted living facilities (“ALFs”). OIG maintains a skepticism toward for-profit hospices, and specifically identifies these hospice providers as potential bad actors. OIG highlights certain data points to support such skepticism, providing that, while for-profit hospices billed 41 percent of their general inpatient care stays inappropriately, nonprofit and government-owned hospices billed only 27 percent of their general inpatient stays inappropriately. Also, based on its findings, OIG stated that hospices were more likely to bill
inappropriately for general inpatient care provided in SNFs than in any other care setting. Moreover, OIG believes that hundreds of hospices targeted beneficiaries in certain care settings, such as ALFs, who have long lengths of stay in order to receive higher Medicare payments. Again, OIG specifically draws attention to for-profit hospices whose service and billing practices result in reimbursement levels of thousands of dollars more than nonprofit hospices per beneficiary in ALFs. Similarly, OIG believes that for-profit hospices also target beneficiaries in nursing facilities because these beneficiaries commonly have conditions associated with less complex care, longer stays, and more Medicare payments.

**Documentation**

Another area of focus in OIG’s recommendations is the adequacy of physician attestations, clinical documentation, financial records, and other documents that support claims for reimbursement. The study found that some hospice physicians are not meeting requirements when certifying beneficiaries. In particular, physicians did not explain their clinical findings or attest that their findings were based on their examination of the beneficiary or review of medical records. Relatedly, many physicians were found to have provided patients and their families with incomplete or inaccurate election statements resulting in a lack of clarity among beneficiaries, their families, and caregivers around what beneficiaries are entitled to receive or give up with the election of hospice services.

**Medical Necessity and Eligibility and Appropriateness of Benefits**

OIG also discovered a number of fraud schemes involving hospices inappropriately billing beneficiaries. For example, OIG identified fraud schemes in which hospice providers paid recruiters to target beneficiaries who were not eligible for hospice care and other schemes in which physicians falsely certified a patient’s eligibility for hospice care. Beneficiaries who are inappropriately enrolled in hospice care may unwittingly forgo needed treatment or will not have their services reimbursed as Medicare pays only for palliative care and not for curative treatment.

**Takeaway**

The key to mitigating the risks identified in the Portfolio and shielding hospice providers from government enforcement inquiries or actions is maintaining an effective corporate compliance program. Even if a hospice provider already has a compliance program in place, it must be reevaluated based on OIG’s recent findings. The compliance program should focus on ensuring that providers are providing the appropriate level of care in the appropriate care setting. Providers should provide the four levels of Medicare reimbursed hospice care based on each patient’s medical need and, when appropriate, regardless of reimbursement considerations. Physicians must accurately certify a beneficiary’s terminal illness and the appropriateness of hospice care. Consequently, hospices need to ensure that claims data is as accurate as possible. Hospices must
also make sure that proper education materials on the hospice benefit are provided to their patients and their caregivers.

OIG’s scrutiny remains focused on the for-profit hospice industry, but there still appears to be a disconnect between the expectations of enforcement authorities and actual practice of providers. It is expensive to build a top-quality compliance program and the providers that are able to do so are often the highest-performing for-profit hospices in terms of finances. This may explain the trend for small nonprofit, community hospices to be moving in the direction of selling to the top-performing for-profit systems. The small nonprofit hospices, which OIG indicates are not the bad actors, likely stretch limited resources to provide top-quality care while also maintaining the necessary compliance standards to mitigate risks. This is due to (1) the lack of resources to adequately manage staffing fluctuations (especially in rural areas), (2) the lack of market power or internal leadership for the negotiation of expensive but necessary electronic medical record systems and supplies, and (3) the very limited resources to implement robust compliance infrastructure, monitoring, and training.

Quality Program Considerations

A common thread woven throughout the Portfolio is the emphasis that OIG places on the need for increased attention to the quality of hospice care. In particular, OIG describes elements of hospice care where quality is lacking and attributes some specific quality issues to the current payment methodology used by Medicare for hospice services.

Elements of Hospice Care with Trends of Poor Quality

OIG described specific instances in which evaluations and investigations revealed that hospice services have fallen short of quality care. The Portfolio also notes instances of hospices consistently failing to provide the services identified in the patient’s plan of care. OIG stated that adherence to a plan of care for a beneficiary is crucial and that the plans should be individualized and detailed, especially with respect to the scope and frequency of needed services. OIG also provides examples of hospices failing to properly manage a beneficiary’s medication, leaving the beneficiary in pain for long periods of time. While the examples of hospices failing to provide quality care are concerning, it appears that these reports reflect isolated bad actors in the hospice industry. However, one wonders if the broader skepticism associated with hospice quality of care by OIG can be attributed to a difference in the understanding of disease progression and treatment alternatives.

Quality Issues Attributed to Payment Methodology

The Portfolio opines that Medicare’s current reimbursement methodology contributes to the issue of poor quality. The Medicare hospice benefit pays for every day that a patient is in care, as opposed to paying for specific services provided to beneficiaries. OIG
asserts that this payment methodology incentivizes hospices to provide sub-par services to patients because they will be paid the same rate regardless of (1) the quantity or quality of services provided, (2) the distribution of services on weekdays versus weekends, and (3) whether services are provided in a nursing facility or in a beneficiary’s home. OIG illustrates these points with data from 2012, showing that hospices typically provide less than five hours of visits per week, and that the visits were mainly from aides. Hospices in 2012 also provided significantly less services on the weekends, despite the fact that they are paid the same for each day of the week. It is not clear whether this reflects staffing challenges or if it even reflects an actual deviation from care standards.

OIG also expresses significant concern that payment for hospice care is not tied to any quality measures and recommends that CMS alter the system to tie payment to quality of care. Thus far, CMS has maintained that it does not have the statutory authority to introduce the quality measures that OIG suggests into the hospice payment methodology. However, the discord here could be an indication that a major hospice payment reform could be initiated in the future.

**Takeaway**

In light of the emphasis that OIG places on the quality of care throughout the Portfolio, hospice facilities should be proactive rather than reactive in building a robust quality-oriented program. Stakeholders should monitor the areas of concern identified by OIG and assess the status of these highlighted concerns in anticipation of their possible impact on payment in the future. Stakeholders should also conduct an assessment of their compliance programs to identify any areas of enforcement risk based on the concerns expressed by OIG in the Portfolio.

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This Client Alert was authored by Kathleen M. Premo, Francesca R. Ozinal, and Megan Robertson. For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.