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Eli's Hospice Insider

Compliance: OIG Takes Another Run At Hospice Program Integrity Recommendations

Watchdog agency reiterates advice to toughen surveys, implement alternative sanctions, and much more.

It was hospices' turn to be on the hot seat in the HHS Office of Inspector General's latest semiannual report to Congress.

In the report released Dec. 3, the OIG highlights not only multiple fraud cases resolved in the April 1 to Sept. 30 time period covered in the report, but also a July portfolio report on hospice program integrity.

The "OIG has identified significant vulnerabilities in the Medicare hospice program affecting quality of care and program integrity," the report stresses. The report "highlights key vulnerabilities and makes 15 recommendations for protecting beneficiaries and improving the program."

Among those recommendations are making intermediate sanctions available for surveyors to impose; requiring physicians to sign off on changing hospice levels of care; and potentially implementing a case mix system that could take into account the patient's place of residence (see more details and the other recommendations in Eli's HCW, Vol. XXVII, No. 30).

"Hospices do not always provide needed services to beneficiaries and sometimes provide poor quality care. Inappropriate billing and fraud by hospice providers cost Medicare hundreds of millions of dollars," the OIG slams in the report. And "the current payment system creates incentives for hospices to minimize their services and seek beneficiaries who have uncomplicated needs."

The OIG takes its hospice emphasis up a level of not only including the topic in its report, but also highlighting it in the accompanying press release. The problems it found "cost taxpayers hundreds of millions of dollars," the OIG stresses in the release.

Why the interest in hospice this time? "Hospice use has grown steadily over the past decade, with Medicare paying $16.7 billion for this care for 1.4 million beneficiaries in 2016," the OIG notes in the report. "Our findings make clear that more must be done to protect Medicare beneficiaries and the integrity of the program."

In addition to rehashing the portfolio report, the semiannual report singles out these cases:

Case #1: Caris Healthcare has agreed to pay $8.5 million to "resolve allegations that, from April 1, 2010, through December 31, 2013, Caris submitted false claims and improperly retained payments from Medicare for services provided to patients who were ineligible for hospice benefits because they were not terminally ill," the report says. Caris parent **National Healthcare Corp.** revealed a whistleblower lawsuit against the company over ineligible hospice patients in 2016 (see Eli's HCW, Vol. XXVI, No. 1). Tennessee-based Caris operates in Missouri, Tennessee, Virginia, Georgia, and South Carolina.

Case #2: The Senior Medicare Patrol project reported $2.0 million in expected Medicare recoveries, "which came primarily from one project that prompted law enforcement to open an investigation that resulted in a settlement with a hospice company," according to the report. The SMP recruits and trains retired professionals and other senior citizens to prevent, recognize, and report healthcare fraud, errors, and abuse, the OIG notes. In 2017, the 53 SMP projects had a total of 6,130 active team members who conducted 26,429 group outreach and education events, reaching an estimated 1.9 million people.

Note: The report is at https://oig.hhs.gov/reports-and-publications/archives/semiannual/2018/2018-fall-sar.pdf.

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