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Fraud & Abuse: OIG Calls Out Hospices For Fraud Related To GIP, Nursing Home Patients

Don't be surprised to see intermediate sanctions, tougher medical review, and other crackdown activities in the future.

Hospices are getting painted with a broad fraud brush by the feds, and life may become more painful as a result.

A new report from the **HHS Office of Inspector General**, Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio, reviews the watchdog agency's findings about the hospice industry going back more than a decade.

"Hospices do not always provide needed services to patients and sometimes provide poor quality care," the OIG says in a release. "Patients and their families and caregivers do not receive crucial information to make informed decisions about their care. And taxpayers are bankrolling much of this poor care and fraud through the Medicare hospice benefit."

There's no doubt that hospice's growth has sparked much interest from the fraud-fighting agency. Medicare paid $16.7 billion for 1.4 million hospice beneficiaries in 2016. That compares to $9.2 billion for fewer than 1 million beneficiaries in 2006, the OIG notes in the report summary.

The report works through a laundry list of hospice problems, ranging from upcoding to higher levels of care to cherry-picking financially lucrative patients to outright fraud.

The **National Hospice & Palliative Care Organization** cautions that "outliers cited in the report do not adequately reflect the context of hospice care provision in the U.S.," according to a release. "Incidents of deliberate fraud and abuse should be viewed separately from unintentional documentation or mathematical errors in an extraordinarily burdensome and complicated regulatory environment."

The OIG urges the **Centers for Medicare & Medicaid Services** to "improve the quality of care for beneficiaries and strengthen program integrity" with these seven recommendations:

1. Strengthen the survey process. Improvement would include using claims and survey data to target surveys. Surveyors could focus on hospices providing only one level of care, providers rarely providing physician services or care on the weekend, and those with repeat deficiencies.

2. Establish additional remedies for hospices with poor performance. Intermediate sanctions could be in hospices' future if CMS heeds this recommendation. Like HHAs, hospices would face sanctions including payment suspensions for new admissions and civil money penalties.

3. Add more data to Hospice Compare. CMS should display claims-based and survey deficiency data on the website, the OIG urges. CMS already has finalized providing claims-based data in its 2019 payment rule, points out the **National Association for Home Care & Hospice**.

4. Educate beneficiaries, their families and caregivers about hospice. Medicare should furnish more consumer-friendly resources via partners such as hospitals and caregiver groups.

5. Promote physician involvement and accountability to ensure that beneficiaries get appropriate care. The OIG urges "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." In addition, "the hospice could also

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have the physician sign off on the level of care at reasonable intervals," as determined by CMS, during the GIP stay.

Why? "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," the OIG argues.

6. Strengthen billing oversight. CMS should use claims data analysis to target for audits providers with a heavy Skilled Nursing Facility and/or Assisted Living Facility patient base; with a high percentage of lucrative patient diagnoses; that don't provide all levels of care; with a high level of GIP care for SNF patients; with lengthy GIP stays; and those with high levels of payment for Part D drugs for their patients.

7. Take steps to tie payment to beneficiary care needs and quality of care. CMS should base payment on a patient's care needs - presumably through a case mix system - and place of residence (nursing home), the OIG urges.

What the OIG neglects to mention in this report is underutilization of hospice care, NHPCO maintains. Data show that 28 percent of beneficiaries received care for only seven days or less in 2016, the trade group points out. "Like intentional fraud, this is unacceptable."

CMS rejects more than half of the OIG's hospice recommendations, and "we generally agree," NHPCO points out. But you can bet many of these program integrity strategies will eventually make it into practice, observers predict.

"A number of the areas are under scrutiny by one or more oversight entity, including the OIG, CMS, Medicare Administrative Contractors (MACs) and others," NAHC highlights.

Take action: "It is advisable that hospices examine their admission, care planning, and care processes with the OIG's recommendations in mind to ensure that eligible hospice patients are receiving all hospice benefit services that are appropriate for the treatment of their terminal condition and any related conditions," NAHC urges in its member newsletter.

Meanwhile, "we look forward to working with the Administration to simplify and streamline the hospice benefit and compliance process and to ease the governmental red tape in order to encourage honest and law-abiding hospice providers while protecting the public from unacceptable intentional abuse," NHPCO says. "This includes … to focus government efforts on truly abhorrent providers and spare compliant programs from needless and duplicative investigation."

Note: The report is at https://oig.hhs.gov/oei/reports/oei-02-16-00570.pdf.

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