NHPCO Compilation of OIG Reports on Hospice Care
1995 – 2015

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In 1995, a joint initiative referred to as Operation Restore Trust (ORT) was established between OIG, the Health Care Financing Administration (HCFA) and the Administration on Aging. Among its objectives, Project ORT seeks to identify vulnerabilities in the Medicare program and develop solutions that would reduce Medicare’s exposure to fraud, abuse and waste.

Project ORT targeted five States (California, Florida, Illinois, New York and Texas) that account for approximately 40 percent of Medicare expenditures and beneficiaries. These projects focus on home health care, nursing home care, durable medical equipment and hospice care.

November 1997

| Enhanced Controls Needed to Assure Validity of Medicare Hospice Enrollments |

**OBJECTIVE**

The objective of this report was to consolidate and present issues disclosed by our ongoing Project Operation Restore Trust (ORT) audits of Medicare hospice services. Some of the hospices which we have audited and referred to in this report are also the subject of continuing Office of Inspector General (OIG) review.

The Medicare hospice program, while highly respected and successful in its mission, is a program which has experienced a substantial number of ineligible enrollments as identified in our audits. The reviews focused on determining whether the beneficiaries met the Medicare definition of “terminally ill” at the time of enrollment in the hospice program. The audits covered 12 large hospices located in 4 ORT States (Illinois, Florida, Texas, and California). Working with us, physicians from Medicare Peer Review Organizations (PROs) reviewed the medical files of all 2,109 long-term beneficiaries in those hospices that had been in care over 210 days, or that had been discharged from hospice at some point after reaching the 210 day threshold. The PRO physicians concluded that 1,373 of the selected beneficiaries were ineligible for hospice because, at the time of initial diagnosis, they were not terminally ill as defined by Medicare regulations, i.e., having a life expectancy of 6 months or less (we herein after use the phrase “terminally ill” as defined in Medicare regulations).
ineligible payments made to these hospices. The remaining seven hospices are pending further OIG review of their activities. Combing the findings on all 12 hospices, Medicare paid about $83 million on behalf of the
1,373 ineligible beneficiaries. Payments for some of these beneficiaries could be continuing today. For 262 additional beneficiaries reviewed, eligibility could not be established because medical evidence was missing from patient files or was incomplete. Medicare payments applicable to these 262 patients totaled about $14 million.

These ORT reviews followed a more limited audit of hospices in Puerto Rico which noted large numbers of ineligible beneficiaries. An island-wide statistical sample in Puerto Rico disclosed that about $20 million was paid by Medicare for beneficiaries who were not terminally ill at the time of diagnosis. This amount together with our results at the selected hospices in ORT States brings the total of identified Medicare payments for ineligible recipients to more than $100 million. We recommended to HCFA that it recover about $37.2 for ineligible payments made to these hospices.

We have identified several underlying factors which we believe contributed to the problems we noted in our hospices audits.

- There has been less rigorous enforcement of the 6-month prognosis requirement by the hospice industry, especially for various non-cancer diagnosed patients. This softening is most apparent in the enrollment of nursing facility residents that have chronic medical problems common to an elderly population. About 60 percent of the 1,373 ineligible beneficiaries identified during our reviews were nursing facility patients.
- Hospice regulations applicable to nursing home residents are complex. The regulations prohibit Medicare payments for hospice care on behalf of beneficiaries receiving Medicare funded services in skilled nursing facilities. Paradoxically, Medicare payments for hospice care are permissible when the beneficiary is receiving Medicaid funded services in a nursing facility. The joint funding by the Medicare and Medicaid programs for these nursing home residents open the possibility for abusive practices.
- A nationwide chain of hospices paid an amount in excess of the usual Medicaid reimbursement to nursing facilities and used marketing materials which downplayed or ignored the 6-month prognosis requirement. In addition, the chain had a large sales staff which was paid commissions in amounts based on the length of a patient’s stay. These practices created a climate conducive to enrollment of hospice patients who were not terminally ill.
- Internal controls are weak in the areas of physician certifications of terminal illness, claims processing, and medical review at the RHHI, audit procedures at the RHHIs for “cap” report reviews, and the overall design of the reimbursement “cap” system—the method of paying hospices a maximum amount of Medicare funds based on a census count of beneficiaries enrolled.
Some of the problems noted in this report are longstanding and have been pointed out by others. A recent
article in *New England Journal of Medicine* concluded that patients in large and for-profit hospices have relatively long survival periods after enrollment and suggested that such hospices may encourage early enrollments to recoup the high up-front costs associated with admissions. Other questions were posed in the article regarding whether such hospices have efficient “outreach” programs or place fewer “barriers to enrollment.” We believe the results of our audits as detailed in this report will help HCFA respond to these questions. Other recently issued OIG reports have highlighted vulnerabilities in the Medicare program for hospice beneficiaries residing in nursing homes.

**RECOMMENDATIONS**

To date, we have issued 5 individual reports to HCFA recommending that the RHHIs recover $17.2 million for payments made for ineligible beneficiaries. The remaining 7 hospices representing ineligible payments totaling $65.8 million are pending additional 01(3) review of their activities. In this report, we are making broader recommendations for HCFA to consider that, in our opinion, will prevent various problems or abusive practices we have identified in the hospice program from reoccurring. Our recommendations include:

- Reinforcing the “6-month prognosis” requirement through a direct bulletin or memorandum from HCFA to industry advocacy groups for dissemination to all hospices.
- Prohibiting the practice of hospices paying nursing facilities more for “room and board” than the hospices receive from the State Medicaid agencies on behalf of dually eligible beneficiaries.
- Informing hospices that marketing materials should prominently feature Medicare eligibility requirements and monitoring the use of sales commissions as incentives for patient recruiting.
- Making hospice physicians more accountable for their certifications of terminal prognosis by requiring that the certification/recertification forms signed by these physicians contain a statement concerning the penalties for false claims.
- Strengthening claims processing controls at the RHHIs with more focus on front-end reviews and nontraditional, suspect, or exceedingly vague diagnoses.
- Seeking legislative change for a more meaningful “cap” or maximum amount for hospice payments and instructing the RHHIs to establish standard audit procedures for these “cap” reports submitted by hospices.
- Proposing legislation to restructure the use of benefit periods so that individuals who do not need or no longer need hospice care could be discharged without prejudice to eligibility during a defined hold harmless period of program adjustments.
- Seeking a legislative amendment to make changes to the existing payment methodology for dually eligible nursing facility residents, by reducing to the lowest level necessary the Medicare hospice payment for these nursing facility patients.
The Balanced Budget Act of 1997, enacted after publication of our draft report, resulted in numerous modifications of Medicare’s hospice benefit. These modifications included allowing hospices to discharge patients whose conditions improved without loss of future benefits to the hospice beneficiary (which
addressed one of the above recommendations) and a new requirement for more frequent certifications of eligibility after 180 days of hospice care.

The HCFA generally concurred with the recommendations in our draft report. They noted, however, that from their readings the art of accurate predictions about terminal prognoses is not exact. Although they do not believe this negates the findings overall (giving recognition to the PROS that reviewed our cases), they noted there could be some degree of inaccuracy in some of the individual cases found ineligible. We appreciate the state of the art, but we have no reason to dispute the medical opinion of the PRO reviewers who determined that 1,373 beneficiaries were not terminally ill as defined by HCFA.

We have paraphrased HCFA’S response after each recommendation in the Results of Review section of the draft report. Additional changes may be made during the preparation of the final report.

|----------------|-----------------|-----------------------------------|---------------------------------------------------|

**Brief description of**

Lower frequency of services, the overlap of services and the questionable enrollment in hospice by nursing home patients suggest that current payment levels for hospice care in nursing homes may be excessive.

Nursing home hospice patients received nearly 46 percent fewer nursing and aide services from hospice staff than hospice patients living at home. Three out of four patients received only basic nursing and aide visits. Many of these services were also provided by the nursing home staff when hospice staff were not present. Yet, hospices get paid the same amount for nursing home patients as they receive for patients living at home. In addition, two different sets of medical reviewers disagreed with the hospice’s initial prognosis in nearly one out of six patients.

**Continued growth in Medicare hospice expenditures for nursing home patients is expected.**

In 1995, we estimate that 17 percent of Medicare hospice patients lived in a nursing home. About 1 percent of nursing home patients in 1996 elected the hospice benefit. Nursing home patients are seen by hospices as an effective way of expansion. The repeal of the 210 day limit on hospice care also provided hospices with additional incentives to serve nursing home patients.

To address our findings, we recommend that the Health Care Financing Administration
These modifications can include but are not limited to lowering hospice payments for patients who reside in nursing homes or revising requirements for services provided by nursing homes for terminal patients.

We suggest that representatives from the nursing home and hospice industry along with HCFA work in a collaborative manner to develop additional options to preserve and enhance hospice care for those who need it when living in a nursing home.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration, the Assistant Secretary for Planning and Evaluation and the Assistant Secretary for Management and Budget. We also solicited and received comments on the draft report from the National Hospice Organization and the Hospice Association of America. We have made changes based on these comments and have consolidated our first three draft findings into one.

An underlying theme to the comments was a belief that it was inappropriate to recommend eliminating Medicare’s hospice benefit for patients living in nursing homes. However, there was general agreement on the need to examine Medicare and Medicaid payment for hospice patients living in nursing homes and to clarify the future role of nursing home staff in providing palliative care for patients with terminal illness.

Summary of Findings

(1) Almost all hospices reviewed pay nursing homes the same or more than what Medicaid would have paid for nursing home care if the patient had not elected hospice.

(2) The six hospices paying more than 100 percent of the Medicaid daily rate for nursing home care have a higher percentage of patients in nursing homes.

(3) Both the hospice and the nursing home can benefit financially by enrolling patients in hospice.

(4) Some hospice contracts with nursing homes contain provisions that raise questions about inappropriate patient referrals between hospices and nursing homes.

RECOMMENDATIONS
Given the above information, and information in our companion report entitled “Hospice Patients in Nursing Homes”, we are concerned that some decisions about patient care can be potentially influenced by financial rather than clinical factors. Financial incentives between hospices and nursing homes that induce referrals may implicate the Medicare anti-kickback statute. Any contracts with potentially troublesome language will be reviewed further by appropriate components of the Office of Inspector General. These offices may take additional action as necessary.

We recommend that the Health Care Financing Administration (HCFA) work with the hospice associations to educate the hospice and nursing home communities to help them avoid potentially fraudulent schemes to obtain money from these programs, including Medicare and Medicaid, the OIG actively investigates fraudulent schemes to obtain money from these programs and, when appropriate, issues Special Fraud Alerts that identify segments of the health care industry that are particularly vulnerable to abuse. This Special Fraud Alert focuses on the interrelationship between the hospice and nursing home industries and describes some potentially illegal practices the OIG has identified in arrangements between these providers.


**PURPOSE**
To describe services for and eligibility status of Medicare hospice beneficiaries. **FINDINGS**

- Hospice agencies seemed to plan for and provide appropriate services.

- A significant portion of hospice patients in nursing homes were ineligible.

We found a significant association between living in a nursing home and being ineligible for the hospice benefit. Twenty-nine percent of sampled hospice beneficiaries in nursing homes were ineligible. However, only 2 percent of beneficiaries not residing in nursing homes were ineligible. Overall, 7 percent of beneficiaries in nursing homes were ineligible for hospice care, and 81 percent were eligible.
eligible. We could not determine eligibility for 12 percent of the beneficiaries.

**AGENCY COMMENTS**

The HCFA Administrator reviewed our draft report, and agreed that problems exist with the hospice benefit provided to beneficiaries in nursing homes. She stated that HCFA staff are currently studying the issues involved and working to identify appropriate ways to correct the problems.

The President of the National Hospice Association (NHO) and the Executive Director of the Hospice Association of America (HAA) also commented on our draft report. Both agreed with our finding that, overall, the program seemed to be working well, but some problems exist with hospice care in nursing home settings.

The NHO President expressed concern about the study’s description of patients as being ineligible when our reviewers and the patient’s attending physician differed in their medical opinions about prognosis of death. He was also concerned that, as a result of continuing OIG scrutiny, hospice services may be underutilized, and hospices may not be enrolling eligible beneficiaries. While we recognize the difficulty of making prognosis of death, we believe that, overall, our study correctly describes both the general success of hospices in service delivery and the program vulnerability in the nursing home area. We certainly do not condone depriving any beneficiary of services to which...

| 1999 | Federal Register / Vol. 64, No. 192 / Tuesday, October 5, 1999 / | Publication of the OIG Compliance Program, Guidance |

**Brief description of findings**

**Elements for an Effective Compliance Program**

Through experience, the OIG has identified seven fundamental elements to an effective compliance program. They are:

• implementing written policies, procedures and standards of conduct;
• designating a compliance officer and compliance committee;
• conducting effective training and education;
• developing effective lines of communication;
• enforcing standards through well publicized disciplinary guidelines;
• conducting internal monitoring and auditing; and
• responding promptly to detected offenses and developing corrective action.

Note: This publication is a comprehensive list of risk areas, eligibility requirements – terminal
concerns, retention of records.


**Brief description of findings**

1. Eighty-six percent of hospices were certified within 6 years, as required, while 14 percent averaged 3 years past due.
2. Health deficiencies were cited for 46 percent of hospices surveyed and for 26 percent of hospices investigated for complaints; many deficiencies related to patient care.
3. CMS and State agencies rarely use methods other than certification surveys and complaint investigations to monitor or enforce hospice performance.

**OBJECTIVE**

1. To determine the percentage of Medicare hospice beneficiaries who reside in nursing facilities.
2. To describe the characteristics of Medicare hospice beneficiaries who reside in nursing facilities and compare these characteristics to those of hospice beneficiaries who reside in other settings.

**FINDINGS**

- Twenty-eight percent of Medicare hospice beneficiaries resided in nursing facilities in 2005.
- Hospice beneficiaries in nursing facilities were more than twice as likely as beneficiaries in other settings to have terminal diagnoses of ill-defined conditions, mental disorders, or Alzheimer's disease.
- On average, beneficiaries in nursing facilities spent more time in hospice care and were associated with higher Medicare reimbursements than beneficiaries in other settings.

**CONCLUSION**
who reside in other settings, we found that beneficiaries in nursing facilities tended to be older and more likely to have ill-defined conditions. Also, their time in care was longer and more costly.

| Year | OIG | Brief description of
|------|-----|------------------------|
| 2008 | Federal Register /Vol. 73, No. 190 /Tuesday, September 30, 2008 /Notices | **OIG**  
**Supplemental Compliance Program Guidance for Nursing**  

**March 2008**  
**OEI-02-06-00222**  
**Memorandum Report: "Hospice Beneficiaries' Use of Respite Care"**  

**RESULTS**

1. **Two Percent of Hospice Beneficiaries Received Respite Care During 2005**

In 2005, 2 percent of all hospice beneficiaries, or 17,669 beneficiaries, received respite care. Fifty-four beneficiaries received respite care longer than the 5 consecutive days allowed by Federal regulations and 62 instances in which the use of respite care may have been inappropriate. We also found a number of instances in which the use of respite care may have been inappropriate. Fifty-four beneficiaries received respite care longer than the 5 consecutive days allowed by Federal regulations and 62 beneficiaries received respite care while residing in nursing facilities, contrary to Federal requirements. We will provide additional information about these potentially inappropriate cases to CMS in a separate memorandum. In addition, we note that the information that is available on hospice claims limits CMS's ability to determine whether hospice agencies are complying with the requirements that they may not be reimbursed for more than 5 consecutive days of respite care at a time.

We found that 2 percent of all hospice beneficiaries received respite care during 2005. Most of these beneficiaries received respite care for a total of 5 days or less. We also found a number of instances in which the use of respite care may have been inappropriate. Fifty-four beneficiaries received respite care longer than the 5 consecutive days allowed by Federal regulations and 62 beneficiaries received respite care while residing in nursing facilities, contrary to Federal requirements. We will provide additional information about these potentially inappropriate cases to CMS in a separate memorandum. In addition, we note that the information that is available on hospice claims limits CMS's ability to determine whether hospice agencies are complying with the requirement that they may not be reimbursed for more than 5 consecutive days of respite care at a time.

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The most common diagnosis categories for beneficiaries who received respite care were cancer, circulatory disease, and ill-defined conditions. These were also the most common diagnosis categories for hospice beneficiaries who did not receive respite care. The two groups differed slightly in terms of geographic location. As Table 1 shows, beneficiaries who received respite care were more likely to reside in the Midwest and West, compared to hospice beneficiaries who did not receive respite care.

2. Most Hospice Beneficiaries Who Received Respite Care Received It for 5 Days or Less

3. A Small Number of Beneficiaries Received Respite Care for More Than 5 Consecutive Days

4. A Small Number of Beneficiaries Received Respite Care While They Were Residents of a Nursing Facility

CONCLUSION

We found that respite care was infrequently used in 2005. Two percent of all hospice beneficiaries received respite care and most of these beneficiaries received the care for a total of 5 days or less. We also found a number of instances in which the use of respite care may have been inappropriate. Fifty-four beneficiaries received respite care for more than 5 consecutive days and 62 beneficiaries received respite care while residing in nursing facilities, even though respite care is designed to relieve a beneficiary’s caregiver. One beneficiary was included in both of these groups. We will provide additional information about these potentially inappropriate cases to CMS in a separate memorandum.

In addition, we note that the information that is available on the hospice claim limits CMS’s ability to determine whether hospice agencies are complying with the requirement that they may not be reimbursed for more than 5 consecutive days of respite care at a time.

This report is being issued directly in final form because it contains no recommendations. If you have questions or need additional information about this report, please contact OIG's Health Care Group at (202) 690-7000.
OBJECTIVES
To determine the extent to which hospice claims for beneficiaries in nursing facilities in 2006 met Medicare coverage requirements.

FINDINGS

• Eighty-two percent of hospice claims for beneficiaries in nursing facilities did not meet at least one Medicare coverage requirement. Eighty-one percent of claims did not meet at least one Medicare coverage requirement pertaining to election statements, plans of care, services, or certifications of terminal illness. An additional 1 percent of claims were undocumented. Medicare paid approximately $1.8 billion for these claims.

Claims from not-for-profit hospices were less likely to meet Medicare coverage requirements than those from for-profit hospices. Specifically, 89 percent of claims from not-for-profit hospices did not meet Medicare requirements, compared to 74 percent of claims from for-profit hospices.

• Thirty-three percent of claims did not meet election requirements. For 4 percent of claims, there were no election statements. For another 29 percent of claims, the election statements did not meet one or more regulations. Most commonly, the statements did not explain that hospice care was palliative rather than curative or that the beneficiaries waived Medicare coverage of certain services related to their terminal illnesses.

For another 9 percent of claims, the election statements contained misleading language about the beneficiaries’ right to revoke the election of hospice care.

• Sixty-three percent of claims did not meet plan of care requirements. For 1 percent of claims, the hospices did not establish plans of care for the beneficiaries. For another 62 percent of claims, the plans did not meet at least one Federal requirement. These plans of care were not established by an interdisciplinary group; they did not include necessary components, such as a detailed description of the scope and frequency of services; or they did not specify intervals for review, as required.

• For 31 percent of claims, hospices provided fewer services than outlined in beneficiaries’ plans of care. For 31 percent of claims, the hospices did not provide the number of services outlined in the plans of care that they established. Most commonly, the hospices provided services to the beneficiaries but not as frequently as called for in the plans of care. In the most extreme cases, there was no documentation in the medical records of any visits for a particular service.

• Four percent of claims did not meet certification of terminal illness requirements. For 4 percent of claims, the certifications were missing or did not meet one or more Federal
requirements. For these claims, the certifications did not specify that the individuals’
prognoses were for life expectancies of 6 months or less if the terminal illness ran its normal
course; they were not supported by clinical information and other documentation in the
medical records; or they were not signed by physicians.
RECOMMENDATIONS

Based on the findings in this report, we recommend that the Centers for Medicare & Medicaid Services (CMS):

- **Educate hospices about the coverage requirements and their importance in ensuring quality of care.**
  
  CMS should educate hospices about the coverage requirements, particularly for election statements, plans of care and their review, and certifications of terminal illness. It should pay particular attention to not-for-profit hospices, given the higher rate at which their claims did not meet requirements.

- **Provide tools and guidance to hospices to help them meet the coverage requirements.** These tools should include clear and specific instructions, such as model text for election statements, a checklist of items that must be in the plans of care, and guidance on complying with the certification of terminal illness regulations.

- **Strengthen its monitoring practices regarding hospice claims.** CMS should effectively use targeted medical reviews and other oversight mechanisms to improve hospice performance and compliance with Medicare requirements, especially with respect to establishing plans of care and providing services that are consistent with these plans of care. Additionally, as we recommended in a previous report, CMS should conduct more frequent certification surveys of hospices as a way to enforce the requirements.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all three of our recommendations. In response to our first recommendation, CMS stated that it has made presentations at industry conferences and participated in other events with hospice associations. CMS also noted that its Web site has a training broadcast for State surveyors that is available to hospice providers. CMS stated that it has educated providers about the requirements of the new Conditions of Participation (CoP), issued June 5, 2008. These CoPs address patient care planning and the care of patients who reside in nursing facilities.

In response to our second recommendation, CMS stated that it has issued new Hospice Program Interpretive Guidance, a tool used by providers and State Survey agencies to determine compliance with the CoPs. CMS also stated that it held three satellite training sessions to educate stakeholders on the new requirements. We encourage CMS to continue educating providers and to give them detailed instructions that encompass the new requirements as well as existing requirements that have not been revised but are equally important. We also encourage CMS to augment these efforts with specific tools that address the problems outlined in this report, such as model text for election statements.

In response to our third recommendation, CMS stated that it will instruct Medicare contractors to consider the issues in this report when prioritizing its medical review strategies or other interventions.
CMS also stated that it will share this report and relevant claim information from OIG with the Recovery Audit Contractors.

We have made changes to the final report based on CMS’s technical comments, as appropriate.
RESULTS
Thirty-One Percent of Medicare Hospice Beneficiaries Resided in Nursing Facilities in 2006; Medicare Paid
$2.59 Billion for Their Hospice Care

Based on claims data for all Medicare beneficiaries receiving hospice care, we found that 31 percent of hospice beneficiaries resided in nursing facilities in 2006, compared to 28 percent in 2005. In 2006, 289,544 beneficiaries received hospice care while residing in nursing facilities.

Medicare paid hospices approximately $2.59 billion for care provided to beneficiaries residing in nursing facilities in 2006. On average, Medicare paid $960 per week for each hospice beneficiary in a nursing facility. This amount did not cover physician services, which were paid for separately from the daily rate.

By far, the most common level of hospice care provided to these beneficiaries was routine care. Ninety-one percent of their hospice claims were for routine care only. Another 3 percent were for general inpatient care only. Most of the remaining claims were for a combination of routine care and one or more other levels of care. See Table 1.

Hospices Most Commonly Provided Nursing, Home Health Aide, and Medical Social Services; They Also
Commonly Provided Drugs

Based on the medical record review, hospices provided nursing services to beneficiaries for 96 percent of claims in 2006. Hospices furnished home health aide services to beneficiaries for 73 percent of claims and medical social services for 68 percent of claims. Hospices provided counseling for 58 percent of claims. Volunteer and other miscellaneous services were provided to a lesser extent. Physical therapy, occupational therapy, and speech-language pathology services occurred only in rare instances. See Table 2. In addition to these services, drugs were provided to beneficiaries for 96 percent of claims.

The medical record review revealed some differences between the types and frequencies of
Hospices Provided an Average of 4.2 Visits Per Week for the Three Most Common Services Combined

Hospices provided an average of 4.2 visits per week for nursing services, home health aide services, and medical social services combined. Although nursing services were furnished for the greatest percentage of claims, they did not occur the most frequently. Home health aide services were provided more often, at an average of 2.2 times per week. For over half of the claims, beneficiaries received about 1 to 3 home health aide visits per week. Nursing services averaged 1.7 visits per week, with beneficiaries receiving about 1 to 2 nursing visits per week for two-thirds of the claims. Medical social services usually occurred on a monthly or bimonthly basis, averaging about 1.7 visits per month.

As noted in the methodology, durations were not recorded for a significant percentage of visits, so projecting the average length of visits from our sample was unfeasible. Based on the limited number of visits whose lengths were recorded and which were for routine care only, we found that home health aide visits were 65 minutes on average, although their duration ranged from 2 minutes to 8 hours. Nursing services were shorter, at 53 minutes on average, and ranged from 5 minutes to 4 hours. Medical social service visits were shorter still, at 43 minutes on average, and ranged from 5 minutes to 2.6 hours.

CONCLUSION

We found that 31 percent of Medicare hospice beneficiaries resided in nursing facilities in 2006. Medicare paid hospices approximately $2.59 billion for care provided to beneficiaries in nursing facilities in 2006. On average, Medicare paid $960 per week for hospice care for each hospice beneficiary in a nursing facility, not including payment for physician services. This care most commonly included nursing, home health aide, and medical social services. Hospices furnished an average of 4.2 visits per week for these three services combined. They also commonly provided drugs.

The results of this memorandum report can help CMS and other decisionmakers determine whether the types and frequencies of hospice services provided to beneficiaries in nursing facilities meet the goals of the hospice benefit. The results can also help decisionmakers determine whether current payment rates are aligned with the hospice services being provided.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report September 2010 OEI: 02-05-00224 Memorandum Report: Questionable Billing for Physician http://oig.hhs.gov/oei/reports/oei-02-06-00224.pdf Brief description of report
## Findings

$566,000 in questionable billing for physician services under Part B. 1/3 of questionable claims were from Florida.

### Action for CMS

Potential program vulnerability. CMS should continue to

### Summary

Medicare spending on hospice care for nursing facility residents has grown nearly 70 percent since 2005. Additionally, hundreds of hospices had a high percentage of their beneficiaries residing in nursing facilities, and most of these hospices were for-profit. Compared to hospices nationwide, these high-percentage hospices received more Medicare payments and served beneficiaries who spent more time in care. High percentage hospices typically enrolled beneficiaries whose diagnoses required less complex care and who already lived in nursing facilities before they elected hospice care.

Medicare currently pays hospices the same rate for care provided in nursing facilities as it does for care provided in other settings, such as private homes. Unlike private homes, nursing facilities are staffed with professional caregivers and are often paid by third party payers, such as Medicaid. These facilities are required to provide personal care services, which are similar to hospice aide services that are paid for under the hospice benefit.

Some hospices may be seeking beneficiaries with particular characteristics, including those with conditions associated with longer but less complex care. Such beneficiaries are often found in nursing facilities. By serving these beneficiaries for longer periods, the hospices receive more Medicare payments, which can contribute to larger profits.

We recommend that CMS:

1. monitor hospices that depend heavily on nursing facility residents and
2. modify the payment system for hospice care in nursing facilities.

CMS concurred with both of our recommendations. It also agreed that the current payment structure may provide incentives for hospices to seek out beneficiaries in nursing facilities, who
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<td>A-06-10-00059</td>
<td>Medicare Could Be Paying Twice For Prescription Drugs For Beneficiaries In Hospice</td>
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**Executive Summary**

During calendar year 2009, Medicare Part D paid for prescription analgesic, antinausea, laxative, and antianxiety drugs, as well as prescription drugs used to treat chronic obstructive pulmonary disease and amyotrophic lateral sclerosis, that likely should have been covered under the per diem payments made to hospice organizations. As a result, the Medicare program could be paying twice for prescription drugs for hospice beneficiaries: once under the Medicare Part A hospice per diem payments and again under Medicare Part D.

To be eligible for Medicare hospice care, a beneficiary must be entitled to Part A of Medicare and be certified as terminally ill (i.e., having a medical prognosis that life expectancy is 6 months or less if the disease runs its normal course). Under the Medicare Part D program, individuals entitled to benefits under Medicare Part A may obtain voluntary coverage for prescription drugs.

We recommended that CMS:

1. educate sponsors, hospices, and pharmacies that it is inappropriate for Medicare Part D to pay for drugs related to hospice beneficiaries' terminal illnesses;
2. perform oversight to ensure that Part D is not paying for drugs that Medicare has already covered under the per diem payments made to hospice organizations; and
3. require sponsors to develop controls that prevent Medicare Part D from paying for drugs that are already covered under the per diem payments.

CMS concurred with our first and third recommendations but did not concur with our second recommendation.
Executive Summary

Hospice general inpatient care (GIP) is for pain control or symptom management provided in an inpatient facility that cannot be managed in other settings. The care is intended to be short-term and is the second most expensive level of hospice care. GIP may be provided in one of three settings: a Medicare-certified hospice inpatient unit, a hospital, or skilled nursing facility (SNF).

Centers for Medicare & Medicaid Services (CMS) staff have expressed concerns about possible misuse of GIP, such as care being billed for but not provided, long lengths of stay, and beneficiaries receiving care unnecessarily. In addition, the Federal government recently reached a $2.7 million settlement with a hospice for allegedly billing Medicare for GIP when beneficiaries actually received routine home care, which has a lower reimbursement rate.

Findings: found that Medicare paid $1.1 billion for GIP in 2011, most of which was provided in hospice inpatient units, as opposed to hospitals or SNFs. Twenty-three percent of Medicare hospice beneficiaries received GIP during the year. One-third of beneficiaries’ GIP stays exceeded 5 days, with 11% lasting 10 days or more. The hospices that used inpatient units provided GIP to more of their beneficiaries and for longer periods of time than hospices that used other settings. Nine hundred fifty three hospices, or 27% of Medicare hospices, did not provide any level of hospice care other than routine home care.

Action for CMS: These results raise several questions about GIP. Long lengths of stay and the use of GIP inpatient units need further review to ensure that hospices are using GIP as intended and providing the appropriate level of care. CMS should focus on hospices that do not provide GIP and ensure that these hospices are providing beneficiaries access needed to levels of care at the end of

| May 2013 | A-01-12-00507 | Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care | https://oig.hhs.gov/oas/reports/region1/11200507.asp |

Brief description of Executive Summary

Medicare beneficiaries’ discharges from acute-care hospitals to hospice care increased significantly from 161,661 discharges in calendar year (CY) 2007 to 269,117 discharges in 2010 or approximately 66
beneficiaries discharged to hospice care in CY 2007 to $2.7 billion in CY 2010 or 80 percent. Currently, Medicare has two “transfer payment policies” that adjust payments for discharges from hospitals to other hospitals or post-acute care facilities that are made sooner than a Medicare-established average length of stay (an early discharge). When a beneficiary is discharged early from a hospital to hospice care, however, Medicare does not have a transfer payment policy to adjust the payment to the hospital. During our audit period, more than 30 percent of discharged from hospitals to hospice care were early and so would have been subject to a transfer payment policy if Medicare had one.

Our objective was to determine how a hospital transfer payment policy for early discharged to hospice care would financially affect Medicare Part A and hospitals.

On the basis of our sample results, we estimated that Medicare could have saved $602.5 million for calendar years 2009 and 2010 by applying a hospital transfer payment policy for early discharges to hospice care. Medicare payments based on a per diem rate rather than a full payment policy for the sampled claims would have resulted in $380,000 in savings. Approximately 30 percent of all hospital discharges to hospice care were early discharges that would have received per diem payments rather than full payments under a hospital transfer payment policy. Additionally, this transfer payment policy would have not caused a significant financial disadvantage for hospitals or disproportionally affected any hospital.


**Brief description of Executive Summary**

This report follows up on the 2007 OIG report Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight (OEI-06-05-00260), which found that the most recent recertification survey for 14% of State-surveyed hospices had occurred more than 6 years previously, with an average of 9 years. Further, when surveys did occur, 46% of the surveyed hospices received citations for health deficiencies, with the most frequently cited deficiencies related to care planning and quality issues.

Findings: The frequency of recertification surveys has not improved since 2005. Seventeen percent of State- surveyed hospices had not been recertified within the 6 years prior to the index date of February 28, 2013, with some hospices experiencing longer intervals since their last survey. In 12 states, more than 25% of hospices had not been recertified within the previous 6 years. These
CMS and contracted State survey agencies can ensure hospice compliance with Medicare CoPs and quality-of-care requirements for hospices.

Recommendations: CMS seek statutory or regulatory timeframes for the frequency of hospice recertification surveys. CMS should consider setting this survey frequency standard at 3 years, to match the 3-year interval used by accrediting organizations (as approved by CMS); however, given resource limitations, setting a mandatory frequency—even for an interval of more than 3 years—could help to ensure improvement in survey frequency and avoid lengthy intervals between surveys for


Brief description of Executive Summary

The report is an audit investigation to determine whether Ohio properly claimed Federal Medicaid reimbursement for hospice claims submitted by hospices in Ohio. The Department of Job and Family Services (the Ohio State Agency) administers its Medicaid program in accordance with the Centers for Medicare & Medicaid Services (CMS) approved State plan. According to the State plan if a patient is terminally ill (his/her life expectancy is under 6 months) then they are eligible to elect hospice care under the Medicaid program. For hospices to be covered under Medicaid they must follow the State Medicaid Manual Issued by CMS.

Findings: After reviewing 100 sample claims OIG found that The State agency did not always properly claim Federal Medicaid reimbursement for hospice claims. Of the 100 sampled claims the State agency properly claimed Federal Medicaid reimbursement for 84 claims. The State agency did not properly claim Federal Medicaid reimbursement for the 16 remaining claims. In addition, hospices did not always meet election statement requirements. Of the 100 claims reviewed, hospices met the election statement requirements for 40 claims. Hospices did not meet the election statement requirements for the remaining 60 claims.

Recommendations: After investigation OIG recommends that the State agency takes several measures to ensure that improper Federal Medicaid reimbursement does not occur. The State agency should ensure that hospice claims are processed correctly, and adjusted when necessary, to meet Medicaid reimbursement requirements; monitor hospices to ensure that Federal and State requirements are met with regard to election statement content; and establish a uniform election statement requirements for hospice claims. Hospices should meet the election statement requirements for hospice claims.

May 2013 | A-01-12-00507 | Medicare Could Save Millions by Implementing a Hospital Transfer Policy for Early Discharges to Hospice Care | [http://oig.hhs.gov/oas/reports/region1/11200507.pdf](http://oig.hhs.gov/oas/reports/region1/11200507.pdf)

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Executive Summary

Medicare beneficiaries’ discharges from acute-care hospitals (hospital) to hospice care increased significantly from 161,661 discharges in calendar year (CY) 2007 to 269,117 discharges in CY 2010 or approximately 66%. Medicare Part A payments to hospitals increased from $1.5 billion for the services they provided to beneficiaries discharged to hospice care in CY 2007 to $2.7 billion in CY 2010 or 80%. Currently, Medicare has two “transfer payment” policies that adjust payments for discharges from hospitals to other hospitals or post-acute facilities that are made sooner than a Medicare-established average length of stay (an early discharge). When a beneficiary is discharged early from a hospital to hospice care, however, Medicare does not have a transfer payment policy to adjust the payment to the hospital. During our audit period, more than 30 percent of the discharges from hospitals to hospice care were early and so would have been subject to a transfer payment policy if Medicare had had one. Our objective was to determine how a hospital transfer payment policy for early discharges to hospice care would financially affect Medicare Part A and hospitals.

Findings: On the basis of our sample results, we estimated that Medicare could have saved $602,519,187 for CYs 2009 and 2010 by applying a hospital transfer payment policy for early discharges to hospice care. Medicare payments based on a per diem rate rather than a full payment for the sampled claims would have resulted in $379,844 in savings. Approximately 30 percent of all hospital discharges to hospice care were early discharges that would have received per diem payments rather than full payments under a hospital transfer payment policy. In addition, this transfer payment policy would not have caused a significant financial disadvantage for hospitals or disproportionately affected any hospital.

Recommendation: we recommend that the Centers for Medicare & Medicaid Services (CMS) change its regulations or pursue a legislative change, if necessary, to establish a hospital transfer payment policy for early discharges to hospice care.

Centers for Medicare and Medicaid Services Comments
In written comments on our draft report, CMS stated that it would like to study our recommendation further. CMS stated that adopting a transfer policy for hospice may “produce lower than estimated savings by discouraging hospitals from making transfers to more appropriate and cost effective care settings until a patient’s length of stay would not result in a reduction of payment to hospitals.” Furthermore, CMS stated that it needs to explore whether it has the authority “to expand the [post acute-care] transfer adjustment to hospices.”

OIG Response: Regarding CMS’s comments on the possibility that hospitals would not make transfers to hospice to avoid a reduction in payment, an overwhelming majority of hospital officials stated in response to our questionnaire that a reduction in hospital payments resulting from a...
Executive Summary

The Medicare hospice benefit allows providers to claim Medicare reimbursement for hospice services provided to individuals with a life expectancy of 6 months or less and who have elected hospice care. Previous Office of Inspector General reviews found that a high percentage of hospice claims did not meet certain Medicare requirements. Our objective was to determine whether hospice services claimed for Medicare reimbursement by The Community Hospice, Inc. (Community) complied with Medicare requirements.

Our review covered 9,147 beneficiary-months for which Community received Medicare reimbursement totaling $28,396,090 for hospice services provided during calendar year 2010. A beneficiary-month includes all hospice services provided to a beneficiary during 1 month. We reviewed all Medicare payments for hospice services related to our random sample of 100 beneficiary-months.

Findings: Community claimed Medicare reimbursement for some hospice services that did not comply with certain Medicare requirements. Of the 100 beneficiary-months in our random sample for which Community claimed Medicare reimbursement, 93 beneficiary-months complied with Medicare requirements, but 7 did not. The improper payments occurred because Community did not always (1) maintain adequate documentation to support a beneficiary’s eligibility for hospice services or (2) ensure that it billed Medicare for the appropriate level of hospice care. On the basis of our sample results, we estimated that Community improperly received at least $447,467 in Medicare reimbursement for hospice services that did not comply with certain Medicare requirements.

Recommendations: We recommend that Community:

| January 2015 | OEI-02-14-00070 | Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities | http://oig.hhs.gov/oei/reports/oei-02-14-00070.pdf |
Executive Summary

The objectives of this report were to 1) describe the trends in Medicare payments for hospice care provided in assisted living facilities (ALFs); 2) describe the characteristics of beneficiaries who receive hospice care in ALFs; 3) determine the types and frequency of hospice services provided to beneficiaries residing in ALFs; and 4) determine the extent to which some hospices receive a high percentage of their Medicare reimbursement from care provided in ALFs.

Findings: Medicare payments for hospice care in ALFs more than doubled in 5 years, totaling $2.1 billion in 2012. Hospices provided care much longer and received much higher Medicare payments for beneficiaries in ALFs than for beneficiaries in other settings. Hospice beneficiaries in ALFs often had diagnoses that usually require less complex care. Hospices typically provided fewer than 5 hours of visits and were paid about $1,100 per week for each beneficiary receiving routine home care in ALFs. Also, for-profit hospices received much higher Medicare payments per beneficiary than nonprofit hospices.

Recommendations: we recommend that CMS, as part of its ongoing hospice reform efforts, 1) reform payments to reduce the incentive for hospices to target beneficiaries with certain diagnosis and those likely to have long stays, 2) target certain hospices for review, 3) develop and adopt claims-based measures of quality, 4) make hospice data publically available for beneficiaries, and 5)
Recommendations: We recommend the State agency:

- Refund the $8,405,262 to the Federal government and
- Continue to monitor hospices to ensure they comply with Federal and State Requirements.


**Executive Summary**

In Puerto Rico, CMS contracts with the health department to conduct certification surveys of hospices. These surveys determine whether hospices meet Medicare health, safety, and program standards, as well as Federal and Commonwealth requirements related to personnel qualifications.

The review consisted of Servicios personal who provided direct care to Medicare beneficiaries during the period of July 1, 2008 through June 30, 2010. During this period, a total of 170 Servicios workers provided care to Medicare beneficiaries. Of the 170 workers, 130 workers’ personnel records did not contain documentation to support compliance with one or more Federal and Commonwealth requirements. The health departments’ most recent certification survey did not find any types of deficiencies identified in this report, therefore, CMS’s reliance on health department surveys could not ensure quality of care and that adequate protection was provided to Medicare beneficiaries.

Recommendations: To improve protection provided to Medicare beneficiaries, the OIG recommends that CMS work with the health department to ensure that Servicios meets all Federal and Commonwealth requirements for professional licensing and certification, criminal background checks, health certificates, and training.