Legal Insight

OIG Issues Report on Hospice Program Vulnerabilities
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In July 2018, the Department of Health and Human Services’ Office of Inspector General (OIG) issued a report entitled, *Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity* (OEI-02-16-00570) (“OIG Report”).¹ The OIG Report summarizes the results and recommendations stemming from the agency’s in-depth look into the hospice care industry since 2005 to identify trends in utilization and reimbursement, as well as key vulnerabilities in the hospice program. The OIG Report concludes by recommending 16 specific actions to improve the Medicare hospice program benefit and notes that the Centers for Medicare & Medicaid Services (CMS) concurred with six recommendations, did not concur with nine recommendations, and remained neutral on one recommendation.

Hospice has been an area of the steady growth and increasing importance within the Medicare program over the past decade, and OIG notes that Medicare paid $16.7 billion in 2016 alone for the 1.4 million beneficiaries electing hospice care. In light of the hospice industry’s exponential growth, OIG voiced concerns about certain program vulnerabilities:

- **Quality of Care** - OIG identified that some hospices are not providing required services and/or the quality of care is poor. OIG also noted that, in some cases, hospices did not effectively manage symptoms or medications for beneficiaries.

- **Beneficiary and Family Education** - OIG noted that beneficiaries and their families/caregivers may not receive adequate information to make informed decisions about their care and, in some cases, were unaware that electing the hospice benefit would limit the beneficiary’s ability to receive curative treatment.

- **Inappropriate Billing for Higher Levels of Hospice Care** - OIG indicated that hospices may bill and get reimbursed for a higher level of care (i.e., General Inpatient Care) when that level of care is not needed by the beneficiary. OIG also noted concerns about fraud schemes, such as schemes to enroll beneficiaries who are not eligible for hospice care and billing for services that were never provided.

- **Improper Financial Incentives** – OIG indicated that the current payment system creates incentives for hospices to seek beneficiaries who have uncomplicated needs and may require longer lengths of stay.

Based on these vulnerabilities, OIG made recommendations to CMS to implement 16 specific actions. The following is a brief summary of the action items and CMS’s response:

- **Strengthen the Survey Process** – OIG recommended that CMS utilize claims data analysis and focus surveyors on hospices with repeat deficiencies and hospices that do not provide all levels of care, provide infrequent physician services, or rarely provide hospice care on weekends. CMS did not concur with the recommendation and noted that additional actions are not necessary as surveyors already review prior survey findings and complaint allegations. CMS also responded that the survey process is not intended to be an audit process to look at medical necessity.

¹ A full copy of the report is available [here](#).
■ **Seek Statutory Authority for Additional Remedies for Poor Performance** – CMS remained neutral on the OIG’s recommendation to seek statutory authority to adopt intermediate remedies (prior to termination) for poor provider performance, such as civil monetary penalties, denials of payment for new admissions or for all patients, or other options.

■ **Improve Consumer Access to Hospice Data and Beneficiary/Caregiver Education** - OIG recommended that beneficiaries and their families/caregivers have access to additional information on hospices to help make informed choices (i.e., on Hospice Compare) and that CMS work with other stakeholders, such as hospitals and caregiver groups, to improve beneficiary/caregiver education on the hospice benefit. CMS concurred about the development of additional claims-based information for inclusion on the Hospice Compare website and to collaborate with its partners to provide further education on the hospice benefit. However, CMS did not concur that deficiency data from surveys, including information about complaints filed and resulting deficiencies, should be included on Hospice Compare.

■ **Promote Physician Involvement and Accountability** – OIG suggested several potential safeguards to increase physician involvement and accountability specifically with regard to the use of general inpatient care, but CMS did not concur with the recommendations and noted that the hospice interdisciplinary group, which is required to approve general inpatient care, already includes a physician.

■ **Strengthen Hospice Oversight To Address Inappropriate Billing** - OIG recommended the use of claims data analysis to target hospices with certain practices or characteristics that raise red flags. OIG also identified general inpatient care, particularly when provided in a skilled nursing facility setting, as another area of concern, and recommended a comprehensive prepayment review strategy to address long general inpatient care stays. OIG also advised CMS to work directly with hospices to ensure drugs are covered under the hospice benefit as necessary, and drug costs are not inappropriately shifted to the Medicare Part D Program. CMS concurred with all recommendations except for the recommendation about hospice drug coverage.

■ **Linking Payment to Beneficiary Care Needs and Quality of Care** – OIG recommended further assessment of the current payment system to tie payments to beneficiaries’ care needs and quality of care. CMS did not concur with any of the recommendations about hospice payment, citing to recent reform of the payment system to better align payment with beneficiary care needs during the course of hospice treatment.

In light of the OIG Report, hospice providers can expect additional OIG scrutiny in the near future work focusing on the quality of care in hospices and hospice billing (particularly for general inpatient care). In addition, based on OIG’s recommendations and CMS’s response to the recommendations, CMS and its contractors will likely continue to focus on inappropriate billing for hospice care based on claims data level analysis.
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