

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**HOSPICES INAPPROPRIATELY
BILLED MEDICARE OVER
\$250 MILLION FOR GENERAL
INPATIENT CARE**



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Inspector General**

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EXECUTIVE SUMMARY: HOSPICES INAPPROPRIATELY BILLED MEDICARE OVER \$250 MILLION FOR GENERAL INPATIENT CARE OEI-02-10-00491

WHY WE DID THIS STUDY

Recent investigations by the Office of Inspector General have shown a number of instances in which hospices inappropriately billed Medicare for hospice general inpatient care (GIP). Misuse of GIP includes care being billed but not provided and beneficiaries receiving care they do not need. Such misuse has human costs for this vulnerable population as well as financial costs for Medicare.

The goals of hospice care are to help terminally ill beneficiaries with a life expectancy of 6 months or less to continue life with minimal disruptions and to support beneficiaries' families and other caregivers. The care is palliative, rather than curative. Hospices must establish an individualized plan of care for each beneficiary. GIP is the second most expensive level of hospice care and is intended to be short-term inpatient care for symptom management and pain control that cannot be handled in other settings.

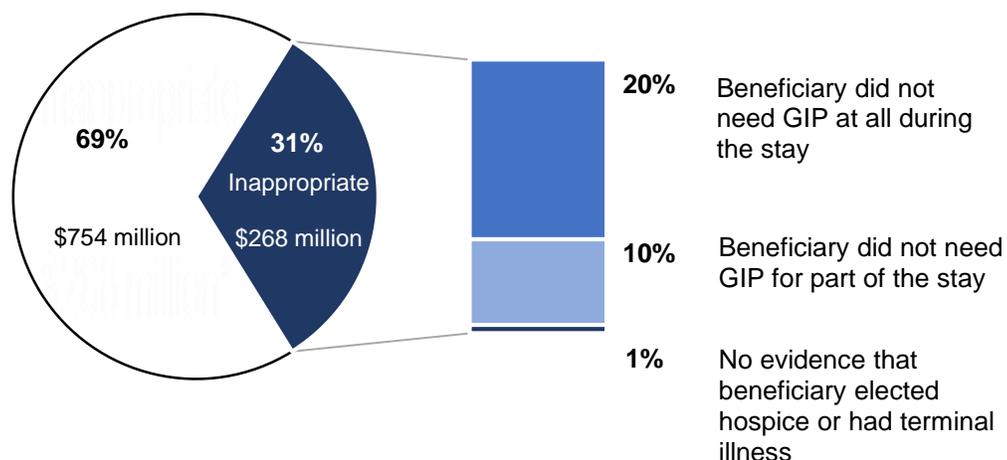
HOW WE DID THIS STUDY

We based this study on data from a medical record review of a stratified random sample of all GIP stays in 2012. We analyzed the results of the medical record review to estimate the percentage of GIP stays that were billed inappropriately. We also used Medicare Part D data to identify the drugs paid for by Part D and provided to beneficiaries during GIP stays.

WHAT WE FOUND

We found that hospices billed one-third of GIP stays inappropriately, costing Medicare \$268 million in 2012. Hospices commonly billed for GIP when the beneficiary did not have uncontrolled pain or unmanaged symptoms.

Percentage of Inappropriate GIP Stays, 2012



For example, a hospice billed for GIP for a beneficiary with a circulatory disease who had no unmanaged symptoms. This beneficiary could have been cared for at home, but the hospice billed Medicare for 46 consecutive days of GIP. The hospice was paid just over \$31,000 for the stay.

Some States, such as Florida, had many inappropriate GIP stays. Hospices were more likely to inappropriately bill for GIP provided in skilled nursing facilities than GIP provided in other settings. For-profit hospices were more likely than other hospices to inappropriately bill for GIP. We also found that Medicare sometimes paid twice for drugs because they were paid for under Part D when they should have been provided by the hospice and covered under the hospice daily payment rate. Further, hospices did not meet all care planning requirements for 85 percent of GIP stays and sometimes provided poor-quality care. For example, one hospice provided GIP to a beneficiary with dementia for 16 days, but his pain was never brought under control.

WHAT WE RECOMMEND

The findings in this report make clear the need to address the misuse of GIP and hold hospices accountable when they bill inappropriately or provide poor-quality care. We recommend that the Centers for Medicare & Medicaid Services (CMS) (1) increase its oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries; (2) ensure that a physician is involved in the decision to use GIP; (3) conduct prepayment reviews for lengthy GIP stays; (4) increase surveyor efforts to ensure that hospices meet care planning requirements; (5) establish additional enforcement remedies for poor hospice performance; and (6) follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor-quality care. CMS concurred with all six recommendations.

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OBJECTIVES

1. To determine the extent to which hospices inappropriately billed Medicare for general inpatient care (GIP) in 2012.
2. To determine the extent to which hospices did not meet care planning requirements for beneficiaries receiving GIP in 2012.
3. To describe instances in which hospices provided poor-quality care.

BACKGROUND

The goals of hospice care are to help terminally ill beneficiaries with a life expectancy of 6 months or less to continue life with minimal disruptions and to support beneficiaries' families and other caregivers. The care is palliative, rather than curative. In 2013, Medicare paid \$15.1 billion for hospice care for 1.3 million beneficiaries.¹

The Office of Inspector General (OIG) has had concerns about the possible misuse of GIP, which is the second most expensive level of hospice care. For example, in 2014, the owner of a hospice chain was charged with fraud for engaging in a scheme to obtain higher Medicare payments by improperly billing GIP. The hospice was also allegedly paying nursing facilities \$250 per day for every patient on GIP.² In 2012, a former hospice owner was sentenced to 28 months in prison for defrauding Medicare of over \$3 million by billing for GIP but providing a lower level of hospice care.³ In 2011, a hospice agreed to pay \$2.7 million for billing Medicare for GIP when it was not required.⁴ In addition, previous OIG work has raised concerns about duplicate payments made by

¹ Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Medicare Payment Policy*, March 2015, ch. 12. Accessed at http://medpac.gov/documents/reports/mar2015_entirereport_revised.pdf?sfvrsn=0 on May 11, 2015.

² Federal Bureau of Investigation (FBI), "Illinois Hospice Executive Charged with Federal Healthcare Fraud for Allegedly Falsely Elevating Level of Patients' Care" January 27, 2014. Accessed at <http://www.fbi.gov/chicago/press-releases/2014/illinois-hospice-executive-charged-with-federal-health-care-fraud-for-allegedly-falsely-elevating-level-of-patients-care> on May 8, 2015.

³ FBI, "Former Hospice Owner Sentenced for Health Care Fraud" February 1, 2012. Accessed at <http://www.fbi.gov/birmingham/press-releases/2012/former-hospice-owner-sentenced-for-health-care-fraud> on May 8, 2015.

⁴ FBI, "Hospice Home Care to Pay \$2,700,000 Settlement in Medicare Fraud Case," December 9, 2011. Accessed at <http://www.fbi.gov/littlerock/press-releases/2011/hospice-home-care-to-pay-2-700-000-settlement-in-medicare-fraud-case> on May 8, 2015.

Medicare Part D for prescriptions that should have been covered under the hospice benefit.⁵

OIG also has had concerns about hospice beneficiaries receiving inadequate care planning and poor-quality care. Previous OIG reports have found that hospice oversight is lacking and that the most common deficiencies cited for hospices centered on patient care planning and quality.⁶

This report is part of OIG's larger body of work on hospice care, which includes a companion report that describes the use of GIP in 2011.⁷ That report found that 23 percent of Medicare hospice beneficiaries received GIP during the year and one-third of beneficiaries' GIP stays exceeded 5 days, with 11 percent lasting 10 days or more. Another companion report will assess election statements and certifications of terminal illness for Medicare beneficiaries who received GIP.⁸

The Medicare Hospice Benefit

To be eligible for Medicare hospice care, a beneficiary must be entitled to Medicare Part A and be certified as having a terminal illness with a life expectancy of 6 months or less if the disease runs its normal course.⁹ Upon a beneficiary's election of hospice care, the hospice agency assumes responsibility for medical care related to the beneficiary's terminal illness and related conditions.

Hospice care includes, among other things, nursing care, medical social services, hospice aide services, medical supplies (including drugs and biologicals), and physician services. The beneficiary waives all rights to Medicare payment for services related to the curative treatment of the terminal condition or related conditions but retains rights to Medicare payment for services to treat conditions

⁵ OIG, *Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice*, A-06-10-00059, June 2012.

⁶ OIG, *Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight*, OEI-06-05-00260, April 2007.

⁷ OIG, *Medicare Hospice: Use of General Inpatient Care*, OEI-02-10-00490, May 2013.

⁸ OIG, *Hospices Should Improve Their Election Statements and Certifications of Terminal Illness*, OEI-02-10-00492, forthcoming.

⁹ Social Security Act, §§ 1814(a)(7)(A) and 1861(dd)(3)(A), 42 U.S.C. §§ 1395f(a)(7)(A) and 1395x(dd)(3)(A); 42 CFR §§ 418.20 and 418.22. Certification is based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness.

unrelated to the terminal illness.¹⁰ Beneficiaries may revoke their election of hospice care and return to standard Medicare coverage at any time.¹¹

Hospice General Inpatient Care

The Medicare hospice benefit has four levels of care: routine home care, continuous home care, GIP, and inpatient respite care. GIP is the second most expensive level of hospice care and, next to routine home care, is the most commonly used.

GIP is intended to be short-term and may be provided only in three settings: a hospice inpatient unit, a hospital, or a skilled nursing facility (SNF).¹² A physician's order is not required for GIP. GIP is for pain control or acute or chronic symptom management that cannot be managed in other settings, such as the beneficiary's home.¹³ These acute hospice care services are to ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to a lower level of hospice care.¹⁴ As with all covered hospice services, hospices are required to provide GIP if it is needed by the beneficiary.¹⁵ Hospices may enter into arrangements with facilities to provide GIP.¹⁶ The hospice retains oversight of staff and services for all arranged services to ensure the provision of quality care.¹⁷

Medicare pays hospices a daily rate from the day a beneficiary elects hospice care to the day of discharge. GIP and the other levels of hospice care each has an all-inclusive daily rate that is paid through Part A.¹⁸ Medicare pays \$672 per day for GIP, compared to \$151 per day for routine home care, which is the most common level of care. The daily rate is paid to the hospice for each day that a beneficiary

¹⁰ Social Security Act, §§ 1812(d)(2)(A) and 1861(dd)(1), 42 U.S.C. §§ 1395d(d)(2)(A) and 1395x(dd)(1); 42 CFR § 418.24(d). CMS has developed the Medicare Care Choices Model, a demonstration program that will allow certain beneficiaries to receive palliative care services from certain hospice providers while concurrently receiving services provided by their curative care providers. The model will enable CMS to study whether access to such services improves quality of life, increases patient satisfaction, and reduces Medicare expenditures. See CMS, *Medicare Care Choice Model*. Accessed at <http://innovation.cms.gov/initiatives/Medicare-Care-Choices/> on May 18, 2015.

¹¹ Social Security Act, § 1812(d)(2)(B), 42 U.S.C. § 1395d(d)(2)(B); 42 CFR § 418.28.

¹² 42 CFR § 418.108(a) and (b). Note that Medicare regulations do not specify what is meant by short-term for GIP.

¹³ 42 CFR § 418.302(b)(4).

¹⁴ 79 Fed. Reg. 50451, 50455 (Aug. 22, 2014). Accessed at <http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18506.pdf> on June 19, 2015.

¹⁵ Social Security Act, § 1861(dd)(2)(A)(i), 42 U.S.C. § 1395x(dd)(2)(A)(i).

¹⁶ 42 CFR § 418.108.

¹⁷ 42 CFR § 418.100.

¹⁸ For continuous home care, the hospice is paid an hourly rate based upon the number of hours of continuous care furnished to the beneficiary on that day. The daily continuous home care rate is divided by 24 hours to determine an hourly rate. A minimum of 8 hours of predominantly nursing care must be provided. CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 11, § 30.1.

is in hospice care, regardless of the amount of services furnished on a particular day. The rates are adjusted on the basis of the beneficiary's geographic location. See Table 1 for the unadjusted payment rates for each level of care in fiscal year (FY) 2012. Beneficiaries generally do not pay copays for hospice care.¹⁹

Table 1: Unadjusted Daily Medicare Hospice Payment Rates by Level of Care, FY 2012

Routine Home Care	\$151.03
Continuous Home Care	\$881.46
General Inpatient Care	\$671.84
Inpatient Respite Care	\$156.22

Source: CMS, "Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and the Hospice Pricer for FY 2012," Transmittal 2260, Change Request 7518, July 29, 2011.

Regardless of the level of care provided, the hospice must establish an individualized plan of care for each beneficiary it serves. The plan of care must be written by an interdisciplinary group that includes a physician, nurse, social worker, and pastoral or other counselor. The plan must include all services the beneficiary needs in relation to the terminal illness, including interventions to manage pain and symptoms, and the scope and frequency of the needed services. The hospice interdisciplinary group must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.²⁰

Hospice Drugs and the Medicare Part D Benefit

For all hospice beneficiaries, the hospice is required to provide drugs related to the palliation and management of the terminal illness and related conditions.²¹ These drugs are used primarily for the relief of pain and symptom control.²² Their cost is covered by the all-inclusive daily rate paid to the hospice.

The Medicare Part D program provides an optional prescription drug benefit to Medicare beneficiaries.²³ Under the program, private insurance companies—referred to as sponsors—provide drug coverage to beneficiaries who choose to

¹⁹ Hospices may charge beneficiaries a 5 percent copay for inpatient respite care. See 42 CFR § 418.400.

²⁰ 42 CFR §§ 418.200, 418.56.

²¹ 42 CFR § 418.106; CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 9, § 40.5.

²² 42 CFR § 418.202(f).

²³ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173; Social Security Act, §§ 1860D-1 to 1860D-43, 42 U.S.C. §§ 1395w-101 to 1395w-153.

enroll.²⁴ When a hospice beneficiary is enrolled in Part D, Part D pays for drugs unrelated to the terminal illness. The hospice is still required to provide drugs related to the palliation and management of the terminal illness and related conditions. The hospice is allowed to charge the beneficiary a copay, not exceeding \$5, for each prescription.²⁵

Because drugs related to the beneficiary's terminal illness are covered under the hospice benefit, they are excluded from coverage under Part D.²⁶ In 2014, CMS issued guidance to Part D sponsors that focused on some commonly used hospice drugs. The guidance strongly encouraged sponsors to place beneficiary-level prior authorization requirements on four categories of drugs that are typically used by hospice beneficiaries: analgesics, anti-nauseants, laxatives, and anti-anxiety drugs.²⁷ CMS expects that hospices will routinely provide these types of drugs so Part D sponsors are instructed to reject claims for these drugs for hospice beneficiaries.

CMS Oversight

Hospices must be certified to participate in the Medicare program.²⁸ CMS contracts with State Survey and Certification agencies to conduct onsite surveys of hospices at the time of initial certification, for recertification, and in response to complaints. These surveys determine whether the hospice meets Medicare requirements. For example, surveyors must determine whether plans of care are individualized, patient-specific, and developed by all members of the interdisciplinary group.²⁹

Surveyors must cite deficiencies when hospices fail to meet requirements. The only enforcement action that CMS can initiate against hospices that do not correct deficiencies is termination from the Medicare program.³⁰ In contrast, CMS has a variety of enforcement actions available for other types of Medicare providers, such as nursing facilities and home health agencies. These actions include civil

²⁴ Social Security Act, §§ 1860D-1(a)(1)(A), 42 U.S.C. § 1395 w-101(a)(1)(A) and 42 CFR § 423.104.

²⁵ 42 CFR § 418.400.

²⁶ Social Security Act, § 1860D-2(e)(2)(B), 42 U.S.C. § 1395w-102(e)(2)(B); 42 CFR § 423.100, *Part D drug*, (2)(i).

²⁷ CMS, *Part D Payment for Drugs for Beneficiaries Enrolled in Medicare Hospice*. Accessed at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2014-PartD-Hospice-Guidance-Revised-Memo.pdf> on June 12, 2015.

²⁸ Social Security Act, §§ 1814(a) and 1866, 42 U.S.C. §§ 1395f(a) and 1395cc.

²⁹ CMS, *State Operations Manual, Appendix M - Guidance to Surveyors: Hospice*, Tag L545. Accessed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_m_hospice.pdf on June 19, 2015.

³⁰ 42 CFR § 488.7(d) and 42 CFR § 489.53.

monetary penalties and denial of Medicare payments.³¹ OIG has previously recommended that CMS seek legislation to establish additional enforcement remedies for poor hospice performance.³²

Related Work

This report is part of OIG's larger body of work examining the Medicare hospice benefit. A recent OIG report found that Medicare payments for hospice care in assisted living facilities (ALF) 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 compared to beneficiaries in any other setting. Hospices typically provided fewer than 5 hours of visits per week and were paid about \$1,100 per week for each beneficiary receiving routine home care in ALFs.³³

In 2011, OIG issued a report that found that hospices with a high percentage of their Medicare beneficiaries residing in nursing facilities received more Medicare payments per beneficiary and served beneficiaries who spent more time in hospice care compared to hospices nationwide.³⁴ In addition, a series of OIG reports addressing CMS oversight of hospices found that 14 percent of hospices were past due for certification in 2005 and that the frequency of recertification had not improved by 2013.³⁵ The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) mandated surveys of hospices at least every 3 years.³⁶

METHODOLOGY

We based this study on data from a medical record review of a stratified random sample of 565 GIP stays in 2012. We also used Medicare Part D data to identify the drugs paid for by Part D and provided to beneficiaries during GIP stays. We considered a GIP stay to be claims for GIP for the same beneficiary in the same setting, from the same hospice, and the start date of a subsequent claim was the same day, or the next day, as the ending date of the previous claim. Unless otherwise stated, all differences noted in the findings are statistically significant. See Appendix A for more detailed information about the methodology. See

³¹ 42 CFR § 488.406 and 42 CFR § 488.820.

³² OIG, *Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight*, OEI-06-05-00260, April 2007.

³³ OIG, *Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities*, OEI-02-14-00070, January 2015.

³⁴ OIG, *Medicare Hospices That Focus on Nursing Facility Residents*, OEI-02-10-00070, July 2011.

³⁵ OIG, *Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight*, OEI-06-05-00260, April 2007. OIG, *Frequency of Medicare Recertification Surveys for Hospices is Unimproved*, OEI-06-13-00130, August 2013.

³⁶ 42 U.S.C. §§ 1395x(dd)(4)(C).

Appendix B for all statistical estimates and 95-percent confidence intervals and Appendix C for chi-square tests for statistically significant differences.

Limitations

This review determined whether hospice billing for GIP was appropriate. We did not independently verify the beneficiary's prognosis for a life expectancy of 6 months or less. In addition, this review focuses on instances in which the beneficiary did not receive the number of services that were needed based on an assessment of the medical record. It does not determine all instances of poor-quality care.

Standards

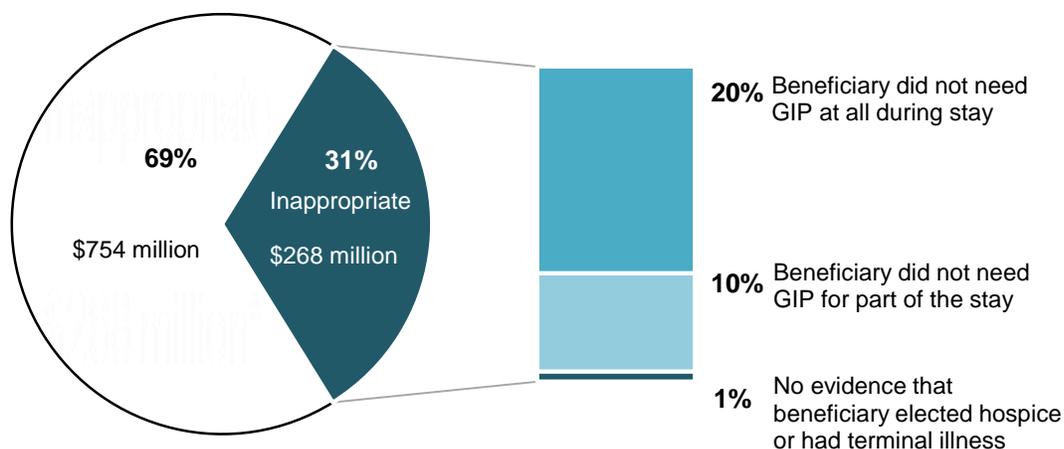
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Hospices billed one-third of GIP stays inappropriately, costing Medicare \$268 million in 2012

In 2012, hospices frequently billed Medicare for providing GIP to beneficiaries who did not need this level of care. GIP is solely for pain control or acute or chronic symptom management that cannot be provided in other settings. For 20 percent of GIP stays in 2012, the beneficiary did not need GIP at all during the stay. See Chart 1. For an additional 10 percent of GIP stays, the beneficiary needed GIP at some point, but not for the entire stay. In these cases, the hospice commonly continued to bill GIP for many days after the beneficiary's symptoms were under control. In 1 percent of stays, there was no evidence that the beneficiary elected hospice care or was even certified as having a terminal illness.

Chart 1: Percentage of Inappropriate GIP Stays, 2012



Source: OIG analysis of medical record review results, 2015.

Medicare inappropriately paid hospices \$268.1 million for GIP in 2012.³⁷ The inappropriate payments represent 26 percent of the \$1.0 billion paid to hospices for GIP stays in 2012.³⁸ For the vast majority of inappropriate GIP stays, the hospice should have billed for routine home care instead of GIP. GIP is

³⁷ For stays in which there was no evidence that the beneficiary elected hospice care or was certified as having a terminal illness, we considered the entire amount Medicare paid for the GIP stay to be inappropriate. For other stays, we considered inappropriate the difference between the amount Medicare paid for GIP and the amount Medicare would have paid had the hospice billed for the level of care that the beneficiary needed.

³⁸ These numbers and others presented in the report are rounded. They cannot always be used to recreate percentages and totals presented in the report because our calculations for these figures are based on unrounded numbers.

reimbursed at a much higher rate than routine home care. In 2012, hospices were paid \$672 per day for GIP whereas they were paid \$151 per day for routine care.³⁹

Hospices commonly billed for GIP when the beneficiary did not have uncontrolled pain or unmanaged symptoms

In 89 percent of inappropriate GIP stays, the hospice billed for GIP even though the beneficiary did not have uncontrolled pain or unmanaged symptoms or the beneficiary received care that could have been provided at home. For example, one hospice billed GIP for 29 days for a beneficiary who was in no apparent distress and whose symptoms were managed with oral medications. The hospice received almost \$21,000 from Medicare for this inappropriate GIP stay. In another example, a hospice billed for 6 days of GIP for an 85-year-old beneficiary with dementia. The hospice placed the beneficiary in GIP and did not change her plan of care or order new medications. The hospice received just over \$3,700 from Medicare for this GIP stay.

Hospices sometimes billed inappropriately for GIP because of caregiver issues. This occurred in 15 percent of the inappropriate GIP stays. Such issues include the caregiver being overwhelmed. GIP is not intended to be used in these situations. A different level of hospice care—inpatient respite care—is designed to provide relief to caregivers. The GIP daily rate is typically four times greater than the inpatient respite care daily rate. In 2012, hospices were paid a base rate of \$672 per day for GIP and \$156 per day for inpatient respite care.⁴⁰

Examples of inappropriate billing related to caregiver issues include a hospice billing for GIP when a beneficiary's wife was exhausted, and a hospice billing for GIP when a beneficiary's son needed a break. In the latter case, the physician had noted in the medical record that the beneficiary needed inpatient respite care, not GIP.

Some States had many inappropriate GIP stays

Some States stand out for the number of inappropriate GIP stays found in our sample.⁴¹ For example, our sample included 99 GIP stays in Florida.⁴² More than half (52) of these stays were inappropriate. One of these inappropriate stays involved a 75-year-old man who had no complaints of discomfort and whose needs were met with basic nursing and hospice services. He did not need, nor did

³⁹ These are the unadjusted daily payment rates for FY 2012. CMS, "Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and the Hospice Pricer for FY 2012," Transmittal 2260, Change Request 7518, July 29, 2011. Accessed at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7518.pdf> on March 25, 2015.

⁴⁰ Ibid.

⁴¹ Because of the size of our sample, we are not able to project these numbers to the population of all stays but can report only on the sample.

⁴² Florida hospices billed for 21 percent of all GIP stays in 2012.

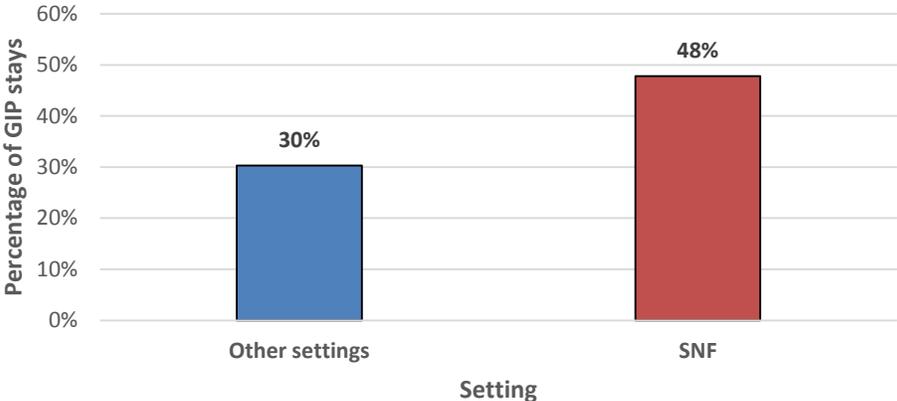
he receive, acute care during his GIP stay, yet the hospice billed 16 days of GIP for him, totaling more than \$11,000.

Ohio and Arizona also stood out. After Florida, these States had the highest number of inappropriate stays in our sample. In Ohio, 18 of the 33 sample GIP stays were inappropriate, including a six-day stay for a beneficiary with Alzheimer’s disease who did not have unmanaged symptoms. In Arizona, 17 of the 31 sample stays were inappropriate. In one inappropriate stay, the beneficiary requested bingo night on the first day. The beneficiary’s symptoms were controlled, yet she remained in GIP for 14 days, which cost Medicare more than \$10,000.

Hospices billed inappropriately for about half of GIP stays in SNFs

Hospices were more likely to inappropriately bill for GIP provided in SNFs than GIP provided in other settings, namely hospitals and hospice inpatient units. Forty-eight percent of GIP stays in SNFs were inappropriate compared to 30 percent in other settings. See Chart 2.

Chart 2: Inappropriate GIP Stays by Setting, 2012



Note: The difference between SNFs and other settings is statistically significant at the 95-percent confidence level. Source: OIG analysis of medical record review results, 2015.

For 39 percent of GIP stays in SNFs, the beneficiary did not need that level of care at all during the stay. For an additional 9 percent, the beneficiary needed GIP at some point, but not for the entire stay. For example, a hospice billed for 13 days of GIP for a beneficiary whose symptoms were under control by the third day. The hospice received about \$9,300 for this stay.

The diagnoses of beneficiaries receiving GIP in SNFs differed from those of beneficiaries receiving GIP in other settings. GIP stays in SNFs were more likely to involve a beneficiary diagnosed with a mental disorder, ill-defined condition, or Alzheimer's disease. In 36 percent of the GIP stays in SNFs, the beneficiary was diagnosed with one of these conditions compared to 22 percent of GIP stays in the other settings. Previous OIG work found that beneficiaries with these types of diagnoses typically receive less complex hospice care than beneficiaries with other diagnoses.⁴³ This work also raised concerns about the potential for hospices to target beneficiaries with conditions associated with less complex care because they may offer hospices the greatest financial gain.

For-profit hospices were more likely than other hospices to bill inappropriately for GIP

For-profit hospices billed 41 percent of their GIP stays inappropriately. In comparison, other hospices, including nonprofit and government-owned hospices, billed 27 percent of their GIP stays inappropriately.

For-profit hospices were more likely than other hospices to bill for GIP in the SNF setting. For-profit hospices accounted for one-third of all GIP stays but two-thirds of GIP stays in SNFs.

⁴³ OIG, *Medicare Hospices That Focus on Nursing Facility Residents*, OEI-02-10-00070, July 2011 and *Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities*, OEI-02-14-00070, January 2015.

Examples of Inappropriate Billing by For-Profit Hospices

- A hospice billed for 51 days of GIP for a beneficiary who needed only routine home care. The beneficiary's symptoms were under control and she needed assistance only with personal care, eating, and the administration of medication. Medicare paid the hospice almost \$30,000 for over 7 weeks of GIP.
- A hospice billed for GIP for a beneficiary with a circulatory disease who had no unmanaged symptoms. This beneficiary could have been cared for at home, but the hospice billed Medicare for 46 consecutive days of GIP in an inpatient unit. The hospice was paid just over \$31,000 for the stay.
- A hospice billed for GIP for a beneficiary in Florida who entered GIP for symptom management. Her symptoms were managed within 2 days, yet she remained in GIP for 15 additional days. Medicare paid close to \$12,000 for this stay.

Medicare sometimes paid twice for drugs for beneficiaries receiving GIP

The Medicare Part A hospice benefit covers drugs for beneficiaries through the daily rate paid to hospices. These drugs must be used primarily for the relief of pain and symptom control related to the hospice beneficiary's terminal illness.⁴⁴ They are supposed to be provided by the hospice. However, our sample of GIP stays included many instances in which Medicare Part D paid for these drugs for hospice beneficiaries.

Specifically, Part D inappropriately paid for over half (110 of 198) of the drugs billed to Part D that were provided to beneficiaries in our sampled GIP stays.⁴⁵ The 110 drugs were used primarily for the relief of pain and symptom control related to the hospice beneficiary's terminal illness, and therefore, should have been provided by the hospice and covered under the daily rate. Medicare is paying twice when Part D pays for drugs that are already covered by the Part A hospice benefit. Also, beneficiaries may be paying for copays for the Part D drugs.

In recent guidance, CMS has encouraged Part D sponsors not to pay for analgesic, antinausea, laxative, or antianxiety drugs for hospice beneficiaries because they are commonly used in hospice care and hospices are expected to provide them.

⁴⁴ 42 CFR §418.202 (f).

⁴⁵ Because of the size of our sample, we are not able to project these numbers to the population of all stays and report only on the sample.

Although some of the inappropriately paid drugs associated with our sample were in these categories, many others were not. Of the 110 drugs, 30 were analgesic, antinausea, laxative, or antianxiety drugs. The remaining 80 drugs for which Part D inappropriately paid were in other categories, which included diuretics and anticonvulsants.

Hospices did not meet care planning requirements for 85 percent of GIP stays

Hospices are required to develop an individualized written plan of care for each beneficiary they serve. The plan of care must meet a number of requirements. For instance, it must include a detailed statement of the scope and frequency of needed services and must be developed by an interdisciplinary group.⁴⁶ Care plans are important because they help ensure that beneficiaries receive the care and attention they need and that care is coordinated effectively.

For 72 percent of GIP stays, the hospice care plan was missing at least one key element

In 72 percent of GIP stays, the hospice did not include either the frequency or the scope of at least one type of main service in the care plan. These services include physician, nursing, and medical social services.

In some instances, care plans included a general description of care and did not appear to take into account the individual needs of the beneficiary. For example, a hospice billed for 4 days of GIP for a beneficiary in an inpatient unit. The plan of care was not individualized, lacked details, and included general language, such as "...to manage pain and other symptoms."

In about half the stays, the hospice care plan was not developed by all the required parties

For 49 percent of GIP stays, hospices did not involve all the required members in care planning.⁴⁷ A pastoral or other counselor was missing in 44 percent of stays and a social worker was not involved in 34 percent of stays. In 12 percent of stays, hospices did not involve the physician in the care planning. A nurse was not involved in 5 percent of stays. It is important for all disciplines to be involved in the care planning to ensure that all of the needs of the beneficiary are planned for and met.

⁴⁶ 42 CFR § 418.56(b) and (c)(2).

⁴⁷ A number of stays had more than one required member who was not involved in the care planning. As a result, the sum of all the percentages that follow in the next few sentences does not equal 49 percent.

Examples of Care Plans That Did Not Meet Requirements

- The plan of care developed by a for-profit hospice for an 85-year-old beneficiary with a disease of the nervous system did not include drugs and treatment necessary to meet the beneficiary's needs. The only problem identified in the care plan was weakness. None of the required interdisciplinary team members were involved in developing the plan. The hospice billed for a 10-day GIP stay in a hospice inpatient unit, totaling about \$7,500.
- A nonprofit hospice billed for 5 days of GIP for a 91-year-old beneficiary in a SNF but did not establish an adequate care plan. The beneficiary was diagnosed with an ill-defined condition and was placed in GIP for both pain and symptom management. Only the nurse and the physician developed the care plan, which did not include the frequency of nursing services. The beneficiary's pain remained uncontrolled for the first 4 days. Medicare paid the hospice nearly \$3,600 for the GIP stay.

Hospices sometimes provided poor-quality care and often did not provide intense services

In 9 percent of GIP stays, the hospice did not provide enough nursing, physician, or medical social services. These services are particularly important during GIP stays because this level of care is for pain control or acute or chronic symptom management that cannot be provided in other settings. For these stays, the hospices did not provide as many visits as the beneficiary needed or did not provide the care that the beneficiary needed during the visit. In some cases, these hospices were not able to effectively manage beneficiaries' symptoms or medications.

Examples of Poor-Quality Care During GIP Stays

- A 101-year-old beneficiary with dementia was cared for by a for-profit hospice in Alabama. His pain was never under control despite spending 16 days in GIP in a SNF. The beneficiary suffered significant pain during personal care and wound care. The hospice did not change the pain medication until the last day, when the dosage was slightly increased. In addition, the beneficiary needed an alternating pressure mattress at the start of the GIP stay, but the hospice did not order it for more than a week. Medicare paid the hospice more than \$9,500 for this stay.
- An 86-year-old beneficiary under the care of a for-profit hospice in Arizona had end stage renal disease and suffered from severe pain. He was also at high risk for severe respiratory distress. The hospice did not change his medication for 3 days even though his symptoms had not improved. For instance, the beneficiary's breathing was labored, but the hospice did not provide intervention or change his plan of care. Medicare paid the hospice over \$5,000 for the GIP stay.
- A 70-year-old beneficiary who had dementia was cared for by a hospice in Puerto Rico. The hospice billed Medicare for 17 days of GIP in a hospital. The hospice nurse did not provide any visits and instead called the patient's family to find out how he was doing. Medicare paid almost \$8,000 for the stay.
- An 89-year-old beneficiary was under the care of a nonprofit hospice that billed for 16 days of GIP in a SNF. The beneficiary's symptoms were uncontrolled for 14 days during which the hospice rarely changed his medication dosage. The patient continued to experience respiratory distress and anxiety. The hospice did not order any medical social services although the beneficiary and his family could have benefited from increased hospice services and emotional support. The hospice received just over \$11,600 for this GIP stay.
- A 66-year-old beneficiary with cancer was in pain throughout his GIP stay in a SNF. The beneficiary's severe pain was not managed, and he did not have frequent assessments and adjustments of his care plan to bring the pain under control. Also, more involvement from the interdisciplinary team members was needed during the stay. The hospice was paid more than \$2,000 for this patient's stay.

Hospices often did not provide intense services to beneficiaries in GIP

Subcutaneous and intravenous treatments are not requirements of GIP stays, nor are they always appropriate during GIP stays.⁴⁸ However, these types of services may be provided in many cases, given that GIP is specifically for pain control or acute or chronic symptom management that cannot be managed in other settings.

Hospices did not provide any medication subcutaneously to beneficiaries in more than three-quarters of GIP stays. Hospices did not provide medication, electrolytes, vitamins, parenteral nutrition, fluids, or infusions intravenously to beneficiaries in more than half of GIP stays. Hospices did not provide treatment either subcutaneously or intravenously in approximately one-third of GIP stays. GIP stays in SNFs again stand out. Hospices did not provide treatment subcutaneously or intravenously in 70 percent of GIP stays in SNFs, compared to 32 percent in other settings.

⁴⁸ For the purpose of this finding, we refer to subcutaneous and intravenous treatments as “intense services.”

CONCLUSION AND RECOMMENDATIONS

Hospices inappropriately billed one-third of GIP stays in 2012; this misuse of GIP cost Medicare \$268 million dollars. In some cases, hospices billed for GIP when the beneficiary did not have uncontrolled pain or unmanaged symptoms, a requirement of GIP. In other cases, the care the beneficiary needed could have been provided at home. Hospices were more likely to inappropriately bill for GIP provided in SNFs than in other settings. Also, for-profit hospices were more likely than other hospices to bill inappropriately. Medicare sometimes paid twice for drugs for hospice beneficiaries. This is because Part D paid for drugs that were already covered by the Part A hospice benefit. In addition, hospices did not meet care planning requirements for 85 percent of GIP stays. Finally, hospices sometimes provided poor-quality care.

The findings in this report make clear the need to address the misuse of GIP and hold hospices accountable when they bill inappropriately or provide poor-quality care. The IMPACT Act of 2014 will increase the number of hospice surveys conducted, but more needs to be done. This report shows that misuse of GIP has human costs for this vulnerable population as well as financial costs for Medicare. Ensuring that hospices provide the appropriate level of care in the most suitable setting is essential to meeting beneficiaries' needs, providing them quality care, and protecting the integrity of Medicare's hospice benefit.

We recommend that CMS:

Increase its oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries

CMS should increase and better target its hospice program integrity efforts. CMS should instruct its contractors to conduct more medical reviews of hospice GIP claims and particularly focus on GIP provided in SNFs and GIP provided by for-profit hospices, given the higher rates at which their stays were inappropriate. As part of these efforts, contractors should identify hospices with recurring problems. They should target these hospices in their reviews. These efforts will help to ensure that hospice payments are appropriate for the level of care that the beneficiary needs and is receiving.

Also, CMS should ensure that it does not pay twice for drugs that are covered under Part D and provided to beneficiaries in hospice care. It should ensure that hospices are paying for these drugs and that they are not being billed to Part D. As part of its efforts, CMS should instruct its contractors to identify hospices that have beneficiaries with high numbers of Part D drugs and target these hospices for further review. CMS could consider including measures that identify high amounts of Part D billing for hospice beneficiaries in its Fraud Prevention System.

Ensure that a physician is involved in the decision to use GIP

Involving physicians in the decisions to start and continue GIP would help ensure that GIP is used appropriately. One way to accomplish this is to require that hospices obtain a physician's order to change the level of care to GIP and include the ordering physician's National Provider Identifier on the hospice claim. The hospice should also have the physician sign off on the level of care at reasonable intervals during the GIP stay. These intervals should be determined by CMS. Making the physician more accountable and requiring some record of the physician's involvement would add another safeguard for ensuring that the beneficiary needs GIP.

Conduct prepayment reviews for lengthy GIP stays

When a beneficiary has a long stay in GIP, it raises questions about whether GIP is the appropriate level of care and, if it is, whether the beneficiary's symptoms are being effectively managed. CMS should conduct prepayment reviews for GIP stays exceeding a reasonable threshold, such as 7 days. CMS should determine this threshold by consulting hospice and palliative care experts and analyzing data on the length of GIP stays. These reviews, based on information provided by the hospice, would determine whether GIP was appropriate for each day of the stay or if another level of care, such as routine home care or inpatient respite care, was more appropriate. Conducting prepayment reviews of lengthy GIP stays would establish additional safeguards to ensure appropriate duration of care and help prevent inappropriate payments for GIP stays. These reviews could also promote effective symptom management and reduce the time beneficiaries' pain and other symptoms are unmanaged.

Increase surveyor efforts to ensure that hospices meet care planning requirements

State surveyors are CMS's primary tool to verify that hospices are meeting care planning requirements and to enforce these requirements. CMS should increase surveyor efforts to make hospices more accountable. It should train surveyors to ensure that they appropriately cite hospices with deficiencies when their care planning is not individualized, does not include the scope and frequency of services, and is not developed by the required parties. Care planning that meets requirements is essential for delivering high-quality services for beneficiaries and their families.

Establish additional enforcement remedies for poor hospice performance

CMS's only enforcement remedy against poorly performing hospices is termination from the Medicare program. Although potentially very serious, problems with care planning and quality may not always merit termination. Termination can disrupt care for beneficiaries and families. As we have recommended previously, CMS should seek authority to establish less severe remedies to address performance problems. A potential array of enforcement

measures could include directed plans of correction, directed in-service training, denials of payment for new admissions or for all patients, civil monetary penalties, and imposition of temporary management.

Follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor-quality care

In a separate memorandum, we will provide CMS information about the stays that were inappropriate and the inappropriate Part D payments in which Medicare paid twice for drugs for beneficiaries receiving GIP. CMS should review this information and take appropriate action. Appropriate actions could include, but are not limited to: (1) recoupment of any inappropriate payments or (2) provider education on how to properly bill for GIP stays.

We will also provide CMS with a list of the hospices in our sample that provided poor-quality care. CMS should provide the list to State Survey and Certification agencies so they can prioritize these hospices for review.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all six of our recommendations.

CMS concurred with our first recommendation to increase its oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries. CMS stated that it is procuring a national Durable Medical Equipment and Home Health/Hospice Recovery Audit contractor that will conduct claim reviews and recoup overpayments and pay underpayments, as necessary.

CMS concurred with our second recommendation to ensure that a physician is involved in the decision to use GIP. CMS stated that it has concerns that requiring a physician's order for GIP could affect access for patients and will work with the hospice community to explore other options for expanding physician involvement. OIG agrees that access to care is crucial. However, requiring a physician's order for GIP should not affect access. The hospice physician should already be actively involved in the care of a beneficiary, especially if the beneficiary has symptoms severe enough that they cannot be controlled at home. In addition, hospices must make physician services routinely available on a 24-hour basis 7 days a week. Requiring a physician's order for GIP for beneficiaries who need that level of care should not place an undue burden on the physician or the hospice. It makes the physician more accountable and adds another safeguard for ensuring that the beneficiary needs GIP.

CMS concurred with our third recommendation to conduct prepayment reviews for lengthy GIP stays. CMS stated that it will work with its contractors to conduct such reviews.

CMS concurred with our fourth recommendation to increase surveyor efforts to ensure that hospices meet care planning requirements. CMS stated that it will revise the Basic Hospice Training for surveyors to emphasize care planning reviews.

CMS concurred with our fifth recommendation to establish additional enforcement remedies for poor hospice performance. CMS stated that it will consider submitting a proposal as part of the budget process that would seek authority to establish additional enforcement remedies.

Finally, CMS concurred with our sixth recommendation to follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor-quality care. CMS stated that it will determine an appropriate number of claims to review. CMS also plans to instruct State Survey and Certification agencies to review the hospices identified in this report as having provided poor-quality care and take appropriate action. CMS also stated that it will reiterate its guidance to Part D sponsors concerning prior authorization of the four categories of drugs.

APPENDIX A

Detailed Methodology

Selection of Statistical Sample for Medical Record Review

Using CMS's National Claims History file, we extracted all Medicare Part A hospice claims that had service dates in 2012 and were received through December 2012. The claims included information about the level of hospice care, such as GIP, and the setting, such as a SNF. We combined the claims to identify all GIP stays. We considered a GIP stay to be claims for GIP for the same beneficiary in the same setting, from the same hospice, and the start date of a subsequent claim was the same day, or the next day, as the ending date of the previous claim. We identified 282,225 GIP stays in 2012 for 252,759 beneficiaries.

We selected a stratified simple random sample of 570 GIP stays from this file. We stratified the sample by whether GIP was provided in SNFs or in other settings to determine whether there were any statistical differences between estimates for these two groups at the 95-percent confidence level. We also stratified the sample by Medicare payments to enhance the precision of our statistical estimates.⁴⁹ The sample included 5 strata. See Table A-1.

Table A-1: Population, Strata, and Sample Size

Stratum	Number of Stays in the Population	Number of Stays in the Sample
GIP stays in SNFs	18,030	116
GIP stays in other settings for which the paid amount was at most \$3,000	152,086	120
GIP stays in other settings for which the paid amount was more than \$3,000, but at most \$7,000	82,096	171
GIP stays in other settings for which the paid amount was more than \$7,000, but at most \$16,000	26,502	120
GIP stays in other settings for which the paid amount was more than \$16,000	3,511	43
Total	282,225	570

Source: OIG analysis of medical record review, 2015.

⁴⁹ The dollar amounts in each stratum were determined by the distribution of the universe of GIP stays.

We did not contact the hospices that billed for five of the stays in our sample because these hospices were under investigation by OIG. Our final sample included 565 stays.

Next, we matched the hospice provider numbers from the claims data with the Certification and Survey Provider Enhanced Reports to determine the ownership status of each hospice (e.g., for-profit or nonprofit).

Lastly, we used the Medicare Part D data to identify the drugs paid for by Part D for the beneficiaries in the sampled GIP stays. To do this, we matched each beneficiary's Health Insurance Claims Number to the Part D prescription drug event data for 2012.

Medical Record Review

We used a contractor to collect and review the medical records associated with each sampled stay. We received a 100-percent response rate from the hospices we contacted.

For each stay, we requested that the hospice provide all medical records relating to the hospice services provided to the beneficiary during the GIP stay identified for review. The documentation included the hospice election statement, all certifications of terminal illness that cover the review period, clinical information and other documentation that support the medical prognosis, all assessments that cover the review period, all plans of care that cover the review period, including any updates or changes to the plans, and a record of all hospice services provided during the review period, including those provided under arrangement or contract with the hospice. Hospices are required to keep all of this information in the clinical record that they establish for every individual receiving care and services.⁵⁰ The contractor identified stays for which the hospice did not provide an election statement or certification of terminal illness.

The contracted reviewers included four registered nurses, each of whom had experience providing and managing hospice care. For each stay, they used a standardized instrument based on Medicare coverage requirements and CMS guidance to review the beneficiary's care planning and services provided by the hospice.

For each day in each GIP stay, the reviewers determined whether GIP was appropriate for the beneficiary based on his or her needs. GIP is solely for pain control or acute or chronic symptom management that cannot be provided in other settings. If the reviewers determined that GIP was not appropriate, they determined the appropriate level of care (e.g., routine home care). In addition, for stays in which Part D paid for a drug for the beneficiary, the reviewers determined

⁵⁰ 42 CFR § 418.104.

whether the drugs were related to the palliation and management of the terminal illness or related conditions.

The reviewers also determined whether the physician and nursing services provided during the GIP claim period met the beneficiary's needs or whether the beneficiary needed more services or services of a higher level of intensity. They also determined whether the beneficiary needed more medical social services than were provided.⁵¹

Lastly, for each stay, the reviewers determined whether the plan of care met key Medicare requirements.⁵² Specifically, they determined whether it included a detailed scope and frequency of the services and whether the services met the beneficiary's needs. The reviewers also determined whether the plan of care was developed by the required members of an interdisciplinary group that included a physician, nurse, social worker, and pastoral or other counselor. The reviewers also described any instances of poor-quality care.

Analysis

We analyzed the results of the medical record review to estimate the percentage of GIP stays that were billed inappropriately. We included stays in which the beneficiary did not need GIP at all, and stays in which the beneficiary did not need GIP for part (e.g., two or more consecutive days) of the stay. We also counted as inappropriately billed all stays in which the hospice did not provide an election statement or certification of terminal illness.

We estimated the amount that inappropriate stays cost Medicare. For stays in which the beneficiary did not elect hospice or was not certified as having a terminal illness with a prognosis of 6 months or less, we considered the entire amount Medicare paid for the GIP stay to be inappropriate. For stays in which the beneficiary elected hospice and was certified as having a terminal illness but did not need GIP for part or all of the stay, we considered inappropriate the difference between the amount Medicare paid for GIP and the amount Medicare would have paid had the hospice billed the appropriate level of care.

We estimated the percentage of inappropriate stays that were in SNFs and the percentage that were in other settings, namely hospitals and hospice inpatient units. We also estimated the percentage of inappropriate stays that were billed by for-profit hospices and the percentage that were billed by other types of hospices, such as nonprofits or those that were government owned. We used a chi-square to test for statistically significant differences between GIP stays provided in SNFs and those provided in other settings. We also tested for statistically significant differences between GIP stays in for-profit hospices and those in all other

⁵¹ A service could be provided directly by hospice staff or under arrangement with the hospice.

⁵² The reviewers took into account the plan of care and any updates that covered the GIP stay identified for review.

hospices. Unless otherwise stated, all differences noted in the findings are statistically significant at the 95-percent confidence level.

We also analyzed the results of the medical record review to determine the number of drugs associated with our sample that Part D paid for inappropriately. We then determined how many of these drugs were included in the four categories addressed in CMS guidance: analgesics, antinauseants, laxatives, and antianxiety drugs.⁵³ Because of the size of our sample, we are not able to project these numbers to the population of all stays, so the numbers presented are solely based on the sample.

We also determined whether hospices provided beneficiaries with subcutaneous or intravenous treatment, which we refer to as “intense services.” These services are not required for beneficiaries receiving GIP, but are commonly provided, given that GIP is for pain control or acute or chronic symptom management that cannot be managed in settings other than inpatient.

Lastly, we analyzed the plans of care to determine whether hospices met the Medicare coverage requirements. Specifically, we analyzed the percentage of stays that were missing required elements in care plans.⁵⁴ We also analyzed the percentage of stays that had plans of care that were not developed by all required members of an interdisciplinary group.⁵⁵

⁵³ These categories were also used in a prior OIG study. See OIG, *Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice* (A-06-10-00059).

⁵⁴ According to Federal requirements, the plan of care must include a detailed statement of the scope and frequency of needed services. See 42 § 418.56(c)(2).

⁵⁵ According to Federal requirements, the interdisciplinary group must include a physician, nurse, social worker, and pastoral or other counselor. See 42 CFR §§ 418.200, 418.56(a).

APPENDIX B

Statistical Estimates and Confidence Intervals

Table B-1: Sample Sizes, Point Estimates, and Confidence Intervals for Inappropriate Billing

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower Limit	Upper Limit
Percentage of GIP stays billed inappropriately	565	31.4%	27.0%	36.2%
Percentage of GIP stays in which the beneficiary did not need GIP at all during the stay	565	20.3%	16.4%	24.8%
Percentage of GIP stays in which the beneficiary needed GIP at some point, but not the entire stay	565	9.7%	7.6%	12.4%
Percentage of GIP stays in which the hospice did not have evidence that the beneficiary elected hospice care or was certified as having a terminal illness	565	1.4%	0.5%	3.6%
Percentage of GIP stays for which hospices billed Medicare appropriately	565	68.6%	63.8%	73.0%
Dollar amount paid inappropriately	565	\$268,090,214	\$235,669,213	\$300,511,215
Percentage of total GIP payments that Medicare inappropriately paid	565	26.2%	23.2%	29.3%
Percentage of inappropriate GIP stays for which the hospice should have billed some or all days as routine care	233	93.0%	85.9%	96.7%
Percentage of inappropriate GIP stays in which the beneficiary did not have unmanaged symptoms or received care that could have been provided at home	233	88.6%	81.2%	93.4%
Percentage of inappropriate GIP stays in which the beneficiary received GIP because of caregiver issues	233	14.7%	9.6%	21.8%

continued on the next page

Table B-1: Sample Sizes, Point Estimates, and Confidence Intervals for Inappropriate Billing (Continued)

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower Limit	Upper Limit
Percentage of GIP stays in SNFs that were inappropriate	113	47.8%	38.7%	57.1%
Percentage of GIP stays in other settings that were inappropriate	452	30.3%	25.6%	35.4%
Percentage of GIP stays in SNFs in which the beneficiary did not need GIP at all during the stay	113	38.9%	30.3%	48.3%
Percentage of GIP stays in SNFs in which the beneficiary did not need GIP for part of the stay	113	8.8%	4.8%	15.8%
Percentage of GIP stays in SNFs in which the beneficiary was diagnosed with a mental disorder, ill-defined condition, or Alzheimer's disease	113	36.3%	27.9%	45.6%
Percentage of GIP stays in other settings in which the beneficiary was diagnosed with a mental disorder, ill-defined condition, or Alzheimer's disease	452	22.1%	17.7%	27.2%
Percentage of GIP stays in for-profit hospices that were billed inappropriately	200	41.4%	32.7%	50.7%
Percentage of GIP stays in other types of hospices, including nonprofit and government-owned hospices, that were billed inappropriately	365	27.4%	22.4%	33.1%

Source: OIG analysis of medical record review results, 2015.

Table B-2: Sample Sizes, Point Estimates, and Confidence Intervals for Care Planning Requirements

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower Limit	Upper Limit
Percentage of GIP stays that did not meet care planning requirements	565	84.6%	80.7%	87.8%
Percentage of GIP stays that were missing at least one key element of the care plan	565	72.3%	67.2%	76.8%
Percentage of GIP stays that did not involve all the required parties in developing the care plan	565	49.0%	43.6%	54.3%
Percentage of GIP stays in which a pastoral or other counselor was not involved in development of the care plan	565	44.4%	39.1%	49.8%
Percentage of GIP stays in which a social worker was not involved in development of the care plan	565	34.4%	29.4%	39.8%
Percentage of GIP stays in which a physician was not involved in development of the care plan	565	11.9%	8.5%	16.3%
Percentage of GIP stays in which a nurse was not involved in development of the care plan	565	5.3%	3.5%	8.0%

Source: OIG analysis of medical record review results, 2015.

Table B-3: Sample Sizes, Point Estimates, and Confidence Intervals for Quality-of-Care Concerns

Estimate Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower Limit	Upper Limit
Percentage of GIP stays that did not provide enough nursing, physician, or medical social services	565	9.5% ¹	6.8%	13.1%
Percentage of GIP stays in which the hospice did not provide subcutaneous treatment	565	75.8%	70.9%	80.1%
Percentage of GIP stays in which the hospice did not provide intravenous treatment	565	50.8%	45.4%	56.1%
Percentage of GIP stays in SNFs in which the hospice did not provide subcutaneous or intravenous treatment	113	69.9%	60.7%	77.7%
Percentage of GIP stays in other settings in which the hospice did not provide subcutaneous or intravenous treatment	452	32.3%	27.4%	37.7%

¹The point estimate was 9.49 percent, which rounded to 9 percent as a whole number in the text.

Source: OIG analysis of medical record review results, 2015.

APPENDIX C

Chi-square Tests for Statistically Significant Differences

Table C-1: Chi-square Test Comparing GIP Stays in SNFs and Other Settings

	Percentage of GIP Stays Provided in SNFs	Percentage of GIP Stays Provided in Other Settings	P-Value ¹
Percentage of GIP stays billed to Medicare inappropriately	47.8%	30.3%	0.0008
Percentage of GIP stays in which the beneficiary was diagnosed with a mental disorder, ill-defined condition, or Alzheimer's disease	36.3%	22.1%	0.0037
Percentage of GIP stays in which the hospice did not provide intravenous and subcutaneous treatment	69.9%	32.3%	<.0001

¹Differences between percentages of stays provided in SNFs and other settings were statistically significant at the 95-percent confidence level.

Source: OIG analysis of medical record review results, 2015.

Table C-2: Chi-Square Test Comparing GIP stays in For-profit Hospices and all Other Hospices, including Nonprofit and Government Owned

	Percentage of GIP Stays in For-profit Hospices	Percentage of GIP Stays in all Other Hospices	P-Value ¹
Percentage of GIP stays that were billed inappropriately	41.4%	27.4%	0.0087

¹Differences between percentages of stays in for-profit hospices and all other hospices were statistically significant at the 95-percent confidence level.

Source: OIG analysis of medical record review results, 2015.

APPENDIX D

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

To: Daniel R. Levinson
Inspector General
Office of Inspector General

From: Andrew M. Slavitt */S/*
Acting Administrator
Centers for Medicare & Medicaid Services

Subject: Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care (OEI-02-10-00491)

The Centers for Medicare & Medicaid Services (CMS) thanks you for your continued work on hospice, and appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS's mission is to provide Medicare beneficiaries with access to high quality health care while protecting taxpayer dollars. CMS is concerned about the possible misuse of hospice generally, including care being billed for but not provided, long lengths of stay, and beneficiaries receiving unnecessary care.¹ However, Medicare payments for General Inpatient Care (GIP) account for only 1.5% of Medicare hospice expenditures. Additionally, CMS analysis of GIP claims finds that utilization of this level of care is low and has remained flat over several years. CMS is also concerned that Medicare beneficiaries continue to have access to this important hospice service and CMS is working to improve appropriate use. As a result, CMS is developing a strategy that targets improper payments without unnecessarily increasing documentation and audit burden on legitimate providers.

Due to concerns over potential fraud, waste, and abuse in hospice, CMS has made significant changes in hospice payment policy in recent years to reward providers that provide high quality care and reduce improper payments. The Affordable Care Act (ACA) gave CMS the authority to reform hospice payment policies, and established a quality reporting program for hospices. In accordance with the ACA, starting in FY 2014, hospices that have failed to meet quality reporting requirements may receive a reduction to their payment. The ACA also authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and to reform how Medicare pays for hospice services.

CMS has implemented the requirement in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) that Medicare-certified hospices have mandatory surveys every 36 months. In addition, CMS now requires hospices to report and share standardized assessment data, which allows providers to facilitate more coordinated care, with the goal of improving Medicare beneficiary outcomes.

¹ <http://oig.hhs.gov/oei/reports/oei-02-10-00490.pdf>

CMS educates providers on proper billing through policy guidance and provides individual providers with comparative billing reports. CMS has issued two sets of comparative reports on hospice services and in 2014, CMS issued guidance to clarify the criteria for determining payment responsibility under the Part A hospice benefit and Part D for drugs for hospice beneficiaries. CMS verifies that the hospice and Part D programs correctly pay for prescription drugs covered under each respective Medicare benefit while allowing for timely access to needed prescription medications.

OIG Recommendation

OIG recommends that CMS increase its oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries.

CMS Response

CMS concurs with this recommendation. CMS has increased the oversight of hospice services through the policy changes described above, targeted education, and the use of the Fraud Prevention System to identify potential providers for further audits and investigations. CMS works closely with the OIG Office of Investigations on civil and criminal cases. For the hospices identified in the report, CMS requests that OIG share the information so CMS can conduct further analysis.

In addition, CMS is procuring a national Durable Medical Equipment (DME) and Home Health/Hospice Recovery Audit contractor. This contractor will conduct reviews of applicable claim types through the appropriate review methods and work with CMS and the Home Health/Hospice MACs to adjust claims to recoup overpayments and pay underpayments, as necessary. CMS is also using prescription drug event data to compare Part D utilization and gross covered drug costs for beneficiaries in a hospice election period. CMS issued revised policy effective October 1, 2014 to encourage sponsors to place prior authorization requirements on the four categories of drugs used in OIG's review. CMS is continuing to conduct additional analyses to evaluate the impact of the revised policy.

OIG Recommendation

OIG recommends that CMS ensure that a physician is involved in the decision to use GIP.

CMS Response

CMS concurs with this recommendation. CMS has existing requirements for physician involvement in the Interdisciplinary Group (IDG), which is responsible for establishing policies for the day-to-day provision of hospice care and services. However, CMS has concerns that requiring a physician's order for GIP could potentially cause delays in access for patients that have symptoms of such severity that they cannot be controlled at home. Also, the addition of a third physician National Provider Number on the hospice claim form would require substantial systems changes and cost without clear benefit, and create potential confusion regarding existing

requirements for physician involvement in the IDG. CMS will work with the hospice community to explore other options for expanding physician involvement.

OIG Recommendation

OIG recommends that CMS conduct prepayment reviews for lengthy GIP stays.

CMS Response

CMS concurs with this recommendation. CMS will work with the Medicare Administrative Contractors to conduct prepayment reviews of lengthy GIP stays.

OIG Recommendation

OIG recommends that CMS increase surveyor efforts to ensure that hospices meet care planning requirements.

CMS Response

CMS concurs with this recommendation. CMS will revise the Basic Hospice Training for surveyors to place appropriate emphasis on care planning reviews during the survey process. The IMPACT Act required that the interval between hospice surveys is not less frequently than once every 36 months.

OIG Recommendation

OIG recommends that CMS establish additional enforcement remedies for poor hospice performance.

CMS Response

CMS concurs with this recommendation. The Fiscal Year 2016 President's budget does not include a proposal to seek authority to establish additional enforcement remedies for poor hospice performance; however, CMS will consider submitting this proposal in the future as part of the budget process. In addition, CMS plans to address the issue of poor hospice performance through its currently established regulatory protocols and the other recommendations the OIG made in this report.

OIG Recommendation

OIG recommends that CMS follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor quality care.

CMS Response

CMS concurs with this recommendation. CMS requests that OIG furnish the necessary data to follow-up on these claims. Upon receipt of the files from OIG, CMS will conduct an analysis to determine the potential return on investment from a medical review of the claims provided. Based on the analysis and contractor resources, CMS will determine an appropriate number of claims to review. CMS will also continue to use the Medicare Learning Network, weekly electronic newsletters and quarterly compliance newsletters to educate providers on avoiding common Medicare billing errors. CMS will instruct State Survey and Certification agencies to

review the hospices identified in this study to have provided poor quality of care and take appropriate action as indicated. Relative to Part D payments, CMS will share the data analysis findings with sponsors and reiterate our guidance concerning prior authorization of the four categories of drugs and retroactive recovery of identified inappropriate payments from the hospices.

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