

Increased Fraud and Abuse Scrutiny of Hospice Reimbursement

Between 2005 and 2011, Medicare spending on hospice care for nursing home residents increased 70 percent.¹ Hospice services are available under Medicare for patients who are terminally ill and have a life expectancy of 6 months or less. Additionally, a physician must certify that the individual qualifies for the *Medicare Hospice Benefit* and periodically re-certify that the patient is eligible for hospice benefits.² Violation of either of these conditions is considered fraud. While fraud and abuse scrutiny has increased across the healthcare industry, particularly since the formation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) in May 2009,³ reimbursement for hospice services has received specific attention due, in part, to reports by the Medicare Payment Advisory Committee (MedPAC) regarding increased lengths of stay for residents in hospice enterprises over the past several years. As a result of this increased scrutiny, many hospice providers that allegedly sought false Medicare claims have been subject to whistleblower suits, and are now facing legal and financial repercussions.

A recent 2012 whistleblower suit involving two former employees of AseraCare Hospice, a company owned by Golden Living that operates 65 hospice centers across 19 states, accused AseraCare of “...reckless business practices.”⁴ The suit alleged that the company sought claims for hospice care for patients who were not terminally ill in order to maximize Medicare reimbursements, and that from 2005 to 2009, approximately 36 percent to 79 percent of patients discharged were still living.⁵ The government joined the whistleblower suit on January 12, 2012, and is seeking treble damages and a penalty of \$5,000 to \$11,000 per claim.⁶

In another recent case of alleged Medicare fraud, Hospice Care of Kansas (HCK) was accused, by a former nurse, of billing Medicare for hospice services provided to ineligible patients, i.e., those patients with more than 6 months to live. An investigation revealed that HCK provided aggressive incentives to employees, physicians, and local nursing homes, including financial gains, gift cards, and free vacations, in order to generate high referrals of ineligible patients, i.e., approximately 25 percent of the enrolled patients at HCK in 2005 did not meet hospice eligibility requirements.⁷ Ultimately, HCK settled the case for \$6.1 million in June 2012.⁸

As mentioned above, a June 2008 MedPAC Report stated that hospice utilization trends showed an increase in lengths of stay at for-profit hospice care facilities, and higher total reimbursement costs related to hospice care. The 2008 Report also noted that the regulations and payment system for Medicare hospice care has not been updated since 1983, “...expos[ing] weaknesses in the Medicare payment system and adverse incentives that may unduly influence some hospices to provide care in a manner not warranted by patients’ clinical needs,” and specifically “...provid[ing] an incentive for hospices to seek patients likely to have long hospice episodes, which are more profitable...”⁹

In a subsequent March 2012 Report, MedPAC stated that the average length of stay for hospice users grew 59 percent, from 2000 (54 days) to 2010 (86 days).¹⁰ The 2012 Report echoed the findings and recommendations first stated in the 2008 Report regarding a need for greater accountability and quality data collection from providers regarding the utilization of Medicare hospice benefits.¹¹

The U.S. Department of Health and Human Services (HHS) and the Office of Inspector General (OIG) recommended in the *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011*, that CMS begin to monitor payments to “...hospices that depend heavily on nursing facility residents and modify the payment system for hospice care in nursing facilities,” and modify the current hospice reimbursement structure, which incentivizes hospices to target “...nursing facility beneficiaries who often receive longer but less complex care.”¹² While, to date, no action has been taken to change reimbursement incentives for hospice services, fraud and abuse scrutiny of these facilities will likely continue to be present going forward as the U.S. healthcare delivery system evolves within the new era of reform.

1 “The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011” United States Department of Health and Human Services, February 2012, p. 48.

2 “Who Pays for Home Care Services,” National Association for Home Care, 1996, <http://www.nahc.org/consumer/wpfhcs.html> (Accessed 2/21/13).

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- 3 “United States Intervenes in False Claims Act Lawsuit Against Orlando, Florida-area Hospice,” the United States Department of Justice, September 6, 2012, <http://www.justice.gov/opa/pr/2012/September/12-civ-1080.html> (Accessed 2/21/13).
- 4 “AseraCare Hospice Accused by U.S. of Defrauding Medicare,” By Tom Schoenberg and Peter Waldman, Bloomberg, January 3, 2012.
- 5 *Ibid.*
- 6 “U.S. Files Complaint Against National Chain Of Hospice Providers Alleging False Claims On The Medicare Program” The United States Attorneys Office Northern Districts of Alabama, Press Release, January 12, 2012, <http://www.justice.gov/usao/aln/News/January%202012/January%202012,%20US%20Files.html> (Accessed 2/26/2013).
- 7 “Aunt Midge Not Dying in Hospice Reveals \$14B Market,” By Peter Waldman, Bloomberg, December 6, 2011.
- 8 “Hospice Care of Kansas and Texas-based Parent Company to Pay \$6.1 Million to Resolve Allegations of False Claims” United States Department of Justice, Press Release, June 21, 2012, <http://www.justice.gov/opa/pr/2012/June/12-civ-768.html> (Accessed 2/26/2013).
- 9 “Evaluating Medicare’s Hospice Benefit,” MedPAC Report to the Congress, June 2008, p. 203-206, 233.
- 10 “Hospice Services: Assessing Payment Adequacy and Updating Payments,” MedPAC Report to the Congress, March 2012, p. 282.
- 11 *Ibid.*, p. 284.
- 12 HHS, February 2012.



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