Chapter 1020
Hospices

Overview

Hospice is an end of life, palliative care program furnished by an array of caregivers in various settings, including a person's residence (which may be a private home, a nursing home, or assisted living facility), inpatient hospice facility, skilled nursing facility, or a hospital. Covered by a variety of third party payers, including Medicare, Medicaid, Veterans Health Administration, and private insurance, hospice benefits are fundamentally different from other health care benefits that instead focus on diagnostic and curative treatment. With its acceptance and focus on the impending death of an individual, hospice care seeks to relieve pain and suffering— (i.e., "palliative care")— as well as address the emotional and spiritual needs of beneficiaries and their families during the final days or months of a terminal illness. Originally developed with terminally ill cancer patients in mind, hospices now serve patients (and their families) with a wide variety of terminal illnesses, including end stage Alzheimer's, dementia, congestive heart failure, kidney disease and other non-cancer diagnoses and conditions.

Hospices are also paid differently than most other healthcare providers. For instance, under Medicare, hospices receive a fixed-rate, per diem payment, based on the type of hospice services furnished. Care coordination with other caregivers is also an essential part of the benefit. Medically necessary physician services furnished to hospice patients are generally billed separately through the hospice.

Both the number of hospice organizations and the utilization of hospice services have grown significantly over the last years. As such, third party payers, particularly the Medicare and Medicaid programs, have targeted hospices for several program integrity concerns. These include billing for beneficiaries who are not hospice-eligible (i.e., they do not have a terminal illness with a life expectancy of six months or less if the illness runs its normal course), underutilization of items or services related to the terminal illness, billing for higher levels of care than are medically appropriate, and compliance with an assortment of technical billing requirements. Although a variety of payers, including private insurers, cover hospice benefits, this discussion will focus primarily on hospice billing requirements and practices under the Medicare and Medicaid programs. (Medicare Advantage plans do not currently cover hospice enrollees—their enrollees who elect hospice return to the fee-for-service program—but this could change in the future.)

In addition to technical billing and medical necessity issues, the provision of hospice care to nursing home and assisted living facility residents (which is common in the industry) implicates various program integrity concerns. For discussion of anti-kickback concerns that arise in the treatment of hospice patients in nursing homes, see *Chapter 1815, Hospice and Nursing Home Relationships*.

For further discussion of general risk areas in billing, see *Tab Section 600, Billing Practices—General Risk Areas*. Penalties for fraudulent billing practices are covered in *Chapter 210, Penalties*.

1020.10 Law and Regulatory Summary

1020.10.10
General Requirements

1020.10.10.10
The Medicare Hospice Benefit

The hospice benefit was established by Congress in 1983 as a discrete Medicare benefit available to terminally ill beneficiaries. Hospice care allows terminally ill individuals to function with minimal disruption in normal activities while remaining primarily in the home environment. As such, hospice services related to terminal illnesses are palliative—focusing on pain control and symptom management—rather than curative in nature.[1]

The recognition of impending death allows beneficiaries to reject curative treatment for their terminal illnesses and to elect palliation of their terminal illnesses when conventional medical approaches may no longer be appropriate or effective.

[1] Social Security Act § 1812(d) [42 U.S.C. § 1395d(d)].

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Hospice care is broad in scope; the benefit applies to both the patient and the patient's family. The hospice organization's caregiving team is made up of specially trained staff from the fields of medicine, nursing, and social work, in addition to therapists, spiritual counselors, and unpaid volunteers.[2]

Under the Medicare hospice benefit (and most Medicaid programs follow suit), a hospice may admit a patient only after two physicians— the patient's attending physician and the hospice's medical director—have certified that the patient has a terminal illness with a prognosis of six months or less to live if the terminal illness runs its normal course.[3] In some instances, the patient's attending physician is also the hospice medical director, in which case only that physician is required to certify to the patient's terminal illness. The admissions process usually involves other clinical staff at the hospice, including admissions nurses who may assess the patient's clinical presentation to assist physicians in determining if the patient meets the various applicable Medicare guidelines for terminal illness required for the hospice benefit.

Although MedPAC has recommended that Medicare provide for hospice coverage through Medicare Advantage (MA) plans,[4] such plans may not, as of 2018, offer a hospice benefit. As a result, MA plan enrollees will receive hospice benefits under the original Medicare fee-for-service program.[5]

1020.10.10.20
Eligibility for and Election of Hospice

To qualify for the Medicare hospice benefit, a patient must be eligible for Medicare and certified as having a terminal illness, defined as a medical prognosis that the beneficiary has a life expectancy of six months or less if the illness runs its normal course.[6] Medicare regulations contain detailed requirements for the content and timing of these certifications, both verbal and written.[7] For the initial 90-day certification period, two physicians must certify to terminal illness (unless there is no separate attending physician) and for the subsequent 90-day certification period (and 60-day recertification periods thereafter), only the hospice medical director must certify to terminal illness (see discussion below). As a result of the Patient Protection and Affordable Care Act (ACA),[8] Medicare now also requires a face-to-face visit by a physician or nurse practitioner no more than 30 calendar days prior to the start of the third certification period (*see discussion below*). A certifying physician must base his/her recertification at least in part on the findings of the face-to-face visit.

A beneficiary who elects to enroll in a hospice program waives all rights to Medicare coverage of curative care related to the terminal illness. The beneficiary's election of hospice is a critical component of coverage and hospice organizations must carefully follow those election requirements. Importantly—and the source of significant confusion among medical professionals, suppliers, patients, and patients' families— even when a beneficiary elects the hospice benefit, Medicare will continue to cover and pay separately for services furnished by the patient's non-hospice attending physician and for the treatment of conditions unrelated to the terminal illness.[9] What constitute conditions unrelated to the beneficiary's terminal illness can raise difficult gray area questions that also give rise to payment and, in some cases, program integrity scrutiny. For instance, the Centers for Medicare & Medicaid Services (CMS) emphasized that nearly all drugs and durable medical equipment (DME) provided to a hospice patient will relate in some way to that patient's terminal illness.[10] If the beneficiary is incapacitated (physically or mentally), a representative (someone authorized under state law to make such election decisions on behalf of the beneficiary, including a legal guardian) may act on the beneficiary's behalf to elect the hospice benefit. As of April 2018, the OIG has initiated an audit of Part D billings for hospice patients.[11]

A qualified beneficiary's election of hospice is voluntary and may be revoked at any time by the beneficiary or his/her representative. Beneficiaries who revoke their hospice benefits can return to curative treatment and may later elect to receive hospice care, if they are eligible.[12]

Likewise, a hospice agency can discharge a beneficiary if it determines that the beneficiary's condition has improved or stabilized and thus he or she is no longer terminally ill (often referred to as a "discharge for extended prognosis") and Medicare's eligibility criteria for hospice is no longer met; the patient moves out of the hospice service area or transfers to another hospice; or the hospice determines, under a policy set by the hospice for the purpose of addressing "discharge for cause" (see *Discharge from Hospice Care*, § 1020.20.70), that the patient's behavior is disruptive, abusive, or uncooperative to the extent that delivery of

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[2] Office of Inspector Gen. (OIG), U.S. Dep't of Health & Human Servs. (HHS), Compliance Program Guidance for Hospices, 64 Fed. Reg. 54,031, 54,032 (Oct. 5, 1999). Note that hospice is the only Medicare benefit that requires the organization to use unpaid volunteers for some of its services.

[3] 42 C.F.R. § 418.25(a).

[4] MedPAC, Report to the Congress: Medicare Payment Policy, (Mar. 2014).

[5] 42 C.F.R. § 422.320.

[6] Social Security Act § 1861(dd)(3)(A) [42 U.S.C. § 1395x(dd)-(3)(A)]; 42 C.F.R. §§ 418.3, 418.20.

[7] 42 C.F.R. § 418.22.

[8] Pub. L. No. 111-148 § 6407, 124 Stat. 119 (2010).

[9] Social Security Act § 1812(d)(2)(A) [42 U.S.C. § 1395d(d)(2)-(A)]; 42 C.F.R. § 418.24(d). Medicare covered services not related to a hospice patient's terminal condition is coded under a billing modifier "GW."

[10] CMS, Memorandum on Part D Payment for Drugs for Beneficiaries Enrolled in Hospice.

[11] OIG, Active Work Plan Item: Duplicate Drug Claims for Hospice Beneficiaries (Aug. 2017).

[12] Social Security Act § 1812(d)(2)(B) [42 U.S.C. § 1395d(d)(2)-(B)]; 42 C.F.R. § 418.28.

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care to the patient or the ability of the hospice to operate effectively is seriously impaired or refuses to permit a face-to-face visit before the third certification period.[13] Such "live discharges" also may occur when a hospice patient and/or the patient's representative elects to receive curative or other care from hospitals or other acute care facilities when the hospice has no arrangement or contract with that facility. In such instances, hospices are expected to try to contract with the facility (if the care was related to the terminal illness) and educate the patient and caregivers on the need for appropriate coordination to avoid such potential live discharges, which themselves can create program integrity concerns if they occur frequently.

A beneficiary discharged from hospice care (for any reason other than transfer to another hospice) immediately resumes full coverage under the regular Medicare program.[14]

1020.10.10.30
Standards for Hospice Certification and Reimbursement

A hospice program must meet stringent standards to qualify for reimbursement under the Medicare hospice benefit.[15] The hospice is responsible for providing all services necessary to conform to the patient's written plan of care that is developed and monitored by an interdisciplinary team. The team must include a physician, nurse, home health aide, social worker, and pastoral or other counselor.[16]

The plan of care must be individually tailored to meet the needs of each beneficiary. The following services and supplies can be included:[17]

- nursing care provided by or under the supervision of a registered professional nurse;
- physical or occupational therapy or speech-language pathology services;
- medical social services under the direction of a physician;
- trained home health aide services;
- homemaker services;
- medical supplies reasonable and necessary for palliation and management of the terminal illness, including drugs, biologicals, and the use of medical appliances;
- physician services;
- short-term inpatient care in an appropriate inpatient facility, such as a participating hospice inpatient unit or participating hospital or nursing home that meets hospice qualification requirements (e.g., 24-hour registered nurse availability);
- counseling—including dietary counseling and bereavement counseling for the immediate family[18]—with respect to care of the terminally ill beneficiary and adjustment to the beneficiary's death; and
- any other item or service that is specified in the plan of care and for which payment otherwise might be made under Medicare.

Substantially all "core services"—which include nursing, counseling, and medical social services—must be provided directly by hospice employees. Hospice services outside of these core services can be provided by nonhospice practitioners under contract, but only if the hospice maintains managerial control over the provision of such services.[19] Hospice organizations affiliated with other health care provider organizations (such as a hospital, nursing home or home health agency) should consider these rules on core services furnished by hospice employees carefully when entering into employee sharing arrangements.

In its 1999 Compliance Program Guidance for Hospice, the OIG recommended that a hospice's written policies and procedures reflect and reinforce current federal health care requirements regarding eligibility for hospice reimbursement. The policies must create a mechanism that enables the billing staff to communicate effectively and accurately with the clinical staff. Policies and procedures should:[20]

- provide for complete and timely documentation of the specific clinical factors that qualify a patient for the hospice benefit;
- delineate who has the authority to make changes in the patient record;
- emphasize that patients should be admitted to hospice care only when appropriate documentation supports the applicable reimbursement eligibility criteria;
- indicate that diagnosis and procedure codes for hospice services reported on the reimbursement claim should be based on the patient's clinical condition as reflected in the medical record; and
- provide that compensation for hospice admission personnel, billing department personnel, and billing consultants should not offer any financial in-

[13] 42 C.F.R. § 418.26(a).
[14] 42 C.F.R. § 418.26(c).
[15] *See* 42 C.F.R. § § 418.50 et seq.
[16] Social Security Act § 1861(dd)(2)(B) [42 U.S.C. § 1395x(dd)(2)(B)]; 42 C.F.R. §§ 418.68(a), 418.202.
[17] Social Security Act § 1861(dd)(1) [42 U.S.C. § 1395x(dd)(1)]; 42 C.F.R. § 418.58.
[18] CMS is allowed to waive the requirement that all hospices provide dietary counseling. These waivers are available to an agency or organization only if it is located in an area that is not an urbanized area—as defined by the Bureau of Census—and can demonstrate to CMS that it has been unable, despite diligent efforts, to recruit appropriate personnel. Hospices will be required to submit evidence to establish that diligent efforts have been made. Social Security Act § 1861(dd)(5)(C) [42 U.S.C. § 1395x(dd)(5)(C)].
[19] Social Security Act § 1861(dd)(2)(A) [42 U.S.C. § 1395x(dd)(2)(A)]; 42 C.F.R. § 418.80.
[20] OIG, Compliance Program Guidance for Hospices, 64 Fed. Reg. at 54,037-54,038.

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centive to bill for hospice care when applicable hospice eligibility criteria are not met.

Like many other provider types, hospices were mandated under the ACA to begin reporting quality data to CMS under its Hospice Quality Reporting Program (HQRP).[21] Among measures in the Hospice Item Set (HIS) that entities are expected to report are the percentage of patients who receive pain screening during hospice and, for those patients screened that report pain, the percentage that receive a clinical pain assessment within 24 hours.[22] In 2014, CMS began penalizing hospices that fail to submit the required data to the HQRP. As of 2018, hospices that fail to comply with these requirements incur a two percentage point reduction to the market basket percentage increase for the corresponding fiscal year.[23]

The ACA also required CMS to create a website to report quality measures provided by hospice programs across the country.[24] In August 2017, CMS unveiled the Hospice Compare website, which was intended to give patients, family members, and providers a snapshot of the quality of care each hospice provides.[25] The launch was followed by controversy over inaccurate data, as well as issues related to certain search functions. Since the release, CMS has issued guidance for hospice providers on updating demographic data. [2627] It has also indicated, on its website, that it is working improve data accuracy. CMS is likely to continue to revise the Hospice Compare user experience.

1020.10.10.40
Fixed Fee Per Diem System

With rare exceptions, Medicare reimburses hospices at a fixed per diem rate, based on the geographic location of the patient (not the location of the hospice itself) and the level of care required.[28] Separate payment amounts are determined for each of the following care categories:[29]

- routine home care (the most common form of hospice care);
- continuous home care, consisting predominantly of nursing care on a continuous basis (of at least eight hours a day) at the patient's home (services may be provided up to 24 hours a day under plan of care);[30]
- inpatient respite care, consisting of respite care in an approved facility on a short-term basis (not to exceed five days) to provide caregivers with a "respite"; [31]and
- general inpatient care, consisting of general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings. This level of care is typically furnished in a hospice inpatient unit, a hospital, or a skilled nursing facility.

Hospices may not charge a patient for services for which the patient is entitled to have payment made under Medicare.[32]

The vast majority of patients enrolled in hospice care receive routine home care which may be furnished in a home or a caregiver's residence, group home, nursing home or assisted living facility.[33] In some instances, terminally ill beneficiaries with only days to live or intractable, uncontrolled pain elect hospice, receive general inpatient level of care or continuous care, and die without having received routine home care.

The amount or expense of services provided by the hospice for any particular beneficiary is not considered when Medicare reimbursement is calculated.[34] Thus, the hospice bears the financial burden for the cost of care required by its patients. Nevertheless, Medicare certified hospices are still required to create and submit Medicare cost reports, as are all other Medicare providers whose services are covered under the Part A benefit. But unlike other Part A providers, hospices are not eligible for extra payment for "outlier" cases that may involve extraordinary costs. Indeed, in an effort to limit high hospice cost payments, the Medicare benefit includes two payment "caps"—one for general inpatient stays and the other aimed at limiting the effect on Medicare payments of multiple long length of stay patients. (See below at *1020.10.10.60.*)

Through the ACA, Congress directed the HHS to collect and analyze data, consult with stakeholders (e.g., hospice providers, MedPAC), and promulgate regulations after October 1, 2013, to reform the methodology for calculating hospice payments.[35] Effective January 2016, hospice payment includes two routine home care rates: a higher rate effective during the first 60 days of a hospice election and a lower rate for days 61 and

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[21] ACA § 3004(c); 42 U.S.C. § 1395f(i)(5).

[22] *See* CMS, Hospice Quality Reporting: Current Measures (as of Jan. 24, 2018).

[23] *See* Medicare Program; FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements, 82 Fed. Reg. 36,638 (Oct. 1, 2017).

[24] ACA § 3004(c); 42 U.S.C. § 1395f(i)(5)(E).

[25] Hospice Compare is *available at* https://www.medicare.gov/hospicecompare/.

[26] ACA § 3004(c); 42 U.S.C. § 1395f(i)(5)(E).

[27] CMS, How to Update Hospice Demographic Data (Nov. 24, 2017).

[28] Social Security Act § 1814(i) [42 U.S.C. § 1395f(i)]; 42 C.F.R. §§ 418.302, 418.306.

[29] 42 C.F.R. § 418.302.

[30] Continuous home care is furnished only during brief periods of crisis as described in 42 C.F.R. § 418.204(a) and only as necessary to maintain the terminally ill patient at home. 42 C.F.R. § 418.302(b). Overuse of this level of care has been the focus of program integrity scrutiny as Medicare pays a significantly higher per diem rate for this level of care.

[31] Note that CMS allows for a small copayment of up to 5 percent of the inpatient respite care rate, but hospices often waive this payment. *See* § 1020.10.10.70.

[32] 42 C.F.R. § 418.301(c).

[33] Office of Evaluation & Inspections (OEI), OIG, Hospice Patients in Nursing Homes (No. OEI-05-95-00250, Sept. 1997), at 1.

[34] *See* 42 C.F.R. § 418.302.

[35] ACA § 3132; 42 U.S.C. § 1395f(i)(6).

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later.[36] Additionally, there are intensity add-on payments available for hospice social worker and nursing visits provided during the last seven days of life as part of routine home care. CMS projected this change would compensate for periods of crisis when patient needs typically surge and more intensive services are warranted, requiring higher wage rates and highly trained clinicians. In addition to this payment report, the Hospice Cost Report Data collects information on cost and statistical data for providers including cost, expenses, revenues, quality, and star rating. Information from the cost reports is used for future payment rate recommendations. Payment rates for hospice care, the hospice aggregate cap amount, and the hospice wage index are updated annually.

1020.10.10.50
Billing for Physician Services

Medicare per diem payments to hospices include reimbursement for the general supervisory services of a medical director and the plan of care and care supervision activities of physician members of the interdisciplinary team, irrespective of whether the physician is the attending physician, as well as reimbursement for a face-to-face visit.[37] Conversely, medically necessary physician services for a hospice patient, irrespective of whether related or unrelated to the terminal illness, may be separately billed to Medicare. Two modifiers are used for processing medical services: the "GV" modifier and "GW" modifier.[38] Professional services of an "attending physician" are submitted with the GV modifier when the services meet specified conditions. Services provided to a hospice patient that are not related to the treatment and management of the patient's terminal illness are submitted with the GW modifier. Beginning January 1, 2019, physician assistants will be able to provide and manage hospice care to Medicare beneficiaries, both as attending physicians to hospice patients and by performing other functions within their scope of practice.[39]

The hospice itself may, however, elect to seek and receive Medicare reimbursement for the medically necessary professional services of its employed and contracted attending physicians, who are paid by the hospice through a salary or other means.[40] The amount paid by the Medicare Administrative Contractor (MAC) to the hospice is the lesser of the hospice's actual charge for the physician service or 100 percent of the Medicare physician fee schedule amount for physicians (85 percent for nurse practitioners). What the physician receives as payment for the physician services will depend on the terms of his/her contract with the hospice. This reimbursement will, however, count toward the hospice's aggregate cap, discussed below.

The hospice is also eligible to receive payments for pre-election evaluation and counseling services that do not count towards the aggregate cap.[41] These physician services, like palliative care services, are billed to the Medicare Part B contractor.

A one-time payment may be made to a hospice for evaluation and counseling services furnished by a physician who is either the medical director of or employee of a hospice agency.[42] In order to be eligible to receive these services, a beneficiary must:

- be determined to have a terminal illness;
- not have made a hospice election; and
- not previously have received the pre-election hospice services. [43]

Services under this benefit are those necessary to evaluate the individual's need for pain and symptom management and counsel the individual regarding hospice and other care options and may include advising the individual regarding advanced care planning.[44] Since such services also are available through other Medicare benefits, this service may not be reasonable and necessary for all individuals. To the extent that beneficiaries already have received Medicare-covered evaluation and counseling with respect to end-of-life care, the hospice pre-election benefit would seem duplicative, CMS has said.[45] However, the agency advised, if a beneficiary or the beneficiary's physician deems it necessary to seek the expertise of a hospice medical director or physician employee, the benefit is available to ensure that a beneficiary's end-of-life options for care and pain management are addressed.

Because the decision to utilize evaluation and counseling services is determined by the beneficiary or the beneficiary's physician, the service may not be initiated by the hospice.[46] Since the hospice is the entity that would be receiving payment for the service, payments by hospice agencies to physicians or others in a position to refer patients for services furnished under this provision may implicate the federal anti-kickback statute, CMS said.

Attending physicians not employed by or under contract with hospices who provide medical services to hospice beneficiaries may seek and receive Medicare Part B reimbursement directly, under the Medicare physician fee schedule.[47] Because these payments are made to the attending physicians themselves, and not to the hospice, this reimbursement does not count toward the hospice's aggregate cap, discussed below.

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[36] CMS, Medicare Claims Processing Manual (Pub. 100-04), ch. 11, § 30.2.
[37] 42 C.F.R. § 418.304(a).
[38] Medicare Claims Processing Manual (Pub. 100-04), ch. 11, § 40.2.
[39] 42 U.S.C. § 1395x(dd)(3)(B).
[40] 42 C.F.R. § 418.304(b), (e). Nurse practitioners are eligible.
[41] 42 C.F.R. § 418.304(d).
[42] Social Security Act § 1812(a)(1)(5) [42 U.S.C. § 1395d(a)(5)].
[43] CMS, Medicare Benefit Policy Manual (Pub. 100-02), ch. 9, § 80.
[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] 42 C.F.R. § 418.304(c).

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1020.10.10.60
Caps on Hospice Payments

Under Medicare, the hospice benefit is subject to two types of payment caps or limits:

- Inpatient Cap: For a given cap year (running from November 1 to October 31), CMS limits the total number of days of inpatient care the hospice can furnish to 20 percent of the total patient care days. This is calculated at the end of the cap year by the MAC.[48] This particular cap is rarely triggered.
- Aggregate Cap: For a given cap year, the limit on the total amount of Medicare payments is equal to a "cap amount" (determined annually at the end of the cap year by CMS) multiplied by the number of beneficiaries who elected hospice care during the cap year.[49] For the 2018 cap year, the cap amount is $28,689.04.

Payments for services received in excess of these cap limits must be refunded by hospices to the Medicare program. According to a March 2018 report by MedPAC, although the inpatient cap is rarely exceeded, the number of hospices exceeding the aggregate cap, while historically low, has increased in recent years, peaking in 2009.[50] In 2009, the number of hospices exceeding that cap reached 12.5 percent and has been oscillating in the years since. MedPAC found that increases in the number of hospices and increases in very long stays have resulted in more hospices exceeding the aggregate cap.

CMS's calculation of the aggregate cap amount was the subject of considerable litigation, with plaintiffs challenging CMS's methodology of treatment of Medicare beneficiaries with more than one year of hospice enrollment. On April 14, 2011, CMS issued a ruling entitled "Medicare Program; Hospice Appeals for Review of an Overpayment Determination" (CMS-1355-R), which set forth an alternative methodology for calculating the aggregate caps for hospices with respect to these beneficiaries.[51] Later that year, CMS issued a final rule, effective October 1, 2011, setting forth changes to the cap calculation methodology, with a transition period for certain eligible hospices.[52] CMS has continued to update its cap calculation methodology, as well as the rules attendant to refunding cap overpayments. For the 2014 cap year, for instance, hospices are required to calculate and refund any aggregate cap overpayment liability within 5 months of the close of the cap year (in other words, by March 31 of the subsequent year).[53] Failure to calculate and refund any aggregate cap liabilities could result in a suspension of payment until the required cap reporting is filed with a hospice's MAC. [54]

1020.10.10.70
Coinsurance Payments

Hospices may charge patients for the coinsurance payment for prescribed palliative drugs and biologicals furnished to non-inpatient hospice beneficiaries, up to a $5 cap. A hospice's coinsurance schedule must be approved in advance by the Part A MAC.[55]

Hospices may also charge patients coinsurance for each respite care day, equal to five percent of the CMS payment for a respite care day.[56] Hospices often do not charge for the respite coinsurance. Hospices may not otherwise charge for coinsurance.

1020.10.20
Hospice Care Provided in Nursing Homes

When it was first enacted, the hospice benefit was limited to beneficiaries living at home or as inpatients at a hospice facility. In 1986, the hospice benefit was expanded to include qualified individuals living or residing in nursing homes,[57] but, because Medicare hospice data did not readily allow identification of nursing home residents, only estimates of this figure could be made. One study estimated that 45 percent of hospice patients lived in nursing homes between 1996 and 1999.[58] In 2007, CMS required that hospices begin reporting additional location information on their claim forms through the use of Healthcare Common Procedure Coding System (HCPCS) Q-codes that described the setting where claimed hospice care was provided.[59]Through this reporting process, CMS hoped to enhance its ability to ensure payment accuracy and to better track how services are provided under the Medicare hospice benefit.[60]

Many nursing home residents are "dual eligibles"—that is, they are Medicare beneficiaries on account of their old age or disability and they have some level of Medicaid eligibility based upon financial means. So-called "nursing homes" vary greatly and are distinguishable from Medicare certified skilled nursing facilities or rehabilitation facilities. Most nursing home patients' stays (room and board) are covered by Medicaid and assistance with bathing and dressing and other requirements for daily living are included in the room and board payment (which is also typically a per diem payment). The combination of these Medicare and Medicaid benefits has created a need for significant care coordination and in some instances, has created im-

[48] *See* 42 C.F.R. § 418.302(f).
[49] *See* 42 C.F.R. § 418.309.
[50] MedPAC, Report to the Congress: Medicare Payment Policy, Chapter 12: Hospice Services (Mar. 2018), at 327-328.
[51] CMS Ruling No. CMS-1355-R, Hospice Appeals for Review of an Overpayment Determination (Apr. 14, 2011).
[52] 76 Fed. Reg. 47,302, 47,308-314 (Aug. 4, 2011).
[53] 79 Fed. Reg. 50,452, 50,472 (Aug. 2, 2014).
[54] *Id.*
[55] 42 C.F.R. § 418.400(a).
[56] 42 C.F.R. § 418.400(b).
[57] Pub. L. No. 99-272, § 9505(a)(2).
[58] Campbell, D., J. Lynn, T. Louis, et al. "Medicare program expenditures associated with hospice use," *Annals of Internal Medicine* 140, no. 4. pp. 269-278 (Feb. 17, 2004).
[59] Instructions for Reporting Hospice Services in Greater Line Item Detail (July 28, 2006).
[60] *Id.* at 2.

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proper financial incentives and problematic billing arrangements that have increasingly become a focus of government health care program and policymaker scrutiny.

Despite several MedPAC recommendations and concerns about the potential for duplicate payments based on potentially overlapping per diem payment systems, and despite the ACA's mandate for hospice payment reform, as of April 2018, Medicare has not established a separate payment rate for hospice services provided in a nursing facility.[61] In fact, for the most part, Medicare treats hospice beneficiaries living in nursing homes exactly the same as beneficiaries living in their own homes; for services provided to patients in nursing homes, hospices receive the same fixed per diem home care rate. Therefore, hospice patients who reside in nursing homes are responsible for payment of room and board charges.[62] And in an anachronistic twist, federal Medicare rules have in most states mandated that the hospice organization, as the care coordinator, bill the state Medicaid programs for the room and board furnished to Medicaid recipients by the nursing home. The state Medicaid program must by federal statute pay to the hospice at least at 95 percent of the Medicaid rate whereby the hospice must then remit at least that payment amount to the nursing home as a form of "pass through" payment.[63]

This Medicare/Medicaid payment dichotomy creates a somewhat circular billing arrangement. Specifically, billing for hospice services to nursing home patients who are dually eligible for Medicare and Medicaid operates as follows:[64]

- as usual, the hospice bills the Medicare program the daily fixed rate for the patient's hospice care;
- the nursing home no longer bills the state Medicaid program for the patient's room and board;
- the nursing home bills the resident for any patient pay amount;
- the nursing home bills and receives payment for room and board from the hospice pursuant to a written contract;
- the hospice bills the state Medicaid program for the patient's room and board, supposedly taking into account any patient pay responsibility from information furnished by the nursing home or the state Medicaid program;[65]
- the Medicaid program must pay at least 95 percent of the Medicaid daily nursing home room and board rate to the hospice (which in reality means it pays only 95 percent); and
- most hospices have a contractual obligation to nursing homes to pay at least 100 percent of the Medicaid daily room and board rate and remit that amount to the nursing home.

Once the hospice benefit is elected, the hospice is in charge of the beneficiary's care coordination and care planning (and the nursing home is no longer in such control). The hospice can involve nursing home personnel in the administration of prescribed medication and other therapies only to the extent that the hospice would routinely use the services of a hospice patient's family or caregiver in implementing the plan of care.[66] The hospice also can arrange for non-core hospice services to be provided by nursing home personnel, but the hospice must assume professional management responsibilities for these services.[67] Sometimes when a nursing home agrees to provide such non-core services on behalf of a hospice, an additional payment by the hospice to the nursing home may be appropriately made. But given the referral source status of most nursing homes, such arrangements should be carefully devised, reflected in a written agreement with only a fair market value payment for necessary services.

The provision of hospice care to patients residing in nursing homes has led to several types of program integrity concerns, including:[68]

- lower frequency of services provided by the hospice to nursing home residents that is inconsistent with the plan of care;[69]
- overlap of services provided by hospices and nursing homes to nursing home residents enrolled in the hospice benefit;[70]
- substitution of nursing or aide care furnished by hospice personnel in lieu of nursing home personnel; and
- questionable enrollment in hospice by nursing home residents.[71]

1020.10.30
Coordination of DME, Medical Suppliers, and Pharmacy

Under the Medicare hospice benefit, the cost of DME, medical supplies, prescription medications and biologics related to palliative care and management of hospice patients' terminal illness are included in the

[61] OIG, Special Fraud Alert: Fraud and Abuse in Nursing Home Arrangements With Hospices, 63 Fed. Reg. 20,415, 20,416 (April 15, 1998).

[62] Medicare Benefit Policy Manual (Pub. 100-02), ch. 9, § 20.3.

[63] 42 U.S.C. § 1396a. In at least one state, Pennsylvania, nursing homes continue to bill Medicaid for the room and board for residents who have elected hospice and so there is no pass-through payment.

[64] Medicare Benefit Policy Manual (Pub. 100-02), ch. 9, § 20.3.

[65] OIG and state Medicaid programs have started to audit this "patient pay" issue and have found that state Medicaid programs have faulty systems sometimes resulting in significant overpayments.

[66] OIG, Compliance Program Guidance for Hospices, 64 Fed. Reg. at 54,039.

[67] Social Security Act § 1861(dd)(2)(A) [42 U.S.C. § 1395x-(dd)(2)(A)]; 42 C.F.R. § 418.80.

[68] *See* OEI, Hospice Patients in Nursing Homes (No. OEI-05-95-00250, September 1997).

[69] *See Nursing Home Residents*, § 1020.20.30.40.

[70] *See id.* at § 1020.20.20.20.

[71] *See id.* at § 1020.20.10.50.

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Medicare per diem reimbursement to the hospice.[72] In 2014, CMS revised guidance, which stated hospice providers will provide all of the medications that are reasonable and necessary for the palliation and management of a beneficiary's terminal illness and related conditions, by clarifying what is considered "related to" the terminal condition.[73] Based on this guidance, prior approval is only required for four specific classes of drugs: analgesics, antinauseants, laxatives, and anti-anxiety drugs. CMS sought to remove barriers to beneficiary access, and Part D sponsors are not required to place prior authorization requirements on other categories of drugs beyond normal compliance and utilization review.

Because the provision of these items is the financial responsibility of the hospice, hospices will enter into negotiated fee arrangements with various suppliers and pharmacies, in accordance with applicable laws, including the fraud and abuse laws. Some suppliers and pharmacies have, however, submitted claims for reimbursement directly to federal health care programs, including Medicare Part D and Medicaid programs, for DME, supplies, and medications/biologics furnished to hospice patients for palliative care. Because such practices have increasingly attracted the attention of Medicare recovery audit contractors (RACs) and government enforcement agencies, including the OIG, it is recommended that hospices create and maintain proper controls (e.g., vendor oversight policies, contractual provisions) to ensure that the Medicare program and other payers are billed appropriately by the hospice and its partners for prescription drugs and DME.

1020.10.40
Hospice and Accountable Care Organizations

As accountable care organizations (ACOs), promoted by Congress under the ACA's Medicare Shared Savings Program, increase in prevalence, hospice participation may likewise increase. Although the hospice model of care may not be fully compatible with the goals and incentives of other ACO providers (e.g., quality of care measures on preventative care may not be appropriate for the hospice population), ACOs may seek the involvement of hospices to broaden their pool of patients and to complement the types of traditional medical services furnished by hospitals and physician practices. Under CMS regulations, hospices are eligible to join already-formed ACOs as an "other ACO participant" but may not directly participate in the establishment of an ACO.[74]

There are additional similar pilot programs offered by CMS that seek to more closely tie Medicare payment with quality incomes, including the Bundles Payments for Care Improvement (BPCI) initiative.[75] While hospices again may not be able to directly participate in the BPCI program, there may be greater opportunities for hospices to partner with other provider types to assist in meeting the heightened quality of care requirements. Hospice and palliative care programs that are part of an integrated health and hospital system have been increasingly active in ACO activities. With the potential of a carve-in of the hospice benefit into the Medicare Advantage benefit, hospices will face increasing pressure to provide innovative care models, likely with reimbursement that is at a lower per diem rate or based on some other payment methodology.

The reduction of hospital readmissions (for which hospitals are penalized under the ACA) have been a significant focus area for hospice/hospital collaborations.

1020.10.50
Advance Beneficiary Notices

An advance beneficiary notice (ABN) is a written notice given to a Medicare beneficiary before the furnishing of healthcare items or services when the provider believes that Medicare probably or certainly will not pay for some or all of the items or services because of a Social Security Act exclusion.[76]

There are three situations in which hospice services may be denied that could trigger liability protections under statutory limitation of liability provisions:[77] 1) when a beneficiary is ineligible because he or she is not "terminally ill" as defined by SSA § 1861(dd)(3)(A); 2) specific items and/or services that are billed separately from the hospice payment, such as physician services, were not reasonable and necessary as defined in either SSA § 1862(a)(1)(A) or SSA § 1862(a)(1)(C); and 3) the level of hospice care is determined not reasonable or medically necessary specifically for the management of the terminal illness and related conditions.[78] Patients receiving care or staying in an inpatient unit when they do not meet the general inpatient level of care standards may be charged a room and board rate, for instance, with an ABN.

In the latter case regarding the level of care, CMS payment policies require that the provider, not the beneficiary, absorb liability for changes in the level of care made during claim adjudication. Furthermore, since providers are billing what they believe to be a covered level of care, there would be no anticipation of noncoverage in these cases. Therefore, this case would never involve delivery of an ABN to a hospice beneficiary. However, in those instances when a patient specifically requests a general inpatient level of care despite it being medically unnecessary or respite care beyond the five days allowed under Medicare rules, hospices should

[72] 42 C.F.R. § 418.106.

[73] CMS, Medicare Drug Benefit and C & D Data Group, Part D Payment for Drugs for Beneficiaries Enrolled in Medicare Hospice (July 18, 2014).

[74] 42 C.F.R. § 400.202.

[75] ACA § 3023.

[76] For additional information on ABNs, *see* CMS, Medicare Claims Processing Manual (Pub. 100-04), ch. 30, § 40.3; *Chapter 1030, Clinical Laboratories*, § 1030.20.20.40).

[77] Social Security Act § 1879 [42 U.S.C. § 1395pp].

[78] Medicare Claims Processing Manual (Pub. 100-04), ch. 30, § 50.14.4.1.

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provide an ABN to the patient for these services and require that the patient reimburse the hospice directly.

If the beneficiary requests it, a hospice may submit a Medicare claim for initial determination of statutorily excluded services.[79] On such "no pay" claims, the hospice should enter the appropriate modifier to indicate that it realizes that the furnished services are excluded, but that it is requesting a denial notice from Medicare in order to bill Medicaid or other insurers.

1020.20 Industry Compliance Guidelines

1020.20.10
Eligibility for Hospice Care

1020.20.10.10
Terminal Illness Requirement

Billing fraud pertaining to hospice eligibility requirements has been a frequent subject of hospice industry investigations and audits by the OIG and with increased frequency, the U.S. Department of Justice (DOJ) following the filing of *qui tam* False Claims Act complaints.

For hospice services to be reimbursed by Medicare, the beneficiary must have a life expectancy of six months or less, assuming that the beneficiary's illness runs its normal course.[80] The fact that a hospice patient lives beyond this six-month period does not, in and of itself, constitute grounds for a determination that the beneficiary was not eligible for hospice care and is often just a reflection of the difficulty in predicting with any degree of certainty, the timing of death.

Nonetheless, much has been misunderstood about the hospice benefit and the federal enforcement community added to this confusion when in the mid-1990s, as part of its "Operation Restore Trust," it began a series of audits and enforcement actions against hospices that continued to serve patients beyond six months of the start of hospice care. At the same time, the OIG identified instances of potential fraud whereby hospices would provide services to beneficiaries who, under any objective analysis, were not terminally ill.

A 1995 Medicare Advisory Bulletin reported the OIG's concern that some hospices, in an effort to maximize their Medicare reimbursement, might knowingly make incorrect determinations of a person's life expectancy for the purpose of meeting hospice eligibility criteria. The bulletin said that:

> In several medical reviews of beneficiary eligibility for hospice, the OIG has found significant inaccuracies in the determinations of terminal illness. For instance, investigators have encountered hospices that asked nurse employees to alter notes in patients' records or to otherwise misrepresent patients' medical conditions, in order to falsify the existence of a terminal condition. There have also been cases where physician certifications of terminal illness have been medically questionable.[81]

Such concerns have continued in the last two decades with a marked increase in the focus on hospice program integrity by CMS Medicare contractors, OIG, DOJ, and state Attorneys General and their Medicaid Fraud Control Units (MFCUs). In addition, policy makers have expressed ongoing concern. In late 2008, MedPAC convened an expert panel from the hospice industry, which found that some hospices were enrolling and recertifying patients who were not clinically eligible for hospice care under the Medicare benefit. A consensus emerged that greater accountability and oversight were needed in the certification and recertification process.[82] This conclusion followed on the heels of Medicare's first major reworking, finalized in 2008, of its Medicare Conditions of Participation rules for hospices that also tightened technical payment rules and eligibility.[83] Based in part on MedPAC's recommendations, Medicare amended its regulations, effective October 1, 2009, to require that Medicare eligibility certifications also include a brief narrative explanation, composed by a physician who has at least reviewed the clinical records, of the clinical findings supporting a life expectancy of six months or less and to include such brief narrative statements and related physician attestations as part of the certification and recertification forms (see § 1020.20.10.20 *Physician Certification Requirement*). The regulations require a physician narrative for every certification and prohibit use of checkboxes or cloned narrative language.[84]

To further address the concern that the hospice benefit was being abused through the furnishing of hospice care to beneficiaries who were not clinically eligible, as part of the ACA, Congress mandated a face-to-face visit before the third certification period by a physician or nurse practitioner.[85] Medicare finalized its hospice face-to-face regulations in November 2010,[86] which were revised in October 2011.[87] The hospice face-to-face visit and related attestation requirements were, for enforce-

[79] *Id*. at § 50.3.24.
[80] 42 C.F.R. § 418.3.
[81] OIG, Medicare Advisory Bulletin on Hospice Benefits, 60 Fed. Reg. 55,721 (Nov. 2, 1995).
[82] CMS, Medicare Hospice Wage Index for Fiscal Year 2010, 74 Fed. Reg. 39,394 (Aug. 6, 2009) (final rule).
[83] CMS, Medicare and Medicaid Programs: Hospice Conditions of Participation, 73 Fed. Reg. 32,088 (Jun. 5, 2008) (final rule).
[84] 42 C.F.R. § 418.22.
[85] ACA § 6407; 42 U.S.C. § 1395f(a)(7).
[86] CMS, Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices, 75 Fed. Reg. 70,372, 70,463 (Nov. 17, 2010).
[87] CMS, Medicare Program; Hospice Wage Index for Fiscal Year 2012, 76 Fed. Reg. 47,302, 47,314 (Aug. 4, 2011) (final rule).

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ment purposes, effective in April 2011. Physicians or nurse practitioners who conduct face-to-face visits may not bill for these services directly, unless they also provide additional medically necessary services that are unrelated to the patient's terminal illness. [88] Given CMS's position that virtually all of a hospice patient's symptoms will be related to the terminal illness, there will likely be few instances when a separately identifiable service will be billable by the physician or nurse practitioner during a face-to-face visit. Moreover, patients or caregivers can refuse to permit the face-to-face visit, which could result in the beneficiary's discharge from hospice for cause.[89]

A hospice that submits claims to Medicare under circumstances where it knows of the absence of a terminal condition can be liable for overpayments and other sanctions for the submission of false claims.[90] Hospices should create oversight mechanisms to ensure that the terminal illness of a Medicare beneficiary is appropriately verified and the specific factors qualifying the patient as terminally ill are properly documented.[91]

Any assessment of the terminal illness of a Medicare beneficiary should be completed prior to billing Medicare for hospice care. Indeed, under Medicare billing rules, a hospice may not bill Medicare until it has received a properly completed, written certification of terminal illness, subject to certain exceptions.[92] Most electronic medical record systems for hospice have built-in controls to ensure that hospice service claims are not billed until a completed certification of terminal illness is obtained.

1020.20.10.20
Physician Certification Requirement

The primary control to ensure that a beneficiary qualifies for hospice services is the physician certification and recertification of terminal illness. According to the hospice regulations, and as explained above, the initial certification must be made by both the beneficiary's attending physician, if one exists, and the hospice physician.[93] For subsequent election periods, certification is required only by the medical director or physician member of the hospital interdisciplinary group.[94] Nurse practitioners, even those who perform the face-to-face visit before the start of a third certification period, may not certify a terminal diagnosis or re-certify terminal diagnosis or prognosis—only a physician may do so. In the event that a beneficiary's attending physician is a nurse practitioner,[95] the hospice medical director and/or physician designee may certify or re-certify the terminal illness.[96]

Since the enactment of the Balanced Budget Act of 1997, the Medicare hospice benefit has been divided into the following benefit periods:[97]

- the initial 90-day period;
- one subsequent 90-day period; and
- subsequent, unlimited 60-day benefit periods.

At the beginning of each benefit period, the hospice must obtain a certification that the patient is terminally ill.[98] Certification must be based on the clinical judgment of the hospice physician or medical director regarding the normal course of the individual's illness, specify that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course, and include a brief narrative explanation of the clinical findings that support this life expectancy determination.[99] This regulatory requirement became effective in October 2009.[100] Failure to adhere to this requirement can create overpayment risk.

The medical director must consider at least the following information before certifying that a patient is terminally ill: diagnosis of the patient's terminal condition; other health conditions, whether related or unrelated to the terminal condition; and current clinically relevant information supporting all diagnoses.[101]

The OIG, in its 1999 Compliance Program Guidance for Hospice, recommended that a hospice's written policies and procedures should require, at a minimum, that the:[102]

- hospice physician and attending physician thoroughly review and certify the admitting diagnosis and prognosis before the patient is admitted for hospice services;
- patient's medical record contains complete documentation to support the certification made by the hospice physician or attending physician;
- patient is informed of the determination of the life-limiting condition;
- patient is aware that the goal of hospice is directed toward relief of symptoms, rather than the cure of the underlying disease;

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[88] CMS, Medicare Claims Processing Manual (Pub. 100-04), ch. 11, § 40.

[89] 75 Fed. Reg. at 70,438.

[90] 74 Fed. Reg. at 55,722.

[91] OEI, Medicare Hospice Beneficiaries: Services and Eligibility (No. OEI-04-93-00270, Apr. 1998).

[92] 42 C.F.R. § 418.22(2).

[93] 42 C.F.R. § 418.25(a).

[94] 42 C.F.R. § 418.22(c)(2).

[95] Section 408 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 17 Stat. 2066, changed the statutory definition of "attending physician" to include nurse practitioners with respect to some (but not all) aspects of hospice services.

[96] CMS, Medicare Benefit Policy Manual (Pub. 100-02), ch. 9, § 40.1.3b. Nurse practitioners also may not bill for medical services other than those described in this manual section, and may not bill for any service that duplicates what a hospice nurse would provide in the absence of a physician. *Id.* at § 40.1.3.

[97] *See* Social Security Act § 1812(d) [42 U.S.C. § 1395d(d)].

[98] 42 C.F.R. § 418.22(a); *see* Social Security Act § 1814(a)(7) [42 U.S.C. § 1395f(a)(7)].

[99] CMS, Hospice Wage Index for Fiscal Year 2010, 74 Fed. Reg. at 39,398; 42 C.F.R. § 418.22(b)(3).

[100] 42 C.F.R. § 418.22(b)(3).

[101] 42 C.F.R. § 418.25(b).

[102] OIG, Compliance Program Guidance for Hospices, 64 Fed. Reg. at 54,038.

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- patient's medical condition and status is sufficiently reviewed during the interdisciplinary group (now called interdisciplinary team) meetings; and
- clinical progression or status of a patient's disease and medical condition are properly documented.

Medicare has no prescribed hospice certification form. The form may vary from hospice to hospice. Likewise, despite industry requests for examples of acceptable brief physician narratives, CMS has declined to provide them. Electronic hospice certification forms have become more prevalent with the adoption of electronic health records. In any event, the certifying physician must sign and date the certification. In March 2008, CMS issued additional guidance on signature requirements.[103] In that guidance, CMS clarified that Medicare requires a legible identifier for services provided and that, for medical review purposes, there must be a handwritten or electronic signature (stamped signatures are not acceptable) accompanying an order or other medical record documentation. The noted exception is that facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

CMS also cautioned that providers using electronic systems should recognize that there is a potential for misuse or abuse with alternate signature methods. Facsimile and hard copies of a physician's electronic signature must be in the patient's medical record for the certification of terminal illness for hospice. For example, providers should have a system and software products that are protected against modification and should apply administrative procedures that meet the requirements of recognized standards and laws. The individual whose name is on the alternate signature method and the provider both bear the responsibility for the authenticity of the information being attested to. Physicians also should check with their attorneys and malpractice insurers in regard to the use of alternative signature methods, CMS said. Where state law, licensure, or practice regulations are more restrictive than Medicare, state law standards must be met.[104]

CMS guidance permits the brief narrative to either be part of the certification and recertification forms, or an addendum to the certification and recertification forms which is electronically or hand-signed by the physician. If the narrative is part of the certification or recertification form, it must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician also must sign immediately following the narrative in the addendum. Although the Medicare rules are not precise on this point, the physician completing the brief narrative should also be the certifying physician. The narrative must reflect the patient's individual clinical circumstances; it should not contain only checked boxes or standard language used for all patients but rather must be sufficiently individualized. In the case of the initial certification either the attending physician or the hospice medical director must compose and sign the narrative, which must include, under the physician signature, a statement indicating that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, examination of the patient.

In addition, no more than 30 calendar days prior to the start of the third hospice benefit period and no more than 30 calendar days prior to every subsequent benefit period, a face-to-face encounter by a hospice physician or nurse practitioner is required. The hospice physician or nurse practitioner must attest to the patient's continued eligibility for hospice benefits and a hospice physician (not necessarily the one who conducted the face-to-face encounter) must certify the patient's terminal illness and compose a recertification narrative.

Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. Initially, the clinical information may be provided verbally, but must be appropriately documented in the medical record and included as part of the hospice's eligibility assessment.[105] Medicare contractors frequently deny payment for inattention to detail in appropriately documenting verbal certifications of terminal illness and their dates received. Even when a patient clearly appears terminal, failure to obtain a proper certification of terminal illness may result in payment denial or an overpayment determination.[106] Poor documentation of the face-to-face visit (discussed above) or a missing or unsigned attestation statement that the findings of the face-to-face visit were provided to the certifying physician for the start of the third certification period also is often basis upon which Medicare contractors will deny claims.

Physician certifications and necessary oversight are important to ensure that a hospice has adequate documentation to demonstrate it billed and received proper reimbursement for its hospice services. It is also important to ensure that a hospice timely identifies patients who are not initially or are no longer clinically appropriate for hospice if they are no longer terminal. Proper live discharge processes are also important to develop. The OIG has noted that insufficient oversight of patients is especially prevalent for those patients receiving more than six consecutive months of hospice care.[107]

[103] CMS Transmittal No. 248, Change Request No. 5971 (March 28, 2008).

[104] *Id.*

[105] 42 C.F.R. § 418.22(b)(2).

[106] *See* In the case of Continuum Hospice Care, DAB Departmental Appeals Council decision October 28, 2009.

[107] OIG, Compliance Program Guidance for Hospices, 64 Fed. Reg. at 54,036.

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1020.20.10.30
Timing of Certification

Although the OIG recommends that appropriate physicians certify terminal illness before a patient is admitted to hospice care,[108] that suggestion is not always practicable for a patient who is actively dying and who needs immediate palliative care. Medicare regulations require a certification to be completed no later than two calendar days after a patient is admitted initially or certified for an additional benefit period.[109] By "two calendar days," CMS means by the end of the third day.[110] Clinical documentation supporting the medical prognosis must accompany the certification and be on file with in the beneficiary's medical record.[111] If the hospice cannot obtain a written certification within two calendar days, Medicare regulations permit it to obtain oral certification (not to be confused with a "verbal order") within two calendar days, and then complete written certification before submitting a claim for payment.[112]

The hospice must obtain written certification of terminal illness for each certification period, even if the patient signed only a single election and it continues in effect for an unlimited number of periods.[113] If certification requirements are not met, no payment may be made for the days prior to oral or written certification and faulty certification documentation may give rise to a refund request or possible overpayment.[114] Medicare hospice payment begins with the day of certification, i.e., the date oral certification (or written certification if that is done first) is obtained. If the physician forgets to date the certification, a notarized statement or some other acceptable documentation may be obtained to verify when the certification was obtained. However, in overpayment appeals of overpayment determinations based on such technical billing miscues, not all administrative law judges have permitted after the fact notarized statements from the certifying physicians as to the date of such certification. Physician certifications of terminal illness may be completed up to two weeks before hospice care is elected.[115]

1020.20.10.40
Informed Consent for Hospice Election

A beneficiary's decision to elect the Medicare hospice benefit has significant consequences, because a hospice patient waives the right to receive: (1) standard Medicare benefits—including any curative treatment—related to the terminal illness; and (2) with certain exceptions, Medicare services equivalent to hospice care.[116] Because of the importance of hospice elections, a hospice must ensure that a beneficiary is informed about the shift from curative to palliative care that will result from such an election.[117] Medicare contractors, including Zone Program Integrity Contractors (ZPICs), have made payment denial determinations for failure to secure informed consent documentation.

A hospice must establish policies and procedures to ensure that the beneficiary's hospice election was informed and voluntary.[118] As such, the patient's hospice election statement must include:[119]

- identification of the particular hospice that will provide care to the beneficiary;
- the beneficiary's or representative's (as applicable) acknowledgment that the beneficiary has a full understanding of hospice care, particularly the palliative rather than curative nature of treatment;
- the beneficiary's or representative's acknowledgment that he or she understands that certain Medicare services are waived by the election;
- the effective date of the election, which can be the first day of hospice care or a later date, but cannot be a retroactive date;
- the patient's or representative's designated attending physician (if they have one), including enough detail to clearly identify the attending physician, such as full name, office address, or National Provider Identifier (NPI) (effective for hospice elections on/after October 1, 2014);
- the patient's or representative's acknowledgement that the designated attending physician was his or her choice (effective for hospice elections on/after October 1, 2014); and
- the signature of the patient or his or her representative.

1020.20.10.50
Nursing Home and Assisted Living Facility Residents and Eligibility

A 1997 OIG study found that hospice patients living in nursing homes were especially vulnerable to premature hospice enrollment. Based on two different sets of medical reviews, the study projected that 16 percent of hospice patients living in nursing homes did not qualify for Medicare's hospice benefit at the time of enrollment.

In some cases, the study's records showed that, while the beneficiaries did have a terminal condition, they had been stable, with little sign of deterioration or decline,

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[108] 64 Fed. Reg. at 54,038.

[109] 42 C.F.R. § 418.22(a)(3).

[110] CMS, Medicare Benefit Policy Manual (Pub. 100-02), ch. 9, § 20.1.

[111] 42 C.F.R. §§ 418.22(b)(2), (d)(2).

[112] 42 C.F.R. § 418.22(a)(3).

[113] 42 C.F.R. § 418.22(a)(1).

[114] CMS, Medicare Benefit Policy Manual (Pub. 100-02), ch. 9, § 20.1.

[115] *Id.*

[116] 42 C.F.R. § 418.24(d); *See* Social Security Act § 1812(d) [42 U.S.C. § 1395d(d)].

[117] 42 C.F.R. § 418.24(b)(2).

[118] If a beneficiary is physically or mentally incapacitated, election of hospice can be executed by the beneficiary's representative (as defined in 42 C.F.R. § 418.13). 42 C.F.R. § 418.24(a).

[119] 42 C.F.R. § 418.24(b).

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at the time of hospice election. The medical reviewers concluded that, while the hospice benefit might eventually have been appropriate, the election of hospice was premature.[120]

Another 1997 OIG study reported that about 60 percent of the ineligible beneficiaries identified during the OIG reviews were nursing facility residents.[121]

A 1998 OIG study corroborated the findings of the earlier reports, concluding that "a significant portion of hospice patients in nursing homes were ineligible for the Medicare hospice benefit."[122]

The study found a significant association between living in a nursing home and being ineligible for the hospice benefit. Of all sampled beneficiaries in nursing homes, 29 percent were ineligible. However, only 2 percent of beneficiaries not living in nursing homes were ineligible.[123]

A 2015 OIG study on hospice care furnished to patients residing in assisted living facilities (ALFs) identified the existence of certain financial incentives for hospices to target ALF residents because the current payment system offered hospices opportunities for higher profits by providing less complex hospice care than beneficiaries located in other care settings.[124] Although this study did not assess the hospice eligibility status of these ALF residents or whether these hospice services were appropriate,[125] the OIG, citing a 2012 MedPAC report,[126] noted that further monitoring and examination were needed to better understand why ALF residents had long hospice stays.[127] Based on recommendations from the OIG, in April 2015, CMS contractor TMF Health Quality Institute updated its annual Program for Evaluating Payment Patterns Electronic Report (PEPPER) for hospices to focus on additional targets related to ALFs.[128] The PEPPER Reports began using both routine and continuous home care provided in an ALF as measurements that may indicate that either: (1) beneficiaries who reside in ALFs are being enrolled in hospice when they may not meet hospice eligibility criteria; or (2) the hospice is providing a higher level of care than required.

1020.20.20
Duplicate Billing

1020.20.20.10
General Guidelines

Duplicate billing—also known as double billing—refers to the practice of submitting more than one claim for the same item or service. Duplicate billing occurs when a claim for an item or service is submitted twice to the government or to more than one primary payer, either by the same or different providers.[129]

Although duplicate billing can be the result of an unintentional billing error, systematic or repeated duplicate billing where the hospice knew or should have known of the repeated errors may be viewed as a false claim, especially if resulting overpayments are not refunded promptly.[130]

Further information on the practice of duplicate billing can be found in *Chapter 630, Duplicate Billing*.

When a beneficiary makes an election to receive services covered by the Medicare hospice benefit, that beneficiary waives the right to receive Medicare reimbursement for any nonhospice treatment related to his or her terminal illness. Accordingly, a hospice should ensure that it is not involved with a health care provider that submits its own claims to Medicare for services. Such nonreimbursable services include:[131]

- standard Medicare benefits for treatment of the terminal illness;
- treatment by another hospice not arranged for by the patient's hospice;
- outpatient prescription drugs related to the terminal illness dispensed by a pharmacy; and
- care from another provider that duplicates care the hospice is required to furnish.

A hospice provider should work with other providers to coordinate care and ensure appropriate billing if any of these situations occur. Where a single episode of care culminates in an inpatient admission and also involves services by two different providers, it is critical for each provider to maintain a clear record of the services provided.[132]

1020.20.20.20
Duplicate Billing for Hospital Patients and Nursing Home Residents

The hospice benefit primarily is provided to beneficiaries living at home. However, it also is available to eligible beneficiaries residing in other facilities, such as skilled nursing facilities, group homes, and nursing homes. The provision of hospice care in such federally funded facilities—which already provide a degree of

[120] OEI, Hospice Patients in Nursing Homes (No. OEI-05-95-00250, Sept. 1997), at 8.

[121] Office of Audit Services (OAS), OIG, Enhanced Controls Needed to Assure Validity of Medicare Hospice Enrollments (No. A-05-96-00023, Nov. 4, 1997), at 7.

[122] OEI, Medicare Hospice Beneficiaries: Services and Eligibility (No. OEI-04-93-00270, Apr. 1998), at 4.

[123] *Id.* at 4-5.

[124] OIG, Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities (No. OEI-02-14-00070, Jan. 2015).

[125] *Id.* at 8.

[126] MedPAC, Report to the Congress: Medicare Payment Policy (Mar. 2012), ch. 11.

[127] OIG, Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities (No. OEI-02-14-00070, January 2015), at 1.

[128] TMF Health Quality Institute, Hospice PEPPER User's Guide, 6th Ed. (Apr. 2015).

[129] *See* OIG, Compliance Program Guidance for Hospices, 64 Fed. Reg. at 54,037.

[130] *Id.*

[131] OIG, Compliance Program Guidance for Hospices, 64 Fed. Reg. at 54,036.

[132] *Id.*

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custodial care—can lead to impermissible duplicate billing.

A 1995 OIG Medicare Advisory Bulletin reported that the OIG had uncovered situations where duplicate claims were submitted by a hospice and other providers for services related to the beneficiary's terminal illness. The bulletin said that, in a nationwide audit of services provided to Medicare beneficiaries enrolled in hospice programs, approximately $21.6 million was improperly paid to hospitals and nursing homes for the treatment of hospice beneficiaries. It warned:

> Hospices are required to make financial arrangements for hospitalization, nursing services and all other health care needs related to the beneficiary's terminal illness and included in the hospice plan of care. The costs of these services should be paid by the hospices.[133]

Hospitals may, however, distinguish claims for services unrelated to a patient's terminal illness by adding condition code 07 to such claims.[134]

1020.20.20.30
Duplicate Billing for Medicare Advantage Patients

There have been allegations of lack of compliance with the regulatory requirements for Medicare fee-for-service MAC processing hospice claims for Medicare Advantage (MA) beneficiaries, according to a CMS clarification of payment responsibilities of fee-for-service contractors as they relate to hospice members enrolled in MA organizations.[135] Hospices should bill their MACs for Medicare beneficiaries who have MA coverage in the same manner that they bill beneficiaries with fee-for-service coverage.

Regulations require MACs to maintain payment responsibility for MA plan enrollees who elect hospice.[136] During the time the hospice election is in effect, monthly capitation payment to the MA organization is reduced to an amount equal to the adjusted excess amount determined under 42 C.F.R. § 422.312. Claims may be submitted by the hospice provider, the provider treating an illness not related to the terminal condition, or the MA organization to a fee-for-service contractor of CMS, but only for the following services: (1) hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice; (2) services of the enrollee's attending physician if the physician is not employed by or under contract to the enrollee's hospice; (3) services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or (4) services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again.[137]

1020.20.30
Underutilization

1020.20.30.10
General Guidelines

Underutilization of health care services is the knowing denial of needed care in order to keep costs low. When a beneficiary is receiving hospice care, the hospice is paid a predetermined fee for each day during the length of care, no matter how much care the hospice actually provides. This means that a hospice might have a financial incentive to reduce the number of services provided to each patient, because the hospice will get paid the same amount regardless of the number of services provided.[138]

Once a Medicare beneficiary elects hospice care, the hospice is responsible for furnishing—either directly or through arrangements with other providers—all supplies and services that relate to the beneficiary's terminal condition, except the services of an attending physician. If a hospice does not provide those drugs and supplies that are related to the terminal illness (which in some cases may include expensive palliative chemotherapy drugs), that can be viewed as "stinting" on care for which the hospice is responsible. And as noted above, RACs are auditing pharmacies and DME suppliers to determine if drugs or supplies they furnished and billed to Medicare should have instead been billed to the responsible hospice. Hospice beneficiaries have the right to receive covered medical, social, and emotional support services from the hospice directly and should not be forced to seek such care from nonhospice providers.[139]

A hospice is accountable for the appropriate allocation and utilization of its resources in order to provide optimal care consistent with the needs of a patient, family, or representative. Increasingly, hospices are developing and implementing their own formularies for drugs and supplies to better manage and coordinate the provision of hospice care with fixed resources, in a process similar to those adopted by health plans and other providers (e.g., hospital pharmacy and therapeutics committees). The implementation of such formularies, if done thoughtfully, can help hospices avoid making decisions that could result in stinting.

A 1995 OIG Medicare Advisory Bulletin reported that Medicare had received complaints about hospices neglecting patient needs and ignoring reasonable requests for treatment. The complaints included concerns about

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[133] OIG Medicare Advisory Bulletin on Hospice Benefits, 60 Fed. Reg. at 55,722.

[134] CMS, Medicare Claims Processing Manual (Pub. 100-04), ch. 11, § 50.

[135] CMS, Program Memorandum-Intermediaries/Carriers No. AB-02-015 (Feb. 2002).

[136] 42 C.F.R. §§ 417.585(b), 418.20(b).

[137] CMS, Program Memorandum-Intermediaries/Carriers No. AB-02-015 (Feb. 2002).

[138] OIG, Compliance Program Guidance for Hospices, 64 Fed. Reg. at 54,035.

[139] OIG, Medicare Advisory Bulletin on Hospice Benefits, 60 Fed. Reg. at 55,722.

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limited availability of durable medical equipment for patients as their medical condition declined, and failure to provide continuous care for periods of crisis due to staff shortages.

The bulletin also advised hospices that they should not refuse to address health care needs relating to a beneficiary's terminal diagnosis.[140]

A 2013 OIG Memorandum Report found that 27 percent of Medicare hospices did not provide any general inpatient care (GIP), the second most expensive level of hospice care, despite the fact that the beneficiaries served by these hospices had terminal illnesses identical to those of beneficiaries served by hospices that had provided GIP.[141] The OIG noted that hospices that did not provide GIP were more likely to be for-profit entities and have a smaller census than hospices that did provide GIP.[142] The OIG recommended that CMS focus on these hospices to ensure that hospice beneficiaries had access to necessary levels of care.[143]

1020.20.30.20
Revocation of Hospice for Expensive Care

The OIG has found that some hospices may put pressure on patients to revoke the hospice benefit when the required palliative care related to the terminal illness becomes too expensive for the hospice to deliver. For example, certain chemotherapy or radiation to shrink tumors may be palliative and not curative in nature, but are often very expensive. Certain medications or therapies may also be very expensive. In these situations, the OIG has observed that patients who were eligible for and desire hospice care might be pressured to revoke such care.

In its 1995 Medicare Advisory Bulletin, the OIG reported that it had learned of hospices that induced beneficiaries to revoke the hospice election if expensive palliative treatment—even for a temporary period—became necessary. Such a practice can be very costly to the beneficiary. The bulletin warned that, "as a consequence, beneficiaries may then be burdened with substantial copayments that would not be charged under hospice."[144] Note, this observation may be accurate for Medicare patients who are not dual (Medicare/Medicaid) eligible.

CMS tracks live discharges in the PEPPER system and reports out hospices that have higher than average live discharges, including those by patient revocation. In 2016, MedPAC examined this issue and questioned whether higher rates of live discharge indicate issues with program integrity, such that the hospice provider is not meeting patient needs or there is a problem with quality of care.[145] In comments to the CMS Administrator, MedPAC reiterated concerns about potentially avoidable hospice transitions that include live discharge where providers don't offer patients access to all levels of hospice care.[146]

Although a hospice can discharge a patient if it discovers that the patient is not terminally ill, hospices should not encourage a patient to revoke the benefit merely to avoid the obligation to pay for hospice services related to the terminal illness that have become too costly.[147] The hospice conditions of participation require providers to have the ability to provide the four levels of hospice care (i.e., routine home care, continuous home care, inpatient respite care, and general inpatient care), and there may be additional scrutiny on providers that have a history of not providing all levels of care.[148] Hospices have developed other appropriate mechanisms to control such costs including education of patients about other palliation options and drug formularies. Such cost control measures should be thoughtfully developed to avoid the appearance of stinting of necessary care.

1020.20.30.30
Plan of Care

A hospice should take all reasonable steps to ensure that a written plan of care is established and maintained for each beneficiary who receives hospice services, and that the care provided is in accordance with the plan.[149]

The plan must be established by the beneficiary's attending physician, the hospice physician, and the interdisciplinary team.[150] Each beneficiary's needs should be continuously assessed and all treatment options explored and evaluated in the context of the beneficiary's symptoms. Medicare regulations require the hospice to review, revise, and document the plan at least every 15 calendar days.[151] Interdisciplinary groups must meet at least once every 14 days.

Typically, when a beneficiary enrolls in hospice, the hospice agency assigns a team of individuals to provide care required by the terminal condition. After a preliminary examination, usually performed by a nurse, all members of the team meet to outline a plan of care to specifically meet the physical, emotional, spiritual, and other needs that the beneficiary or family might require.[152] Appropriate physician involvement in the plan of care is important.

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[140] *Id.*

[141] OIG, Medicare Hospices: Use of General Inpatient Care (No. OEI-02-10-00490, May 2013) at 9-10.

[142] *Id.* at 10.

[143] *Id.* at 11.

[144] *Id.*

[145] MedPAC, Report to the Congress: Medicare Payment Policy, Chapter 11 (Hospice Services) (Mar. 2016), at 311.

[146] MedPAC, Comment Letter to CMS Administrator Seema Verma regarding Proposed Rule FY 2018 Hospice Payment Rate Update, File Code CMS-1675-P (June 2, 2017).

[147] Medicare Benefit Policy Manual (Pub. 100-02), ch. 9, § 20.2.1.

[148] 42 C.F.R. § 418.302.

[149] 42 C.F.R. § 418.56(e)(2).

[150] 42 C.F.R. § 418.56(a).

[151] 42 C.F.R. § 418.56(d).

[152] *Id. See also* OEI, Medicare Hospice Beneficiaries: Services and Eligibility (No. OEI-04-93-00270, Apr. 1998), at 4.

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According to the OIG, a hospice's written policies and procedures should require, at a minimum, that:[153]

- a plan of care be established by the hospice physician and interdisciplinary team before the hospice bills for care provided to a patient;
- the plan of care include an assessment of the hospice patient's needs and identification of services—including the management of discomfort and symptom relief—and a detailed assessment of the scope and frequency of services needed to meet the beneficiary's and family's needs;
- the plan of care be reviewed and updated, at intervals specified in the plan, by the attending physician, hospice physician, and interdisciplinary team;
- the hospice properly document any review or update of a hospice patient's plan of care by the attending physician, hospice physician, and interdisciplinary team; and
- the hospice regularly review the appropriateness of interdisciplinary team services and level of services being provided, patient admission to hospice, patient length of stay delays, and specific treatment modalities.

1020.20.30.40
Underutilization and Nursing Home and Assisted Living Facility Residents

Underutilization of hospice palliative care services has been noted as a risk area for hospices that serve beneficiaries living in nursing homes and ALFs. Because of the overlap in services that these facilities and hospices provide, it is likely that hospice care in nursing homes and ALFs will allow one provider or the other the opportunity to reduce services and costs.[154]

Some OIG reports have found that residents of nursing homes and ALFs generally receive fewer services from their hospice than patients who receive hospice services in their own homes. In a 1997 report, it was found that many nursing home hospice patients were receiving only basic nursing and aide visits—the same services provided by nursing home staff as part of room and board when hospice staff were not present.[155] In a 2009 report, among other findings, the OIG noted that 82 percent of hospice claims for nursing home residents did not fully meet the plan of care requirements.[156] Also, in a 2011 report, prepared in response to OIG and MedPAC concerns about these types of services, the OIG noted the growth in the number of hospices that serve a high percentage of nursing home residents, who often require less complex care and allow hospices to earn higher profits.[157] A 2015 OIG Report on hospice services furnished to ALF residents had similar findings, noting that hospice services furnished to ALF residents were primarily aide services (e.g., personal care) and that ALF residents had conditions that typically required less complex hospice care.[158] Moreover, the 2015 report found that hospice physicians rarely saw beneficiaries who received hospice care in the ALF setting.[159]

Additional treatments provided by hospice staff—such as nursing and aide visits—often were clearly within the professional skills of the nursing home staff. The reports found that the nature of services provided by hospice staff, while appropriate and efficacious, appeared to differ little from the services a nursing home would have provided if the patient was not enrolled in hospice.

When a resident of a nursing home elects the Medicare hospice benefit, the hospice and nursing home should work together to establish a plan of care that coordinates the hospice philosophy with an assessment of the individual's unique living situation in the nursing home.

In general, a hospice should use nursing home personnel to assist with the administration of a patient's prescribed therapies only to the extent that the hospice would routinely use the services of a patient's family or caregiver in implementing the plan of care.[160] Of course, use by a hospice of nursing home staff for certain palliative care services for which the hospice is responsible, and a higher than fair market value payment for such services may also raise anti-kickback concerns. Conversely, the anti-kickback statute may be implicated if nursing homes encourage and permit hospice clinical staff to substitute for the personal care services they (the nursing homes) are responsible for furnishing under a room and board rate. Thus careful care coordination between the nursing home and hospice is also important to address those anti-kickback concerns as well.

Hospices should implement policies and procedures to ensure that they comply with all Medicare conditions of participation, which require that:[161]

- the hospice routinely provides substantially all core services available to meet the needs of the patient in terms of palliation and management of terminal illness;[162]

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[153] OIG, Compliance Program Guidance for Hospices, 64 Fed. Reg. at 54,038.

[154] *Id.*

[155] OIG, Hospice Patients in Nursing Homes (No. OEI-05-95-00250, Sept. 1997), at 7.

[156] OIG, Hospice Patients in Nursing Homes: Compliance with Medicare Coverage Requirements (No. OEI-02-06-00221, Sept. 2009), at 12.

[157] OIG, Medicare Hospices that Focus on Nursing Facility Residents (No. OEI-02-10-00070, July 2011), at 12.

[158] OIG, Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities (No. OEI-02-14-00070, January 2015), at 114.

[159] *Id.*

[160] OIG, Compliance Program Guidance for Hospices, 64 Fed. Reg. at 54,039.

[161] CMS, Hospice Conditions of Participation, 73 Fed. Reg. 32,088 (June 5, 2008) (final rule). *See* 42 C.F.R. §§ 418.52-418.116.

[162] 42 C.F.R. § 418.64.

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- the hospice retains professional responsibility for services—such as personal care, nursing, and pain-control medication—furnished by nursing home staff;[163]
- all the care furnished by a nursing home related to the terminal illness or related conditions is in accordance with the hospice plan of care;[164]
- the hospice and nursing home communicate with each other when any changes are indicated to the plan of care, are aware of the other's responsibilities in implementing the plan of care, and complete those respective functions;[165]
- evidence of the coordinated plan of care is present in the clinical records of both providers;[166]
- the hospice develops, implements and maintains a hospice-wide quality assessment and performance improvement (QAPI) program that, among other requirements, uses quality indicator data to measure and improve the provision of palliative care and hospice services;[167] and
- substantially all core services are provided directly by hospice employees[168] and the hospice does not rely on employees of the inpatient facility to furnish needed nursing, physician, counseling, or medical social services.[169]

1020.20.30.50

Respite Care and Nursing Homes

Respite care is intended to give family members a respite from caregiving. An April 2008 OIG report found that few Medicare beneficiaries receiving hospice care in 2005 also received respite care and that some of that care may have been provided inappropriately under Medicare rules.[170] While just two percent of all hospice beneficiaries received respite care in 2005, 54 beneficiaries received respite care longer than the five consecutive days allowed by federal regulations[171] and 62 beneficiaries received respite care while residing in nursing facilities, contrary to federal requirements, the report said. The OIG made no recommendations to CMS in the report.

1020.20.40

Levels and Location of Hospice Care

1020.20.40.10

Levels of Care

Hospice services are reimbursed on a fixed, per diem basis unrelated to the specific services performed; the rate of reimbursement is based instead on the level of care provided. Each level of care—routine home care, continuous home care, inpatient respite care, or general inpatient care—is reimbursed at a different daily rate.[172]

Because there are different payment amounts for the different levels of hospice care, a hospice must ensure that it bills only for those services that are reasonable and medically necessary. A hospice cannot bill Medicare for a higher level of service than is required by the patient's medical condition.[173]

Hospice patients pay virtually no co-pays or deductibles, and Medicare pays a per diem reimbursement, even in cases where patients are not seen every day by hospice personnel. If higher levels of hospice care, such as continuous home care of GIP, are billed without the medical necessity for such services, those hospices may be subject to program integrity scrutiny. Indeed, since 2008, hospices have been investigated for providing excessive continuous care as well as general inpatient care. Providers should be aware of these inherent vulnerabilities and monitor any practices that could attract law enforcement scrutiny. The OIG has recommended scrutiny of GIP stays of seven days or longer,[174] and CMS Program Integrity Contractors as of 2017 were applying such scrutiny in their audits.

OIG investigations have focused on whether certain hospices falsified patient medical records and plans of care to exaggerate the negative aspects of the patient's condition to justify reimbursement. Other investigations have focused on aggressive marketing to attract and knowingly enroll into the hospice program beneficiaries who were not clinically eligible for the hospice benefit. Yet other investigations have focused on maximizing Medicare revenue by billing for a higher level of care.

A hospice's compliance program should provide that it seek reimbursement only for services that:

- are reasonable and necessary for the palliation and management of terminal illness, and
- were ordered by a physician or other appropriately licensed individual.

The OIG recommends that the hospice's compliance program communicate to physicians, patients, and hospice personnel authorized to certify and admit patients for hospice care that services will be paid only if they

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[163] 42 C.F.R. § 418.112(b).
[164] *Id.*
[165] 42 C.F.R. § 418.112(c).
[166] *Id.*
[167] 42 C.F.R. § 418.58.
[168] 42 C.F.R. § 418.64.
[169] In limited circumstances, CMS can approve a waiver of the requirement for core nursing services to be provided by a hospice that is located in a non-urbanized area. 42 C.F.R. § 418.66.
[170] OIG, Hospice Beneficiaries' Use of Respite Care (No. OEI-02-06-00222, April 2, 2008).
[171] CMS, Medicare Benefit Policy Manual (Pub. 100-02), ch. 9, § 40.2.2.
[172] 42 C.F.R. § 418.302(g).
[173] OIG, Compliance Program Guidance for Hospices, 64 Fed. Reg. at 54,036.
[174] OEI, Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care (OEI-02-10-00491, Mar. 2016).

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are reasonable and necessary for the patient, given the clinical condition.[175]

1020.20.40.20
Location of Service

Medicare payments for hospice services are adjusted by an area wage index.[176] Hospices must submit claims based on the geographic location at which the service is furnished, not the location of the hospice itself.[177]

Incorrect designation of the place of service could significantly alter reimbursement and result in overpayment for services performed. Nonetheless, as noted above, whether routine home care is furnished in a patient's home or a nursing home, the hospice reimbursement rate is the same.

1020.20.50
Discharge from Hospice Care

Discharge Planning. A hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill. The discharge planning process must include planning for any necessary family counseling, patient education, or other services before a patient is discharged because he or she is no longer terminally ill.[178]

Discharge for Cause. Regulations finalized in 2005 for the first time allowed a patient to be discharged from hospice for cause.[179] This power is intended to be used in very limited circumstances to address, for example, cases hospice staff have reported in which patients consistently refuse to permit the hospice to visit or deliver care, it is dangerous for staff to visit the home, or a patient repeatedly leaves the service area, CMS said in the preamble to the regulation.[180] It may be invoked only when the hospice has determined, under its discharge-for-cause policy, that the behavior of the patient (or other person or persons in the patient's home) is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.[181]

Before seeking to discharge a patient for cause, the hospice must:

- advise the patient that a discharge for cause is being considered,
- make a serious effort to resolve the problem(s) presented by the patient's behavior or situation,
- ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services, and
- document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records for the patient.

As of January 1, 2009, discharges for cause also must be identified on Medicare claims submitted when beneficiaries are discharged.[182] Discharge for cause identifies a discharge from the provider's care, not from the Medicare hospice benefit, CMS said in a transmittal.[183]

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[175] *Id.*.

[176] 42 C.F.R. § 418.306(c); *see* CMS, Transmittal No. 1292, Change Request No. 5670 (July 13, 2007).

[177] 42 C.F.R. § 418.302; *see* OIG, Compliance Program Guidance for Hospices, 64 Fed. Reg. at 54,036.

[178] 42 C.F.R. § 418.26(d).

[179] CMS, Hospice Care Amendments, 70 Fed. Reg. 70,532 (final rule) (Nov. 22, 2005).

[180] *Id.* at 70,540.

[181] 42 C.F.R. § 418.26(a)(3); CMS, Medicare Benefit Policy Manual (Pub. 100-02), ch. 9, § 20.2.1.

[182] CMS, Transmittal No. 1558, Change Request No. 6115 (July 18, 2008).

[183] *Id.*

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1020.30 Enforcement

1020.30.10 Enforcement Priorities

1020.30.10.10 OIG Work Plans

Through its work plan, the OIG highlights its current focus areas under the Medicare and Medicaid programs. Historically, the OIG announced its work plan annually or semi-annually; however, in June 2017, the OIG announced its intent to update its work plan webpage in order to allow providers to more timely identify and respond to emerging fraud and abuse issues.

Duplicate Drug Claims for Hospice Beneficiaries. Since first raising the issue in its FY 2009 Work Plan, the OIG has continued to review the appropriateness of drug claims for Medicare beneficiaries who receive Medicare Part A hospice benefits and Part D prescription drug coverage. In an August 2017 work plan update, the OIG stated that hospice providers are required to render all services necessary for the palliation and management of a beneficiary's terminal illness and related conditions, including prescription drugs.[184] Based on its own work, the OIG found that Medicare may have paid twice for prescription drugs for hospice beneficiaries—once under the Part A per diem rate, and again under Part D drug plans. In 2018, the OIG plans to review the appropriateness of Part D drug claims for individuals who are receiving hospice benefits under Part A. It will also review whether Part D continues to pay for prescription drugs that should have been covered under the per diem payments made to hospice organizations.

Medicare Payments for Unallowable Overlapping Hospice Claims and Part B Claims. In July 2017, the OIG stated it intends to review Medicare Part A payments to hospices to determine whether claims billed to Medicare Part B for items and services were allowable and in accord with federal regulations.[185] Generally, certain items, supplies, and services furnished to inpatients are covered under Part A and should not be separately billable to Part B. In its FY 2010 Work Plan, the OIG expressed concern regarding Part B covered drugs (e.g., physician administered drugs or drugs used in conjunction with DME).[186] The OIG's findings were reported in June 2012 and are summarized in § 1020.30.10.20, below.[187] Prior OIG audits, investigations, and inspections had identified this as an area for noncompliance with Medicare billing requirements.

Medicare Payments for Hospice General Inpatient Care. In its 2016 Work Plan, the OIG revised what it had previously said about hospice general inpatient care in its 2015 Work Plan. The OIG said it would review the use of general inpatient care and assess the appropriateness of inpatient care claims and the content of election statements of hospice patients who receive inpatient care. It also said it would review medical records to ensure that the services billed to Medicare are medically necessary. Lastly, the OIG said it would review beneficiaries' plans of care to determine if they are meeting key requirements for hospice patients. [188]

Medicare Payments for Chronic Care Management. Beginning January 1, 2015, Medicare paid separately for Chronic Care Management (CCM) for Medicare beneficiaries who have multiple significant chronic conditions that place them at significant risk of death, acute exacerbation/decompensation, or functional decline. In its 2017 Work Plan, the OIG stated that it planned to determine whether payments for CCM were in accordance with Medicare requirements.[189]

Review of Hospices' Medicare Reimbursement Requirements. In its FY 2017 Work Plan, the OIG discussed Medicare conditions of and limitations on payment for hospice services.[190] During 2018, the agency plans to review hospice medical records and billing documentation to determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.

Hospice Home Care—Frequency of Nurse On-Site Visits to Assess Quality of Care and Services. In its FY 2017 Work Plan, the OIG addressed the Medicare requirement that a registered nurse make an on-site visit to the patient's home at least once every 14 days to assess the quality of care and services provided by the hospice aide and ensure that services ordered by the hospice interdisciplinary group meet the patient's needs.[191] The OIG will review whether registered nurses made required on-site visits to the homes of Medicare beneficiaries who were in hospice care.

Hospices in Assisted Living Facilities. In the 2014 Work Plan, the OIG said it would continue its review of the extent to which hospices serve Medicare beneficiaries who reside in ALFs, which it focused on in FY 2013 and 2014. The OIG would determine the length of stay, levels of care received, and common terminal illnesses of beneficiaries who receive hospice care in ALFs. By performing this review, the OIG intended to provide HHS with information relevant to CMS's effort to reform the hospice payment system, collect data relevant

[184] OIG, Active Work Plan Item: Duplicate Drug Claims for Hospice Beneficiaries (Aug. 2017).

[185] OIG, Active Work Plan Item: Medicare Payments for Unallowable Overlapping Hospice Claims and Part B Claims (July 2017).

[186] OIG, Fiscal Year 2010 Work Plan at 35.

[187] OAS, Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice (No. A-06-10-00059, June 2012).

[188] OIG, Fiscal Year 2015 Work Plan at 9 and Fiscal Year 2016 Work Plan at 12.

[189] OIG, Fiscal Year 2017 Work Plan at 30.

[190] *Id.* at 25.

[191] *Id.*

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to revising hospice payments, and develop quality measures for hospices.[192] The OIG's findings were reported in January 2015 and are summarized in Section 1020.30.10.20, below.[193]

Acute Care Hospital Inpatient Transfer to Inpatient Hospice Care. The OIG said in both its 2012 and 2013 Work Plans that it would review Medicare claims for inpatient stays to identify where patients were transferred to a hospice and a financial or common ownership relationship existed between the providers.[194] The OIG in 2013 recommended establishing a hospital transfer payment policy for early discharges to hospice care. The report noted that 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.[195]

Hospice Marketing Practices and Financial Relationships with Nursing Facilities. The relationships between hospices and nursing facilities have historically been an area of focus for the OIG.[196] For FYs 2012 and 2013, the OIG said it would continue its review of hospice marketing materials and practices and their financial relationships with nursing facilities.[197] The OIG's interest in these areas is based, in part, on a 2009 OIG finding that 82 percent of claims for hospice services furnished to nursing facility residents failed to meet the Medicare coverage requirements.[198] The OIG also referenced a 2009 MedPAC finding that hospices and nursing homes may be engaging in inappropriate enrollment and compensation arrangements (e.g., aggressive marketing to nursing facility residents).[199]

1020.30.10.20
Audit and Inspection Reports

A September 2009 OIG inspection report discovered that Medicare paid about $1.8 billion for hospice care claims in 2006 that did not meet at least one coverage requirement.[200] The report on Medicare hospice care for beneficiaries in nursing facilities found that 81 percent of claims did not meet at least one coverage requirement in regard to election statements, plans of care, services, or certifications of terminal illness. Additionally, one percent of claims were not sent with appropriate documentation. The OIG's recommendations for the Medicare program included stronger monitoring practices for hospice claims and more frequent certification surveys.

The report also found that not-for-profit hospices were less likely to meet coverage requirements than for-profit hospices: 89 percent of claims from not-for-profit hospices did not meet the requirements, compared with 74 percent of claims from for-profit hospices. It recommended that CMS provide tools and guidance to hospices to help them meet the coverage requirements and strengthen its monitoring practices regarding hospice claims. CMS agreed with the recommendations, stating that it has made efforts to educate hospices about coverage requirements, including conditions of participation issued in 2008,[201] through presentations at industry conferences and website broadcasts for state surveyors. CMS further stated that it will "instruct Medicare contractors to consider the issues in this report when prioritizing its medical review strategies or other interventions."

Released with the OIG inspection report was a companion report detailing specific services provided to Medicare hospice beneficiaries in nursing facilities.[202] The report said that in FY 2001, 580,000 Medicare beneficiaries received hospice care, a number that increased by 62 percent to 939,000 beneficiaries in FY 2006. Over that same period, Medicare spending on hospice care rose from $3.6 billion to $9.2 billion in FY 2006. The OIG found that 31 percent of Medicare hospice beneficiaries resided in nursing facilities in FY 2006, and that Medicare paid hospices approximately $2.59 billion for care provided to those beneficiaries. On average, according to the report, Medicare paid $960 per week for hospice care for each hospice beneficiary in a nursing facility, not including payment for physician services. Hospices most commonly provided nursing services, home health aide services, and medical social services, the report said; the hospices furnished an average of 4.2 visits per week for these three services combined. The hospices also commonly provided drugs. The OIG did not make any recommendations in the companion report, but stated that the results could "help CMS and other decisionmakers determine whether the types and frequencies of hospice services provided to beneficiaries in nursing facilities meet the

[192] OIG, Fiscal Year 2015 Work Plan at 9; Fiscal Year 2014 Work Plan at 9.

[193] OIG, Medicare Hospice Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities (No. OEI-02-14-00070, Jan. 2015).

[194] OIG, Fiscal Year 2012 Work Plan at I-6, Fiscal Year 2013 Work Plan at 3.

[195] OAS, Medicare Could Save Millions by Implementing a Hospital Transfer Payment Policy for Early Discharges to Hospice Care (No. A-06-10-00059, May 28, 2013).

[196] OIG, Medicare Hospices That Focus on Nursing Home Residents (No. OEI-02-10-00070, July 19, 2011); OIG, Fiscal Year 2011 Work Plan at I-13.

[197] OIG, Fiscal Year 2012 Work Plan at I-12, Fiscal Year 2013 Work Plan at 11.

[198] OIG, Hospice Patients in Nursing Homes: Compliance with Medicare Coverage Requirements (No.OEI-02-06-00221, Sept. 2009), at 12.

[199] MedPAC, Report to the Congress: Medicare Payment Policy, March 2009, ch. 6, Reforming Medicare's Hospice Benefit.

[200] OIG, Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities (No. OEI-02-06-00221, Sept. 2009).

[201] Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Hospice Conditions of Participation, 73 Fed. Reg. 32,088. *See* text at n.101, *supra.*

[202] OIG, Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities (No. OEI-02-06-00223, Sept. 4, 2009).

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goals of the hospice benefit and whether current payment rates are aligned with the hospice services being provided."

Another OIG inspection report, released in July 2011, found that hospices with a high percentage of nursing home patients received larger Medicare payments than hospices in general in 2009.[203] The OIG reported that hospices that had at least two-thirds of their Medicare beneficiaries in nursing homes received an average Medicare payment of $21,000 per beneficiary, compared with an $18,000 Medicare payment for all hospices. The report also found that 51 percent of nursing home residents served by high-percentage hospices were diagnosed with ill-defined conditions, mental disorders, and Alzheimer's disease, all conditions that usually require less complex care. Across all hospices, the report said, the three conditions accounted for only 32 percent of beneficiaries.

Based on these findings, OIG expressed concern that some hospices may be seeking out beneficiaries with particular characteristics, including those with conditions associated with longer but less complex care. It recommended that CMS: (1) increase the monitoring of hospices with high percentages of nursing home patients to ensure that the hospices are meeting all Medicare requirements, and (2) reduce Medicare payments for hospice care provided to nursing home residents, which would remove the incentive for hospices to seek out nursing home beneficiaries.

CMS agreed with both recommendations and said it would provide the information in the report to RACs and MACs for use in claims review. CMS also said it was in the early stages of a project to alter the payment structure to address the incentive that may exist for hospices to seek out nursing home beneficiaries.

In June 2012, the OIG reported on its audit of Medicare payments made for prescription drugs dispensed to hospice patients.[204] The audit's purpose was to find whether Medicare Part D paid for prescription drugs that were payable under the hospice per diem payment. Based on its examination of 2009 claims data, the OIG confirmed that Medicare Part D payments were made for certain types of medications that were covered in the hospice per diem rate, effectively resulting in duplicate payments (one to the pharmacy, the other to the hospice). Moreover, the OIG learned that Part D sponsors did not have procedures to identify and properly handle claims for such prescription drugs.

CMS concurred with the OIG's recommendation that CMS educate stakeholders on appropriate billing practices for these drugs and require Part D sponsors to develop appropriate controls to prevent making payments for these drugs. CMS did not, however, concur with a recommendation that CMS conduct oversight activities of Part D sponsors to ensure that inappropriate payments are not made absent evidence to support the costs and challenges of implementing such oversight.

In May 2016, the OIG published a report on the use of general inpatient care (GIP) hospice services, following a similar 2013 study examining 2011 claims.[205] In the 2013 study, the OIG determined that its findings raised additional questions for review, including whether the GIP services furnished were appropriate. The study found that, while the duration of GIP stays are expected to be short, a third of such stays exceeded five days, with 11 percent lasting 10 or more days. Moreover, hospices that used inpatient units provided GIP to beneficiaries more frequently than beneficiaries located in other settings. The 2016 study, which looked at 2012 GIP claims, determined that Medicare paid $1.0 billion for GIP care. Hospices billed one-third of GIP stays inappropriately when the beneficiary did not have uncontrolled pain or unmanaged symptoms, costing Medicare $268 million in 2012. That year, Medicare reimbursed $672 per day for GIP and $151 per day for routine care. OIG determined that the hospices should have instead billed for routine home care instead of GIP, which is reimbursed at a much higher rate.

In the 2016 report, the OIG recommended that CMS: (1) increase 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 these recommendations.

In its 2016 Semiannual Report,[206] the OIG reported that it found that hospices billed one-third of GIP stays inappropriately, costing Medicare $268 million in 2012. The OIG said CMS concurred with its recommendations that CMS: increase its oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries; ensure that a physician is involved in the decision to use GIP; conduct prepayment reviews for lengthy GIP stays; increase oversight efforts to ensure hospices are meeting care planning requirements; establish additional enforcement repercussions for poor hospice performance; and follow up on inappropriate GIP stays, inappropriate Part D payments and hospices that provided poor quality of care.

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[203] OIG, Medicare Hospices That Focus on Nursing Home Residents (No. OEI-02-10-00070, July 19, 2011).

[204] OAS, Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice (No. A-06-10-00059, June 2012).

[205] OEI, Hospitals Inappropriately Billed Medicare Over $250 Million for General Inpatient Care (OEI-02-10-00491, May 2016) at 8-9; Medicare Hospice: Use of General Inpatient Care (No. OEI-02-10-00490, May 2013) at 9-10.

[206] OIG, Semiannual Report October 1, 2015 - March 31, 2016, at 2, 3.

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In January 2015, the OIG released its inspection report on hospice services furnished to Medicare beneficiaries residing in ALFs.[207] The OIG found that these services cost the Medicare program $2.1 billion in 2012, a doubling of such costs over the preceding 5 year period. The study also reported that hospice care furnished to beneficiaries in the ALF setting received much higher Medicare payments than hospice care furnished in other settings despite a separate finding that such beneficiaries had diagnoses that typically required less complex hospice care and primarily received routing home care services.[208] The OIG found that patients in the ALF setting received a median of 98 days of hospice care, nearly double what beneficiaries received in nursing home settings and more than twice the care received in a home setting.

The report also noted that ALF residents were the most likely to have very long stays in hospice care, with 36 percent of ALF residents receiving more than 180 days of hospice care. Moreover, most hospice services furnished in ALFs were aide services (e.g., personal care services), and ALF residents were less likely to receive visits from hospice physicians or care over the weekend. The OIG also observed that for-profit hospices tended to receive higher Medicare payments on a per beneficiary basis than nonprofit hospices due to higher median hospice days and higher use of the more expensive levels of hospice care.

The OIG concluded that these findings suggested a number of hospice payment reforms to CMS, which said it would consider those recommendations.[209]

In July 2018, the OIG released a portfolio titled "Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity."[207] There, the OIG reported that some hospices fail to provide necessary services to beneficiaries and provide poor quality care. The portfolio noted that some hospices do not manage symptoms or medications effectively, leaving beneficiaries in unnecessary pain, and some fail to provide beneficiaries and their families and caregivers necessary information to make informed decisions about care. The OIG also found that fraud schemes involving hospices cost Medicare hundreds of millions of dollars. Such schemes may involve billing for an expensive level of care not necessary for the beneficiary, enrolling beneficiaries who are not eligible for hospice care, or billing for services never provided. The OIG concluded that the existing payment system, which pays a hospice for every day a beneficiary is in its care without regard for quantity or quality of care, creates incentives for hospices to minimize their services and seek beneficiaries with uncomplicated needs.

The portfolio included 15 recommendations to CMS, which relate to the following areas of improvement:

- strengthening the survey process through claims and deficiency data analysis to better ensure that hospices provide beneficiaries with needed services and quality care;
- seeking statutory authority to establish additional remedies for hospices with poor performance;
- developing and disseminating additional information on hospices to help beneficiaries and their families and caregivers make informed choices;
- educating beneficiaries and their families and caregivers about the hospice benefit through consumer-friendly educational resources;
- promoting physician involvement and accountability to ensure that beneficiaries get appropriate care;
- strengthening oversight of hospices to reduce inappropriate billing through data claims analysis, reviews, a comprehensive prepayment review strategy, and a strategy to ensure hospice drug costs are not shifted to Part D; and
- taking steps to tie payment to beneficiary care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs, seeking statutory authority if necessary.

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[207] OIG, Medicare Hospice Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities (No. OEI-02-14-00070, Jan. 2015).

[208] *Id.* at 9 and 12.

[209] *Id.* at 21 and 22.

[207] OIG, Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity (No. OEI-02-16-00570, July 2018).

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Enforcement Actions

Settlement Agreements, Court Rulings, and Administrative Rulings		
Settlement/Ruling	**Alleged Misconduct**	**Resolution/Penalties**
Caris Healthcare, L.P. (settlement announced June 25, 2018).	A hospice chain, in an effort to meet the aggressive admissions and census targets it set, admitted patients whose medical records didn't support a terminal prognosis and regularly altered patient assessments to support improper care. Despite being alerted to patients' ineligibility through internal audits and concerns raised by employees, the chain took no meaningful action to determine if improper payments had been made and continued to submit claims for the patients.	The hospice agreed to pay $8.5 million to resolve the allegations. See *Hospice Chain Pays $8.5M to Settle Improper Medicare Billing*, Health Care Daily Rep. (June 26, 2018).
Horizons Hospice, LLC (settlement announced Feb. 8, 2018).	From June 2007 to August 2012, a hospice falsified patient records and filed false claims with Medicare portraying patients as eligible for hospice services when in fact they hadn't been diagnosed as having less than six months to live as required to qualify for hospice services.	The hospice agreed to pay $1.24 million to resolve the allegations. See 29 *BNA's Health Care Daily Rep.* (Dec. 20, 2017).
North Central Hospice, LLC d/b/a Haven Hospice (settlement announced Dec. 20, 2017).	From 2011 through 2017, a hospice billed Medicare and Medicaid for excessively long and unnecessary stays. During that time period, the hospice had over 60 patients in care for three years or longer when federal programs typically only pay for hospice care for terminally ill patients with a life expectancy of six months or less.	The hospice agreed to pay $5 million to resolve the allegations. See 246 *BNA's Health Care Daily Rep.* (Dec. 26, 2017).
Genesis Healthcare, Inc. (settlement announced June 16, 2017).	From 2005 through 2013, a company's hospice and skilled nursing subsidiaries knowingly submitted false claims to Medicare, TRICARE and Medicaid for hospice services provided to patients who were not terminally ill, therapy to patients who no longer required it, and therapy that was not provided at all. The subsidiaries also submitted bills for inappropriate physician evaluation management services, outpatient therapy services that were not medically necessary or were unskilled in nature, and services that were grossly substandard or worthless.	The parent company agreed to pay $53.6 million to resolve the allegations. Notably, the settlement agreement did not include a cooperation clause and the company was not required to enter into a corporate integrity agreement. See 21 *BNA's Health Care Fraud Rep.* 383 (June 21, 2017).
Serenity Hospice and Palliative Care (settlement announced Oct. 7, 2015).	A hospice submitted claims to Medicare for hospice services provided to patients who were ineligible for hospice care or were improperly referred to the hospice.	The hospice agreed to pay $2.2 million to resolve the allegations. See 197 *BNA's Health Care Daily Rep.* (Oct. 13, 2015).

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Settlement Agreements, Court Rulings, and Administrative Rulings		
Guardian Hospice of Georgia LLC (settlement announced Oct. 2, 2015).	A hospice submitted false claims to Medicare for patients who were not terminally ill. The hospice failed to properly train its staff on hospice eligibility requirements and set aggressive targets to recruit and enroll patients.	The hospice agreed to pay $3 million to resolve the allegations. See 192 *BNA's Health Care Daily Rep.* (October 5, 2015).
Alive Hospice, Inc. (settlement announced Sept. 10, 2015).	A hospice submitted claims to various government healthcare programs for general inpatient hospice care provided to patients who did not qualify for the care.	The hospice agreed to pay $1.5 million to resolve the allegations. See 177 *BNA's Health Care Daily Rep.* (Sept. 14, 2015).
St. Joseph Hospice Entities (settlement announced Sept. 3, 2015).	A hospice group submitted claims to Medicare for continuous home care hospice services for patients who did not qualify for the services.	The hospice and its majority owner and manager agreed to pay $5,687,518 to resolve the allegations.
Covenant Hospice, Inc. (settlement announced June 18, 2015).	A hospice submitted claims to Medicare, Tricare and Medicaid for general inpatient hospice care, the highest level of care for reimbursement, that should have been for routing home care, the lowest level, and the hospice's medical records did not support the medical necessity of the inpatient care.	The hospice agreed to pay $10.1 million to resolve the allegations. See 119 *BNA's Health Care Daily Rep.* (June 22, 2015).
United States ex rel. Cordingley and Jones v. Good Shepherd Hospice, Mid America, Inc., No. 4:11-cv-1087 (W.D. Mo. settlement announced Feb. 6, 2015).	A multistate hospice operator knowingly submitted claims to Medicare for patients who were not terminally ill. The hospice pressured staff to meet admission and census targets and paid bonuses to staff based on the number of patients enrolled at the hospice. The hospice hired medical directors based on their ability to refer patients and failed to properly train staff on the hospice eligibility requirements.	The hospice operator agreed to pay $4 million to settle the allegations and each individual hospice agreed to enter into a corporate integrity agreement. See 28 *BNA's Health Care Daily Rep.* (Feb. 11, 2015).
United States ex rel. Smallwood v. Thi of Mich. LLC, No. 2:14-cv-00227 (N.D. Ala. settlement announced Mar. 13, 2014).	A multistate hospice operator over a five year period admitted patients who were not qualified for hospice benefits, paid illegal inducements to its staff for increasing the number of patients admitted, and operated a gainsharing program that paid financial incentives to employees for reducing the cost of patient care and increasing the number of patients in its facilities. Staff members rationed supplies and substituted cheaper medications in ways that negatively affected patient care. Medicare funds that should have been spent on patient care were diverted to pay the employee incentives.	The hospice operator agreed to pay $3.9 million to settle the allegations. See 18 *BNA's Health Care Fraud Rep.* 240 (Mar. 19, 2014).

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Settlement Agreements, Court Rulings, and Administrative Rulings		
United States ex rel. Stone v. Hospice of the Comforter, Inc., No. 6:11-cv-1498 (M.D. Fla., settlement approved Oct. 28, 2013).	A hospice knowingly submitted about $11 million in false claims to Medicare for patients who were not terminally ill. The hospice's chief executive officer verbally instructed employees to admit Medicare recipients for hospice care, regardless of their eligibility determination.	The hospice agreed to pay $3 million to resolve the allegations.
United States and State of Florida ex rel. Numbers and Davis v. Hernando-Pasco Hospice Inc., No. 10-cv-00912 (M.D. Fla., settlement July 22, 2013).	A hospice company caused staff to admit ineligible patients in order to meet targets set by management and adopted procedures to delay and discourage staff from discharging patients who were not appropriate for hospice services. The company instructed staff to make false or misleading statements in patients' medical records to make them appear eligible when they were not. It also billed the government at higher reimbursement rates than it was entitled to receive, and provided illegal kickbacks when it provided free services to skilled nursing facilities in exchange for patient referrals.	The hospice company agreed to pay $1 million to resolve allegations. The two relators' collective share was $250,000.
Voyager HospiceCare, Inc. & Hospice Care of Kansas, LLC (June 5, 2012).	The hospice and its subsidiary are alleged to have submitted or caused the submission of false Medicare claims for patients who were not terminally ill.	The hospice agreed to pay $6.1 million to resolve the false claims case. The settlement included no admission of wrongdoing by either Voyager or Hospice Care of Kansas.
Hospice Family Care, Inc. (announced May 31, 2012).	The hospice and its two owners allegedly submitted claims to Medicare for patients who were either completely or partially ineligible for hospice care or were provided a higher level of care than was medically necessary.	The hospice agreed to pay $3.7 million. The owners were excluded from participation in any Federal health care program for a period of seven years.
Odyssey HealthCare, Inc. (announced March 2, 2012).	In three False Claims Act cases, qui tam relators alleged that Odyssey submitted claims for unnecessary continuous home care services.	The company denied any liability but agreed to pay $25 million to resolve the allegations and entered into a five-year Corporate Integrity Agreement (CIA).
Hospice Home Care, Inc. (Dec. 9, 2011).	Qui tam relator alleged that the hospice billed Medicare for general inpatient care when the patients only required or received routine care.	The hospice agreed to pay $2.7 million to resolve the allegations.
Diakon Lutheran Social Ministries d/b/a Diakon Hospice Saint John (Dec. 1, 2011).	After voluntary disclosure, the hospice entered into a Settlement Agreement to resolve allegations that the hospice had billed Medicare for hospice services provided to beneficiaries who did not qualify for hospice.	The hospice agreed to pay $10.6 million to resolve the allegations.

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Settlement Agreements, Court Rulings, and Administrative Rulings		
Jackie Randolph Gist (Good Samaritan Hospice USA Inc.) (plea agreement entered September 2010).	As CEO, Gist allegedly caused hospital to submit claims to Medicare for services provided in an inpatient facility, when in the fact the services were routine, non-inpatient services, leading to a loss to the Medicare program of $3,192,285.	Gist was sentenced to 28 months in prison.
SouthernCare, Inc. (Jan. 15, 2009).	Two former employees alleged that the hospice billed Medicare for hospice services provided to beneficiaries who did not qualify for hospice.	The hospice denied any liability but agreed to pay $24.7 million to resolve the allegations and entered into a five-year CIA.
Kaiser Foundation Hospitals (Nov. 12, 2009).	The hospice allegedly billed Medicare for hospice services without obtaining the required written certifications of terminal illness.	Kaiser denied liability but agreed to pay $1.8 million to resolve the allegations.
United States ex rel. Roberts v. Sunrise Senior Living Inc., No. CV 05-3758-PHX-MHM, (D. Ariz., Aug. 14, 2009).	The hospice allegedly admitted patients who did not meet the Medicare requirements for hospice. The government also contended that the hospice and its owners falsified and backdated patient medical records and certification of hospice eligibility determinations, permitted unlicensed persons to approve physician prescriptions, and provided financial incentives to induce hospice referrals.	The hospice agreed to pay $750,000 to resolve the allegations.
Emmanuel Ridge Hospice Ministry v. CMS (July 2009).	The hospice allegedly allowed its state license to expire and was subsequently terminated from participation in the Medicare program.	The termination was upheld by the Administrative Law Judge. (DAB Decision CR1974).

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Settlement Agreements, Court Rulings, and Administrative Rulings		
Roberto Ruiz (Southwest Internal Medicine Group) (June 2009).	Ruiz allegedly violated the False Claims Act by falsely representing that he was not employed or paid under an agreement by patients' hospice providers, when he was being paid as a medical director and home care physician.	Ruiz paid $525,000 to resolve the allegations.
S-Hospice Group Inc. (N.D. Texas agreement announced May 29, 2008).	The hospice allegedly received payment for unallowable hospice items and services and misrepresented to Medicare the medical conditions of patients to ensure they would be admitted for hospice care. The hospice group also allegedly misrepresented to physicians the medical conditions of patients so they could be certified for admission. The hospice also misrepresented the purpose and criteria of Medicare's hospice benefit to ensure patients met admission requirements.	The hospice agreed to pay $500,000 to resolve the allegations. The owners and the hospice also entered into a five-year CIA with the OIG.
Odyssey HealthCare Inc. (E.D. Wisc. settlement announced July 13, 2006).	The hospice allegedly submitted claims to Medicare for hospice services to Medicare beneficiaries who did not qualify for hospice care because they did not have a life expectancy of six months or less.	The hospice denied any liability but agreed to pay $13 million, and entered into a five-year CIA.
Settlement Agreement Between New York (New York Attorney General) and 77 Hospitals (agreement announced July 23, 2001).	Hospitals across New York allegedly overbilled the state's Medicaid program for the treatment of hospice patients. The hospitals billed Medicaid for patients transferred to them for treatment from various hospices, even though Medicaid already pays hospices for inpatient care at hospitals. The correct procedure was for hospitals to have billed the hospices for the treatment.	The hospitals agreed to pay $1.7 million to settle the allegations.

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