

Investigation exposes corruption in for-profit hospice care

By Paula Hartman-Stein, Ph.D.

An exposé jointly published in December by The New Yorker and ProPublica has revealed fraud, patient mistreatment, and predatory practices among certain for-profit hospice businesses in the U.S.

The investigation points to the current Medicare reimbursement structure as enabling providers to exploit dying patients because hospice care largely takes place behind closed doors, with families not realizing when patient needs are not being met.

In a short time, the extensive media investigation gained attention and traction.

Three weeks after the publication, a bipartisan group in Congress wrote a letter to the Department of Health and Human Services asking for an investigation and increased scrutiny of hospice care. In New York, Gov. Kathy Hochul is considering signing legislation to outlaw the creation of new for-profit hospice providers.

Some in the palliative care field pushed back, calling for blocking the article from social media platforms, alleging the reporter only described a few bad actors.

Ira Byock, M.D., former president of the American Academy of Hospice and Palliative Medicine, wrote in an op-ed piece published by the online medical news website STAT, “I applaud the media for calling attention to deficiencies that can harm people during the most vulnerable times in their lives. I am hopeful that the article will spark a long-overdue internal reckoning by the field — my field — and the industry we gave rise to.”

For her article, *ProPublica* reporter Ava Kofman interviewed 150 patients, family members, hospice workers, attorneys and auditors who agreed the essential mission of the hospice movement is to bring greater comfort and control to patients at the end-of-life is praiseworthy. However, many described easy ways to cut corners on care that led to a system ripe for a “for-profit hustle” paid for by taxpayers.

To qualify for hospice, patients must forgo medical care meant to cure and be certified by two physicians as having less than six months to live. The article details cases of solicitation of whether they were near death. One national for-profit chain, AseraCare, sent marketing staff in Alabama to birthday parties at housing projects and promoted programs to those near the poverty line that “offered medications, nursing visits, nutritional supplements, and light housekeeping—all for free.” The marketer found people with chronic illnesses, such as heart disease and diabetes, but added symptoms, such as shortness of breath, to prove the likelihood of the terminal stage of illness.

Admission quotas were rewarded with cash bonuses and perks. When quotas were not met, threats of being fired loomed large. Once a hospice application is accepted, and the program is running, oversight appears to be minimal.

The Center for Medicare and Medicaid Services (CMS) oversees the reimbursement for hospice care and recognizes that an individual may not die within the requisite six months of the benefit term. CMS requires repayment from hospices when the patient’s length of stay exceeds six months if there is no recertification by a hospice physician or nurse practitioner. A patient can continue hospice services if a qualified provider had a

face-to-face encounter with the patient documenting the clinical findings supporting a life expectancy of 6 months or less.

According to Kofman's investigation, in order to keep its money stream, some hospices discharge or "dump" patients who are not dying fast enough but who still need care the system had been providing.

The most egregious example occurred in Frisco, Texas when a for-profit hospice owner tried to evade repayment by ordering staff to overdose patients who were staying on the service too long. Following an FBI investigation, the owner faced a sentence of 13 years in prison for fraud, but in a plea deal, no charges of patient deaths were mentioned.

Modest beginnings and exponential growth

In the 1960s an English physician and social worker, Dame Cicely Saunders, promoted the hospice philosophy in the U.S. with the goal of treating the needs of the whole patient, i.e., reducing physical and psychological suffering and enabling spiritual needs to be met. In 1969 psychiatrist Elisabeth Kubler-Ross, M.D., published *On Death and Dying*, a groundbreaking book that convinced the American public that end-of-life care in the hospital setting could be inhumane. Five years after its publication, the first American hospice opened in Connecticut.

Recognizing the potential for cost savings by reducing medically unnecessary procedures at end-of-life, hospice became a Medicare benefit in 1982 under the Reagan administration. In 2022 half of all Americans die while receiving hospice care, which has led to it becoming a multi-million-dollar business.

In 2023, Medicare will reimburse hospice providers approximately \$203 per patient per day, covering all care costs regardless of the number of services provided on a given day, including days when the hospice provides no services. In 1983, the reimbursement was about \$100 a day.

In both the non-profits and for-profits, the patient's primary care physician, who may have known the patient for decades, is typically cut out of the per diem benefit, no longer providing input for care decisions and leaving those up to a hospice-based physician. According to Byock, "It's a cruel irony that many American hospice programs have now become barriers to dying patients seeing physicians."

Imbalance between for-profit and non-profit hospices

In 2000, for-profit hospices owned 30 percent of the market. In 2018, 66.4 percent of hospices were controlled by for-profit businesses, based on data from the Center for Disease Control, with the figure approaching 70 percent in 2022, according to Kofman.

In a 2022 study in the *Journal of General Internal Medicine*, for-profit hospices reported receiving 51.6 percent more total Medicare payments and 33.6 percent more per patient. The study shows that higher costs relate to longer lengths of stay because for-profits typically enroll more patients with dementia than with diseases such as cancer. For-profits also enroll a greater proportion of racial and ethnic minorities and have grown in urban areas where poor minority populations tend to live.

Greater profits are possible by decreasing the frequency of staff visits, reluctance to discharge inappropriate patients, and hiring undertrained staff, all typical allegations made by insider whistleblowers who report suspicions to Medicare, often triggering audits.

Quality of care issues

Medicare requires hospice programs to deliver four levels of care – routine home care, respite care, continuous care and general inpatient care. Approximately 53 percent of all American hospices provide no general inpatient care.

According to Byock, “During the 1980s and 1990s, hospice programs earned reputations for excellence and reliability. While some still offer excellent care, quality varies widely from program to program.”

Another situation rife with potential problems is the use of “protocol medicine” that does not individualize patient care.

For this article, a psychologist who requested anonymity described the death of her 87-year-old father. Both she and her cousin, a retired nurse, suspected he was being overdosed with morphine during the last days before his in-patient hospice Medicare benefit was expected to end. The daughter had stayed by her father’s side for more than two weeks while he was hospitalized for head trauma and transferred to the non-profit hospice service associated with a hospital.

Within hours of her returning to her home state, she received a call that her father died. When asked about the timing of his last dose of morphine, the hospice nurse acknowledged his death occurred shortly after morphine was administered. That dose was not given because of pain complaints but because the medication was scheduled on a time-based order under a standard medical protocol.

Following his death, the daughter considered legal action against the hospice. Ultimately, she chose to forgo a lawsuit after her late father’s primary care physician of more than 30 years warned her that it would be a tough case to prove, even though he had made pro bono visits to her father during his hospice stay and reported unexpected improvement just a few days earlier.

In 2019, the Office of Inspector General of the U.S. Department of Health and Human Services issued a report that more than 80 percent of all hospice programs (both for-profit and not-for-profit) had deficiencies in care, including nearly 20 percent that demonstrated one or more serious deficiencies.

According to Kofman, seven out of 10 of the largest hospices in the U.S. have been sued at least once due to testimony of former employee whistleblowers. The report details examples of hospice fraud investigations that were largely inconsequential to them financially in the long run.

Despite the problems cited in the investigation, many families are grateful for the care and support received from hospice providers. Sara Honn Qualls, Ph.D., Kraemer Family professor of aging studies and professor of psychology at the University of Colorado, said, “I have personally had wonderful experiences with hospice for my family members and patients, so I believe very much in the model. But like all models, exploitation is possible.”

After publishing the results of her investigation, Kofman wrote a guide for families to avoid hospice fraud - <https://www.propublica.org/article/how-to-research-your-hospice-and-avoid-hospice-fraud>.

The official CMS website for publicly reporting quality measures is Care Compare on Medicare.gov, created to help consumers compare hospice providers' performance and assist patients and families to choose programs.

Quality improvement and reform

CMS is developing a new patient assessment tool, Hospice Outcomes and Patient Evaluation (HOPE), to help hospices improve their understanding of the needs of the patients and contribute to the plan of care based on real-time interactions throughout the dying process.

In December, CMS released the Hospice Quality Reported Program report of 2022 which provides information from literature reviews and expert interviews supporting the expansion of the hospice quality reporting program. A recommendation from the Journal of General Internal Medicine that would potentially dissuade fraud is to tie reimbursement to clinical quality outcomes.

The media exposé brought a spotlight on the corruption in the current system resulting in a clarion call for reform in this arm of American healthcare.

Byock has hope for the future of hospice. "At its best, this kind of care is nearly magical in its ability to restore seriously ill people to a sense of living during dying. But for hospice to have any chance of surviving with its therapeutic potential intact, leaders in the field must confront their own denial. In this situation, we are either the solution to the problem or the problem itself."