Office of the Inspector General
Commonwealth of Massachusetts

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Inspector General

MassHealth's Administration of the Hospice Benefit

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Executive Summary

Hospice care provides for the palliation and management of terminal illnesses, but does not provide for curative treatment of an illness or injury. Palliative treatment is patient- and family-centered care that makes quality of life the priority by anticipating, preventing, and treating suffering. To that end, hospice care involves a group of comprehensive services that address physical, intellectual, spiritual, and emotional needs, and which facilitate patient autonomy, access to information, and choice. Hospice providers care for patients wherever they live, including private homes, assisted living facilities, and skilled nursing facilities.

The Office examined claims for hospice and other end-of-life care for MassHealth members and HSN users. The goal of the review was to determine whether there were any systemic issues that made the hospice program vulnerable to fraud, waste, or abuse by providers. In this review, the Office examined hospice claims for 10,117 MassHealth members with dates of service from January 1, 2015 through December 31, 2016. For this period, 67 hospice providers submitted claims to MassHealth, and MassHealth paid these providers over $153 million for 10,176 hospice stays. MassHealth paid an average of $15,186 per member who received hospice services during this time.

Initial findings. The Office initially found that MassHealth members stand out in three ways from hospice patients nationally. First, MassHealth members with dementia-related primary diagnoses received hospice care more than members with other primary diagnoses, and at a higher rate than nationally. Second, MassHealth members with cancer and heart- and lung-related diagnoses used hospice care at a lower rate than patients across the nation. Finally, MassHealth members leave hospice care as live discharges at higher rates than in other states.

In-depth analysis. After conducting this initial overview, the Office conducted an in-depth analysis of a number of issues, including the length of hospice stays, types of diagnoses on hospice claims, and hospices with multiple indicators of potential fraud, waste, or abuse of the hospice program. Overall, the Office's review did not find widespread fraud, waste, or abuse in the hospice program. There were, however, instances in which the Office noted that certain providers' claim histories raised questions regarding compliance with the hospice regulations. The Office has given the names of those providers to MassHealth for additional review. In addition, the Office recommends a number of measures that would assist MassHealth in identifying fraud, waste, and abuse in the hospice program.

Long-term hospice stays. For example, the Office identified seven hospices that provided hospice care to members for substantially longer than expected – some by as much as 80% longer. The Office recommends that MassHealth conduct an in-depth review of the hospice providers that the Office identified to determine whether those providers are committing fraud, waste, or abuse. The Office also recommends that MassHealth consider requiring a physician to conduct a face-to-face examination of members remaining on hospice longer than the anticipated life expectancy set out by the regulations (180 days).

Hospice care for members with dementia-related illnesses. The Office further found that members with dementia-related diagnoses accounted for the largest share of MassHealth payments in the review, and received hospice care at a higher rate than in other states. The Office

therefore recommends that MassHealth evaluate those hospices that provided services for shorter than the average length of service to determine if they are providing appropriate clinical care for members with dementia at the end of life. If so, the Office recommends that MassHealth determine whether and how other providers can replicate their approval processes and the resulting hospice services.

Moreover, MassHealth must ensure that those members with dementia-related diagnoses are receiving care in the appropriate clinical setting and are not receiving hospice care for the convenience of the provider or for fraudulent billing purposes. The Office also recommends that MassHealth consider implementing specific guidelines for hospice admission, either adopting the Medicare guidelines or another set of objective measures, to help providers determine when a person with dementia should begin receiving hospice care.

Hospice and skilled nursing facility collaborations. The Office identified four pairs of hospice providers and skilled nursing facilities that frequently collaborated in providing care to members receiving hospice services. As a result, the Office recommends that MassHealth review collaborations that this report identified to determine whether these hospices are providing services in a manner that is consistent with the regulatory requirements of the program. The Office also recommends that MassHealth consider reviewing frequent skilled nursing facility and hospice collaborations as one possible indicator of fraud, waste, or abuse of the program.

Multiple indicators of potential fraud, waste, or abuse. Finally, the Office looked at multiple indicators of potential fraud, waste, or abuse and found several providers who scored high on five or more indicators. Accordingly, the Office recommends that MassHealth add to its program integrity activities by analyzing multiple fraud indicators to more effectively identify potential fraud, waste, or abuse by hospice providers.

Background

I. The Office of the Inspector General.

Created in 1981, the Office of the Inspector General ("Office") was the first state inspector general's office in the country. The Legislature created the Office at the recommendation of the Special Commission on State and County Buildings, a legislative commission that spent two years probing corruption in the construction of public buildings in Massachusetts. The commission's findings helped shape the Office's broad statutory mandate, which is the prevention and detection of fraud, waste, and abuse in the expenditure of public funds and the use of public property. In keeping with this mandate, the Office investigates allegations of fraud, waste, and abuse at all levels of government; reviews programs and practices in state and local agencies to identify systemic vulnerabilities and opportunities for improvement; and assists the public and private sectors to help prevent fraud, waste, and abuse in government spending.

The Office has considerable experience reviewing and analyzing healthcare programs, including issues relating to costs, eligibility, documentation, and verification. The Office also has issued a number of analyses, reports, and recommendations regarding the Massachusetts Medicaid ("Medicaid") program, the Health Safety Net ("HSN") program, healthcare reform, and other healthcare topics.

In July 2017, the Legislature enacted chapter 47 of the Acts of 2017. Section 103 of that law directed the Office to study and review the Medicaid and HSN programs:

> Notwithstanding any general or special law to the contrary, in hospital fiscal year 2018, the office of inspector general may expend a total of $1,000,000 from the Health Safety Net Trust Fund established in section 66 of chapter 118E of the General Laws for costs associated with maintaining a health safety net audit unit within the office. The unit shall continue to oversee and examine the practices in hospitals including, but not limited to, the care of the uninsured and the resulting free charges. The unit shall also study and review the Medicaid program under said chapter 118E including, but not limited to, a review of the program's eligibility requirements, utilization, claims administration and compliance with federal mandates. The inspector general shall submit a report to the chairs of the senate and house committees on ways and means on the results of the audits and any other completed analyses not later than March 1, 2018.

Pursuant to this legislative mandate, the Office examined claims for hospice and other end-of-life care for MassHealth members and HSN users.[1] The goal of the review was to determine whether there were any systemic issues that made the hospice program vulnerable to fraud, waste, or abuse by providers. Overall, the Office found that there were no indicators of widespread fraud, waste, or abuse in the hospice program. However, the Office did identify

[1] For ease of reference, this report will refer to individuals who utilize the Medicaid program as "MassHealth members" and those who utilize the HSN program as "HSN users."

certain providers whose claim patterns signaled potential fraud or abuse of the hospice program. The Office also makes a number of recommendations for the MassHealth program regarding factors to consider as it updates and strengthens its program integrity efforts.

II. The Medicaid program.

The federal government created the national Medicaid program in 1965 to provide medical assistance to low-income Americans, particularly children, through a shared state-federal commitment. Today, the national Medicaid program pays for medical care, as well as long-term nursing and other care, for tens of millions of Americans. At the federal level, the Centers for Medicare & Medicaid Services ("CMS") administers the program. Each state administers its own version of Medicaid in accordance with a CMS-approved state plan. Although the states have considerable flexibility in designing and operating their Medicaid programs, they must comply with applicable federal and state laws and regulations. In Massachusetts, the Executive Office of Health and Human Services includes the Office of Medicaid ("MassHealth"), which oversees the Medicaid program.

Some adults are eligible for both Medicaid and Medicare ("dual eligible"). These adults may be eligible for both programs based on their disability, low economic status, or chronic medical condition. For certain types of healthcare services, Medicare and Medicaid may each pay for a part of a patient's care. For example, for dual eligible hospice patients living in skilled nursing facilities, Medicare pays for the hospice care while Medicaid pays for room and board at the facilities.

III. The Health Safety Net program.

In 1985, the Legislature created the uncompensated care pool ("UCP") with the goal of "more equitably distributing the burden of financing uncompensated acute hospital services across all acute hospitals[.]"[2] The purpose of the UCP was to pay for medically necessary services that acute care hospitals and community health centers provided to eligible low-income uninsured and underinsured patients. In addition, the UCP reimbursed hospitals for bad debt for patients from whom the hospitals were unable to collect payment.

In 2006, the Legislature created the Health Safety Net ("HSN") program, funded by the Health Safety Net Trust Fund, to replace the UCP. The stated purpose of the HSN program was to "maintain a healthcare safety net by reimbursing hospitals and community health centers for a portion of the cost of reimbursable health services provided to low-income, uninsured or underinsured residents of the commonwealth."[3] Initially, the Division of Healthcare Finance and Policy managed the HSN program, but in 2012 the Legislature transferred that responsibility to MassHealth.

[2] G.L. c. 6A, § 75 (repealed 1988).

[3] G.L. c. 118E, § 66.

IV. Hospice Care

Hospice care provides for the palliation and management of terminal illnesses, but does not provide for curative treatment of an illness or injury. Palliative treatment is patient- and family-centered care that makes quality of life the priority by anticipating, preventing, and treating suffering. To that end, hospice care involves a group of comprehensive services that address physical, intellectual, spiritual, and emotional needs, and which facilitate patient autonomy, access to information, and choice. Hospice providers care for patients wherever they live, including private homes, assisted living facilities, and skilled nursing facilities.

Research regarding hospice has shown that patients who receive hospice care tend to have lower rates of hospitalization, admission to intensive care units, and invasive procedures[4] while reporting greater satisfaction with the care and pain management that they received.[5] In fact, CMS is conducting a consumer assessment of hospice care to gather information on the experiences of hospice patients and their families. CMS will publish the results of this survey in the winter of 2018. With regard to the cost of hospice care, one study indicates that patients with poor-prognosis cancer who enrolled in hospice care for five to eight weeks resulted in significant cost savings to the Medicare program.[6]

However, research indicates that hospice care generally begins too late to provide the full benefit to patients. One study concluded that brief hospice stays may mean that patients were hospitalized unnecessarily immediately before entering hospice, and therefore received costly and unnecessary high-tech treatment in the weeks immediately before they entered hospice.[7] In another study, half of the patients received hospice care for less than thirteen days.[8] A different study found intensive-care use, hospitalization, and the rate of health care transitions from one care environment to another increased in the last month of life before patients entered hospice.[9]

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[4] Kumar, P. *et al.*, Family perspectives on hospice care experiences of patients with cancer, 35(4) Journal of Clinical Oncology 432 (2017); Akron General Visiting Nurse Service, Hospice care linked to improved outcomes, better patient experience, national study finds, 18(3) Cleveland Clinic (Nov/Dec/Jan 2016/2017) (citing Kleinpell, R. *et al.*, Exploring the association of hospice care on patient experience and outcomes of care, BMJ Supportive and Palliative Care (Aug. 16, 2016)); Obermeyer, Z. *et al.*, Association between the Medicare hospice benefit and health care utilization and costs for patients with poor-prognosis cancer, 312(18) Journal of American Medical Association 1888 (2014).

[5] Fox News, Hospice care improves patient experience (Sept. 6, 2016) (citing Kleinpell, R. *et al.*, Exploring the association of hospice care on patient experience and outcomes of care, BMJ Supportive and Palliative Care (Aug. 16, 2016)).

[6] Obermeyer, Z. *et al.*, Association between the Medicare hospice benefit and health care utilization and costs for patients with poor-prognosis cancer, 312(18) Journal of the American Medical Association 1888-96 (2014).

[7] Christakis, N. and Escarce, J., Survival of Medicare patients after enrollment in hospice programs, 335 New England Journal of Medicine172-78 (July 1996).

[8] Gill, T. *et al.*, Distressing symptoms, disability, and hospice services at the end of life: prospective cohort study, 66(1) Journal of the American Geriatrics Society 41-47 (Sept. 2017).

[9] Obermeyer, Z. *et al.*, Association between the Medicare hospice benefit and health care utilization and costs for patients with poor-prognosis cancer, 312(18) Journal of the American Medical Association 1888-96 (2014).

A. The MassHealth Hospice Program[10]

MassHealth pays for hospice care. The MassHealth hospice benefit pays for the coordination of care for a terminal illness and any related conditions; nursing services; medical services; physician services; bereavement and other counseling; physical, occupational, and speech therapy and language therapy; hospice aide and homemaker services; and drugs and durable medical equipment. The hospice team includes a doctor, registered nurse, social worker, and pastoral or other counselor who provide services to the person and the person's family.

For the purpose of MassHealth's hospice care, a terminal illness means that a person's life expectancy is six months or less if the illness runs its normal course. When a MassHealth member chooses to receive hospice care, the member waives the right to Medicaid benefits for healthcare services that would treat the terminal illness. However, Medicaid continues to pay for services that are unrelated to that illness.[11]

Within two calendar days after the beginning of hospice services, MassHealth requires the hospice provider to obtain a certification from either the medical director of the hospice or the physician member of the hospice's interdisciplinary team, as well as from the member's physician, if the member has one. That certification states that the member is terminally ill and provides for 90 days of hospice care. After those 90 days, a member may receive hospice care for another 90-day period, followed by an unlimited number of 60-day periods. For each of these extension periods, the hospice must obtain an additional written certification from either the medical director of the hospice or the physician member of the hospice interdisciplinary team. Each certification must state that the member's life expectancy is six months or less and must include a brief narrative explaining the clinical findings that support the life expectancy.[12]

There are several types of MassHealth reimbursement for hospice services. For example, there are two categories of payments for home care (routine and continuous), which refers to hospice services that occur where a member lives, as opposed to care that occurs in a hospital.[13] MassHealth also pays for inpatient respite (up to five days), which provides short-term care when necessary to relieve the family members or other people caring for the member at home. MassHealth also pays for inpatient care for its members using the hospice benefit. As of January 1, 2016, there are two payment rates for routine home care (one rate for days 1 through 60 of hospice care and another rate for days 61 or more days) as well as an additional amount for care that occurs in the last seven days of a member's life.

For members who reside in skilled nursing facilities and have only Medicaid coverage, MassHealth makes two payments to the hospice provider: a monthly payment for room and

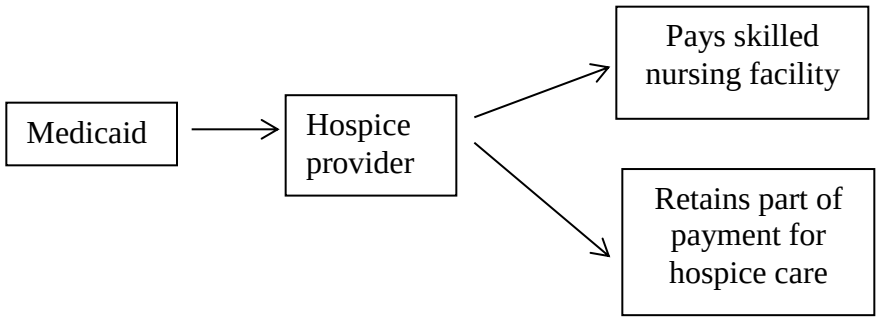
[10] 130 CMR 437.400 *et seq*.

[11] 130 CMR 437.412(B).

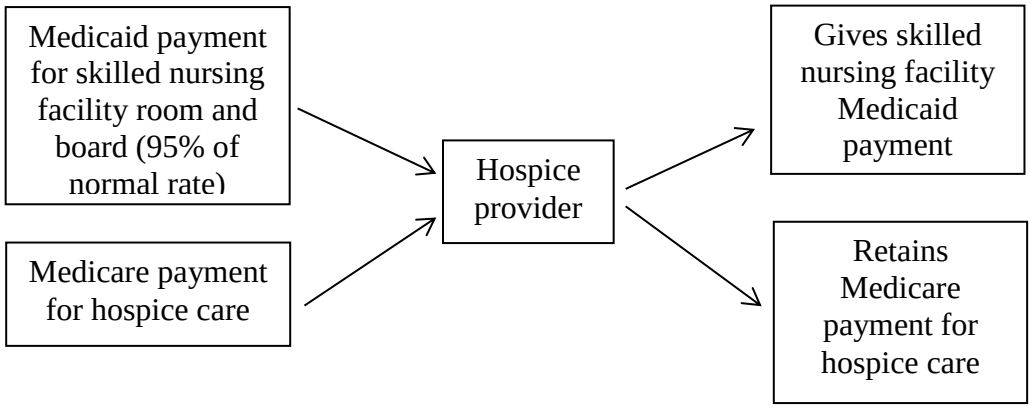
[12] 130 CMR 437.411(C).

[13] Routine home care refers to regular daily assistance that a member receives at home or in a skilled nursing facility. Continuous home care refers to predominantly nursing care that a member receives on a continuous basis at home or in a skilled nursing facility; continuous home care occurs for brief periods of crisis to keep the member at home.

board at the facility and a daily payment for the hospice care. The hospice then pays the skilled nursing facility a contractually agreed-upon rate for the member's room and board while retaining payment for the hospice care that it provides.



For dual eligible members (those with both Medicare and Medicaid coverage) who reside in skilled nursing facilities, MassHealth pays the hospice provider a set amount each month that the hospice provider pays to the skilled nursing facility for the member's room and board. Medicare then pays the hospice a daily rate for providing hospice care.



B. Program Integrity for the MassHealth Hospice Program

MassHealth has a subdivision – referred to as the "hospice program" – that oversees the administration of hospice benefits. The MassHealth hospice program reviews monthly reports regarding hospice enrollment with aggregate information about members who have elected to use the hospice benefit. Those reports include information such as how long members have received hospice care, the kinds of diagnoses members receiving hospice care have, and whether the hospice enrollment forms are complete. The program uses this information to monitor how providers are caring for members and may follow up with providers as necessary. The program also issues bulletins to update providers on changes to the hospice benefit. For example, the

most-recent hospice bulletin focuses primarily on how providers should identify dementia diagnoses on claims for hospice services.[14]

In addition, MassHealth's claim processing system automatically detects claims that conflict with the requirements of the program. For example, if a person has elected hospice care and a provider files a claim for home health services or another service that is duplicative of the hospice services, the system will deny that claim. MassHealth also has an Office of Clinical Affairs ("OCA") that reviews complaints that MassHealth receives about hospice providers. If OCA receives a complaint, it will review the provider's claims and may conduct an audit of the provider's medical records.

MassHealth has recently hired a new vendor to help continue to develop methods to detect fraud, waste, and abuse. MassHealth reports that the vendor is in the process of making recommendations to the hospice program, and the program is working to validate the recommendations. For example, the recommendations are likely to include new guidelines regarding how to evaluate when members with dementia-related illnesses should begin receiving hospice care.

[14] Memorandum from Daniel Tsai, Assistant Secretary for MassHealth, to Hospice Providers Participating in MassHealth (Feb. 2018), available at: www.mass.gov/files/documents/2018/02/06/hos-12.pdf.

Findings

The Office reviewed hospice claims for 10,117 MassHealth members[15] with dates of service from January 1, 2015 through December 31, 2016.[16] For this period, 67 hospice providers submitted claims to MassHealth. MassHealth paid these providers over $153 million for 10,176 hospice stays.[17] MassHealth paid an average of $15,186 per member who received hospice services during this time. This group of MassHealth members had different numbers and lengths of hospice stays:

- 8,352 members, or 70%, had one hospice stay that began and ended within the two years under review.
- 1,308 members, or 11%, started receiving hospice care during the two years under review and were still receiving hospice care at the end of the period (December 31, 2016).
- 341 members, or 3%, had multiple hospice stays during the two years under review.
- 88 members, or less than 1%, were receiving hospice care both at the beginning and end of the two years under review, which means that each of the 88 were on hospice either continuously or intermittently for more than two years.
- 28 members, or less than 1%, had hospice stays that began before the two-year period and ended before December 31, 2016.

Turning next to the terminal conditions that qualified these members to receive hospice care, the vast majority of members had just one primary diagnosis on the claim from the first day of a hospice stay.[18] These claims included more dementia-related diagnoses[19] than any other diagnosis. Specifically, there were:

[15] This represents all members who received hospice care in calendar years 2015 and 2016, with the exception of 1,846 members (15%) whom the Office excluded because their hospice claim history was incomplete for the purpose of this review.

[16] The Office set out to review both MassHealth members and Health Safety Net users. However, there was only one Health Safety Net user who had only five days of claims before being transferred to MassHealth coverage.

[17] A hospice "stay" is one that began with a claim for hospice services. If that hospice stay ended and was then followed by another hospice claim within seven days, it was treated as part of the same stay. If the second hospice claim followed more than seven days later, it was treated as a second stay.

[18] The review grouped the primary diagnoses on the claim(s) for the first day of each hospice stay into eleven categories using the National Center for Health Statistics, International Classification of Diseases, Ninth and Tenth Revisions.

[19] The review grouped different types of dementia-related diagnoses, including Alzheimer's disease, into this one category.

Table 1. Primary diagnoses for MassHealth members on the first day of hospice.

Primary diagnosis	**2015**	**2016**	**Both years together**
Dementia-related	37.99%	38.18%	36.58%
Cancer	17.16%	15.95%	17.35%
Heart failure	9.68%	9.33%	9.67%
Stroke	4.35%	10.10%	7.25%
Parkinson's disease	2.68%	3.12%	2.83%
Renal failure	2.36%	2022%	2.48%
Respiratory illnesses	1.82%	5.07%	3.44%
Liver failure	1.34%	1.33%	1.43%
Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)	0.15%	1.13%	0.14%
HIV	0.1%	0.08	0.09%
Other	22.40%	14.68%	18.75%

As the largest percentage of primary diagnoses for MassHealth members were dementia-related, the review compared this result with national percentages for dementia-related diagnoses. The Centers for Medicare and Medicaid Services ("CMS") collects diagnoses for Medicare patients receiving hospice care. CMS indicates that for calendar year 2015, approximately 18% of patients on hospice had dementia diagnoses and 80% had non-dementia-related diagnoses.[20] Specifically, CMS reported:

Table 2. Primary diagnoses reported by CMS for calendar year 2015.

Primary diagnosis	**2015**
Cancer	28%
Dementia-related	18%
Heart failure	19%
Other	14%
Respiratory illnesses	10%
Stroke	9%

Similarly, for calendar years 2013, 2014, and 2015, a national hospice provider organization reported primary diagnoses for hospice admissions.[21] The National Hospice and Palliative Care Organization's ("NHPCO") findings are set out in the table below.

[20] Centers for Medicare and Medicaid Services, Medicare Provider Data 2015, available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Hospice2015.html.

[21] The National Hospice and Palliative Care Organization ("NHPCO") represents hospice and palliative care programs and providers in the United States. It also advocates on behalf of terminally ill people and their families. https://www.nhpco.org/.

Table 3. NHPCO primary diagnoses for hospice admissions.

NHPCO primary diagnosis	2013	2014	2015
Cancer	36.6%	36.5%	27.7%
Dementia-related	15.2%	14.8%	16.5%
Heart disease	13.4%	14.7%	19.3%
Lung disease	9.9%	9.3%	10.9%
Other	6.9%	8.3%	16.7%
Stroke or coma	5.2%	6.4%	8.8%
Kidney disease	3.0%	3.0%	--[22]
Liver disease	2.1%	2.3%	--
Non-ALS motor neuron	1.8%	2.1%	--
Debility	5.4%	1.9%	--
ALS	0.4%	0.4%	--
HIV / AIDS	0.2%	0.2%	--

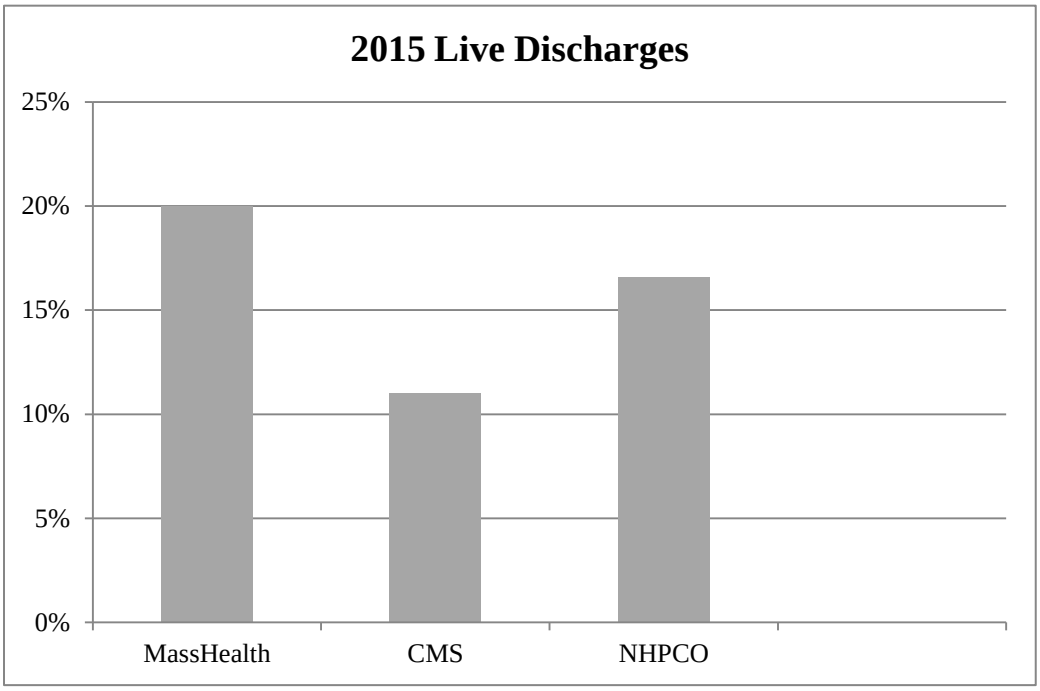
The review also examined the number of MassHealth members whose hospice stays did not end with the member's death. This is referred to as a "live discharge."[23] A member may leave hospice for a variety of reasons, including the member's hospitalization, decision to leave hospice care, disqualification from hospice care, or out-of-state move. Live discharges also can be a flag for fraud, waste, or abuse because it can indicate that hospice providers are treating patients who are not at the end of their life, or that hospice providers are discharging patients rather than providing necessary, but more expensive, hospital care.[24] For calendar year 2015, MassHealth, CMS, and NHPCO reported:

[22] The data for 2016 did not include these diagnoses.

[23] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-06.html.

[24] *See, e.g.*, https://www.npr.org/sections/health-shots/2017/08/11/542607941/nearly-1-in-5-hospice-patients-discharged-while-still-alive; https://homehealthcarenews.com/2017/07/hospices-may-profit-from-live-discharges; https://mississippitoday.org/2016/10/20/mississippis-sky-high-hospice-discharge-rates-point-to-fraud.

Table 4. Live discharges for MassHealth, CMS, and NHPCO for calendar year 2015.



Thus, this initial overview shows that MassHealth members stand out in three ways from hospice patients nationally. First, MassHealth members with dementia-related primary diagnoses received hospice care more than members with other primary diagnoses, and at a higher rate than nationally. Second, MassHealth members with cancer and heart- and lung-related diagnoses used hospice care at a lower rate than patients across the nation. Finally, MassHealth members leave hospice care as live discharges at higher rates than in other states.

After conducting this initial overview, the Office conducted an in-depth review of a number of issues, including the length of hospice stays, types of diagnoses on hospice claims, and hospice with multiple indicators of potential fraud, waste, or abuse of the hospice program. Overall, the Office's review did not find widespread fraud, waste, or abuse in the hospice program. There were, however, instances in which the Office noted that several providers' claim histories raised questions regarding compliance with the hospice regulations. The Office has given the names of those providers to MassHealth for additional review. The Office has also set out below a series of recommendations relating to programmatic and program integrity improvements.

I. Although the majority of hospice stays were shorter than predicted, seven hospice providers exceeded the predicted lengths of stay by substantial amounts of time.

To qualify for the MassHealth hospice benefit a member must be terminally ill and have a life expectancy of six months or less. Because the hospice benefit requires a certification of this prognosis, a pattern of hospice stays that exceed this length of time may indicate that a provider is, in some cases, certifying and serving members who may not qualify for the benefit. To evaluate whether hospices were regularly providing hospice care that exceeded six months,

this review studied MassHealth members' length of stays at specific hospices during the two years under review.

A. The review identified hospice providers that cared for members for longer than the predicted length of stay.

1. Methodology

To identify hospices that provided longer than predicted hospice care, the review examined those hospices that provided care to more than 50 MassHealth members in the two-year time period. This ensured that the results were not skewed by hospices with only a few MassHealth members who had long hospice stays. In addition, only the 8,352 members whose hospice stays both began and ended during the review period were included to ensure that the review could measure the entire length of stay. Finally, a regression analysis[25] identified predicted lengths of stay using, among other factors, each MassHealth member's age, gender, and primary diagnoses. Using the results of this analysis, the review compared the actual lengths of stay and predicted lengths of stay.

2. Findings

Of the 45 hospices included in this part of the review, the majority – 31 hospices – had members whose actual lengths of stay were shorter than their predicted lengths of stay. This suggests that the majority of hospice providers were appropriately certifying and serving their MassHealth members. It may also suggest that their MassHealth patients began receiving hospice services closer to the end of their lives. Overall, the regression analysis demonstrated that the majority of the MassHealth members received hospice care for limited periods of time.

Some hospice providers, however, cared for members whose actual lengths of stay substantially exceeded the predicted lengths of stay. The review divided all 45 of the hospice providers into three groups:

Group 1: Providers with average length of hospice stays more than 20% higher than predicted (7 hospice providers);

Group 2: Providers with average length of hospice stays between 10% and 20% higher than predicted (7 hospice providers); and

Group 3: All other providers (31 providers).

The predicted lengths of stay for the three groups were similar (all within three days). The average length of hospice stays for Groups 1 and 2 were 44.7 days and 19.5 days longer than Group 3, respectively.

[25] This regression analysis used several pieces of information from the group as a whole to create a prediction about individual members of the group.

Table 5. Hospices' actual and predicted lengths of stay.

Hospices with more than 50 hospice stays	Average length of stay (days)	Predicted average length of stay (days)	Difference between actual and predicted length of stay (days)	Percentage difference between actual and predicted length of stay
All (45 hospices)	**57.9**	**59.7**	**-1.1**	**-3%**
Group 1: Hospices with average length of stay greater than 20% more than predicted length of stay (7 providers)	92.6	62.2	30.4	39.27%
Group 2: Hospices with average length of stay 10–20% more than predicted length of stay (7 providers)	67.4	58.7	8.7	13.79%
Group 3: All other hospices (31 providers)	47.9	59.4	-11.5	-21.43%

Looking more closely at Group 1 indicated that seven hospices had actual lengths of stay that exceeded the predicted lengths of stay by substantial amounts of time:

- Two hospices had average lengths of stay that were 82% higher than predicted; and
- Five hospices had average lengths of stay more than 20% higher than predicted.

These findings suggest that MassHealth members by and large are receiving hospice care during the last six months of their terminal illnesses. Accepting that certain individuals may have received long-term hospice care for appropriate clinical reasons, the review identified two specific hospices that regularly provided care to patients for substantially longer than expected. The review was not able to identify any other factor to explain these longer stays. Accordingly, this pattern raises questions about whether these hospices are engaging in fraud, waste, or abuse of the MassHealth hospice program, and specifically whether those specific hospices may be submitting hospice claims for members who are not receiving or do not qualify for hospice care. The Office provided MassHealth with the names of these hospices and recommends that MassHealth conduct an in-depth review of those providers to determine whether they are committing fraud, waste, or abuse.

The Office also recommends that MassHealth consider creating a requirement that a physician conduct a face-to-face examination of members remaining on hospice for the third certification and beyond. Requiring an in-person evaluation for members on hospice for longer than 180 days could deter hospice providers from providing continuous hospice care to members who do not require it. This requirement would also provide an additional way for MassHealth to conduct program integrity activities by determining the appropriateness of long-term hospice care, evaluating which providers are certifying the members, and identifying which hospice providers are caring for patients on a long-term basis.

B. The review identified 88 MassHealth members who had significantly long hospice stays.

To better understand the characteristics of members with significantly long hospice stays, the review took an in-depth look at 88 of the MassHealth members who were receiving hospice both at the beginning and end of the two years under review. Each of the 88 members was on hospice either continuously or intermittently for more than two years. To determine how long these members were receiving hospice services and better understand the course of their illness(es) and hospice stays, this part of the review included these members' entire MassHealth hospice claim history.

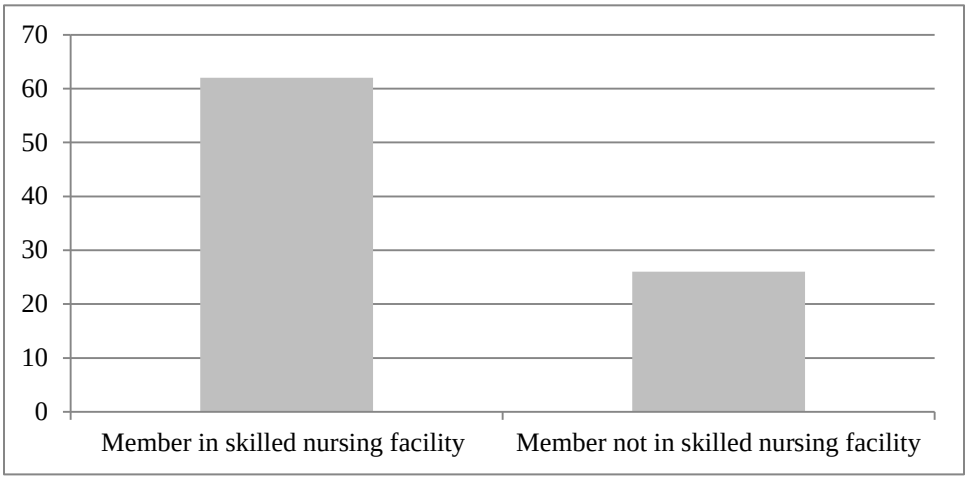
These members had between one and seven hospice stays while they were MassHealth members. Twenty-seven received hospice care continuously without a break; the other 61 members left hospice care at least once.

Table 6. Number of hospice stays and number of members.

Number of hospice stays	Number of members
1	27
2	45
3	13
4	2
5	0
6	0
7	1

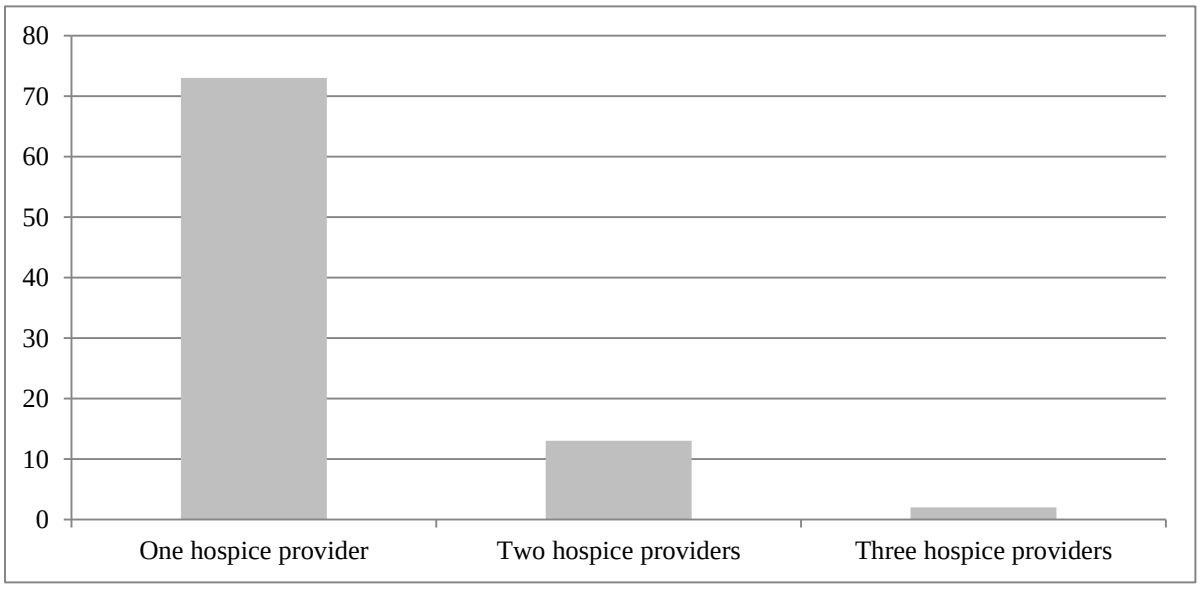
The length of each hospice stay ranged from one day to 1,382 days (3.7 years). The average hospice stay was for 446 days (1.2 years); both the average and median hospice stay were slightly longer than 1 year. Most of the group – 62 members – received hospice care in a skilled nursing facility.

Table 7. Members with notably long hospice stays in skilled nursing facilities and those not in such facilities.



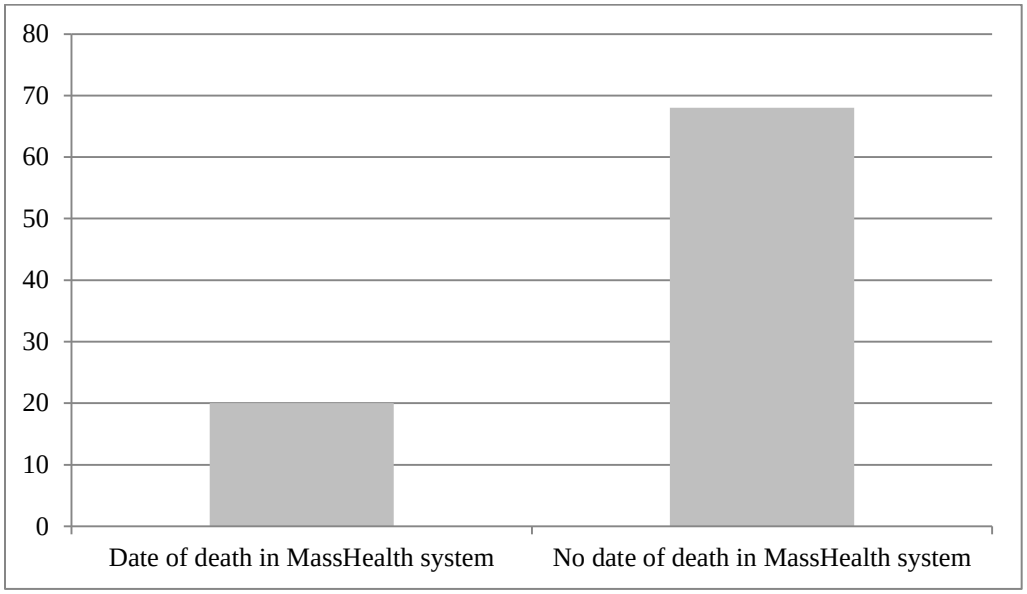
The majority of the group – 73 members – received hospice care from only one hospice provider; 13 members received hospice care from two providers and two members received hospice care from three providers.

Table 8. Number of hospice providers caring for each MassHealth member with notably long hospice stay(s).



As of December 31, 2016, the MassHealth system indicated that 20 of the 88 members had died, leaving 68 of these members enrolled in the MassHealth hospice program.

Table 9. Members with date of death recorded in MassHealth system.



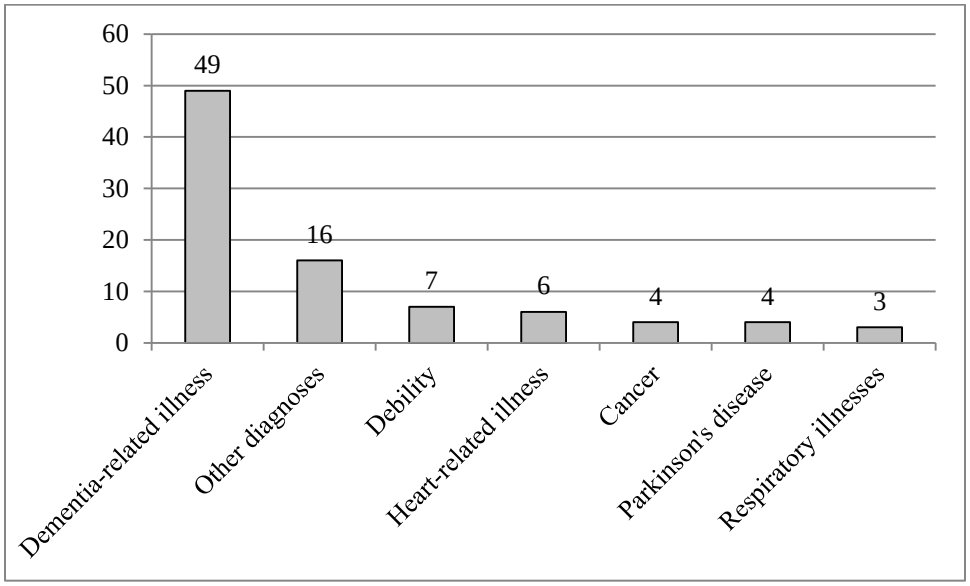
Looking next to the terminal conditions for which these members were receiving hospice care, the primary diagnoses from the claim(s) for the first day of each hospice stay were grouped into nine broad categories.[26] Of these primary diagnoses, there were:

- 49 for dementia-related illness (55.68%);
- 16 for other diagnoses (18.19%);[27]
- 7 for debility (7.95%);
- 6 for heart-related illnesses (6.82%);
- 4 for cancer (4.55%);
- 4 for Parkinson's disease (4.55%); and
- 3 for respiratory illnesses (3.41%).

[26] National Center for Health Statistics, International Classification of Diseases, Ninth and Tenth Revisions.

[27] These diagnoses did not occur frequently and could not be grouped together (*e.g.*, one member with a brain injury; one member with the effects of a stroke).

Table 10. Distribution of primary diagnoses for members with notably long hospice stays.



Thus, more than half of the 88 members on long-term hospice had a dementia-related primary diagnosis, which reinforces the importance of understanding this population's use of the hospice benefit. This also reinforces the importance better understanding how healthcare providers are determining that members with dementia-related primary diagnoses qualify for the hospice program.

II. MassHealth members with dementia-related primary diagnoses account for the largest share of MassHealth hospice payments.

MassHealth members with dementia-related diagnoses are important to this review because they account for the largest share – 47% – of MassHealth hospice payments. For all of the members in this review, MassHealth paid approximately $72 million for hospice services that began with a primary diagnosis of a dementia-related illness. Based on the high percentage of MassHealth members with dementia-related diagnoses receiving hospice care and the length of some of their hospice stays, the review next examined claims data to determine whether any hospice providers were serving significantly more MassHealth members with a dementia-related diagnosis than other hospice providers.

Dementia often progresses over several years from diagnosis to death. Several factors distinguish dementia-related illnesses from other medical conditions, including the typically long duration of dementia-related illnesses, the difficulty in assessing the long-term prognosis,[28] the different kinds of dementia,[29] and most patients' need for long-term care.

[28] SL Mitchell, Advanced Dementia, 372 New England Journal of Medicine 2533-40 (2015).

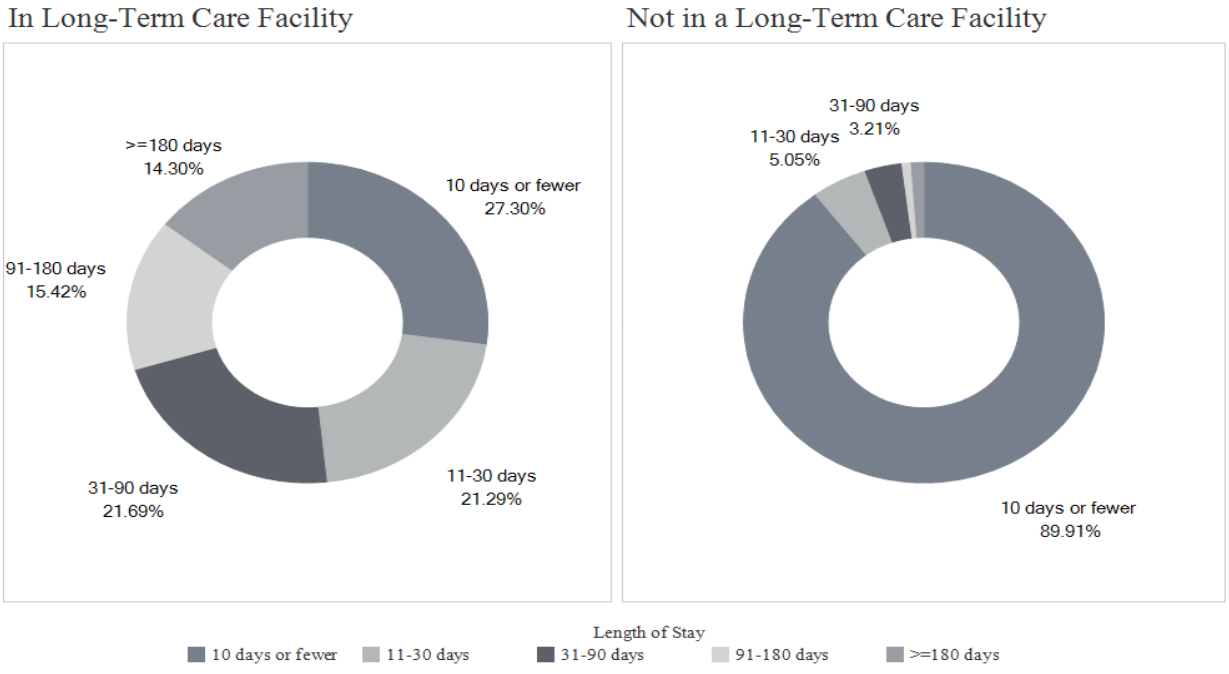
[29] The types of dementia referenced here include but are not limited to Alzheimer's disease, vascular dementia, dementia with Lewy bodies, mixed dementia, and frontotemporal dementia.

A. The largest share of MassHealth hospice payments in this review were for members with dementia-related diagnoses residing in long-term care facilities.

This part of the review focused on MassHealth members whose hospice stays both began and ended during the two years under examination. Of the approximately $89 million in MassHealth hospice payments for this subgroup, MassHealth paid slightly more than $39 million (44%) for hospice services that began with a dementia-related primary diagnosis. Members with dementia-related diagnoses residing in skilled nursing facilities, intermediate care facilities for individuals with developmental disabilities, and rest homes ("long-term care facilities")[30] accounted for 84% of these payments.

Most MassHealth members with dementia-related diagnoses receiving hospice care resided in long-term care facilities (approximately 92% of the members). Of those members, approximately 14% received hospice care for more than 180 days; 27% received hospice care for less than 10 days. By contrast, 90% of MassHealth members with dementia-related illnesses who did not reside in long-term care facilities had hospice stays of less than 10 days.

Table 11. Length of hospice stays for MassHealth members with dementia-related diagnoses residing in and out of long-term care facilities.



[30] This group does not include stays at rehabilitation hospitals, long-term care hospitals, or short-term skilled nursing facilities, which are often paid for by Medicare.

Some notable findings for MassHealth members with dementia-related illnesses receiving hospice care are that those residing in long-term care facilities:

- Received hospice care that was eight-to-nine times longer than for those not in such facilities; and
- Generated MassHealth hospice payments that were on average $13,518 greater than for other diagnoses.

These findings suggest that long-term care facilities may be educating MassHealth members with dementia-related illnesses (and their families) about the availability of hospice services or are taking a more active role in making the hospice benefit available to them earlier in their disease progression. It is also likely that the healthcare professionals at long-term care facilities are more knowledgeable than most family members about hospice care based on their experience working with patients at the end of life. However, it is unclear from this review why members living in long-term care facilities are receiving more hospice care than those members residing elsewhere. It is also unclear whether and why members living in long-term care facilities need hospice care more than members residing elsewhere.

B. Seven of the 66 hospices in this review provided services to 45% or more MassHealth members with dementia-related primary diagnoses.

To determine which hospices provided longer-term hospice care for members with dementia-related diagnoses, the review next focused on the 8,440 MassHealth members who had at least one complete hospice stay during, or whose hospice stay(s) started and ended outside of, the two-year review period. Of these members, 35% had a dementia-related primary diagnosis on their initial hospice claim. Of the members receiving hospice care in skilled nursing facilities, 40% had a dementia-related diagnosis. Of the members residing in other settings, 13% had a dementia-related diagnosis. Smaller hospices tended to have a lower proportion of members with dementia-related diagnoses than the larger hospices. Members with dementia-related diagnoses received longer term hospice care than members with other diagnoses, and overall accounted for 49% of MassHealth hospice claims and 45% (approximately $45 million) of hospice payments.

With this perspective, the focus turns to those hospices providing services to larger-than-typical numbers of members with dementia-related diagnoses. Among the hospices in this part of the review, 40 hospices served 50 or more MassHealth members with dementia-related diagnoses. As in Section I above, the review included only these hospices so that the results were not skewed by hospices with only a few MassHealth members. The average length of stay in these hospices for the members in this part of the review was 60.1 days.

Seven of those 40 hospices provided services to almost half of the MassHealth members in this review with dementia-related primary diagnoses. Furthermore:

- Four of the seven hospices had members with average lengths of stay over 10% greater than the average of 60.1 days, indicating a longer use of hospice than for MassHealth members receiving hospice services from other providers.

- Two of the seven had members with average lengths of stay lower than the average.
- All seven hospices had total MassHealth hospice payments above the median and five had total payments above the average.
- Five of the seven hospices had payments per member above the average for all hospice payments.

Only one of these seven hospices advertises as specializing in dementia care for hospice patients.

Table 12. Hospices with a high proportion of members with dementia-related diagnoses.

MassHealth hospice providers	Members in the review with dementia-related diagnosis	Percentage of members in the review with dementia-related diagnosis	Average length of stay for members with dementia-related diagnosis (days)	Average hospice payment per member for members with dementia-related diagnosis
All hospices (66 hospices)				
Average	129	28.2%		
Median	78	28.0%		
Hospices with high number of members with dementia-related diagnoses (7 hospices)				
Hospice A	86	63.7%	73	$14,285
Hospice B	186	60.6%	100	$17,850
Hospice C	118	50.9%	62	$10,166
Hospice D	123	46.4%	79	$13,773
Hospice E	31	45.6%	85	$15,278
Hospice F	59	45.4%	34	$5,601
Hospice G	164	45.0%	95	$16,225

Certain of these hospices are worthy of further review for several reasons. First, it would be worthwhile to compare how these seven hospices assess and certify members with a dementia-related primary diagnosis. In addition, examination of the four hospices providing services to members with dementia-related illnesses for a longer-than-average length of time could potentially uncover fraud, waste, or abuse of the hospice program. Finally, examining the two hospices providing services for less than the average length of service could offer insight into certifying and caring for MassHealth members with dementia-related diagnoses at the end of life.

MassHealth members with dementia-related diagnoses who reside in skilled nursing facilities appear more likely to receive hospice care than members with non-dementia-related diagnoses. As MassHealth is in the process of evaluating how it addresses hospice care for members with dementia-related diagnoses, the Office has several recommendations for the hospice program. First, the Office recommends that MassHealth evaluate the two hospices that provided services for shorter than the average length of service to determine if they are providing appropriate clinical care for members with dementia at the end of life. If so, MassHealth should determine whether and how other providers can replicate those two hospices' certification processes and the resulting hospice services.

The Office also recommends that MassHealth examine the four hospices providing services to members with a dementia-related diagnosis for a longer-than-average length of service to determine whether there is fraud, waste, or abuse of the hospice program. Specifically, MassHealth must ensure that those members with dementia-related diagnoses are receiving care in the appropriate clinical setting and are not receiving hospice care for the convenience of the provider or for fraudulent billing purposes. The Office further recommends that the MassHealth hospice program consider implementing specific guidelines for hospice admission, either adopting the Medicare guidelines or another set of objective measures, to help providers determine when a person with dementia should begin receiving hospice care.[31] Adopting this type of guidelines would help to ensure that members with dementia receive hospice care at an appropriate time in the course of their illness, and would also provide MassHealth with an objective measure to evaluate the initiation of hospice care for these members.

III. Four pairs of hospice providers and skilled nursing facilities that frequently collaborated in providing care to members receiving hospice services.

The review examined hospices that served MassHealth members residing in skilled nursing facilities and identified frequent collaborations between specific hospices and specific facilities. In particular, the review looked at hospices that cared for MassHealth members who had one hospice stay during the study period (8,352 members), as well as hospices that cared for members whose hospice stay began during the review period and who remained on hospice at the end of the review period (1,308 members).

The review identified four hospice providers and four skilled nursing facilities with a notably high number of collaborations for MassHealth members. These four providers accounted for 77,343 days of hospice care and $13.7 million in MassHealth hospice payments.

Collaboration 1

Hospice 1 provided 35,205 days of hospice care and received $5.9 million in MassHealth hospice payments during the two-year review period. Of this, Hospice 1 received $2.9 million

[31] For example, the New England Journal of Medicine included an alternate measure for estimating survival of less than six months in patients with dementia. *See* Susan L. Mitchell, Advanced Dementia, 372 New England Journal of Medicine 2533, 2535 (2015), available at: http://www.nejm.org/doi/pdf/10.1056/NEJMcp1412652.

(50%) for members residing in Skilled Nursing Facility 1. For this collaboration, the average length of hospice care was 114 days; 47% of hospice cases extended for more than 90 days.

Collaboration 2

Hospice 2 provided 24,776 days of hospice care and received $4.5 million in MassHealth hospice payments during the review period. Of this total, $3.1 million (69%) were for members residing in Skilled Nursing Facility 2. For this collaboration, the average length of hospice care was 102 days; 35% of hospice stays extended for more than 90 days.

Collaboration 3

Hospice 3 provided 9,745 days of hospice care and received $1.9 million in MassHealth hospice payments during the review period. Of these payments, $1.7 million (87%) were for members in its affiliated Skilled Nursing Facility 3. For this collaboration, the average length of hospice care was 70 days; 24% of hospice cases extended for more than 90 days.

Collaboration 4

Hospice 4 provided 7,617 days of hospice care and received $1.4 million in MassHealth hospice payments during the review period. Of this total, $1.2 million (83%) were for members residing in the affiliated Skilled Nursing Facility 4. For this collaboration, the average length of hospice care was 70 days; 23% of hospice cases extended for more than 90 days.

The fact that a particular hospice company regularly provides care to MassHealth members in a particular skilled nursing facility is not, in and of itself, enough to raise a red-flag indicating improper behavior. However, observing frequent hospice-nursing facility collaborations, combined with longer hospice stays, raises a question of whether the hospice care being provided is consistent with the standards of the MassHealth hospice program. It also gives rise to a question of whether there is an improper relationship between the skilled nursing facility and hospice provider, as well as whether the skilled nursing facilities are recognizing members' right to choose their own hospice provider.

Situations in which the same hospice companies are providing care to MassHealth members in the same skilled nursing facilities are not, in and of themselves, enough to raise a red flag indicating improper behavior. However, looking at frequent partners combined with the longer-than expected lengths of hospice care raises a question of whether the hospice care being provided is consistent with the standards of the MassHealth hospice program, whether members are permitted to choose their own hospice provider, and whether there is any unique relationship between the facilities and hospice providers. The Office recommends that MassHealth review the four collaborations that this report identified to determine whether these hospices are providing services in a manner that is consistent with the regulatory requirements of the program, or whether these collaborations have a motive more closely related to the hospices' and skilled nursing facilities' revenue.

As MassHealth works with its new vendor to put additional data analytics in place to detect fraud, waste, and abuse of the hospice program, the Office also recommends that it

consider reviewing frequent skilled nursing facility and hospice collaborations as one possible indicator of fraud, waste, or abuse of the program.

IV. The review identified four hospices with multiple indicators of potentially questionable practices.

In addition to looking at individual issues relating to hospice care, this review also evaluated a group of seven factors that together can help indicate whether a particular hospice is engaging in fraud, waste, or abuse. Using multiple factors to target fraud, waste, or abuse allows identification of hospices with potentially questionable patterns of claims, which in turn could identify those hospices engaged in potential fraud, waste, or abuse. To this end, the review examined:

- The percentage of hospice cases with members who did not die while in hospice care;
- The average length of hospice stay;
- The percentage of hospice patients with stays lasting more than 180 days;
- The ratio of actual to predicted length of stay;
- The percentage of members residing in skilled nursing facilities;
- The percentage of members with a dementia-related primary diagnosis; and
- Hospice providers averaging 25 or more MassHealth members per year.

Each of these seven factors is readily available in claims data. Several – particularly the number of discharges other than death – may suggest that the hospice provided care to a member who may not have qualified for the hospice benefit based on the member's medical prognosis. Other factors – such as the average length of hospice stays and the percentage of stays lasting more than 180 days – focus on stays that extend well beyond the initial certification periods. The ratio of actual to predicted length of stay relates to longer-than-expected stays. Some factors, specifically the percentage of members residing in skilled nursing facilities and the percentage of members with a dementia-related diagnosis, focus on whether the member's place of residence or diagnosis might create incentives for or potential for fraud, waste, or abuse. The final factor, hospices with an average of 25 or more MassHealth members, might reflect the hospices with sufficient numbers of MassHealth patients to warrant engaging in fraud, waste, or abuse.

In this review, each hospice received one point for each factor on which it received a score greater than the average. The sum of points resulted in a score that ranged from zero to six (no hospice had all seven factors flagged). The review then ranked the hospices based on their scores.

Table 13. Hospices with multiple indicators of potential fraud, waste, or abuse.

Number of indicators (number of hospices, members)	Percentage of stays ending without death	Average length of hospice stay (days)	Percentage of stays over 180 days	Percentage of members with skilled nursing facility claims	Percentage of members with dementia-related diagnosis
All hospices in this part of the review (66 hospices, 8,352 members)	16.5%	51.0	6.7%	80.2%	33.1%
Small hospices (26 hospices, 513 members)	19.5%	40.3	4.6%	71.5%	25.5%
Large hospices (40 hospices, 7,839 members)	15.4%	57.1	7.8%	83.9%	35.5%
Hospices with 6 indicators (4 hospices, 970 members)	17.4%	80.9	14.4%	92.5%	50.2%
Hospices with 5 indicators (8 hospices, 2,679 members)	15.2%	73.2	13.3%	88.3%	45.6%
Hospices with 4 indicators (7 hospices, 834 members)	17.6%	61.6	8.9%	90.2%	35.3%
Hospices with 3 indicators (5 hospices, 1,363 members)	15.6%	55.0	6.1%	78.2%	46.1%
Hospices with 2 indicators (13 hospices 1,674 members)	16.8%	44.8	4.9%	72.2%	28.2%
Hospices with 1 indicator (3 hospices, 319 members)	13.5%	30.7	3.8%	78.1%	27.0%

Table 14. Percentage of hospice stays ending without death.

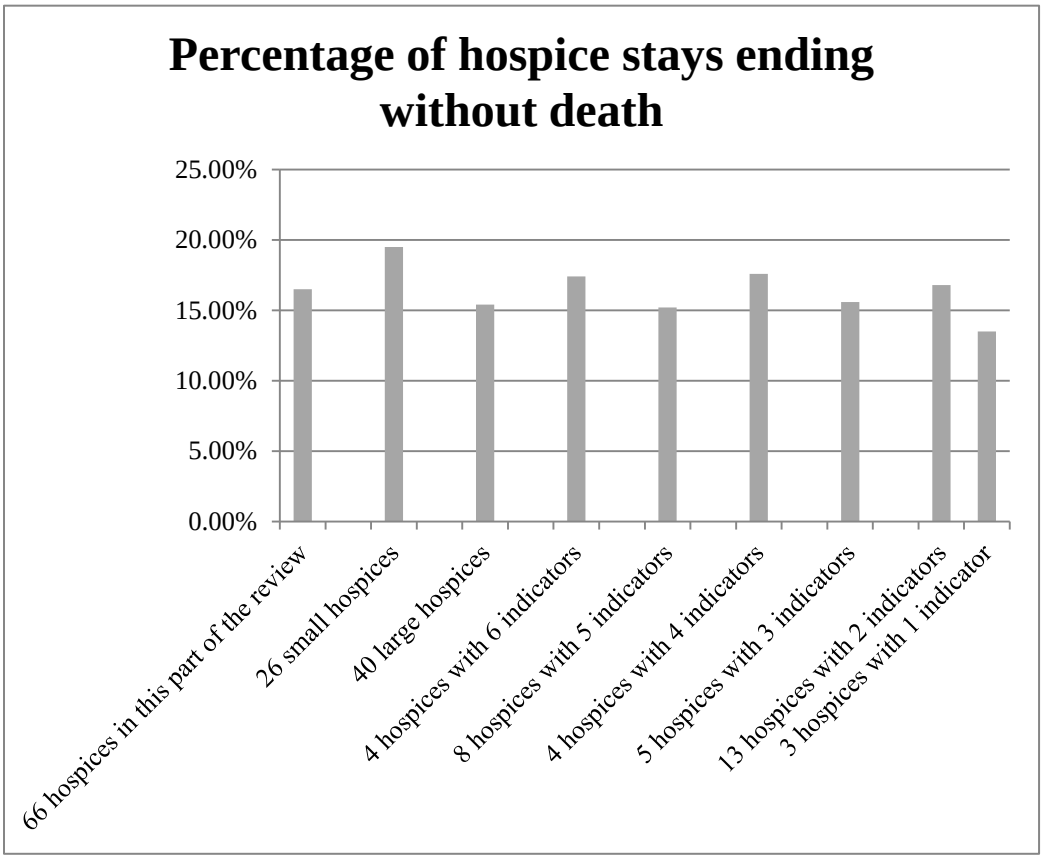


Table 15. Average length of hospice stay (days).

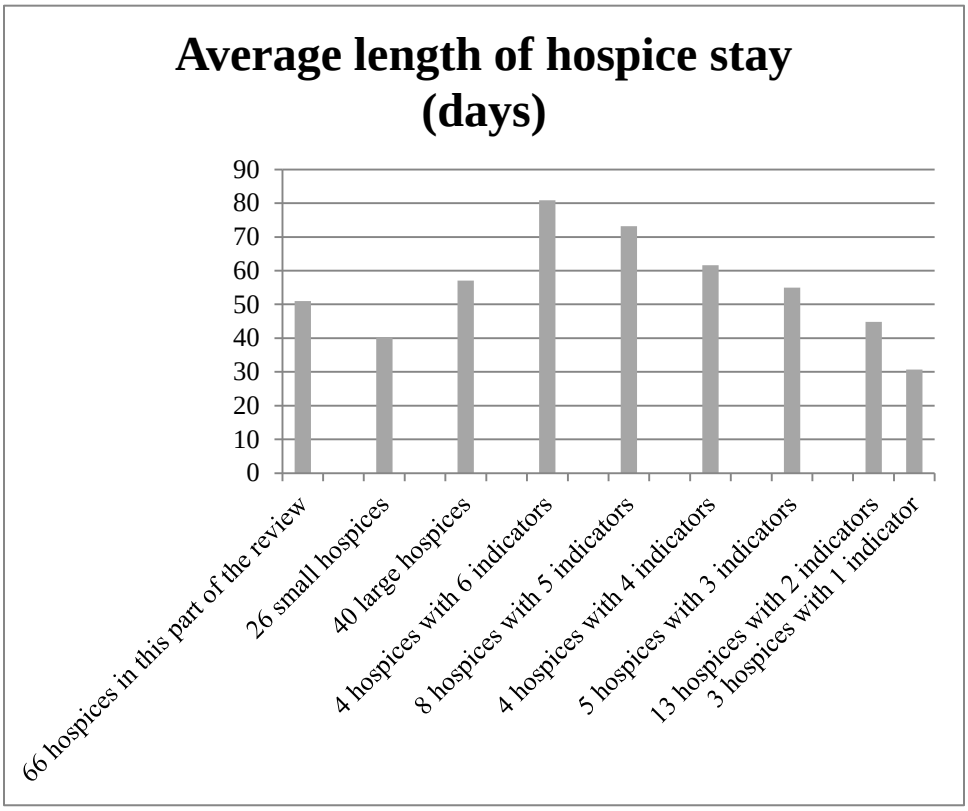


Table 16. Percentage of stays over 180 days.

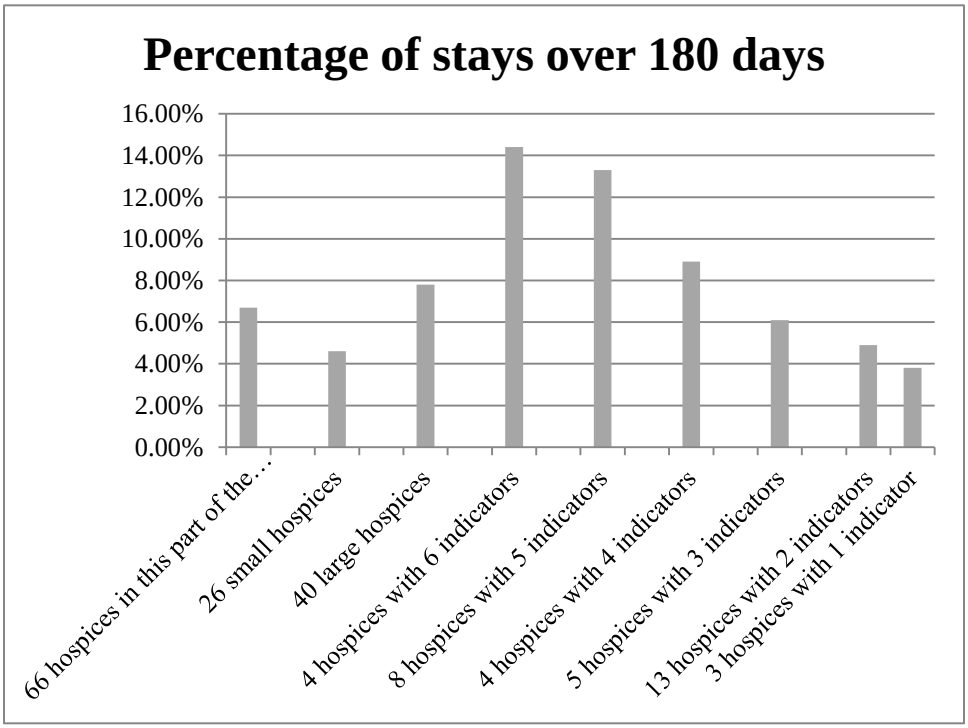


Table 17. Percentage of members with skilled nursing facility claims.

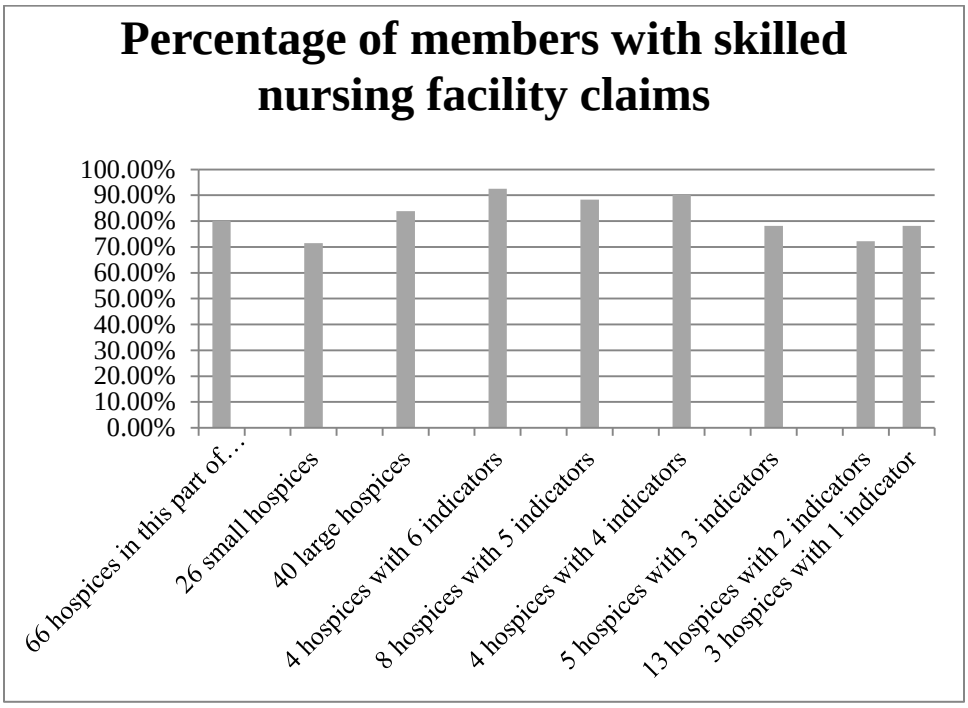
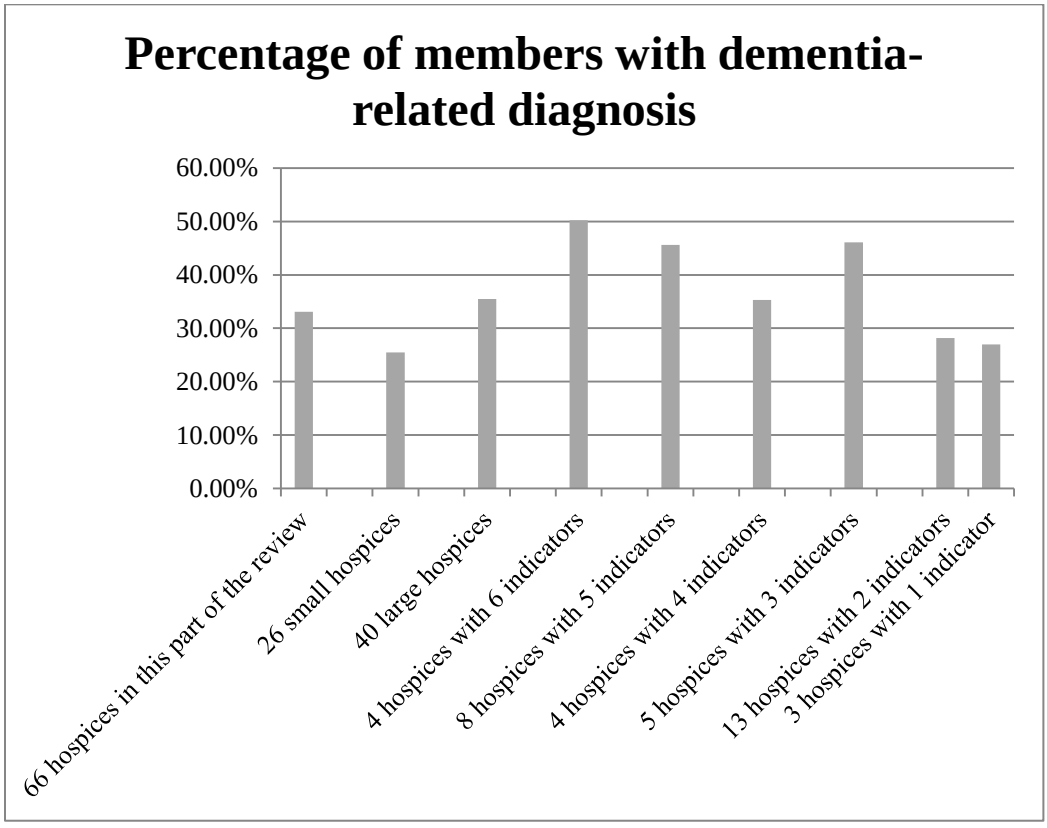


Table 18. Percentage of members with dementia-related diagnosis.



By combining these factors, distinct patterns of hospice use emerge:

- Among the large hospices (hospices that provided services to more than 50 MassHealth members):
  - four hospices were above the average on six factors;
  - eight hospices were above the average on five factors; and
  - seven hospices were above the average on four factors.
- The small hospices (fewer than 50 MassHealth members) as a group averaged 1.6 factors (well below the 3.4 average of the larger hospices).
- The smaller hospices had a lower percentage of nursing home use, a lower percentage of members with dementia-related diagnoses, and shorter lengths of hospice stay.
- The smaller hospices exceeded the larger hospices in the percentage of stays not ending in death.

Thus, examining these individual factors together provides an opportunity to identify hospices that stand out in more than one area. It is plausible that a hospice could have a patient mix with unusual needs that would generate a high score in one or two areas. But when hospices, like the four identified in this review, score high on the majority of these factors, it raises the question of whether they are engaging in fraud, waste, or abuse of the hospice program. At a minimum, the four hospices with six scores greater than the average merit scrutiny. The Office has referred the providers with a high score in a majority of areas to MassHealth to review for fraud, waste, or abuse of the hospice program.

Examining individual indicators of the misuse of the hospice benefit is productive, but examining them together provides an opportunity to identify hospices that are outliers in more than one area. It is plausible that a hospice could have a patient mix with unusual needs that would generate a high score in one or two areas. But when hospices score high on the majority of these factors, it raises the question of whether they are engaging in fraud, waste, or abuse of the hospice program.

The Office recommends that MassHealth examine the hospices that had five or more fraud indicators and consider whether any other combination of indicators warrants further review. The Office also recommends that when MassHealth expands its program integrity activities with its new vendor, it incorporate multiple factors into its data analysis to better identify potential fraud, waste, or abuse. These factors include:

- the percentage of hospice stays with members who did not die while in hospice care;
- the average length of hospice stay;
- the percentage of hospice patients with stays lasting more than 180 days;
- the ratio of actual to predicted length of stay;
- the percentage of members residing in skilled nursing facilities; and
- the percentage of members with a dementia-related diagnosis; and

- hospice providers averaging 25 or more members per year.

MassHealth should also consider including such factors as payments to for-profit hospices compared to non-profit hospices; the source of the referrals that the provider receives (*e.g.*, is the hospice provider receiving the majority of patients from one healthcare provider); and whether the diagnosis on the referral is consistent with a recent treatment diagnosis.

Recommendations

Based on the findings, the Office makes the following recommendations:

I. Longer-than predicted stays.

Specific hospices appeared to provide care for significantly longer than expected and no other factor in this review explained this finding. This suggests that those specific hospices may be submitting hospice claims for members who are not receiving, or who do not qualify for, hospice care. The Office recommends that MassHealth conduct an in-depth review of the hospice providers that the Office identified to determine whether these providers are committing fraud, waste, or abuse. The Office also recommends that MassHealth consider creating a requirement similar to Medicare that requires a physician to conduct a face-to-face examination of members remaining on hospice for more than 180 days (the third certification and beyond). Requiring an in-person evaluation for members on hospice for longer than 180 days could deter hospice providers from providing continuous hospice care to members who do not require it. This requirement would also provide an additional way for MassHealth to conduct program integrity activities by determining the appropriateness of long-term hospice care, evaluating which providers are certifying the members, and identifying which hospice providers are caring for patients on a long-term basis.

II. Dementia-related diagnoses.

MassHealth members with dementia-related diagnoses who reside in skilled nursing facilities appear more likely to receive hospice care than members with non-dementia-related diagnoses. As MassHealth is in the process of evaluating how it addresses hospice care for members with dementia-related diagnoses, the Office has several recommendations for the hospice program. First, the Office recommends that MassHealth evaluate the two hospices that provided services for shorter than the average length of service to determine if they are providing appropriate clinical care for members with dementia at the end of life. If so, MassHealth should determine whether and how other providers can replicate those two hospices' certification processes and the resulting hospice services.

The Office also recommends that MassHealth examine the four hospices providing services to members with a dementia-related diagnosis for a longer-than-average length of service to determine whether there is fraud, waste, or abuse of the hospice program. Specifically, MassHealth must ensure that those members with dementia-related diagnoses are receiving care in the appropriate clinical setting and are not receiving hospice care for the convenience of the provider or for fraudulent billing purposes. The Office further recommends that the MassHealth hospice program consider implementing specific guidelines for hospice admission, either adopting the Medicare guidelines or another set of objective measures, to help providers determine when a person with dementia should begin receiving hospice care.[32]

[32] For example, the New England Journal of Medicine included an alternate measure for estimating survival of less than six months in patients with dementia. *See* Susan L. Mitchell, Advanced Dementia, 372 New England Journal of Medicine 2533, 2535 (2015), available at: http://www.nejm.org/doi/pdf/10.1056/NEJMcp1412652.

Adopting this type of guideline would help to ensure that members with dementia receive hospice care at an appropriate time in the course of their illness, and would also provide MassHealth with an objective measure to evaluate the initiation of hospice care for these members.

III. Collaborations.

The Office found four instances in which many of the MassHealth members in a skilled nursing facility received hospice services from the same hospice provider. A close collaboration between a skilled nursing facility and hospice does not, by itself, indicate any improper conduct. However, looking at frequent collaborations, combined with longer-than expected lengths of hospice care, does raise questions, including whether the hospice care being provided is consistent with the standards of the MassHealth hospice program, whether members are permitted to choose their own hospice provider, and whether there is any unique relationship between the facilities and hospice providers. The Office recommends that MassHealth review the four collaborations that this report identified to determine whether these hospices are providing services in a manner that is consistent with the requirements of the program.

As MassHealth works with its new vendor to put additional data analytics in place to detect fraud, waste, and abuse of the hospice program, the Office also recommends that it consider reviewing frequent skilled nursing facility and hospice collaborations as one possible indicator of fraud, waste, or abuse of the program.

IV. Multiple factors.

Examining individual indicators of the misuse of the hospice benefit is productive, but examining them together provides an opportunity to identify hospices that are outliers in more than one area. When hospices score high on the majority of factors, it raises the question of whether they are engaging in fraud, waste, or abuse of the hospice program.

The Office recommends that MassHealth review the hospice services provided by the programs with five or more fraud indicators and consider whether any other combination of indicators warrants further review. The Office also recommends that when MassHealth expands its program integrity activities with its new vendor, it incorporate multiple factors into its data analysis to better identify potential fraud, waste, or abuse. These factors include:

- the percentage of hospice cases with members who did not die while in hospice care,
- the average length of hospice stay,
- the percentage of hospice patients with stays lasting more than 180 days,
- the ratio of actual to predicted length of stay, the percentage of members residing in skilled nursing facilities, and
- the percentage of members with a dementia-related diagnosis, and hospice providers averaging 25 or more members per year.

MassHealth should consider such factors as the payments made to for-profit hospices compared to non-profit hospices; the source of the referrals that the provider receives (*e.g.*, is the hospice provider receiving the majority of patients from one healthcare provider); and whether the diagnosis on the referral is consistent with a recent treatment diagnosis.

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Appendix A

Table 19. Comparing length of stay and MassHealth payments for members with dementia-related diagnoses to those without dementia-related diagnoses.

	All diagnoses			Members with dementia-related diagnoses	
	All Dementia	**Other than dementia**		**In long-term care facility**	**Not in long-term care facility**
Number of members in this sample	2,910	5,442		2,692	218
Total days of hospice care	222,107	284,120		220,052	2,055
Average days of hospice care (per stay)	76.3	52.2		81.7	9.4
Median days of hospice care (per stay)	28.0	18.0		33.0	4.0
Percentage by length of stay					
10 days or fewer	32.0%	37.8%		27.3%	89.9%
11–30 days	20.1%	23.5%		21.3%	5.0%
31–90 days	20.3%	21.0%		21.7%	3.2%
91–180 days	14.3%	10.3%		15.4%	0.9%
181–270 days	6.7%	4.2%		7.2%	0.5%
271–365 days	3.4%	1.9%		3.6%	0.0%
366–545 days	2.6%	1.1%		2.8%	0.5%
≥ 546 days	0.7%	0.2%		0.7%	0.0%
Average payments per member in review period					
All MassHealth payments	$61,681	$53,381		$62,835	$47,424
Non-hospice payments	$48,265	$44,098		$48,407	$46,514