OIG Continues to Intensify Its Scrutiny of Hospice Care

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The Patient Protection and Affordable Care Act requires the Centers for Medicare & Medicaid Services (CMS) to reform the hospice payment system, collect data relevant to revising payments, and develop quality measures. As part of its continuing scrutiny of hospice care, the Department of Health and Human Services Office of Inspector General issued a new report, *Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities, OEI – 02-14-00070*, on January 14, 2015. While the report focuses on hospice care in Assisted Living Facilities (ALFs), the OIG pointedly noted throughout that "many of the issues identified pertain to the hospice benefit more broadly."

The OIG's review and assessment of hospice care has been both extensive and penetrating. In May 2013, OIG reported that more than 900 hospices did not provide any general inpatient care to Medicare beneficiaries and more than 400 hospices did not provide any level of hospice care other than routine home care. *Medicare Hospice: Use of General Inpatient Care, OEI-02-10-00490*. In July 2011, OIG issued a report that found that hospices with a high percentage of their Medicare beneficiaries residing in nursing facilities received more Medicare payments per beneficiary and served beneficiaries who spent more time in hospice care. *Medicare Hospices That Focus on Nursing Facility Residents, OEI-02-10-00070*. Another report, *Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities, OEI-02-06-00223*, from July 2009, determined that Medicare paid an average of $960 per week for hospice care comprising an average of 4.2 visits per week for each beneficiary in a nursing facility in 2006. In September 2009, OIG found that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements. *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance With Medicare Coverage Requirements, OEI-02-06-00221*. In a report announced in March 2008, OIG identified a number of cases in which the use of inpatient respite care for beneficiaries in nursing facilities may have been inappropriate. *Hospice Beneficiaries' Use of Respite Care, OEI-02-06-00222*.

OIG FINDINGS

In this latest report, the OIG has found that Medicare payments for hospice care in ALFs more than doubled in five years, totaling $2.1 billion in 2012, a 119% increase over 2007 spending. During that time, the OIG noted, Medicare spending for hospice care provided in other settings increased by 38%, from $9.3 billion to $12.9 billion, while Medicare spending for hospice care overall increased by 46%, from $10.3 billion to $15.0 billion. Medicare payments for hospice care in ALFs accounted for 14% of the total Medicare spending on hospice care in 2012.

These increases were fueled, according to the OIG, by ALF beneficiaries receiving hospice care for much longer periods and higher reimbursement values than beneficiaries in other settings. ALF beneficiaries received hospice care for a median of 98 days, almost twice as long as beneficiaries in nursing facilities and more than twice as long as beneficiaries at home. Thirty-six percent of ALF beneficiaries spent more than 180 days in hospice care, compared to 28% in nursing facilities and 22% at home. Eighteen percent of ALF beneficiaries were in hospice care for more than a year, compared with 14% in nursing facilities and 10% at home.

The OIG further found that, while ALF patients had diagnoses requiring less complex care,

Medicare reimbursements for these patients were more than twice as much as the median amounts for beneficiaries in nursing facilities and at home. While ALF hospice patients received an average of 4.8 hours of visits per week, the OIG found that their care was mostly provided by aides: 2.8 hours were for hospice aide services, 1.7 hours were for nursing services, and 0.3 hours were for medical social services. Hospice physicians rarely saw patients in ALFs, and hospice care typically did not extend to the weekends.

As it has in other areas, the OIG also found that for-profit providers received higher Medicare payments per patient than non-profits, and that patients in for-profit ALFs had longer stays than those in non-profit ALFs. From 2007 through 2012, the median Medicare payment per beneficiary in for-profit hospices was $18,261, while the median payment in the nonprofit facilities was $13,941. The median time in care for beneficiaries in for-profit hospices was 111 days, compared to a median of 85 days for nonprofit hospices.

OIG RECOMMENDATIONS

As the OIG stated, its report "raises concerns about the financial incentives created by the current payment system and the potential for hospices to target beneficiaries in ALFs who have long lengths of stay or have certain diagnoses because they may offer the hospices the greatest financial gain." Commenting that it had "identified similar concerns in other parts of the benefit," the OIG further specified that "the findings in this and previous OIG reports show that payment reform and more accountability are needed to reduce incentives for hospices to focus solely on certain types of diagnoses or settings and ensure that hospices are providing quality care to those who are eligible."

Accordingly, the OIG has recommended that CMS:

1. **Reform payments to reduce the incentive for hospices to target beneficiaries with certain diagnoses and those likely to have long stays.**

2. **Target certain hospices for review.** CMS should focus on certain hospices, including hospices that receive a high percentage of their payments from ALF beneficiaries, hospices with a high percentage of beneficiaries receiving care for over 180 days, hospices with a high percentage of beneficiaries with certain diagnoses, and hospices with a high percentage of beneficiaries who rarely receive hospice visits. The OIG expanded the recommendation, urging CMS to include these measures in its Fraud Prevention System to identify these hospices for further review.

3. **Develop and adopt claims-based measures of quality.** Claims-based measures could include the average number of services the hospice provides, the types of services, how often physician visits are provided, and how often a hospice provides services on the weekend.

4. **Make hospice data publicly available for beneficiaries.** While CMS continues to develop and test quality measures, it should take the interim step of making other hospice data available through a Hospice Compare feature on the Medicare.gov website. This could include information on the services provided, such as the average number of services the hospice provided, the types of services, how often physician visits are provided, and how often a hospice provided services on the weekend, which would enable beneficiaries and their families to compare hospice care services.

5. **Provide additional information to hospices to educate them about how they compare to their peers.** Specifically, CMS could include other target areas in these reports, such as the percentage of beneficiaries in specific settings or with certain diagnoses and the percentage of beneficiaries receiving higher levels of hospice care.

CMS concurred with all of the OIG's recommendations. In particular, with respect to the OIG's first recommendation to reform the payments system, CMS responded that it is analyzing possible reform options, including a model in which the per diem rates would be higher at the beginning and end of a beneficiary's time in hospice care and lower in the middle.

CONCLUSION

The OIG has made it abundantly clear that it will continue to focus on and target hospice policies and payments. Hospice providers, in general and in ALFs, should evaluate their practices, including types of patients cared for and staffing for patient needs, in light of the concerns expressed in the report, both in light of what surely will be changes in the regulations and in light of likely investigative scrutiny under the False Claims Act by the OIG's Office of Investigations and the Department of Justice. In particular, where the OIG's concerns may bear on specific practices, providers should evaluate their compliance programs and consider retaining outside counsel, both to handle an internal investigation and to evaluate the advisability of self-disclosures.

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