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# OIG Reports Signal Movement On Medicare Hospice Payment

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Recommendations in a report released last month portend far-reaching changes to reimbursement for Medicare hospice benefit services, including a potential overhaul of the per diem payment methodology and a corresponding reduction of payments in various care settings.

The January 2015 U.S. Department of Health and Human Services Office of Inspector General report focuses on hospice services provided to residents of assisting living facilities and builds upon the findings of four other hospice-related investigations conducted over the past five years concerning nursing facilities, questionable physician billing practices and the misuse of the second-most costly level of hospice care.

These OIG investigations and related data collection activities were prompted by the Affordable Care Act, which directs that HHS "implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care" by Oct. 1, 2013. With mandated payment reforms already overdue by over a year and in light of payment reform recommendations contained in recent OIG and Medicare Payment Advisory Commission reports, hospice providers should anticipate regulatory action in 2015 from the Centers for Medicare & Medicaid Services.

The findings and recommendations of the OIG's most recent report mirror those of previous investigations, offering valuable insight into what hospice payment reform likely will entail and which providers will be impacted the most.

While for-profit hospices that service beneficiaries in nursing homes and ALFs have been the target of the bulk of the OIG's criticisms, all hospices treating beneficiaries with ill-defined conditions, mental disorders and Alzheimer's disease may be impacted by the OIG's proposal that hospice payment rates be tied to beneficiaries' needs.

Presently, three of the four levels of hospice care services — routine home care, general inpatient care and inpatient respite care — are reimbursed through Medicare Part A at a daily rate for each day a beneficiary is on hospice care, irrespective of the quantity of services furnished on any particular day, or

whether any services are provided at all. The fourth and most expensive level of care — continuous home care — is paid on an hourly rate based on the number of hours of services provided per day.

A 2011 OIG report concerning hospice services provided in nursing facilities concluded that, when compared to typical hospices, hospices with more than two-thirds of their patients residing in nursing facilities (dubbed "high percentage hospices") received more Medicare payments per beneficiary and served beneficiaries who spent more time in care. Specifically, the OIG found that:

- Medicare paid an average of $3,182 more per beneficiary for beneficiaries served by high-percentage hospices than it paid per beneficiary for those served by hospices overall.

- Medicare beneficiaries served by high-percentage hospices received hospice care for a median of three weeks longer than the typical hospice beneficiary.

- High-percentage hospices enrolled beneficiaries whose diagnoses required less complex care (i.e., patients with ill-defined conditions and mental disorders) by a ratio of 51 to 32 percent.

Based on these findings, OIG concluded that certain hospices were intentionally seeking out beneficiaries (often found in nursing homes) with particular characteristics, including those with conditions associated with longer but less complex care. The OIG reasoned that by serving these beneficiaries for extended periods, these hospices receive more Medicare payments per beneficiary, resulting in higher profits.

The OIG's most recent report found these trends even more pronounced with respect to hospices servicing ALF residents. The January report includes the following findings:

- Beneficiaries residing in ALFs received hospice care much longer than beneficiaries in any other setting. The median length of hospice care provided to ALF residents was 98 days, almost twice as long as that received by nursing home residents, and more than twice as long as received by beneficiaries in the home setting.

- Due to the long duration of stays in hospice care for beneficiaries in ALFs, Medicare paid twice as much for care for ALF residents than for beneficiaries in any other setting.

- Sixty percent of hospice beneficiaries in ALFs had diagnoses of ill-defined conditions, mental disorders or Alzheimer's disease, compared to 54 percent of nursing facility beneficiaries and 27 percent of hospice patients residing at home. Such diagnoses typically receive less complex care and fewer services than other terminal conditions.

- On average, hospices servicing ALF residents provided fewer than five hours of visits per week and were paid about $1,100 per week for each beneficiary. Most of these visits were conducted by aides, with a substantially smaller percentage of visits for nursing and medical social services. Twenty-five hospices received $2.3 million in payments for beneficiaries who received no services at all.

- For-profit hospice providers serving beneficiaries in ALFs received a median payment of $18,621 per beneficiary compared to $13,941 for nonprofits from 2007 through 2012. The median duration of hospice care by for-profits also exceeded that of nonprofit hospices by roughly four weeks.

As in its report regarding nursing homes, the OIG concluded that its findings raise "concerns about the financial incentives created by the current payment system and the potential for hospices to target beneficiaries" in certain settings and with certain diagnoses "because they may offer the hospices the greatest financial gain."

The most potentially consequential aspect of the OIG's latest report is its recommendation that CMS reform hospice payment methodologies in such a manner as to "tie payment rates to beneficiaries' needs." Hinting at the shape such reforms might take, the OIG added that "[c]urrently, hospices must conduct for each beneficiary a comprehensive assessment that identifies the beneficiary's need for hospice care and services and the need for physical, psychological, emotional and spiritual care. These needs and others that affect the care a beneficiary requires could be considered in setting payment rates."

In its comments to OIG's draft report, CMS concurred with the office's recommendation and signaled a retreat from uniform per diem rates throughout a hospice patient's care. CMS revealed that it is analyzing implementation of a model recommended by MedPAC "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."

In response, OIG encouraged CMS to consider other options predicating payment on the specific needs of the beneficiary and taking into account the number and types of hospice visits and services needed. These could potentially take the form of a sliding-scale formula or tiered schedule for per diem rates, contingent upon beneficiary diagnosis and anticipated service consumption as reflected in the beneficiary's comprehensive assessment. CMS may even opt to go a step further and compute daily payment levels within a graduated range based on the quantity and quality of services actually provided on any given day.

While the primary focus of the OIG's reports has been underutilization, overutilization of higher levels of care also has been identified as a growing concern. Accordingly, it is more likely that payment reform will consist of modifications within the per diem rate framework than a shift toward a fee-for-service system with respect to the three less costly levels of hospice care.

Regardless of the specific model adopted, these changes will undoubtedly be aimed at, and have a disproportionate impact upon, reimbursement to hospice providers who provide care for individuals in the nursing home and ALF settings.

Accordingly, hospice providers should remain vigilant for news regarding CMS rulemaking and, when the proposed rule is published, take advantage of the comment period to ensure that CMS takes into account their concerns.

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