

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE HOSPICES THAT
FOCUS ON NURSING FACILITY
RESIDENTS**



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E X E C U T I V E S U M M A R Y

OBJECTIVES

1. To describe the growth of the Medicare hospice benefit in nursing facilities from 2005 to 2009.
2. To identify hospices with a high percentage of their Medicare beneficiaries residing in nursing facilities in 2009.
3. To describe characteristics of such hospices and their beneficiaries.

BACKGROUND

The Medicare hospice benefit allows a beneficiary with a terminal illness to forgo curative treatment for the illness and instead receive palliative care. The Office of Inspector General (OIG) has recently raised a number of concerns about Medicare hospice care for nursing facility residents. OIG found that 31 percent of Medicare hospice beneficiaries resided in nursing facilities in 2006 and that 82 percent of hospice claims for these beneficiaries did not meet Medicare coverage requirements. Also, the Medicare Payment Advisory Commission (MedPAC) noted in a report to Congress in 2009 that hospices and nursing facilities may be involved in inappropriate enrollment and compensation.

This report is the first in a series by OIG that addresses the concerns identified by OIG and MedPAC. This first report describes the growth in hospice care from 2005 to 2009 and focuses on hospices that served a high percentage of nursing facility residents in 2009. It is based primarily on the Minimum Data Set and the hospice 100-percent Standard Analytical File from the Centers for Medicare & Medicaid Services (CMS). Companion reports will assess the marketing practices of a sample of these hospices, as well as their business relationships with nursing facilities.

FINDINGS

Medicare spending on hospice care for nursing facility residents has grown nearly 70 percent since 2005. Total Medicare spending for hospice care for nursing facility residents grew by 69 percent from 2005 to 2009, increasing from \$2.55 billion to \$4.31 billion. At the same time, the number of hospice beneficiaries in nursing facilities increased by 40 percent. The total number of hospices providing care to Medicare beneficiaries also grew, with a continuing trend toward for-profit

hospices. In 2009, for-profit hospices were reimbursed, on average, 29 percent more per beneficiary than nonprofit hospices and 53 percent more per beneficiary than government-owned hospices.

Hundreds of hospices had more than two-thirds of their beneficiaries in nursing facilities in 2009; most of these hospices were for-profit. Almost 8 percent of hospices had two-thirds or more of their Medicare beneficiaries residing in nursing facilities. In total, there were 263 such hospices, hereinafter referred to as high-percentage hospices. Seventy-two percent of high-percentage hospices were for-profit, compared to 56 percent of all hospices. On average, high-percentage hospices served beneficiaries in 20 nursing facilities.

High-percentage hospices received more Medicare payments per beneficiary and served beneficiaries who spent more time in care. 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. High-percentage hospices served beneficiaries who spent more days in hospice care, which contributed to higher Medicare payments. By the end of 2009, the median number of days in hospice care for a beneficiary served by a high-percentage hospice was 3 weeks longer than the median number of days for a typical hospice beneficiary.

High-percentage hospices typically enrolled beneficiaries whose diagnoses required less complex care and who already lived in nursing facilities. Together, beneficiaries with ill-defined conditions, mental disorders, and Alzheimer's disease accounted for over half (51 percent) of the beneficiaries served by high-percentage hospices. In contrast, 32 percent of all hospice beneficiaries had one of these three conditions as their terminal diagnoses; beneficiaries with these conditions typically received routine home care, which is less complex and costly than other levels of hospice care.

In 2009, the vast majority—almost 90 percent—of beneficiaries who lived in nursing facilities and received care from high-percentage hospices had resided in the facilities before electing hospice care. In comparison, 79 percent of all hospice beneficiaries who received care in nursing facilities resided in the facilities before electing hospice care.

RECOMMENDATIONS

Some hospices may be seeking out beneficiaries with particular characteristics, including those with conditions associated with longer but less complex care. Such beneficiaries are often found in nursing facilities. By serving these beneficiaries for longer periods, the hospices receive more Medicare payments per beneficiary, which can contribute to higher profits.

As the growth in Medicare spending on hospice care for nursing facility residents continues, special attention should be paid to hospices that depend heavily on nursing facility residents. OIG plans to look at the marketing practices of these hospices and their relationships with nursing facilities. Also, the Patient Protection and Affordable Care Act requires Medicare hospice payment reform not earlier than October 1, 2013. In light of this requirement, CMS may find this report helpful as it considers options for reforming the hospice payment system.

We recommend that CMS:

Monitor hospices that depend heavily on nursing facility residents.

CMS should target its monitoring efforts on hospices with a high percentage of beneficiaries in nursing facilities and should closely examine whether these hospices are meeting Medicare requirements.

Modify the payment system for hospice care in nursing facilities.

Medicare currently pays hospices the same rate for care provided in nursing facilities as it does for care provided in other settings, such as private homes. The current payment structure provides incentives for hospices to seek out beneficiaries in nursing facilities, who often receive longer but less complex care. To lessen this incentive, CMS should reduce Medicare payments for hospice care provided in nursing facilities, seeking statutory authority, if necessary. Unlike private homes, nursing facilities are staffed with professional caregivers and are often paid by third-party payers, such as Medicaid. These facilities are required to provide personal care services, which are similar to hospice aide services that are paid for under the hospice benefit.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with both of our recommendations. In response to our first recommendation, to monitor hospices that depend heavily on nursing facility residents, CMS stated that it will share the information in this report with Recovery Audit Contractors (RAC) and Medicare Administrative Contractors (MAC). RACs review Medicare claims on a postpayment basis to identify inappropriate payments. Further, CMS noted that it will continue to emphasize to the MACs the importance of this issue when prioritizing their medical review strategies or other interventions.

In response to our second recommendation, to modify the payment system for hospice care in nursing facilities, CMS agreed that incentives to seek out beneficiaries in nursing facilities may exist in the current payment structure. CMS stated that it is in the early stages of its reform efforts. It is conducting initial analysis and will convene a technical advisory panel. Finally, CMS stated that it intends to analyze a variety of data and information on patient resource use by site, length of stay, and patient characteristics. We support CMS's efforts and encourage it to focus its analysis and reform efforts on lessening the incentive for hospices to inappropriately seek out beneficiaries in nursing facilities.



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BACKGROUND

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In addition, in a report to Congress in 2009, the Medicare Payment Advisory Commission (MedPAC) stated that hospices and nursing facilities both have incentives to refer and admit to hospice individuals likely to have long stays.² MedPAC highlighted instances in which hospices aggressively marketed their services to such individuals by “trolling” for patients in nursing facilities and using marketing materials that did not mention terminal illness as a Medicare coverage requirement. It also noted that hospices and nursing facilities may be involved in inappropriate enrollment and compensation. Consequently, MedPAC recommended in its report that OIG investigate relationships between nursing facilities and hospices as well as investigate hospice marketing practices and materials.

This report is the first in a series by OIG that addresses the concerns identified by OIG and MedPAC. This first report describes the growth in hospice care from 2005 to 2009 and focuses on hospices with a high percentage of Medicare beneficiaries residing in nursing facilities. Companion reports will assess the marketing practices of a sample of

¹ OIG, *Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities*, OEI-02-06-00223, September 2009; OIG, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance With Medicare Coverage Requirements*, OEI-02-06-00221, September 2009.

² MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2009, ch. 6: “Reforming Medicare’s Hospice Benefit.”

these hospices, as well as their business relationships with nursing facilities.

The Medicare Hospice Benefit

The goals of hospice care are to help terminally ill beneficiaries continue life with minimal disruption and to support beneficiaries' families and other caregivers throughout the process. The care may be provided to individuals and their families in various settings, including the home or other places of residence, such as a skilled nursing facility or other nursing facility.

To be eligible for Medicare hospice care, a beneficiary must be entitled to Part A of Medicare and be certified as having a terminal illness with a life expectancy of 6 months or less if the disease runs its normal course.³ Upon a beneficiary's election of hospice care, the hospice assumes the responsibility for medical care for the beneficiary's terminal illness. This care is palliative, rather than curative. It includes, among other things, nursing care, medical social services, hospice aide services (sometimes referred to as home health aide services), medical supplies, and physician services. The beneficiary waives all rights to Medicare payment for services related to the curative treatment of the terminal condition or a related condition, but retains rights to Medicare payment for services to treat conditions unrelated to the terminal illness.⁴ Beneficiaries may revoke their election of hospice care and return to standard Medicare coverage at any time.⁵

Beneficiaries are entitled to receive hospice care for two 90-day periods, followed by an unlimited number of 60-day periods.⁶ The periods need not be consecutive. At the start of each period of care, an attending physician must certify that the beneficiary is terminally ill and has a life expectancy of 6 months or less. For care to be covered under Part A,

³ Social Security Act, §§ 1814(a)(7)(A) and 1861(dd)(3)(A), 42 U.S.C. §§ 1395f(a)(7)(A) and 1395x(dd)(3)(A); 42 CFR §§ 418.20 and 418.22. Certification is based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness.

⁴ Social Security Act, §§ 1812(d)(2)(A) and 1861(dd)(1), 42 U.S.C. §§ 1395d(d)(2)(A) and 1395x(dd)(1); 42 CFR § 418.24(d).

⁵ Social Security Act, § 1812(d)(2)(B), 42 U.S.C. § 1395d(d)(2)(B); 42 CFR § 418.28.

⁶ Social Security Act, § 1812(a)(4), 42 U.S.C. § 1395d(a)(4). Prior to 1990, Medicare provided hospice coverage for a maximum of 210 days.

hospices must be certified by Medicare.⁷ Hospices may be for-profit, nonprofit, or government owned.

Levels of care. The Medicare hospice benefit has four levels of care: routine home care, continuous home care, inpatient respite care, and general inpatient care.⁸ Each level has an all-inclusive daily rate that is paid through Part A. The rate, which in 2009 ranged from \$140 to \$817 before locality adjustments, is paid to the hospice for each day that a beneficiary is in hospice care, regardless of the number of services furnished. Medicare pays hospices the same rate for care provided in nursing facilities as it does for care provided in other settings, such as private homes. Routine home care is the most common level of care. Appendix A provides detailed information on these four levels of care and their payment rates, as well as on hospice services overall.

Hospice care in nursing facilities. When a beneficiary resides in a nursing facility, the hospice is responsible for providing hospice services to the beneficiary. The nursing facility provides room and board, as well as care unrelated to the terminal illness. Medicare reimburses the hospice according to the level of care provided, and the beneficiary or a third-party payer pays the nursing facility for room and board.⁹

If a beneficiary is dually eligible for Medicare and Medicaid, then Medicaid pays the beneficiary's hospice for room and board at a rate equal to at least 95 percent of the per diem rate that the State would have paid for nursing facility care.¹⁰ The hospice receives the payment from the State and pays the nursing facility for the beneficiary's room and board. The hospice must have a written agreement with the nursing facility under which the hospice assumes responsibility for determining the course of the individual's hospice care, and the facility agrees to provide room and board.¹¹

⁷ Social Security Act, §§ 1814(a) and 1866, 42 U.S.C. §§ 1395f(a) and 1395cc; 42 CFR § 418.116(a).

⁸ 42 CFR § 418.302.

⁹ Centers for Medicare & Medicaid Services (CMS), *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 9, § 20.3. Accessed at <http://www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf> on June 30, 2011.

¹⁰ Social Security Act, § 1902(a)(13)(B), 42 U.S.C. § 1396a(a)(13)(B).

¹¹ 42 CFR §§ 418.112(b)–(c); CMS, *State Operations Manual*, Pub. 100-07, ch. 2, § 2082D. Accessed at <http://www.cms.hhs.gov/manuals/downloads/som107c02.pdf> on June 30, 2011.

Claims Processing and Program Safeguard Activities

CMS contracts with four Medicare Administrative Contractors (MAC) to process and pay Medicare hospice claims in different geographic areas of the country. In addition to developing local coverage determinations, the MACs apply processing edits to reject, deny, or suspend claims. Using proactive data analysis, they may conduct medical reviews of claims to prevent improper payments or to collect overpayments. In addition, they conduct outreach and education for providers.

CMS also contracts with Program Safeguard Contractors (PSC) and Zone Program Integrity Contractors (ZPIC) to identify fraud and abuse in their jurisdictions. These contractors analyze data to check for aberrant billing and investigate allegations of fraud and abuse. They may refer claims to MACs to collect overpayments or to law enforcement for further investigation. CMS is transitioning the role of the PSCs to the ZPICs.

Related Work

This report is part of OIG's continuing work on Medicare hospice care. In 2007, OIG issued a report that found that, on average, beneficiaries in nursing facilities spent more time in hospice and were associated with higher overall Medicare payments than beneficiaries in other settings.¹² Another report determined that Medicare paid an average of \$960 per week for hospice care for each hospice beneficiary in a nursing facility.¹³ This care most commonly included nursing, hospice aide, and medical social services. Hospices made an average of 4.2 visits per week for these three services combined.

Additionally, OIG identified a number of cases in which the use of inpatient respite care for beneficiaries in nursing facilities may have been inappropriate.¹⁴ OIG also found instances in which Medicare paid physicians for services related to a beneficiary's terminal illness under

¹² OIG, *Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings*, OEI-02-06-00220, December 2007.

¹³ OIG, *Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities*, OEI-02-06-00223, September 2009. Payment for physician services was not included in the analysis for this report.

¹⁴ OIG, *Hospice Beneficiaries' Use of Respite Care*, OEI-02-06-00222, March 2008. For a definition of inpatient respite care, see Appendix A.

Part B, while also paying the same physicians for services for the terminal illness under Part A.¹⁵

METHODOLOGY

This report is based on analysis of a number of data files from CMS. These files included the Minimum Data Set (MDS), the hospice 100-percent Standard Analytical File, the Medicare Enrollment database, the Online Survey and Certification Reporting System, and the Healthcare Cost Report Information System. Our analysis included all 3,385 Medicare-certified hospices that served Medicare beneficiaries in 2009.

Identifying Hospice Beneficiaries in Nursing Facilities

Using the MDS, we identified beneficiaries who resided in nursing facilities in 2009. The MDS includes assessments of nursing facility residents. We used MDS assessments from January 2006 through December 2009 to create a record of the dates when each beneficiary resided in a nursing facility.¹⁶ We matched this file to the Medicare Enrollment database by Social Security number to identify the Health Insurance Claim Number for each beneficiary.

We used the hospice 100-percent Standard Analytical File to identify all beneficiaries who received hospice care in 2009 and to determine the amount of time they had spent in hospice care since 2006. For each beneficiary with at least one claim in 2009, we extracted the beneficiary's hospice claim(s) with service dates from January 2006 through December 2009. To identify beneficiaries who received hospice care in a nursing facility in 2009, we used beneficiaries' Health Insurance Claim Numbers and matched the 2009 hospice care dates to the 2009 nursing facility stay dates. We also used the MDS to identify the nursing facilities in which Medicare hospice beneficiaries resided.

Identifying High-Percentage Hospices

Using the hospice 100-percent Standard Analytical File, we identified all hospices that provided care to Medicare beneficiaries in 2009. For

¹⁵ OIG, *Questionable Billing for Physician Services for Hospice Beneficiaries*, OEI-02-06-00224, September 2010.

¹⁶ Beginning in 2007, hospice claims included information about the setting in which hospice care was provided. We used the MDS, however, to identify the nursing facilities and determine the dates the hospice beneficiaries resided in the facilities from 2006 through 2009.

each of these hospices, we calculated the total number of beneficiaries served in 2009 and the number of beneficiaries served who received hospice care while residing in nursing facilities in 2009. We used these data to determine the percentage of beneficiaries served by each hospice who received care while residing in nursing facilities in 2009. We considered hospices with two-thirds or more of their beneficiaries in nursing facilities as having a high percentage of their beneficiaries in nursing facilities.¹⁷ These hospices are hereinafter referred to as “high-percentage hospices.”

Characteristics of Hospices

We used the Online Survey and Certification Reporting System to determine whether each hospice was for-profit, nonprofit, or government owned. For hospices that did not clearly report their ownership status in the Online Survey and Certification Reporting System, we obtained additional ownership information from the Healthcare Cost Report Information System.

Analysis of Data

We analyzed the data to determine Medicare spending in 2009 for hospice care overall and for hospice care for nursing facility residents. We also determined the total number of Medicare hospice beneficiaries and the number of beneficiaries who received hospice care while residing in nursing facilities in 2009. We compared these numbers to 2005 data reported in our earlier study, entitled *Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings*.¹⁸ Additionally, we determined the percentage of hospices that were for-profit, nonprofit, or government owned and the average amount Medicare paid per beneficiary in 2009 for each type of hospice.

We then examined the characteristics of high-percentage hospices. We determined their type of ownership, the States they were located in, and the number of nursing facilities in which they served beneficiaries in 2009. We also compared the characteristics of the high-percentage hospices to those of all hospices and highlighted key differences. This analysis included average Medicare payments per beneficiary and the

¹⁷ When identifying high-percentage hospices, we included only hospices that served at least 10 Medicare beneficiaries in 2009.

¹⁸ OIG, *Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings*, OEI-02-06-00220, December 2007.

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amount of time that beneficiaries spent in hospice care since 2006. With respect to the latter, we looked at the median number of days that beneficiaries spent in hospice care and the percentage of beneficiaries who received hospice care for extended periods (i.e., 6 months or more of hospice care since 2006). We used the period of 6 months or more because to be eligible for Medicare hospice care, a beneficiary must be certified as having a terminal illness with a life expectancy of 6 months or less if the disease runs its normal course.

We also looked at the percentage of beneficiaries served by each hospice who elected hospice care before, after, or at the same time as they became nursing facility residents. In addition, we analyzed the terminal diagnoses of hospice beneficiaries and the levels of care (i.e., routine home care, continuous home care, inpatient respite care, and general inpatient care) provided by hospices in 2009.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

Medicare spending on hospice care for nursing facility residents has grown nearly 70 percent since 2005

Medicare hospice spending for nursing facility residents has grown significantly. As shown in Table 1, Medicare’s total spending

for hospice care for nursing facility residents rose 69 percent from 2005 to 2009, going from \$2.55 billion to \$4.31 billion. The growth of Medicare spending for hospice care in nursing facilities exceeded that for hospice care overall. Total Medicare payments for all hospice care, regardless of setting, increased 53 percent over the same 4 years, from \$7.92 billion to \$12.08 billion.

The number of Medicare hospice beneficiaries residing in nursing facilities also increased during these 4 years, although not as much as spending. While spending grew 69 percent, the number of hospice beneficiaries in nursing facilities increased 40 percent. Almost 337,000 hospice beneficiaries lived in nursing facilities in 2009, up from approximately 240,000 in 2005. The total number of Medicare hospice beneficiaries in all settings also rose during this time period, but to a lesser extent. In 2009, there were over 1 million hospice beneficiaries, an increase of almost 25 percent over 2005 totals.

Table 1: Medicare Hospice Care from 2005 to 2009: Growth in Spending and in Number of Beneficiaries

| | 2005 | 2009 | Percentage Increase |
|--|----------------|-----------------|---------------------|
| Spending on hospice care in nursing facilities | \$2.55 billion | \$4.31 billion | 69% |
| Spending on hospice care in all settings | \$7.92 billion | \$12.08 billion | 53% |
| Number of hospice beneficiaries in nursing facilities | 240,000 | 337,000 | 40% |
| Number of hospice beneficiaries in all settings | 871,000 | 1,085,000 | 25% |

Source: OIG analysis of CMS data, 2010; and OIG, *Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings*, OEI-02-06-00220, December 2007.

The total number of hospices providing care to Medicare beneficiaries in all settings grew, with a continuing trend toward for-profit hospices

Between 2005 and 2009, the number of Medicare hospices increased 17 percent, with a total of 3,385 hospices providing care to Medicare beneficiaries in 2009. This increase was primarily among for-profit hospices. In 2009, more than half of Medicare hospices (56 percent) were for-profit, an increase from 13 percent of hospices in 1992, 28 percent in 2001, and 45 percent in 2005.¹⁹

In addition, Medicare paid for-profit hospices more per beneficiary than it paid nonprofit and government-owned hospices. In 2009, for-profit hospices were reimbursed, on average, 29 percent more per beneficiary than nonprofit hospices and 53 percent more per beneficiary than government-owned hospices. Medicare paid for-profit hospices an average of \$12,609 per beneficiary, compared to \$9,749 per beneficiary paid to nonprofit hospices and \$8,260 per beneficiary paid to government-owned hospices.

Hundreds of hospices had more than two-thirds of their beneficiaries in nursing facilities in 2009; most of these hospices were for-profit

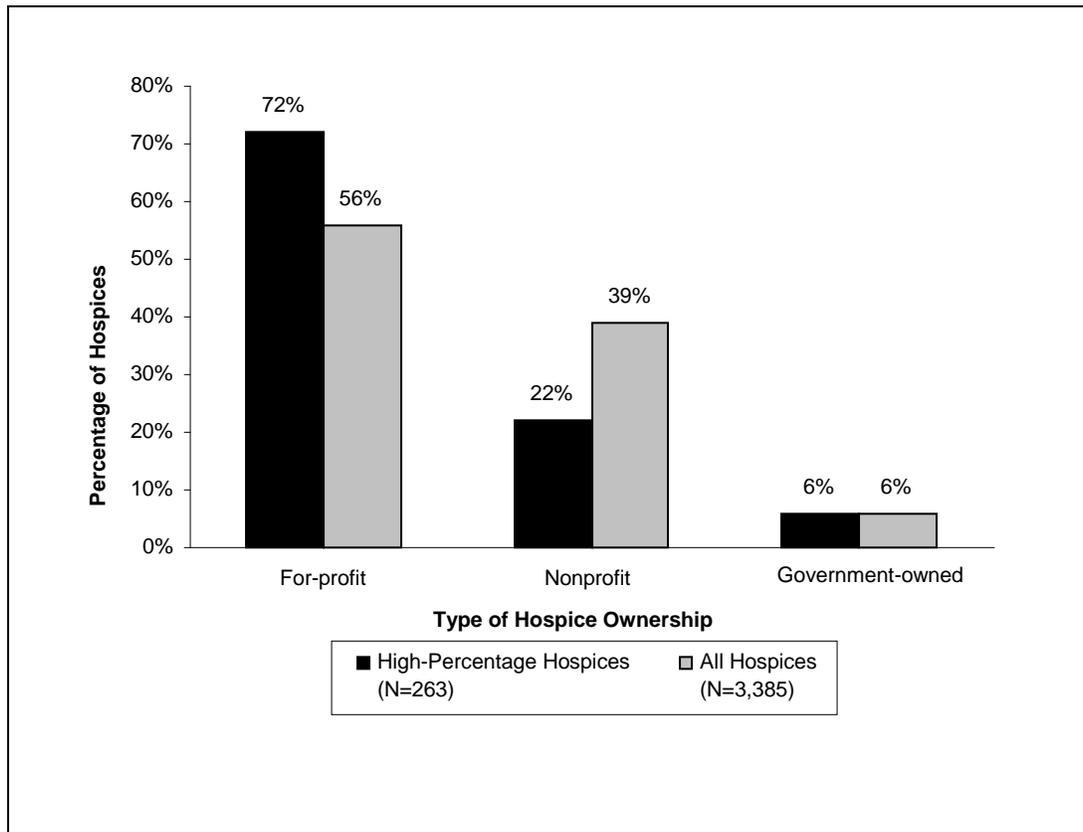
Nationwide, 31 percent of Medicare hospice beneficiaries resided in nursing facilities in 2009. Almost all hospices

(96 percent of the 3,385 hospices that served Medicare beneficiaries) provided care in 2009 for at least one beneficiary who resided in a nursing facility. Over half of all hospices had at least one-quarter of their beneficiaries in nursing facilities, and 19 percent had more than half in nursing facilities. Almost 8 percent of all hospices had two-thirds or more of their Medicare beneficiaries residing in nursing facilities. In total, there were 263 of these high-percentage hospices.

As shown in Figure 1, high-percentage hospices were more likely than hospices overall to be for-profit and less likely to be nonprofit. Of high-percentage hospices, 72 percent were for-profit and 22 percent were nonprofit. Of hospices overall, 56 percent were for-profit and 39 percent were nonprofit.

¹⁹ OIG, *Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings*, OEI-02-06-00220, December 2007.

FIGURE 1:
Hospice
Ownership
in 2009



Source: OIG analysis of CMS data, 2010.

*Percentages do not sum to 100 percent because of rounding.

Thirty-seven percent of high-percentage hospices were located in four States: Iowa, Massachusetts, Ohio, and Pennsylvania. Some States had a disproportionate number of high-percentage hospices. Iowa had 11 percent of high-percentage hospices even though it had less than 3 percent of all hospices in 2009. The opposite was true in California, which had less than 1 percent of high-percentage hospices but 7 percent of all hospices.

High-percentage hospices tended to serve beneficiaries in multiple nursing facilities. On average, high-percentage hospices were associated with 20 nursing facilities. Hospices in general also tended to serve beneficiaries in multiple nursing facilities, although not to the same extent as high-percentage hospices. Overall, hospices were associated with an average of 15 nursing facilities.

High-percentage hospices received more Medicare payments per beneficiary and served beneficiaries who spent more time in care

Taking into account beneficiaries in all settings, on average, Medicare paid \$3,182 more per beneficiary for beneficiaries served by high-percentage hospices than it paid per beneficiary for those served

by hospices in general.²⁰ As shown in Table 2, Medicare paid an average of \$21,306 for each beneficiary served by high-percentage hospices, as opposed to an average of \$18,124 per beneficiary served by hospices in general.

High-percentage hospices served beneficiaries who spent more days in hospice care. By the end of 2009, the median number of days in hospice care for a beneficiary served by a high-percentage hospice was 3 weeks longer than the median number of days for a typical hospice beneficiary (52 days compared to 31 days).²¹ This longer time in care accounted for the higher payments per beneficiary paid to high-percentage hospices.

High-percentage hospices were also more likely to serve beneficiaries who spent more than 6 months in hospice care. Twenty-eight percent of beneficiaries in high-percentage hospices received hospice care for 6 months or more, compared to 21 percent of beneficiaries served by hospices in general.

Table 2: Hospice Payments and Duration

| | High-Percentage Hospices | All Hospices |
|--|--------------------------|--------------|
| Average payments per beneficiary | \$21,306 | \$18,124 |
| Median number of days in hospice care | 52 days | 31 days |
| Percentage of beneficiaries who received hospice care for 6 months or more | 28% | 21% |

Source: OIG analysis of CMS data, 2010.

²⁰ Hospice payments include reimbursement for all days during which a beneficiary received hospice care in any setting starting in January 2006 and ending in December 2009.

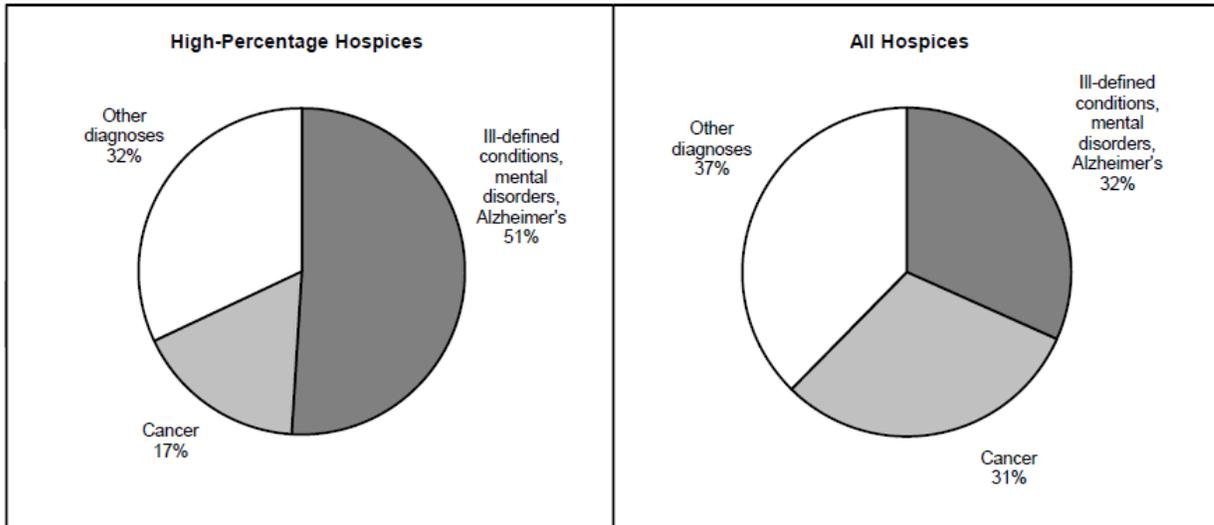
²¹ The number of days in hospice care includes all days during which a beneficiary received hospice care in any setting starting in January 2006 and ending in December 2009.

High-percentage hospices typically enrolled beneficiaries whose diagnoses required less complex care and who already lived in nursing facilities

High-percentage hospices commonly served beneficiaries who had diagnoses such as ill-defined conditions and mental disorders, including dementia. Ill-defined conditions include, among other things, adult failure to

thrive, senility without psychosis, and unspecified debility.²² Together, beneficiaries with ill-defined conditions, mental disorders, and Alzheimer’s disease accounted for over half (51 percent) of the beneficiaries served by high-percentage hospices. See Figure 2. In contrast, 32 percent of beneficiaries served by all hospices had one of these three conditions as their terminal diagnoses. More specifically, 27 percent of beneficiaries served by high-percentage hospices had ill-defined conditions as their terminal diagnoses, compared to 17 percent of beneficiaries served by hospices in general. Beneficiaries with ill-defined conditions, mental disorders, or Alzheimer’s disease typically received less complex care.

FIGURE 2: Diagnoses of Hospice Beneficiaries in 2009



Source: OIG analysis of CMS data, 2010.

²² The International Classification of Diseases, 9th Revision, Clinical Modification, categorizes several diagnoses as “symptoms, signs, or ill-defined conditions.” This report refers to all diagnoses listed under “symptoms, signs, or ill-defined conditions” as “ill-defined conditions.”

F I N D I N G S

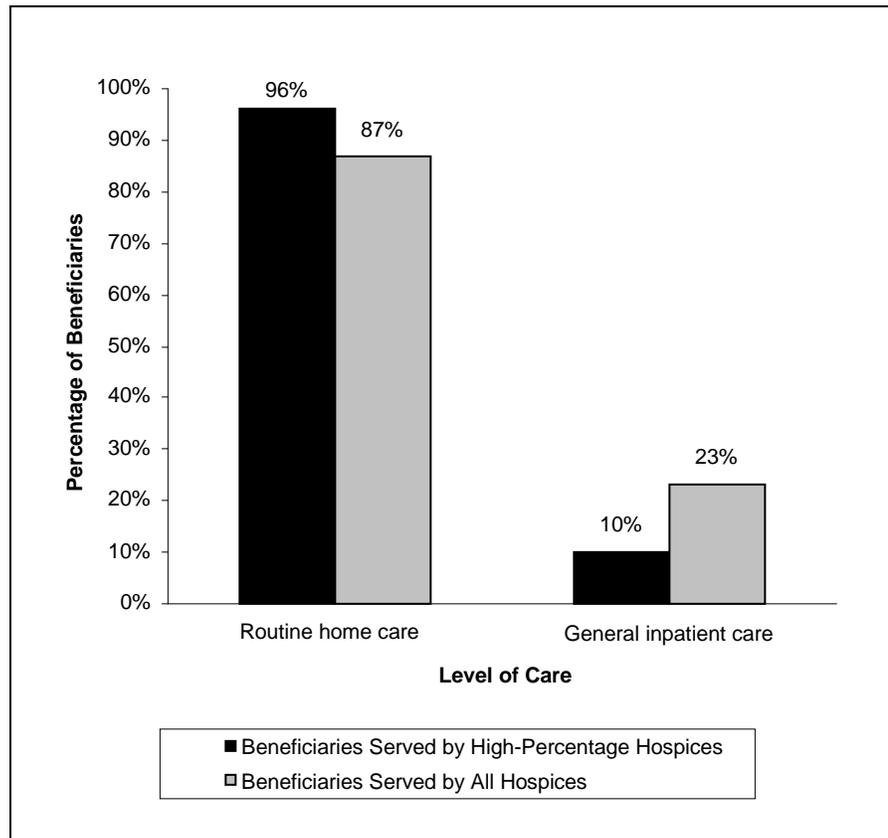
At the same time, high-percentage hospices were less likely to serve beneficiaries with terminal diagnoses of cancer. Seventeen percent of beneficiaries served by high-percentage hospices had cancer diagnoses, compared to 31 percent of all hospice beneficiaries. Cancer patients often required complex care. They also typically received hospice care for substantially fewer days than beneficiaries with diagnoses such as ill-defined conditions.

High-percentage hospices provided more routine home care and less general inpatient care than hospices overall. As shown in Figure 3, 96 percent of hospice beneficiaries served by high-percentage hospices received routine home care, compared to 87 percent of all hospice beneficiaries. Further, only 10 percent of beneficiaries served by high-percentage hospices received general inpatient care, compared to 23 percent of all hospice beneficiaries. General inpatient care is a more complex level of care than routine home care. The two other levels of care—continuous home care and inpatient respite care—were provided infrequently by high-percentage hospices as well as by hospices overall.

These findings show that high-percentage hospices tended to serve beneficiaries with ill-defined conditions, mental disorders, or Alzheimer’s disease who typically received routine home care, as opposed to the more complex and costly levels of hospice care. Routine home care is the least expensive level of hospice care, and high-percentage hospices were thus more likely to receive lower payment rates per day. However, their beneficiaries spent more days in hospice care, causing high-percentage hospices’ Medicare payments per beneficiary to be higher, on average, than those for hospices overall. The differences between high-percentage hospices and hospices overall indicate that high-percentage hospices may target certain types of beneficiaries.

F I N D I N G S

FIGURE 3: Levels of Care Received by Hospice Beneficiaries in 2009



Source: OIG analysis of CMS data, 2010.

High-percentage hospices commonly served beneficiaries who resided in nursing facilities before electing hospice care

In 2009, the vast majority—almost 90 percent—of beneficiaries who lived in nursing facilities and received care from high-percentage hospices had resided in the facilities before electing hospice care. In comparison, 79 percent of all hospice beneficiaries who received care in nursing facilities resided in the facilities before electing hospice care. The remaining 21 percent elected hospice care before or at the same time as they entered nursing facilities. Regarding both high-percentage hospices and hospices overall, beneficiaries who resided in nursing facilities before electing hospice care usually resided in the facilities for more than 2 months before election.



R E C O M M E N D A T I O N S

Medicare spending on hospice care for nursing facility residents has grown nearly 70 percent since 2005. Also, hundreds of hospices had a high percentage of their beneficiaries residing in nursing facilities and most of these hospices were for-profit. Compared to hospices nationwide, these high-percentage hospices received more Medicare payments per beneficiary and served beneficiaries who spent more time in care. They also typically enrolled beneficiaries who required less complex care and who already lived in nursing facilities before they elected hospice care.

These findings indicate that some hospices may be seeking out beneficiaries with particular characteristics, including those with conditions associated with longer but less complex care. Such beneficiaries are often found in nursing facilities. By serving these beneficiaries for longer periods, the hospices receive more Medicare payments per beneficiary, which can contribute to larger profits.

OIG reported in previous work that Medicare paid an average of \$960 per week for hospice care for each hospice beneficiary in a nursing facility. In addition to providing medication, this care most commonly included nursing, hospice aide, and medical social services. Hospices provided an average of 4.2 visits per week for these three services combined. Also, the majority (82 percent) of hospice claims for nursing facility residents did not meet Medicare coverage requirements.

As the growth in Medicare spending on hospice care for nursing facility residents continues, special attention should be paid to hospices that depend heavily on nursing facility residents. OIG plans to look at the marketing practices of these hospices and their relationships with nursing facilities. Also, the Patient Protection and Affordable Care Act requires Medicare hospice payment reform not earlier than October 1, 2013.²³ In light of this requirement, CMS may find this report helpful as it considers options for reforming the hospice payment system.

²³ Patient Protection and Affordable Care Act, P.L. 111-148 § 3132(a).

R E C O M M E N D A T I O N S

We recommend that CMS:

Monitor hospices that depend heavily on nursing facility residents

CMS should target its monitoring efforts on hospices with a high percentage of beneficiaries in nursing facilities and should closely examine whether these hospices are meeting Medicare requirements. CMS could focus its medical record reviews on beneficiaries with certain conditions who spend extended periods in hospice care and who are also more likely to require less complex care.

Modify the payment system for hospice care in nursing facilities

Medicare currently pays hospices the same rate for care provided in nursing facilities as it does for care provided in other settings, such as private homes. The current payment structure provides incentives for hospices to seek out beneficiaries in nursing facilities, who often receive longer but less complex care. To lessen this incentive, CMS should reduce Medicare payments for hospice care provided in nursing facilities, seeking statutory authority to do so, if necessary. Unlike private homes, nursing facilities are staffed with professional caregivers and are often paid by third-party payers, such as Medicaid. These facilities are required to provide personal care services, which are similar to hospice aide services that are paid for under the hospice benefit.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with both of our recommendations. In response to our first recommendation, to monitor hospices that depend heavily on nursing facility residents, CMS stated that it will share the information in this report with Recovery Audit Contractors (RAC) and MACs. RACs review Medicare claims on a postpayment basis to identify inappropriate payments. Further, CMS noted that it will continue to emphasize to the MACs the importance of this issue when prioritizing their medical review strategies or other interventions.

In response to our second recommendation, to modify the payment system for hospice care in nursing facilities, CMS agreed that incentives to seek out beneficiaries in nursing facilities may exist in the current payment structure. CMS stated that it is in the early stages of its reform efforts. It is conducting initial analysis and will convene a technical advisory panel. Finally, CMS stated that it intends to analyze a variety of data and information on patient resource use by site, length

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of stay, and patient characteristics. We support CMS's efforts and encourage it to focus its analysis and reform efforts on lessening the incentive for hospices to inappropriately seek out beneficiaries in nursing facilities.

The full text of CMS's comments can be found in Appendix B.

Hospice Services, Levels of Care, and Payment Rates

The Medicare hospice benefit covers nursing care, medical social services, hospice aide and homemaker services, physician services, counseling, physical therapy, occupational therapy, and speech-language pathology services. It also includes short-term inpatient care, medical supplies (including drugs and biologicals), and the use of medical appliances. In addition, the hospice benefit covers any other service that is specified in the plan of care as reasonable and necessary for the palliation and management of the terminal illness and related conditions and for which payment may otherwise be made under Medicare.²⁴

The Centers for Medicare & Medicaid Services (CMS) publishes general hospice payment rates annually to be used for each level of care.²⁵ The rates are adjusted based on the beneficiary's geographic location. The levels of care and each level's Medicare unadjusted daily rate for fiscal year 2009 are as follows:

- Routine Home Care (\$139.97): The routine home care rate is paid to the hospice for each day that the beneficiary is under the care of the hospice and is not receiving one of the other levels of care. Routine home care includes, but is not limited to, nursing and hospice aide services. Routine home care may be provided in the home or other places of residence, such as a nursing facility.
- Continuous Home Care (\$816.94): Continuous home care is allowed only during brief periods of crisis in which a beneficiary requires continuous care to achieve palliation or management of acute medical symptoms. It is covered only as necessary to maintain the terminally ill beneficiary at home. The care must be predominantly nursing care. Continuous home care may be provided in the home or other places of residence, such as a nursing facility. The continuous home care rate is divided by 24 hours to determine an hourly rate. A minimum of 8 hours must be provided.

²⁴ Social Security Act, § 1861(dd)(1), 42 U.S.C. § 1395x(dd)(1); 42 CFR § 418.202(i).

²⁵ CMS, *Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and the Hospice Pricer for FY 2009*, Transmittal 1570, Change Request 6155. Accessed at <http://www.cms.gov/transmittals/downloads/R1570CP.pdf> on June 30, 2011.

- Inpatient Respite Care (§144.79): Respite care is short-term inpatient care provided to the beneficiary when necessary to relieve the beneficiary’s caregiver(s). Respite care may be provided only on an occasional basis and is not reimbursed for more than 5 consecutive days. Respite care may be provided in a Medicare- or Medicaid-certified hospice inpatient facility, hospital, skilled nursing facility, or other nursing facility.
- General Inpatient Care (§622.66): General inpatient care is for pain control and symptom management that cannot feasibly be provided in other settings. General inpatient care may be provided in a Medicare- or Medicaid-certified hospice inpatient facility, hospital, or skilled nursing facility.

Medicare has two annual caps on hospice reimbursement. The first cap limits the total number of days of inpatient care that a hospice may provide to 20 percent of the hospice’s total patient care days.²⁶ Inpatient care includes two of the four levels of hospice care: general inpatient care and inpatient respite care.

The second cap limits the total reimbursement that a hospice may receive in a given year. The total annual payments to a hospice may not exceed a set per-patient amount multiplied by the number of beneficiaries who elected to receive hospice care from that hospice during the annual cap period.²⁷ For 2009, this per-patient amount was \$23,014.50.²⁸

²⁶ Social Security Act, § 1861(dd)(2)(A)(iii), 42 U.S.C. § 1395x(dd)(2)(A)(iii); 42 CFR § 418.302(f).

²⁷ Social Security Act, § 1814(i)(2), 42 U.S.C. § 1395f(i)(2); 42 CFR § 418.309.

²⁸ CMS, *Hospice Aggregate Cap Amount for 2009*, May 5, 2009. Accessed at https://www.cms.gov/Hospice/downloads/2009_Aggregate_cap_amount_FINAL_5.4.09.pdf on June 30, 2011.

Centers for Medicare & Medicaid Services Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 02 2011

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, M.D.
Administrator */S/*

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Hospices That Focus on Nursing Facility Residents (OEI-02-10-00070)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and respond to the Office of Inspector General's (OIG) Draft Report titled "Medicare Hospices that Focus on Nursing Facility Residents" (OEI-02-10-00070).

The Medicare hospice benefit is intended to assist terminally ill individuals, with a prognosis of six months or less if the disease runs its normal course, while remaining in their homes. A patient elects hospice care, and in doing so foregoes curative care for the terminal and related condition. Instead, the patient receives palliative care for relief of pain and symptom management. Hospices are paid a per-diem rate for every day a patient elects the benefit. In recent years the OIG has raised a number of concerns about Medicare hospice care provided to patients whose home is a nursing facility. In 2009, the OIG reported their findings that 31 percent of Medicare hospice patients reside in nursing facilities and 82 percent of hospice claims for these patients did not meet one or more Medicare coverage requirements for the benefit. Medicare's Payment Advisory Commission (MedPAC) has also expressed concerns surrounding hospice care provided to nursing home residents. In the 2009 Report to Congress, MedPAC stated that hospices and nursing facilities both have incentives to refer and admit to hospice individuals likely to have long stays. The report also noted that hospices and nursing facilities may be involved in inappropriate enrollment and compensation. MedPAC recommended that the OIG investigate relationships between nursing facilities and hospices as well as investigate hospice marketing practices and materials.

This report is the first in a series by OIG that addresses the concerns identified by OIG and MedPAC. The report describes a 70 percent growth in hospice care provided to nursing home residents from 2005-2009. It also describes that Medicare expends more per patient to hospices with a high percentage of patients in nursing facilities when compared to overall expenditures per hospice patient, yet these nursing facility patients exhibit conditions which require less

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complex care. The report urges CMS to target hospices with high percentages of patients residing in nursing homes for review, and urges CMS to reduce payments for these patients. The OIG's analysis is helpful, and reinforces some concerns we have regarding payment vulnerabilities associated with hospice patients in nursing facilities. We plan to further investigate these concerns as part of our hospice payment reform efforts.

The OIG has two recommendations for CMS in this draft report. Below are the CMS responses to those recommendations.

OIG Recommendation

The OIG recommends that CMS should target its monitoring efforts on hospices with a high percentage of beneficiaries in nursing facilities and should closely examine whether these hospices are meeting Medicare requirements. CMS could focus its medical record reviews, perhaps by concentrating on beneficiaries with certain conditions who spend extended periods of time in hospice care and who are also more likely to require less complex care.

CMS Response

The CMS concurs. The CMS will share the information included in this report with the Recovery Auditors and Medicare Administrative Contractors (MACs). The Recovery Auditors review Medicare claims on a post-payment basis and are tasked with identifying inappropriate payments to providers and suppliers. While CMS does not mandate areas for Recovery Audit review, we will share this information with the Recovery Auditors. We will also continue to emphasize to the MACs the importance of this issue when prioritizing their medical review strategies or other interventions.

OIG Recommendation

The OIG recommends that CMS modify the hospice payment system for hospice care in nursing facilities because the current payment structure provides incentives for hospices to seek out beneficiaries in nursing facilities who often receive longer but less complex care. To lessen this incentive, the OIG recommends that CMS should reduce Medicare payments for hospice care provided in nursing facilities, seeking statutory authority, if necessary. The OIG states that unlike private homes, nursing facilities are staffed with professional caregivers and are often paid by a third -party payer such as Medicaid. These facilities are required to provide personal care services, which are similar to hospice aide services that are paid for under the hospice benefit.

CMS Response

We concur with the recommendation and agree that the incentives may exist in the current payment structure. The Affordable Care Act calls for CMS to reform hospice payments no earlier than October 2013. We are in the early stages of our reform efforts. We are conducting initial data analysis and will convene a technical advisory panel in the Summer of 2011. We are also working in collaboration with the Assistant Secretary of Planning and Evaluation to develop

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analysis that may be used to inform the technical advisory panel discussions and the broader reform.

We intend to analyze a variety of data and information to inform us of patient resource use by site, length of stay, and patient characteristics. The findings from this analysis and additional analysis recommended by the technical advisory panel to be performed will inform our development of alternative payment models. The goal of hospice reform is to more accurately align payment with patient resource use while mitigating program vulnerabilities.

We thank the OIG for presenting its findings and we appreciate their perspective on these issues. CMS appreciates OIG's efforts and insight on this report and looks forward to continually working with OIG on issues related to waste and abuse in the Medicare program.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Meridith Seife, Deputy Regional Inspector General.

Nancy Harrison served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the New York regional office who contributed to the report include Rose Goldberg, Olivia Herman, and Michael Rubin; other central office staff who contributed include Rob Gibbons and Sandy Khoury.

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