OIG Report Scrutinizes Hospice Care Provided in Assisted Living Facilities

by Allan D. Jergesen

In January, the Office of Inspector General of the U.S. Department of Health and Human Services ("OIG") released a report reviewing hospice care provided to Medicare beneficiaries in assisted living facilities ("ALFs") [1]. The report finds that Medicare spending on hospice services in ALFs has surged in recent years, and that Medicare may be creating improper financial incentives for hospices to provide care to beneficiaries in ALFs. It recommends that the Centers for Medicare and Medicaid Services ("CMS") examine certain billing trends and reform the hospice payment model to reduce the incentives that may be leading to overbilling by some hospices for care provided in ALFs.

The report finds the following:

1. Medicare reimbursement of hospice care in ALFs has more than doubled since 2012, while the overall growth rate of ALFs during this same period has been limited;
2. ALF-based patients received hospice care for twice as long as patients in other settings (on average, 98 days in ALFs versus 30-50 days in other settings);
3. On average, Medicare paid more than twice as much per beneficiary for hospice care provided in ALFs than for care provided in other settings;
4. Hospice care in ALFs is generally less complex than care provided in other settings, but is reimbursed at the same daily rate;
5. The average ALF-based hospice beneficiary receives less than five hours of hospice care per week;
6. Although Medicare requires hospices to make services available seven days a week, only 7% of ALF-based hospice care occurs over the weekend; and
7. For-profit hospices receive thousands more dollars per ALF-based beneficiary than nonprofit hospices, due to longer duration of care and billing at the highest reimbursement level (continuous care, intended only for intensive "ramp-up" and "ramp-down" hospice care).

Based on the above findings, the report recommends that CMS take the following actions:

1. Reform the payment system by tying payment rates to

beneficiaries' needs;

2. Target certain hospices for review, including hospices that:
    1. have a higher percentage of beneficiaries in ALFs;
    2. have a higher percentage of beneficiaries receiving extended hospice care;
    3. have a high incidence of low-complexity diagnoses (such as dementia, Alzheimer's Disease, or "adult failure to thrive"); or
    4. provide primarily low-complexity hospice services in ALFs, such as routine home care.
3. Develop claims-based quality measures to track the quantity and type of services hospice provided in ALFs;
4. Publish individual hospice reimbursement data (for example, on a "Hospice Compare" page on the Medicare website);
5. Provide expanded comparative information to hospices to educate hospices about how they compare to their peers.

While the report does not expressly accuse hospices of overbilling for ALF-based services, it does send a clear message that the OIG considers certain billing practices to be questionable. In response to the report, CMS has acknowledged that hospice reimbursement should be evaluated, but that further investigation will be necessary before it can implement many of the report's recommendations. Nevertheless, hospices are well-advised to review their ALF-based practices now to reduce the risk of becoming a target for CMS audits later.

References

[1] Office of Inspector General, *Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities* (2015), available at: http://oig.hhs.gov/oei/reports/oei-02-14-00070.pdf. Last accessed March 9, 2015.

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