

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE HOSPICES HAVE  
FINANCIAL INCENTIVES TO  
PROVIDE CARE IN ASSISTED  
LIVING FACILITIES**



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Inspector General

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# **EXECUTIVE SUMMARY: MEDICARE HOSPICES HAVE FINANCIAL INCENTIVES TO PROVIDE CARE IN ASSISTED LIVING FACILITIES**

## **OEI-02-14-00070**

### **WHY WE DID THIS STUDY**

Medicare hospice care is intended to help terminally ill beneficiaries continue life with minimal disruption and to support families and caregivers. Care may be provided in various settings, including a private home or other places of residence, such as an assisted living facility (ALF). Pursuant to the Patient Protection and Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) must reform the hospice payment system, collect data relevant to revising payments, and develop quality measures. This report provides information to inform those decisions and is part of the Office of Inspector General's (OIG) larger body of work on hospice care. While the report focuses on ALFs, many of the issues identified pertain to the hospice benefit more broadly.

### **HOW WE DID THIS STUDY**

We based this study on an analysis of all Medicare hospice claims from 2007 through 2012. We used Certification and Survey Provider Enhanced Reports data and Healthcare Cost Report Information System reports for information on hospice characteristics.

### **WHAT WE FOUND**

Medicare payments for hospice care in ALFs more than doubled in 5 years, totaling \$2.1 billion in 2012. Hospices provided care much longer and received much higher Medicare payments for beneficiaries in ALFs than for beneficiaries in other settings. Hospice beneficiaries in ALFs often had diagnoses that usually require less complex care. Hospices typically provided fewer than 5 hours of visits and were paid about \$1,100 per week for each beneficiary receiving routine home care in ALFs. Also, for-profit hospices received much higher Medicare payments per beneficiary than nonprofit hospices. This report raises concerns about the financial incentives created by the current payment system and the potential for hospices to target beneficiaries in ALFs because they may offer the hospices the greatest financial gain. Together, 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.

### **WHAT WE RECOMMEND**

We recommend that CMS, as part of its ongoing hospice reform efforts: (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, (3) develop and adopt claims-based measures of quality, (4) make hospice data publicly available for beneficiaries, and (5) provide additional information to hospices to educate them about how they compare to their peers. CMS concurred with all five recommendations.

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## OBJECTIVES

1. To describe the trends in Medicare payments for hospice care provided in assisted living facilities (ALFs).
2. To describe the characteristics of beneficiaries who receive hospice care in ALFs.
3. To determine the types and frequency of hospice services provided to beneficiaries residing in ALFs.
4. To determine the extent to which some hospices receive a high percentage of their Medicare reimbursement from care provided in ALFs.

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## BACKGROUND

The goals of hospice care are to help terminally ill beneficiaries with a life expectancy of 6 months or less 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 a skilled nursing facility; a private home; or other places of residence, such as an ALF.

Little is known about hospice care provided in ALFs; however, some concerns exist. According to the Medicare Payment Advisory Commission (MedPAC),<sup>1</sup> long hospice stays among ALF residents are not understood and bear further monitoring and examination.<sup>2</sup> MedPAC also found that, under the current payment system for Medicare hospice, very long stays in hospice care are more profitable for providers than shorter stays.<sup>3</sup> Hospices are paid a daily rate for every day a beneficiary is in hospice care, regardless of whether services are provided on a particular day. Therefore, a hospice stands to gain financially if it provides minimal services to a beneficiary over a long period of time.

Pursuant to the Patient Protection and Affordable Care Act (ACA), the Centers for Medicare & Medicaid Services (CMS) must reform the hospice payment system, collect data relevant to revising hospice payments, and develop quality measures for hospices.<sup>4</sup> This report provides data that will help inform CMS's decisions as it fulfills these ACA requirements.

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<sup>1</sup> MedPAC is an independent Congressional agency that advises Congress on issues affecting the Medicare program.

<sup>2</sup> MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2012, ch. 11.

<sup>3</sup> MedPAC, *Report to the Congress: Reforming the Delivery System*, June 2008, ch. 8.

<sup>4</sup> ACA, P.L. 111-148, §§ 3004(c) and 3132.

This report is part of the Office of Inspector General's (OIG's) larger body of work on hospice care. While it focuses on ALFs, many of the issues in this report pertain to the hospice benefit more broadly. They are similar to those that both OIG and MedPAC have identified in other hospice settings, such as nursing facilities.<sup>5</sup>

### **The Medicare Hospice Benefit**

To be eligible for Medicare hospice care, a beneficiary must be entitled to Medicare Part A and be certified as having a terminal illness with a life expectancy of 6 months or less if the disease runs its normal course. Upon a beneficiary's election of hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary's terminal illness and related conditions. This care is palliative, rather than curative. It includes, among other things, nursing care, medical social services, hospice aide services, medical supplies (including drugs and biologicals), and physician services. The beneficiary waives all rights to Medicare payment for services related to the curative treatment of the terminal condition or related conditions but retains rights to Medicare payment for services to treat conditions unrelated to the terminal illness.<sup>6</sup> Beneficiaries may revoke their election of hospice care and return to standard Medicare coverage at any time.<sup>7</sup>

Beneficiaries are entitled to receive hospice care for two 90-day periods, followed by an unlimited number of 60-day periods.<sup>8</sup> The benefit periods need not be consecutive. At the start of each period of care, a hospice physician must certify that the beneficiary is terminally ill and has a life expectancy of 6 months or less. Beginning in 2011, for the third and all subsequent benefit periods, a hospice physician or hospice nurse practitioner must perform a face-to-face visit and explain why the clinical

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<sup>5</sup> OIG, *Medicare Hospices That Focus on Nursing Facility Residents*, OEI-02-10-00070, July 2011; MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2013, ch. 5.

<sup>6</sup> CMS has developed the Medicare Care Choices Model, a demonstration program that will allow certain beneficiaries to receive palliative care services from certain hospice providers while concurrently receiving services provided by their curative care providers. The Model will enable CMS to study whether access to such services improves quality of life, increases patient satisfaction, and reduces Medicare expenditures.

<sup>7</sup> Social Security Act, §§ 1812(d)(2), 1814(a)(7)(A) and 1861(dd)(1), 42 U.S.C. §§ 1395d(d)(2), 1395f(a)(7)(A), and 1395x(dd)(1); 42 CFR §§ 418.20, 418.22, 418.24(d) and 418.28.

<sup>8</sup> Social Security Act, § 1812(a)(4), 42 U.S.C. § 1395d(a)(4); 42 CFR § 418.21. Prior to 1990, Medicare provided hospice coverage for a maximum of 210 days.

findings support a life expectancy of 6 months or less.<sup>9</sup> For care to be covered under Part A, hospices must be certified by Medicare.<sup>10</sup>

The Medicare hospice benefit has four levels of care: routine home care, continuous home care, general inpatient care, and inpatient respite care. Not all levels of care are allowed in all settings. For instance, routine home care and continuous home care are allowed in ALFs, but general inpatient care and inpatient respite care are not.

Each level has an all-inclusive daily rate that is paid through Part A. For continuous home care, the hospice is paid an hourly rate based upon the number of hours of continuous care furnished to the beneficiary on that day.<sup>11</sup> For all other levels of care, the daily rate is paid to the hospice for each day that a beneficiary is in hospice care, regardless of the amount of services furnished on a particular day. The rates are adjusted on the basis of the beneficiary’s geographic location. See Table 1 for the unadjusted payment rates for each level of care in fiscal year (FY) 2012.

**Table 1: Unadjusted Daily Medicare Hospice Payment Rates by Level of Care, FY 2012**

Level of Care	Unadjusted FY 2012 Rate
Routine Home Care	\$151.03
Continuous Home Care	\$881.46
General Inpatient Care	\$671.84
Inpatient Respite Care	\$156.22

Source: CMS, “Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and the Hospice Pricer for FY 2012,” Transmittal 2260, Change Request 7518, July 29, 2011.

Routine home care is the most common level of hospice care provided. Medicare reimburses the hospice at this rate for each day that the beneficiary is under the care of the hospice and is not receiving one of the other levels of care. Continuous home care is allowed only during brief periods of crisis (i.e., when a beneficiary requires continuous home care to achieve palliation or management of acute medical symptoms) and only as necessary to maintain the individual at home. General inpatient care is for pain control or symptom management that cannot be managed in other

<sup>9</sup> Social Security Act, § 1814(a)(7)(D), 42 U.S.C. § 1395f(a)(7)(D); 42 CFR §§ 418.22(a)(4) and (b)(3)(v).

<sup>10</sup> Social Security Act, §§ 1814(a) and 1866, 42 U.S.C. §§ 1395f(a) and 1395cc.

<sup>11</sup> The daily continuous home care rate is divided by 24 hours to determine an hourly rate. A minimum of 8 hours of predominantly nursing care must be provided. CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 11, § 30.1.

settings, such as the beneficiary's home.<sup>12</sup> Inpatient respite care is short-term inpatient care provided to the beneficiary when necessary to relieve the beneficiary's caregiver(s).<sup>13</sup>

Some physician services relating to the terminal illness are paid separately, in addition to the daily rate.<sup>14</sup> If the beneficiary's attending physician is an employee of or is under contract with the hospice provider, Medicare pays the hospice for physician services under Part A and the hospice compensates the physician through salary or some other arrangement.<sup>15</sup> In these instances, the Part A hospice claim will include a code for physician services in a line item separate from the daily rate.

### **Hospice Utilization in ALFs**

ALFs cover a wide range of facility types and care types and are typically for seniors who need some assistance with daily living. No Medicare standards for ALFs exist; each State defines and regulates ALFs differently. Some ALFs may be referred to as "adult foster homes" or "residential care facilities." ALFs generally provide housekeeping services, meals, and assistance with activities of daily living.

Given the lack of consistent terminology, policymakers have had difficulty identifying the number of ALFs and the total number of beds in ALFs. A report by the AARP Public Policy Institute estimated the number of beds in these types of facilities in 2010 to be 1.2 million.<sup>16</sup> AARP also cited an earlier study by the Assistant Secretary for Planning and Evaluation that reported almost 1 million ALF beds in 2007.

Many Medicare beneficiaries reside in ALFs, but Medicare does not pay for ALF services. However, Medicaid may pay for ALF services for Medicaid beneficiaries under certain circumstances, such as a home and community-based waiver.<sup>17</sup>

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<sup>12</sup> 42 CFR § 418.302(b)(4). It is intended to be short-term and may be provided in one of three settings: a Medicare-certified hospice inpatient unit, a hospital, or a skilled nursing facility. See 42 CFR § 418.108.

<sup>13</sup> 42 CFR § 418.302(b); 42 CFR § 418.204(a) (defining "periods of crisis"); and CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 11, § 30.1.

<sup>14</sup> 42 CFR § 418.304. While the daily rate includes hospice physicians' medical director supervisory services and administrative services, including plan of care services, other physician services are billed separately.

<sup>15</sup> A nurse practitioner can be designated as the attending physician. See 42 CFR § 418.304(e)(1).

<sup>16</sup> Robert Mollica, Ari Houser, and Kathleen Ujvari, AARP Public Policy Institute, *Insight on the Issues: Assisted Living and Residential Care in the States in 2010*, July 2012, p. 1. Accessed at [http://www.aarp.org/content/dam/aarp/research/public\\_policy\\_institute/ltc/2012/residential-care-insight-on-the-issues-july-2012-AARP-ppi-ltc.pdf](http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/residential-care-insight-on-the-issues-july-2012-AARP-ppi-ltc.pdf) on August 7, 2014.

<sup>17</sup> For information on Medicaid reimbursement to ALFs, see OIG, *Home and Community-Based Services in Assisted Living Facilities*, OEI-09-08-00360, December 2012.

Medicare pays hospices for certain levels of hospice care provided in ALFs. The hospice agency is responsible for providing the hospice care. Medicare currently pays hospices the same rate for those levels of care provided in ALFs as it does for other settings, such as private homes.

### **Changes to Hospice Benefit**

ACA requires CMS to reform the hospice payment system no earlier than October 2013.<sup>18</sup> CMS is gathering information and conducting studies as it considers payment reform options. Also, ACA established a quality reporting program for hospices.<sup>19</sup> CMS must develop quality measures for hospices, and hospices must report these data to CMS. Hospices began using the Hospice Item Set (HIS) in July 2014 to collect and submit standardized data on each patient they admit and discharge. The HIS will be used to calculate quality measures involving pain management and other treatment issues. In addition, CMS will begin implementing the hospice Experience of Care Survey in 2015 to gather information on the experiences of hospice patients and their caregivers with hospice services.<sup>20</sup>

### **Related Work**

This report is part of OIG's continuing work on Medicare hospice care. In 2013, OIG found 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.<sup>21</sup>

In 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.<sup>22</sup> Another report determined that Medicare paid an average of \$960 per week for hospice care for each beneficiary in a nursing facility in 2006.<sup>23</sup> This care most commonly included nursing, home health aide (also known as hospice aide), and medical social services. Hospices provided an average of 4.2 visits per week for these three services combined.

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<sup>18</sup> ACA, P.L. 111-148 § 3132.

<sup>19</sup> ACA, P.L. 111-148 § 3004(c).

<sup>20</sup> 78 Fed. Reg. 48234, 48257-62 (Aug. 7, 2013). CMS plans to develop additional measures to be used in future years.

<sup>21</sup> OIG, *Medicare Hospice: Use of General Inpatient Care*, OEI-02-10-00490, May 2013.

<sup>22</sup> OIG, *Medicare Hospices That Focus on Nursing Facility Residents*, OEI-02-10-00070, July 2011.

<sup>23</sup> 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.



OIG also has conducted several studies identifying inappropriate Medicare payments in hospice. In 2009, OIG found that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements.<sup>24</sup> In addition, in a 2008 report, OIG identified a number of cases in which the use of inpatient respite care for beneficiaries in nursing facilities may have been inappropriate.<sup>25</sup>

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## METHODOLOGY

We used data from three sources: (1) National Claims History file for Medicare hospice claims, (2) Certification and Survey Provider Enhanced Reports (CASPER) data to describe hospice characteristics (e.g., for-profit or nonprofit), and (3) Healthcare Cost Report Information System reports for supplementary information on hospice characteristics (e.g., when CASPER did not indicate a hospice's ownership status).

We analyzed all Medicare hospice claims from 2007 (the first year that hospice claims indicated place of service) through 2012. We used the Healthcare Common Procedure Coding System (HCPCS) codes on the claims to identify the setting where the care was provided, such as an ALF, private home, or nursing facility. We determined total Medicare spending on hospice and the amount and percentage of Medicare spending for hospice care provided in ALFs for each year. We compared the increase in and total spending on hospice care provided in ALFs to hospice care provided in all other settings.

Next, we identified the beneficiaries who received care in ALFs in 2012. We used the claims from 2007 through 2012 to determine their total time in hospice care. We used the HCPCS codes on the claims to identify the primary settings where the beneficiaries received hospice care. The primary setting is where the beneficiary spent more of his or her time from 2007 through 2012. For the purposes of this report, we refer to beneficiaries who spent more of their time in hospice care in ALFs than in any other setting as "beneficiaries in ALFs." We determined the median amount Medicare paid and the median number of days in hospice care per beneficiary for each of the main settings in which hospice care was provided. These settings include: ALFs, nursing facilities, private homes, and skilled nursing facilities.

We then determined the extent to which beneficiaries in ALFs (those beneficiaries whose primary setting was an ALF) had long lengths of stay

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<sup>24</sup> OIG, *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance With Medicare Coverage Requirements*, OEI-02-06-00221, September 2009.

<sup>25</sup> OIG, *Hospice Beneficiaries' Use of Respite Care*, OEI-02-06-00222, March 2008.

on hospice care. We calculated the percentages of these beneficiaries who received care between 180 and 365 days and more than 365 days. We compared these results to results for beneficiaries in other settings. We also determined how the most common terminal illnesses of beneficiaries in ALFs differed from those of beneficiaries in other settings and which illnesses were associated with less complex care.<sup>26</sup>

Next, we determined the percentage of days that hospices provided routine home care and continuous home care in ALFs. We then analyzed the number of visits that hospices provided in ALFs in 2012 to beneficiaries receiving routine home care. These visits were for nursing, hospice aide, and medical social services. We determined the average number of hours of visits provided to beneficiaries per week, as well as the way in which these hours were distributed on different days of the week. We also determined what percentage of beneficiaries received visits while in ALFs from hospice physicians and how many hospices provided these types of visits.

We analyzed the extent to which hospice care provided in ALFs differed on the basis of the ownership status of the hospice. We used CASPER to determine the ownership status of the hospice.<sup>27</sup> When CASPER did not indicate the hospice's ownership status, we used Healthcare Cost Report Information System reports. For hospices that provided care in ALFs, we analyzed payments and days on hospice by ownership status.

Lastly, we determined the extent to which some hospices received a high percentage of their Medicare reimbursement from care provided in ALFs. This analysis was limited to hospices that provided care in ALFs to at least 10 beneficiaries in 2012. We identified the hospices that had more than half of their Medicare payment amounts from care provided in ALFs as those targeting ALFs. We then described the characteristics of these hospices, including their ownership status, their locations, and their sizes.<sup>28</sup> We also grouped these hospices into national chains on the basis of the hospice names and information on their public Web sites.

### **Limitations**

Medicare hospice claims do not include any information about the ALFs where services were provided. Also, information about ALFs, such as the

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<sup>26</sup> On the basis of their terminal illnesses, we compared the complexity of hospice care that beneficiaries received. We considered hospice care less complex if beneficiaries were less likely to have received the general inpatient or continuous home levels of care.

<sup>27</sup> For beneficiaries who received care from more than one hospice, we used the ownership status of the hospice that provided most of the beneficiary's care.

<sup>28</sup> We considered a hospice to be large if it provided care to more than 320 Medicare beneficiaries in 2012, medium if it provided care to between 91 and 320 Medicare beneficiaries, and small if it provided care to 90 or fewer beneficiaries.

name, size, and services available, is not available on a national basis. For this reason, we could not make any statements about the characteristics of ALFs where hospice care was provided.

For this report, we present information on the types and frequencies of services provided by hospices in ALFs. We did not assess eligibility status for the hospice benefit or assess whether services were appropriate.

### **Standards**

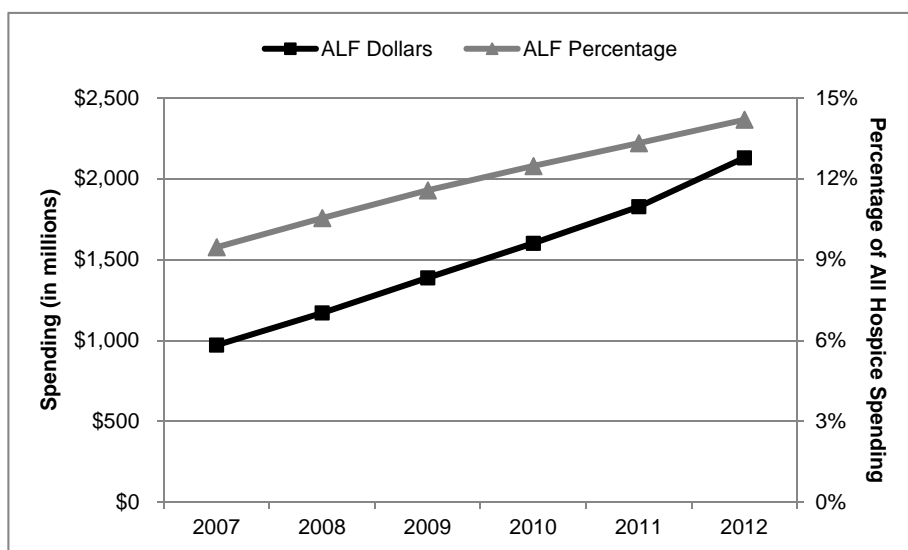
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

## FINDINGS

### Medicare payments for hospice care in ALFs more than doubled in 5 years, totaling \$2.1 billion in 2012

Medicare paid \$2.1 billion for hospice care provided in ALFs in 2012, an increase of 119 percent since 2007. See Figure 1. During that time, Medicare spending for hospice care provided in settings other than ALFs increased 38 percent, from \$9.3 billion to \$12.9 billion.<sup>29</sup> Overall, Medicare spending for all hospice care increased 46 percent, from \$10.3 billion to \$15.0 billion.

Figure 1: Medicare Hospice Spending in ALFs, 2007-2012



Source: OIG analysis of CMS data, 2013

In 2012, Medicare payments for care in ALFs accounted for 14 percent of total Medicare spending on hospice care. Ten percent of Medicare hospice beneficiaries received at least some care in ALFs. Seventy-three percent of Medicare hospices provided care in ALFs during the year.

### Hospices provided care much longer and received much higher Medicare payments for beneficiaries in ALFs

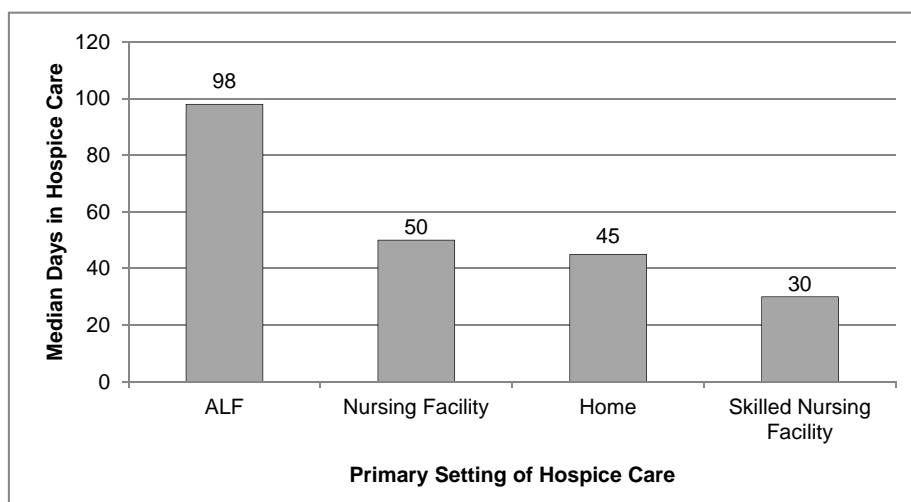
Of those who received hospice care in 2012, a total of 120,444 beneficiaries received care primarily in ALFs. That is, they spent more of their time in hospice care in ALFs than in any other setting from

<sup>29</sup>Medicare spending for hospice care provided in settings other than ALFs increased from \$9,293,069,781 in 2007 to \$12,868,920,994 in 2012.

2007 through 2012.<sup>30</sup> The vast majority of these beneficiaries were in ALFs for at least 90 percent of their time in hospice care.

Hospices provided care to beneficiaries in ALFs much longer than to beneficiaries in any other setting. Beneficiaries in ALFs received hospice care for a median of 98 days, which is almost twice as long as that received by beneficiaries in nursing facilities and more than twice as long as that received by beneficiaries at home. See Figure 2.

**Figure 2: Median Days in Hospice Care per Beneficiary, by Setting**



Source: OIG analysis of CMS data, 2013.

Note: Includes beneficiaries who received hospice care in 2012.

Includes beneficiaries' total time in hospice care from 2007 through 2012

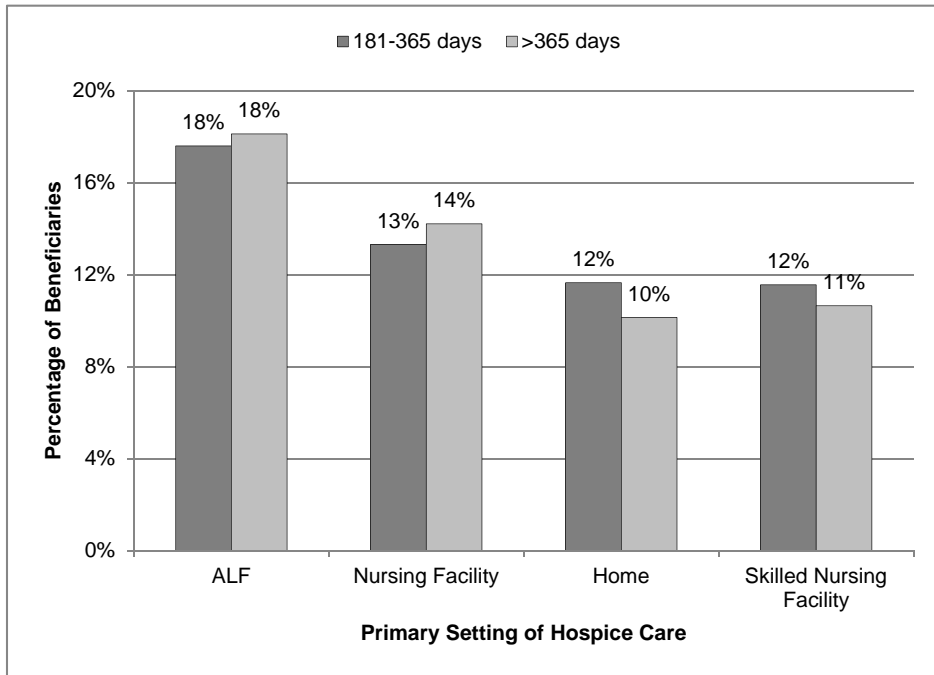
***Over one-third of beneficiaries in ALFs received hospice care for more than 180 days***

Beneficiaries in ALFs were the most likely to have very long stays in hospice care. Thirty-six percent of beneficiaries in ALFs spent more than 180 days in hospice care, compared to 28 percent of beneficiaries in nursing facilities and 22 percent of beneficiaries at home. See Figure 3.

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<sup>30</sup> Hereafter, we refer to these beneficiaries as “beneficiaries in ALFs.”

**Figure 3: Percentage of Beneficiaries With Long Lengths of Stay, by Setting**



Source: OIG analysis of CMS data, 2013.

Note: Includes beneficiaries who received hospice care in 2012.

Includes beneficiaries' total time in hospice care from 2007 through 2012.

Because of rounding, the percentages in the table do not sum to the percentages referenced in the text.

Eighteen percent of beneficiaries in ALFs received hospice care for more than a year. In comparison, 14 percent of beneficiaries in nursing facilities and 10 percent of beneficiaries at home received hospice care for more than a year. Five percent of beneficiaries in ALFs received hospice care for 2 years or more.

***Medicare paid twice as much for care for beneficiaries in ALFs than for beneficiaries in other settings***

Medicare paid much more for hospice care provided to beneficiaries in ALFs than for hospice care provided to beneficiaries in other settings. The median amount Medicare paid for hospice care provided from 2007 through 2012 to beneficiaries in ALFs was \$16,195, more than twice as much as the median amounts for beneficiaries in nursing facilities and beneficiaries at home. See Table 2.

**Table 2: Medicare Payments per Beneficiary, by Setting**

Primary Setting of Hospice Care	Number of Beneficiaries	Median Payment per Beneficiary
ALF	120,444	\$16,195
Nursing Facility	195,820	\$8,077
Home	673,312	\$7,526
Skilled Nursing Facility	87,282	\$5,635

Source: OIG analysis of CMS data, 2013.

Note: Includes beneficiaries who received hospice care in 2012.

Includes payments made during beneficiaries' total time in hospice care from 2007 through 2012.

The long lengths of stay in hospice care for beneficiaries in ALFs explain the higher Medicare payments for these beneficiaries. Medicare payments are a function of time spent in hospice care. Medicare pays a hospice for every day starting from the day a beneficiary elects hospice care and ending with the day of discharge, regardless of the amount of services furnished on a particular day.

### **Most beneficiaries in ALFs had diagnoses that typically require less complex care**

Sixty percent of beneficiaries who received care primarily in ALFs had diagnoses of ill-defined conditions, mental disorders, or Alzheimer's disease as their terminal illness.<sup>31</sup> Mental disorders include dementia. Ill-defined conditions include, among other things, adult failure to thrive, senility without psychosis, and unspecified debility.<sup>32</sup> Beneficiaries with these types of diagnoses typically receive less complex hospice care than beneficiaries with other diagnoses.

Beneficiaries in ALFs were six times more likely to have these diagnoses than a diagnosis of cancer. Beneficiaries with cancer often require complex care and receive hospice care for substantially fewer days than beneficiaries with diagnoses such as ill-defined conditions.

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<sup>31</sup> The International Classification of Diseases, 9<sup>th</sup> 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."

<sup>32</sup> Beginning on October 1, 2014, hospices are no longer allowed to report debility or adult failure to thrive as a beneficiary's principal diagnosis. Hospices will be able to indicate these diagnoses as secondary, but CMS will require hospices to identify a more definitive principal diagnosis. See 78 Fed. Reg. 48234, 48246 (Aug. 7, 2013).

Beneficiaries in ALFs were more likely than beneficiaries in any other settings to have diagnoses of ill-defined conditions, mental disorders, or Alzheimer’s disease. The largest difference was between beneficiaries in ALFs and beneficiaries in the home. Beneficiaries in ALFs were more than twice as likely as beneficiaries in the home to have one of these diagnoses. They were also far less likely than beneficiaries in the home to have a diagnosis of cancer. See Table 3.

**Table 3: Medicare Beneficiaries’ Terminal Illness Diagnoses, by Setting**

Primary Setting of Hospice Care	Percentage of Beneficiaries With Diagnoses of Ill-Defined Conditions, Mental Disorder, or Alzheimer’s Disease	Percentage of Beneficiaries With Diagnosis of Cancer
ALF	60%	10%
Nursing Facility	54%	13%
Skilled Nursing Facility	52%	15%
Home	27%	38%

Source: OIG analysis of CMS data, 2013.

Note: Includes beneficiaries who received hospice care in 2012.

### **Hospices typically provided fewer than 5 hours of visits per week and were paid about \$1,100 per week for each beneficiary receiving routine home care in an ALF**

Routine home care accounted for nearly all the care hospices provided in ALFs in 2012. Hospices billed for routine home care for 99 percent of the days they provided care in ALFs during the year.<sup>33</sup> Medicare paid an average of \$156 per day for this care, amounting to \$1,091 per week for a beneficiary receiving routine home care in an ALF. Hospices provided an average of 4.8 hours of visits per week to these beneficiaries. These visits ranged from 0 to 66 hours per week.

In addition to covering visits and services such as care planning, the daily payment covers medical appliances and supplies, including drugs that are used primarily for the relief of pain and symptom control related to the individual's terminal illness or related conditions. Hospices are required to provide these services as needed. A hospice is paid for every day a beneficiary is under its care, regardless of how many services it provides.

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<sup>33</sup> Hospices billed for continuous home care for the remaining 1 percent of days.

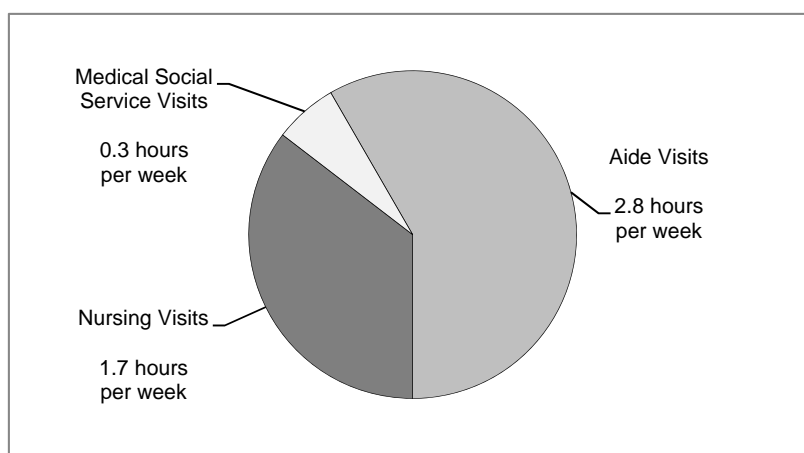


Twenty-five hospices did not report making any visits to their beneficiaries receiving routine care in ALFs in 2012. This involved 210 beneficiaries. The hospices received a total of \$2.3 million from Medicare for these beneficiaries.

### ***Hospices provided mostly aide visits***

Most hospice visits were from aides. On average, of the 4.8 hours of visits per week to beneficiaries, 2.8 hours were for hospice aide services, 1.7 hours were for nursing services, and 0.3 hours were for medical social services. See Figure 4. Nursing and medical social services are core hospice services.<sup>34</sup> Hospice aide services include personal care services, such as bathing, and household services, such as light cleaning and laundering.

**Figure 4: Average Hours per Week of Hospice Visits Provided to Beneficiaries Receiving Routine Home Care in ALFs, 2012**



Source: OIG analysis of CMS data, 2013.

### ***Hospice physicians rarely saw beneficiaries who received care in ALFs***

The daily rate Medicare pays to hospices includes general supervisory services and plan of care services by hospice physicians. Other services by hospice physicians are billed separately. In 2012, hospices billed physician services for 20 percent of the beneficiaries they served in ALFs. Therefore, 80 percent of beneficiaries were not provided hospice physician services while they were in ALFs other than supervisory and/or care

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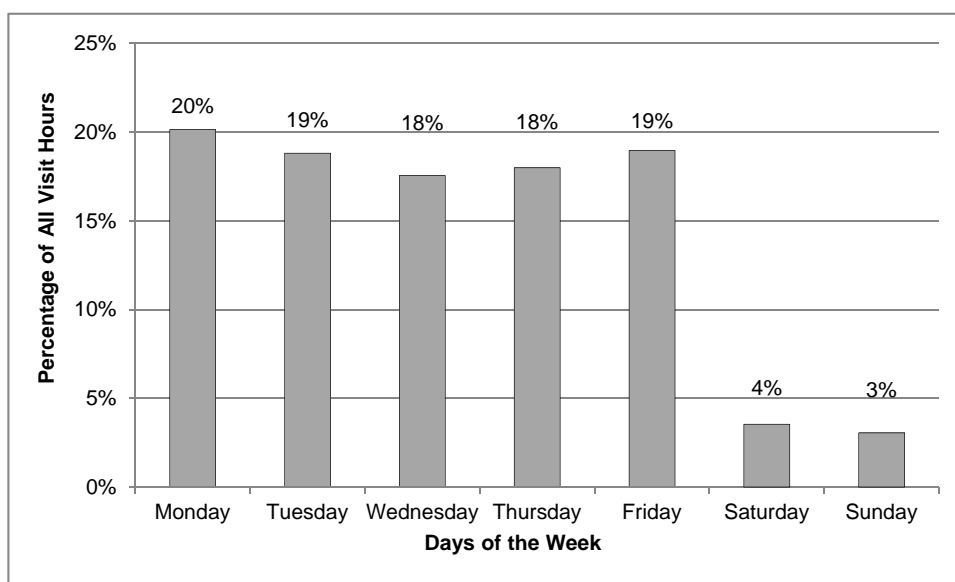
<sup>34</sup> A hospice must routinely provide substantially all core services directly by hospice employees. 42 CFR § 418.64.

planning services. Two-thirds of hospices did not provide other physician services to any of the beneficiaries they served in ALFs in 2012.

### ***Hospices seldom provided services in ALFs on weekends***

Hospices must make services available, as needed, on a 24-hour basis.<sup>35</sup> In 2012, hospices provided the great majority of their visits in ALFs during the workweek and rarely on weekends. Specifically, between 18 and 20 percent of visit hours in ALFs were provided on each of the weekdays. In contrast, only four percent of the hours were provided on Saturdays and three percent on Sundays. See Figure 5.

**Figure 5: Percentage of Visit-Hours Provided to Beneficiaries Receiving Routine Home Care in ALFs by Day of the Week, 2012**



Source: OIG analysis of CMS data, 2013.

Note: Totals do not sum to 100 percent because of rounding.

### **For-profit hospices received much higher Medicare payments per beneficiary than nonprofit hospices**

In 2012, there were 2,709 Medicare hospices that provided care in ALFs. Of these, 62 percent were for-profit and 33 percent were nonprofit.<sup>36</sup> For-profit hospices received a total of \$1.4 billion for care in ALFs in 2012.

<sup>35</sup> Social Security Act, § 1861(dd)(2)(A)(i), 42 U.S.C. § 1395x(dd)(2)(A)(i).

<sup>36</sup> The remaining hospices either were Government owned or were categorized as “Other.”

For-profit hospices received thousands of dollars more than nonprofits per beneficiary in ALF. The median amount Medicare paid for-profit hospices was \$18,261 per beneficiary in ALF for care from 2007 through 2012. In comparison, the median for nonprofits was \$13,941.

Beneficiaries in ALFs who were served by for-profit hospices were in hospice care longer than those who were served by nonprofit hospices. The median time in hospice care for the for-profit hospices' beneficiaries was almost 4 weeks longer than the median for nonprofit hospices. The median for for-profit hospices was 111 days, in contrast to the median of 85 days for nonprofit hospices. See Table 4.

**Table 4: Median Days in Hospice per Beneficiary in ALF by Hospice Ownership**

Hospice Ownership	Number of Beneficiaries	Median Days in Hospice
For Profit	72,627	111
Nonprofit	44,238	85
Government	2,317	67
Other	1,097	71

Source: OIG analysis of CMS data, 2013.

Note: Includes beneficiaries who received hospice care in 2012 and were primarily in ALFs.

Includes beneficiaries' total time in hospice care from 2007 through 2012.

We were unable to determine the hospices' ownership for 165 beneficiaries in ALFs.

In addition, for-profit hospices received a higher percentage of their Medicare reimbursement from care in ALFs. In 2012, for-profit hospices received a median of 11 percent of their Medicare reimbursement for care provided in ALFs, compared to 7 percent for nonprofit hospices.

***Some for-profit hospices stand out for their use of the most expensive level of hospice care***

Continuous home care is the most expensive level of hospice care and is rarely provided in ALFs. However, one large national for-profit chain stands out for its use of continuous home care in ALFs. In 2012, hospices in this chain received far more Medicare payments for continuous home care in ALFs than all other hospices combined. Hospices in this chain received a total of \$41.7 million for continuous home care in ALFs, which is 64 percent of all Medicare payments for this level of care in ALFs during the year. In comparison, the hospices in this chain received 11 percent of Medicare payments for all routine home care provided in ALFs during the year.

## **Many for-profit hospices targeted ALFs**

Ninety-seven hospices relied on ALFs for most of their Medicare payments. For these hospices, care provided in ALFs accounted for more than half of the Medicare payments they received in 2012. The majority of these (90 of 97) were for-profit hospices.

Medicare paid these for-profit hospices \$193 million in 2012 for care provided in ALFs. Most of the hospices were medium or large in size, serving at least 150 Medicare hospice beneficiaries during the year.

Almost half of the 90 hospices were part of hospice chains. Notably, eight of the nine hospices with the highest Medicare payment amounts for care provided in ALFs were part of hospice chains. In 2012, Medicare paid each of these hospices between \$4.6 million and \$12.2 million for care provided in ALFs.

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## CONCLUSION AND RECOMMENDATIONS

While the growth in ALFs in general appears limited, Medicare spending for hospice care in ALFs more than doubled over 5 years to \$2.1 billion in 2012. Hospices provided care much longer and received much higher Medicare payments for beneficiaries in ALFs than for beneficiaries in other settings. Hospice beneficiaries in ALFs often had diagnoses that usually require less complex care. Hospices typically provided fewer than 5 hours of visits per week and were paid about \$1,100 per week for each beneficiary receiving routine home care in ALFs. Also, for-profit hospices received much higher Medicare payments per beneficiary than nonprofit hospices, and many for-profit hospices targeted ALFs.

This 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. It also raises questions about whether Medicare is paying appropriately for hospice care in ALFs and whether beneficiaries are receiving the services they need during their last months of life. We have identified similar concerns in other parts of the benefit. Notably, a previous OIG report raised these concerns regarding beneficiaries in nursing facilities. Previous OIG reports also have found that hospices often did not provide the number of services outlined in the plans of care they established and that several hundred hospices did not provide any level of hospice care other than routine home care.

Together, 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. Hospice is an important benefit for Medicare beneficiaries and should be appropriately safeguarded.

We recommend that CMS, as part of its ongoing hospice reform efforts:

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

Under ACA, CMS is required to reform the hospice payment system. These reforms should be structured to reduce the incentive for hospices to target certain beneficiaries and ensure that hospices are providing high quality care to those who are eligible. One way to do this is to tie payment rates to beneficiaries' needs.

Currently, 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, psychosocial, emotional, and spiritual care. These needs and others that affect the care a beneficiary requires could be considered in setting payment rates.

### **Target certain hospices for review**

CMS should focus its reviews on certain hospices. These should include hospices that receive a high percentage of their payments from providing care to beneficiaries in ALFs, 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.

CMS should include these measures in its Fraud Prevention System to identify these hospices for further review.

### **Develop and adopt claims-based measures of quality**

To meet ACA requirements, CMS has adopted several quality measures that will be calculated using data collected and reported by hospices. Currently, these measures address pain management and other treatment matters. In addition, CMS should develop and adopt measures that address issues raised in this report. These additional measures would be based on information obtained from claims submitted by hospices for Medicare payment. As discussed in MedPAC's report to Congress, hospice experts have also supported a claims-based approach. 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.

### **Make hospice data publicly available for beneficiaries**

For a variety of other types of providers, CMS provides information to beneficiaries and the public on the Medicare.gov Web site. CMS should do the same for hospices. 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 Web site. This could include information similar to the information included in this report, but for individual hospices. For example, it 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.

This information would enable beneficiaries, their caregivers, and the public to compare hospices. It also would educate them about the benefit

and help them make informed choices about which hospices best meet their needs.

**Provide additional information to hospices to educate them about how they compare to their peers**

CMS provides hospices with comparative information annually in its Program for Evaluating Payment Patterns Electronic Reports. The goal of these reports is to help hospices guide their internal auditing and monitoring activities. Currently, however, CMS includes only two target areas in these reports: live discharges and long lengths of stay.

CMS should provide hospices with additional information to further educate them about how they compare with other Medicare hospices. 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.

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## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In comments on our draft report, CMS concurred with all five of our recommendations.

CMS concurred with our first recommendation, to reform payments to reduce the incentive for hospices to target beneficiaries with certain diagnoses and those likely to have long stays. CMS stated that it is analyzing possible reform options that focus on new payment models as a result of recommendations from MedPAC. MedPAC has recommended 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. In addition, we encourage CMS to consider other options, particularly those that tie the specific needs of the beneficiary—as identified in the beneficiary's comprehensive assessment—to payment rates and take into account the number and types of hospice visits and services needed, regardless whether they are at the beginning or end of the beneficiary's time in hospice care.

CMS concurred with our second recommendation, to target certain hospices for review. It stated that it supports the development of Fraud Protection System models targeting hospices that have a high percentages of beneficiaries who rarely receive visits, as well as considering hospices that provide high percentages of their beneficiaries at the continuous care level.

CMS concurred with our third recommendation, to develop and adopt claims-based measures of quality. CMS stated that it will consider including claims-based measures as part of its measure development, such as 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.

CMS concurred with our fourth recommendation, to make hospice data publicly available for beneficiaries. CMS stated that it plans to publicly report data from the Hospice Item Set as well as any future measures to be developed in the Hospice Quality Reporting Program. We support these plans and reiterate that while CMS continues to develop and test quality measures, it should take the interim step of making available to the public claims-based hospice data regarding the number and types of services a hospice provides, including physician services and services on the weekend.

Lastly, CMS concurred with our fifth recommendation, to provide additional information to hospices to educate them about how they



compare to their peers. CMS stated that the development and implementation of a standardized data set for hospices must precede providing information to hospices about how they compare to their peers or for public reporting of hospice quality measures. CMS said that hospice review and public reporting may occur during the FY 2018 Annual Payment Update Year. We urge CMS to consider analyzing and making available measures based on the claims data as a first step so that hospices have some ability to see how they compare to their peers more immediately.

The full text of CMS's comments is provided in Appendix A.

## APPENDIX A

### Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** OCT 27 2014

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** Marilyn Tavenner */S/*  
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities (OEI-02-14-00070)

Thank you for the opportunity to review and comment on the above-subject OIG draft. The objective of this study was to describe the trends in Medicare payments for hospice care provided in assisted living facilities (ALFs), to describe the characteristics of beneficiaries who receive hospice care in ALFs, to determine the types and frequency of hospice services provided to beneficiaries residing in ALFs, and to determine the extent to which some hospices receive a high percentage of their Medicare reimbursement from care provided in ALFs.

The OIG recommendation and the Centers for Medicare & Medicaid Services' (CMS) response are discussed below.

#### **OIG Recommendation**

The OIG recommends that CMS reform payments to reduce the incentive for hospices to target beneficiaries with certain diagnoses and those likely to have long stays.

#### **CMS Response**

The CMS concurs with the recommendation, which directly aligns with CMS' charge under the Affordable Care Act, to reform the hospice payment system, collect data relevant to revising hospice payments, and develop quality measures for hospices. OIG's report provides useful data and related recommendations that will help inform CMS' decisions as it fulfills these Affordable Care Act requirements.

As part of its hospice payment reform efforts, CMS is working with several research contractors conducting comprehensive data analysis on hospice utilization trends. As a part of this analysis, our contractor developed a technical report titled, "Medicare Hospice Payment Reform: Analyses to Support Payment Reform", dated May 1, 2014 (hereafter, referred to as the May 2014 Technical Report). The May 2014 Technical Report, and an updated literature review, is available on our hospice center web page at <http://www.cms.gov/Center/Provider-Type/Hospice-Center.html> in the "Research and Analyses" section.

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As a result of MedPAC's recommendations in their June, 2013 Report to Congress on Medicare and the Health Care Delivery System, we are also analyzing possible reform options that focus on new payment models. These payment models recognize the changing needs of hospice beneficiaries throughout the course of a hospice election and adjust payment rates accordingly.

Effective April 1, 2014, hospices are now required to provide more specific information on hospice claims. Hospitals are required to report additional claims data to support payment reform, as authorized by Section 3132(a) of the Affordable Care Act. Additional data requirements include reporting visits for general inpatient care, the service facility National Provider Identifier where the service was performed when the service is not performed at the same location as the billing hospice's location, and use of infusion pumps and prescription drugs. The collection of this data will help to further identify beneficiary needs as we develop potential payment reform models.

**OIG Recommendation**

The OIG recommends that CMS target certain hospices for review.

**CMS Response**

The CMS concurs with this recommendation and specifically supports development of Fraud Protection System (FPS) models targeting hospices with a high percentage of beneficiaries who rarely receive hospice visits. Hospices providing no visits to high volumes of terminal patients should be considered high risk.

CMS also supports inclusion in FPS models the consideration of hospices which provide high percentages of patients at the continuous care level.

**OIG Recommendation**

The OIG recommends that CMS develop and adopt claims-based measures of quality.

**CMS Response**

The CMS concurs with the recommendation to develop and adopt claims-based measures of hospice quality. Earlier this year, a Technical Expert Panel met to review the results of an environmental scan of quality measures to support the future development of the Hospice Quality Reporting Program. As part of our measure development, we will consider including claims-based measures, such as "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."

**OIG Recommendation**

The OIG recommends that CMS make data publicly available for beneficiaries.

**CMS Response**

The CMS concurs with this recommendation -- which fits right into CMS' push for transparency -- for CMS to develop and share hospice data with the public. Plans are underway to publicly report data from the Hospice Item Set as well as any future measures to be developed in the HQR. Public reporting may occur during FY 2018 Annual Payment Update (APU) year. This will allow time for data analysis, review of the appropriateness of each measure for public reporting, as well as allow hospices the required time to review their own data prior to implementation. It is critical that CMS establish the reliability and validity of the measures prior to public reporting in order to demonstrate the ability of the measures to distinguish the quality of the services provided. In order to accomplish this, at least four quarters of data will need to be analyzed. CMS will announce the timeline for public reporting of data in future rulemaking and allow for public comment on what we should consider when developing future proposals related to public reporting.

**OIG Recommendation**

The OIG recommends that CMS provide additional information to hospices to educate them about how they compare to their peers.

**CMS Response**

The CMS concurs with the recommendation for providing hospices with additional information to educate them about how they compare with other Medicare hospices. We expect the information to be available soon and that it will help hospices and the public compare the performance of hospices. The development and implementation of a standardized data set for hospices must precede providing information to hospices about how they compare to their peers or for public reporting of hospice quality measures. It is critical to establish the reliability and validity of the measures prior to hospice review or public reporting in order to demonstrate the ability of the measures to distinguish the quality of services provided. Data collected by hospices during the first three quarters of CY 2015 will be analyzed starting in the fourth quarter of CY 2015. Decisions about whether to report some or all of the quality measures to hospices or publicly will be based on the findings of analysis of the CY 2015 data. In addition, as noted, the Affordable Care Act requires that reporting be made public on a CMS Web site and that providers have an opportunity to review their data prior to public reporting. We will develop the infrastructure for public reporting, and provide hospices an opportunity to review their data. In

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light of all the steps required prior to data being publicly reported, we anticipate that hospice review and public reporting will not be implemented in FY 2016. Hospice review and public reporting may occur during the FY 2018 APU year, allowing ample time for data analysis, review of measures' appropriateness for use for public reporting, and allowing hospices the required time to review their own data prior to public reporting. We will announce the timeline for hospice review and public reporting of data in future rulemaking.

We appreciate the efforts that went into this report and look forward to working with OIG on future issues.

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## ACKNOWLEDGMENTS

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

Deputy Regional Inspector General Nancy Harrison served as the team leader for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Jenell Clarke-Whyte, Jennifer Karr, and Michael Rubin. Central office staff who provided support include Heather Barton, Berivan Demir Neubert, and Christine Moritz.

# Office of Inspector General

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