FYI:

OIG Report: Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities

HOSPICE FUNDAMENTALS SUBSCRIBER EMAILS -- January 27, 2015

The Least You Need to Know: *The OIG kicked off 2015 with the release of a report highlighting the growth of services in the assisted living facility (ALF) setting. Based solely on data drawn from claims, the report was spiced up with a generous (and unbecoming) dollop of innuendo. This FYI reviews the report, the five recommendations made to CMS and grades the OIG in their presentation of three sections.*

Additional Information:

Given the perennial focus on hospice care in the nursing home, it took many people by surprise when hospice in assisted living facilities turned up as one of the two hospice projects in the FY 2014 OIG Work Plan. In the project description in that document they noted that they planned to look at length of stay, levels of care received and common diagnoses of beneficiaries who receive hospice care in ALFs in order to

1. Provide information relevant to the hospice payment system reform
2. Follow up on the MedPAC observation that long stays in the ALF indicate the need for further monitoring and examination

Links to Other Material:

OIG Report: Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities http://oig.hhs.gov/oei/reports/oei-02-14-00070.pdf

and

FYI: 6.4 OIG FY 2014 Work Plan http://origin.library.constantcontact.com/download/get/file/1102576162398-805/6_4BA_OIGFYI2014WorkPlan.pdf

Report Information & Where It Came From

Data was obtained data from 3 databases. The primary source was the claims file; the other two sources were used to determine tax-status of providers.

The OIG did not assess eligibility status for the hospice benefit or assess whether services were appropriate.

Data Highpoints

- Beneficiaries in ALFs had longer lengths of stay – over 1/3 had stays in excess of 180 days - resulting in higher per-beneficiary cost to Medicare
- Medicare payments for hospice care in ALFs doubled between 2007 and 2012; due to lack of statistics OIG is unable to report increase or decrease in total # of ALF beds for the same period
- Sixty percent of beneficiaries in ALFs had diagnoses of ill-defined conditions, mental disorders (dementia was classified in this category) or Alzheimer's disease as their primary hospice diagnosis
- For-profits received higher per beneficiary payments due to longer lengths of stay
- Some hospices provided the majority of their care in ALFs

OIG Recommendations to CMS

Below are the recommendations made to CMS; none is earth-shaking and CMS agreed with all.

OIG RECOMMENDATIONS	COMMENTS FROM HOSPICE FUNDAMENTALS
Reform payments to reduce the incentive for hospices to target beneficiaries with certain diagnoses and those likely to have long stays	**One thing with which almost everyone agrees: our payment methodology needs to be updated.** What worked in 1983 – paying the exact same amount for every day of care for every beneficiary – does not work so well now.
Target certain hospices for review	**Makes good sense**
Develop and adopt claims-based measures of quality *Make hospice data publicly available for beneficiaries, and* *Provide additional information to hospices to educate them about how they compare to their peers.*	**Do you remember what a Medicare hospice claim looked like ten years ago?** It identified the hospice, the beneficiary, the attending physician, the hospice diagnosis code, days of care at each level, beneficiary status as of the through-date – and that's about it. Then MedPAC observed that it was hard to tell much about hospice services due to the dearth of information on the claims, CMS took heed and life changed. More data elements support more analysis - and now the OIG recommends developing, adopting, and publicly reporting measures drawn from claim-level data elements *(and notes that it is an idea supported by hospice experts)*. **Hospice Fundamentals supports public reporting that allows meaningful comparison but beware, in this report the OIG demonstrates MIAB – *More Is Always Better* – thinking** *(reread the report if you have doubts*). Although seductive in its simplicity, more does not define high quality hospice care. It's the opposite of what a Prudent Hospice is aiming for: the right amount provided at the right time by the right IDG member(s). MIAB thinking erodes that goal. **A better suggestion?** Use the claims level data to guide survey activity. Few reported visits to patients should equal more frequent visits from surveyors.

The ALF Setting

What Exactly Is an ALF? Good question, no good answer. It's an ill-defined level of care that includes adult foster care homes, shiny new facilities operated by companies from the hospitality industry and everything in between. Because there is no Medicare funding for this level of care there are no consistent Federal standards. Each state has its own rules, payment and survey mechanisms.

How Many Facilities and How Many Beds Are There? No one knows. As the OIG notes in the report, solid data on the number of ALFs and the total number of beds is lacking. They include numbers from two reports – one from the AARP Public Policy Institute that estimated the number of beds at 1.2 million in 2010 and one from the Assistant Secretary for Planning and Evaluation that reported almost 1 million in 2007.

Who Resides in ALFs? Theoretically, individuals primarily needing assistance with activities of daily living rather than healthcare. In reality, hospices report regularly working with residents whose needs would be better met at a higher level of care. In some states, licensure rules spell out specific care needs or diagnoses that require transferring residents to a higher level of care, others don't.

What about Staffing? Requirements vary from state to state but the norm is unlicensed caregivers that have met any minimum training standards defined in the state licensure rules. Staff to resident ratios vary widely from state to state and, within the same state, from facility to facility.

What Specific Rules Apply to Hospice Care in the ALF Setting? Although there is a condition and six standards in the Medicare Conditions of Participation that spell out requirements for providing care in nursing facilities, there are no specific Medicare regulations for provision of hospice care in ALFs.

Presentation of the Data

Although the numbers in this report are interesting *(note that the OIG says that they expect that these types of issues exist in all areas of care provision, not just in ALFs)*, the spin that OIG put on some of them was more interesting. Data are data but what is emphasized and how it is presented moves it in certain directions. We decided to give them a grade for objective reporting and, because they did very poorly, we tossed in some questions and suggestions for how it could have been improved.

SECTION HEADER	TO IMPROVE YOUR GRADE
Hospice physicians rarely saw beneficiaries who receive 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 planning services. Two-thirds of hospices did not provide other physician services to any of the beneficiaries they served in ALFs in 2012.	**1.** Upon review of the Medicare Conditions of Participation we do not find a requirement that a hospice must routinely provide direct physician services to its patients. If you are aware of such a requirement, please include the appropriate citation. **2.** If no such requirement exists, are you implying that the beneficiaries had unmet medical needs? If yes, please indicate appropriate supporting evidence.
Hospices seldom provided services in ALFs on weekends 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.	**As you noted (with correct citation), a Medicare-certified hospice must make services available, as needed, on a 24-hour basis.** **1.** Are you implying that this set of beneficiaries experienced unmet needs on the weekends? What evidence supports this? **2.** How does the % of care delivered to beneficiaries at routine home care level on Saturdays and Sunday in the ALF setting compare to %s in other settings?
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.	**1.** What was the distribution of the remainder of the CHC days? **2.** In previous reports you have indicated concern that some providers do not provide all four levels of care. Does the omission of that information in this report indicate that all 2,709 hospices provided CHC in this setting or that this issue is no longer of interest to the OIG?

Actions of a Prudent Hospice™

ONE. Does the culture in your hospice support MIAB thinking? In certain departments but not in others? Give it some thought, and if the answer to either question is yes, start to think about what might support a shift to more mature thinking.

TWO. There is absolutely nothing that prohibits a hospice from developing expertise and focusing on care in one type of setting – but it is important that any hospice doing so be fully aware that it may lead to more intense scrutiny.

a. Does your hospice focus on specific settings?

b. Do you know the related compliance and risk areas?

c. Do you have appropriate and effective audits and monitors in place to give you the information to tell you how you are doing in those areas?

THREE. For all hospices, how are your monitors? Are you looking at and comparing the following for each care setting?

a. Percentage of total days of care
b. Average length of stay
c. Median length of stay
d. Length of stay for active census
e. Length of stay for discharged patients (all d/c reasons)
f. Number of visits per discipline
g. Ancillary costs (by category)
h. Live discharge rate for no longer eligible

FOUR. If you said "What monitor?" in response to the preceding question, your first order is to get the your reports set up and make sure that they are run (and reviewed) on a regular basis (frequency will vary by size).

FIVE. Are you paying for everything you should be for residents residing in ALFs? Are residents or families getting monthly charges for items that should have been covered under the hospice Medicare benefit?

SIX. If your state Medicaid pays for the ALF care, look carefully at those regulations.

SEVEN. How does your hospice look regarding % of visits provided on the weekends? We ask because it's interesting to look into – not because we assume that more is better. Here are some starter questions for you – and they apply to all settings.

a. If you have patients getting daily aide or nursing visits M-F but nothing on the weekends, how do you explain that from a care planning perspective?

b. Are you tracking and trending after hours calls? How many calls could have been managed / prevented before the call came in?

c. When there are symptom or medication changes on Friday, is there follow-up on Saturday? Ditto Sunday follow-up for Saturday changes.

d. When patients begin to transition or actively die on Thursday or Friday are visits made over the weekend?

e. How many live discharges (revocations, discharge out of the service area, including to a non-contracted facility) occur on Saturday, Sunday or Monday?

EIGHT. The report notes that twenty-five hospices did not report making any visits to their total of 210 beneficiaries receiving care in ALFs in 2012. The claims processed; they were paid $2.3 million for the year. That's an extreme case but it raises the question – how well is your reporting system working? It's been such a busy period that you may not have had a chance to test it – but it's a good idea to give it a look. Claims will process with wildly inaccurate numbers – but we'll all pay the price down the line.