

# Health Reform WK-EDGE Alerts, STRATEGIC PERSPECTIVES: CMS moves quickly as hospice costs rise, stays get longer, (Jul. 9, 2015)

[Click to open document in a browser](#)

By Patricia K. Ruiz, J.D.

The term “hospice” is largely associated with the end of a patient’s life—as it should be. Hospice, which focuses on palliative care for the relief of pain and symptom management, rather than curative care, originally was touted as a means to cut down on the costs of aggressive end-of-life treatments. In recent years, however, the rising popularity of hospice care has resulted in longer and longer hospice stays and, instead of cutting down costs at the end of a patient’s life, Medicare is seeing costs from hospice stays grow significantly. Between 2007 and 2015, Medicare has seen hospice care payments to assisted living facilities (ALFs) more than double. The large jump in Medicare payments as well as the relatively low complexity of the services needed by hospice beneficiaries serves as an incentive for hospices to target Medicare beneficiaries in ALFs.

This Strategic Perspective discusses the rising popularity of hospice care as well as the trend of increasingly long hospice stays and how these longer stays affect Medicare payments. It also discusses CMS’ Proposed rule for the 2016 hospice payment system and its plans for addressing these issues.

## Cutting Down Costs of End-of-life Care

“When a Medicare beneficiary elects to receive hospice care, the beneficiary waives his or her right to Medicare payments for services that are related to the treatment of the terminal condition for which hospice care was elected, except for those services provided by the designated hospice and the beneficiary’s attending physician,” Serra J. Schlanger, an associate in the Health Care and Life Sciences practice of Epstein Becker Green, told Wolters Kluwer. “Hospice providers are responsible for covering those items and services that are reasonable and necessary for the palliation and treatment of a patient’s terminal and related conditions.”

There has been a significant jump in the utilization of hospice care since the introduction of Medicare hospice benefits, which can be attributed to two main factors, Schlanger said. “First, the population seeking hospice care has expanded from primarily patients with cancer diagnoses to include patients with other terminal illnesses. Second, increased awareness of the interdisciplinary approach of hospice care and a growing preference for care provided in home- and community-based settings has helped lead a shift toward increased utilization of hospice services.”

**Costs climbing instead of falling.** The rise in the use of hospice care has produced unexpected results. According to a study published in the *New England Journal of Medicine (NEJM)* titled *Changes in Medicare Costs with the Growth of Hospice Care in Nursing Homes*, use of hospice by nursing home residents increased substantially between 2004 and 2009, with the proportion of nursing home decedents using hospice rising from 27.6 percent in 2004 to 39.8 percent in 2009. While the increase in hospice use seems to have led to a reduced number of hospital transfers, feeding-tube use, and intensive care unit (ICU) use, the average hospice stay increased from 72.1 days in 2004 to 92.6 days in 2009. This resulted in a mean net increase in Medicare expenditures of \$6,761 within that time period. These numbers reflect an increase in hospice care spending rather than the intended reduction on spending for hospital and other care.

Dr. Pedro Gozalo of Brown University, who led the study’s research team, said that the higher costs may be due in part to the enrollment of patients in hospice earlier than before and that such patients are more likely to be suffering from problems such as dementia that make predicting how long the patient will live more difficult. For example, although some patients may appear frail, after a few weeks go by, they perk up and may be stable for two to three more years. It is just not easy to predict how long a patient will live in those cases, Gozalo said.

## Increased Incentive for Treating Hospice Patients in Assisted Living Facilities

The HHS Office of Inspector General (OIG) published a report showing that hospices have financial incentives to target beneficiaries in assisted living facilities (ALFs)—which are defined by the OIG as facilities that “generally

provide housekeeping services, meals, and assistance with activities of daily living—compared to other settings (*OIG Report*, No. OEI-02-14-00070, January 13, 2015). The OIG found that hospice providers experienced greater financial gain treating ALF patients because of the lower complexity of care required by such patients (see *Hospice providers target ALFs for higher payments and less complex care*, January 15, 2015).

Sections 3004(c) and 3132 of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) require CMS to “reform the hospice payment system, collect data relevant to revising hospice payments, and develop quality measures for hospices.” The OIG conducted its study based on these requirements and found that while ALFs did not grow significantly in number, Medicare hospice payments to ALFs increased 119 percent between 2007 and 2012, rising to a total of \$2.1 billion in 2012. Among hospices providing care in ALFs, the OIG also found that, compared to other settings, care typically lasted longer (a median of 98 days, almost twice as long as in other settings) and resulted in higher Medicare payments (a median of \$16,195, almost twice as high as in nursing facilities and private homes).

Despite the rising costs, beneficiaries in ALFs generally required less complex care as a result of their diagnoses. The report found that such patients were six times more likely to be diagnosed with ill-defined conditions, mental disorders, or Alzheimer’s, as opposed to terminal conditions such as cancer. On average, Medicare paid \$1,091 per week for 4.8 hours of hospice visits to beneficiaries in ALFs, and the majority of these visits were by aides, as 80 percent of beneficiaries in ALFs did not receive hospice physician services other than for supervisory or care planning services. Significantly, the OIG found that for-profit hospices received much higher reimbursements than nonprofit hospitals.

**Recommendations.** The OIG recommended that CMS consider reforming the hospice payment system to pay hospice providers in accordance with the needs of each beneficiary rather than an all-inclusive day rate. The reforms should be focused on hospice providers that target beneficiaries in ALFs.

### **Proposed Changes to the Hospice Payment System**

CMS’ proposed changes to the hospice regulations address the concerns related to the rising costs and longer stays (*Proposed rule*, 80 FR 25832, May 5, 2015). Citing section 3132 of the ACA, CMS also would collect more data and diagnoses to inform future changes to the hospice payment system (see *Hospice rules would IMPACT potential for abuse*, May 5, 2015).

Acknowledging that the later days of longer hospice stays typically involve fewer minutes per day of care than shorter stays, CMS proposed to set one daily rate (\$137.48) for the first 60 days of hospice care that transitions to a lower daily rate (\$95.48) beginning on the 61st day. CMS also proposed making an additional service intensity add-on (SIA) payment for the additional time and resources used during the last seven days of a patient’s life. This SIA payment is intended to reflect the U-shaped pattern of resource use in hospice care, with the most intensive services provided at the beginning and end of the stay. The SIA payment is only available in situations in which: (1) routine home care is provided; (2) with visits from a registered nurse or social worker; (3) during the last seven days before the patient’s death; and (4) the setting is not a nursing facility or skilled nursing facility.

Additionally, the Proposed rule would require a list the diagnoses of every patient regardless of whether it is related to the terminal condition on the hospice claim. The purpose of including the list of diagnoses is to ensure that hospices perform comprehensive assessments for each patient on admission and update the information when there is any change.

“The inclusion of all of a patient’s diagnoses on hospice claims is a bit of a double-edged sword for hospice providers,” said Schlanger. “Providers may be able to better establish the patient’s terminal prognosis by including a complete profile of a patient’s medical history and applicable diagnoses codes. However, the Proposed rule does not indicate how hospice providers can identify which diagnoses are related to the patient’s terminal illness and which diagnoses are unrelated. Since hospice providers are responsible for providing the items and services that are reasonable and necessary for the palliation and treatment of a patient’s terminal and related conditions, it would be helpful for hospice providers to have the ability to identify which diagnoses are related to the terminal illness.”

## **Conclusion**

While CMS' Proposed rule makes strides toward removing opportunities for hospices to take advantage of Medicare beneficiaries, providers may seek more clarification before a final version of the rule comes out.

"The 2016 Proposed rule includes a number of changes that could help alleviate concerns that have been raised about lengths of stay, skilled nursing visits, and the 'unbundling' of services," Schlanger said. "However, the Proposed rule still leaves certain questions unanswered and may give rise to more questions as these proposed changes are implemented. Hospice providers should expect some degree of change to occur when the final rule is released later this year."

Attorneys: Serra J. Schlanger (Epstein Becker Green)

MainStory: StrategicPerspectives HospiceNews MedicarePartANews NewsFeed