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Yet Another Cliff-Hanging OIG Report

Law360, New York (May 15, 2013, 12:37 PM ET) -- On May 3, the policy and evaluation division of the U.S. Department of Health and Human Services' Office of the Inspector General released its memorandum report, "Medicare Hospice: Use of General Inpatient Care."[1] The OIG report is part of an ongoing series of studies and ongoing audits that the OIG is conducting on general inpatient care (GIP), and the report is strikingly similar to certain data that was reported by Centers for Medicare & Medicaid Services' contractor Abt Associates at the April 25, 2013, National Hospice and Palliative Care Organization's Management and Leadership Conference.

The OIG report leaves several questions unanswered, namely whether the OIG believes there is abuse and whether they believe Medicare should change its rules for GIP. The OIG report contains no recommendations, per se, but notes that the OIG will continue to study issues related to GIP furnished to Medicare beneficiaries, including an upcoming audit report based on a medical review of GIP charts.

Hospice GIP Data and OIG Report Findings

The OIG report revealed that Medicare spent $1.1 billion on hospice inpatient stays in 2011, representing 8 percent of the total $13.7 billion Medicare spent on hospice care that year. The OIG report noted that most of these GIP claims were for services rendered in hospice inpatient units and not hospitals, skilled nursing facilities (SNFs) or other settings where hospice GIP may be furnished.

The OIG report also presented several interesting findings related to disparities in the average length of stay for each care setting and variations in patterns of utilization for GIP. Because the OIG report was not an "audit" of specific claims or hospice services, no findings related to potential overpayments were made.

However, requests from the OIG's Office of Evaluation and Inspections division to many hospice organizations for GIP medical records are outstanding with return dates of May 15th. Specific OIG findings on whether GIP level of care was appropriate based on medical record reviews will not be far behind.

GIP is the second most expensive level of hospice care after continuous care, and it is intended for short-term care to manage pain or symptoms that cannot be managed in other settings.[2] GIP may be provided in a hospital, SNF or a Medicare-certified hospice inpatient unit.[3] Medicare-certified hospice inpatient units can be freestanding facilities or share space in another health care facility, such as a nursing home.

The OIG report noted that GIP stays in hospice inpatient units were 50 percent longer than GIP stays in hospital settings and 29 percent longer than GIP stays in SNFs. The OIG has indicated that it will conduct further study of this trend in inpatient units.

While Medicare policy does not place any express restrictions on the number of days GIP may be provided, the care is intended to be provided on a short-term basis. Medicare payment policy also has a payment cap set at 20 percent of the hospice's total patient care days, which effectively limits the utilization of GIP.

The OIG report results showed that 33 percent of GIP stays in 2011 lasted longer than five days, with 11 percent of GIP stays lasting 10 days or more. The average GIP length of stay for a hospice inpatient unit was 6.1 days, compared with 4.1 days in a hospital and 4.8 days in an SNF.

In addition to observing longer lengths of stay in hospice inpatient units, the OIG also found that hospice inpatient units provided the greatest share of GIP, accounting for 58 percent of all GIP provided to Medicare beneficiaries, compared with 33 percent in hospitals and 8 percent in SNFs.

Additionally, the OIG found that hospices with inpatient units were more likely to provide GIP to beneficiaries than hospices without inpatient units. Hospices with inpatient units provided GIP to 35 percent of beneficiaries, compared with 12 percent for hospices without inpatient units. This finding is not surprising, given that, among other reasons, hospices with inpatient units are far more likely to receive referrals of hospice-eligible patients who are likely to require GIP level of care.

Conversely, hospice providers that furnished little to no GIP (more than 25 percent of hospices in 2011) and little to no respite or continuous care may find themselves answering further questions as to why they are not providing those levels of care, given that Medicare requires hospices to furnish or arrange to furnish all four levels of care. With the OIG report's finding that 429 hospices provided only routine home care in 2011, these hospices may find themselves ripe targets for scope of service and quality questions.

Continuing its trend of noting differences between the for-profit and not-for-profit sectors, the OIG found that 69 percent of hospices that did not provide GIP in 2011 were for-profit providers, although a clear majority (54 percent) of hospices that furnished GIP was for-profits.

As is often the case, such statistics can be largely illusory. The OIG report's findings on GIP services among small hospices likely provide more meaningful statistics, with the OIG noting that 63 percent of hospices that did not provide GIP were "small" (defined as furnishing services to fewer than 90 Medicare beneficiaries in 2011), and only 18 percent of small hospices provided GIP.

The number of hospice providers that are not providing GIP proved to be an area of concern in the OIG report, with the OIG even proposing that the CMS consider using hospices' ability to provide all four levels of hospice service as a potential future quality measure. The OIG further urged the CMS to focus on whether hospices that do not provide or otherwise arrange for GIP are ensuring that beneficiaries receive access to the appropriate level of care at the end of their lives.

Hospice providers, especially those in the 63 percent of small hospices not currently providing GIP, may wish to examine their ability to provide or furnish necessary care in order to avoid scope-of-service inquiries and prepare for the implementation of the quality and hospice payment system reforms mandated by the Affordable Care Act, which are set to take effect by fiscal year 2014 (i.e., no later than October 1, 2013).[4]

Potential Implications

To ensure that hospices are providing the appropriate level of care to beneficiaries, the OIG report concluded that longer lengths of stay and greater utilization of GIP by hospices with inpatient units are issues warranting further review. While the OIG report does not contain any formal recommendations, the OIG was clear in insinuating that long lengths of stay and higher use of GIP by some hospices with inpatient units are issues of potential concern.

The OIG was also clear in communicating concern surrounding the substantial percentage of hospices that are not currently providing or otherwise arranging for GIP. Although it was not a formal recommendation to the CMS, the express reference in the conclusion of the OIG report to the option of using a hospice's ability to provide all four levels of hospice service as a future quality measure underscores the importance of this issue to the OIG.

The OIG report will be accompanied in the future by a companion report that the OIG is preparing on the appropriateness of hospice GIP provided to Medicare beneficiaries. The forthcoming companion report will focus on a medical record review of GIP claims from 2012 and examine clinical issues surrounding GIP.

These reports on hospice GIP mark the latest iteration of the OIG's ongoing examination of the Medicare hospice benefit. As Medicare considers the findings of the OIG's various hospice reports, hospice providers that regularly furnish GIP should not be surprised to find future changes to Medicare GIP reimbursement as well as greater scrutiny of previous claims for Medicare GIP by Medicare audit contractors.

This is especially true in light of the Medicare Payment Advisory Commission's calls for hospice payment reform and Congress' mandated Medicare payment reform for hospice as part of the ACA.

Additionally, hospices that do not provide GIP and that, consequently, do not face GIP Medicare claims scrutiny should be mindful that the CMS, in the future, may question their failure to provide adequate levels of care to beneficiaries who elect hospice care.

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[1] U.S. Dep't of Health & Human Servs, Office of Inspector Gen., Medicare Hospice: Use of General Inpatient Care (May 3, 2013), available at http://oig.hhs.gov/oei/reports/oei-02-10-00490.pdf.

[2] 42 C.F.R. § 418.302(b)(4). For GIP, Medicare regulations do not specify what is meant by "short-term."

[3] 42 C.F.R. § 418.108(a), (b).

[4] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148 § 3132(a)(1)(B), 124 Stat. 431.