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CMS RELEASES STUDY OF GENERAL INPATIENT HOSPICE CARE

Recently, the Centers for Medicare & Medicaid Services ("CMS") released the results of a study of hospice general inpatient care ("GIP") based on an analysis of Medicare Part A hospice claims for beneficiaries who received GIP in 2011. The intent was to identify suspected abuse of GIP in hospice inpatient facilities by hospice providers because this is the second most expensive level of hospice care. There are four levels of care with unadjusted daily Medicare hospice payment rates as follows: Routine Home Care ($146.63); Inpatient Respite Care ($151.67); General Inpatient Care ($652.27); and Continuous Home Care ($855.79).

The data revealed that 58% of GIP was provided in hospice inpatient units as compared to 33% in hospitals and 8% in skilled nursing facilities ("SNFs"). The data indicated that the top reasons claims for hospice GIP provided in inpatient facilities did not meet the criteria for this level of care were due to: (1) inappropriate settings and lengths of stay; (2) services that were not provided; and (3) services provided that were unnecessary.

In almost all categories analyzed, hospices utilizing GIP in hospice inpatient units had a greater dependence on GIP dollars than hospices utilizing other settings, such as hospitals and SNFs, and had longer stays by as much as 50% more than hospitals and 29% more than SNFs.

In summary, while there are no recommendations by CMS at this time, the results indicate a need to: (1) consider hospice payment reform; (2) develop hospice quality measures; and (3) implement additional oversight to ensure that GIP is used as intended for short-term pain control and symptom management.

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