MAR 31 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General

SUBJECT: Memorandum Report: "Hospice Beneficiaries' Use of Respite Care," OEI-02-06-00222

This memorandum report describes hospice beneficiaries' use of inpatient respite care in 2005 and identifies billing practices for such care. It is part of ongoing work by the Office of Inspector General (OIG) on the Medicare hospice benefit and is a followup to an earlier OIG report, "Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings," OEI-02-06-00220.

In response to our previous report, staff at the Centers for Medicare & Medicaid Services (CMS) asked us to provide additional information about hospice beneficiaries' use of inpatient respite care. Respite care is short-term inpatient care that provides respite for the individual's family or other persons caring for the individual at home.[1] Staff at CMS were concerned particularly about beneficiaries' use of inpatient respite care when they resided in nursing facilities.

We found that 2 percent of all hospice beneficiaries received respite care during 2005. Most of these beneficiaries received respite care for a total of 5 days or less. We also found a number of instances in which the use of respite care may have been inappropriate. Fifty-four beneficiaries received respite care longer than the 5 consecutive days allowed by Federal regulations and 62 beneficiaries received respite care while residing in nursing facilities, contrary to Federal requirements. We will provide additional information about these potentially inappropriate cases to CMS in a separate memorandum. In addition, we note that the information that is available on hospice claims limits CMS's ability to determine whether hospice agencies are complying with the requirement that they may not be reimbursed for more than 5 consecutive days of respite care at a time.

[1] 42 CFR § 418.204(b).

BACKGROUND

The Medicare Hospice Benefit

The Medicare hospice benefit allows a beneficiary with a terminal illness to forgo curative treatment for the illness and instead receive palliative care, which is the relief of pain and other uncomfortable symptoms. To be eligible for Medicare hospice care, a beneficiary must be entitled to Part A of Medicare and be certified as having a terminal prognosis with a life expectancy of 6 months or less, should the disease run its normal course. The number of Medicare beneficiaries receiving hospice care has increased significantly in recent years, growing from approximately 594,000 in 2001 to 871,000 in 2005.[2]

Inpatient Respite Care

Inpatient respite care (hereafter referred to as "respite care") is one of four levels of hospice care available to Medicare beneficiaries. The other levels are routine home care, which is the most commonly provided level of care; continuous home care; and general inpatient care.[3] Respite care is short-term inpatient care provided to the beneficiary when necessary to relieve the beneficiary's caregiver. The Medicare unadjusted daily rate[4] for respite care in 2005 was $126.18. In addition, hospice agencies may bill beneficiaries for 5 percent of the daily rate for respite care.[5] The amount collected from the beneficiary is not reported on Medicare hospice claims.

Respite care may be provided directly by the hospice agency or indirectly under arrangements made by the hospice. Respite care must be provided by a hospice, hospital, skilled nursing facility, or intermediate care facility that meets the standards for respite care set forth in regulation.[6]

Respite care is subject to several limitations. Respite care may be provided only on an occasional basis and may not be reimbursed for more than 5 consecutive days at a time.[7] Also, the total number of inpatient care days (general inpatient care or respite) for Medicare beneficiaries in a particular hospice agency may not exceed 20 percent of the total days for which these beneficiaries had elected hospice care.[8]

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[2] Centers for Medicare & Medicaid Services, "Medicare Hospice Data – 1998-2005" (December 26, 2007). Available online at http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/downloads/HospiceData1998-2005.pdf. Accessed January 15, 2008.

[3] General inpatient care is for pain control or symptom management that cannot be managed in other settings. 42 CFR § 418.302(b)(4).

[4] Payment rates are adjusted to reflect local differences in wages. 42 CFR § 306(c).

[5] 42 CFR § 418.400(b).

[6] 42 CFR §§ 418.98 and 418.100.

[7] 42 CFR § 418.204(b)(2).

[8] 42 CFR § 418.98(c).

METHODOLOGY

The information provided in this memorandum report is based on an analysis of Medicare claims for hospice care. It is based on the same data that we used in our previous report, "Medicare Hospice Care: A Comparison of Beneficiaries in Nursing Facilities and Beneficiaries in Other Settings," OEI-02-06-00220.

As we did in our previous report, we identified all beneficiaries who received hospice care in 2005 using the Medicare Part A hospice claims from the National Claims History file for 2005. We also included claims from the 2006 file that covered days of service that occurred in 2005. Hospice agencies typically submit claims that cover a 1-month period. Therefore, some claims from the 2006 file included days from 2005. We identified the beneficiaries who received respite care by using the revenue codes on their hospice claims.

We identified the beneficiaries who received respite care and resided in nursing facilities using the Minimum Data Set (MDS). We compared beneficiaries' respite claim dates to beneficiaries' MDS dates to identify the beneficiaries who received respite care while they were in nursing facilities. The MDS includes assessments on all residents in Medicare-certified or Medicaid-certified long term care facilities, including skilled nursing facilities. For the purpose of this report, we refer to all such facilities as nursing facilities. We considered a beneficiary to be a resident of a nursing facility if the beneficiary had an MDS assessment. Nursing facilities complete these assessments at scheduled intervals during a resident's time in a facility and when a resident's health status changes.

We analyzed the claims data to determine the proportion of hospice beneficiaries who received respite care during 2005, the number of days that they received respite care, and the number of claims that they had that included respite care. Finally, we identified the hospice beneficiaries who received respite care for more than 5 consecutive days and those who received respite care while they were residents of nursing facilities.

We had to limit our analysis in several ways because of the information that was available on hospice claims. Hospice claims include the number of days for each level of care but they do not include the specific dates that the beneficiaries received each level of care. Therefore, we had to base the number of beneficiaries who received respite care for more than 5 consecutive days on the claims that included only respite care. We also identified beneficiaries who had claims that included respite care and other levels of hospice care. In these cases, we could not determine whether the dates that the beneficiaries received respite care were consecutive. Therefore, the number of beneficiaries who received respite care for more than 5 consecutive days could be higher than stated in the findings.

This review was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

RESULTS

Two Percent of Hospice Beneficiaries Received Respite Care During 2005

In 2005, 2 percent of all hospice beneficiaries, or 17,669 beneficiaries, received respite care. Medicare payments for respite care for these beneficiaries were approximately $12.8 million, an average of $722 per beneficiary who received respite care.

The most common diagnosis categories for beneficiaries who received respite care were cancer, circulatory disease, and ill-defined conditions. These were also the most common diagnosis categories for hospice beneficiaries who did not receive respite care. The two groups differed slightly in terms of geographic location. As Table 1 shows, beneficiaries who received respite care were more likely to reside in the Midwest and West, compared to hospice beneficiaries who did not receive respite care.

Table 1: Location of Hospice Beneficiaries During 2005

Region	Hospice Beneficiaries Who Received Respite Care	Hospice Beneficiaries Who Did Not Receive Respite Care
Northeast	11%	17%
Midwest	30%	24%
South	34%	38%
West	24%	20%

Source: Office of Inspector General analysis of 2005 Medicare claims, 2007.
Note: Percentages do not add up to 100 percent because of rounding.

Most Hospice Beneficiaries Who Received Respite Care Received It for 5 Days or Less

Eighty-one percent of beneficiaries who received respite care received it for a total of 5 days or less in 2005. On average, beneficiaries received respite care for 5.6 days in 2005. The number of days in respite care ranged from 1 to 122. In addition, 92 percent of beneficiaries who received respite care in 2005 had one or two claims that included respite care. The remaining 8 percent of beneficiaries had three or more claims that included respite care. These beneficiaries often received respite care every month during which they were in hospice care.

Beneficiaries who had three or more respite claims had diagnoses different from those of beneficiaries who had fewer claims. Table 2, on the next page, shows the distribution of the most common diagnosis categories for these two groups of beneficiaries. Beneficiaries with three or more respite claims were more than twice as likely to have Alzheimer's or another nervous system disease, compared to beneficiaries with fewer claims. Also, beneficiaries with three or more respite claims were less than half as likely to have cancer, compared to those with fewer claims.

Table 2: Common Diagnosis Categories of Hospice Beneficiaries

Diagnosis Categories	Beneficiaries With One or Two Claims That Included Respite Care	Beneficiaries With Three or More Claims That Included Respite Care
Alzheimer's and Other Nervous System Diseases	11%	24%
Cancer	38%	17%
Circulatory Diseases	20%	23%
Ill-Defined Conditions	11%	15%
Mental Disorders	4%	7%
Respiratory Diseases	9%	8%
Other	7%	6%

Source: Office of Inspector General analysis of 2005 Medicare claims, 2008.

A Small Number of Beneficiaries Received Respite Care for More Than 5 Consecutive Days

According to Federal regulation, respite care may not be reimbursed for more than 5 consecutive days.[9] We identified 54 beneficiaries who received respite care for more than 5 consecutive days in 2005. One of these beneficiaries received respite care for 122 consecutive days at a cost of $16,726. The 54 beneficiaries did not exhibit any significant patterns in terms of diagnoses, hospice providers, or location by State.

Another 685 beneficiaries had claims for respite care for more than 5 days. However, these claims included at least one other level of care in addition to respite care. Because of the information that was available on the hospice claims, we could not determine whether the days on which these beneficiaries received respite care were consecutive.

A Small Number of Beneficiaries Received Respite Care While They Were Residents of a Nursing Facility

Respite care is intended to provide respite for the beneficiary's family or other persons caring for the beneficiary at home. It is to be provided "only when necessary to relieve the family members or other persons caring for the [beneficiary]."[10] Beneficiaries who were cared for at home sometimes entered nursing facilities to receive respite care and then remained in the facilities instead of returning home. These beneficiaries typically entered facilities and received 5 days of respite care. After 5 days, the beneficiaries did not return home but instead stayed in the facilities and received routine or other levels of hospice care.

However, we identified 62 beneficiaries who received respite care in 2005 when they had already been residing in nursing facilities. Beneficiaries who reside in facilities are cared for by facility staff, unlike beneficiaries who reside at home and are often cared for by

[9] 42 CFR § 418.204.
[10] 42 CFR § 418.204(b).

family members. The beneficiaries who received respite care while already residing in nursing facilities did not exhibit any significant patterns in terms of diagnoses or hospice providers. Nineteen of the sixty-two beneficiaries were from Texas or California.

CONCLUSION

We found that respite care was infrequently used in 2005. Two percent of all hospice beneficiaries received respite care and most of these beneficiaries received the care for a total of 5 days or less. We also found a number of instances in which the use of respite care may have been inappropriate. Fifty-four beneficiaries received respite care for more than 5 consecutive days and 62 beneficiaries received respite care while residing in nursing facilities, even though respite care is designed to relieve a beneficiary's caregiver. One beneficiary was included in both of these groups. We will provide additional information about these potentially inappropriate cases to CMS in a separate memorandum.

In addition, we note that the information that is available on the hospice claim limits CMS's ability to determine whether hospice agencies are complying with the requirement that they may not be reimbursed for more than 5 consecutive days of respite care at a time.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-02-06-00222 in all correspondence.