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HealthCare Appraisers' Industry Insight

HOSPICE TENANCY AND INPATIENT SERVICES ARRANGEMENTS – OPPORTUNITIES AND RISKS

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INTRODUCTION

Prior to the COVID-19 pandemic, many hospitals had begun to expand their outpatient service offerings, as a result of an increasing number of unoccupied inpatient beds.[1] Furthermore, with the number of Americans aged 65 or older expected to double between 2018 and 2060,[2] hospice agencies are expecting to see a significant increase in the demand for their services.[3] Naturally, an increasing number of partnerships between hospitals and hospice agencies seems inevitable, particularly in light of the recent increases in Medicare reimbursement for the highest levels of hospice care (including hospice services rendered in an approved, inpatient setting).[4]

HealthCare Appraisers has noticed an increased number of hospitals entering into arrangements with hospice agencies, whereby the hospitals agree to allow the agencies to utilize their inpatient beds (*i.e.*, tenancy arrangements) and/or provide various inpatient services to patients of the hospice agencies (*i.e.*, inpatient services arrangements) rather than letting their inpatient beds to go un- or under-utilized. For hospice agencies, these arrangements ensure their steady and reliable access to high quality inpatient care in an approved setting, with the added benefit of increased reimbursement from Medicare.[5,6]

As the demand for hospice services increases, such arrangements are expected to become even more commonplace and will likely grow to represent a larger share of hospital revenue. While these arrangements may confer many benefits to both hospice agencies and hospitals,[7] there are key

[1] Recent trends had suggested that a growing number of procedures that were previously performed in the inpatient setting were being moved to the outpatient setting due to technological advancements and shifting financial incentives. See, Ken Abrams, Andreea Balan-Cohen, and Priyanshi Durbha, *Growth in Outpatient Care – The Role of Quality and Value Incentives*, DELOITTE INSIGHTS (Aug. 15, 2018), https://www2.deloitte.com/us/en/insights/industry/health-care/outpatient-hospital-services-medicare-incentives-value-quality.html.

[2] Mark Mather, Paola Scommegna, and Lillian Kilduff, *Fact Sheet: Aging in the United States*, POPULATION REFERENCE BUREAU (Jul. 15, 2019), https://www.prb.org/aging-unitedstates-fact-sheet/.

[3] *See, e.g.*, Jim Parker, *Upswing in Hospice Utilization, Length of Stay*, HOSPICE NEWS (Apr. 11, 2019), https://hospicenews.com/2019/04/11/upswing-in-hospice-utilization-length-of-stay/.

[4] In 2019, CMS announced significant changes in the hospice reimbursement rates for FY 2020. Notably, the per diem rates for hospice care rendered in the inpatient setting increased dramatically from FY 2019 to FY 2020 (*i.e.*, from $758.07 to $1,021.25 for General Inpatient Care, and from $176.01 to $450.10 for Inpatient Respite Care).

[5] "General inpatient care (GIP) may only be provided in a Medicare participating hospital, SNF, or hospice inpatient facility. Respite care may only be provided in a Medicare participating hospital or hospice inpatient facility, or a Medicare or Medicaid participating nursing facility." *See*, Medicare Benefit Policy Manual, *Chapter 9 – Coverage of Hospice Services Under Hospice Insurance*, § 40.1.5 – Short Term Inpatient Care.

[6] Furthermore, by partnering with established, well-respected hospitals in their communities, hospice agencies can help to safeguard against deficiencies in patient care, such as those cited in a recent Office of Inspector General (OIG) report, which found over 80% of hospice agencies surveyed had at least one deficiency, with the most common types of deficiencies involving "poor care planning, mismanagement of aid services, and inadequate assessment of beneficiaries." U.S. Dept. of Health and Human Services, Office of Inspector General, *Hospice Deficiencies Pose Risks to Medicare Beneficiaries*, 2020 (OEI-02-17-00020).

[7] Benefits for hospitals include, but are not limited to: (i) Securing a stable stream of revenue through tenancy arrangements, (ii) Ensuring hospital inpatient beds are appropriately utilized; and (iii) Creating opportunities for additional revenue through inpatient services rendered to hospice agencies' patients. Benefits for hospice agencies include, but are not limited to: (i) Ensuring stable and reliable care for patients in an approved setting, and (ii) Securing needed inpatient care at a negotiated rate.

compliance requirements the parties must meet to enter into such transactions. In this article, we describe the various types of arrangements between hospitals and hospice agencies, as well as areas that require special attention in order to ensure compliance with applicable healthcare fraud and abuse laws.

TYPES OF ARRANGEMENTS OBSERVED

The scope of services outsourced by hospice agencies ranges from basic tenancy to full-service general inpatient care, and everything in between, as detailed below:

- **Tenancy Only Arrangements:** Under tenancy only arrangements, the hospital will provide dedicated inpatient beds to the hospice agency on a contingency basis. In addition to the use of the inpatient beds, tenancy of a hospice unit may include the hospice agency's use of various spaces throughout the hospital such as nurse's stations, break rooms, medication rooms, family waiting rooms, staff conference rooms, and other essential rooms that are typical of a hospice setting.
- **Inpatient Services Arrangements:** Under inpatient services arrangements, a hospital may provide: (i) all-inclusive patient care as per the hospice inpatient care standards, which may include 24-hour nursing services in accordance with the patient-specific hospice plan of care, as well as diagnostic lab and radiology services; and/or (ii) certain miscellaneous services, including room and board, meal service, oxygen, linens, housekeeping services, and internal hospital transportation.
- **Hybrid Tenancy and Inpatient Services Arrangements:** In other arrangements, the division of labor between the hospice agency and the hospital may be less clearly defined, with both entities providing discrete sets of services that are not readily categorizable under Medicare's defined levels of care. For example, rather than bearing responsibility for all inpatient care included in the hospice patient's plan of care, the hospital may only provide tenancy of the unit and limited inpatient procedures, with the hospice agency providing the bulk of the direct patient care services (*e.g.*, 24-hour nursing services, pharmacy services, etc.).

BILLING ISSUES AND TYPICAL COMPENSATION STRUCTURES

Hospice industry data suggest that the Medicare program is the primary payor of hospice services in the marketplace.[8] As such, hospice providers reasonably plan and structure their provision of hospice services to comport with Medicare requirements for payment. Medicare reimbursement for hospice care is set by CMS annually based on a prospectively-determined per diem payment rate adjusted by the Hospice Wage Index, a national survey of costs reported by hospice providers. The Medicare *per diem* payment rates are based on the level of care rendered by the hospice agency, which are: (i) Routine Home Care, (ii) Inpatient Respite Care, (iii) Continuous Home Care, and (iv) General Inpatient Care. Each level of care varies significantly not only in terms of the site of service (i.e., in the patient's home or in a Medicare approved facility), but also in terms of the level of direct patient care provided, with Routine Home Care representing the lowest level of service and General Inpatient Care representing the highest level of service.

Under Medicare, the *per diem* payment is intended to cover the costs that a hospice agency incurs in furnishing the items and services identified in a patient's plan of care that are necessary for the management of a hospice patient's terminal condition.[9] As such, pursuant to the Medicare Benefit Policy Manual,[10] Medicare will generally not provide reimbursement for: (i) Hospice care provided by any hospice

[8] This is based on data from a 2012 report published by the National Hospice and Palliative Care Organization, indicating that Medicare is the primary payor for more than 80% of hospice patients nationwide. Based on our knowledge of payor trends, we do not believe that the proportion of hospice patients with Medicare as their primary payor has changed substantially in the time since this 2012 report.

[9] Management of the terminal condition includes: (i) Regular visits by a nurse or other hospice staff member; (ii) Consultation from hospice physicians; (iii) Expert management of pain and other symptoms; (iv) Medications, medical equipment, and supplies; (v) Coordination of care and medications; and (vi) Guidance, emotional, and spiritual support for patients and their caregivers.

[10] *See*, Medicare Benefit Policy Manual, Chapter 9 – *Coverage of Hospice Services Under Hospice Insurance.*

agency other than the hospice agency designated by the hospice patient,[11] or (ii) Medicare services that are related to the terminal condition (or related conditions) for which the hospice benefit was elected.[12]

As such, hospitals are generally unable to separately bill and collect from patients and/or payors for services rendered to a hospice patient when those services are related to the patient's terminal condition.[13] Therefore, under an arrangement with a hospice agency for outsourced services, a hospital's sole source of remuneration for services rendered must derive from the hospice agency. Below is a summary of some of the most common mechanisms for compensating hospitals for the delivery of hospice inpatient services observed by HealthCare Appraisers.

- **Tenancy Only Arrangements:** In the case of a tenancy only arrangement, the hospice agency will frequently compensate the hospital through either a *per diem* payment[14] for each occupied bed or a fixed monthly fee for the exclusive use of a designated number of beds.
- **Inpatient Services Arrangements:** In the case of an inpatient services arrangement, the hospice agency will typically compensate the hospital through an additional per diem payment for each day inpatient services are provided to a patient, which will typically vary based on the level and intensity of services rendered by the hospital.
- **Hybrid Tenancy and Inpatient Services Arrangements:** Because the mix of services varies from contract to contract under hybrid arrangements, the compensation terms may likewise vary considerably. However, one of the more common compensation mechanisms for these types of arrangements involves a fixed, base payment for tenancy of the unit plus an additional per procedure fee for any inpatient ancillary services performed.[15]

FMV PITFALLS – WHY AN EXPERIENCED VALUATOR IS ESSENTIAL

While Medicare specifies various levels of reimbursement for hospice care, the levels of reimbursement are not easily translatable into payment rates for tenancy and inpatient services that may be rendered by a hospital. In particular, the Medicare payment rates are specifically intended to cover the cost of all items and services needed to manage the hospice patient's terminal condition. Therefore, regardless of the level of outsourcing by a hospice agency to a hospital, a hospice agency will always maintain responsibility for certain functions, such as responsibility for the overall hospice plan of care. As such, parties must exercise caution when tying payment rates for services rendered under such arrangements to the Medicare per diem rates to ensure that each party is appropriately compensated for the items and services rendered to the patient during the inpatient stay.

FMV TAKEAWAY

Determining the FMV payment rate requires not only a deep understanding of the Medicare payment rates, but also the specific items and services provided by both the hospice agency and hospital under their applicable arrangement. Selection of an experienced valuator with detailed knowledge of hospice tenancy and inpatient services arrangements can ensure that arrangements are consistent with FMV and compliant with applicable healthcare fraud and abuse laws.

[11] Unless provided under arrangements made by the designated hospice agency

[12] Exceptions include services provided by the hospice patient's attending physician or nurse practitioner, provided that the attending physician or nurse practitioner is not an employee of the designated hospice agency or receiving compensation from the designated hospice agency for their services.

[13] If a hospital provides services to a hospice patient that are unrelated to the terminal condition for which the hospice benefit was elected, then the hospital may separately bill and collect for the services.

[14] In such an arrangement, there would typically be a fixed per diem payment or fixed monthly payment for tenancy of the unit (*i.e.*, the exclusive right to use and occupy the beds and other, reasonable common areas in the hospital, such as patient waiting areas, nurses stations, etc.). However, when a patient is admitted to the hospice unit for inpatient services, an additional *per diem* payment would be owed to the hospital for each occupied bed day (*i.e.*, each day a patient is admitted to the hospital and receiving inpatient care).

[15] Frequently, compensation for the inpatient ancillary procedures will be based on a pre-determined percentage of the then-current Medicare allowable reimbursement (as adjusted for the facility's geographic region) for the applicable service(s) provided (e.g., radiology, lab, etc.).