

SECTION

11

Other services

Dialysis

Hospice

Clinical laboratory

Chart 11-1. Number of dialysis facilities is growing, and most facilities are for profit and freestanding

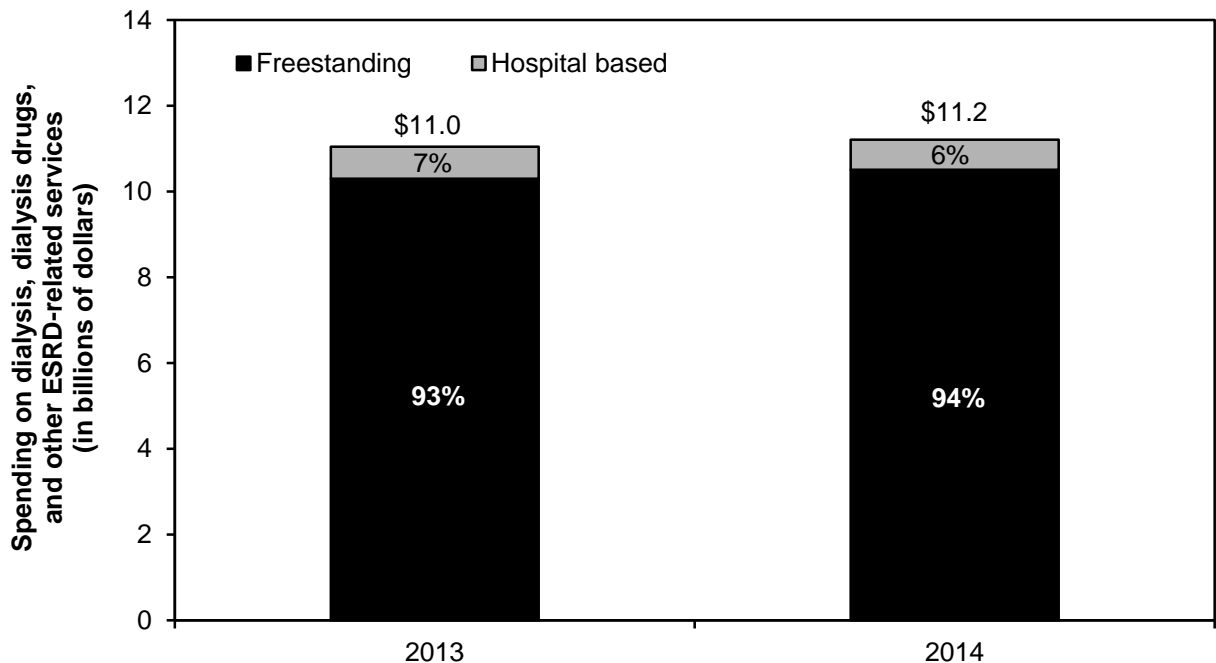
	2015	Average annual percent change	
		2010–2015	2014–2015
Total number of:			
Dialysis facilities	6,475	3%	3%
Hemodialysis stations	113,422	3	2
Mean number of hemodialysis stations per facility	18	-0.1	-0.3
	<u>Percent of total</u>		
Hospital based	7%	-5	-3
Freestanding	93	4	3
Urban	80	4	3
Rural, micropolitan	13	2	2
Rural, adjacent to urban	5	1	1
Rural, not adjacent to urban	3	2	3
Frontier	1	1	0
For profit	87	4	3
Nonprofit	13	-3	0

Note: "Nonprofit" includes facilities designated as either nonprofit or government. "Average annual percent change" is based on comparing 2010, 2014, and 2015 end-of-year files. Components may not sum to totals due to rounding.

Source: Compiled by MedPAC from the 2010, 2014, and 2015 CMS Dialysis Compare end-of-year files.

- Between 2010 and 2015, the number of freestanding and for-profit facilities increased, while hospital-based and nonprofit facilities decreased. Freestanding facilities increased from 90 percent to 93 percent of all facilities, and for-profit facilities increased from 83 percent to 87 percent of all facilities.
- Between 2010 and 2015, the proportion of facilities located in rural areas has remained relatively constant.
- Since 2010, the number of facilities has increased 3 percent per year. The average size of a facility has remained relatively constant, averaging about 18 dialysis treatment stations per facility (17.6 stations in 2010, 17.6 stations in 2014, and 17.5 stations in 2015).

Chart 11-2. Medicare spending for outpatient dialysis services furnished by freestanding and hospital-based dialysis facilities, 2013 and 2014



Note: ESRD (end-stage renal disease).

Source: Compiled by MedPAC from the 2013 and 2014 institutional outpatient files from CMS.

- In 2014, total spending for dialysis, dialysis drugs, and ESRD-related clinical laboratory tests was \$11.2 billion. In 2014, Medicare paid all facilities under a modernized prospective payment system that includes in the payment bundle certain dialysis drugs and ESRD-related clinical laboratory tests that were separately paid before 2011. In 2013, most facilities were paid under the new PPS.
- Between 2013 and 2014, total ESRD expenditures increased by about 1 percent.
- Freestanding dialysis facilities treated most dialysis beneficiaries and accounted for 94 percent of expenditures in 2014.

Chart 11-3. The ESRD population is growing, and most ESRD patients undergo dialysis

	2003		2009		2013	
	Patients (thousands)	Percent	Patients (thousands)	Percent	Patients (thousands)	Percent
Total	452.2	100%	575.3	100%	661.6	100%
Dialysis	325.8	72	406.3	71	468.4	71
In-center hemodialysis	293.8	65	367.8	64	412.8	62
Home hemodialysis*	1.7	0.4	5.5	1	8.5	1
Peritoneal dialysis*	29.0	6	31.3	5	45.4	7
Unknown	1.3	0.3	1.7	0.3	1.7	0.3
Functioning graft and kidney transplants	126.4	28	168.9	29	193.3	29

Note: ESRD (end-stage renal disease). Totals may not equal sum of components due to rounding. Data include both Medicare and non-Medicare patients.
*Home dialysis methods.

Source: Compiled by MedPAC from the United States Renal Data System.

- Persons with ESRD require either dialysis or a kidney transplant to maintain life. The total number of ESRD patients increased by 4 percent annually between 2003 and 2013.
- In hemodialysis, a patient's blood flows through a machine with a special filter that removes wastes and extra fluids. In peritoneal dialysis, the patient's blood is cleaned by using the lining of his or her abdomen as a filter. Peritoneal dialysis is the most common form of home dialysis.
- Most ESRD patients undergo hemodialysis administered in a dialysis facility three times a week. Between 2003 and 2013, the total number of in-center hemodialysis patients grew by 3 percent annually while the total number of peritoneal dialysis patients increased by 5 percent annually. Although a smaller proportion of all dialysis patients undergo home hemodialysis, the number of these patients grew 18 percent per year during this time period.
- Functioning graft patients are patients who have had a successful kidney transplant. Patients undergoing kidney transplant may receive either a living kidney or a cadaveric kidney donation. In 2013, 33 percent of transplanted kidneys were from living donors and the remainder were from cadaver donors (data not shown).

Chart 11-4. Asian Americans and Hispanics are among the fastest growing segments of the ESRD population

	Percent of total in 2013	Average annual percent change 2008–2013
Total (N = 661,648)	100%	4%
Age (years)		
0–17	1	0.3
18–44	16	1
45–64	44	4
65–79	30	6
80+	9	4
Sex		
Male	57	4
Female	43	3
Race/ethnicity		
White	62	4
African American	31	3
Native American	1	2
Asian American	6	6
Hispanic	17	6
Non-Hispanic	83	3
Underlying cause of ESRD		
Diabetes	37	4
Hypertension	25	5
Glomerulonephritis	16	2
Other causes	21	4

Note: ESRD (end-stage renal disease). Totals may not equal sum of the components due to rounding. ESRD patients include those who undergo maintenance dialysis and those who have a functioning kidney transplant.

Source: Compiled by MedPAC from the United States Renal Data System.

- Among ESRD patients, 39 percent are over age 65. About 60 percent are White.
- Diabetes is the most common cause of renal failure.
- The number of ESRD patients increased by 4 percent annually between 2008 and 2013. Among the fastest growing groups of patients are Asian Americans and Hispanics.

Chart 11-5. Characteristics of Medicare fee-for-service dialysis patients, 2014

	Percent of all FFS dialysis patients
Age (years)	
Under 45	12%
45–64	38
65–74	26
75–84	18
85+	6
Sex	
Male	55
Female	45
Race	
White	48
African American	36
All other	16
Residence	
Urban county	82
Rural county, micropolitan	11
Rural county, adjacent to urban	5
Rural county, not adjacent to urban	2
Frontier county	1
Prescription drug coverage status	
Enrolled in Part D plan or other source of creditable drug coverage	89
LIS	58
Dually eligible for Medicare and Medicaid	48

Note: FFS (fee-for-service), LIS (low-income [drug] subsidy). Urban counties contain a core area with 50,000 or more people, rural micropolitan counties contain at least one cluster of at least 10,000 and fewer than 50,000 people, rural counties adjacent to urban areas do not have a city of 10,000 people in the county, and rural counties not adjacent to urban areas do not have a city of 10,000 people. Frontier counties are counties with six or fewer people per square mile. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of dialysis claims files and denominator files from CMS.

- Compared with all Medicare patients, FFS dialysis patients are disproportionately younger and African American (see Chart 2-5).
- In 2014, nearly 20 percent of FFS dialysis patients resided in a rural county.
- Nearly half of all dialysis patients were dually eligible for Medicare and Medicaid services.
- Nearly 90 percent of FFS dialysis patients were enrolled in Part D plans or had other sources of creditable drug coverage.

Chart 11-6. Aggregate margins varied by type of freestanding dialysis facility, 2014

Type of facility	Percentage of freestanding facilities	Aggregate margin
All facilities	100%	2.1%
Urban	80	2.9
Rural	20	-2.7
Treatment volume (quintile)		
Lowest	20	-15.4
Second	20	-6.6
Third	20	-0.6
Fourth	20	3.8
Highest	20	8.1

Note: Margins include payments and costs for composite rate services, injectable drugs, and other end-stage renal disease-related services.

Source: Compiled by MedPAC from 2014 cost reports and the 2014 institutional outpatient file from CMS.

- For 2014, the aggregate Medicare margin for composite rate services and injectable drugs was 2.1 percent.
- Generally, freestanding dialysis facilities' margins vary by the size of the facility; facilities with greater treatment volume have higher margins on average. Differences in capacity and treatment volume explain some of the differences observed between the margins of urban and rural facilities. Urban facilities are larger on average than rural facilities with respect to the number of dialysis treatment stations and Medicare treatments provided. Some rural facilities have benefited from the low-volume adjustment that is included in the new end-stage renal disease payment method that began in 2011.

Chart 11-7. Medicare hospice spending and average length of stay were virtually unchanged in 2014

	2000	2013	2014	Average annual change, 2000–2013	Change, 2013–2014
Beneficiaries in hospice (in millions)	0.534	1.315	1.324	7.2%	0.7%
Medicare payments (in billions)	\$2.9	\$15.1	\$15.1	13.5%	–0.2%
Average length of stay among decedents (in days)	53.5	87.8	88.2	3.9%	0.5%
Median length of stay among decedents (in days)	17	17	17	0 days*	0 days*

Note: Average length of stay is calculated for decedents who used hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime. Due to rounding, the percentage change displayed in the chart may not equal the percentage change calculated using the yearly data displayed in the chart.

*This figure reflects the raw change rather than the percentage change.

Source: MedPAC analysis of the denominator file, the Medicare Beneficiary Database, and the 100 percent hospice claims standard analytic file from CMS.

- The number of Medicare beneficiaries receiving hospice services has more than doubled since 2000 and grew modestly in 2014, suggesting that access to hospice care has increased.
- Average length of stay held steady at about 88 days between 2013 and 2014, after a long period of growth.
- Total Medicare payments to hospices were about \$15.1 billion in 2014, about the same as 2013.

Chart 11-8. Hospice use increased across beneficiary groups from 2000 to 2014

	Share of decedents using hospice			Average annual percentage point change 2000–2013	Percentage point change 2013–2014
	2000	2013	2014		
All	22.9%	47.3%	47.8%	1.9%	0.5%
FFS beneficiaries	21.5	46.2	46.7	1.9	0.5
MA beneficiaries	30.9	50.6	50.8	1.5	0.2
Dual eligibles	17.5	42.1	42.4	1.9	0.3
Non–dual eligibles	24.5	48.9	49.4	1.9	0.5
Age (years)					
<65	17.0	29.2	29.4	0.9	0.2
65–84	24.7	45.3	45.6	1.6	0.3
85+	21.4	55.0	56.0	2.6	1.0
Race/ethnicity					
White	23.8	49.2	49.7	2.0	0.5
Minority	17.3	37.0	37.6	1.5	0.6
Gender					
Male	22.4	43.3	43.7	1.6	0.4
Female	23.3	50.9	51.4	2.1	0.5
Beneficiary location					
Urban	24.3	48.5	48.9	1.9	0.4
Micropolitan	18.5	44.3	44.7	2.0	0.4
Rural, adjacent to urban	17.6	42.9	43.2	1.9	0.3
Rural, nonadjacent to urban	15.8	38.0	38.7	1.7	0.7
Frontier	13.2	32.3	32.3	1.5	0.0

Note: FFS (fee-for-service), MA (Medicare Advantage). “Beneficiary location” refers to the beneficiary’s county of residence. Urban, micropolitan, and rural designations are based on the urban influence codes. The frontier category is defined as population density equal to or less than six persons per square mile.

Source: MedPAC analysis of data from the denominator file and the Medicare Beneficiary Database from CMS.

- Hospice use grew in almost all beneficiary groups in 2014, continuing the trend of a growing proportion of beneficiaries using hospice at the end of life.
- Despite this growth, hospice use continued to vary by demographic and beneficiary characteristics. Medicare decedents who were older, White, female, MA enrollees, not dual eligible, or living in an urban area were more likely to use hospice than their respective counterparts.

Chart 11-9. Number of Medicare-participating hospices has increased due to growth in for-profit hospices

	2000	2012	2013	2014
All hospices	2,255	3,727	3,925	4,092
For profit	672	2,199	2,418	2,590
Nonprofit	1,324	1,320	1,309	1,302
Government	257	208	198	200
Freestanding	1,069	2,643	2,844	3,027
Hospital based	785	568	553	535
Home health based	378	492	503	506
SNF based	22	23	25	24
Urban	1,424	2,670	2,885	3,016
Rural	788	983	992	991

Note: SNF (skilled nursing facility). Numbers may not sum to totals because of missing data for a small number of providers.

Source: MedPAC analysis of Medicare cost reports, Provider of Services file, and the standard analytic file of hospice claims from CMS.

- There were nearly 4,100 Medicare-participating hospices in 2014. Most of them were for-profit hospices.
- Between 2000 and 2014, the number of Medicare-participating hospices grew by more than 1,800 providers. For-profit hospices accounted almost entirely for that growth.
- Growth in the number of providers has occurred predominantly among freestanding and home health–based providers. The number of hospital-based providers has declined.
- The number of hospices in rural areas changed little between 2013 and 2014.

Chart 11-10. Hospice cases and length of stay, by diagnosis, 2014

Diagnosis	Share of total cases	Percent of cases with length of stay greater than 180 days
Cancer (except lung cancer)	21%	10%
Circulatory, except heart failure	16	24
Alzheimer's and similar diseases	14	37
Heart failure	10	21
Lung cancer	8	9
Chronic airway obstruction, NOS	6	28
Respiratory disease	5	14
Nervous system, except Alzheimer's	4	32
Other	3	13
Genitourinary disease	3	8
Organic psychoses	3	24
Dementia	2	28
Digestive disease	2	9
Adult failure to thrive or debility, NOS	1	23
All	100	20

Note: NOS (not otherwise specified). Cases include all patients who received hospice care in 2014, not just decedents. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim. The percentage of cases with length of stay greater than 180 days reflects the share of hospice patients who received hospice care in 2014 whose lifetime length of hospice stay exceeded 180 days at the end of 2014 (or at the time of death or discharge in 2014 if the beneficiary was not enrolled in hospice at the end of 2014). "Share of total cases" column may not sum to 100 percent because of rounding.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file from CMS and the Medicare Beneficiary Database.

- In 2014, the most common terminal diagnosis among Medicare hospice patients was cancer (all types), accounting for about 29 percent of cases. The next most common diagnoses were heart failure and other circulatory conditions (26 percent of cases) and neurological conditions (Alzheimer's disease, nervous system disorders, organic psychoses, and dementia) (23 percent of cases).
- Length of stay varies by diagnosis. Nearly one-quarter or more of hospice patients in 2014 with circulatory conditions, Alzheimer's disease, chronic airway obstruction, nervous system disorders other than Alzheimer's, organic psychoses, and dementia had lengths of stay exceeding 180 days. Long hospice stays were least common among beneficiaries with genitourinary disease, digestive disease, and cancer.

Chart 11-11. Hospice length of stay has changed little since 2012, after a more than decade-long period of growth in the longest stays

Year	Average length of stay (in days)	Percentiles of length of stay (in days)				
		10th	25th	50th	75th	90th
2000	53.5	3	6	17	56	141
2001	54.9	3	6	17	57	146
2002	58.2	3	6	17	59	157
2003	62.2	3	6	17	62	170
2004	66.0	3	5	17	63	180
2005	71.3	3	5	17	67	194
2006	75.6	3	5	17	70	208
2007	79.7	3	5	17	73	222
2008	83.4	2	5	17	75	235
2009	84.4	3	5	17	76	237
2010	86.1	3	5	17	77	240
2011	86.3	2	5	17	78	240
2012	88.0	2	5	18	80	246
2013	87.8	2	5	17	79	246
2014	88.2	2	5	17	79	247

Note: Data reflect hospice length of stay for Medicare decedents who used hospice at the time of death or before death. "Length of stay" reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his or her lifetime.

Source: MedPAC analysis of the denominator file and the Medicare Beneficiary Database from CMS.

- Average length of stay among decedents grew from nearly 54 days in 2000 to 88 days in 2012 and has held steady at about 88 days through 2014.
- In 2014, the 10 percent of hospice decedents with the longest stays (i.e., the 90th percentile) received 247 days or more of hospice care, similar to the two prior years. Before 2012, most growth in hospice length of stay occurred among decedents with the longest stays. Between 2000 and 2012, the 90th percentile in length of stay grew from 141 days to 246 days.
- Short stays in hospice have changed little since 2000. The median length of stay in hospice was about 17 days from 2000 to 2014. Hospice length of stay at the 25th percentile has been 5 or 6 days and at the 10th percentile has been 2 or 3 days since 2000.

Chart 11-12. Hospice length of stay among decedents, by beneficiary and hospice characteristics, 2014

	Average length of stay (in days)	Length of stay percentiles (in days)		
		10th	50th	90th
Beneficiary				
Diagnosis				
Cancer	53	3	18	130
Neurological	148	3	33	447
Heart/circulatory	89	2	14	262
Debility or adult failure to thrive	102	3	20	307
COPD	121	2	25	363
Other	48	2	7	124
Site of service				
Home	90	4	26	238
Nursing facility	110	3	21	329
Assisted living facility	154	5	51	441
Hospice				
For profit	107	3	21	314
Nonprofit	67	2	13	179
Freestanding	91	2	17	257
Home health based	71	2	16	192
Hospital based	58	2	13	152

Note: COPD (chronic obstructive pulmonary disease). Average length of stay is calculated for Medicare beneficiaries who died in 2014 and used hospice that year, and it reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his or her lifetime. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file data, Medicare Beneficiary Database, Medicare hospice cost reports, and Provider of Services file data from CMS.

- Hospice average length of stay among decedents varies by both beneficiary and provider characteristics. Most of this variation reflects differences in length of stay among patients with the longest stays (i.e., at the 90th percentile). Length of stay varies much less for patients with shorter stays (i.e., at the 10th or 50th percentile).
- Beneficiaries with neurological conditions, COPD, or debility or adult failure to thrive have the longest stays, while beneficiaries with cancer have the shortest stays on average.
- Beneficiaries who receive hospice services in assisted living facilities and nursing facilities have longer stays on average than beneficiaries who receive care at home.
- For-profit and freestanding hospices have longer average lengths of stay than nonprofit and provider-based (home health– and hospital-based) hospices.

Chart 11-13. More than half of Medicare hospice spending in 2014 was for patients with stays exceeding 180 days

	Medicare hospice spending, 2014 (in billions)
All hospice users in 2014	\$15.1
Beneficiaries with LOS > 180 days	8.8
Days 1–180	2.8
Days 181–365	2.8
Days 366+	3.2
Beneficiaries with LOS ≤ 180 days	6.1

Note: LOS (length of stay). LOS reflects the beneficiary's lifetime LOS as of the end of 2014 (or at the time of death or discharge in 2014 if the beneficiary was not enrolled in hospice at the end of 2014). All spending reflected in the chart occurred only in 2014. Break-out groups do not sum to total because of rounding and because they exclude about \$0.1 billion in payments to hospices for physician visits.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file data and the common Medicare enrollment file from CMS.

- In 2014, Medicare hospice spending on patients with stays exceeding 180 days was nearly \$9 billion, more than half of all Medicare hospice spending that year.
- About \$3.2 billion, or about 20 percent, of Medicare hospice spending in 2014 was on hospice care for patients who had already received at least one year of hospice.

Chart 11-14. Hospice aggregate Medicare margins, 2007–2013

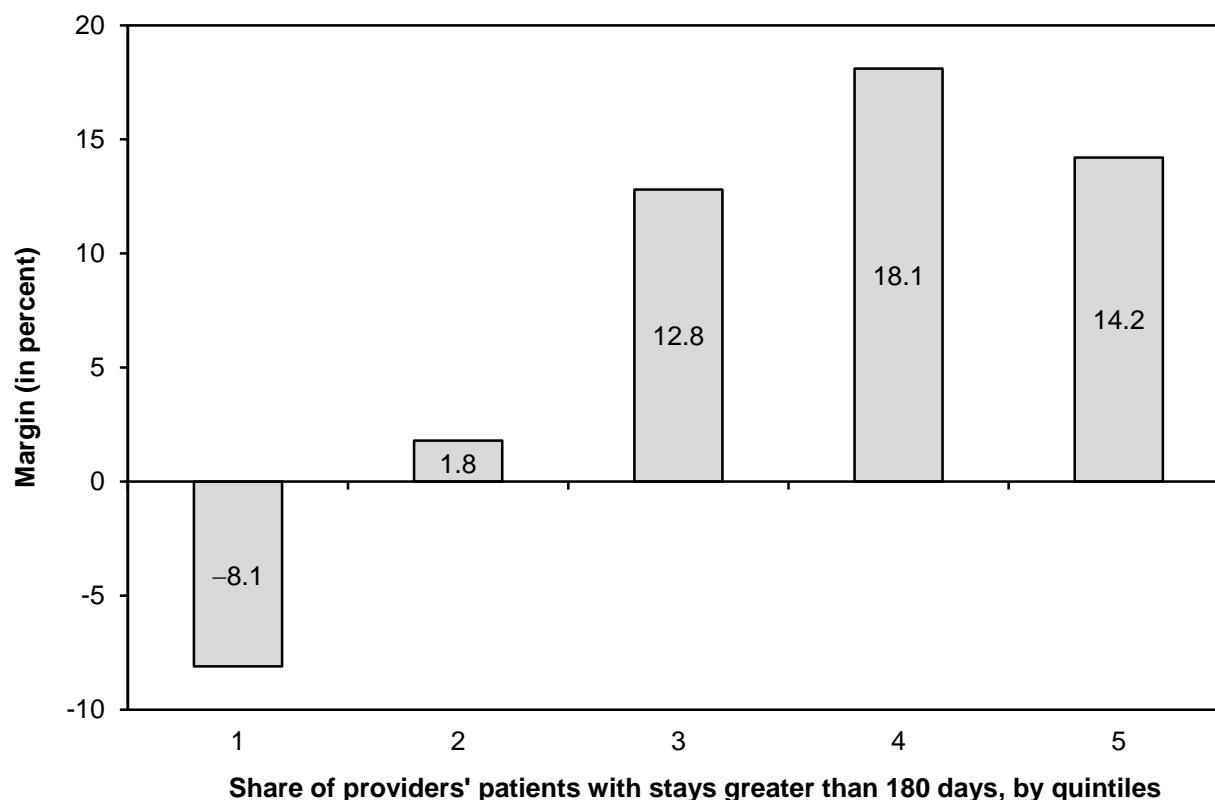
	Share of hospices (2013)	Medicare margin				
		2007	2010	2011	2012	2013
All	100%	5.8%	7.4%	8.8%	10.0%	8.6%
Freestanding	72	8.7	10.7	11.8	13.3	12.0
Home health based	13	2.3	3.2	6.1	5.7	2.2
Hospital based	14	-10.9	-16.6	-16.0	-16.8	-16.7
For profit	62	10.4	12.3	14.8	15.4	14.7
Nonprofit	33	1.6	3.0	2.4	3.7	1.2
Government	5	N/A	N/A	N/A	N/A	N/A
Urban	74	6.3	7.7	9.1	10.3	8.9
Rural	26	1.4	5.2	6.0	7.3	6.1
Below cap	89.3	6.1	7.7	9.1	10.4	8.8
Above cap	10.7	2.5	3.2	4.1	5.2	7.0
Above cap (including cap overpayments)	10.7	20.5	17.4	18.4	21.3	20.2

Note: N/A (not available). Margins for all provider categories exclude overpayments to above-cap hospices except where specifically indicated. Margins are calculated based on Medicare-allowable, reimbursable costs. The percentage of freestanding and provider-based (home health–based and hospital-based) hospices does not sum to 100 percent because skilled nursing facility–based hospices are not broken out separately. The percentage of hospices may not sum to 100 percent for other categories due to rounding.

Source: MedPAC analysis of Medicare hospice cost reports, 100 percent hospice claims standard analytic file, and Medicare Provider of Services data from CMS.

- The aggregate Medicare margin was 8.6 percent in 2013, down from 10.0 percent in 2012. The implementation of the sequester beginning April 2013 accounts for this decline in the margin. The sequester reduced hospice revenues in the 2013 cost report year by about 1.3 percent.
- Margin estimates do not include nonreimbursable costs associated with bereavement services and volunteers (which, if included, would reduce margins by at most 1.4 and 0.3 percentage points, respectively). Margins also do not include the costs and revenues associated with fundraising.
- Freestanding hospices had higher margins than provider-based (home health– and hospital-based) hospices, in part, because of differences in their indirect costs. Provider-based hospices' indirect costs are higher than those of freestanding providers and are likely inflated because of the allocation of overhead from the parent provider.
- In 2013, for-profit hospice margins were strong at 14.7 percent. The aggregate margin for nonprofit hospices was 1.2 percent. The subset of nonprofit hospices that were freestanding had a higher margin, 5.2 percent (not shown in chart).
- Hospices that exceeded the cap (Medicare's aggregate average per beneficiary payment limit) had a margin of more than 20 percent before the return of the cap overpayments.

Chart 11-15. Medicare margins were higher among hospices with more long stays, 2013



Note: Margins exclude overpayments to hospices that exceeded the cap on the average annual Medicare payment per beneficiary. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports and 100 percent hospice claims standard analytic file from CMS.

- Medicare’s per diem payment system for hospice provides an incentive for longer lengths of stay.
- Hospices with more patients who had stays greater than 180 days generally have higher margins. In 2013, hospices in the lowest length-of-stay quintile had a margin of –8.1 percent compared with an 18.1 percent margin for hospices in the second highest length-of-stay quintile.
- Margins were somewhat lower in the highest length-of-stay quintile (14.2 percent) compared with the second highest quintile (18.1 percent) because some hospices in the highest quintile exceeded Medicare’s aggregate payment cap and were required to repay the overage. Hospices exceeding the cap had a margin of more than 20 percent before the return of overpayments (see Chart 11-14).

Chart 11-16. Hospices that exceeded Medicare's annual payment cap, selected years

	2002	2010	2011	2012	2013
Share of hospices exceeding the cap	2.6%	10.1%	9.8%	11.0%	10.7%
Average payments over the cap per hospice exceeding the cap (in thousands)	\$470	\$426	\$424	\$510	\$460
Payments over the cap as a percent of overall Medicare hospice spending	0.6%	1.1%	1.1%	1.4%	1.3%

Note: The cap year is defined as the period beginning November 1 and ending October 31 of the following year. These estimates of hospices that exceeded the aggregate cap are based on the Commission's analyses. While the estimates are intended to approximate those of the Medicare claims-processing contractors, they are not necessarily identical to the contractors' estimates because of differences in available data and methodology.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file data, Medicare hospice cost reports, Provider of Services file data from CMS, and CMS Providing Data Quickly system. Data on total spending for each fiscal year are from the CMS Office of the Actuary.

- The share of hospices exceeding the aggregate cap declined slightly from 11.0 percent in 2012 to 10.7 percent in 2013.
- Medicare payments over the cap represented 1.3 percent of total Medicare hospice spending in 2013.
- On average, above-cap hospices exceeded the cap by about \$460,000 per provider in 2013, down from about \$510,000 per provider in 2012.

Chart 11-17. Hospice live-discharge rates, 2012–2014

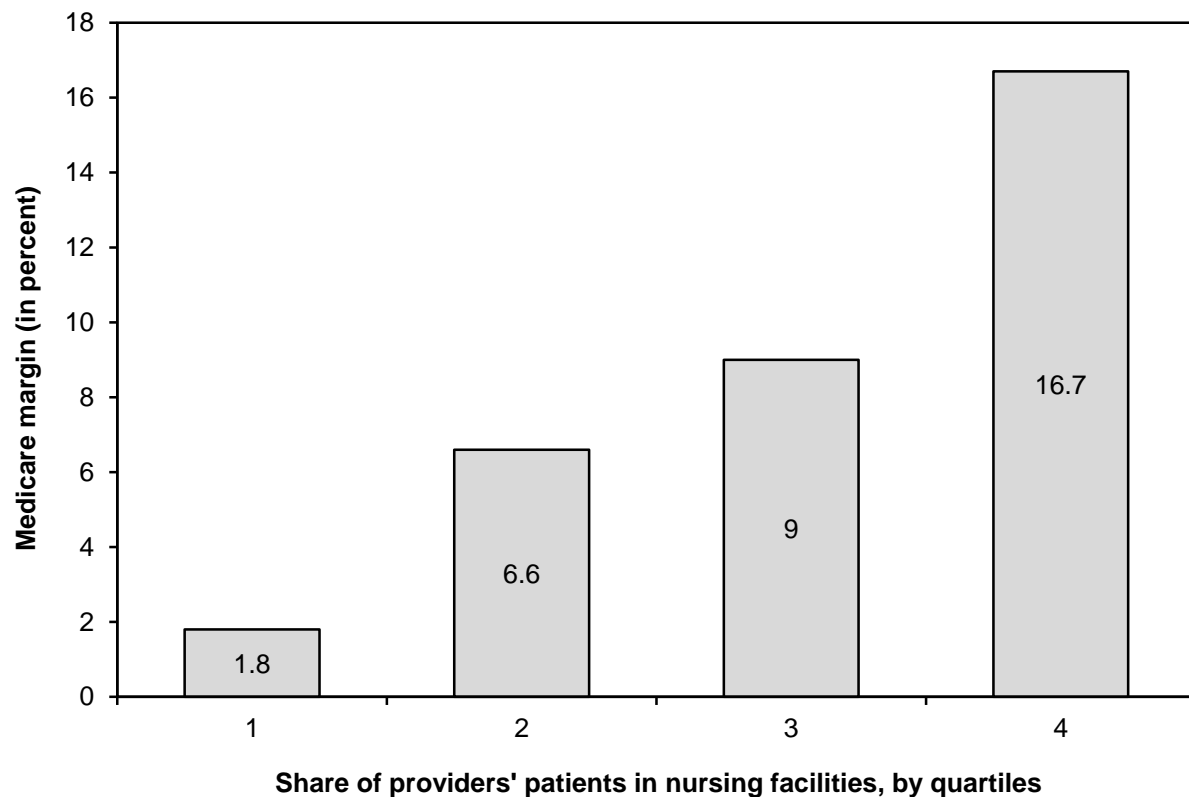
	2012	2013	2014
Live discharge as a share of all discharges	18.5%	18.4%	17.2%
Reason for live discharge			
No longer terminally ill	38	42	43
Beneficiary revocation	45	40	39
Transfer hospice providers	10	11	12
Move out of service area	5	5	5
Discharge for cause	2	2	2
Providers' rate of live discharge as a share of all discharges, by percentile			
10th percentile	9.3	9.3	8.5
25th percentile	13.0	13.2	12.3
50th percentile	19.4	19.4	18.7
75th percentile	30.8	30.2	30.1
90th percentile	50.0	47.4	50.0

Note: The information on reason for live discharge for 2012 is based on data reported for the last six months of 2012. A "discharge for cause" may occur under certain circumstances if the patient's behavior is disruptive, abusive, or uncooperative. Percentages may not sum to 100 due to rounding.

Source: MedPAC analysis of 100 percent hospice claims standard analytic file.

- In 2014, about 17.2 percent of hospice discharges were live discharges, down from 18.4 percent in 2013.
- In 2014, the most common reasons for live discharge were that the beneficiary was no longer terminally ill (43 percent) and the beneficiary revoked his or her hospice election and returned to conventional care (39 percent). Live discharges resulting from a patient transferring hospice providers, moving out of the hospice provider's service area, or being discharged for cause occurred less frequently.
- Live-discharge rates vary across providers. The 10 percent of hospices with the highest live-discharge rates (i.e., the 90th percentile) had live discharges account for half of their discharges in 2014.

Chart 11-18. Margins were higher among hospices with a greater share of their patients in nursing facilities, 2013

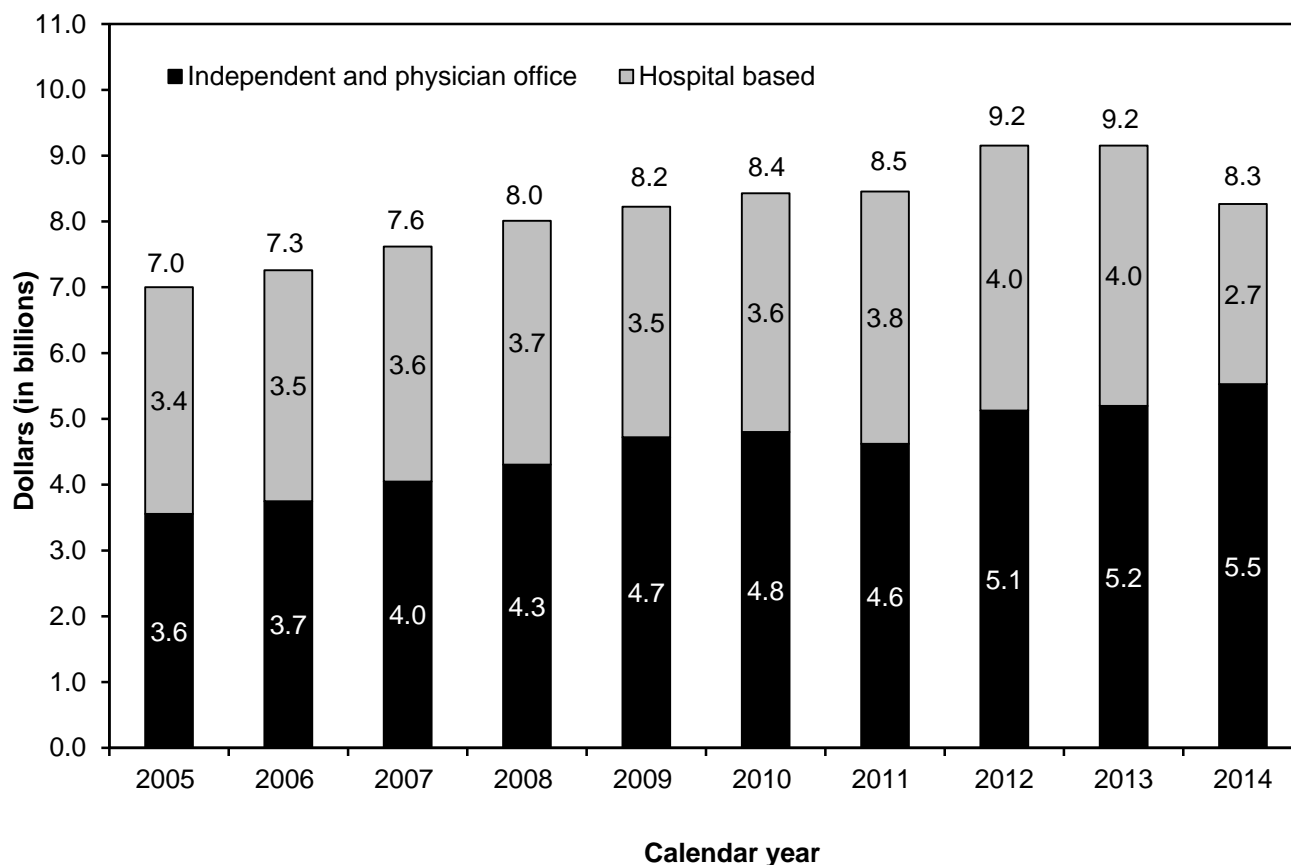


Note: Margins exclude overpayments to hospices that exceed the cap on the average annual Medicare payment per beneficiary. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports and 100 percent hospice claims standard analytic file from CMS.

- Hospices with a large share of their patients in nursing facilities have higher margins than other hospices.
- The higher profitability of hospices serving many nursing facility patients may be due to a combination of factors, such as longer lengths of stay, possible efficiencies in treating patients in a centralized location (e.g., lower mileage costs and less staff time for travel), and overlap in responsibilities between the hospice and the nursing facility.

Chart 11-19. Medicare spending for clinical laboratory services, 2005–2014



Note: Spending is for services paid under the clinical laboratory fee schedule. Hospital-based services are furnished in labs owned or operated by hospitals. Total spending appears on top of each bar. The components of each bar may not sum to the total at the top of each bar due to rounding. The spending data include only program payments; there is no beneficiary cost sharing for clinical lab services.

Source: The annual report of the Boards of Trustees of the Medicare trust funds 2015.

AT THE TIME THIS DATA BOOK WAS PREPARED, THE MEDICARE TRUSTEES' REPORT (WHICH IS THE CUSTOMARY SOURCE OF DATA FOR THIS CHART) HAD NOT YET BEEN RELEASED FOR 2016. THIS CHART REFLECTS DATA FROM THE 2015 MEDICARE TRUSTEES' REPORT. THE READER IS ADVISED TO CONSULT THE 2016 TRUSTEES' REPORT DIRECTLY, WHEN AVAILABLE, FOR THE MOST CURRENT VERSION OF THESE DATA.

- Medicare spending for clinical laboratory services in all settings grew by an average of 3.4 percent per year between 2005 and 2013. This growth was primarily driven by rising volume since there were very few increases in payment rates during those years.
- Medicare spending for lab services declined by 9.7 percent in 2014 because, beginning in 2014, most lab tests provided in hospital outpatient departments are no longer paid separately under the clinical lab fee schedule. Instead, most of these tests are packaged with their associated visits or procedures under the hospital outpatient prospective payment system.
- In 2014, independent and physician-office labs accounted for 67 percent of Medicare spending for all lab services; hospital-based labs accounted for the remaining 33 percent. Clinical lab services accounted for 1.4 percent of total Medicare spending in 2014 (data not shown).

