

CHAPTER

6

**Reforming Medicare's
hospice benefit**

R E C O M M E N D A T I O N S

- 6-1** The Congress should direct the Secretary to change the Medicare payment system for hospice to:
- have relatively higher payments per day at the beginning of the episode and relatively lower payments per day as the length of the episode increases,
 - include a relatively higher payment for the costs associated with patient death at the end of the episode, and
 - implement the payment system changes in 2013, with a brief transitional period.

These payment system changes should be implemented in a budget-neutral manner in the first year.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

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- 6-2A** The Congress should direct the Secretary to:
- require that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180th-day recertification and each subsequent recertification and attest that such visits took place,
 - require that certifications and recertifications include a brief narrative describing the clinical basis for the patient’s prognosis, and
 - require that all stays in excess of 180 days be medically reviewed for hospices for which stays exceeding 180 days make up 40 percent or more of their total cases.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

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- 6-2B** The Secretary should direct the Office of Inspector General to investigate:
- the prevalence of financial relationships between hospices and long-term care facilities such as nursing facilities and assisted living facilities that may represent a conflict of interest and influence admissions to hospice,
 - differences in patterns of nursing home referrals to hospice,
 - the appropriateness of enrollment practices for hospices with unusual utilization patterns (e.g., high frequency of very long stays, very short stays, or enrollment of patients discharged from other hospices), and
 - the appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admissions practices.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

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- 6-3** The Secretary should collect additional data on hospice care and improve the quality of all data collected to facilitate the management of the hospice benefit. Additional data could be collected from claims as a condition of payment and from hospice cost reports.

COMMISSIONER VOTES: YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

Reforming Medicare's hospice benefit

Chapter summary

The Medicare hospice benefit was established in 1983 to provide beneficiaries at the end of life with an alternative to conventional medical interventions. Beneficiaries electing hospice could forgo conventional treatments and opt to receive palliative care and other benefits consistent with their personal preferences about end-of-life care. The creation of the Medicare hospice benefit was more than just a change to the Medicare benefits package, it was a statement recognizing and respecting social values and patient preferences at the end of life. Since Medicare began covering hospice care, the share of beneficiaries electing it has grown, as there has been increased recognition that hospice can appropriately care for patients with noncancer diagnoses. Hospice now provides care to beneficiaries with a wide range of terminal conditions, in contrast to the earlier years of the benefit when most hospice enrollees were cancer patients.

Along with this expansion, hospice stays have grown longer, with especially rapid growth occurring since 2000. Medicare hospice spending

In this chapter

- Overview of Medicare's hospice benefit
- Trends in hospice use
- Need for payment system reform
- Additional refinements to the hospice payment system
- Conclusions and implications for future work

also rose rapidly, more than tripling between 2000 and 2007, when it reached \$10 billion. Over this time, the number of Medicare-participating hospices increased by more than 1,000 providers, nearly all of which were for-profit entities. The Commission's analysis of the hospice benefit in our June 2008 report shows that Medicare's hospice payment system contains incentives that make very long stays in hospice profitable for the provider, which may have led to inappropriate utilization of the benefit among some hospices. We also find that the benefit lacks adequate administrative and other controls to check the incentives for long stays in hospice and that CMS lacks data vital to the effective management of the benefit.

To address these problems, we propose recommendations to reform the payment system, to ensure greater accountability within the hospice benefit, and to improve data collection and accuracy. In making these recommendations, the Commission recognizes the importance of the hospice benefit and its substantial contribution to end-of-life care for beneficiaries. The goal of these recommendations is to strengthen the hospice payment system and not discourage enrollment in hospice, while deterring program abuse. Thus, the Commission's recommendations are intended to encourage hospices to admit patients at a point in their terminal disease that provides the most benefit for the patient.

Our approach to hospice payment system reform moves away from Medicare's current flat per diem payment system to one under which per diem payments for an episode of care begin at a relatively higher rate but then decline as the length of the episode increases. Our revised system provides an additional payment at the end of the episode, reflecting hospices' higher level of effort at the time of a patient's death. These changes would be made in a budget-neutral manner in the first year. The resulting payment stream would better reflect changes in hospices' level of effort in providing care throughout the hospice episode. We believe the design of this payment system will promote hospice stays of a length consistent with hospice as an end-of-life benefit (reducing the number of extremely long stays) and will

provide incentives for hospices to more closely monitor patients' admissions and continued eligibility for hospice. Very long hospice stays work against the statutory presumption that hospice costs Medicare less than conventional end-of-life care, and they blur the distinction between hospice and long-term care. Given the response of some hospices to the incentives in the current payment system that promote long stays, coupled with the inherent challenges in predicting life expectancy and determining which patients are appropriate for hospice, we believe these changes to improve the incentives in the hospice payment system are imperative.

The model of the revised payment system we propose is conceptual and illustrates the general principles and policy direction the payment system should encompass. In the chapter, we provide two illustrations of how the payment levels could be structured, but they are not the only sets of payment levels that could be considered. If the proposed payment system were enacted by 2013, as we recommend, the final payment levels would be established by CMS through notice and comment rulemaking. CMS is expected to have additional data before 2013 that could inform establishment of the payment levels. However, given that such data are likely to include inappropriate responses by some providers to the financial incentives in the current payment system, policymakers may wish to set payment rates on a more normative basis to achieve desired policy goals.

The Congress should direct the Secretary to change the Medicare payment system for hospice to:

- *have relatively higher payments per day at the beginning of the episode and relatively lower payments per day as the length of the episode increases,*
- *include a relatively higher payment for the costs associated with patient death at the end of the episode, and*
- *implement the payment system changes in 2013, with a brief transitional period.*

These payment system changes should be implemented in a budget-neutral manner in the first year.

Recommendation 6-1

**COMMISSIONER VOTES:
YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2**

The revised payment system will provide incentives for appropriate lengths of stay in hospice, but additional controls are needed to ensure an adequate

level of accountability for the hospice benefit. Greater physician engagement is needed in the process of certifying and recertifying patients' eligibility for the Medicare hospice benefit. More oversight of hospices' compliance with Medicare eligibility criteria is necessary. These measures are directed at hospices that tend to enroll very-long-stay patients and in so doing will have the effect of helping to ensure that hospice is used to provide the most appropriate care for eligible patients. In addition, potential conflicts of interest among hospices and other providers caring for hospice patients need to be addressed. For example, consistent with the payment system incentives we have identified, some hospices seem to draw a disproportionate share of patients from nursing facilities. These hospices are more likely to be for profit and have an average length of stay nearly 50 percent greater than hospices with a low share of institutionalized patients.

Recommendation 6-2A

COMMISSIONER VOTES:

YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

The Congress should direct the Secretary to:

- *require that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180th-day recertification and each subsequent recertification and attest that such visits took place,*
- *require that certifications and recertifications include a brief narrative describing the clinical basis for the patient's prognosis, and*
- *require that all stays in excess of 180 days be medically reviewed for hospices for which stays exceeding 180 days make up 40 percent or more of their total cases.*

Recommendation 6-2B

COMMISSIONER VOTES:

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The Secretary should direct the Office of Inspector General to investigate:

- *the prevalence of financial relationships between hospices and long-term care facilities such as nursing facilities and assisted living facilities that may represent a conflict of interest and influence admissions to hospice,*
- *differences in patterns of nursing home referrals to hospice,*
- *the appropriateness of enrollment practices for hospices with unusual utilization patterns (e.g., high frequency of very long stays, very short stays, or enrollment of patients discharged from other hospices), and*
- *the appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admissions practices.*

Lastly, more and better data are needed to refine the new payment system as changes are implemented. For example, hospice claims should contain information on the kind and duration of visits provided to a patient to better understand care provided and to differentiate patterns of care among different types of patients and hospices. Hospice cost reports should include additional information on revenues and should be subject to additional reviews to ensure they serve as accurate fiscal documents. Such data will enhance CMS's ability to monitor hospice utilization trends and ensure that the payment system does not create adverse financial incentives. ■

The Secretary should collect additional data on hospice care and improve the quality of all data collected to facilitate the management of the hospice benefit. Additional data could be collected from claims as a condition of payment and from hospice cost reports.

Recommendation 6-3

YES 15 • NO 0 • NOT VOTING 0 • ABSENT 2

Background

Medicare's hospice benefit was established in 1983 in part to provide Medicare beneficiaries with an alternative approach to care at the end of life consistent with the preferences of those who do not want intensive medical interventions. Hospice permits beneficiaries at the end of life to opt for a death at home, surrounded by friends and family, rather than in an institutional clinical setting. The creation of the Medicare hospice benefit was more than just a change to the Medicare benefits package, it was a statement recognizing and respecting social values and patient preferences at the end of life.

Few, if any, components of the Medicare program invoke such sensitive issues as does hospice. The election of hospice is not an easy decision for a patient to make; neither is it necessarily an easy decision for some physicians and other providers to accept. In electing hospice, the patient, his or her family, and medical practitioners must recognize and come to terms with the proximity of life's end. While hospice can offer a rich array of benefits to the dying patient, far beyond the conventional care Medicare covers, it is an election beneficiaries and their families do not take lightly. Further, hospice election may create or exacerbate ethical dilemmas among some physicians who care for patients as they near the end of life. The U.S. medical establishment has long regarded the preservation and prolongation of life as goals of modern medicine. Some physicians caring for dying patients who wish to elect hospice may not be able to reconcile the patient's hospice election with their own training to do everything possible to stave off death, especially if there are differences of opinion between the patient and his or her family about the choice of care at the end of life. Such issues are further complicated when financial incentives bear on decisions about end-of-life care.

Beyond the personal considerations, financial incentives in some cases may influence a beneficiary's (or the family's if the beneficiary is not capable of doing so because of his or her terminal condition) decision to elect hospice. We heard from an expert panel we convened in October 2008 that the rich benefits of hospice—with minimal beneficiary cost sharing—may lead some patients, families, and providers to implicitly regard hospice as a source of basic health care for failing patients who did not qualify for skilled nursing facility or home health care and did not qualify for Medicaid or otherwise could not afford other sources of long-term custodial care.

Other financial incentives have implications for providers and the Medicare program overall. Because of the sensitivities surrounding the end of life, Medicare must walk a fine line in managing the hospice benefit. Because of the ambiguity in predicting death within the six-month time frame the benefit was designed for, Medicare cannot establish criteria for admission to hospice that are too strict, lest such criteria unduly restrict access to hospice care. Yet the program has a fiduciary responsibility to manage the benefit to achieve the best possible value for the program's beneficiaries and the taxpayers who fund Medicare. Health care at the end of life is costly. For the last two decades, the 5 percent of beneficiaries who die in a given year account for roughly one-quarter of Medicare spending in that year. Currently, Medicare beneficiaries incur roughly \$40,000 or more in spending in their last year of life. The hospice benefit was established through legislation in 1983 to offer beneficiaries an alternative to conventional care at the end of life but also with the expectation that Medicare spending for hospice patients would be lower than that for conventional care. Thus, recognizing the delicate nature of providing care at such an emotionally charged phase of the patient's life, efforts to ensure appropriate use of the hospice benefit will help ensure its availability for patients now and in the future.

Overview of Medicare's hospice benefit

The Medicare hospice benefit covers palliative and support services for beneficiaries who have a life expectancy of six months or less if the terminal disease with which they have been diagnosed follows its normal course. The hospice benefit provides for a rich array of medical and support services to patients and their families (MedPAC 2008). To access these services, beneficiaries must elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for curative treatment for the terminal illness. The attending physician, the medical director, or the physician designee and an interdisciplinary group must establish and maintain a written plan of care for each hospice enrollee. That plan must assess the patient's needs, identify services to be provided (including management of discomfort and symptom relief), and describe the scope and frequency of services needed to meet the patient's and family's needs.

Beneficiaries elect hospice for defined benefit periods. Two physicians, the patient's attending physician (if any)

**TABLE
6-1**

Growth in hospice use suggests beneficiary access to care is growing

Category	2000		2007		Percent change, 2000-2007	Average annual percent change, 2000-2007	Percent of Medicare hospice patients served, 2006
	Number	Percent of total	Number	Percent of total			
Type of hospice							
All	2,319	100%	3,261	100%	41%	5%	100%
For profit	750	32	1,641	50	119	12	41
Freestanding	548	24	1,395	43	155	14	35
Provider based	202	9	246	8	22	3	6
Nonprofit	1,228	53	1,208	37	-2	0	54
Freestanding	498	21	520	16	4	1	31
Provider based	730	31	688	21	-6	-1	23
Freestanding	1,136	49	2,063	63	82	9	69
Provider based	1,183	51	1,198	37	1	0	31
Rural	875	38	1,128	35	29	4	14
Urban	1,444	62	2,133	65	48	6	86
Number of hospice patients	513,000		1,000,000		95	10	
Medicare hospice spending (in billions)	\$2.9		\$10.1		248	20	

Note: The data on for-profit and nonprofit hospices do not sum to the all hospice total because the total also includes hospices with government or other ownership.

Source: MedPAC analysis of data from hospice claims, cost reports, and provider of service file from CMS, and CMS Providing Data Quickly query, <https://pdq.cms.hhs.gov>, accessed January 6, 2009.

and a hospice physician, are required to initially certify that the patient’s prognosis is terminal (i.e., the patient has a life expectancy of six months or less if the disease runs its normal course) for the patient to be eligible to elect hospice. The first hospice benefit period is 90 days. If the patient’s terminal illness continues to engender the likelihood of death within six months, the patient can be recertified for another 90 days. After the second 90-day period, the patient can be recertified for an unlimited number of 60-day periods, as long as he or she continues to have a life expectancy of 6 months or less. Beneficiaries can switch from one hospice to another once during a hospice election period and can disenroll from hospice at any time. After the initial certification, recertifications of hospice eligibility are solely within the purview of the hospice medical director and do not require certification of the patient’s original physician.

When the Congress established the Medicare hospice benefit, there was a strong expectation that, in addition to providing patients with an option for care consistent with

their personal preferences, hospice would result in lower costs to the Medicare program than conventional medical interventions at the end of life. The Congress put two limits on Medicare payments to hospices to ensure that would be the case. The first limit was on the percentage of Medicare payments a hospice could receive for inpatient care; no more than 20 percent of a hospice’s days could be paid at an inpatient service rate. The second limit was an aggregate per beneficiary limit on overall payments; this limit has come to be known as the “hospice cap.”

The Medicare payment rates and the hospice cap are updated annually. The Medicare payment rates for hospices are updated by the inpatient hospital market basket. The hospice cap is updated by the medical care expenditure category of the consumer price index for all urban consumers. (More detailed information on the hospice payment system is available at http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_hospice.pdf.)

Trends in hospice use

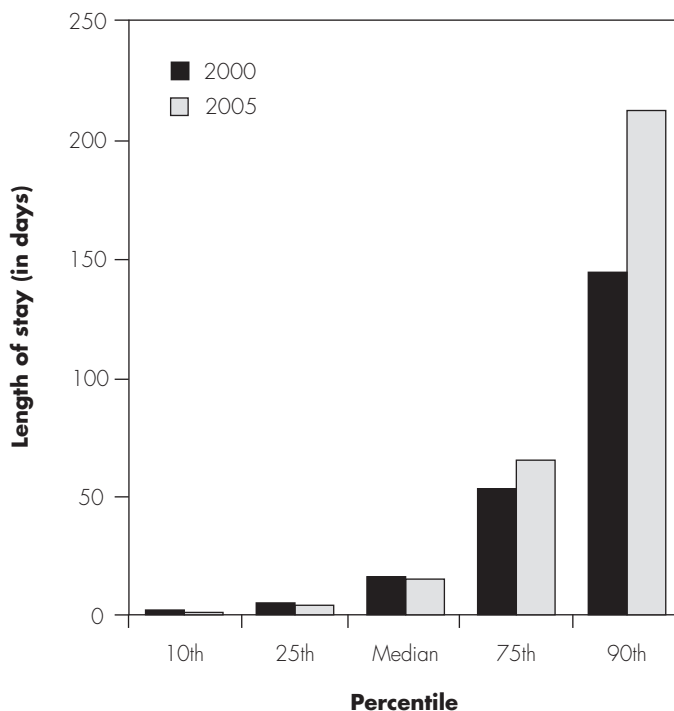
Use of the hospice benefit increased slowly for its first 10 years. Early in the benefit's history, most beneficiaries who elected hospice had terminal diagnoses of cancer. Since 2000, however, utilization has increased dramatically. By 2005, nearly 40 percent of the Medicare-decedent population had elected hospice, suggesting that many more beneficiaries have access to hospice than was the case at the outset of the benefit. In 2007, about 1,000,000 beneficiaries were enrolled in hospice, more than double the number who took advantage of the benefit a decade earlier. Between 2000 and 2007, Medicare spending for hospice more than tripled, from \$2.9 billion to just over \$10 billion (Table 6-1).

The number of Medicare-participating hospices has also grown rapidly in recent years; between 2000 and 2007, the number grew from just over 2,300 to more than 3,200, or by about 5 percent per year. Nearly all this growth was in for-profit hospices, which grew nearly 12 percent annually over this period, while the number of nonprofit hospices remained flat. Some of the growth in the number of hospices was in response to the increasing demand for hospice services (resulting from recognition that hospice services are appropriate for noncancer patients). However, a large part may also have been due to financial incentives in Medicare's hospice payment system, under which long stays are more profitable than short stays. Between 2000 and 2005, a pronounced increase occurred in hospice average length of stay, and long hospice stays got longer (Figure 6-1). At the same time, the median hospice stay was virtually unchanged throughout this period, remaining at just over two weeks. While the increase in very long hospice stays is a concern, so too is the persistence of very short hospice stays. With very short hospice stays, the patient does not fully benefit from all that hospice has to offer. In many cases, it may be desirable for these very-short-stay hospice patients to be admitted to hospice earlier in the progression of their terminal disease to enable them to receive the most benefit from hospice.

The Commission's analysis found several distinct patterns underlying the broader spending and utilization trends identified (MedPAC 2008). These patterns included a pronounced shift in patients' terminal diagnoses, the profitability of longer stays, and gaps in accountability for appropriate benefit use. We also noted that additional data were needed on hospices' costs and provision of services

FIGURE 6-1

Long hospice stays got longer from 2000 to 2005, while short stays were virtually unchanged



Note: Data are for decedent beneficiaries in both fee-for-service Medicare and Medicare Advantage.

Source: MedPAC analysis of 2007 100 percent Medicare Beneficiary Database file from CMS.

to assess what Medicare's spending for hospice care was buying.

With respect to patient diagnosis, we found that patients with neurological, cardiac, or nonspecific terminal diagnoses made up a growing share of the Medicare hospice patient population, in contrast to the early years of the benefit when almost all hospice patients had been diagnosed with cancer. Noncancer patients made up only 24 percent of the Medicare hospice population in 1992 (Hogan 2001) but represented 66 percent of patients in 2006. Noncancer patients tended to have longer stays in hospice and partially accounted for the steady increase in average hospice length of stay since 2000 (Table 6-2, p. 356).

However, change in patient mix does not explain all the change in length of stay that we see over this period. For example, hospices that exceed Medicare's limit on aggregate per beneficiary payments (the hospice cap—discussed later) have a mix of patients more skewed

**TABLE
6-2**

Mean length of hospice stay varies by disease category, 2006

Disease category	Mean length of stay (in days)	Percent of cases with length of stay greater than 180 days
Alzheimer's and other cerebrotdegenerative diseases	88	31.1%
Nervous system diseases except Alzheimer's	86	28.2
Dementia	78	26.2
Organic psychoses	77	25.4
Chronic airway obstruction, not otherwise specified	73	23.9
Unspecific symptoms/signs	72	21.3
Debility, not otherwise specified	70	20.8
Heart failure	66	20.3
Circulatory diseases except heart failure	57	18.7
Other cancer	47	8.9
Lung cancer	45	7.7
Other	43	12.6
Respiratory	41	12.0
Digestive diseases	38	8.7
Genitourinary diseases	25	4.7
All	59	16.8

Note: Mean length of stay reflects calculation based on subset of claims for which length of stay could be determined.

Source: MedPAC analysis of Medicare hospice 100 percent standard analytical file from CMS.

toward conditions likely to engender longer stays in hospice. However, these hospices (which have the highest average length of stay of any hospice group) have longer stays for all diagnoses than hospices that do not exceed the cap, suggesting that factors other than patient mix influence length of stay.

One explanation for the increasing length of stay is that Medicare's payment system rewards hospices that admit (and retain) patients likely to have long stays, with profitability increasing almost linearly with the average length of stay (Figure 6-2). Conversely, hospices with the shortest average lengths of stay have negative margins, consistent with anecdotal reports we have heard that very short hospice stays are generally unprofitable. While the

trends in admissions we observed in part reflect a natural progression of the hospice population becoming more representative of the mortality profile for the Medicare population overall, we believe these payment system incentives may improperly influence hospice length of stay for some providers.

Along with length of stay, the number of hospices exceeding Medicare's payment limit increased as well. We estimate that the number of hospices exceeding the cap (\$20,585.39 per beneficiary for the cap year ending October 31, 2006) increased by a third from 220 in 2005 to 293 in 2006.¹ Hospices that exceeded the Medicare payment cap tended to be smaller than those that remained below the cap, were more likely to be for profit, were newer, and were often located in regions with a high degree of hospice market saturation. Total Medicare hospice payments exceeding the cap increased between 2005 and 2006, from \$166 million to \$213 million (of a Medicare spending base of \$9.2 billion), or roughly 2.3 percent of total Medicare hospice payments. Among hospices that exceeded the cap, the average payments per hospice subject to recovery fell by 4 percent between 2005 and 2006. Because the number of hospice users has increased steadily, the growing cap liability does not appear to have created access problems for Medicare beneficiaries. New hospices continue to enter the program at a steady rate, with more than 240 new hospices certified to participate in Medicare in 2007.

To help put the findings of our analytic work into context, we convened a hospice expert panel in October 2008. The panel reflected a broad range of hospice interests, including hospice medical directors, administrators, and nurses. Membership included representatives of for-profit and nonprofit providers from various geographic regions of the country. A medical director of one of CMS's claims processing contractors responsible for the hospice benefit also participated. The panel provided input in several areas: short and long hospice stays, the hospice medical director's role in certifying (and recertifying) patients, and the role of local coverage determinations (LCDs) in guiding hospices on identifying patients eligible for the Medicare hospice benefit. The panel's comments provided invaluable context for our quantitative analyses and helped focus attention on areas of specific interest to the Commission.

With respect to accountability, our analytic work and input from our expert panel—as well as more recent discussions with individual hospices, hospice associations, and patient

advocacy groups—suggested the need for additional oversight of the hospice benefit. Nearly all groups we met with described “bad actors” operating within the hospice benefit, who—either by intent or by uninformed disregard of the applicable rules—were using the benefit in a way inconsistent with statutory intent and regulatory constraints. The groups, however, did not quantify the prevalence of such behavior.

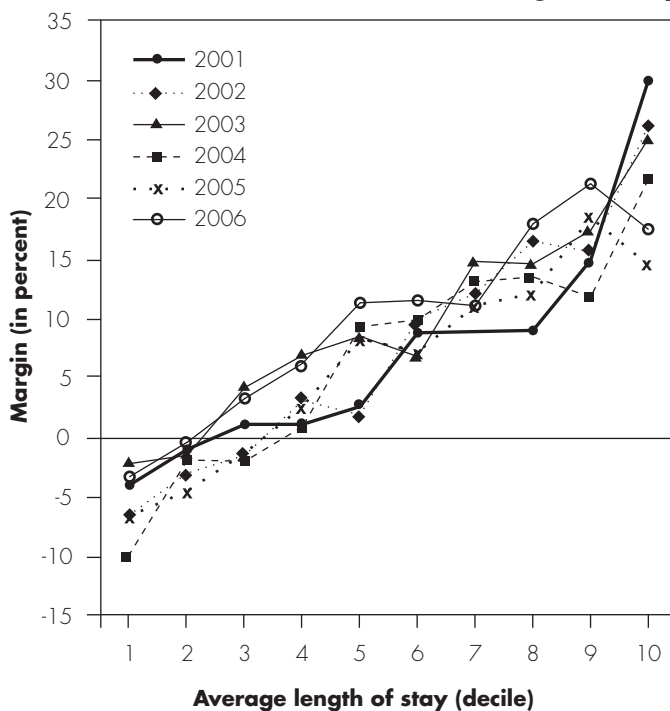
We determined that oversight is warranted to prevent some hospices from acting on the financial incentives in the payment system. We heard that some hospices engage in misleading marketing and admissions practices (e.g., “trolling” for patients in nursing homes or using marketing materials that did not mention the need for a terminal illness to qualify for hospice). Similarly, our expert panel and others described situations in which some hospices do not discharge patients whose conditions improve while under hospice care to the point that they are no longer clinically eligible. At the extreme, these practices may be motivated by financial considerations. For example, certifying parties may seek to advance the financial interests of the hospice that employs them or through financial relationships among providers involved in care of the end-of-life patient, such as retainers paid to nursing home medical directors to serve as hospice referral sources. Because of the correlation between longer stays and profitability, we concluded that greater accountability was needed from hospice providers—in particular hospice medical directors—to ensure appropriate hospice admissions and recertifications.

Alternatively, some of the utilization patterns we observed suggested a lack of training or experience in identifying patients appropriate for admission to hospice. This problem may have been particularly acute among new hospices, as Medicare’s conditions of participation for hospices are generally regarded as easy to meet. The utilization patterns also may have reflected variation in how the hospice coverage guidelines of Medicare’s claims processing contractors are interpreted and put into effect among individual hospices. Lastly, these patterns also may have reflected variation in hospice medical directors’ or hospice physicians’ involvement in the hospice patients’ care. Physicians responsible for certifying and recertifying a patient’s eligibility for hospice may inappropriately delegate much of this responsibility to other parties.

Lastly, we found that Medicare-participating hospices submit relatively little information to CMS about the services they furnish to their patients, making it difficult

FIGURE 6-2

Hospice profitability generally increases as a function of length of stay



Note: Data are for freestanding facilities.

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

for policymakers to ascertain what spending for hospice care is buying. Until very recently, hospice claims indicated only the number of days of each type of care for which a beneficiary was enrolled. CMS has recently begun collecting information about certain hospice visits on claims, but more information is needed. In addition, hospice cost reports lack essential information—for example, most hospice cost reports do not collect information on hospice revenues. Having data on hospice revenues on the cost reports would allow policymakers to more readily assess hospices’ financial performance under Medicare and overall.

Need for payment system reform

The Commission explored alternatives that would encourage hospices to admit patients at the point in their terminal disease that provides the most benefit for the

patient. Our findings suggest that Medicare's payment system for hospice needs to be significantly revised so that hospice care for Medicare beneficiaries who elect the benefit is appropriate. The current payment system does not help Medicare effectively meet this goal.

In considering potential changes to the hospice payment system, the Commission recognizes the importance of the hospice benefit and its substantial contribution to end-of-life care for beneficiaries. The goal of payment system reform is to strengthen the hospice payment system and not discourage enrollment in hospice, while deterring program abuse. Thus, the Commission intends that such reforms provide incentives to encourage hospices to admit patients at the point in their terminal disease that provides the most benefit for the patient.

Incentives in current system favor longer stays

Medicare's hospice payment system favors patients with longer stays. Under the current per diem system, the level of payment to the hospice for routine home care, which makes up more than 90 percent of Medicare's payments to hospices, is constant throughout the episode.² The constancy of the per diem payment over the course of an episode, however, is misaligned with a hospice's costs during the episode. That is, a hospice's costs typically follow a U-shaped curve, with higher costs at the beginning and end of an episode. This cost curve reflects hospices' higher service intensity at the time of the patient's admission and the time surrounding the patient's death. When hospice stays are very short, hospices may operate unprofitably because they have little opportunity to recoup their beginning- and end-of-episode costs, given the short intervening period of relatively lower costs. This dynamic presents a policy problem: Patients who have short stays in hospice generally do not have time to benefit from the range of care that hospice provides. Very short hospice stays may also reflect referral to hospice only after significant Medicare expenditures on extensive acute interventions, or after a patient's Medicare-covered days in a skilled nursing facility have been exhausted.

By contrast, patients with longer hospice stays typically have fewer resource needs. Long-stay hospice patients may receive fewer visits per week than short-stay patients and require a somewhat lower skill mix. These lower needs could occur because some patients are admitted early in the course of their terminal disease, before they demonstrate a need for the array of services hospice offers. It is also possible that a given patient's condition may

not follow a predictable trajectory. Given that the current payment system does not require hospices to visit a patient each day to receive a per diem payment, some hospices can admit patients who require very little hospice care, while generating the same level of revenues as a patient who needs more care. As a result, a strong correlation exists between length of hospice stay and profitability. This correlation may partly explain the entry of new for-profit hospices in Medicare to the near exclusion of other types of hospices and growth in the number of patients with longer stays. The concern is that some new hospice providers, which are predominantly for profit, may be pursuing a business model based on maximizing length of stay, and thus profitability.

Many members of the expert panel we convened in October 2008 agreed that some hospices may respond aggressively to these financial incentives, developing marketing materials aimed at inducing patients likely to have long stays to elect hospice and limiting (or even prohibiting) physicians from visiting patients as part of the recertification process to determine continued eligibility for the benefit. In terms of very short hospice stays, the panel pointed to larger health care system issues related to caring for terminal patients (e.g., reluctance among physicians, patients, and their families to recognize a terminal situation and the financial incentives of acute care providers to continue treating a terminal patient) as more significant factors in explaining short hospice stays. However, the panelists suggested that payment also played a role (reinforcing the perception that these stays are generally unprofitable).³ We have concluded that payment system changes could help create incentives for hospices to admit patients at a more appropriate point in the course of their illness and reduce incentives for very long stays.

Recommended payment system revision

Several options exist for revising the payment system to reduce or eliminate the long-stay incentive. For example, payments could be made on a per visit basis, requiring hospices to provide a service on site as a condition of payment. Such an approach might ensure transparency in the provision of care from the payer's perspective, but it would not directly address hospice length of stay. Alternatively, hospices could receive a single prospective payment for an entire episode of care and could be obligated to provide hospice care for the duration of the episode, regardless of the patient's longevity in the benefit. Such an approach would remove the adverse financial consequences associated with short stays under the

current payment system. However, given the uncertainty associated with predicting life expectancy, it is unclear whether providers would be in a position to undertake the financial risk associated with a per episode payment. Therefore, we recommend payment system changes that retain the per diem payment structure of the current system but provide incentives for hospices to be more proactive in admitting short-stay patients earlier in the course of their terminal condition, while discouraging very long stays—in other words, encouraging hospices to admit patients at the point in their terminal illness that provides the most benefit to the patient.

Intensity-adjusted payment throughout episode, with end-of-episode payment to reflect higher intensity at the time of the patient's death

Under the alternative we recommend, Medicare could adjust payments to reflect changing resource intensity through the course of the episode. For example, hospices would receive a relatively higher per diem payment for the first 30 days of an episode and receive progressively lower per diem payments for subsequent 30-day periods. To reflect hospices' higher level of effort surrounding a patient's death, the payment system could incorporate an additional payment at the end of the episode.⁴ The hospice would receive the end-of-episode payment only if the patient died, not if he or she transferred to another hospice or revoked election of the benefit. These payment changes would be budget neutral.

Given the U-shaped cost curve of hospice episodes, we believe this approach would better fit the way hospice care is provided under typical circumstances. Medicare has a precedent for such an approach in the prospective payment system for inpatient psychiatric facilities (IPFs).⁵ When we analyzed the visit intensity of short and long hospice stays using data from a large national proprietary hospice chain, we found that, as length of stay increased, the number of visits per week declined, and the skill mix of the hospice staff providing those visits also declined (MedPAC 2008). As a result, the intensity-adjusted payment approach, with a payment to reflect the higher intensity of hospices' efforts at the time of the patient's death, may be appropriate for hospice as well.

In modeling the intensity-adjusted payment system, we chose two sets of payment weights to illustrate how changing the magnitude of the intensity adjustment affects providers. (Note: These payment weights are intended to be illustrative; CMS would determine a final set of weights.) Under each approach, a per diem base payment

amount for home care is multiplied by a relative weight to calculate the per diem payment rate. These sets of weights are illustrated in Figure 6-3 (p. 360).⁶

There are several key assumptions in our model worth noting. First, we continue to reimburse hospices for routine home care on a per diem basis. We also assume that continuous home care (currently reimbursed at an hourly rate) would be paid under the same per diem intensity-adjusted payment system as routine home care, while general inpatient care and inpatient respite care would continue to be reimbursed as they are under the current payment system (based on their own flat per diem rates). If the intensity-adjusted payment system were implemented, there may be reasons to consider the interaction between the intensity adjustment and the continuous home care level of care.

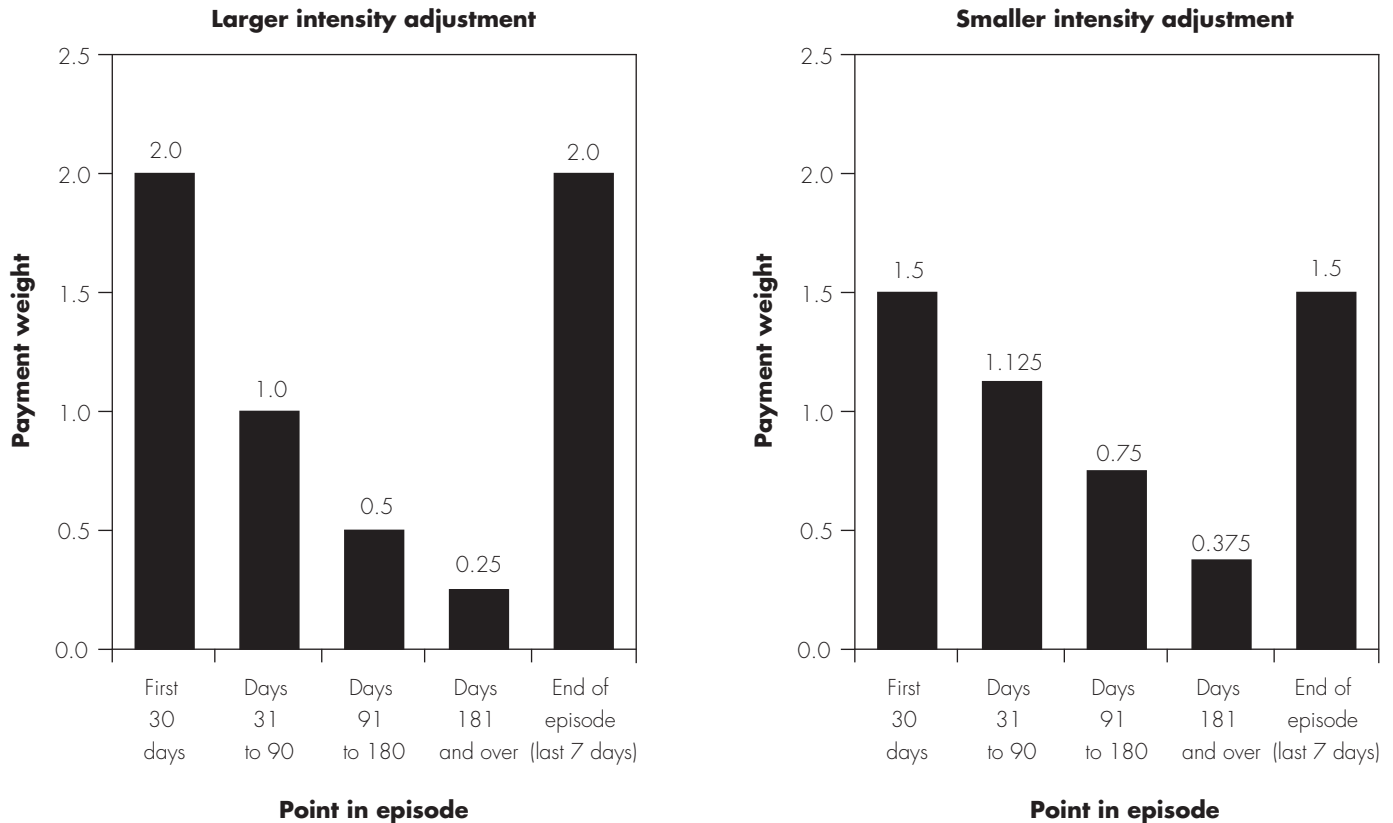
In contrast to the current system, payments for home care under the intensity-adjusted payment system are higher at the beginning and end of an episode, with declining payments in the intervening days. The per diem rate for the end-of-episode payment—which in our illustration reflects seven days of care—would be set at a level equal to the payment rate for the initial 30 days of the episode—the highest payment rate in the new system. To avoid inappropriately duplicating payments, we configured our illustrative model so that the end-of-episode payment would not be made if the patient died during the first 30 days. The per diem base payment rate under either set of weights would be established so that aggregate payments under the new payment system would be budget neutral to aggregate payments under the existing system. Under the new system, payments would be redistributed as a function of length of stay; payments for what are currently very long stays would decrease, and payments for short stays would increase.

Illustrative effects of intensity-adjusted payment approach

Our preliminary analysis suggests that, under either set of illustrative payment weights, the intensity-adjusted approach would redistribute Medicare hospice payments among hospices in a manner consistent with reducing the incentives for long hospice stays. Aggregate payments to the 20 percent of hospices with the smallest share of stays exceeding 180 days would increase by between 16.6 percent and 24.1 percent, while aggregate payments to the 20 percent of hospices with the greatest share of stays exceeding 180 days would decrease by between 6.6 percent and 10.8 percent, depending on which set

FIGURE 6-3

Illustrative alternative sets of intensity-adjusted payment weights used in modeling hospice payment system



Note: Payment weights are not applicable to inpatient care. To avoid inappropriately duplicating payments, an end-of-episode payment would not be made if the patient died during the first 30 days.

of payment weights is used (Table 6-3). Aggregate payments to for-profit hospices would decline by between 3.2 percent and 5.0 percent, and aggregate payments to freestanding facilities would go down by between 2.3 percent and 3.2 percent. These shifts are driven by the new system’s impact as a function of length of stay; however, both freestanding and for-profit hospices tend to have patients who incur longer hospice stays than provider-based and nonprofit hospices. Conversely, nonprofit hospices, provider-based hospices, and rural hospices—which traditionally have had negative margins—would see an increase in their payments on average, enough to push their aggregate Medicare margins into positive territory. Nonprofit hospices would see an increase in their aggregate payments between 2.5 percent and 4.1 percent, while provider-based hospices would see an increase in aggregate payments between 7.8 percent and 10.9 percent.

Rural hospices would see their aggregate payments increase by between 2.2 percent and 2.8 percent.

The payment system changes would have differential impacts on payments to hospices within each of these groups, with these differences primarily driven by length of stay. Table 6-4 (p. 362) shows the proportion of hospices that would experience payment changes of various magnitudes (payments increase by more than 2 percent, payments change by less than 2 percent, and payments decrease by more than 2 percent) under the set of weights with the larger intensity adjustment.

Overall, about 58 percent of hospices would see their payments increase by more than 2 percent, 34 percent would see them decrease by more than 2 percent, and 8 percent would see a change in payment of less than 2

percent. Nearly all hospices (97 percent) whose share of stays exceeding 180 days is in the lowest quintile would see their Medicare payments increase by more than 2 percent under the new system. The percentage of hospices seeing payment increases would decline in each successive quintile, while the proportion of hospices experiencing payment decreases would go up as the share of stays exceeding 180 days increased. In the highest quintile, 78 percent of hospices would see payment declines of 2 percent or more. But even within the quintile with the highest share of stays exceeding 180 days, at least 13 percent of hospices would see increases in their payments relative to the current system. This phenomenon reflects the fact that it is not only the percentage of stays that exceed 180 days that determines the impacts but also the percentage of total patient days of care that exceed the 180-day threshold. Within each of the standard provider categories for which we assess impacts (e.g., profit status, whether the entity is provider based or freestanding, geography), some hospices would see their payments increase under the new system, and some would experience reduced payments. These impacts reflect the mix of hospices by length of stay within each provider category.

Since the revised payment system reduces payments to hospices whose patients incur very long stays, we anticipate that the revised payment system would reduce the number of hospices exceeding the cap. Under the two sets of weights we modeled, the number of hospices exceeding the cap decreased by 26 percent under the smaller intensity adjustment and by 45 percent under the larger adjustment.

The redistributive effects of the new payment system on Medicare hospice payments will likely trigger behavioral responses among hospices, which could have implications for Medicare beneficiaries and the program. The extent to which the implications of the new payment system affect hospices (and their patients) depends largely on the hospices' lengths of stay.

For example, hospices will need to be more judicious in timing admission for patients with terminal diseases that typically have long stays in hospice (e.g., congestive heart failure or degenerative neurological conditions). Hospices that once relied on diagnosis alone when accepting a referral may now implement greater controls, such as following Medicare guidelines more closely or following admissions criteria developed by some hospices that better identify patients entering the last six months of life. As a result, long-stay patients will likely see shorter stays in

**TABLE
6-3**

Effects of new hospice payment system vary as a function of length of stay

Category of hospice	Percent change in payments	
	Larger intensity adjustment	Smaller intensity adjustment
Share of stays over 180 days		
Lowest quintile	24.1%	16.6%
Second quintile	10.3	7.0
Third quintile	0.8	0.6
Fourth quintile	-9.6	-7.1
Highest quintile	-10.8	-6.6
Freestanding	-3.2	-2.3
Provider based	10.9	7.8
For profit	-5.0	-3.2
Nonprofit	4.1	2.5
Urban	-0.4	-0.3
Rural	2.8	2.2

Note: Model includes impacts of an end-of-episode payment for patients who die while covered by hospice. Analyses exclude inpatient care and cap overpayments.

Source: MedPAC estimates based on hospice claims and cost report data from CMS for 2006.

hospice than have occurred recently. However, we would not expect the revised payment system to result in reduced access for these patients, given that payments would continue as long as the patient was enrolled. Instead, it is the timing of the admission that is likely to change.

The payment policy change described here would also likely affect hospices that focus on admitting patients who commonly have long hospice stays. We have found that hospices that exceed Medicare's hospice payment limit—by virtue of having among the longest average length of stay among all hospices—tend to be newer hospices and often emerge in markets where there is already a strong hospice provider presence. These hospices may have focused on admitting patients with a long length of stay either as a business model (given the profitability of long-stay patients) or because existing providers had established relationships with referral sources in a market that ensured a balanced mix of short- and long-stay patients, leaving patients with more uncertain prognoses

**TABLE
6-4**

Impacts of new payment system with larger intensity adjustment vary within each hospice type

Percent of hospices whose payments:

Category of hospice	Decline by more than 2 percent	Decline by less than 2 percent or increase by less than 2 percent	Increase by more than 2 percent
All	34%	8%	58%
Share of stays over 180 days			
Lowest quintile	1	2	97
Second quintile	6	5	89
Third quintile	24	12	64
Fourth quintile	59	13	28
Highest quintile	78	9	13
Freestanding	45	9	46
Provider based	14	6	79
For profit	50	9	41
Nonprofit	20	7	73
Urban	37	9	55
Rural	28	7	65

Note: Model includes impacts of an end-of-life payment for patients who die while covered by hospice. Analyses exclude inpatient care and cap overpayments.

Source: MedPAC estimates based on hospice claims and cost report data from CMS for 2006.

for the newer providers. In either case, these hospices may have difficulty adapting to the incentives of the recommended payment system change. Some hospices that have traditionally focused on long-stay patients may wish to move to admissions practices more consistent with those for which the proposed payment system revision provides incentives. These hospices would likely incur significant costs in ensuring that their clinical staff (physician and nonphysician) were adequately trained in hospice and palliative medicine to be able to better assess the clinical signs associated with impending death on a condition-specific basis. These costs would likely erode their historically high margins by some degree. Ultimately, the pool of eligible patients in a given market may not be sufficient to preserve the existence of a large number of small hospices, given the policy's focus on providing incentives for appropriate hospice stays, and some small hospices may have to merge with larger ones to better manage costs and achieve a sufficient patient base to manage risk.

The revised payment system may also trigger behavioral responses on the part of hospices that admit patients likely to have short stays as well as provider-based hospices' parent providers that may be likely to refer such patients to hospice. Hospices that admit short-stay patients will likely see improved financial performance under the new system, as the higher payments early in the episode will better reflect the costs they incur. It is possible that these increased payments would provide an additional incentive to hospices that admit short-stay patients to take greater efforts to obtain referrals for these patients earlier in the progression of their terminal disease. These incentives may have an additional effect in the case of provider-based entities. Currently, hospital-based and other provider-based hospices tend to have negative Medicare hospice margins. Under the new system, parent providers may not face such losses by referring a patient to hospice as they would under the current payment system.

By the same token, these incentives may also, at the margins, induce some providers to refer, and hospices to

admit, more patients for whom hospice would offer little benefit given the shortness of their remaining life. Such a change would be contrary to the intent of the policy—the goal is to increase the length of what are currently three-day stays, not to increase the number of three-day stays. The proposed payment system could provide additional incentives for more hospitals, nursing homes, and home health agencies to open Medicare-participating hospices. Medicare would need to closely monitor changes in the hospice user and provider populations to ensure that there was no dramatic increase in the number of extremely short-stay patients or in the number of provider-based hospices with very short average lengths of stay—phenomena that may suggest an inappropriate behavioral response to the incentives in the proposed payment system.

Benefits of the intensity-adjusted approach

The intensity-adjusted approach could help mitigate the adverse financial incentives associated with both long and short hospice stays. Payments under a revised system would provide a clear signal to hospices to pay close attention to the clinical indicators of their long-stay patients. Payments could be structured in such a way that a minimum “maintenance” payment could be made for legitimately long-stay patients. Further, the reduction in payments over time could be structured to better ensure that hospice expenditures do not exceed costs incurred by comparable patients who elected conventional care, helping to ensure consistency with one of the original legislative underpinnings of the Medicare hospice benefit. Additionally, this approach (with a final payment made at the time of the patient’s death) would provide appropriate financial compensation to hospices for increased service intensity near the time of death, consistent with the objective of the hospice benefit as an end-of-life benefit, rather than to those hospices that pursue a business model suggestive of long-term custodial care.

Despite the factors arrayed against admitting short-stay patients to hospice sooner—ranging from the financial incentives of acute care providers to use aggressive end-of-life treatments to patient, family, and physician outlooks on the acceptance of impending death—our proposed changes in the payment system may have a positive impact on the admission of short-stay patients. By establishing higher payments for the early stages of the hospice episode, Medicare would at least remove a disincentive for hospices to admit patients likely to have short stays. The payment system would encourage appropriately, but not excessively, long stays.

Implementation issues

Implementing such a revised payment system would require many policy decisions, including at what level to set the payment weights, the length of time each payment weight would be in effect, the duration of the period covered by the end-of-episode payment, and how to treat patients who are discharged from and readmitted to hospice. In an ideal world, such decisions would be fully informed by empirical data—for example, efficient providers’ costs of providing hospice care for patients at a given point in the hospice stay. Such data are limited in the case of Medicare’s hospice benefit. However, the data that exist, as well as data forthcoming from CMS’s claims data collection effort, reflect current practices, including inappropriate responses to payment system incentives by some providers. Therefore, policymakers may wish to set payment rates on a more normative basis to achieve desired policy goals.

To illustrate the potential impacts of an intensity-adjusted payment system, we had to make assumptions about the various implementation parameters. The assumptions were informed by data on aggregate Medicare payments for hospice, current law payments for episodes of given lengths, the current level of the Medicare hospice cap, and our understanding of hospices’ relative levels of effort in the course of episodes informed by discussions with hospices and hospice associations and by our analysis of data from a large national for-profit hospice chain. We fine-tuned our assumptions through an iterative evaluation of their effects on desired policy outcomes—most importantly, changing the current payment system’s incentives for long stays in hospice to incentives that provide more balanced incentives that do not favor one set of patients over another.

Nevertheless, our assumptions, and the resulting illustrative models, comprise only two examples of many possible configurations. Other options are possible within the general construct of the intensity-adjusted payment approach, coupled with an end-of-life adjustment. Other options may be informed by the data CMS has recently begun to collect on hospice claims, notably visits provided to hospice patients during the course of their episodes of care. Other data—such as visit duration data—may also be useful as well as information on the degree to which total episode costs are correlated with the intensity of visits. Some of this information has not yet been produced for CMS to use in managing the benefit. Nevertheless, the revisions to the payment system articulated here represent a substantial improvement over the existing system.

Because the intent of the proposed changes in the payment system is to improve the financial incentives in the payment system so that they do not favor very long stays over relatively shorter stays, the Commission has recommended implementing the changes in a budget-neutral manner in the first year (2013). Nevertheless, the Commission is concerned that aggregate Medicare spending on hospice may be excessive given that it includes spending for very-long-stay patients who in some cases may not have been appropriately admitted. In the upcoming years, before 2013, the Commission intends to examine the effect of very long stays on aggregate Medicare hospice spending and may consider additional adjustments to the payment system through the annual update, the hospice cap, or medical review if warranted.

RECOMMENDATION 6-1

The Congress should direct the Secretary to change the Medicare payment system for hospice to:

- **have relatively higher payments per day at the beginning of the episode and relatively lower payments per day as the length of the episode increases,**
- **include a relatively higher payment for the costs associated with patient death at the end of the episode, and**
- **implement the payment system changes in 2013, with a brief transitional period.**

These payment system changes should be implemented in a budget-neutral manner in the first year.

RATIONALE 6-1

Medicare’s current payment system contains incentives that may induce some providers to admit patients likely to have inappropriately long stays in hospice. Such stays are inconsistent with the statutory underpinning that hospice is an end-of-life benefit (rather than a long-term care benefit) and may result in hospice expenditures that exceed the costs of conventional end-of-life care. Further, long stays in hospice undermine the presumption that hospice should result in lower Medicare spending at the end of life. The payment system change we propose would reduce the incentives for excessively long stays in hospice while still affording hospices some financial protection against costs incurred in caring for unavoidably long stays.

Spending

- The proposed change in the payment system would have no direct spending implications in the first year, because it is implemented in a budget-neutral manner. The change will result in relatively small reductions in Medicare spending in the longer term—less than \$100 million over five years.

Beneficiary and provider

- The proposed payment system is expected to result in some beneficiaries being admitted to hospice at a more appropriate time in their terminal illness. Given the policy goal of reducing the number of very long stays in hospice, the proposed system will likely result in some patients having shorter stays due to being admitted at a more appropriate point in their terminal illness or, in some cases, due to discharge from hospice if some patients are determined no longer to be eligible because of improved prognosis. At the same time, patients with conditions that typically generate short hospice stays under the current system may have the opportunity for longer stays, thus obtaining greater benefit from enrollment in hospice at the end of life. In the aggregate, we believe this proposal will not affect beneficiaries’ ability to access hospice care, but they will do so at a more appropriate time in their terminal disease.
- Impacts on hospice providers will largely vary as a function of length of stay. Aggregate payments will be the same as they would have been under the current system. However, hospices that now have very long average lengths of stay (including those with a high percentage of patients who do not die in a given year) will see their payments reduced and will have to reorganize their business models. Hospices with shorter average lengths of stay will receive increases in payments.

Additional refinements to the hospice payment system

While the reform of Medicare’s payment system for hospice is a necessary step, additional administrative improvements must also be made. CMS needs to instill greater accountability among the physicians and hospices that provide care under the benefit, and it needs better data to manage the benefit effectively.

Accountability

Compliance with Medicare’s rules, regulations, and guidelines pertaining to the hospice benefit varies among hospices. Some of this variance may reflect a lack of training, a deliberate response to financial incentives, or a desire to provide care to patients with unmet chronic care needs who may not meet the hospice eligibility criteria. Complex financial relationships—especially between hospices and nursing homes or other long-term care providers—may inappropriately affect admissions to hospice and recertification of hospice patients, giving at least the appearance of financial impropriety. At the same time, CMS does not have sufficient resources to devote to enforcing and auditing hospice compliance with program rules. In addition, there may be a role for the Medicare program to educate beneficiaries and their families on the purpose of the hospice benefit as an end-of-life benefit rather than a chronic care benefit.

More safeguards needed in recertifying long-stay patients

The increasing proportion of hospice patients with a length of stay exceeding 180 days and the variation in length of stay across hospices raise concern that there is insufficient accountability and enforcement related to enrollment and recertification of Medicare hospice patients. The expert panel of hospice providers we convened in October 2008 agreed that many providers comply with the Medicare hospice eligibility criteria but also indicated that some hospices do not, highlighting the need for greater accountability and enforcement. Some panelists pointed to questionable practices among certain providers in their communities that suggested possible program abuse.

Current Medicare policy on certifications and recertifications Expert panel members noted that hospices vary in the degree of rigor they apply to the recertification process. Under Medicare’s current policy, to admit a beneficiary to hospice, the beneficiary’s attending physician (if any) and a hospice physician must certify that the beneficiary is terminally ill. After the initial 90-day certification, continued enrollment in hospice requires recertification of the patient’s eligibility for hospice only by the hospice medical director or a physician member of the hospice’s interdisciplinary group. CMS policy requires that the written certifications and recertifications indicate that the patient’s life expectancy is six months or less if the disease runs its normal course and include the physician’s signature (42 CFR §418.22). Information that would

support the terminal prognosis is required to be included in the medical record.⁷

LCDs developed by Medicare claims processing contractors provide general and condition-specific clinical criteria for determining whether a patient qualifies for the hospice benefit based on a life expectancy of six months or less.⁸ If a patient does not meet the LCD criteria, the patient may be considered eligible if a physician certifies that the patient’s life expectancy is six months or less based on clinical aspects of the patient’s condition not addressed by the LCD.

Hospice expert panel generally agreed more accountability and enforcement needed Panelists generally agreed that some hospices enroll and recertify beneficiaries who do not meet the terminal illness criteria—because of limited medical director engagement in the recertification process, inadequate charting of the patient’s condition (or in some cases even deliberate mischarting), or a lack of staff training.

The panel further discussed a tension that can exist between the hospice physician and the hospice’s nonphysician staff that may lead to inappropriate recertification in some circumstances. One panelist noted the contradiction that hospice is explicitly organized as a “nonmedical” benefit, although hospice eligibility requires a medical decision. Panelists indicated that in some cases physicians deferred too much authority for making determinations of continued eligibility to nonphysician staff. These staff members, by virtue of their day-to-day contact with patients, may develop emotional attachments that color their view (and sometimes their charting) of a patient’s continued eligibility for the benefit.

One panelist suggested that some hospices are “sloppy” in their admissions, admitting patients too early in their terminal disease progression or retaining them when they are no longer eligible. Panelists attributed this practice in part to a lack of appropriate education and experience in palliative medicine among some hospice physicians. The panelists suggested a number of ways to improve the level of clinical competence in this area, such as having hospice as a rotation site for residency programs, requiring hospice medical directors to obtain continuing medical education in hospice and palliative care medicine, and requiring a formal certification program for hospice medical directors.

At the extreme, several panelists provided anecdotal information about questionable practices by some hospices, suggesting possible program abuse. They

described instances in which some hospices: prohibited their physicians from visiting patients to determine continued eligibility; failed to discharge patients with improved prognoses; enrolled patients who were not admitted or were discharged by other hospices for failure to meet coverage criteria; disregarded eligibility requirements entirely; and aggressively marketed their service to individuals residing in nursing facilities, who were likely to have long lengths of stay. Other panelists described conflicts of interest in the referral relationships between some nursing homes and hospices. For example, common ownership—or a shared medical director—or other financial relationships provided financial incentives for inappropriate hospice referrals and enrollment. Still other instances panelists cited involved practices on the part of some hospices whose written marketing materials explicitly excluded critical clinical criteria (e.g., the six-month prognosis) in asking recipients of the materials to consider hospice as an end-of-life alternative. Other industry sources described instances of hospice staff approaching the families of nursing facility residents with neurological diseases, offering the family “extra assistance” for the patient, without mentioning the word “hospice.”

Expert panel members offered several suggestions for possible steps to increase accountability, while urging increased enforcement of existing Medicare policy concerning hospice eligibility as outlined in the LCDs:

- ***Require a physician or advanced practice nurse (APN) visit prior to the 180-day recertification.*** Several panelists supported a requirement that a hospice physician visit the patient at the time of the 180-day recertification to assess continued eligibility. A few panelists indicated that was current practice at their hospice. Some panelists expressed concern about the feasibility of such a requirement for rural hospices. However, one panelist from a rural state said it was common practice for the medical director to visit very-long-stay patients to get a clear picture of the patient’s condition. Another suggestion was made that allowing APNs to perform the visits might ameliorate the issue.⁹ For a visit requirement to be effective, physicians would need to attest that the visit took place.
- ***Increase enforcement of existing hospice eligibility criteria in LCDs.*** Panelists generally viewed the hospice eligibility criteria in the LCDs as reasonably effective in identifying patients likely to have a life expectancy of six months or less. To the extent that the

LCDs have been implicated as a potential contributor to variation in length of stay, panelists were of two minds. On the one hand, some members of the panel believed the evidence base of the LCDs for some conditions would need to be strengthened for them to be more effective in identifying terminal patients appropriate for hospice. (Several panelists asserted that when their hospices determined that eligibility requirements for a condition were insufficient to reliably result in appropriate lengths of stay, they took the initiative to add criteria to the guidelines.) While these panelists suggested that there may be potential to strengthen the criteria in the LCDs for some conditions, they did not believe the content of the LCDs was the main factor contributing to the increase in very long hospice stays. On the other hand, several panelists provided anecdotal reports of some hospices disregarding the eligibility criteria in the LCDs. They indicated that to the extent that hospices disregard the eligibility guidance, greater Medicare program oversight could appropriately reduce lengths of stay. Panelists agreed that more enforcement of existing LCDs is needed and that it should be targeted to those providers with aberrant patterns of enrollment and lengths of stay. In some cases, LCDs may need to be strengthened to effectively identify the appropriate point in a patient’s terminal illness for admission to hospice. It would be difficult, however, to develop a definitive “cookbook” approach to eligibility criteria. However, some hospices on their own initiative have developed additional guidelines on eligibility criteria to ensure that patients are appropriately admitted to and kept in hospice. Given the key role of LCDs in assisting hospices’ clinicians in determining initial and continued eligibility for hospice, it may be beneficial for CMS and its contractors to consider sponsoring a forum via which hospices and other clinicians involved in end-of-life care could share these practices.

Nonetheless, the objective of the policy outlined here should be to focus on the extreme actors in the industry. To do so, Medicare claims processing contractors could be required to review all recertifications beyond 180 days for hospices with an exceptionally large share of their cases exceeding 180 days. This action would have the effect of focusing on long stays, in hospices that tend to have long stays, and would not subject all hospices to additional review and administrative burden. Yet this heightened level of

review would engender additional costs to CMS and its contractors, and the Commission would strongly urge the Congress to ensure that adequate resources are dedicated to these efforts.

- ***Require that written certifications and recertifications include a brief narrative explanation of the clinical findings that support a life expectancy of six months or less.*** Many panelists agreed that it would be beneficial to require that certifications and recertifications include a brief narrative statement of the clinical basis for a patient's terminal prognosis. Panelists indicated that the physician certifying eligibility can reasonably be expected to synthesize in a few sentences the clinical aspects of the patient's condition that support the prognosis. Such a requirement would encourage greater physician engagement in the certification and recertification process by focusing attention on the physician's responsibility to certify the clinical rationale for the terminal prognosis supported in the patient's medical record.

Relationships between hospices and long-term care facilities need greater oversight

The election of the Medicare hospice benefit by beneficiaries residing in nursing facilities—and potentially those residing in assisted living facilities—represents a particularly delicate juncture and is a likely area for greater oversight. Medicare beneficiaries residing in nursing facilities (which can include nursing homes, intermediate care facilities, and skilled nursing facilities) make up a considerable share of those who elect hospice at the end of life, representing roughly 20 percent of the Medicare hospice population. These beneficiaries are more likely than others to have terminal diseases with a long end-of-life trajectory—such as degenerative neurological diseases or nonspecific conditions, such as adult failure to thrive or nonspecific debility. They are more likely to have physical impairments that affect their activities of daily living. In addition, many nursing home residents have degenerative neurological diseases that result in impaired mental capacity and thus may not be fully able to make choices about their health care. These patients' use of hospice warrants special attention. Providers may respond to unique payment incentives that come into play at the intersection of nursing facilities and hospices. These incentives may help explain the patterns of hospice care we have observed in recent years, most notably the increase in the length of hospice stays and the increase in hospice election by nursing home residents.

Nursing facilities have incentives to refer patients early in terminal disease progression Nursing facilities and hospices have incentives to refer and admit certain beneficiaries to hospice due to financial incentives potentially accruing to both types of providers. When a nursing facility resident enrolls in hospice, the nursing facility continues to provide room and board services (e.g., assistance with activities of daily living) to the patient, while the hospice provides core palliative services related to the patient's terminal illness.¹⁰ The nursing facility and the hospice both have responsibility for aspects of the patient's care, which may result in reduced workload for both entities. For example, when some of the resident's care is provided by the hospice—especially care provided by hospice-supplied home health aides—there may be a reduction of effort on the part of the nursing facility's staff who otherwise would provide assistance with activities of daily living. Similarly, a hospice may provide fewer home health aide visits to a nursing facility resident than it would to a patient residing in the community because of the availability of nursing facility staff to assist with activities of daily living. The hospice may also realize reduced staffing and transportation costs when serving nursing facility patients—for example, if a nurse or home health aide visits three beneficiaries in one nursing facility rather than traveling to three private homes. Under the current payment system, the hospice is paid the same amount for routine home care provided to a nursing facility resident as for routine home care provided to a beneficiary in a private home.

Incentives to refer patients to hospice may be even greater if a beneficiary is dually eligible for Medicare and Medicaid. Medicare makes payments directly to the hospice for palliative care services, and the state Medicaid agency—which had been reimbursing the nursing facility for the patient's room and board—now makes those payments to the hospice. The hospice then reimburses the nursing facility for room and board (CMS 2003). There may be the potential for additional financial incentives associated with the hospice's payment to the nursing facility because the hospice and nursing facility negotiate the level of payment for room and board and in some cases additional services the nursing facility provides on behalf of the hospice. Some of these contractual arrangements have been described in work by the Office of Inspector General (OIG 1997).

As a result of these various incentives, both nursing homes and hospices have an interest in carefully managing the nursing home patient's election of hospice to ensure the

**TABLE
6-5**

Characteristics of institutionalized and noninstitutionalized Medicare hospice beneficiaries, 2006

Beneficiary characteristics	Hospice beneficiaries	
	Institutionalized	Noninstitutionalized
Percent of all hospice beneficiaries	18.0%	82.0%
Percent eligible for Medicare and Medicaid	51.1	16.6
Average age (in years)	84.6	80.0
Percent female	72.5	54.9
Percent of all beneficiaries by diagnosis		
Ill-defined debility	12.7	6.2
Alzheimer's disease	11.8	4.1
Circulatory diseases	11.1	10.7
Dementia	10.5	2.7
Cancer (lung and other)	10.2	41.9
Unspecific symptoms/signs	9.6	4.4
Heart failure	7.2	8.1
Organic psychosis	7.2	2.3
Chronic airway obstruction, not otherwise specified	4.1	5.7
Multiple diagnoses during episode	3.6	2.7
Genitourinary diseases	3.6	3.4
Nervous system	3.4	2.2
Respiratory diseases	2.1	2.8
Other	2.0	1.8
Digestive diseases	0.9	1.7

Note: Institutionalized beneficiaries are defined as beneficiaries who spent at least 90 days in a nursing facility leading up to or during their hospice stay.

Source: MedPAC analysis of hospice claims and beneficiary data from CMS for 2006.

most benefit to each provider. Both providers have an interest in identifying patients likely to have long stays in hospice and enrolling them in the Medicare hospice benefit.

Characteristics of institutionalized Medicare hospice beneficiaries and hospices that serve them To examine the nature of institutionalized beneficiaries and the hospices that serve them, we compared these beneficiaries with their noninstitutionalized counterparts.¹¹ Institutionalized Medicare hospice beneficiaries differed from those residing in other settings (e.g., their homes in the community) in terms of their Medicaid status, age, gender, and diagnosis. Of the 730,000 Medicare hospice beneficiaries included in this analysis in

2006, approximately 18 percent were institutionalized in a nursing facility (Table 6-5). As expected, many institutionalized hospice users (just above 50 percent) were eligible for both Medicaid and Medicare. In contrast, 17 percent of hospice beneficiaries residing in other settings were dually eligible. Lastly, institutionalized beneficiaries were much more likely than beneficiaries living in the community to have the terminal diagnoses that typically incur long hospice stays, such as Alzheimer's disease, dementia, and ill-defined debility. Patients with these diagnoses are likely to have longer stays, at least in part because their terminal status is more subject to judgment.

Institutionalized beneficiaries typically had longer hospice stays than other beneficiaries. On average, in 2005,

**TABLE
6-6**

Characteristics of hospice providers with few institutionalized beneficiaries compared to providers with a large proportion of institutionalized beneficiaries

	Low-institutionalized hospices (less than 15 percent institutionalized)	High-institutionalized hospices (more than 40 percent institutionalized)
Number of providers serving institutionalized beneficiaries, 2006	1,329	290
Average percent of institutionalized beneficiaries as proportion of caseload, 2006	9%	52%
Percent, 2006:		
Freestanding	57	80
For profit	45	72
Urban	68	74
Average length of episode (in days), 2005	79	117
Percent of stays above 180 days, 2005	14%	24%

Note: Low- and high-institutionalized hospices are defined based on the percent of Medicare patients institutionalized—less than 15 percent and more than 40 percent, respectively. Patients are considered institutionalized if they spent at least 90 days in a nursing facility leading up to or during their hospice stay.

Source: MedPAC analysis of hospice claims and beneficiary data from CMS for 2004, 2005, and 2006.

institutionalized Medicare hospice beneficiaries spent over 50 percent more days enrolled in hospice than hospice beneficiaries residing in other settings. For most terminal diagnoses, institutionalized beneficiaries also had longer episodes than their counterparts residing in other settings with the same diagnoses. Institutionalized beneficiaries with cancer had hospice lengths of stay twice as long as did beneficiaries with cancer in other settings. In addition, hospice episodes extending longer than the six-month presumptive eligibility period were more common among the institutionalized beneficiaries in our analysis. In 2005, 21 percent of institutionalized beneficiaries were enrolled in hospice for longer than six months. In contrast, 12 percent of beneficiaries residing in other settings were enrolled in hospice for longer than six months.

Hospices with a high proportion of institutionalized patients are more likely to be freestanding and for profit We examined two groups of providers serving institutionalized beneficiaries: those that did not rely on the institutionalized beneficiary population as a large proportion of their caseload (“low-institutionalized hospices,” representing roughly 50 percent of all hospices) and those that did (“high-institutionalized hospices,” making up 10 percent of hospices). Institutionalized beneficiaries accounted for no more than 15 percent of low-institutionalized hospices’ caseloads (Table 6-6). By contrast, high-institutionalized hospices focused 40

percent or more of their business on institutionalized beneficiaries.

Fifty-seven percent of low-institutionalized hospices were freestanding, fewer than half (45 percent) were for profit, and just over two-thirds were in urban locations. In 2005, the low-institutionalized hospices had an average episode length of 79 days, with 14 percent of the beneficiaries they served having episodes longer than 180 days.

High-institutionalized hospices, on the other hand, were more likely to be freestanding (80 percent), for profit (72 percent), and urban (74 percent). In addition, in 2005, high-institutionalized providers had episode lengths that averaged about 50 percent longer (117 days) and had almost twice the proportion of stays exceeding 180 days (24 percent).

In addition to the differences in length of stay between high-institutionalized hospices and low-institutionalized hospices, there may also be differences in the services these two types of hospices provide to beneficiaries. It is possible that hospices may furnish fewer visits or different types of visits to institutionalized patients because long-term care facility staff may be available to provide assistance. In the future, as more data become available, the Commission intends to evaluate how the hospice services provided to institutionalized beneficiaries

compare with services provided to beneficiaries living in the community and to assess whether a separate payment policy for patients in long-term care facilities is warranted.

Role of nursing facility medical director in hospice referrals A nursing facility medical director often serves as a resident's primary care physician and consequently becomes responsible for determining the patient's ongoing health status. Therefore, the medical director is typically in a position to arrange for hospice services when the beneficiary's health status is determined to be terminal. In that capacity, the nursing facility medical director would be one of the cosigners of the certification of eligibility for hospice. Under such arrangements, the nursing facility medical director can potentially be a source of real or perceived financial conflict of interest with respect to hospice referrals.

RECOMMENDATION 6-2A

The Congress should direct the Secretary to:

- **require that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180th-day recertification and each subsequent recertification and attest that such visits took place,**
- **require that certifications and recertifications include a brief narrative describing the clinical basis for the patient's prognosis, and**
- **require that all stays in excess of 180 days be medically reviewed for hospices for which stays exceeding 180 days make up 40 percent or more of their total cases.**

RATIONALE 6-2A

Hospice length of stay varies considerably, with strong evidence that the payment system contains incentives for long stays, which are counter to the fiscal interest of the Medicare program. Some of the variation may also reflect a lack of physician oversight of hospice patients' care. Requiring documented physician oversight may ensure better adherence to Medicare's hospice coverage criteria that guide determinations of eligibility for the benefit. Additional medical review of long stays by CMS or its contractors—such as fiscal intermediaries, Medicare administrative contractors, program integrity contractors, and recovery audit contractors—at hospices with an exceptionally large share of their stays exceeding 180 days may identify providers with inappropriate admissions or recertification practices.

Spending

- While hospices would bear the cost of additional recertification visits, if billable services are provided during the course of a recertification visit, Medicare spending would increase slightly. However, the review of claims from hospices with very long lengths of stay should have the effect of delaying hospice admission for patients of questionable eligibility, which would lower the rate of future growth in Medicare spending for hospice. In net, this recommendation is estimated to lower Medicare spending for hospice by less than \$10 million in the first year and by less than \$100 million over five years. CMS or its contractors would incur administrative costs in reviewing long hospice stays; we estimate that the protocols we have specified here would entail roughly 10,000 medical reviews (out of more than 850,000 hospice stays). Further, some of the aberrant patterns of admissions may stem from inadequate oversight of hospices by CMS and its contractors. CMS should be given the resources necessary to enforce existing policies applicable to the hospice benefit and any new policies adopted on the basis of recommendations here. In addition, some components of our accountability recommendations will likely be more effective if they are supported by increased frequency and regularity of CMS provider survey efforts. Hospice is unique among Medicare-participating providers in its lack of a statutorily prescribed schedule of compliance surveys. It is essential that the Congress provide CMS with the resources necessary to carry out this effort.

Beneficiary and provider

- We do not expect this recommendation to result in a decline in access to hospice care for Medicare beneficiaries; rather, we expect it to result in some beneficiaries being admitted to hospice at a more appropriate time during their terminal illness. We believe the more rigorous documentation requirements and oversight procedures we are recommending will make hospices more attuned to the implications of admitting patients to hospice earlier than their disease trajectory would warrant. Therefore, we expect that some patients who currently engender very long stays in hospice would have shorter stays in the future, as they are admitted at a more appropriate stage in their terminal disease. These requirements should help ensure that only

genuinely eligible patients are enrolled in the benefit and thus help minimize the disruption of hospice patients' end-of-life care.

- Impacts on hospice providers will vary almost completely as a function of length of stay. Additional Medicare contractor review of long-stay cases (greater than 180 days) among hospices whose 180-day stays make up 40 percent or more of their total caseload will not pose an additional burden on hospices whose percentage of such patients is below this threshold. Hospices exceeding this threshold will incur additional costs. We estimate that in 2006, 187 hospices (about 6 percent of all hospices accounting for about 3 percent of hospice stays in that year) had 40 percent or more of their stays exceeding 180 days. On average, 47 percent of these hospices' stays exceeded 180 days, compared with less than 17 percent for all hospices. Also, hospices that currently do not require (or even prohibit) a physician to visit the patient prior to the 180-day recertification and each subsequent recertification will incur costs in providing these visits. Hospices with a greater share of long-stay patients will face greater compliance costs from such a requirement. Some hospices (both long- and short-stay) may incur additional costs from including a brief narrative statement of the clinical basis for the prognosis in certifications and recertifications, but the cost of such activities is expected to be modest.

RECOMMENDATION 6-2B

The Secretary should direct the Office of Inspector General to investigate:

- **the prevalence of financial relationships between hospices and long-term care facilities such as nursing facilities and assisted living facilities that may represent a conflict of interest and influence admissions to hospice,**
- **differences in patterns of nursing home referrals to hospice,**
- **the appropriateness of enrollment practices for hospices with unusual utilization patterns (e.g., high frequency of very long stays, very short stays, or enrollment of patients discharged from other hospices), and**
- **the appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admissions practices.**

RATIONALE 6-2B

Given the incentives in the hospice payment system and the explicit financial arrangements among some providers, nursing facilities and other long-term care facilities may be an attractive source of hospice referrals. A comprehensive OIG review of hospice use by nursing home patients would improve our understanding of how the benefit is used in this context and would quantify the extent to which inappropriate arrangements, such as those described by members of our expert panel and suggested by our own analysis, exist in the hospice and nursing home communities.

IMPLICATIONS 6-2B

Spending

- There are no spending implications stemming from this recommendation. It would require the OIG to expend administrative resources in conducting these reviews.

Beneficiary and provider

- No direct beneficiary implications in the short term, although there could be an indirect impact if providers respond to the OIG examining these issues by changing their enrollment practices.
- No direct impacts on providers in the aggregate, although some hospices may face administrative costs in complying with OIG reviews and requests for information. There could be an indirect impact on providers if they respond to the OIG examining these issues by changing their enrollment practices.

Data needs

Medicare-certified hospices historically have not been required to report much information when submitting claims for reimbursement by the program on behalf of Medicare hospice enrollees. In 2007, CMS issued a program memorandum requiring hospices to begin reporting certain information about the visits they provide to Medicare hospice enrollees on their claims for reimbursement. The hospice industry criticized the CMS requirement on several levels, but after some changes to the requirement, it became effective in July 2008.

Cost reports lack essential information

Hospice cost reports—a potentially valuable data source on hospices' services and costs—are not subject to rigorous

reporting requirements from CMS. Hospice cost reports are not used to adjudicate payments to hospices and do not uniformly include information necessary to determine with greater accuracy the appropriateness of payments. As a result, hospice cost reports can be subject to significant errors, limiting the utility of many hospices' cost reports for the purposes of research or program administration.

As an example of information not collected, Medicare hospice cost reports do not contain charge or payment information. Requiring Medicare payments to be reported in hospice cost reports would allow policymakers to more readily assess hospices' financial performance under Medicare.

Data on the number of days of care attributable to Medicare beneficiaries (non-dual eligibles), Medicaid beneficiaries (non-dual eligibles), and Medicare and Medicaid dual eligibles would be useful for analyzing financial relationships between hospices that receive payments under Medicare's hospice benefit and nursing homes that are the residence of dually eligible beneficiaries who elect hospice. Requiring all hospices to report days of hospice care by type of service, along with the costs and payments attributable to each type of service, would allow for a more comprehensive examination of hospice profitability and the relationship of profitability to length of stay. Requiring hospices to report information on charitable contributions and other revenues would help provide a more complete picture of hospices' financial performance.

Our work using Medicare's hospice cost reports shows that the reports' quality and content could be improved. The new information collection requirements on hospice claims affords CMS the opportunity to make key changes to hospice cost reports. For example, CMS could require hospice cost reports to uniformly include payments, along with aggregated visit information (that could be reconciled with claims data) for each of the four types of currently covered services (routine home care, continuous home care, inpatient respite care, and general inpatient care). To enhance the value of this information for research, program administration, and policy development purposes, CMS could implement stronger cost report edits and additional audit criteria.

Claims information requirements could be improved

Compared with other Medicare provider types, hospices have substantially fewer information requirements when

submitting Medicare claims for reimbursement. Under Medicare's hospice payment system, which pays for each day a beneficiary is enrolled in hospice regardless of whether the hospice provided a service on all the days reimbursed, CMS knows very little about the hospice care that it pays for. Medicare requires only that hospices report days of care at the four designated care levels (routine home care, continuous home care, inpatient respite care, and general inpatient care) on claims for reimbursement. Most hospices submit "batch bills" to Medicare, with each claim covering a 30-day period.

From the information reported on claims, CMS can determine the number of beneficiaries enrolled in hospice, their admitting diagnoses, and the number of covered days for each type of care—but virtually nothing else. CMS has no information on how many visits hospices provided to their enrollees, the type of practitioner providing the visit (e.g., registered nurse, home health aide, social worker), length and content of visit, outcomes, or other basic information. Such data are essential to evaluating the care being provided. Moreover, given that hospice has changed dramatically in several ways in recent years, it is urgent to get basic information on the nature of the benefit.

As of July 2008, CMS began requiring hospices to report additional information on their Medicare claims (CMS 2007). This information includes hospices reporting on a weekly basis the visits provided by nurses (registered, licensed, or nurse practitioner), home health aides, social workers, and physicians (including nurse practitioners serving as the hospice patient's attending physician). We believe the visit information requirement represents a critical first step toward understanding what Medicare is paying for under the hospice benefit. CMS could go further by collecting a broader range of information on the practitioners involved in hospice care.

CMS's decision not to collect information on the length of visits during the first round of data collection justifiably raised industry concerns. In the absence of fully developed and established quality measures in the hospice setting, duration of visits may be one way to assess differences in the relative level of effort among hospices in providing services to their enrollees. We have heard anecdotally from several hospices that the length of time spent on the patient intake process (e.g., assessing medical and medication needs, developing a plan of care, and establishing communications) may be a leading indicator of hospice quality. Additionally, including length of visit on the claims would help illuminate cost differences

among hospices observed in our previous work, and this information could inform future refinements to the hospice payment system.

CMS refrained from implementing this requirement in the first round of data collection due to a desire to minimize the reporting burden on hospices. However, we note that since the home health prospective payment system was implemented in 2000, CMS has required home health agencies to report visit duration in 15-minute increments. It is likely that hospices have the capacity to report this information with little administrative difficulty, especially the home-health-based hospices that make up 20 percent of Medicare-participating hospices. The benefits of additional data (and improved quality of existing data) for the Medicare program and its beneficiaries should outweigh the cost of any additional reporting requirements, and additional visit information (both type and duration of visits) should be required of hospices as a condition of Medicare payment.

RECOMMENDATION 6-3

The Secretary should collect additional data on hospice care and improve the quality of all data collected to facilitate the management of the hospice benefit. Additional data could be collected from claims as a condition of payment and from hospice cost reports.

RATIONALE 6-3

Medicare currently collects minimal information on hospice care. It is insufficient to provide a detailed understanding of what happens during an episode of care, the resources involved, and how resource use varies among patients and among hospices. Hospices' reporting of visit information that began in 2008 is a good first step, but much more information will be needed to modernize the hospice payment system in light of changes in hospice use during the past decade.

IMPLICATIONS 6-3

Spending

- This recommendation would require CMS and its claims processing contractors to expend administrative resources in modifying claims to include additional data elements, implementing claims processing screens, developing new cost reporting standards, and developing program guidance and other instructional materials for Medicare-participating hospices.

Beneficiary and provider

- No direct beneficiary implications.
- This recommendation will have some effects on providers, which are difficult to quantify. They will have to adapt to new claims and cost-reporting requirements in the form of changes to existing information technology systems and training staff on compliance with new claims and cost-reporting requirements.

Conclusions and implications for future work

To ensure that Medicare's hospice benefit, which offers physical and emotional support for Medicare beneficiaries and their families at the end of life, is used as effectively as possible, substantial changes to the benefit should be made. The payment system should be modified to reward appropriate lengths of stay in hospice rather than excessively long stays. Along with payment system changes, Medicare should require greater accountability in the benefit, ensuring more physician involvement in end-of-life care and discouraging relationships among providers that distort hospices' provision of care. CMS will require significantly more data to make these changes and to closely monitor the evolution of the benefit.

In its June 2008 report, the Commission emphasized the urgent need for delivery system reform, given the challenges posed to Medicare by high-spending growth rates with little commensurate improvements in quality or patient care outcomes. Much of the Commission's thinking about delivery system reform was guided by the need to encourage communication among the different providers involved in a beneficiary's care and to develop payment mechanisms (e.g., bundled payments) that would make providers more conscious of the resources used to provide care to a patient throughout an episode of care. Ideally, Medicare's hospice benefit should similarly encompass these principles and is uniquely positioned to play a key role in delivery system reform given the high costs of health care at the end of life and hospices' potential to affect these costs. However, the payment system and other components of the hospice benefit are not sufficiently developed to fulfill this potential. Current patterns of utilization reflect (at least partially) inappropriate provider responses to incentives in the payment system, and available data are not sufficient to provide an understanding of the variation in levels

of hospice care for purposes of constructing bundled payments. As a result, the reforms we recommend here are essential first steps in ensuring that hospice is fully encompassed by delivery system reform.

In the future, the Commission may consider additional measures or reforms related to the hospice benefit. For example, we intend to examine the effect of very long stays on aggregate Medicare hospice spending and may consider additional adjustments to the payment system through the annual update, the hospice cap, or medical review, as warranted. We may also explore whether a separate payment policy for hospice patients in long-term care facilities is warranted when additional data become available. To further strengthen the hospice payment system, it may also be desirable to pursue quality measurement and reporting for hospices. However, as discussed in more detail in our June 2008 report, developing standardized empirical quality measures for hospice that can be used for program administration—either to compare provider performance or to adjust payments under future pay-for-performance

programs—presents unique challenges. The set of hospice characteristics that are correlated with quality is not clear-cut, and structural, process, and outcomes measures are scarce. Measures that rely on patient (or family) perceptions of care are more common, but establishing the validity of those characteristics may be difficult because of their subjective nature. CMS's new conditions of participation require hospices to engage in data-driven quality assessment and performance improvement programs. The conditions of participation provide hospices with the flexibility to select their own quality or outcomes measures, as CMS indicated that it did not believe sufficient information was available at this time to establish national quality benchmarks for hospice (CMS 2008a). Given the challenges, it may take some time before data on the quality of care, resulting from such projects or from administrative or other systematic data, will be available for purposes of comparing quality among hospice providers or to institute quality-based payment incentives in Medicare's hospice payment system. ■

Endnotes

- 1 The hospice cap increases each year by the medical expenditure category of the consumer price index for urban consumers, and the Medicare hospice payment rates increase by the inpatient hospital market basket. Because of the difference in the updates, the hospice cap has increased more than hospice payment rates in recent years. As a result, over time, hospices can provide increasingly more care before hitting the cap. Despite this fact, we have seen an increase over time in the number of hospices exceeding the cap.
- 2 Under the current payment system, most hospice care is routine home care, which is paid at a uniform flat rate throughout the episode. Three other types of hospice care are provided in some circumstances: continuous home care (which is paid an hourly rate) and general inpatient care and inpatient respite care (which are paid different per diem rates).
- 3 The panel described a number of other factors beyond Medicare's payment system that influence hospice length of stay. With respect to long-stay patients, they pointed to the difficulties in precisely predicting likely death for patients with neurological or nonspecific terminal diseases and also noted that admission to hospice can improve a terminal patient's health and well-being, extending the patient's life (the "hospice effect"). They noted other nonclinical factors in addition to payment incentives that lead to long stays, such as market saturation, ownership, and hospice staff's clinical training and qualifications—particularly pertaining to the accuracy of clinical charting and the ability to use this information objectively to assess continued eligibility for hospice. The panel provided information suggesting that nonpayment factors were a larger determinant of short stays in hospice, noting that most short stays came after intensive (and futile) end-of-life acute care interventions. Such stays may reflect payment incentives for nonhospice providers as well as the attitudes of physicians and terminal patients who are reluctant to cease curative treatment.
- 4 Additional policies would likely need to be put in place to prevent inappropriate provider responses to the new payment system and to ensure that Medicare was not overpaying for hospice care under the new system. For example, arguably the payment adjustment made to reflect hospices' higher level of effort at the time of the patient's death should not be made in the case of very-short-stay patients, given that those costs are already factored into the higher early episode payments that would be made under the new system. We have incorporated this approach in our payment model.
- 5 CMS implemented this system in January 2005, pursuant to a mandate in the Balanced Budget Refinement Act of 1999. Under this payment system, per diem payments are adjusted to reflect their position in the length of stay. In the 2009 rate year, IPFs are paid 119 percent or 131 percent of the base payment rate for the first day of the IPF stay (depending on whether the IPF has an emergency department meeting certain standards). The adjustment declines through successive days of the stay, falling to 100 percent of the base payment rate on days 9 and 10, reaching 92 percent of the base payment rate for days beyond the 21st day of an IPF stay (CMS 2008b).
- 6 Under the first set of payment weights (with the larger intensity adjustment), the weights are 2.0 for the first 30 days of hospice care, 1.0 for days 31–90, 0.5 for days 91–180, 0.25 for days 181+, and an end-of-life payment equivalent to a weight of 2.0 for the last 7 days of life. Under the second set of payment weights (with the smaller intensity adjustment), the weights are 1.5 for the first 30 days of hospice care, 1.125 for days 31–90, 0.75 for days 91–180, 0.375 for days 181+, and an end-of-life payment equivalent to a weight of 1.5 for the last 7 days of life. Under either set of weights, the end-of-episode payment would not be made if the patient died during the first 30 days in order to avoid inappropriately duplicating payments.
- 7 While it is required that the medical record include information (e.g., test results) that would support the terminal prognosis, there is not a requirement that the medical record include a statement explaining the reasons for the terminal prognosis.
- 8 Currently, there are three Medicare contractors that process hospice claims. All three have hospice LCDs, and there is some variance in these policies.
- 9 Nurse practitioners are the only type of APN defined for the Medicare hospice benefit, so references to APNs refer to nurse practitioners.
- 10 Room and board services include personal care services, assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies. Core palliative hospice services include nursing care, physician care, counseling, and medical social services related to the diagnosed terminal illness.
- 11 To identify a beneficiary population that might be most affected by this payment intersection, we identified hospice beneficiaries who had spent at least 90 days in a nursing facility leading up to or as a part of their hospice episode.

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