CHAPTER 12

Hospice services

RECOMMENDATION

12 The Congress should eliminate the update to the hospice payment rates for fiscal year 2016.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

(Additionally, the Commission reiterates its March 2009 recommendations on hospice. See text box, pp. 292–293.)

CHAPTER 12

Hospice services

Chapter summary

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill and have a life expectancy of six months or less. Beneficiaries may choose to elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of their terminal condition. In 2013, more than 1.3 million Medicare beneficiaries (including 47 percent of decedents) received hospice services from over 3,900 providers, and Medicare hospice expenditures totaled about $15.1 billion.

Assessment of payment adequacy

The indicators of payment adequacy for hospices, discussed below, are positive.

***Beneficiaries' access to care*—**Hospice use among Medicare beneficiaries has grown substantially in recent years, suggesting greater awareness of and access to hospice services. In 2013, hospice use increased across almost all demographic and beneficiary groups examined. However, rates of hospice use remained lower for racial and ethnic minorities than for Whites.

- ***Capacity and supply of providers*—**The number of hospice providers increased by over 5 percent in 2013, due almost entirely to growth in the number of for-profit hospices. This increase continues a more than decade-long trend of substantial market entry by for-profit providers.

In this chapter

- ***Volume of services*—**In 2013, the proportion of beneficiaries using hospice services at the end of life continued to grow, and average length of stay changed little. Of Medicare beneficiaries who died in 2013, 47.3 percent used hospice, up from 46.7 percent in 2012. Average length of stay among decedents, which increased from about 86 days in 2011 to 88 days in 2012, remained at about 88 days in 2013. The median length of stay for hospice decedents was 17 days in 2013 and has remained stable at approximately 17 or 18 days for more than a decade.

***Quality of care*—**At this time, we do not have data to assess the quality of hospice care provided to Medicare beneficiaries. The Patient Protection and Affordable Care Act of 2010 mandated that a hospice quality reporting program begin by fiscal year 2014. Beginning in 2013, hospices were required to report data for specified quality measures or face a 2 percentage point reduction in their annual update for the subsequent fiscal year. Beginning July 2014, CMS replaced the initial two quality measures with seven new quality measures. In 2015, CMS will implement a hospice experience-of-care survey for bereaved family members. Public reporting of quality information is unlikely before 2017, according to CMS.

***Providers' access to capital*—**Hospices are not as capital intensive as some other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (a 9.6 percent increase in 2013) suggests capital is readily available to for-profit providers. Less is known about access to capital for nonprofit freestanding providers, for whom capital may be more limited. Hospital-based and home health–based hospices have access to capital through their parent providers.

***Medicare payments and providers' costs*—**The aggregate 2012 Medicare margin, which is an indicator of the adequacy of Medicare payments relative to providers' costs, was 10.1 percent, up from 8.8 percent in 2011. The projected margin for 2015 is 6.6 percent, which includes the effect of the sequester.

Because the payment adequacy indicators for which we have data are positive, the Commission believes that hospices can continue to provide beneficiaries with appropriate access to care with no update to the base payment rate in 2016.

Need for payment reform

Medicare's hospice payment system is not well aligned with the costs of providing care throughout a hospice episode. As a result, long hospice stays are generally more profitable than short stays. In March 2009, the Commission recommended that the hospice payment system be reformed to better match service intensity

throughout a hospice episode of care (higher per diem payments at the beginning of the episode and at the end of the episode near the time of death and lower payments in the middle). The issues that led the Commission to make the payment reform recommendation persist, and we are reiterating the recommendation in this report. We are also reiterating the Commission's March 2009 recommendation for focused medical review of hospice providers with many long-stay patients. In our view, implementation of these recommendations would result in substantial improvements to the hospice payment system and greater accountability for the hospice benefit. ■

Background

Medicare began offering a hospice benefit in 1983, pursuant to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The benefit covers palliative and support services for terminally ill beneficiaries who have a life expectancy of six months or less if the terminal illness follows its normal course. A broad set of services is included, such as nursing care; physician services; counseling and social work services; hospice aide (also referred to as home health aide) and homemaker services; short-term hospice inpatient care (including respite care); drugs and biologics for symptom control; supplies; home medical equipment; physical, occupational, and speech therapy; bereavement services for the patient's family; and other services for palliation of the terminal condition. Most commonly, hospice care is provided in patients' homes, but hospice services are also provided in nursing facilities, assisted living facilities, hospice facilities, and hospitals. In 2013, more than 1.3 million Medicare beneficiaries received hospice services, and Medicare expenditures totaled about $15.1 billion.

Beneficiaries may choose to elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of the terminal illness and related conditions. Medicare continues to cover items and services unrelated to the terminal illness. For each person admitted to a hospice program, a written plan of care must be established and maintained by an interdisciplinary group (which must include a hospice physician, registered nurse, social worker, and pastoral or other counselor) in consultation with the patient's attending physician, if any. The plan of care must identify the 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. The first hospice benefit period is 90 days. For a beneficiary to elect hospice initially, two physicians—a hospice physician and the beneficiary's attending physician—are generally required to certify that the beneficiary has a life expectancy of six months or less if the illness runs its normal course.[1] If the patient's terminal illness continues to engender the likelihood of death within 6 months, the hospice physician can recertify the patient for another 90 days and for an unlimited number of 60-day periods after that, as long as he or she remains eligible.[2] Beneficiaries can disenroll from hospice at any time and can reelect hospice for a subsequent period as long as the beneficiary meets the eligibility criteria.

Between 2000 and 2012, Medicare spending for hospice care increased dramatically—more than 400 percent, from $2.9 billion in 2000 to $15.1 billion in 2012. That spending increase was driven by greater numbers of beneficiaries electing hospice and by growth in length of stay for patients with the longest stays. Occurring simultaneously since 2000 has been a substantial increase in the number of for-profit providers.[3]

Medicare spending for hospice services in 2013 was $15.1 billion, about the same as the prior year. The flat spending between 2012 and 2013 partly reflects the effect of the sequester, which reduced Medicare payments to providers by 2 percent beginning April 2013. If the sequester had not been in effect in 2013, Medicare hospice spending would have been about 1.5 percent higher than 2012. Other factors influencing the 2013 spending level include little change in decedent's average length of stay and a slight shift in the mix of hospice patients served, with hospice decedents making up a greater share of hospice providers' caseload in 2013 than 2012.[4]

Medicare payment for hospice services

The Medicare program pays a daily rate to hospice providers. The hospice provider assumes all financial risk for costs and services associated with care for the patient's terminal illness and related conditions. The hospice provider receives payment for every day a patient is enrolled, regardless of whether the hospice staff visited the patient or otherwise provided a service each day. This payment design is intended to encompass not only the cost of visits but also other costs a hospice incurs for palliation and management of the terminal condition and related conditions, such as on-call services, care planning, drugs, medical equipment, supplies, patient transportation between sites of care that are specified in the plan of care, short-term hospice inpatient care, and other less frequently used services.

Payments are made according to a per diem rate for four categories of care: routine home care, continuous home care, inpatient respite care, and general inpatient care (Table 12-1, p. 290). A hospice is paid the routine home care rate (about $159 per day in 2015) for each day the patient is enrolled in hospice, unless the hospice provides care under one of the other three categories. Overall, routine home care accounts for almost 98 percent of hospice care days. The payment rates for hospice are updated annually by the inpatient hospital market basket

TABLE 12–1

Medicare hospice payment categories and rates

Category	Description	Base payment rate, 2015	Percent of hospice days, 2013
Routine home care	Home care provided on a typical day	$159.34 per day	97.6%
Continuous home care	Home care provided during periods of patient crisis	$38.75 per hour	0.4
Inpatient respite care	Inpatient care for a short period to provide respite for primary caregiver	$164.81 per day	0.3
General inpatient care	Inpatient care to treat symptoms that cannot be managed in another setting	$708.77 per day	1.7

Note: Payment for continuous home care (CHC) is an hourly rate for care delivered during periods of crisis if care is provided in the home for 8 or more hours within a 24-hour period beginning at midnight. A nurse must deliver more than half of the hours of this care to qualify for CHC-level payment. The minimum daily payment rate at the CHC level is $310 per day (8 hours at $38.75 per hour); maximum daily payment at the CHC level is about $930 per day (24 hours at $38.75 per hour). The above rates apply to hospices that submit the required data on quality. For hospices that do not submit the required data on quality, the rates are reduced through a 2 percentage point reduction in the annual payment update.

Source: Centers for Medicare & Medicaid Services. 2014. *Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, Quality Reporting Program, and the Hospice Pricer for FY 2015.* Manual System Pub 100–04 Medicare Claims Processing, Transmittal 3023, August 11.

index. Beginning fiscal year 2013, the market basket index has been reduced by a productivity adjustment, as required by the Patient Protection and Affordable Care Act of 2010 (PPACA). An additional reduction to the market basket update of 0.3 percentage point was required in years 2013–2015 and possibly will be required in years 2016–2019 if certain targets for health insurance coverage among the working-age population are met. Beginning in 2014, hospices that do not report data on quality receive a 2 percentage point reduction in their annual payment update. (To date, the vast majority of hospices have met this reporting requirement.) The payment methodology and the base rates for hospice care have not been recalibrated since initiation of the benefit in 1983.

The hospice daily payment rates are adjusted to account for geographic differences in wage rates. From 1983 to 1997, Medicare adjusted hospice payments with a 1983 wage index. In 1998, CMS began using the most current hospital wage index to adjust hospice payments and applied a budget-neutrality adjustment each year to make aggregate payments equivalent to what they would have been under the 1983 wage index. This budget-neutrality adjustment increased Medicare payments to hospices by about 4 percent. The budget-neutrality adjustment is being phased out over seven years, with a 0.4 percentage point reduction in 2010 and an additional reduction of 0.6 percentage point in each subsequent year through 2016.

Beneficiary cost sharing for hospice services is minimal. Prescription drugs and inpatient respite care are the only services potentially subject to cost sharing. Hospices may charge coinsurance of 5 percent for each prescription provided outside the inpatient setting (not to exceed $5) and for inpatient respite care (not to exceed the inpatient hospital deductible). (For a more complete description of the hospice payment system, see http://www.medpac.gov/documents/payment-basics/hospice-services-payment-system-14.pdf?sfvrsn=0.)

Commission's prior recommendations

The Commission's analyses of the hospice benefit in the June 2008 and March 2009 reports found that the structure of Medicare's hospice payment system makes longer stays in hospice more profitable for providers than shorter stays. Hospice visits tend to be more frequent at the beginning and end of a hospice episode and less frequent in the intervening period. The Medicare payment rate, which is constant over the course of the episode, does not take into account the different levels of effort that occur during different periods in an episode. This payment structure may be spurring some providers to pursue business models that maximize profit by enrolling patients more likely to have long stays (Medicare Payment Advisory Commission 2009, Medicare Payment Advisory Commission 2008). The mismatch between Medicare payments and hospice service intensity throughout an episode distorts the distribution of payments across providers, making hospices with longer stays more profitable than those with shorter stays. Our analysis also found that the benefit lacked adequate administrative and other controls to check

the incentives for long stays in hospice and that CMS lacked data vital for effective management of the benefit.

In March 2009, the Commission made recommendations to reform the hospice payment system, ensure greater accountability in use of the hospice benefit, and improve data collection and accuracy. The Commission recommended that the hospice payment system be changed from a flat per diem payment to one in which the payment is higher at the beginning and end of the episode (in the last days of life) and lower in the middle. PPACA gave CMS the authority to make budget-neutral revisions to the hospice payment as the Secretary of Health and Human Services determines appropriate, beginning in fiscal year 2014 or later. To date, CMS has conducted research on payment reform and included in the 2014 hospice proposed rule an update on several payment reform models it may consider adopting, including one approach similar to the Commission's recommendation (Centers for Medicare & Medicaid Services 2013). However, CMS has not made a proposal to revise the hospice payment system. Therefore, we are reiterating the Commission's March 2009 recommendation for payment reform in this report (see text box, pp. 292–293). In addition, our June 2013 report quantifies how the labor cost of hospice visits changes over the course of an episode in a u-shaped pattern and provides an illustrative example of a revised payment system that could be implemented now using existing data (Medicare Payment Advisory Commission 2013).

Currently, a substantial amount of Medicare hospice spending is devoted to long-stay patients, who are more profitable than other patients under the current payment system. In 2013, Medicare spent nearly $9 billion, more than half of all hospice spending that year, on patients with stays exceeding 180 days (Table 12-2). Because the misalignment of the current payment system creates a number of problems (e.g., distorts the distribution of payments across providers, makes the payment system vulnerable to patient selection, and results in program integrity concerns), improvements to the payment system are needed as soon as possible (see text box pp. 292–293.).

In March 2009, the Commission also recommended several steps to increase accountability in the hospice benefit. The Commission recommended requirements for a physician narrative describing the clinical basis for the patient's prognosis in all certifications and recertifications, a face-to-face visit with a physician or nurse practitioner before recertifying patients beyond 180 days of hospice care, and focused medical review of hospice providers with unusually high shares of patients with stays exceeding 180 days. PPACA included provisions similar to all three of these recommended measures. CMS has implemented the first two measures but has not implemented the focused medical review provision. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 modified the hospice-focused medical review provision to address concerns related to beneficiary liability for denied services and the formula for identifying providers for focused medical review. Because the focused medical review provision has yet to be implemented, we are reiterating the Commission's recommendation (see text box, pp. 292–293).[5]

TABLE 12–2 **More than half of Medicare hospice spending in 2013 was for patients with stays exceeding 180 days**

	Medicare hospice spending, 2013 (in billions)
All hospice users in 2013	$15.1
Beneficiaries with LOS > 180 days	8.8
Days 1–180	2.9
Days 181–365	2.8
Days 366+	3.1
Beneficiaries with LOS ≤ 180 days	6.2

Note: LOS (length of stay). LOS reflects the beneficiary's lifetime LOS as of the end of 2013 (or at the time of discharge in 2013 if the beneficiary was not enrolled in hospice at the end of 2013). All spending presented in the chart occurred only in 2013. Break-out groups do not sum to total because they exclude about $0.1 billion in payments to hospices for physician visits.

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

Medicare hospice payment limits ("caps")

The Medicare hospice benefit was designed to give beneficiaries a choice in their end-of-life care, allowing them to forgo conventional treatment (often in inpatient settings) and die at home, with family, and according to their personal preferences. The inclusion of the Medicare hospice benefit in TEFRA was based in large part on the premise that the new benefit would be a less costly alternative to conventional end-of-life care (Government Accountability Office 2004, Hoyer 2007). Studies show

The Commission reiterates its March 2009 recommendations on hospice

Payment reform

In March 2009, the Commission recommended that the hospice payment system be reformed to better align payments with the cost of providing care throughout a hospice episode. Currently, Medicare makes a flat payment per day, even though patients generally receive more hospice visits at the beginning and end of an episode, with fewer visits in the middle of an episode. To address the mismatch between payments and hospice service intensity, the Commission recommended that Medicare move away from the flat per diem payment to one that is higher at the episode's beginning and end and lower in the intervening period.

The Congress gave CMS the authority to revise the hospice payment system in a budget-neutral manner as the Secretary determines appropriate, beginning in 2014 or later. To date, the Secretary has not used that authority. Therefore, we are reiterating the Commission's recommendation on payment reform. That recommendation urged payment reform by 2013. While that time frame has already passed, the indicators that led us to make this recommendation have not changed. Therefore, the need for payment reform continues and the recommendation stands.

For a number of reasons, improvements to the hospice payment system are needed as soon as possible. Currently, a substantial amount of Medicare hospice spending is devoted to long-stay patients, who are more profitable than other patients under the current payment system. In 2013, Medicare spent nearly $9 billion, more than half of all hospice spending that year, on patients with stays exceeding 180 days. Reforming the payment system as the Commission has recommended also addresses concerns about payment rates for very short stays that, because of their high visit intensity, may currently be reimbursed at levels below their cost. Modifying the payment system would help make payments more equitable across providers, decreasing payments to providers who have disproportionately long stays and high margins and increasing payments to providers who have shorter stays and lower margins.

Also, the hospice payment system is vulnerable to patient selection. A hospice that wishes to do so can focus on patient populations likely to have long stays and high profitability (because length of stay varies by observable patient characteristics like diagnosis and location of care). Substantial profit opportunities within the current payment system may have spurred for-profit provider entry into the hospice field and led some

(continued next page)

that beneficiaries who elect hospice incur less Medicare spending in the last two months of life than comparable beneficiaries who do not, but also that Medicare spending for beneficiaries is higher for hospice enrollees in the earlier months before death than it is for nonenrollees. In essence, hospice's net reduction in Medicare spending decreases the longer the patient is enrolled, and beneficiaries with very long hospice stays may incur higher Medicare spending than those who do not elect hospice. (For a fuller discussion of the cost of hospice care relative to conventional care at the end of life, see the Commission's June 2008 report.)

To make cost savings more likely, the Congress included in the hospice benefit two limitations, or "caps," on payments to hospices. The first cap limits the number of days of inpatient care a hospice may provide to 20 percent of its total Medicare patient care days. This cap is rarely exceeded; any inpatient days provided in excess of the cap are reimbursed at the routine home care payment rate.

The second, more visible cap limits the aggregate Medicare payments that an individual hospice can receive. It was implemented at the outset of the hospice benefit to ensure that Medicare payments did not exceed the cost of conventional care for patients at the end of life. Under the cap, if a hospice's total Medicare payments exceed its total number of Medicare beneficiaries served multiplied by the cap amount ($26,725.79 in 2014), it must repay the excess to the program.[6,7,8] This cap is not applied individually to the payments received for each beneficiary but, rather, to the total payments across all Medicare patients served by the hospice in the cap year. The number of hospices exceeding the payment cap historically has been low, but we have found that increases in the number of hospices and increases in very long stays have resulted in more hospices

The Commission reiterates its March 2009 recommendations on hospice (cont.)

providers to pursue revenue-generation strategies such as enrolling patients likely to have long stays who may not meet the hospice eligibility criteria.

Recommendation 6-1, March 2009 report

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.

Focused medical review

Measures consistent with another Commission recommendation for increased hospice accountability (shown below) have been implemented, with the exception of focused medical review. Focused medical review of hospices with unusually high rates of long-stay patients would provide greater oversight of the benefit and target scrutiny toward those providers for whom it is most warranted. Therefore, we are reiterating the recommendation that included focused medical review.

Recommendation 6-2A, March 2009 report

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.** ■

exceeding the cap (with the number peaking in 2009 and beginning to increase again in 2012). With rapid growth in Medicare hospice spending in recent years, the hospice cap is the only significant fiscal constraint on the growth of program expenditures for hospice care (Hoyer 2007).

Are Medicare payments adequate in 2015?

To address whether payments in 2015 are adequate to cover the costs of the efficient delivery of care and how much providers' payments should change in the coming year (2016), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries' access to care by examining the capacity and supply of hospice providers, changes over time in the volume of services provided, quality of care, providers' access to capital, and the relationship between Medicare's payments and providers' costs. Overall, the Medicare payment adequacy indicators for hospice providers are positive. Unlike our assessments of most other providers, we could not use quality of care as a payment adequacy indicator because information on hospice quality is generally not available.

Beneficiaries' access to care: Use of hospice continues to increase

In 2013, hospice use among Medicare beneficiaries increased, continuing the trend of a growing proportion of beneficiaries using hospice services at the end of life. Of the Medicare beneficiaries who died in 2013, 47.3 percent used hospice, up from 46.7 percent in 2012 and 22.9 percent in 2000 (Table 12-3, p. 295). Hospice use varies by beneficiary characteristics (i.e., enrollment in traditional fee-for-service (FFS) Medicare or Medicare Advantage

(MA); beneficiaries who are and are not dually eligible for Medicare and Medicaid; urban or rural residence; and age, gender, and race), but it increased across almost all beneficiary groups examined in 2013.

Use of hospice is somewhat more prevalent among decedents in MA than in FFS. In 2013, about 46 percent of Medicare FFS decedents and 51 percent of MA decedents used hospice. MA plans do not provide hospice services. Once a beneficiary in an MA plan elects hospice care, the beneficiary receives hospice services through a hospice provider paid by Medicare FFS. In March 2014, the Commission urged that this policy be changed, recommending that hospice be included in the MA benefits package (Medicare Payment Advisory Commission 2014).

Hospice use varies by other beneficiary characteristics. In 2013, a smaller proportion of Medicare decedents who were dually eligible for Medicare and Medicaid used hospice compared with the rest of Medicare decedents (42 percent and 49 percent, respectively). Hospice use is most prevalent among older beneficiaries. In 2013, more than half (55 percent) of Medicare decedents age 85 or older used hospice. Female beneficiaries were also more likely than male beneficiaries to use hospice, which partly reflects the longer average life span for women and greater hospice use among older beneficiaries.

Hospice use also varies by racial and ethnic group (Table 12-3). As of 2013, Medicare hospice use was highest among White decedents, followed by Hispanic, African American, Native American, and Asian American decedents. Hospice use grew among all these groups between 2012 and 2013 and has grown substantially for all groups since 2000. Nevertheless, differences in hospice use across racial and ethnic groups persist but are not fully understood. Researchers examining this issue have cited a number of possible factors, such as cultural or religious beliefs, preferences for end-of-life care, socioeconomic factors, disparities in access to care or information about hospice, and mistrust of the medical system (Barnato et al. 2009, Cohen 2008, Crawley et al. 2000).

Hospice use is more prevalent among urban than rural beneficiaries, although use has grown in all types of areas (Table 12-3). In 2013, the share of decedents residing in urban counties who used hospice was about 49 percent; in micropolitan counties, about 44 percent; in rural counties adjacent to urban counties, about 43 percent; in rural nonadjacent counties, 38 percent; and in frontier counties, about 32 percent. Use rates for beneficiaries in all five of these areas increased between 0.3 and 0.9 of a percentage point compared with the prior year.

One driver of increased hospice use over the past decade has been growing use by patients with noncancer diagnoses since there has been increased recognition that hospice can care for such patients. In 2013, 68 percent of Medicare decedents who used hospice had a noncancer diagnosis, similar to 2012, and up from 48 percent in 2000. Analysis by CMS has shown that use of nonspecific diagnoses—debility and adult failure to thrive—as a hospice primary diagnosis had grown substantially since 2002. In a hospice proposed rule issued in spring 2013, CMS expressed concern that nonspecific diagnoses do not convey enough information about a hospice patient's condition and announced its intention to no longer allow debility and adult failure to thrive to be reported on claims as the primary hospice diagnosis (effective October 1, 2014). If patients with these diagnoses have a life expectancy of six months or less, they still qualify for hospice, but the hospice must report a more specific primary diagnosis. With this announcement, the diagnosis mix of hospice patients changed: Fewer decedents were reported to have a primary diagnosis of debility and adult failure to thrive in 2013 (9 percent) than in 2012 (16 percent). As of 2013, the most common noncancer primary diagnoses among hospice decedents were heart and circulatory disorders (19 percent) and neurological conditions (18 percent), each increasing 2 percentage points from 2012 (possibly capturing some patients who would have previously been coded with debility or adult failure to thrive).

Capacity and supply of providers: Supply of hospices continues to grow, driven by growth in for-profit providers

In 2013, 3,925 hospices provided care to Medicare beneficiaries, a 5.3 percent increase from the prior year, continuing more than 10 years of growth in the number of hospices providing care to Medicare beneficiaries (Table 12-4, p. 296). For-profit hospices account almost entirely for the growth in the number of hospices. Between 2012 and 2013, the number of for-profit hospices increased by more than 9 percent, while the number of nonprofit hospices was relatively flat and the number of government hospices declined by about 4 percent. As of 2013, about 61 percent of hospices were for profit, 33 percent were nonprofit, and 5 percent were government.

Looking at type of hospice, freestanding hospices account for most of the growth in the number of providers (Table 12-4, p. 296). From 2012 to 2013, the number of

TABLE 12–3

Use of hospice continues to increase

	Percent of Medicare decedents who used hospice						
	2000	2010	2011	2012	2013	Average annual percentage point change 2000–2012	Percentage point change 2012–2013
All beneficiaries	22.9%	44.0%	45.2%	46.7%	47.3%	2.0	0.6
FFS beneficiaries	21.5	43.0	44.2	45.7	46.2	2.0	0.5
MA beneficiaries	30.9	47.8	48.9	50.4	50.6	1.6	0.2
Dual eligibles	17.5	39.2	40.3	41.6	42.1	2.0	0.5
Nondual eligibles	24.5	45.5	46.8	48.4	48.9	2.0	0.5
Age							
<65	17.0	27.2	27.8	29.2	29.2	1.0	0.0
65–74	25.4	38.6	39.3	40.6	40.7	1.3	0.1
75–84	24.2	45.1	46.3	47.8	48.2	2.0	0.4
85+	21.4	50.4	52.0	54.0	55.0	2.7	1.0
Race/ethnicity							
White	23.8	45.8	47.0	48.6	49.2	2.1	0.6
African American	17.0	34.1	35.4	36.8	37.3	1.7	0.5
Hispanic	21.1	37.0	38.3	39.4	40.2	1.5	0.8
Asian American	15.2	28.1	30.0	31.8	32.0	1.4	0.2
Native American	13.0	30.6	32.4	34.0	34.1	1.8	0.1
Sex							
Male	22.4	40.4	41.3	42.8	43.3	1.7	0.5
Female	23.3	47.2	48.6	50.2	50.9	2.2	0.7
Beneficiary location							
Urban	24.3	45.5	46.6	48.0	48.5	2.0	0.5
Micropolitan	18.5	39.8	41.4	43.4	44.3	2.1	0.9
Rural, adjacent to urban	17.6	38.7	40.2	42.2	42.9	2.1	0.7
Rural, nonadjacent to urban	15.8	34.5	35.9	37.7	38.0	1.8	0.3
Frontier	13.2	30.1	30.7	31.9	32.2	1.6	0.3

Note: FFS (fee-for-service), MA (Medicare Advantage). Beneficiary location reflects the beneficiary's county of residence grouped into four categories (urban; micropolitan; rural, adjacent to urban; and rural, nonadjacent to urban) based on an aggregation of the urban influence codes. The frontier category is defined as population density equal to or less than 6 people per square mile.

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

freestanding providers increased by about 7.6 percent, while the number of hospital-based hospices declined 2.6 percent, and the number of home health–based hospices increased by 2.2 percent.[9] The number of skilled nursing facility (SNF)–based hospices was small, and increased from 23 to 25. As of 2013, about 72 percent of hospices were freestanding, 14 percent were hospital based, 13 percent were home health based, and less than 1 percent were SNF based.

Overall, the supply of hospices increased substantially between 2000 and 2013 in both urban and rural areas, although the number of hospices located in rural areas has declined modestly since 2007 (Table 12-4, p. 296). Roughly proportionate with the share of Medicare beneficiaries residing in each area, 74 percent of hospices were located in urban areas and 26 percent were located in rural areas as of 2013. The number of hospices located in rural areas is not necessarily reflective of hospice access

TABLE 12–4 **Increase in total number of hospices driven by growth in for-profit providers**

Category	2000	2007	2011	2012	2013	Average annual percent change 2000–2007	Average annual percent change 2007–2012	Percent change 2012–2013
All hospices	2,255	3,250	3,585	3,727	3,925	5.4%	2.8%	5.3%
For profit	672	1,676	2,054	2,199	2,411	13.9	5.6	9.6
Nonprofit	1,324	1,337	1,314	1,318	1,314	0.1	–0.3	–0.3
Government	257	237	217	209	200	–1.2	–2.5	–4.3
Freestanding	1,069	2,103	2,491	2,643	2,844	10.1	4.7	7.6
Hospital based	785	683	587	568	553	–2.0	–3.6	–2.6
Home health based	378	443	486	492	503	2.3	2.1	2.2
SNF based	22	21	21	23	25	–0.7	1.8	8.7
Urban	1,424	2,190	2,536	2,670	2,824	6.3	4.0	5.8
Rural	788	1,012	986	983	978	3.6	–0.6	–0.5

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

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

for rural beneficiaries, as demonstrated by the increase in the share of rural decedents using hospice over this period.[10]

Rapid growth in the number of hospices was concentrated in a few states in 2013, while most states experienced modest change in the number of providers. Two states—California and Texas—accounted for 60 percent of the increase in hospice providers. California gained 84 hospice providers and Texas gained 37 hospice providers, an increase from the prior year of 26 percent and 9 percent, respectively. Arizona and Ohio also saw sizable growth—15 percent and 9 percent, respectively—in provider supply (Arizona gained 12 hospices; Ohio, 11 hospices). As of 2013, California, Texas, and Arizona had an above-average supply of hospice providers (as measured by the number of hospices per 10,000 Medicare decedents per state compared with the national average), while Ohio remained below average.

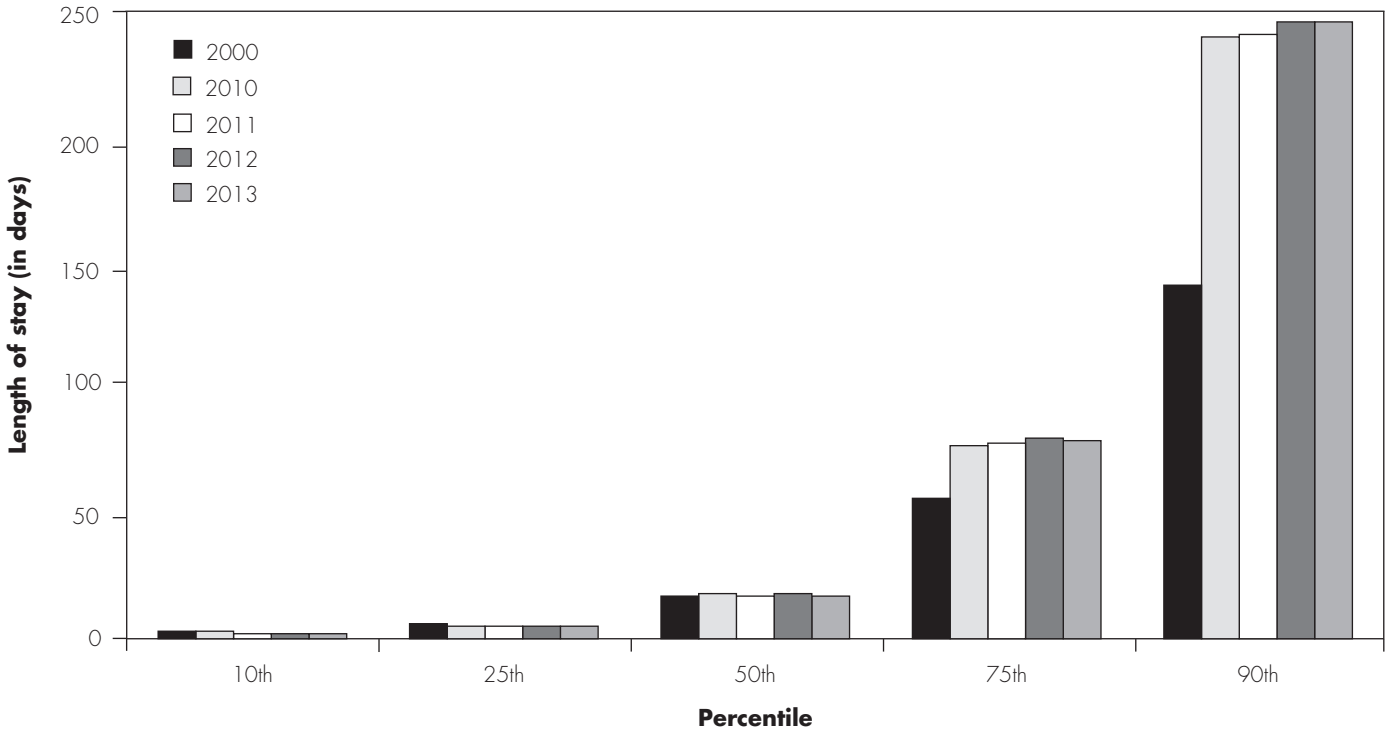
TABLE 12–5 **Hospice expenditures and average length of stay were virtually unchanged in 2013**

Category	2000	2011	2012	2013	Average annual change, 2000–2011	Percent change, 2011–2012	Percent change, 2012–2013
Number of hospice users (in millions)	0.534	1.219	1.274	1.315	7.8%	4.5%	3.2%
Total spending (in billions)	$2.9	$13.8	$15.1	$15.1	15.2%	9.3%	–0.1%
Average length of stay among decedents (in days)	53.5	86.3	88.0	87.8	4.4%	2.0%	–0.2%
Median length of stay among decedents (in days)	17	17	18	17	0 days	1 day	–1 day

Note: Average length of stay is calculated for decedents who used hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime. The number of hospice users, total spending, and average length of stay displayed in the table are rounded; the percent change is calculated using unrounded data.

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

FIGURE 12–1 **Growth in length of stay among hospice patients with the longest stays has slowed**



Note: Length of stay is calculated for decedents who were using hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime.

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

The number of hospice providers is not necessarily an indicator of beneficiary access to hospice because a hospice's service area may extend beyond the boundaries of the county where it is located. The supply of providers—as measured by the number of hospices per 10,000 Medicare decedents—varies substantially across states. As shown in our March 2010 report, there is no relationship between supply of hospices (as measured by number of hospices per 10,000 beneficiaries) and the rate of hospice use (as measured by share of decedents who use hospice before death) across states (Medicare Payment Advisory Commission 2010).

Volume of services: The number of hospice users grew and average length of stay among decedents was virtually unchanged in 2013

The number of Medicare beneficiaries receiving hospice services continued to increase. In 2013, more than 1.31 million beneficiaries used hospice services, up from about 1.27 million in 2012. (Table 12-5). Between 2012 and 2013, the number of hospice users grew 3.2 percent, outpacing growth in the Medicare decedent population (2.5 percent, not shown in table) during this period.

Hospice average length of stay among decedents was 87.8 days in 2013, about the same as the prior year (88 days) (Table 12-5). The flat average length of stay between 2012 and 2013 follows a long period of growth in average length of stay. Between 2000 and 2012, average length of stay grew from about 54 days to 88 days. The increase in average length of stay observed since 2000 in large part reflects an increase in very long hospice stays, while short stays remained virtually unchanged (Figure 12-1). Overall, between 2000 and 2013, hospice length of stay at the 90th percentile grew substantially, increasing from 141 days to 246 days. Growth in very long stays has slowed in recent years. Between 2008 and 2011, the 90th percentile of length of stay grew six days; between 2011 and 2012, it grew five additional days; and in 2013 it was unchanged. Median length, which has held steady at 17 or 18 days

Medicare Care Choices Model demonstration program

CMS has developed a demonstration that will test concurrent palliative and conventional care. Under the Medicare Care Choices Model (MCCM) demonstration, fee-for-service beneficiaries who are hospice eligible but not enrolled in hospice will be permitted to enroll in the demonstration and receive palliative and supportive care from a hospice provider while continuing to receive curative care from other providers. CMS has indicated that one goal of the demonstration is to test whether beneficiaries would be willing to elect supportive palliative care from hospice providers. Another goal is to evaluate the effect of the demonstration on the quality and cost of care and whether beneficiaries choose to enroll in the Medicare hospice benefit later.

Unlike the hospice benefit, under the MCCM, care will be directed by the non-hospice "curative" provider who referred the beneficiary to the demonstration, and the hospice provider will play a supportive role. Hospices providing services under the MCCM "are expected to engage in shared decision making, care coordination and case management of the patient, family, and his/her providers; ensure that the patient's pain and symptoms are managed; offer appropriate levels of counseling; and address other care needs based on a comprehensive assessment and plan of care" (Center for Medicare & Medicaid Innovation 2014). In-home nursing, aide services, and respite care are also offered under the MCCM. Hospices will be paid $400 per month for each enrollee in the MCCM, and beneficiaries will not be liable for cost sharing related to MCCM services.

To be eligible for participation in the demonstration, a beneficiary must have had 2 inpatient hospitalizations in the last 12 months, have certain diagnoses (advanced cancers, chronic obstructive pulmonary disease, congestive heart failure, or HIV/AIDS), live at home (not an assisted living facility or nursing facility), be enrolled in fee-for-service Medicare, and meet the hospice eligibility criteria (a life expectancy of 6 months or less if the disease runs its normal course). The beneficiary must be referred to the demonstration by a provider with whom the beneficiary had at least 3 office visits in the last 12 months for the diagnosis that qualifies the beneficiary for the demonstration. The referring provider must certify that the beneficiary meets the demonstration eligibility criteria. Hospice providers that have exceeded the aggregate cap are not allowed to participate in the demonstration. The demonstration will involve at least 30 hospice providers and 30,000 beneficiaries over a span of 3 years. The start date and hospice providers selected for the demonstration have not yet been announced. ■

since 2000, was 17 days in 2013. In 2013, 25 percent of stays were five days or less, unchanged from the prior year.

The Commission has previously expressed concern about very short hospice stays. More than one-quarter of hospice decedents enroll in hospice only in the last week of life, a length of stay that is commonly thought to be of less benefit to patients than enrolling somewhat earlier. As discussed in our March 2009 report, a Commission-convened panel of hospice industry representatives indicated that very short stays in hospice stem largely from factors unrelated to the Medicare hospice payment system, such as some physicians' reluctance to have conversations about hospice or a tendency to delay such discussions until death is imminent; difficulty some patients and families may have in accepting a terminal prognosis; and financial incentives in the FFS system for increased volume of services (Medicare Payment Advisory Commission 2009).

Some point to the requirement that beneficiaries forgo conventional care to enroll in hospice as a factor that contributes to deferring hospice care, resulting in short hospice stays. CMS is in the process of launching a demonstration program to test concurrent palliative care and curative care. Under the demonstration (called the Medicare Care Choices Model), certain FFS beneficiaries who are hospice eligible but not enrolled in the Medicare hospice benefit will be permitted to enroll in the demonstration and receive palliative and supportive care from a hospice provider while continuing to receive curative care from other providers (see text box). With respect to MA, the Commission's recommendation in March 2014 that hospice be included in the MA benefits

package would give plans greater incentives to develop and test new models aimed at improving end-of-life care and care for beneficiaries with advanced illnesses (e.g., concurrent care or other approaches for providing flexibility in the hospice benefit, palliative care, or shared decision making) (Medicare Payment Advisory Commission 2014).

In addition to concerns about short hospice stays, concerns also exist about the care that patients with advanced illnesses or multiple chronic conditions receive throughout the health care system. Care for these patients is oftentimes fragmented and uncoordinated and does not take into account the individual's overall needs. Also, many patients do not receive adequate information about their condition, prognosis, and treatment options to enable them to make decisions based on their goals and preferences. Some stakeholders have advocated for a variety of policy approaches aimed at improving care for patients with advanced illnesses, such as approaches to pay for or facilitate voluntary advanced care planning or shared decision making, improvements in medical training of health professionals, and advancements in quality measurement (Medicare Payment Advisory Commission 2014).

The Institute of Medicine (IOM) recently issued a report making recommendations on how to improve end-of-life care in the United States (Institute of Medicine 2014). They made a number of recommendations in the area of policies and payment systems, including:

- integrating financing of medical and social services;
- public reporting on quality measures, outcomes, and costs of care near the end of life throughout the health care system for Medicare and other federally funded health care programs;
- creating financial incentives for medical and social services that reduce use of emergency room and acute care services, coordination of care across providers and settings, and improved shared decision making and advanced care planning;
- requiring use of interoperable electronic health care records that contain specific information on advanced care planning; and
- encouraging states to adopt the Physician Orders for Life-Sustaining Treatment paradigm.

The IOM made several other recommendations, such as coverage by government insurers and other payers for comprehensive care for patients with advanced illnesses nearing the end of life; development and adoption of quality measures for clinician-patient conversations and advanced care planning; steps to improve palliative care knowledge and skills among medical professionals; and public education and engagement efforts to provide factual information about care options and to encourage advanced care planning and informed choices based on individual needs and preferences.

Hospice lengths of stay vary by observable patient characteristics, such as patient diagnosis and location, which makes it possible for providers to focus on more profitable patients (Table 12-6, p. 300). For example, Medicare decedents in 2013 with neurological conditions and debility or adult failure to thrive had substantially higher average lengths of stay (147 days and 116 days, respectively) than those with cancer (53 days) and heart or circulatory conditions (81 days). Length of stay is similar for patients with the shortest stays, irrespective of diagnosis, but differs by diagnosis for patients with longer stays. For example, patients with neurological conditions and cancer have similar lengths of stay at the 10th percentile and 25th percentile. However, compared with cancer patients, those with neurological conditions have stays that are about 2 weeks longer at the 50th percentile, about 3 months longer at the 75th percentile, and about 10 months longer at the 90th percentile.

Length of stay also varies by the setting where care is provided. In 2013, average length of stay was higher among Medicare decedents whose main care setting was an assisted living facility (ALF) (152 days) or a nursing facility (111 days) rather than home (89 days) (Table 12-6, p. 300). Length-of-stay differences across settings are most pronounced among patients with longer stays. For example, in 2013, the 75th percentile of length of stay varied by about 100 days across the three settings (86 days at home, 105 days at a nursing facility, and 186 days at an assisted living facility), and the 90th percentile varied by almost 200 days (237 days, 331 days, and 435 days across the three settings, respectively). Even among patients within the same diagnosis group, hospice patients in ALFs had markedly longer stays compared with other settings (data not shown), which warrants further monitoring and investigation in CMS's medical review efforts.

The differences in length of stay by patient characteristics are reflected in differences in length of stay by provider

TABLE 12–6

Hospice length of stay among decedents by beneficiary and hospice characteristics, 2013

Characteristic	Average length of stay (in days)	Percentile of length of stay				
		10th	25th	50th	75th	90th
Beneficiary						
Diagnosis						
Cancer	53	3	6	18	52	129
Neurological conditions	147	3	8	31	167	443
Heart/circulatory	81	2	4	12	66	236
Debility or adult failure to thrive	116	3	8	32	135	336
COPD	113	2	5	22	116	335
Other	42	2	3	6	23	103
Main location of care						
Home	89	4	9	26	86	237
Nursing facility	111	3	6	21	105	331
Assisted living facility	152	5	12	51	186	435
Hospice						
Hospice ownership						
For profit	105	3	6	21	97	306
Nonprofit	68	2	5	14	57	183
Type of hospice						
Freestanding	91	2	5	17	79	257
Home health based	68	2	5	15	61	187
Hospital based	59	2	5	13	51	158

Note: COPD (chronic obstructive pulmonary disease). Length of stay is calculated for Medicare beneficiaries who died in 2013 and used hospice that year and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime. "Main location of care" is defined as the location where the beneficiary spent the largest share of his/her days while enrolled in hospice. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim.

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

type (Table 12-6). In 2013, average length of stay was substantially higher at for-profit hospices than at nonprofit hospices (105 days compared with 68 days). The higher length of stay among for-profit hospices has two components: (1) for-profit hospices have more patients with diagnoses that tend to have longer stays, and (2) for-profit hospice beneficiaries have longer stays for all diagnoses than those of nonprofit hospices. These patterns reinforce the assertion that the payment system favors longer stays and that changes are needed to make it more neutral toward length of stay.

A recent Office of Inspector General (OIG) study of hospice care in ALFs raises similar concerns about the incentives for hospices to focus on certain types of patients under the current payment system (Office of Inspector General 2015). The OIG study concluded that hospices have financial incentives to serve patients in ALFs because they tend to have diagnoses associated with longer stays (e.g., ill-defined conditions, mental disorders, or Alzheimer's disease) that require less complex care and that result in higher payments per patient for the provider. OIG also found that for-profit hospices receive a greater share of their revenue from ALF patients than do nonprofit hospices and that hospice length of stay for ALF residents was longer among for-profit hospices than nonprofits. OIG also identified 97 hospices in 2012 that relied on ALF

TABLE 12–7 **Hospices that exceeded Medicare's annual payment cap, selected years**

	2002	2009	2010	2011	2012
Percent of hospices exceeding the cap	2.6%	12.5%	10.1%	9.8%	11.0%
Average payments over the cap per hospice exceeding the cap (in thousands)	$470	$485	$426	$424	$510
Payments over the cap as percent of overall Medicare hospice spending	0.6%	1.7%	1.1%	1.1%	1.4%
Total Medicare hospice spending (in billions)	$4.4	$12.0	$13.0	$13.8	$15.0

Note: The cap year is defined as the period beginning November 1 and ending October 31 of the following year.

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

patients for more than half their revenues and noted that more than 90 percent of these hospices were for profit. OIG made a number of recommendations, including that CMS should reform the payment system to reduce incentives to target beneficiaries with certain diagnoses and those likely to have long stays and that CMS target certain hospices for review (e.g., those providers with a high share of payments from ALFs, patients with stays greater than 180 days, patients with certain diagnoses, and patients who rarely receive visits).[11]

One pattern of unusual hospice utilization can be found among the 11 percent of hospices in 2012 that exceed the aggregate payment cap.[12] Above-cap hospices have substantially longer lengths of stay than other hospices. About 42 percent of patients receiving care from above-cap hospices in 2012 had stays exceeding 180 days compared with about 20 percent of patients treated by below-cap hospices. As discussed subsequently, above-cap hospices also have substantially higher rates of discharging patients alive than other hospices. These statistics may suggest that above-cap hospices are admitting patients who do not meet the hospice eligibility criteria, which merits further investigation by OIG and CMS.

Between 2011 and 2012, the share of hospices exceeding the cap grew from 9.8 percent to 11 percent, reversing the trend seen since 2009 of a declining share of hospices exceeding the cap (Table 12-7).[13] Among hospices that exceeded the cap, the average amount over the cap was larger in 2012 than in 2011 ($510,000 compared with $424,000). While above-cap hospices are required to return payments that exceed Medicare's cap, the government's ability to obtain repayment from hospices that close is uncertain. At the extreme, at least one hospice provider in 2012 reportedly closed and reopened as a new hospice to avoid repaying cap overpayments (Waldman 2012). In its 2015 hospice final rule, CMS established a policy that will help facilitate cap overpayment collections in the future. Beginning with cap year 2014, hospices are required to perform their own cap overpayment calculation within three to five months of the close of the cap year and pay Medicare back for the calculated overpayments at that time or their payments will be suspended (Centers for Medicare & Medicaid Services 2014). Before this rule, there was typically a 16- to 24-month lag between the close of the cap year and when hospices had to return any overpayments.[14]

Quality of care: Information on hospice quality is limited

We do not have sufficient data to assess the quality of hospice care provided to Medicare beneficiaries because publicly reported information on quality is generally unavailable. PPACA mandated that CMS publish quality measures by 2012. Beginning in fiscal year 2014, hospices that do not report data on quality receive a 2 percentage point reduction in their annual payment update. Public reporting of data on quality from these initiatives is not expected to be available until at least 2017, according to CMS.

For the first year of data reporting, CMS established two quality measures. The first measure tracked pain management, and the second was a process measure designed to help develop future quality measures.[15] These two measures (with small changes) were continued for the second year of the reporting program and affect the payment update for fiscal year 2015. About 10 percent of hospices did not report the required data on quality

and face a 2 percentage point reduction in their update for fiscal year 2015. Nonreporters were generally small providers, and it is possible that some did not report data on quality because they are no longer operating.

Beginning July 2014, CMS replaced the two initial quality measures with seven new quality measures collected using a standardized instrument.[16] The seven quality measures are all process measures (i.e., measures focus on pain screening, pain assessment, dyspnea screening, dyspnea treatment, documentation of treatment preferences, discussion of beliefs and values (if desired by patient), and provision of a bowel regimen for patients treated with an opioid). Hospices are required to report on these seven measures during the second half of calendar year 2014 to receive a full payment update in fiscal year 2016. For the future, CMS has expressed interest in developing outcome measures for symptom management, particularly pain, and patient-reported outcome measures (Centers for Medicare & Medicaid Services 2014).

Beginning in 2015, the hospice quality reporting program will require all hospice providers (except very small providers) to participate in a Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) hospice survey. Hospices will be required to contract with a CMS-approved vendor to administer the survey. The survey will collect information from the patient's informal caregiver (typically a family member) after the patient's death. The survey collects information on aspects of hospice care that are thought to be important to patients and for which informal caregivers are positioned to provide information. In particular, the survey collects information on how the hospice performed in the following areas: communicating, providing timely care, treating patients with respect, providing emotional support, providing help for symptom management, providing information on medication side effects, and training family or other informal caregivers in the home setting. Participation in the CAHPS hospice survey will affect payment updates beginning in fiscal year 2017.

There may also be opportunities to use claims data to develop additional quality measures or program integrity measures. A technical panel of hospice clinicians, researchers, and quality experts we convened in 2011 suggested that some claims-based indicators of quality could be constructed—such as hospices providing few visits in the last days of life, providing no general inpatient or continuous home care to any patients, or having unusually high live-discharge rates—as signals of potentially poor quality. In its 2015 hospice final rule, CMS pointed to patterns of care observed in the claims data in these and other areas that raise concerns about quality of care among some providers. Some of these claims-based measures might be useful in quality reporting programs, transparency initiatives, or value-based purchasing efforts, while others may help inform and target oversight and program integrity activities.[17]

In the 2015 hospice final rule, CMS discussed analyses by its contractor Abt Associates indicating that 14 percent of hospice decedents who received routine home care did not receive any skilled visits from hospice staff in the last two days of life in 2012 (Centers for Medicare & Medicaid Services 2014).[18] The Abt analysis also found that the share of routine home care patients who did not receive a skilled visit in the last two days of life varied across providers. For example, nearly 5 percent of hospices furnished no skilled visits in the last two days of life for more than 50 percent of their routine home care patients (Centers for Medicare & Medicaid Services 2014).

The Commission is concerned by data on the lack of skilled visits in the last two days of life and the variation in these data across providers. The last days of life tend to be some of the most service-intensive days of a hospice stay. Variation in the provision of skilled visits in the last days of life across providers raises questions about whether some providers are meeting the needs of patients and families during this period. Information on a hospice's provision of visits near the end of life could be valuable to beneficiaries and families as they choose a hospice provider and should be considered for inclusion in CMS's quality reporting or transparency initiatives. We also note that CMS is required to pilot test value-based purchasing for hospice in 2016 and that a measure of hospice visits in the last days of life might be a good candidate for a value-based purchasing payment adjuster. In constructing this type of measure for any of these purposes (quality, transparency, and payment adjusting), several issues would need to be considered. These issues include the type of hospice visits included in the measure; the number of days over which visits are measured; which levels of hospice care are included; whether the measure would focus on the presence/absence of at least one visit or the average number of visits received; and whether data would be combined for all of a provider's patients or broken out separately for patients with

TABLE 12–8 **Some hospices did not provide certain levels of hospice care to any patients in 2013**

Category	Percent of hospices that did not provide the following level of care to any patient in 2013: No general inpatient care	No continuous home care	No inpatient respite care	No general inpatient care or continuous home care	No general inpatient care, continuous home care, or inpatient respite care
All hospices	28%	58%	25%	19%	12%
Hospices by total number of Medicare patients in 2013					
Less than 100	57	71	54	41	28
100–199	25	60	22	17	8
200–299	17	58	11	10	2
300–499	8	50	6	5	2
500 or more	2	39	2	1	0

Source: MedPAC analysis of Medicare claims data from CMS.

different lengths of stay, locations of care, or levels of care. The Commission intends to explore these issues further in future work.

CMS also expressed concern that some providers may not have the capacity to provide all four levels of hospice care, which is required by the Medicare hospice conditions of participation.[19] CMS reported that a sizable share of hospice providers did not furnish general inpatient care (21 percent), continuous home care (57 percent), or inpatient respite care (26 percent) to any hospice patient discharged in 2012 (Centers for Medicare & Medicaid Services 2014). CMS noted that a hospice provider not furnishing a particular level of care to any patients during the year does not necessarily mean it does not have the capacity to provide this care, but these data do raise questions that merit further exploration. Examining this issue using 2013 data, we find results generally similar to those of CMS. A substantial share of hospices did not furnish general inpatient care (28 percent), continuous home care (58 percent), or inpatient respite care (25 percent) to any patient in 2013 (Table 12-8). Some hospices did not furnish several levels of care to any patient in 2013. About 19 percent of providers did not provide general inpatient care or continuous home care to any patient in 2013, with the majority of this group (12 percent of providers) also not providing inpatient respite care to any patient in 2013.

Small hospices were more likely than large hospices not to provide the various levels of care, which may reflect several factors. Given their relatively small number of patients, some small hospices may not have had any patients who needed these levels of care. It is also possible that some small hospices find it difficult to provide these levels of care, and so they do not offer them. The lack of provision of the four levels of care among larger hospices, although less common, clearly raises questions about whether these providers have the capacity or willingness to furnish these services. CMS has indicated that it intends to monitor utilization patterns of the four levels of care and refer providers with aberrant patterns to Survey and Certification, or other parts of CMS responsible for program integrity, for further investigation. While this concern is an important issue for providers of all sizes, those with large patient populations that do not provide these levels of care merit the most immediate scrutiny. In addition, it might be useful to beneficiaries choosing a hospice provider if there were information in quality reporting or transparency initiatives as to whether a provider has a history of not furnishing these levels of care to any patients.

Hospice providers will have some rate of live discharges because some patients may change their mind about the type of care they wish to receive and disenroll from hospice and because some hospice patients' conditions may improve and they no longer meet the hospice eligibility criteria. However, substantially higher rates of

TABLE 12–9 **Live discharges as a percent of all discharges, 2012**

	Type of hospice		
Percentile	All	Below cap	Above cap
10th	9%	9%	18%
25th	11	11	27
50th	15	15	38
75th	20	19	49
90th	29	26	67

Note: Hospices that provided care in 2012 but did not provide care in 2013 are excluded from the analysis.

Source: MedPAC analysis of 100 percent hospice standard analytical file (claims) data and the denominator file from CMS.

live discharge than their peers may signal a provider's problems with quality of care or program integrity. A high rate of live discharges could indicate that a hospice provider is not meeting the needs of patients and families, and so they choose to revoke their hospice election. A high rate of live discharges could also signal that the provider is admitting patients who do not meet the eligibility criteria. In 2012, about 17.5 percent of hospice discharges were live discharges. Comparing across providers, live discharges accounted for about 15 percent of the median provider's total discharges (Table 12-9). Ten percent of providers had a live discharge rate of roughly 29 percent or more—at least double the rate of the median provider. Above-cap hospices had particularly high live-discharge rates, ranging from 18 percent at the 10th percentile to 67 percent at the 90th percentile. Live discharges also occurred among below-cap hospices, with the 90th percentile among this group having live discharges account for at least 26 percent of their total discharges. Overall, these data indicate that there are providers—most above-cap hospices and some below-cap hospices—that have high rates of live discharges compared with their peers, which warrants further investigation by CMS or OIG. High live-discharge rates could also be explored as a potential quality indicator.

Providers' access to capital: Access to capital appears to be adequate

Hospices in general are not as capital intensive as other provider types because they do not require extensive physical infrastructure (although some hospices have built their own inpatient units, which require significant capital). Overall, access to capital for hospices appears strong, given the robust entry of for-profit providers into the Medicare program.

The number of for-profit providers grew more than 9 percent in 2013, indicating that capital is accessible to these providers. In addition, there have been a number of mergers and acquisitions of hospice companies in 2013 and 2014. Some have involved for-profit hospices acquiring smaller providers, and others have involved the sale of hospice companies from one private equity group to another. In addition, hospice companies have been acquired by other types of post-acute care providers. Most recently, two large publicly traded post-acute care providers—Kindred and HealthSouth—each announced deals to add home health and hospice to their service offerings through the acquisition of large home health and hospice chains.

Among nonprofit freestanding providers, less is known about access to capital, which may be more limited. Hospital-based and home health–based nonprofit hospices have access to capital through their parent providers, which currently appear to have adequate access to capital in both sectors.

Medicare payments and providers' costs

As part of the update framework, we assess the relationship between Medicare payments and providers' costs by considering whether current costs approximate what providers are expected to spend on the efficient delivery of high-quality care. Medicare margins illuminate the relationship between Medicare payments and providers' costs. We examined margins through the 2012 cost reporting year, the latest period for which complete cost report and claims data are available. To understand the variation in margins across providers, we also examined the variation in costs per day across providers.

Hospice costs

Hospice costs per day vary substantially by type of provider (Table 12-10), which is one reason for differences in hospice margins across provider types. In 2012, hospice costs per day were about $146 on average across all hospice providers, an increase in cost per day of about 1.3 percent from the previous year.[20] Freestanding hospices had lower costs per day than home health–based hospices and hospital-based hospices. For-profit, above-cap, and

rural hospices also had lower costs per day than their respective counterparts.

The differences in costs per day among freestanding, home health–based, and hospital-based hospices largely reflect differences in average length of stay and indirect costs. Our analysis of Medicare cost report data indicates that, across all hospice types, those with longer average stays have lower costs per day. Freestanding hospices have longer stays than provider-based hospices, which accounts for some, but not all, of the difference in costs per day. Another substantial factor is the higher level of indirect costs among provider-based hospices. Indirect costs include, among others, management and administration, accounting and billing, and capital costs. In 2012, indirect costs made up 31 percent of total costs for freestanding hospices compared with 39 percent of total costs for home health–based hospices and 42 percent for hospital-based hospices.[21]

There are several potential drivers of the higher indirect costs among provider-based hospices. The structure of the cost report for provider-based hospices likely results in some overallocation of overhead costs that are not actually related to the hospices' operations or management. It is also possible that provider-based hospices truly have higher indirect costs for certain overhead activities. For example, provider-based hospices might have higher indirect costs than freestanding providers if administrative staff wage rates were higher for parent providers (e.g., hospitals or home health agencies) or if provider-based hospices expended more administrative resources coordinating with their parent provider.

Regardless of the source of the higher indirect costs among provider-based hospices, the Commission believes payment policy should focus on the efficient delivery of services to Medicare's beneficiaries. If freestanding hospices are able to provide high-quality care at a lower cost than provider-based hospices, payment rates should be set accordingly, and the higher indirect costs of provider-based hospices should not be a reason for increasing Medicare payment rates.

TABLE 12–10

Hospice costs per day vary by type of provider, 2012

		Percentile		
	Average	25th	50th	75th
All hospices	$146	$112	$137	$171
Freestanding	140	110	132	159
Home health based	156	114	145	181
Hospital based	189	129	170	216
For profit	132	106	127	153
Nonprofit	164	129	155	190
Above cap	123	100	119	142
Below cap	148	114	139	174
Urban	148	114	138	172
Rural	131	108	133	166

Note: Data reflect aggregate costs per day for all types of hospice care combined (routine home care, continuous home care, general inpatient care, and inpatient respite care). Data are not adjusted for differences in case mix or wages across hospices.

Source: MedPAC analysis of Medicare hospice cost reports and Medicare Provider of Services data from CMS.

Hospice margins

From 2006 to 2012, the aggregate hospice Medicare margin ranged from 5.5 percent to 10.1 percent (Table 12-11, p. 306).[22] As of 2012, the aggregate hospice Medicare margin was 10.1 percent, up from 8.8 percent in 2011. Margins varied widely across individual hospice providers. In 2012, the Medicare margin was –9.6 percent at the 25th percentile, 9.7 percent at the 50th percentile, and 23.6 percent at the 75th percentile of providers. Our estimates of Medicare margins from 2006 to 2012 exclude overpayments to above-cap hospices and are calculated based on Medicare-allowable, reimbursable costs consistent with our approach in other Medicare sectors.[23,24]

We excluded nonreimbursable bereavement costs from our margin calculations. The statute requires that hospices offer bereavement services to family members of their deceased Medicare patients. However, the statute prohibits Medicare payment for bereavement services (section 1814(i)(1)(A) of the Social Security Act). Hospices report the costs associated with bereavement services on the Medicare cost report in a nonreimbursable cost center. If we included these bereavement costs from the cost report in our margin estimate, it would reduce the 2012 aggregate Medicare margin by at most 1.4 percentage points. This estimate is likely an overestimate of the bereavement costs associated with Medicare hospice patients because we

TABLE 12–11

Hospice Medicare margins by selected characteristics, 2006–2012

Category	Percent of hospices 2012	2006	2007	2008	2009	2010	2011	2012
All	100%	6.4%	5.8%	5.5%	7.4%	7.4%	8.8%	10.1%
Freestanding	71	9.7	8.7	8.3	10.2	10.7	11.8	13.3
Home health based	13	3.8	2.3	3.4	5.9	3.2	6.1	5.5
Hospital based	15	–12.7	–10.9	–11.3	–12.2	–16.6	–16.0	–16.8
For profit (all)	59	12.0	10.4	10.3	11.7	12.3	14.8	15.4
Freestanding	51	12.7	11.3	11.5	12.9	13.4	15.9	16.5
Nonprofit (all)	35	1.5	1.6	0.7	3.8	3.0	2.4	3.7
Freestanding	15	5.8	5.6	3.7	6.6	7.6	6.4	7.7
Urban	73	7.1	6.3	5.9	7.9	7.7	9.1	10.3
Rural	27	0.8	1.4	2.1	3.7	5.2	6.0	7.8
Patient volume (quintile)								
Lowest	20	–5.1	–7.9	–8.4	–6.5	–6.5	–4.1	–2.3
Second	20	0.3	1.0	–0.1	2.0	2.0	2.8	5.9
Third	20	2.4	3.0	4.4	4.5	4.5	7.5	9.7
Fourth	20	5.8	5.8	7.2	6.8	6.8	9.9	11.4
Highest	20	8.1	7.0	6.1	9.0	9.0	9.6	10.6
Below cap	89	7.0	6.1	5.9	7.9	7.7	9.1	10.4
Above cap (excluding cap overpayments)	11	0.3	2.5	1.2	1.4	3.2	4.1	5.2
Above cap (including cap overpayments)	11	20.7	20.5	19.0	18.3	17.4	18.4	21.3

Note: Margins for all provider categories exclude overpayments to above-cap hospices, except where specifically indicated. Margins are calculated based on Medicare-allowable, reimbursable costs. The sequester is not included in these margin estimates because the sequester did not begin until April 2013.

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

are not able to separately identify the bereavement costs related to hospice patients from the costs of community bereavement services provided to the family and friends of decedents not enrolled in hospice. Also, it is important to note that hospices may fund bereavement services, which by statute are not reimbursable by Medicare, through donations. Hospice revenues from donations are not included in our margin calculations.

We also excluded nonreimbursable volunteer costs from our margin calculations. As discussed in our March 2012 report, the statute requires Medicare hospice providers to use some volunteers in the provision of hospice care. Costs associated with recruiting and training volunteers are generally included in our margin calculations because they are reported in reimbursable cost centers. The only volunteer costs that would be excluded from our margins are those associated with nonreimbursable cost centers. It is unknown what types of costs are included in the volunteer nonreimbursable cost center. If nonreimbursable volunteer costs were included in our margin calculation, it would reduce the aggregate Medicare margin by 0.3 percentage point.

Freestanding hospices have higher margins (13.3 percent) than home health–based and hospital-based hospices (5.5 percent and –16.8 percent, respectively). Provider-based hospices have lower margins than freestanding providers, partly because of their higher indirect costs (e.g., general and administrative expenses, capital costs). If home health–based and hospital-based hospices had indirect cost structures similar to those of freestanding hospices,

we estimate that the aggregate Medicare margin would be about 9 percentage points higher for home health–based hospices and 14 percentage points higher for hospital-based hospices, and the industry-wide aggregate Medicare margin would be about 2 percentage points higher.[25]

Hospice margins also vary by other provider characteristics, such as type of ownership, patient volume, and urban or rural location. The aggregate Medicare margin was considerably higher for for-profit hospices (15.4 percent) than for nonprofit hospices (3.7 percent). However, freestanding nonprofit hospices, which are not affected by overhead allocation issues, had a higher margin (7.7 percent) than nonprofits overall. Generally, hospices' margins vary by the provider's volume; hospices with more patients have higher margins on average. Overall, hospices in urban areas have a higher aggregate Medicare margin (10.3 percent) than those in rural areas (7.8 percent). The difference between rural and urban margins, while not large, may partly reflect differences in volume.

Hospice profitability is closely related to length of stay. Hospices with longer lengths of stay have higher margins. For example, comparing hospice providers based on the percent of their patients' stays exceeding 180 days, the average margin ranged from –7 percent for hospices in the lowest quintile to 18.3 percent for hospices in the second-highest quintile (Table 12-12). Hospices in the highest length-of-stay quintile had a 13.7 percent average margin after the return of cap overpayments, but without the hospice aggregate cap, these providers' margins would have averaged 20.3 percent. The Commission's recommendation to revise the hospice payment system to pay relatively higher rates per day at the beginning and end of the episode (near the time of the patient's death) and lower rates in the intervening period would better align payments and costs and would likely reduce the variation in profitability across hospices and patients (see text box on this 2009 recommendation, pp. 292–293).

Hospices with a high share of patients in nursing facilities and assisted living facilities also have higher margins than other hospices. For example, in 2012, hospices in the top quartile of share of patients residing in nursing facilities had a 17.1 percent margin compared with a margin of roughly 9 percent in the middle quartiles and a 3 percent margin in the bottom quartile (Table 12-12). Margins also vary by the share of a provider's patients in assisted living facilities, with a margin ranging from about 2 percent in the lowest quartile to 15.1 percent in the highest quartile. Some of the difference in margins among hospices with different concentrations of nursing facility and assisted living facility patients is driven by differences in the diagnosis profile and length of stay of patients in these hospices. However, hospices may find caring for patients in facilities more profitable than caring for patients at home for other reasons in addition to length of stay. As discussed in our June 2013 report, there may be efficiencies in treating hospice patients in a centralized location in terms of mileage costs and staff travel time,

TABLE 12–12

Hospice Medicare margins by length of stay and patient residence, 2012

Hospice characteristic	Medicare margin
Average length of stay	
Lowest quintile	–6.5%
Second quintile	3.6
Third quintile	12.9
Fourth quintile	17.9
Highest quintile	13.4
Percent of stays > 180 days	
Lowest quintile	–7.0
Second quintile	3.3
Third quintile	13.2
Fourth quintile	18.3
Highest quintile	13.7
Percent of patients in nursing facilities	
Lowest quartile	3.0
Second quartile	9.0
Third quartile	9.6
Highest quartile	17.1
Percent of patients in assisted living facilities	
Lowest quartile	2.0
Second quartile	5.3
Third quartile	10.4
Highest quartile	15.1

Note: Margins for all provider categories exclude overpayments to above-cap hospices. Margins are calculated based on Medicare-allowable, reimbursable costs.

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

as well as facilities serving as referral sources for new patients. Nursing facilities may also be a more efficient setting for hospices to provide care because of the overlap in responsibilities between the hospice and the nursing facility. Analyses in our June 2013 report suggest that a 3 percent to 5 percent reduction in the hospice routine home care payment rate for patients in nursing facilities may be warranted because of the overlap in responsibilities between the hospice and the nursing facility (Medicare Payment Advisory Commission 2013).

Projecting margins for 2015

To project the aggregate Medicare margin for 2015, we model the policy changes that went into effect between 2012 (the year of our most recent margin estimates) and 2015. The policies include:

- a market basket update of 2.6 percent for fiscal year 2013, 2.5 percent for fiscal year 2014, and 2.9 percent for fiscal year 2015;
- a reduction to the market basket update of 1.0 percentage point in 2013, 0.8 percentage point in 2014, and 0.8 percentage point in 2015 (reflecting a productivity adjustment and an additional adjustment of –0.3 percentage point each year);
- a 2.0 percent reduction in payments because of the sequester that began in April 2013;
- a reduction in payments for years four through six of the seven-year phase-out of the wage index budget-neutrality adjustment factor, which reduced payments to hospices by 0.6 percentage point in each of the three fiscal years from 2013 through 2015; and
- additional wage index changes, which reduced payments in fiscal years 2013 through 2015.[26]

We also assume a rate of cost growth in 2014 and 2015 that is higher than the historical rate in light of potentially higher administrative costs related to implementing several new administrative requirements (i.e., new claims-data reporting requirements, new quality reporting initiatives, and a revised cost report). Taking these factors into account, we project an aggregate Medicare margin for hospices of 6.6 percent in 2015. The 2015 margin projection includes the effect of the sequester. If the sequester were not in effect in 2015, the margin projection for 2015 would be roughly 2 percentage points higher. This margin projection excludes nonreimbursable costs associated with bereavement services and volunteers (which, if included, would reduce margins by at most 1.4 percentage points and 0.3 percentage point, respectively). The margin projection also does not include any adjustment to remove the effect of the higher indirect costs observed among hospital-based and home health–based hospices (which, if such an adjustment were made, would increase the overall aggregate Medicare margin by up to 2 percentage points).

In considering the 2015 margin projection as an indicator of the adequacy of current payment rates for 2016, one policy of note is the continued phase-out of the wage index budget-neutrality adjustment. Our 2015 margin projection reflects the first six years (through 2015) of the seven-year phase-out of the wage index budget-neutrality adjustment. In 2016, the final year of this phase-out will result in an additional 0.6 percentage point reduction in payments.

How should Medicare payments change in 2016?

Update recommendation

RECOMMENDATION 12

The Congress should eliminate the update to the hospice payment rates for fiscal year 2016.

RATIONALE 12

Our payment indicators for hospice are positive. The number of hospices increased more than 5 percent in 2013 because of the entry of for-profit providers. The number of beneficiaries enrolled in hospice increased, and average length of stay held steady. Access to capital appears adequate. The projected 2015 aggregate Medicare margin is 6.6 percent. Based on our assessment of the payment adequacy indicators, hospices should be able to accommodate cost changes in 2016 without an update to the 2015 base payment rate.

IMPLICATIONS 12

Spending

- Under current law, hospices would receive an update in fiscal year 2016 equal to the hospital market basket index (currently estimated at 2.9 percent), less an adjustment for productivity (currently estimated at 0.5 percent). Hospices may also face an additional 0.3 percentage point reduction in the fiscal year 2016 update, depending on whether certain targets

for health insurance coverage among the working-age population are met. As a result, hospices would receive a net update of 2.1 percent or 2.4 percent (based on current estimates). Our recommendation to eliminate the payment update in fiscal year 2016 would decrease federal program spending relative to the statutory update by between $250 million and $750 million over one year and between $1 billion and $5 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries' access to care. This recommendation is not expected to affect providers' willingness and ability to care for Medicare beneficiaries. ■

Endnotes

1 If a beneficiary does not have an attending physician, the beneficiary can initially elect hospice based on the certification of the hospice physician alone.

2 When first established under TEFRA, the Medicare hospice benefit limited coverage to 210 days of hospice care. The Medicare Catastrophic Coverage Repeal Act of 1989 and the Balanced Budget Act of 1997 eased this limit.

3 In 2000, 30 percent of hospice providers were for profit, 59 percent were nonprofit, and 11 percent were government. As of 2013, about 61 percent of hospices were for profit, 33 percent were nonprofit, and 5 percent were government.

4 Hospice decedents in 2013 (i.e., beneficiaries who received hospice care in 2013 and died in 2013) have substantially fewer days of hospice care than hospice nondecedents (i.e., beneficiaries who received hospice care in 2013 but did not die in 2013).

5 The IMPACT Act of 2014 made technical changes to PPACA's statutory language on focused medical review of hospices. The statutory language was revised to ensure that the beneficiary is not held liable for the cost of services denied under focused medical review. Focused medical review applies to hospices whose percentage of stays exceeding 180 days exceeds a threshold specified by the Secretary. The IMPACT Act also revised the formula for calculating a hospice's percentage of stays exceeding 180 days.

6 The cap year spans November 1 through October 31 (e.g., cap year 2012 spanned November 1, 2011, to October 31, 2012). Medicare payments for the cap year reflect the sum of payments to a provider for services furnished in the cap year. The calculation of the beneficiary count for the cap year is more complex, involving two alternative methodologies. For a detailed description of the two methodologies and when they are applicable, see our March 2012 report (Medicare Payment Advisory Commission 2012).

7 This 2014 cap threshold is equivalent to an average length of stay of 171 days of routine home care for a hospice with a wage index of 1.

8 The IMPACT Act of 2014 changed the annual update factor applied to the hospice aggregate cap for accounting years that end after September 30, 2016. Currently, the aggregate cap is updated annually based on the percentage increase in the medical care expenditure category of the consumer price index for all urban consumers. As a result of the IMPACT Act, the aggregate cap will be updated annually by the same factor as the hospice payment rates (market basket net of productivity and other adjustments). This change will keep the amount of hospice days the aggregate cap is equivalent to constant over time.

9 Type of hospice reflects the type of cost report filed (i.e., the hospice filed a freestanding hospice cost report or was included in the cost report of a hospital, home health agency, or skilled nursing facility). The type of cost report does not necessarily reflect the location where patients receive care. For example, all types of hospices may serve some nursing facility patients.

10 The number of rural hospices is not necessarily reflective of hospice access for rural beneficiaries for several reasons. A count of the number of rural hospices does not capture the size of those hospice providers, their capacity to serve patients, or the size of their service area. Furthermore, a count of hospices located in rural areas does not take into account hospices with offices in urban areas that also provide services in rural areas.

11 The OIG report also recommended that claims-based quality measures be developed and adopted, that hospice quality information be made public, and that CMS provide individual hospices with more information on how their utilization patterns compare with their peers.

12 Above-cap hospices are more likely to be for-profit, freestanding providers and to have smaller patient counts than below-cap hospices.

13 The estimates of hospices over the cap are based on the Commission's analysis. While the estimates are intended to approximate those of the CMS claims processing contractors, differences in available data and methodology have the potential to lead to different estimates. An additional difference between our estimates and those of the CMS contractors relates to the alternate cap methodology that CMS established in the hospice final rule for 2012 (Centers for Medicare & Medicaid Services 2011). Based on that regulation, for cap years before 2012, hospices that challenged the cap methodology in court or made an administrative appeal had their cap payments calculated from the challenged year going forward using a new, alternative methodology. For cap years from 2012 onward, all hospices will have their cap liability calculated using the alternative methodology unless they elected to remain with the original method. For estimation purposes, we have assumed that the alternative methodology was used for cap year 2012. Estimates for cap years 2011 and earlier assumed that the original cap methodology was used.

14 This policy—which requires a hospice to estimate its cap liability within three to five months of the close of the cap

year and remit the calculated overpayments to CMS at that time or face suspension of their payments—should create greater awareness of cap overpayment liabilities by providers and make it more likely that Medicare will collect at least a portion of the overpayments from all above-cap hospices. Because of how the aggregate cap calculation is structured, the amount a hospice owes when the calculation is performed three to five months after the close of the cap will be less than the full amount the hospice owes when the Medicare contractor reconciles the calculation at a later date with more complete claims data. Thus, this policy should ensure that hospices pay a portion of their cap overpayments up front, and then hospices would be liable for the remainder of the overpayments at a later date.

15 The initial two quality measures were (1) the share of patients who reported being uncomfortable because of pain at admission whose pain was brought to a comfortable level within 48 hours and (2) whether the hospice tracked at least 3 quality measures focused on patient care and what those measures were.

16 CMS discontinued collection of the pain outcome measure it adopted in the first year of the reporting program because a high rate of patient exclusion made the measure unstable and because the measure was inconsistently administered across providers.

17 The IMPACT Act of 2014 will increase the frequency of hospice recertification surveys, requiring them to occur no less than every 36 months. This requirement of more frequent surveys may be an opportunity for closer scrutiny of providers with aberrant data that raise questions about quality of care or program integrity.

18 Abt defined skilled visits as visits by a nurse, therapist, or social worker. Their measure does not include visits by a hospice aide, physician, spiritual counselor, or volunteer.

19 While routine home care is the most common level of hospice care, other levels—general inpatient care, continuous home care, and inpatient respite care—are available to manage needs in certain situations. General inpatient care is provided in a facility on a short-term basis to manage symptoms that cannot be managed in another setting. Continuous home care is intended to manage a short-term symptom crisis in the home and involves eight or more hours of care per day, mostly nursing. Inpatient respite care is care in a facility for up to five days to provide an informal caregiver a break. Overall in 2013, 87 percent of hospice beneficiaries received routine home care, 22 percent received general inpatient care, 6 percent received continuous home care, and 4 percent received inpatient respite care (with some receiving more than one type of care).

20 The cost per day calculation reflects aggregate costs for all types of hospice care combined (routine home, continuous home, general inpatient, and inpatient respite care). "Days" reflects the total number of days the hospice is responsible for care for its patients, regardless of whether the patient received a visit on a particular day. The cost per day estimates are not adjusted for differences in case mix or wages across hospices and are based on data for all patients, regardless of payer.

21 In general, hospices with a larger volume of patients have lower indirect costs as a share of total costs. While patient volume explains some of the difference in indirect costs across providers, freestanding hospices have lower indirect costs than provider-based hospices, even for providers with similar patient volumes.

22 The aggregate Medicare margin is calculated as follows: ((sum of total payments to all providers) – (sum of total costs to all providers)) / (sum of total payments to all providers). Estimates of total Medicare costs come from providers' cost reports. Estimates of Medicare payments and cap overpayments are based on Medicare claims data. We present margins for 2012 because it is the most recent period for which we have a complete set of claims data to estimate hospice margins including the effect of the aggregate cap.

23 Hospices that exceed the Medicare aggregate cap are required to repay the excess to Medicare. We do not consider the overpayments to be part of hospice revenues in our margin calculation.

24 Our margin estimates also do not take into account revenues or costs from fundraising and donations.

25 These estimates are adjusted to account for differences in patient volume across freestanding and provider-based hospices.

26 Hospices' payments increase or decrease slightly from one year to the next because of the annual recalibration of the hospital wage index. The annual wage index recalibration was expected to reduce Medicare payments by 0.1 percentage point in each year from 2013 through 2015, according to estimates in the CMS final rules or notices establishing the hospice payment rates for those years.

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