

SECTION
2E

Hospice

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

2E The Congress should update the payment rates for hospice for fiscal year 2011 by the projected rate of increase in the hospital market basket index less the Commission's adjustment for productivity growth.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

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(For additional recommendations on improving the hospice payment system, see text box on pp. 146–147.)

Hospice

Section summary

The Medicare hospice benefit covers palliative and support services for beneficiaries with a life expectancy of six months or less who choose to enroll in the benefit. In 2008, more than 1 million Medicare beneficiaries received hospice services from more than 3,300 providers and Medicare expenditures exceeded \$11 billion.

Assessment of payment adequacy

The indicators of payment adequacy for hospices, discussed below, are generally positive. We believe hospice providers can operate within the current payment system with a moderate update. We therefore recommend that the Congress update payment rates for hospice services by the hospital market basket index, less the Commission’s adjustment for productivity growth.

Beneficiaries’ access to care—Hospice use among Medicare decedents has grown substantially in recent years, suggesting greater awareness of and access to hospice services. Hospice use increased across all demographic and beneficiary characteristics examined. Despite this growth, use remained lower among racial and ethnic minorities.

- **Capacity and supply of providers**—The supply of hospices grew substantially (47 percent) from 2000 to 2008. For-profit providers accounted almost entirely for the increase in the number of hospices.

In this section

- Are Medicare payments adequate in 2010?
- How should Medicare payments change in 2011?

- ***Volume of services***—Medicare spending on hospice services nearly quadrupled between 2000 and 2008, reflecting more beneficiaries enrolling in hospice and longer lengths of stay.

Quality of care—We do not have sufficient evidence to assess quality, as information on quality of care is very limited. Efforts completed or under way might provide a pathway for further development of quality measures.

Providers' access to capital—After the economy wide credit crisis last year, access to capital in the health care sector appears to be normalizing. Hospices are not as capital intensive as some other provider types because they do not require extensive physical infrastructure. Many are too small to attract interest from capital markets. Evidence suggests that access to capital is favorable for large publicly traded hospice companies, for-profit freestanding hospices, and hospital-based and home-health-based hospices. Access to capital for nonprofit freestanding hospices is difficult to assess.

Medicare payments and providers' costs—The aggregate Medicare margin, which is an indicator of the adequacy of Medicare payments relative to costs, was 5.9 percent in 2007. We project that the aggregate margin will decline to 4.6 percent in 2010. These margin estimates exclude the costs of bereavement services (about 1.5 percent of total costs), which are not reimbursable by Medicare. ■

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 are included such as nursing care; physician services; counseling and social worker services; home health aide (also referred to as hospice aide) and homemaker services; short-term inpatient care (including respite care); drugs and biologicals for symptom control; home medical equipment; physical, occupational, and speech therapy; bereavement services for the patient's family; and other services for palliation of the terminal condition. In 2008, more than 1 million Medicare beneficiaries received hospice services and Medicare expenditures exceeded \$11 billion.

Beneficiaries must “elect” the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for curative treatment for the terminal illness. Medicare continues to cover items and services unrelated to the terminal illness. A written plan of care must be established and maintained by the attending physician, the medical director, or another hospice physician and by an interdisciplinary group for each person admitted to a hospice program. The plan of care must identify services to be provided (including management of discomfort and symptom relief) and describe the scope and frequency of services needed to meet the patient's and family's needs.

Beneficiaries elect hospice for defined benefit periods. Under the current policy, the first hospice benefit period is 90 days. For a beneficiary to initially elect hospice, two physicians (the beneficiary's attending physician and a hospice physician) must certify that the beneficiary has a life expectancy of six months or less if the illness runs its normal course. If the patient's terminal illness continues to engender the likelihood of death within 6 months, the patient can be recertified for another 90 days. After the second 90-day period, the patient can be recertified for an unlimited number of 60-day periods, as long as he or she remains eligible.¹ For recertifications, only the hospice physician has to certify that the beneficiary's life expectancy is 6 months or less. Beneficiaries can switch from one hospice to another once during a hospice election period and can disenroll from hospice at any time.

In recent years, Medicare spending for hospice care increased dramatically, and the CMS Office of the Actuary

(OACT) projects continued robust growth. Spending has almost quadrupled since 2000, and OACT projects that hospice spending will almost double over the next 10 years. This spending increase is driven by greater numbers of beneficiaries electing hospice and longer hospice stays.

Medicare payment for hospice

The Medicare program pays a daily rate to hospice providers for each day a beneficiary is enrolled in hospice. The hospice assumes all financial risk for costs and services associated with care related to the patient's terminal illness. The hospice provider receives payment for every day a patient is enrolled, regardless of whether the hospice visited the patient each day. This payment design is intended to encompass not only the cost of visits but also other costs a hospice incurs related to on-call services, care planning, drugs, medical equipment, and supplies related to the patient's terminal condition, patient transportation between hospice care sites, and other less frequently used services.

Payments are made according to a fee schedule that has base payment amounts for four categories of care: routine home care, continuous home care, inpatient respite care, and general inpatient care (Table 2E-1, p. 144). A hospice is paid the routine home care rate for each day the patient is enrolled in hospice, unless the hospice provides continuous home care, inpatient respite care, or general inpatient care. Routine home care accounts for more than 95 percent of hospice care days. The Medicare payment rates for hospice are updated by the inpatient hospital market basket. The payment methodology and the base rates for hospice care have not been recalibrated since initiation of the benefit in 1983.

The daily hospice payment rates are adjusted to account for differences in wage rates among markets. Each category of care's base rate has a labor share, which is adjusted by the hospice wage index for the location where care is furnished and the result is added to the nonlabor portion. From 1983 to 1997, Medicare adjusted hospice payments with a 1983 wage index based on 1981 Bureau of Labor Statistics data. In fiscal year 1998, after a negotiated rule-making process, 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. In fiscal year 2010, CMS

**TABLE
2E-1****Medicare hospice payment categories and rates, FY 2010**

Category	Description	Base payment rate
Routine home care	Home care provided on a typical day	\$143 per day
Continuous home care	Home care provided during periods of patient crisis	\$34.75 per hour
Inpatient respite care	Inpatient care for a short period to provide respite for primary caregiver	\$148 per day
General inpatient care	Inpatient care to treat symptoms that cannot be managed in another setting	\$636 per day

Note: FY (fiscal year). 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 \$278 per day (8 hours at \$34.75 per hour); maximum daily payment at the CHC level is \$834 per day (24 hours at \$34.75 per hour).

Source: CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 1796, "Update to the Hospice Payment Rates, Hospice Cap, Hospice Wage Index and the Hospice Pricer for FY 2010."

began phasing out the budget-neutrality adjustment over seven years. It is reduced by 10 percent in 2010 (a 0.4 percent reduction) and will be reduced an additional 15 percent (a 0.6 percent reduction) each subsequent year, until the budget-neutrality adjustment is eliminated entirely in fiscal year 2016.

Beneficiary cost sharing for hospice services is minimal. Hospices may charge a 5 percent coinsurance (not to exceed \$5) for each prescription furnished outside the inpatient setting. For inpatient respite care, beneficiaries may be charged 5 percent of Medicare's respite care payment per day.

The Commission's analyses of the hospice benefit in our June 2008 and March 2009 reports found that Medicare's hospice payment system contains incentives that make very long stays in hospice more profitable for providers than short stays, which may have led to inappropriate utilization of the benefit among some hospices (Medicare Payment Advisory Commission 2008, Medicare Payment Advisory Commission 2009). We also found that the benefit lacks adequate administrative and other controls to check the incentives for long stays in hospice and that CMS lacks data vital to 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 (see text box, p. 146–147). Since the Commission made its recommendation to reform the hospice payment system, additional data have become available on hospice visit

patterns across episodes of care. These data confirm our prior findings and further support the need for payment system reform. A discussion of our analysis of these newly available data sources can be found in the online appendix to this chapter, available at <http://www.medpac.gov>.

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 intensive conventional treatment (often in inpatient settings) and die at home and with family 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). To achieve this outcome, when the Congress established the hospice benefit it included two limitations, or "caps," on payments to hospices.

The first cap limits the number of days of inpatient care a hospice may provide to not more than 20 percent of its total Medicare patient care days. This cap is rarely exceeded, and when it is, 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 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 payments divided by its total number of beneficiaries exceed the cap amount (\$21,410 in 2007), it must repay the excess to the program.² This cap is not applied individually to the payments received for each beneficiary but to the average of payments across all Medicare patients admitted to the hospice in the cap year. The number of hospices exceeding the average annual payment cap has historically been low, but we have found that increases in the number of hospices and increases in very long stays have resulted in more hospices exceeding the cap. 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 2010?

To address whether payments for the current year (2010) are adequate to cover the costs efficient providers incur and how much providers' costs should change in the coming year (2011), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries' access to care by examining the capacity and supply of hospice providers and changes over time in the volume of services provided, 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 for other providers, we could not use quality of care as a payment adequacy indicator, as information on hospice quality is generally not available.

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

Hospice use among Medicare decedents has grown substantially in recent years, suggesting increased awareness of and access to hospice services. In 2008, about 40 percent of Medicare decedents used hospice, up from 23 percent in 2000 (Table 2E-2, p. 148). From 2007 to 2008, the proportion of Medicare decedents using hospice grew from 39 percent to 40 percent. While hospice use varied by beneficiary characteristics (i.e., fee-for-service (FFS) and managed care, dual and nondual eligibles, age, gender, race), it increased substantially across all beneficiary groups between 2000 and 2007 and more modestly between 2007 and 2008.

Use of hospice is slightly more frequent among beneficiaries in Medicare Advantage than FFS, although differences in hospice use rates have narrowed over time. In 2000, 22 percent of Medicare FFS decedents used hospice compared with 31 percent of Medicare Advantage decedents. By 2008, these use rates rose to 39 percent of Medicare FFS decedents and 44 percent of Medicare Advantage decedents.

Hospice use also varies by other beneficiary characteristics. In 2008, a smaller proportion of Medicare decedents who are dually eligible for Medicare and Medicaid used hospice (36 percent) than nondual eligibles (42 percent). Hospice use is more common among older beneficiaries, with use rates ranging from 25 percent (among Medicare decedents under age 65) to 45 percent (among Medicare decedents age 85 or older) in 2008. Female beneficiaries are also more likely than male beneficiaries to use hospice, which partly reflects the longer average life span among women than men and greater hospice use among older beneficiaries.

Differences also exist in hospice use by racial and ethnic groups. As of 2008, hospice use was highest among white Medicare decedents (42 percent) followed by Hispanic decedents (33 percent), African American decedents (31 percent), Native North American decedents (30 percent), and Asian American decedents (24 percent). Hospice use grew substantially among all these groups between 2000 and 2008. Despite this growth, 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, and mistrust of the medical system (Cohen 2008, Crawley 2000).

One driver of increased hospice use over the last decade has been growth in hospice election by patients with noncancer diagnoses, as there has been increased recognition that hospice can appropriately care for patients with noncancer diagnoses. Patients with noncancer diagnoses accounted for 69 percent of all hospice users in 2008, up from 47 percent in 1998 (Centers for Medicare & Medicaid Services 2009). This greater share of hospice patients with noncancer diagnoses reflects substantial growth in the enrollment of such patients. For example, between 1998 and 2008, the number of hospice users with debility increased from just over 8,500 to nearly 107,000, and the number with Alzheimer's disease or non-

March 2009 Commission recommendations on hospice

The Commission's analyses have shown that the current structure of the hospice payment system makes long stays in hospice more profitable for providers than short stays. These analyses have found that hospice visits tend to be more frequent at the beginning of a hospice episode and at the end of the episode near the time of a patient's death and less frequent in the intervening period. But 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 within an episode. As a result, long hospice stays, which generally have a lower average visit intensity over the course of an episode, are more profitable than short stays. The incentives in the current hospice payment system for long stays may have led to inappropriate utilization of the benefit among some providers. To address these problems, the Commission made the following recommendations in March 2009.

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.

Compared with the current hospice payment system, this payment model would result in a much stronger relationship between Medicare payments and hospices' level of effort in providing care throughout an episode and promote stays of a length consistent with hospice as an end-of-life benefit.

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.**

These steps would help to instill greater accountability in use of the hospice benefit by promoting more physician engagement in the hospice certification and recertification process. The recommendation would also bring more scrutiny to the Medicare claims of hospices with aberrant utilization patterns. CMS has

(continued next page)

Alzheimer's dementia grew from about 28,000 to 174,000 (Centers for Medicare & Medicaid Services 2009).

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

The number of hospice providers has grown substantially in recent years. From 2001 to 2008, the total number of

hospices increased from just over 2,300 to nearly 3,400, an increase of 47 percent (Table 2E-3, p. 149). The most rapid growth occurred between 2003 and 2007, with an average annual growth rate of 8 percent. Growth continued between 2007 and 2008 at a rate of 4 percent. The slower growth rate in 2008 may have been due in part to CMS guidance to state survey and certification agencies in 2007 that placed surveys of hospices applying to be

March 2009 Commission recommendations on hospice (cont.)

adopted one part of this recommendation, requiring that all certifications and recertifications include a brief physician narrative explaining the clinical basis for the prognosis.

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

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

Questions have been raised about the appropriateness of certain practices among some hospices, including relationships between hospices and long-term care

facilities and enrollment and marketing practices. A comprehensive review of these relationships and practices by the Office of Inspector General would provide greater understanding of the nature of these relationships and practices and the degree to which inappropriate behavior may be occurring.

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

Medicare has historically collected minimal information on hospices' services and costs. This recommendation would improve the data on services and costs, which would help facilitate reform and oversight of the benefit. For example, the Commission indicated that hospice claims should contain information on the type and duration of visits provided to better understand patterns of care among patients. Also, hospice cost reports should include additional information on revenues and be subject to additional reviews to ensure that they serve as accurate fiscal documents. Beginning January 2010, CMS expanded its data-reporting requirements for hospice claims consistent with this recommendation, to include the length of visits as well as additional types of visits such as physical, speech, and occupational therapist visits. ■

new Medicare providers (and surveys of certain other providers) in the lowest tier of their workload priorities.³

For-profit hospices account for most of the growth in the number of hospices. From 2001 to 2008, for-profit hospices grew 128 percent, compared with 1 percent growth in nonprofit hospices and 25 percent growth in hospices with government or other ownership. As of 2008, about 52 percent of hospices were for profit, 35 percent were nonprofit, and 13 percent were government or other ownership structures.

Growth in the number of hospices occurred predominantly among freestanding providers. Between 2001 and 2008, freestanding hospices grew 87 percent, compared with a 9 percent increase in home-health-based hospices and a 2 percent decrease in hospital-based hospices. Skilled nursing facility (SNF)-based hospices grew from 12 providers to 19 providers over this period.⁴ As of 2008, 66 percent of hospices were freestanding, 17 percent were home health based, 16 percent were hospital based, and fewer than 1 percent were SNF based.

**TABLE
2E-2****Use of hospice continues to increase**

	Percent of Medicare decedents who used hospice					Average annual percentage point change 2000-2007	Percentage point change 2007-2008
	2000	2005	2006	2007	2008		
All beneficiaries	22.9%	34.2%	37.0%	38.9%	40.1%	2.3%	1.2%
FFS beneficiaries	21.5	33.4	36.2	38.0	39.2	2.4	1.2
MA beneficiaries	30.9	40.3	41.3	42.9	43.9	1.7	1.0
Dual eligibles	17.5	29.8	32.5	34.5	35.8	2.4	1.3
Nondual eligibles	24.5	35.7	38.4	40.3	41.5	2.3	1.2
Age							
<65	17.0	22.4	23.7	24.5	25.0	1.1	0.5
65-74	25.4	32.5	34.2	35.6	36.2	1.5	0.6
75-84	24.2	35.4	38.1	40.1	41.1	2.3	1.0
85+	21.4	37.2	41.0	43.5	45.3	3.2	1.8
Race/ethnicity							
White	23.8	35.6	38.5	40.5	41.8	2.4	1.3
African American	17.0	26.1	28.2	29.9	30.7	1.8	0.8
Hispanic	21.1	29.2	31.2	32.6	32.9	1.6	0.3
Asian American	15.2	20.5	21.9	22.9	24.4	1.1	1.5
Native North American	13.0	26.3	27.6	28.8	29.7	2.3	0.9
Gender							
Male	22.4	31.8	34.1	35.9	36.7	1.9	0.8
Female	23.3	36.3	39.4	41.5	43.0	2.6	1.5

Note: FFS (fee-for-service), MA (Medicare Advantage).

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

The increase in the supply of hospices occurred in both rural and urban areas. Not shown in Table 2E-3, between 2001 and 2008, the number of urban hospices grew about 60 percent and the number of rural hospices grew about 25 percent. As of 2008, about 31 percent of hospices are rural and 69 percent are urban.

Growth in the number of hospices by state between 2001 and 2008 varied, with some states experiencing extremely robust growth (more than doubling in Alaska, Utah, Louisiana, Mississippi, Nevada, Texas, and South Carolina) and others experiencing no growth (South Dakota, West Virginia, and the District of Columbia) or very slight declines in the number of hospice providers (Maryland, New York, and North Dakota). Four states with the highest share of hospices reaching the cap in 2007 (Mississippi, Alabama, Arizona, and Oklahoma) had

above average growth in the number of hospices between 2001 and 2008, with increases in the number of providers ranging from about 62 percent to 160 percent during this time.

Recognizing that the raw number of hospices may not be the best measure of provider capacity, we examined the relationship between the supply of hospices and the rate of hospice use among Medicare decedents across states. As shown in Figure 2E-1, there appears to be no relationship between the supply of hospices (as measured by number of hospices per 1,000 Medicare decedents) and the rate of hospice use (as measured by the percent of Medicare decedents that used hospice) across states. This finding suggests that the number of hospices alone is not necessarily a good indicator of beneficiary access

**TABLE
2E-3**

The total number of hospices rose substantially between 2001 and 2008, driven by growth in for-profit hospices

Category	2001	2002	2003	2004	2005	2006	2007	2008	Aggregate percent change, 2001-2008
All hospices	2,303	2,349	2,464	2,643	2,870	3,073	3,258	3,389	47%
For profit	765	819	922	1,091	1,282	1,464	1,637	1,748	128
Nonprofit	1,184	1,172	1,173	1,171	1,181	1,184	1,188	1,197	1
Government/other	354	358	369	381	407	425	433	444	25
Freestanding	1,196	1,251	1,361	1,541	1,737	1,922	2,098	2,233	87
Home health based	541	530	532	538	566	583	592	592	9
Hospital based	554	553	557	551	553	553	551	545	-2
SNF based	12	15	14	13	14	15	17	19	58

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of data from CMS Providing Data Quickly system, <https://pdq.cms.hhs.gov>, accessed November 20, 2009.

to care, and trends in these statistics should be interpreted cautiously.

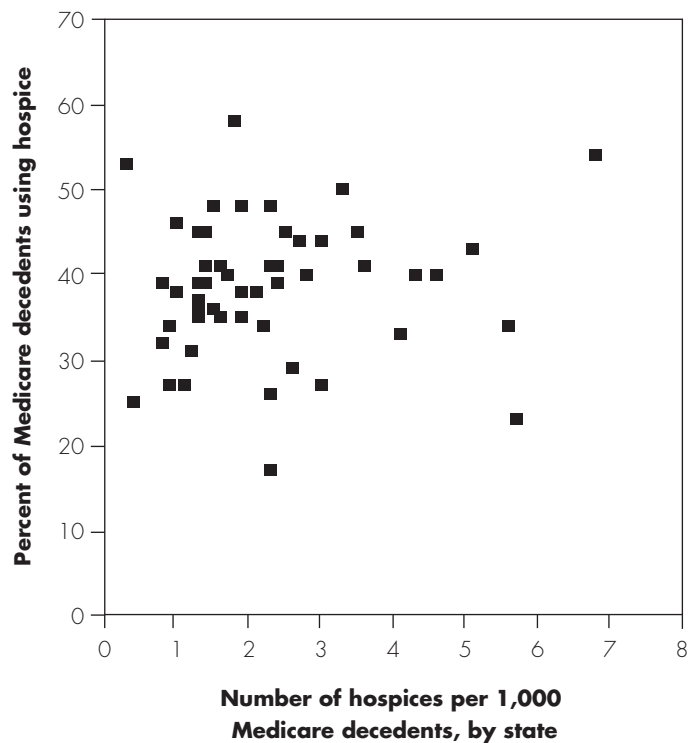
Volume of services: The number of hospice users and average length of stay have increased substantially

The number of Medicare beneficiaries receiving hospice services doubled between 2000 and 2008, surpassing 1 million by 2008 (Table 2E-4, p. 150). The number of hospice users increased rapidly between 2000 and 2007, at an average rate of 10 percent per year, and continued to grow in 2008 at a somewhat slower but still significant rate of 5.5 percent.

The average length of stay also increased substantially over the last decade. Medicare decedents in 2008 who used hospice had an average length of stay of 83 days (over the course of their lifetime), compared with an average of 54 days for their counterparts in 2000. The increased average length of stay reflects in large part an increase in very long hospice stays, while short stays remained virtually unchanged (Figure 2E-2, p. 150). Between 2000 and 2008, hospice length of stay at the 90th percentile grew substantially, increasing from 141 days to 235 days. In contrast, the median length of stay during this period held steady at 17 days and the 25th percentile decreased slightly from 6 days to 5 days. While the increase in very long hospice stays is a concern, so too is the persistence of very short stays. With very short

**FIGURE
2E-1**

Hospice enrollment rates are unrelated to the number of hospices in a state, 2008



Note: Each data point in the chart represents one state.

Source: MedPAC analysis of the denominator file and the Medicare Beneficiary Database from CMS, and data from CMS Providing Data Quickly system, <http://pdq.cms.hhs.gov>.

**TABLE
2E-4**

The volume of hospice use has increased substantially

Category	2000	2007	2008	Average annual percent change 2000-2007	Percent change 2007-2008
Number of hospice users	513,000	1,000,000	1,055,000	10.0%	5.5%
Total spending (in billions)	\$2.9	\$10.3	\$11.2	19.8	8.7
Average length of stay among decedents (in days)	54	80	83	5.8	3.8

Note: Length of stay reflects the total number of days the decedent hospice user was enrolled in the Medicare hospice benefit during his/her lifetime.

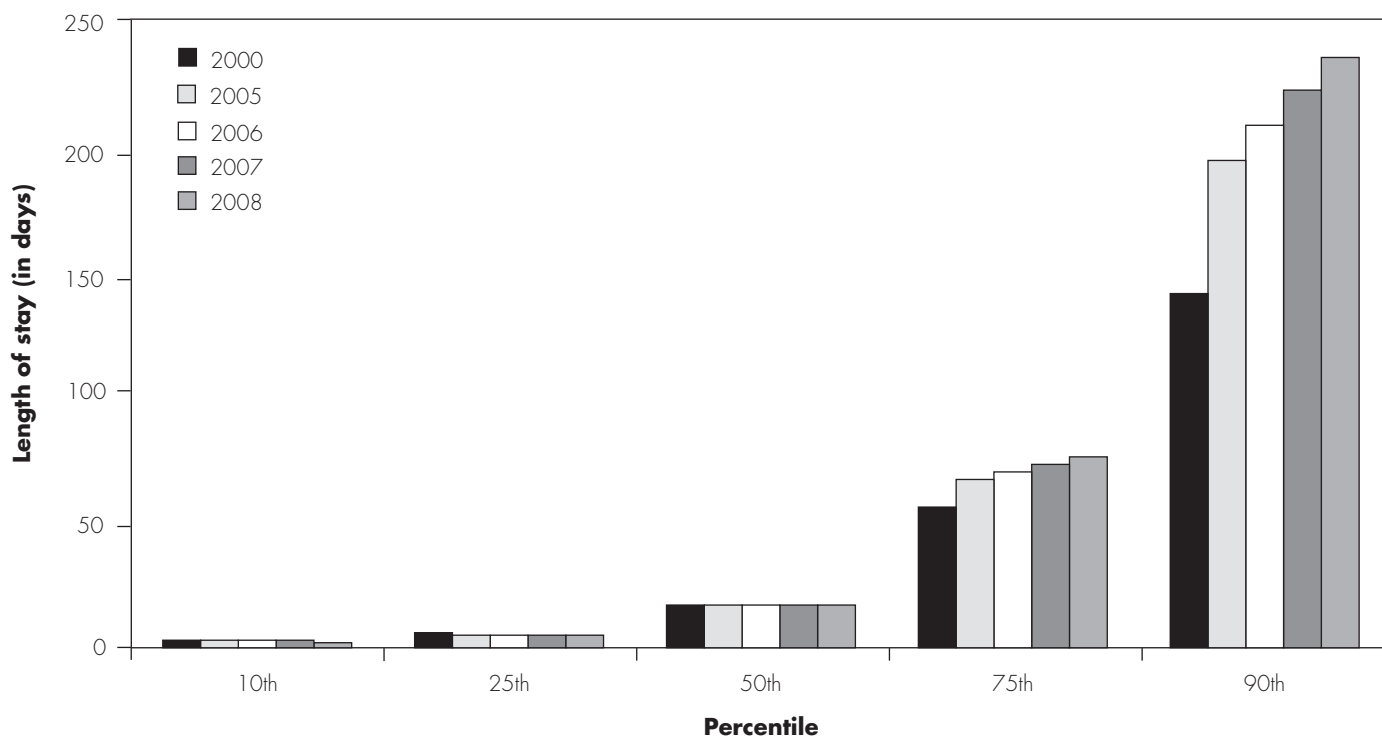
Source: MedPAC analysis of the denominator file, the Medicare Beneficiary Database from CMS, and the 100 percent hospice claims standard analytical file from CMS.

hospice stays, the patient does not fully benefit from all that hospice has to offer. As discussed in our March 2009 report, an expert panel that we convened of hospice industry representatives indicated that very short stays in hospice largely stem from factors unrelated to the

Medicare hospice payment system, such as reluctance among physicians, patients, and their families to recognize a terminal situation and the financial incentives of acute care providers to continue treating a terminal patient (Medicare Payment Advisory Commission 2009).

**FIGURE
2E-2**

Very long hospice stays have grown longer while short stays remained virtually unchanged, 2000-2008



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

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

**TABLE
2E-5****Hospices that exceeded Medicare's annual payment cap, 2002-2007**

Category	2002	2003	2004	2005	2006	2007
Percent of hospices exceeding the cap	2.6%	4.1%	5.8%	7.8%	9.4%	10.4%
Average payments over the cap per hospice exceeding the cap (in thousands)	\$470	\$664	\$749	\$755	\$731	\$612
Payments over the cap as percent of overall Medicare hospice spending	0.6%	1.2%	1.7%	2.2%	2.4%	2.0%
Total Medicare hospice spending (in billions)	\$4.4	\$5.4	\$6.6	\$7.7	\$8.8	\$10.4

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 claims standard analytical file data, Medicare hospice cost reports, Provider of Services file data from CMS, and CMS Providing Data Quickly system. Data on total spending for each fiscal year from the CMS Office of the Actuary.

As discussed in our June 2008 report, the increase in long hospice stays appears to be partly the result of the enrollment of more patients with noncancer diagnoses, for whom it may be harder to predict life expectancy. However, a changing diagnosis profile of patients does not fully explain the growth in very long stays. Some providers, particularly providers that exceeded the hospice cap, appeared to have a higher prevalence of long-stay patients across all diagnoses, suggesting some patient selection may be at work.

The percent of hospices exceeding the cap, while growing each year between 2002 and 2007, appears to be leveling off and remained relatively small at an estimated 10 percent in 2007 (Table 2E-5). Medicare payments over the cap attributable to these hospices represented 2 percent of total hospice payments in 2007. While the number of above-cap hospices increased in 2007, the total dollars of cap overpayments fell slightly from \$211 million in 2006 to \$208 million in 2007 (not shown in the table). As a result, between 2006 and 2007, the average cap overpayment per above-cap hospice declined from about \$731,000 to \$612,000.

As discussed in our June 2008 report, above-cap hospices are more likely to be for-profit, freestanding facilities and to have smaller patient loads than below-cap hospices (Medicare Payment Advisory Commission 2008). They treat a larger share of patients with Alzheimer's disease and other neurological conditions than hospices that do not exceed the cap. Most importantly, hospice providers exceeding the cap exhibit significantly longer lengths of

stay than hospices remaining under the cap, even when taking patient mix into account. For example, the share of hospice users in 2007 with cancer who had stays exceeding 180 days for above-cap hospices (19 percent) was double that for below-cap hospices (9 percent) (Table 2E-6). Between 44 percent and 50 percent of above-cap hospices' patients with neurological conditions, heart or circulatory conditions, or chronic obstructive pulmonary disease had stays exceeding 180 days, compared with 18

**TABLE
2E-6****Percent of hospice users with stays exceeding 180 days, by diagnosis, for above-cap and below-cap hospices, 2007**

Diagnosis	Hospices	
	Above cap	Below cap
All	41%	18%
Cancer	19	9
Neurological conditions	50	29
Heart/circulatory	44	18
Debility	38	22
COPD	47	24
Other	46	20

Note: COPD (chronic obstructive pulmonary disease). Data reflect the percent of hospice users in 2007 whose hospice length of stay was beyond 180 days.

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

**TABLE
2E-7****Hospice live discharges as a percent of all discharges, by diagnosis, for above-cap and below-cap hospices, 2007**

Diagnosis	Hospices	
	Above cap	Below cap
All	46%	16%
Cancer	24	10
Neurological conditions	41	18
Heart/circulatory	55	15
Debility	47	20
COPD	54	19
Other	54	21

Note: COPD (chronic obstructive pulmonary disease).

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

percent to 29 percent of patients with these conditions in below-cap hospices.

Hospices that exceed the cap also have substantially higher rates of live discharges than hospices that do not exceed the cap (Table 2E-7). In 2007, nearly half (46 percent) of all discharges by above-cap hospices in 2007 were live discharges, compared with 16 percent in below-cap hospices. Among patients with similar diagnoses, above-cap hospices also have substantially higher rates of live discharges than below-cap hospices. For example, 55 percent of patients with heart or circulatory conditions were discharged alive in above-cap hospices, compared with 15 percent in below-cap hospices. While hospice is intended to be end-of-life care, the occurrence of some live discharges is not unexpected. A patient's disease may not follow the expected course (e.g., cancer may go into remission) or a patient may decide to revoke the hospice election and return to conventional treatment. However, what is notable about the live discharges by above-cap hospices is how much more frequently they occur compared with below-cap hospices. Above-cap hospices' substantially higher live discharge rates, combined with the longer lengths of stay, raise questions about whether above-cap hospices are admitting patients before they meet the hospice eligibility criteria. The Commission previously recommended that the Office of Inspector

General (OIG) examine the appropriateness of enrollment practices among hospices with unusual utilization patterns. Very high rates of live discharges among some hospices may be an area that could benefit from further examination by the OIG.

Critics of the cap contend that it may force many hospices to go out of business or to limit access to care for noncancer patients or racial and ethnic minorities. We have evaluated this claim and find no evidence to suggest that the growing number of providers exceeding the Medicare limit on payments has affected patients' access to hospice care.

The data in Table 2E-8 show that the Medicare hospice cap is unrelated to hospice use rates across states. For example, Florida, Colorado, Iowa, Oregon, and Delaware have high rates of hospice use among Medicare decedents and few above-cap hospices, which demonstrates that exceeding the cap is not required to achieve high rates of hospice use. Furthermore, hospice use rates vary substantially across states that have a high share of above-cap hospices. On the one hand, Mississippi, the state with the highest share of above-cap hospices (47 percent) has a below average hospice use rate (35 percent of Medicare decedents), whereas Arizona and Utah have both high rates of hospice use and above-cap hospices. Overall, these data suggest that the Medicare hospice cap is unrelated to hospice use rates across states.

Similarly, our analysis of states with the highest hospice use by minority populations found that the cap is unrelated to hospice use by minority populations. States with the highest rates of hospice use by minorities varied in the share of hospices exceeding the cap. The three states with the greatest rates of hospice use among minorities had a very low share of above-cap hospices.

Quality of care: Information on hospice quality is very limited

Publicly reported information on hospice quality is generally not available. The absence of such information reflects the fact that hospice quality measures remain under development. Numerous studies have indicated that hospice improves the quality of remaining life for patients who elect it (Kane et al. 1984, Miller et al. 2003). But developing standardized empirical quality measures that can be used for program administration—either to compare provider performance or to adjust payments under future pay-for-performance programs—presents

unique challenges. The set of hospice characteristics that are correlated with quality is not clear-cut and structural, process, and outcomes measures are scarce. Measures that rely on family perceptions of care are more common, but establishing the validity of those characteristics may be difficult because of their subjective nature. Measures that rely on hospice patient satisfaction exist but are less common and apply only to a subset of patients who are able to provide feedback on care near the end of life. Despite these challenges, there have been a number of efforts to develop hospice quality measures and to collect data. Building on one or more of these efforts or the lessons learned from them may be a possible pathway toward developing quality measures for program administration and public reporting.

Conceptual frameworks for measuring quality

There have been a number of efforts to conceptually define elements of hospice care or end-of-life care that are indicative of high quality. In 1997, the Institute of Medicine (IOM) identified a number of elements that it considered intrinsic to health care systems (including hospices) engaged in providing care at the end of life (Institute of Medicine 1997), including providing or arranging for symptom prevention and relief; attention to emotional and spiritual needs and goals; care for the patient and family as a unit; sensitive communication, goal setting, and advance planning; interdisciplinary care; and services appropriate to the various settings and ways people die. In 2004, the Agency for Healthcare Research and Quality (AHRQ) sponsored an intensive literature review on end-of-life care (including hospices) that focused on relevant patient, family, and provider factors as well as processes and interventions that could be used to identify components of high-quality care (Lorenz et al. 2004).⁵ In 2006, the National Quality Forum (NQF) issued a national framework and preferred practices in palliative and end-of-life care (National Quality Forum 2006). NQF identified a list of 38 preferred practices covering the following eight areas: structures and processes of care; physical aspects of care; psychological and psychiatric aspects of care; social aspects of care; spiritual, religious, and existential aspects of care; cultural aspects of care; care of the imminently dying patient; and ethical and legal aspects of care.

Family and patient surveys

Patient and family assessments can suggest the presence or absence of quality in the hospice care a patient receives.

**TABLE
2E-8**

The hospice cap is unrelated to the use of hospice services across states, 2007

Ten states with highest hospice use rates	Percent of:	
	Decedents using hospice	Hospices exceeding the cap
Arizona	57%	32%
Utah	52	21
Florida	52	5
Colorado	48	2
Iowa	48	1
Oregon	47	2
Delaware	46	0
New Mexico	44	9
Texas	44	10
Michigan	44	3

Source: MedPAC analysis of the denominator file, the Medicare Beneficiary Database, 100 percent hospice claims standard analytical file data, Medicare hospice cost reports from CMS, and the CMS Providing Data Quickly system.

National Hospice and Palliative Care Organization

surveys One of the most widely used assessments is the Family Evaluation of Hospice Care (FEHC), a survey developed and fielded by the National Hospice and Palliative Care Organization (NHPCO), with major analytic and substantive input from researchers at Brown University (Connor et al. 2004, Connor et al. 2005). The data from this survey are not publicly available. The FEHC surveys recipients on how well the hospice attended to family support and information needs, how well the hospice assisted in coordinating care, and the family's perception of how well the hospice cared for the patient overall and met the patient's needs for pain management, assistance with respiratory difficulty, and emotional support. NHPCO also developed the End Results Outcome Measures (EROM) care tool that includes 3 measures: whether the patient's pain was brought to a comfortable level within 48 hours of hospice admission (based on the patient's self-report) and whether unwanted hospitalizations and cardiopulmonary resuscitation were avoided. In October 2006, NQF endorsed national voluntary consensus standards related to the quality of care

for symptom management and end-of-life care for patients with cancer. Among the measures endorsed was NHPCO's FEHC and one measure from the NHPCO EROM on pain control. NHPCO also fields a bereavement survey of family members and is developing a patient evaluation of hospice and palliative care.

National Association for Home Care and Hospice

surveys The National Association for Home Care and Hospice (NAHC) has an abbreviated version of a family satisfaction survey as well as a patient survey. The data from these surveys are not publicly available. Each survey is a single page, and each asks the respondent to rate the hospice's performance by agreeing or disagreeing with statements characterizing how well the hospice met the patient's pain and symptom management and other needs, its communications with the patient and the family, and the hospice staff's personal interactions with the patient. Participating hospices provide the surveys to the patient (two weeks after admission) or the family (two months after the patient's death); respondents return the surveys directly to NAHC, which compiles the data and reports hospice-specific results to each participating hospice. Recently, NAHC has also fielded a bereavement survey.

Benefits and challenges of surveys Family and patient surveys represent potentially useful tools for hospices to identify areas for improvement within their operations. Measuring hospice patient satisfaction, however, is a uniquely difficult endeavor. Because of the physical and emotional effects of a patient's illness, some patients may be unable or limited in their capacity to provide feedback on the hospice care they receive. Efforts to design patient satisfaction measures must confront these and other challenges and do so in a way that is sensitive to the individual circumstances each patient faces near the end of life. Given that much of the hospice benefit consists of emotional, spiritual, and psychological supports, family perceptions may be appropriate indicators of the quality of hospice care. However, there are limitations to the potential use of these types of surveys by the Medicare program in assessing the quality of hospice care. First, the surveys are voluntary, and although the organizations encourage their members to participate in the survey effort, members are not required to do so. Therefore, data obtained from such surveys may not come from a representative sample of hospices. Second, family surveys measure hospice care through the perceptions of family members or persons otherwise closely related to the

hospice patient. The answers of family members may not necessarily reflect the patient's actual experience, particularly if the patient was unable to communicate well. A third limitation of hospice performance assessments by family members is the tendency for respondents to give positive ratings; thus, such assessments may not adequately differentiate performance among hospices. For example, results from the 2005 FEHC suggest that well over 90 percent of survey respondents rated their family member's care as "excellent" or "very good" (Rhodes et al. 2007). These scores may reflect the nature of family members' perceptions—that they greatly appreciate hospice involvement at the end of the patient's life and may not have a frame of reference from which to differentiate various levels of quality of hospice care.

CMS initiatives on hospice quality

CMS does not currently require hospices to report quality data. However, the agency does have initiatives under way related to hospice quality. The Medicare conditions of participation require all hospices to have a quality assessment and performance improvement (QAPI) program. CMS also recently completed a project to identify potential hospice quality measures and is now conducting a follow-up project to test a subset of those measures in a small number of hospices.

QAPI Program As part of revisions to the hospice conditions of participation finalized in 2008, CMS now requires each hospice to have a QAPI program. CMS does not require hospice QAPI programs to focus on specific quality measures but rather allows each hospice to choose quality measures to monitor based on standards of care; findings in the current literature; local, regional, or national quality measurement programs; or quality measures used by other provider types. Hospices are required to collect performance data on measurable quality indicators and demonstrate that they continuously monitor these data and use them on an ongoing basis to improve the quality of their care. QAPI data are not publicly reported. CMS refrained from establishing national quality benchmarks, indicating that "more time is needed to test, refine, and collect further data related to any specific measure before we could establish a nationwide benchmark" (Centers for Medicare & Medicaid Services 2008). However, CMS pointed to a number of resources that might assist hospices in developing QAPI programs (such as NQF's consensus standards for end-of-life care of cancer patients, NQF's preferred practices for palliative

and end-of-life care, the PEACE project, AHRQ's review of end-of-life care and outcomes, NHPCO's initiative to help hospices develop QAPI programs, and the Brown University toolkit of instruments to measure end-of-life care).

CMS testing of quality measures In 2006, CMS began the PEACE project⁶ with the Carolinas Center for Medical Excellence, Medicare's quality improvement organization for North and South Carolina, to identify quality measures for end-of-life care and collect and analyze the instruments available to gather data on those measures. The PEACE project devised a list of 34 potential hospice quality measures. The project has concluded, and CMS is now conducting a follow-up project to test 12 of the quality measures identified by the PEACE project in 7 hospices in New York. The 12 measures fall into a range of areas: structure and process of care, care for physical symptoms and psychosocial symptoms, social and cultural aspects of care, care of the imminently dying, ethical and legal aspects of care, and adverse events. Examples of the quality measures being tested are the percentage of patients with certain symptoms such as pain, nausea, or anxiety who receive treatment or experience symptom relief within a specified time period. Most of the quality measures would rely on information reported in the patient's medical record. One of the 12 quality measures (percentage of families reporting that the hospice attended to family needs for information about medication, treatment, and symptoms) would rely on information from the patient's family. The project is scheduled to be completed in November 2010 and is being conducted in accord with NQF standards.

Public reporting of hospice quality data

In recent years, the American Hospice Foundation has been developing a hospice "report card" that would provide a vehicle for public reporting of quality and other data to allow members of the public to compare hospices' performance in terms of quality. The hospice report card would use many of the measures included in NHPCO's FEHC and one measure from NHPCO's EROM on pain control. It would also report administrative data, such as visits per week and hospice and staff accreditation, and include graphic displays that compare hospices in the same market and the average performance on these quality measures for all hospices in a state.

Florida has a report card on hospice quality for consumers that utilizes data from NHPCO's FEHC (Florida Agency

for Healthcare Administration 2009). The report card, however, does not differentiate well among hospices.⁷ Across most hospices and most quality measures, the ratings are uniformly 5 stars (highest rating), with only a few cases of 4 stars.

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

Following economy wide disruptions in the credit markets in 2008, capital markets in the health care sector appear to be normalizing, as evidenced by high volumes of municipal health care issuances in January 2010 (Cain Brothers 2010). Hospices in general are not as capital intensive as some other provider types because they do not require extensive physical infrastructure (although some hospices have chosen to build their own inpatient units, which requires significant capital). Many hospices are too small to attract interest from capital markets.

Some freestanding hospices are part of large publicly traded chain providers. Recent financial reports for these hospices have been favorable. One large publicly traded hospice chain recently reported strong cash flow and margins and limited debt. Another publicly traded hospice company reported stronger than expected earnings and good cash position. Overall, access to capital for these providers is likely to be solid.

Less information is available on access to capital for smaller freestanding for-profit providers; however, the continued influx of for-profit providers into the market suggests that capital remains accessible. Access to capital for nonprofit freestanding hospices is difficult to assess, although we plan to continue to explore whether there may be sources of information that could provide insight on access to capital for these providers. Hospital-based hospices have access to capital through their parent provider. Problems in the credit markets have eased somewhat from last year and access to capital for hospitals seems to be operating in a more normal manner. Home-health-based hospices also have access to capital through their parent providers, which appear to have adequate access to capital.

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 efficient providers are expected to spend on

**TABLE
2E-9**

**Hospice costs per day vary
by type of provider, 2007**

	Average	Percentile		
		25th	50th	75th
All hospices	\$134	\$103	\$126	\$159
Freestanding	128	100	121	150
Home health based	143	105	131	165
Hospital based	168	112	143	187
For profit	121	94	117	147
Nonprofit	148	115	138	173
Above cap	104	85	102	124
Below cap	139	107	130	163
Urban	137	105	129	162
Rural	119	99	120	151

Note: Data reflect aggregate cost 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 the case mix or wages across hospices.

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

delivering high-quality care. Medicare margins illuminate the relationship between Medicare payments and providers' costs. We examined margins through the 2007 cost-reporting year, the latest period for which both cost report data and claims data are available. An important driver of margins is providers' costs. To better understand the variation in margins across providers, we have also examined the variation in costs per day across providers.

Hospice costs

Hospice costs per day vary significantly by type of provider. This variation is one reason we observe differences in hospice margins across provider types in our subsequent margin analyses. In 2007, hospice costs per day were \$134 on average across all hospice providers (Table 2E-9).⁸ 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 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 the Medicare cost report data indicates that, across all types of hospices, those with longer average lengths of stay have lower costs per day. Freestanding hospices have longer lengths of stay 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. In 2007, indirect costs made up 33 percent of total costs for freestanding hospices compared with 39 percent of total costs for home-health-based hospices and 41 percent of total costs for hospital-based hospices. The higher indirect costs among provider-based hospices suggest that their costs may be inflated because of the allocation of overhead costs from the parent provider.

Hospice margins

From 2001 to 2007, the aggregate hospice Medicare margin was favorable, oscillating from roughly 4.5 percent to 6.5 percent (Table 2E-10).⁹ As of 2007, the aggregate hospice Medicare margin was 5.9 percent, down slightly from 6.4 percent in 2006. Margins varied widely across individual hospice providers. In 2007, the Medicare margin was -13.7 percent at the 25th percentile, 5.3 percent at the 50th percentile, and 20.1 percent at the 75th percentile. Our estimates of Medicare margins from 2001 to 2007 exclude overpayments to above-cap hospices and are calculated based on Medicare allowable, reimbursable costs consistent with our approach in other Medicare sectors.¹⁰

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). We estimate that including bereavement costs would reduce our 2007 aggregate Medicare margin estimate by 1.5 percentage points. Across most hospice types, bereavement costs are similar. Some differences, however, are observed between nonprofit and for-profit providers, with bereavement costs being about 1.9 percent and 1.0 percent of total costs, respectively. We also excluded nonreimbursable volunteer program costs from our margin calculations, which equal 0.3 percent of total costs.¹¹ Hospices are required to use volunteers to provide administrative or patient care

**TABLE
2E-10****Hospice Medicare margins, 2001-2007**

Category	2001	2002	2003	2004	2005	2006	2007
All	4.4%	5.5%	6.6%	5.0%	4.5%	6.4%	5.9%
Freestanding	9.1	9.2	11.0	8.3	7.2	9.7	8.8
Home health based	0.2	1.9	3.9	3.1	3.0	3.8	2.3
Hospital based	-11.6	-9.1	-13.7	-11.6	-9.1	-12.7	-10.0
SNF based	N/A	N/A	N/A	N/A	N/A	N/A	N/A
For profit	13.7	14.9	15.8	11.7	9.8	12.0	10.5
Nonprofit	0.1	0.2	1.1	0.3	0.9	1.5	1.8
Government*	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Urban	4.7	6.1	7.5	5.9	5.1	7.1	6.5
Rural	2.7	0.5	0.3	-2.5	0.0	0.6	1.2
Patient volume (quintile)							
Lowest	-4.8	-6.3	-2.2	-6.2	-6.6	-5.5	-8.2
Second	-3.6	-3.8	-4.3	-1.1	-2.1	0.5	1.1
Third	-1.0	3.9	2.1	1.0	1.9	2.4	3.1
Fourth	4.9	4.6	3.6	2.7	4.2	5.8	6.3
Highest	6.1	7.2	9.6	7.2	5.9	8.1	7.1
Below cap	N/A	5.2	6.8	5.6	5.0	7.1	6.2
Above cap	N/A	14.3	3.5	-3.4	-0.8	0.4	2.6
Above cap (including cap overpayments)	N/A	30.9	23.9	18.9	20.7	20.8	20.4

Note: SNF (skilled nursing facility), N/A (not available). Margins for all provider categories exclude overpayments to above-cap hospices, except where specifically indicated. Margins are calculated based on Medicare allowable, reimbursable costs. There are very few SNF-based providers.

*Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

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

services equal to at least 5 percent of patient care time furnished by paid staff.

Freestanding, for-profit, and urban hospices have higher margins than their counterparts. In 2007, freestanding hospices had an aggregate Medicare margin of 8.8 percent compared with home-health-based hospices at 2.3 percent and hospital-based hospices at -10.0 percent. The aggregate Medicare margin was higher among for-profit hospices (10.5 percent) than nonprofit hospices (1.8 percent). Among nonprofit hospices, differences were substantial in the margins for freestanding and provider-based hospices. Freestanding nonprofit hospices had an aggregate Medicare margin of 5.6 percent compared with 1.5 percent for home-health-based hospices and -9.9 percent for hospital-based hospices in 2007 (data not shown). In 2007, the aggregate Medicare margin was higher among urban hospices (6.5

percent) than for rural hospices (1.2 percent). Overall, hospices' margins vary by size of provider; hospices with more patients have higher margins on average. Hospices with longer lengths of stay also have higher margins (Medicare Payment Advisory Commission 2009).

Differences in margins across freestanding, home-health-based, and hospital-based hospices are in part due to differences in indirect costs, which are higher for provider-based hospices and are likely inflated because of the allocation of overhead costs from the parent provider. If home-health-based and hospital-based hospices had indirect cost structures similar to those for freestanding hospices, we estimate that their margins would be 6 to 10 percentage points higher and the industry wide aggregate Medicare margin would be as much as 2 percentage points higher. We intend to continue to examine the differences in the levels of indirect costs across providers and consider

whether issues with the allocation of overhead from the parent provider warrant the exclusion of provider-based hospices from our margin calculations.

Projecting margins for 2010

To project the aggregate Medicare margin for 2010, we model the policy changes that went into effect between 2007 (the year of our most recent margin estimate) and 2010 as well as any policy changes scheduled to be in effect in 2011 other than the 2011 update. The policies include:

- for fiscal year 2008, a market basket update of 3.3 percent;
- for fiscal year 2009, a market basket update of 3.6 percent;
- for fiscal year 2010, a 1.4 percent update composed of a market basket update of 2.1 percent and a projected 0.7 percent decrease in payments due to wage index changes and the first year of the phase-out of the hospice wage index budget-neutrality adjustment; and
- for fiscal year 2011, a projected 0.6 percent decrease in payments due to the second year of the phase-out of the wage index budget-neutrality adjustment.

Taking into account these policy changes and assuming that hospice costs grow at the same rate as the market basket over this period, we project an aggregate Medicare margin for hospices of 4.6 percent in fiscal year 2010. This margin projection excludes the cost of nonreimbursable bereavement services (about 1.5 percent of total costs). It also does not include any adjustment for the higher indirect costs observed among hospital-based and home-health-based hospices (which would add as much as 2 percentage points to the overall aggregate Medicare margin).

How should Medicare payments change in 2011?

The update in current law for fiscal year 2011 is the forecasted change in the hospital market basket. The market basket increase is currently projected to be 2.4 percent for 2011. However, CMS will update this forecast before using it to update payment rates for fiscal year 2011.

In considering an appropriate update for each sector, the Commission also takes into account improvements in productivity. Competitive markets demand continual improvements in productivity from workers and firms. These workers and firms pay the taxes used to finance Medicare. Medicare's payment systems should exert the same pressure on providers of health services. The Commission begins its deliberations with the expectation that Medicare should benefit from productivity gains in the economy at large (the 10-year average of productivity gains in the general economy is 1.3 percent). In some cases, if the Commission judges that payments are substantially above costs, it may decide not to apply a productivity adjustment because it instead applies a larger reduction to the payment rates (such as a zero update). In the case of hospice, based on our analyses of the various components of the update framework, the Commission believes hospice providers can operate within the current payment system with a moderate update in 2011. Therefore, the Commission recommends that a productivity adjustment be applied to the update for hospice services in 2011.

Update recommendation

We recommend that the Congress update payment rates for hospice services by the hospital market basket index, less the Commission's adjustment for productivity growth. Under the current forecast of the hospital market basket, the Commission's recommendation would update the hospice payment rates by 1.1 percent in 2011. (The market basket forecast will be updated by CMS before implementation, and therefore this number is subject to change.)

RECOMMENDATION 2E

The Congress should update the payment rates for hospice for fiscal year 2011 by the projected rate of increase in the hospital market basket index less the Commission's adjustment for productivity growth.

RATIONALE 2E

Our payment indicators for hospice are generally positive. The number of hospices has increased substantially in recent years, driven by the entry of for-profit providers. The number of beneficiaries enrolled in hospice, average length of stay, and total hospice payments have also increased. The projected 2010 aggregate Medicare margin is 4.6 percent.

Spending

- This recommendation would decrease federal program spending by between \$50 million and \$250 million over 1 year and between \$1 billion and \$5 billion over 5 years.

Beneficiary and provider

- We do not expect this recommendation to have adverse impacts on beneficiaries' access to care. The recommendation may increase financial pressure on some providers, but overall only a minimal effect on providers' willingness and ability to care for Medicare beneficiaries is expected. ■

Endnotes

- 1 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.
- 2 The cap was legislatively set at \$6,500 in 1983 (Dole 1983). It is updated each year for inflation by the medical expenditure category of the consumer price index for urban consumers. The cap is not adjusted for geographic differences in wages. The average annual payment cap is calculated for the period November 1 through October 31 each year. For the year ending October 31, 2007, the cap was about \$21,410. Beneficiaries are counted in a given year if they have filed an election to receive care from the hospice during the period beginning on September 28 before the beginning of the cap period and ending on September 27 before the end of the cap period. If a beneficiary receives care from more than one hospice, each hospice counts the fraction that represents the portion of a patient's total hospice stay spent in that hospice.
- 3 In late 2007, CMS issued guidance to state survey and certification agencies indicating that surveys of new hospices applying to be Medicare providers (as well as other types of providers that have the option of obtaining Medicare status through accreditation rather than state surveys) should be in the lowest tier of their workload priorities.
- 4 This count of SNF-based hospices does not include freestanding hospices that are owned by a company that also owns nursing facilities. While we do not have an estimate of the number of freestanding hospices that are part of these types of joint ownership arrangements, joint ownership relationships exist among some hospice and nursing home chains.
- 5 The Agency for Healthcare Research and Quality analysis also identified patient satisfaction as an indicator of the effectiveness of provision of care at the end of life. As this measure is somewhat distinct from those listed here (it is a patient-centered measure rather than an assessment of the hospice's ability to provide a given intervention), patient satisfaction is discussed in more detail later in this chapter.
- 6 PEACE stands for prepare, embrace, attend, communicate, and empower.
- 7 Part of the reason the Florida report card does not distinguish well among hospice performance may be the broad definition it uses for favorable performance. For example, on questions that asked the family to rate the overall care provided by the hospice or the response by hospice staff on weekends and evenings, there were five possible responses: excellent, very good, good, fair, and poor. The report card assigned stars based on the percentage of favorable responses, with favorable defined as a rating of good, very good, or excellent.
- 8 In the cost-per-day calculation, costs reflect aggregate cost for all types of hospice care combined (routine home care, continuous home care, general inpatient care, and inpatient respite care). Days reflect the total number of days the hospice is responsible for care for Medicare patients, regardless of whether the patient received a visit on a particular day. The costs per day estimates are not adjusted for differences in case mix or wages across hospices.
- 9 The aggregate Medicare margin is calculated by the following formula: $((\text{sum of total payments to all providers}) - (\text{sum of total costs for all providers})) / (\text{sum of total payments to all providers})$. Data on total payments come from the Medicare claims data. Estimates of cap overpayments (which we exclude from the margin calculations unless otherwise noted) are also based on claims data. Data on total costs come from the Medicare cost reports.
- 10 The margin estimates for the period 2001–2005 in this report differ from the estimates for the same time period published in our June 2008 report. The margin estimates in this report exclude overpayments to above-cap providers and exclude Medicare nonreimbursable costs, whereas the prior margin estimates did not.
- 11 Fundraising costs are also considered nonreimbursable and are not included in our margin calculations. These costs amount to 1.5 percent of total costs.

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