ONLINE APPENDIXES 12

Hospice services

ONLINE APPENDIX 12-A

Nonhospice spending for beneficiaries enrolled in hospice

TABLE 12–A1 **Spending and service use paid outside of hospice among hospice beneficiaries, 2012**

Medicare service	Spending (in millions)	Share of spending	Percentage of beneficiaries with overlapping service
All	$1,010	100%	53.2%
Any Part A and Part B	670	66	40.7
Inpatient	224	22	2.3
SNF	41	4	0.5
Home health	32	3	2.9
Outpatient	122	12	14.3
Physician and supplier	202	20	32.0
DME	48	5	9.6
Part D	340	34	34.0

Note: SNF (skilled nursing facility), DME (durable medical equipment). Data do not include physician visits by the hospice patient's attending physician (either those employed by the hospice or independent) that are billed as related to the terminal condition.

Source: Acumen analysis of Medicare claims data.

Medicare's payments to hospices are intended to cover all services associated with the terminal condition and related conditions. For Medicare beneficiaries enrolled in the hospice benefit, Part A and Part B services unrelated to the terminal condition are covered through the regular fee-for-service (FFS) program, even for beneficiaries enrolled in Medicare Advantage (MA). Part D drugs unrelated to the terminal condition are covered through a prescription drug plan or MA prescription drug plan. In the hospice final rule for fiscal year 2014, CMS stated that virtually all services at the end of life are related to the terminal condition and should therefore be covered under the hospice benefit rather than separately paid through FFS or Part D (Centers for Medicare & Medicaid Services 2013). However, little information exists to quantify Medicare spending on nonhospice services. We contracted with Acumen LLC to quantify nonhospice service use and spending on Part A and Part B services and Part D drugs while beneficiaries are enrolled in hospice.

We excluded nonhospice spending that occurred on days in which the beneficiary was admitted to hospice or was discharged alive in order to avoid counting FFS spending that may have occurred before beneficiaries enrolled or after they disenrolled. We included only days in which the beneficiary was enrolled in hospice. Spending estimates do not include physician visits provided by the hospice patient's attending physician (either those employed by the hospice or independent) that are billed as related to the terminal condition.

We found that FFS spending attributable to providing services unrelated to the terminal conditions of hospice enrollees totaled $1 billion in 2012 (Table 12-A1). Spending was highest on Part D drugs ($340 million), representing 34 percent of total nonhospice spending. The next largest shares of spending were for inpatient services ($224 million) and physician and supplier services ($202 million). Within the physician and supplier services category, spending was highest on physician services (evaluation and management visits) ($81 million) and ambulance services ($49 million). From 2011 to 2012, nonhospice spending decreased overall by 1.1 percent. Specifically, spending decreased for some services, such as inpatient and SNF services, but increased for others, such as physician and supplier services, outpatient services, and Part D drugs.

Among beneficiaries using hospice in 2012, 53 percent received at least one Part A or Part B service or Part D drug during their hospice stay in 2012 that was paid for outside the hospice benefit by Medicare FFS, a prescription drug plan, or an MA prescription drug plan. Over the course of an entire episode, about 58 percent of hospice beneficiaries received a service or drug paid for outside the hospice benefit. While a higher proportion of FFS beneficiaries had a claim paid outside of hospice over the course of an episode compared to MA beneficiaries (60 percent vs. 51 percent, respectively), both had high shares.[1]

Among Part D drugs paid for outside the hospice benefit, antidepressants represented the largest share of prescriptions filled (11 percent). Medications for pain management represented 6 percent of prescriptions. Others in the top 10 drug categories included psychotherapeutic agents and drugs typically used to manage chronic conditions, such as beta blockers and antidiabetics. While hospice enrollees' Part D drug use declines somewhat over the course of their hospice episode, a considerable portion of all Part D prescriptions are filled near the end of the episode. For example, among hospice episodes 16 to 28 days long, about a quarter of all Part D prescriptions were filled in the last 7 days of the episode.[2] More detailed clinical information would be needed to determine whether it was appropriate that these prescriptions were paid for by Part D as unrelated to the terminal condition. While patients were likely using many of these pharmaceuticals prior to their hospice admission, if the drugs were used for palliation of the terminal condition or related conditions, the hospice provider becomes financially responsible for the drugs once the beneficiary elects hospice. In a 2012 report, the Office of Inspector General focused on selected Part D drugs that it felt were likely to be related to a hospice patient's terminal condition (analgesics, antinauseants, laxatives, and antianxiety drugs for all hospice patients and certain disease-specific drugs for amyotrophic lateral sclerosis and chronic obstructive pulmonary disease patients); in 2009, they found about $34 million in Part D plan payments for these drugs for hospice beneficiaries (Office of Inspector General 2012).

For Part A and Part B services paid for outside the hospice benefit, data suggest that some portion of services appears related to the beneficiaries' terminal conditions, but the share is difficult to estimate without more detailed clinical information. To get an initial sense, we compared the hospice primary diagnosis to the primary diagnosis on the claims for nonhospice services. Since nonhospice services may be related to the terminal condition even if the primary diagnoses on the hospice and nonhospice claims are different, our approach understates the share of nonhospice services that are related to the terminal condition. Despite this limitation, we found evidence of overlap. For example, among hospice beneficiaries with a terminal diagnosis of cancer who had an inpatient hospital admission paid by Medicare FFS while on hospice, about 19 percent of those stays had a primary diagnosis of cancer reported on the hospital claim. Similarly, among hospice beneficiaries with a terminal diagnosis of cancer who had a home health stay paid by Medicare FFS while on hospice, about 42 percent of those stays had a primary diagnosis of cancer reported on the home health claim. Monitoring whether services are related or unrelated to the terminal condition is difficult. If hospice were included in the MA benefits package (as the Commission recommends in Chapter 13), MA plans would have financial responsibility for all care received by their members who elect hospice and might be better positioned to handle the issue of related and unrelated services through their contractual arrangements with providers. In addition, the amount of nonhospice service use overall for beneficiaries enrolled in hospice indicates the importance of care coordination for hospice patients in FFS and MA. ■

Endnotes

1 We defined MA beneficiaries as those who were enrolled in MA in the month of their beginning service date of a hospice episode.

2 Episode days here do not include "transition" days in which the beneficiary was discharged alive.

References

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013. Medicare program; FY 2014 hospice wage index and payment rate update; hospice quality reporting requirements; and updates on payment reform. Final rule. *Federal Register* 78, no. 152 (August 7): 48234–48281.

Office of Inspector General, Department of Health and Human Services. 2012. *Medicare could be paying twice for prescription drugs for beneficiaries in hospice.* Washington, DC: OIG.