CHAPTER 12

Hospice services

RECOMMENDATION

12 The Congress should eliminate the update to the hospice payment rates for fiscal year 2015.

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

CHAPTER 12

Hospice services

Chapter summary

The Medicare hospice benefit covers palliative and support services for beneficiaries with a life expectancy of six months or less. Beneficiaries must elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of their terminal condition. In 2012, more than 1.27 million Medicare beneficiaries received hospice services from over 3,700 providers, and Medicare expenditures totaled about $15.1 billion.

Assessment of payment adequacy

The indicators of payment adequacy for hospices, discussed below, are generally 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 2012, hospice use increased across all demographic and beneficiary groups examined. However, hospice use rates remained lower for racial and ethnic minorities than for Whites.

- ***Capacity and supply of providers*—**The supply of hospices increased nearly 4 percent in 2012, 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.
- ***Volume of services*—**The proportion of beneficiaries using hospice services at the end of life continues to grow, and average length of stay

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increased in 2012. About 46.7 percent of Medicare beneficiaries who died in 2012 used hospice, up from 45.2 percent in 2011 and 22.9 percent in 2000. Average length of stay among decedents, which increased between 2000 and 2011 from 54 days to 86 days, grew to 88 days in 2012. The median length of stay for hospice decedents was 18 days in 2012 and has remained stable at approximately 17 or 18 days since 2000.

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 must report data for specified quality measures or face a 2 percentage point reduction in their annual update for the subsequent fiscal year. Initially, two limited quality measures were adopted. CMS is replacing those measures in future years. Beginning in July 2014, seven new quality measures will be collected through a standardized data collection instrument. In 2015, a hospice experience-of-care survey for bereaved family members will be implemented. CMS has indicated that public reporting of quality information is unlikely before 2017.

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 6.9 percent increase in 2012) suggests that access to capital is adequate for these 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 Medicare margin, which is an indicator of the adequacy of Medicare payments relative to providers' costs, was 8.7 percent in 2011, up from 7.4 percent in 2010. The projected margin for 2014 is 7.8 percent. The 2014 margin projection is based on the current law payment rates under Title XVIII of the Social Security Act, which does not include the sequester. If the sequester is in effect for 2014, the projected 2014 margin would be about 2 percentage points lower. The margin estimates also exclude 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). Margins also do not include any adjustment for 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 1.5 percentage points).

Given that 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 2015. ■

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 worker 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 may also be provided in nursing facilities, assisted living facilities, hospice facilities, and hospitals. In 2012, more than 1.27 million Medicare beneficiaries received hospice services, and Medicare expenditures totaled about $15.1 billion.

Beneficiaries must 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 initially elect hospice, 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 six 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.

In recent years, Medicare spending for hospice care increased dramatically. Spending exceeded $15 billion in 2012, a more than 400 percent increase since 2000. This 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 during this time period has been substantial entry of for-profit providers.

Medicare's payment to hospice providers does not cover services unrelated to the terminal condition. Instead, Medicare FFS or Part D plans pay the providers or suppliers who furnish these unrelated services. In 2012, Medicare spent about $1 billion on nonhospice services while beneficiaries were enrolled in hospice (for more details see online Appendix 12-A, available at http://www.medpac.gov).[3]

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 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. 302). A hospice is paid the routine home care rate (about $156 per day in 2014) 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 about 97 percent of hospice care days. The payment rates for hospice are updated annually by the inpatient hospital market basket index. Beginning fiscal year 2013, the market

TABLE 12–1

Medicare hospice payment categories and rates

Category	Description	Base payment rate, 2014	Percent of hospice days, 2012
Routine home care	Home care provided on a typical day	$156.06 per day	97.4%
Continuous home care	Home care provided during periods of patient crisis	$37.95 per hour	0.4
Inpatient respite care	Inpatient care for a short period to provide respite for primary caregiver	$161.42 per day	0.3
General inpatient care	Inpatient care to treat symptoms that cannot be managed in another setting	$694.19 per day	1.9

Note: These rates reflect the statutory base rates under Title XVIII of the Social Security Act; they do not reflect the sequester. If the sequester is in effect in 2014, the payments received by hospices would be about 2 percent lower. 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 $303.60 per day (8 hours at $37.95 per hour); maximum daily payment at the CHC level is $910.78 per day (24 hours at $37.95 per hour).

Source: CMS Manual System Pub 100–04 Medicare Claims Processing, Transmittal 2766, "Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, Quality Reporting Program and the Hospice Pricer for FY 2014," August 2013.

basket index is 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 fiscal years 2013 and 2014, and possibly will be in fiscal years 2015 through 2019 if certain targets for health insurance coverage among the working-age population are met. Beginning in fiscal year 2014, hospices that do not report quality data will receive a 2 percentage point reduction in their annual payment update. 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 furnished 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/MedPAC_Payment_Basics_13_hospice.pdf.)

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 report 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.

March 2009 Commission recommendations on hospice

The Commission recommended in March 2009 that the hospice payment system be reformed to better align payments with the cost of care throughout an episode. 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 reprinting the Commission's recommendation on payment reform below. That recommendation, which was made in March 2009, urged payment reform by 2013. While that time frame has already passed, the indicators that led us to make this recommendation have not changed, and thus the need for payment reform still exists and the recommendation stands.

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.

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 reprinting the recommendation that included focused medical review below.

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.** ■

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). The Commission recommended that the hospice payment system be changed from a flat per diem payment to one where 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 reprinting the Commission's March 2009 recommendation for payment reform in this report (see text box). 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).

For a number of reasons, it is important that an initial step to improve the hospice payment system be taken as soon as possible. Improving payment accuracy is important given the substantial amount of Medicare hospice spending devoted to long-stay patients, who are more profitable than other patients under the current payment system. In 2011, Medicare spent nearly $8 billion, more than half of all hospice spending that year, on patients with stays exceeding 180 days (Medicare Payment Advisory Commission 2013).[4] Reforming the payment system as the Commission has recommended would also address concerns about payment for very short stays, which may currently be reimbursed at levels below their cost (due to the high visit intensity of these stays and the fewer days over which to spread fixed costs). 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. Improving the hospice payment system is also important from a program integrity perspective. Financial incentives under the current payment system may have spurred some providers to pursue business models that enroll patients likely to have long stays who may not meet the hospice eligibility criteria, an issue that has also been noted by others (Rau 2011, Whoriskey and Keating 2013).

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, so we are reprinting the Commission's recommendation (see text box, p. 303).[5]

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 that beneficiaries who elect hospice incur less Medicare spending in the last two months of life than comparable beneficiaries who do not, but also show 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 ($26,157.50 in 2013), it must repay the excess to the program.[6, 7] 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 average annual 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 exceeding the cap (with the number peaking in 2009). 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 2014?

To address whether payments in 2014 are adequate to cover the costs efficient providers incur and how much providers' payments should change in 2015, 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 since information on hospice quality is generally not available.

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

Hospice use among Medicare beneficiaries increased in 2012, continuing the trend of a growing proportion of beneficiaries using hospice services at the end of life. In 2012, 46.7 percent of Medicare beneficiaries who died that year used hospice, up from 45.2 percent in 2011 and 22.9 percent in 2000 (Table 12-2, p. 306). Hospice use varies by beneficiary characteristics (i.e., enrollment in traditional fee-for-service (FFS) Medicare or Medicare Advantage (MA); Medicare-only beneficiaries and beneficiaries dually eligible for Medicare and Medicaid; urban and rural residence; and age, gender, and race), but it increased across all beneficiary groups examined in 2012.

Use of hospice is slightly more prevalent among beneficiaries enrolled in MA than in FFS, although differences in hospice use rates have narrowed over time. In 2012, in rounded figures, 46 percent of Medicare FFS decedents and 50 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 (see Chapter 13 for more details).

Hospice use varies by other beneficiary characteristics. In 2012, a smaller proportion of Medicare decedents who were dually eligible for Medicare and Medicaid used hospice compared with the rest of Medicare decedents (about 42 percent and 48 percent, respectively). Hospice use has increased in all age groups but is more prevalent and has grown more rapidly among older beneficiaries. In 2012, more than half (about 54 percent) of Medicare decedents ages 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 among women than men and greater hospice use among older beneficiaries.

Hospice use also varies by racial and ethnic groups (Table 12-2, p. 306). As of 2012, hospice use was highest among White Medicare decedents, followed by Hispanic, African American, Native North American, and Asian American decedents. Hospice use grew among all these groups between 2011 and 2012 and has grown substantially for all groups since 2000. Nevertheless, differences in hospice use across racial and ethnic groups persist. 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 beneficiaries than rural, although use has grown in all types of areas (Table 12-2, p. 306). In 2012, the share of decedents residing in urban counties who used hospice was about 48 percent; in micropolitan counties, 43 percent; in rural counties adjacent to urban counties, 42 percent; in rural nonadjacent counties, 38 percent; and in frontier counties, 32 percent. Use rates for beneficiaries residing in all five of these areas increased between 1 percentage point and 1.9 percentage points 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 2012, 68 percent of Medicare decedents who used hospice had a noncancer diagnosis, up from 48 percent in 2000.[8] Heart and circulatory conditions, neurological conditions, and debility and nonspecific signs and symptoms are the three largest noncancer diagnosis groups, each accounting for 16 percent to 17 percent of hospice decedents in 2012.

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

In 2012, 3,720 hospices provided care to Medicare beneficiaries, a 3.8 percent increase from the prior year (Table 12-3, p. 307). This increase marks a continuation of

TABLE 12–2

Use of hospice continues to increase

	Percent of Medicare decedents who used hospice						
	2000	2009	2010	2011	2012	Average annual percentage point change 2000–2011	Percentage point change 2011–2012
All beneficiaries	22.9%	42.0%	44.0%	45.2%	46.7%	2.0	1.5
FFS beneficiaries	21.5	41.0	43.0	44.2	45.6	2.1	1.4
MA beneficiaries	30.9	46.1	47.8	48.9	50.2	1.6	1.3
Dual eligibles	17.5	37.5	39.2	40.3	41.6	2.1	1.3
Nondual eligibles	24.5	43.4	45.5	46.8	48.3	2.0	1.5
Age							
<65	17.0	26.1	27.2	27.8	29.1	1.0	1.3
65–74	25.4	37.3	38.6	39.3	40.5	1.3	1.2
75–84	24.2	43.1	45.1	46.3	47.7	2.0	1.4
85+	21.4	48.0	50.4	52.0	53.9	2.8	1.9
Race/ethnicity							
White	23.8	43.7	45.8	47.0	48.5	2.1	1.5
African American	17.0	32.6	34.1	35.4	36.7	1.7	1.3
Hispanic	21.1	34.8	37.0	38.3	39.3	1.6	1.0
Asian American	15.2	26.0	28.1	30.0	31.7	1.3	1.7
Native North American	13.0	29.7	30.6	32.4	33.9	1.8	1.5
Sex							
Male	22.4	38.6	40.4	41.3	42.7	1.7	1.4
Female	23.3	45.1	47.2	48.6	50.1	2.3	1.5
Beneficiary location							
Urban	24.3	43.5	45.5	46.6	47.9	2.0	1.3
Micropolitan	18.5	37.5	39.8	41.4	43.2	2.1	1.8
Rural, adjacent to urban	17.6	36.9	38.7	40.2	42.1	2.1	1.9
Rural, nonadjacent to urban	15.8	32.8	34.5	35.9	37.6	1.8	1.7
Frontier	13.2	27.1	30.1	30.7	31.7	1.6	1.0

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 six people per square mile.

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

more than 10 years of growth in the number of hospices providing care to Medicare beneficiaries. For-profit hospices account almost entirely for the growth in the number of hospices. Between 2011 and 2012, the number of for-profit hospices increased 6.9 percent while the number of nonprofit hospices was relatively flat, and the number of government hospices declined by about 3 percent. As of 2012, about 59 percent of hospices were for profit, 35 percent were nonprofit, and 6 percent were government.

Freestanding hospices account for most of the growth in the number of providers (Table 12-3). From 2011 to 2012, the number of freestanding providers increased 5.7 percent while the number of hospital-based hospices declined 2.7 percent, and the number of home health–based hospices increased by 1.4 percent.[9] The number of skilled nursing facility (SNF)-based hospices is small, and increased from 21 to 23. As of 2012, about 71 percent of hospices were freestanding, 15 percent were hospital based, 13 percent

TABLE 12–3 **Increase in total number of hospices driven by growth in for-profit providers**

Category	2000	2007	2010	2011	2012	Average annual percent change 2000–2007	2007–2011	2011–2012
All hospices	2,255	3,250	3,498	3,585	3,720	5.4%	2.5%	3.8%
For profit	672	1,676	1,952	2,054	2,196	13.9	5.2	6.9
Nonprofit	1,324	1,337	1,324	1,314	1,313	0.1	–0.4	–0.1
Government	257	237	222	217	210	–1.2	–2.2	–3.2
Freestanding	1,069	2,103	2,397	2,491	2,633	10.1	4.3	5.7
Hospital based	785	683	612	587	571	–2.0	–3.7	–2.7
Home health based	378	443	466	486	493	2.3	2.3	1.4
SNF based	22	21	23	21	23	–0.7	0.0	9.5
Urban	1,424	2,190	2,430	2,536	2,638	6.3	3.7	4.0
Rural	788	1,012	1,002	986	982	3.6	–0.6	–0.4

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

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

were home health based, and less than 1 percent were SNF based.

Overall, the supply of hospices has increased substantially since 2000 in both urban and rural areas, although the number of hospices located in rural areas has declined modestly since 2007 (Table 12-3). Roughly proportionate with the share of Medicare beneficiaries residing in each area, 73 percent of hospices were located in urban areas and 27 percent were located in rural areas as of 2012. Hospice location does not provide a full picture of access to services because a hospice's service area may extend beyond the boundaries of the county where it is located. 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 and average length of stay grew in 2012

The number of Medicare beneficiaries receiving hospice services continues to increase. In 2012, more than 1.27 million beneficiaries used hospice services, up from about 1.22 million in 2011 and just over 0.53 million in 2000 (Table 12-4, p. 308). Between 2011 and 2012, the number of hospice users grew 4.5 percent, outpacing growth in the Medicare decedent population (1.6 percent) during this period.

Average length of stay among decedents reached 88 days in 2012, up from 86 days in 2011 (Table 12-4, p. 308). Average length of stay, which has increased substantially since 2000, has grown more slowly in the last few years than earlier in this period. 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, p. 308). Between 2000 and 2012, 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, although it increased some in 2012. Between 2008 and 2011, the 90th percentile of length of stay grew six days; between 2011 and 2012, it grew five additional days. In 2012, median length of stay, which held steady at 17 or 18 days since 2000, was 18 days. In 2011, 25 percent of stays were five days or less, unchanged from the prior year.

The Commission has previously expressed concern about very short stays. More than one-quarter of hospice decedents enroll in hospice only in the last week of life, a length of stay which is commonly thought to be of less benefit to patients than enrolling earlier. As we have discussed previously, a complex set of dynamics—largely unrelated to the hospice payment system—contributes

TABLE 12–4

Hospice use and expenditures increased in 2012

Category	2000	2011	2012	Average annual change, 2000–2011	Change, 2011–2012
Number of hospice users	534,000	1,219,000	1,274,000	7.8%	4.5%
Total spending (in billions)	$2.9	$13.8	$15.1	15.2%	9.3%
Average length of stay among decedents (in days)	54	86	88	4.5%	2.0%
Median length of stay among decedents (in days)	17	17	18	No change	+1 day

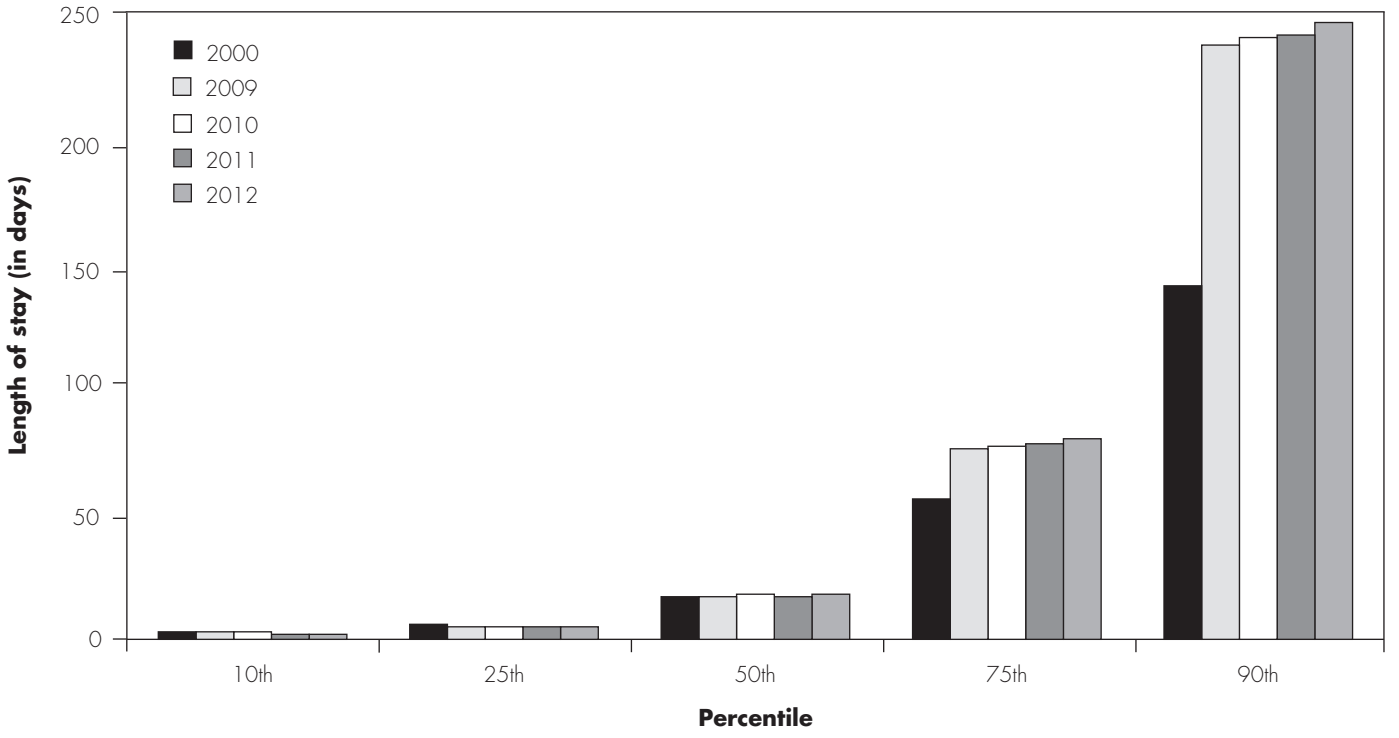
Note: Average length of stay is calculated for decedents who used hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime. The number of hospice users, total spending, and average length of stay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

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

to very short hospice stays (see text box, pp. 310–311). Concern about very short hospice stays is part of a broader concern about the care that patients with advanced illnesses or multiple chronic conditions receive throughout the health care system. Some have advocated for a variety of policy approaches aimed at improving care for patients with advanced illnesses (e.g., approaches to facilitate voluntary advanced care planning or shared decision making, improvements in medical training of health professionals, advancements in quality measurement, and demonstrations of concurrent hospice and conventional care), which we discuss in more detail in the text box (pp. 310–311).

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 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.

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

TABLE 12–5

Hospice length of stay among decedents by beneficiary and hospice characteristics, 2012

Characteristic	Average length of stay	Percentile of length of stay				
		10th	25th	50th	75th	90th
Beneficiary						
Diagnosis						
Cancer	51	3	6	17	51	126
Neurological conditions	139	3	7	26	144	426
Heart/circulatory	76	2	4	11	56	215
Debility	100	3	7	25	105	293
COPD	112	2	5	21	112	333
Other	89	2	4	13	84	266
Main location of care						
Home	90	4	9	27	88	237
Nursing facility	112	3	6	22	107	335
Assisted living facility	154	5	13	53	188	435
Hospice						
Hospice ownership						
For profit	105	3	6	22	97	306
Nonprofit	69	2	5	14	58	185
Type of hospice						
Freestanding	91	3	5	18	80	258
Home health based	70	2	5	16	63	191
Hospital based	59	2	5	13	53	160

Note: COPD (chronic obstructive pulmonary disease). Length of stay is calculated for Medicare beneficiaries who died in 2012 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 or her days while enrolled in hospice.

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

Hospice length of stay varies by observable patient characteristics, such as patient diagnosis and location, which makes it possible for providers to focus on more profitable patients (Table 12-5). For example, Medicare decedents in 2012 with neurological conditions and chronic obstructive pulmonary disease had substantially higher average lengths of stay (139 days and 112 days, respectively) than those with cancer (51 days) and heart or circulatory conditions (76 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 1 week longer at the 50th percentile, about 3 months longer at the 75th percentile, and 300 days longer at the 90th percentile.

Length of stay also varies by location where care is provided. In 2012, average length of stay was higher among Medicare decedents whose main location of care was an assisted living facility (154 days) or a nursing facility (112 days) rather than home (90 days) (Table 12-5). Length of stay differences across settings are most pronounced among patients with longer stays. For example, the 75th percentile of length of stay varied by about 100 days across the three settings (88 days at home, 107 days at a nursing facility, and 188 days at an assisted living facility), and the 90th percentile varied by just under

Potential policy approaches to improve care for patients with advanced illnesses

The share of Medicare beneficiaries receiving hospice at the end of life has increased dramatically since 2000. The Commission views this trend as a positive signal that beneficiaries are increasingly aware of hospice as an option for end-of-life care and are making choices based on their preferences. Despite this important development, a number of concerns about care for patients with advanced illnesses remains. More than one-quarter of hospice decedents enroll in hospice only in the last week of life, resulting in a length of stay which is commonly thought to be of suboptimal benefit to patients. Beyond hospice, concerns also exist about the care patients with advanced illnesses or multiple chronic conditions receive more broadly throughout the health care system. Care for patients with advanced illnesses and multiple chronic conditions oftentimes can be fragmented and may not be consistent with patients' preferences. Below we discuss these concerns in more detail and describe policies that some have suggested might improve quality of care for these patients.

Very short hospice stays

Very short hospice stays have persisted for many years. Since 2000, over a quarter of Medicare hospice decedents enter hospice in the last week of life. It is commonly thought that patients who enter hospice in the last few days of life do not benefit as fully from the palliative and supportive services that hospice offers as patients who enroll 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 fee-for-service (FFS) system for increased volume of services (Medicare Payment Advisory Commission 2009). The issue of the FFS system rewarding volume over quality is a broader issue that affects not only Medicare's hospice services but also Medicare's other services paid under FFS. Payment system reforms such as accountable care organizations—which restructure incentives and focus on the patient's overall needs rather than fragmented services—may help reduce financial incentives that can deter hospice referral.

Some point to the requirement that beneficiaries forgo intensive conventional care to enroll in hospice as a factor that contributes to deferring hospice care, resulting in short hospice stays. The Patient Protection and Affordable Care Act of 2010 mandates a three-year demonstration at 15 sites to test the effect on quality and cost of allowing concurrent hospice and conventional care. However, no funding was appropriated for this demonstration. Recently, CMS indicated publicly that the agency is committed to pursuing a demonstration to test concurrent palliative

(continued next page)

200 days (237 days, 335 days, and 435 days across the three settings, respectively). Length of stay not only is higher but also is growing more rapidly in assisted living facilities than other settings. Between 2009 and 2012, average length of stay among decedents increased 11 days for patients residing in assisted living facilities compared with 5 days for those in nursing facilities and 3 days for those at home. Differences in the diagnosis profile of patients residing in assisted living facilities and nursing facilities compared with patients residing in home settings account for some of the length of stay differences, but the markedly longer stays among assisted living facility residents are not understood and warrant monitoring by CMS and the Office of Inspector General (OIG).

The differences in length of stay by patient characteristics are reflected in differences in length of stay by provider type (Table 12-5, p. 309). In 2012, average length of stay

Potential policy approaches to improve care for patients with advanced illnesses (cont.)

care and conventional care. The time line and details for a demonstration have not been released.

A few private insurers are experimenting with concurrent hospice and conventional care among the commercially insured, working-age, managed care population. One insurer reported that its concurrent-care program resulted in greater hospice enrollment, less use of intensive services, and lower costs (Krakauer et al. 2009). It is uncertain whether this type of approach would yield savings in a Medicare FFS environment, given an elderly population with a greater prevalence of noncancer diagnoses (which tend to result in longer hospice stays) and the absence of health plan utilization management. Currently, under Medicare Advantage (MA), plans have little incentive to offer concurrent care because hospice is carved out of the MA benefits package and beneficiaries who elect hospice receive those services paid by Medicare FFS. If hospice were included in the MA benefits package as the Commission has recommended (see Chapter 13), it would increase incentives for plans to use the flexibility inherent in the MA program to develop and test innovative programs aimed at improving end-of-life care and care for patients with advanced illnesses (e.g., concurrent care or other approaches to provide flexibility in the hospice eligibility critieria, palliative care, and shared decision making).

Broader issues with care for patients with advanced illness

It is commonly thought that Medicare FFS beneficiaries with advanced illnesses or multiple chronic conditions often receive care that is fragmented and uncoordinated and that does not take into account their overall care needs. There is also concern that 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. Shared decision-making tools may offer an opportunity to improve the timeliness and clarity of information patients receive about their condition and treatment options, as well as empower patients to make choices based on their preferences. In addition, steps to make it easier for interested beneficiaries to create advance directives and physician or medical orders for life-sustaining treatment (as well as to make those documents more portable and accessible across care settings and states) may help facilitate care that is consistent with individual patients' preferences. Some have suggested creating a Medicare payment to compensate physicians or interdisciplinary teams for voluntary advanced care planning or shared decision-making consultations on a limited basis (e.g., with limits on the frequency with which it could be billed) as a way to support these efforts. Some have also pointed to a need for better training of health professionals on issues such as patient-centered care, palliative care, and hospice as a longer term approach to improving care for patients with advanced illnesses. There may also be a role for patient experience-of-care surveys or bereaved family member surveys, ideally fielded across multiple settings of care and oversampling relevant populations, to help gauge the extent to which patients (or families) feel they received clear and timely information about their condition and treatment options and had opportunities to participate in their care plans and make choices based on their preferences. ■

was substantially higher at for-profit hospices than at nonprofit hospices (105 days compared with 69 days). Between 2009 and 2012, average length of stay increased five days among for-profit providers and was unchanged among nonprofits. The higher length of stay among for-profit hospices has two components: (1) they have more patients with diagnoses that tend to have longer stays, and (2) they have longer stays for all diagnoses than nonprofits. 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.

One example of unusual hospice utilization patterns is the nearly 10 percent of hospices that exceed the aggregate payment cap. As shown in prior reports, above-cap hospices have substantially higher lengths of stay and rates of discharging patients alive than other hospices.[10] As noted in our March 2012 report, this finding may suggest

TABLE 12–6 **Hospices that exceeded Medicare's annual payment cap, selected years**

	2002	2008	2009	2010	2011
Percent of hospices exceeding the cap	2.6%	10.2%	12.5%	10.1%	9.8%
Average payments over the cap per hospice exceeding the cap (in thousands)	$470	$571	$485	$426	$424
Payments over the cap as percent of overall Medicare hospice spending	0.6%	1.7%	1.7%	1.2%	1.1%
Total Medicare hospice spending (in billions)	$4.4	$11.4	$12.0	$12.9	$13.8

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 and Medicare hospice cost reports from CMS; data on total spending for each fiscal year from the CMS Office of the Actuary.

that above-cap hospices are admitting patients who do not meet the hospice eligibility criteria, which merits further investigation by the OIG and CMS.

In 2011, 9.8 percent of hospices exceeded the cap, down slightly from an estimated 10.1 percent in 2010 (Table 12-6).[11] The share of hospices exceeding the cap thus declined for the second consecutive year, which appears to be a reversal of the trend we observed in the last decade, when a growing share of hospices exceeded the cap.[12] Among hospices that exceeded the cap, the average amount over the cap was slightly smaller in 2011 than in 2010, continuing the trend since 2006 of above-cap hospices exceeding the cap by smaller amounts over time. Taken together, these data may suggest that some hospices are adjusting their admissions and/or discharge patterns to avoid exceeding the cap or to exceed it by less. While above-cap hospices are required to return payments that exceed Medicare's cap, the government's ability to obtain repayment is less certain from hospices that close. 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).

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 quality data will receive a 2 percentage point reduction in their annual payment update.

For the first year of data reporting, CMS established two quality measures. Hospices were required to report these measures in 2013 (based on data from the last three months of 2012) or face a 2 percentage point reduction in their payment update for fiscal year 2014. The first measure, endorsed by the National Quality Forum (NQF), was a pain management measure (i.e., the share of patients who reported being uncomfortable because of pain at admission whose pain was brought to a comfortable level within 48 hours). The second was a process measure designed to help develop future quality measures (i.e., hospices reported whether they were tracking at least three measures focused on patient care and what those measures were). These two measures (with small changes) were continued for the second year of the reporting program; however, CMS has discontinued collection of these measures in subsequent years. Instead, CMS will collect alternative quality measures through a standardized data collection instrument and an experience-of-care survey.[13]

Beginning July 2014, the CMS quality reporting program will require providers to submit quality data for seven measures through a standardized instrument. The purpose of the instrument is to ensure that hospice quality data are collected consistently across providers. The instrument will include seven quality measures recently endorsed by NQF. 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, addressing beliefs and values (if desired by patient), and provision of a bowel regimen for patients treated with an opioid).

Beginning in 2015, the hospice quality reporting program will require all hospice providers (except very small providers) to participate in a hospice experience-of-care survey. CMS has developed the survey using a similar approach to the other Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) surveys. 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 after the patient's death, such as how well the provider communicated with the patient and family. According to CMS, public reporting of quality data from these initiatives is not expected to be available before 2017.

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 adequate.

Trends among for-profit providers suggest adequate access to capital. The number of for-profit providers grew nearly 7 percent in 2012, indicating that capital is accessible to these providers. In addition, several publicly traded hospice companies made investments to expand operations in 2012 and 2013 through acquisition of other hospice providers. Some publicly traded nursing home companies have acquired hospice providers in the last two years and continue to express interest in further expanding into the hospice sector. Private equity groups have also made investments in several hospice companies in 2013, and press reports suggest they generally view the hospice sector favorably.

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.

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 delivering high-quality care. Medicare margins illuminate the relationship between Medicare payments and providers' costs. We examined margins through the 2011 cost reporting year, the latest period for which cost report data and claims data are available. To understand the variation in margins across providers, we also examined the variation in costs per day across providers.

TABLE 12–7

Hospice costs per day vary by type of provider, 2011

		Percentile		
	Average	25th	50th	75th
All hospices	$144	$111	$136	$169
Freestanding	139	110	131	160
Home health based	149	116	146	184
Hospital based	179	121	159	211
For profit	130	106	126	155
Nonprofit	161	126	153	187
Above cap	120	99	119	142
Below cap	146	113	139	173
Urban	146	114	139	172
Rural	129	104	129	163

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 for all patients (regardless of payer) and 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 costs

Hospice costs per day vary substantially by type of provider (Table 12-7), which is one reason for differences in hospice margins across provider types. In 2011, hospice costs per day were $144 on average across all hospice providers, a very slight increase from $143 per day in 2010.[14] 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 the Medicare cost report data indicates that, across all hospice types, those with longer average stays have lower costs per day. Freestanding

TABLE 12–8 **Hospice Medicare margins by selected characteristics, 2005–2011**

Category	Percent of hospices 2011	2005	2006	2007	2008	2009	2010	2011
All	100%	4.6%	6.4%	5.8%	5.5%	7.4%	7.4%	8.7%
Freestanding	69	7.2	9.7	8.7	8.3	10.2	10.7	11.8
Home health based	14	3.1	3.8	2.3	3.4	5.9	3.2	5.0
Hospital based	16	–9.1	–12.7	–10.9	–11.3	–12.2	–16.6	–15.9
For profit (all)	57	9.9	12.0	10.4	10.3	11.7	12.3	14.5
Freestanding	52	10.3	12.7	11.3	11.5	12.9	13.4	15.9
Nonprofit (all)	37	1.0	1.5	1.6	0.7	3.8	3.0	2.5
Freestanding	16	3.8	5.8	5.6	3.7	6.6	7.6	6.4
Urban	72	5.1	7.1	6.3	5.9	7.9	7.7	9.0
Rural	28	0.2	0.8	1.4	2.1	3.7	5.2	6.2
Patient volume (quintile)								
Lowest	20	–6.6	–5.1	–7.9	–8.4	–6.5	–5.1	–4.0
Second	20	–1.6	0.3	1.0	–0.1	2.0	3.5	2.8
Third	20	1.9	2.4	3.0	4.4	4.5	7.1	7.7
Fourth	20	4.4	5.8	5.8	7.2	6.8	7.3	9.9
Highest	20	5.9	8.1	7.0	6.1	9.0	8.3	9.5
Below cap	90.2	5.1	7.0	6.1	5.9	7.9	7.7	9.0
Above cap (excluding cap overpayments)	9.8	–0.8	0.3	2.5	1.2	1.4	3.2	4.1
Above cap (including cap overpayments)	9.8	20.7	20.7	20.5	19.0	18.3	17.4	18.4

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.

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

hospices have longer stays than provider-based hospices, which accounts for some but not all of the difference in costs per day.[15] Another substantial factor is the higher level of indirect costs among provider-based hospices. Indirect costs include, among other things, management and administrative costs, accounting and billing, and capital costs. In 2011, indirect costs made up 34 percent of total costs for freestanding hospices, compared with 39 percent of total costs for home health–based hospices and 42 percent of total costs for hospital-based hospices.[16] 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 to the hospices that are not actually related to the hospices' operations or management. However, it is also possible that provider-based hospices have higher indirect costs for certain overhead activities. For example, we might observe higher indirect costs among provider-based hospices if administrative staff wage rates were higher for parent providers (e.g., hospitals or home health agencies) than for freestanding providers. Regardless of the source of the higher indirect costs among provider-based hospices, the Commission believes the focus should be on the efficient provider. 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.

Hospice margins

From 2005 to 2011, the aggregate hospice Medicare margin ranged from 4.6 percent to 8.7 percent (Table 12-8).[17] As of 2011, the aggregate hospice Medicare margin

was 8.7 percent, up from 7.4 percent in 2010. Margins varied widely across individual hospice providers. In 2011, the Medicare margin was –11.7 percent at the 25th percentile, 7.8 percent at the 50th percentile, and 21.5 percent at the 75th percentile. Our estimates of Medicare margins from 2005 to 2011 exclude overpayments to above-cap hospices and are calculated based on Medicare-allowable, reimbursable costs consistent with our approach in other Medicare sectors.[18, 19]

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 2011 aggregate Medicare margin by at most 1.4 percentage points. This figure is likely an overestimate of the bereavement costs associated with Medicare hospice patients because we 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.

We also excluded nonreimbursable volunteer costs from our margin calculations. As discussed in more detail 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 (11.8 percent) than home health–based and hospital-based hospices (5.0 percent and –15.9 percent, respectively). Provider-based hospices have lower margins than freestanding providers, due in part to their higher indirect costs (e.g., general and administrative expenses and 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 7 percentage points higher for home health–based hospices and 10 percentage points higher for hospital-based hospices, and the industry-wide aggregate Medicare margin would be about 1.5 percentage points higher.[20]

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 (14.5 percent) than for nonprofit hospices (2.5 percent). However, freestanding nonprofit hospices, which are not affected by overhead allocation issues, had a higher margin (6.4 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 (9 percent) than those in rural areas (6.2 percent). The difference between rural and urban margins may partly reflect differences in volume.

Hospice financial performance also varies by length of stay (Table 12-9, p. 316). In 2011, hospices with longer stays had higher margins (with margins dropping some for hospices in the longest stay category because some hospices in that category exceeded the cap and our model assumes the return of cap overpayments by these hospices).[21] 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.

Hospices with a high share of patients in nursing facilities and assisted living facilities also have higher margins than other hospices. For example, in 2011, hospices in the top quartile of the percent of patients residing in nursing facilities had a 15.9 percent margin compared with a margin of roughly 7 percent to 8 percent in the middle quartiles and a 0.9 percent margin in the bottom quartile (Table 12-9, p. 316). Margins also vary by the share of a provider's patients in assisted living facilities, with a margin ranging from roughly 0.8 percent in the lowest quartile to 13.6 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

TABLE 12–9

Hospice Medicare margins by length of stay and patient residence, 2011

Hospice characteristic	Medicare margin
Average length of stay	
Lowest quintile	–6.9%
Second quintile	2.2
Third quintile	10.3
Fourth quintile	16.6
Highest quintile	12.4
Percent of stays > 180 days	
Lowest quintile	–7.1
Second quintile	3.5
Third quintile	10.4
Fourth quintile	15.4
Highest quintile	14.0
Percent of patients in nursing facilities	
Lowest quartile	0.9
Second quartile	7.4
Third quartile	8.1
Highest quartile	15.9
Percent of patients in assisted living facilities	
Lowest quartile	0.8
Second quartile	3.6
Third quartile	9.1
Highest quartile	13.6

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, and 100 percent hospice claims standard analytical file data from CMS.

more profitable than caring for patients at home for reasons in addition to length of stay. As discussed in more detail 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, 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 due to the overlap in responsibilities between the hospice and the nursing facility (Medicare Payment Advisory Commission 2013). Some hospice industry representatives offer a different view of the nursing facility setting, asserting that hospices face higher costs for certain activities in nursing facilities (e.g., educating and coordinating with nursing facility staff and communicating and coordinating with patients' families who may live far away) that offset any efficiencies in the nursing facility setting. However, other industry stakeholders have stated that the nursing facility setting can be more efficient when a hospice has a number of patients clustered in the same facility. The Commission continues to hold that a site-of-service payment adjustment for hospice care in nursing facilities may be appropriate and intends to conduct further research on this issue.

Projecting margins for 2014

To project the aggregate Medicare margin for 2014, we model the policy changes that went into effect between 2011 (the year of our most recent margin estimates) and 2014. The policies include:

- a market basket update of 3 percent for fiscal year 2012, 2.6 for fiscal year 2013, and 2.5 percent for fiscal year 2014;
- a reduction to the market basket update of 1 percentage point in 2013 and 0.8 percentage point in 2014 (reflecting a productivity adjustment and an additional adjustment of –0.3 percentage point each year);
- years three through five 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 2012 through 2014; and
- additional wage index changes, which increased payments in fiscal year 2012 and reduced payments in fiscal years 2013 and 2014.[22]

We also assume a rate of cost growth in 2013 and 2014 that is higher than the historical rate in light of potentially higher administrative costs related to preparing for and/or implementing several new administrative requirements (i.e., new claims data reporting requirements, new quality reporting initiatives, and a potentially revised cost report). Taking these factors into account, we project an aggregate Medicare margin for hospices of 7.8 percent in fiscal year 2014. If the sequester is in effect in 2014, the margin

projection for 2014 would be roughly 2 percentage points lower. 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 for 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 1.5 percentage points).

In considering the 2014 margin projection as an indicator of the adequacy of current payment rates for 2015, one policy of note is the continued phase-out of the wage index budget-neutrality adjustment. Our 2014 margin projection reflects the first five years (through 2014) of the seven-year phase-out of the wage index budget-neutrality adjustment. In 2015, the sixth year of this phase-out will result in an additional 0.6 percentage point reduction in payments.

How should Medicare payments change in 2015?

Update recommendation

RECOMMENDATION 12

The Congress should eliminate the update to the hospice payment rates for fiscal year 2015.

RATIONALE 12

Our payment indicators for hospice are generally positive. The number of hospices has increased in recent years because of the entry of for-profit providers. The number of beneficiaries enrolled in hospice and average length of stay also increased. Access to capital appears adequate. The projected 2014 aggregate Medicare margin is 7.8 percent. Based on our assessment of the payment adequacy indicators, hospices should be able to accommodate cost changes in 2015 without an update to the 2014 base payment rate.

IMPLICATIONS 12

Spending

- Under current law, hospices would receive an update in fiscal year 2015 equal to the hospital market basket index (currently estimated at 2.7 percent), less an adjustment for productivity (currently estimated at 0.3 percent). Hospices may also face an additional 0.3 percentage point reduction in the fiscal year 2015 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 2015 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 Of the $1 billion that Medicare spent on nonhospice services in 2012 for beneficiaries enrolled in hospice, spending was highest on Part D drugs ($340 million), inpatient services ($224 million), physician and supplier services ($202 million), and hospital outpatient services ($122 million). 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. For drugs and services paid for outside the hospice benefit, data suggest that some portion appears related to the beneficiaries' terminal conditions, although the share is difficult to estimate. For more details, see online Appendix 12-A, available at http://www.medpac.gov.

4 In 2011, Medicare hospice spending on patients with stays exceeding 180 days totaled $7.9 billion, more than half of the $13.8 billion in total Medicare hospice spending that year. Of that $7.9 billion, about $5.2 billion was on day 181 and beyond in the beneficiaries' hospice episode, and about $2.7 billion was on day 1 to day 180.

5 PPACA's statutory language on focused medical review has technical issues (Section 1814(a)(7)(D)(ii) of the Social Security Act). Typically, when CMS conducts a medical review and finds that a service is not reasonable or necessary as defined in Section 1862(a)(1) of the Social Security Act or denies a hospice service because the beneficiary is not terminally ill under Section 1879(g)(ii) of the Social Security Act, Section 1879 of the Social Security Act limits beneficiary liability. Under Section 1879, if the beneficiary could not reasonably have been expected to know that the service was not covered, the beneficiary is not financially liable for the service. However, the statutory language associated with the PPACA medical review provision does not reference Section 1879. Consequently, if the PPACA focused medical review provision were implemented, the beneficiary would be fully liable for any services found not covered, even if the beneficiary could not have known the service was not covered. This outcome would be counter to the intent of the provision, which is to focus on providers with unusual utilization patterns and to hold those providers accountable if they are providing noncovered services. The statutory language for the hospice focused medical review provision should be altered so that the standard limitations on beneficiary liability under Section 1879 apply to this provision in the same way they apply to Section 1862(a)(1) or Section 1879(g)(ii). In addition, the statutory language specifying how to calculate a hospice's percentage of stays exceeding 180 days would benefit from clarification to ensure that it identifies those hospices for which stays greater than 180 days make up a high share of that specific hospice's total stays (not a high share of all stays nationally).

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 2013 cap threshold is equivalent to an average length of stay of 170 days of routine home care for a hospice with a wage index of 1.0.

8 In 2009, cancer was the cause of death for about 22 percent of decedents ages 65 or older (Centers for Disease Control and Prevention 2012). Between 2000 and 2012, as hospice use among beneficiaries with noncancer diagnoses grew, the share of hospice decedents with cancer declined from 52 percent to 32 percent. Thus, the share of hospice decedents with cancer has become increasingly similar over time to the share of deaths attributed to cancer.

9 The 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). This information does not necessarily reflect the location where patients receive care. For example, all types of hospices may serve some nursing facility patients.

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

11 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 fiscal year 2012 hospice final rule (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 will have their cap payments calculated from the challenged year going forward using a new alternative methodology. For estimation purposes, we have assumed that the original cap methodology was used for the 2011 cap calculation for all hospices.

12 Because of refinements to our methodology for calculating cap overpayments in 2008 through 2011 (due to changes in data availability and efforts to match as closely as possible the Medicare claims processing contractors' cap calculation approach), the cap estimates displayed in Table 12-6 are not entirely comparable across time. Nevertheless, on the basis of additional analyses we performed using a comparable methodology across time, we found that the share of hospices exceeding the cap increased through 2009 and declined in 2010 and 2011, while the share of total hospice payments over the cap and the average amount of the overpayment per above-cap hospice has declined since 2006.

13 CMS decided not to continue data collection for the NQF-endorsed pain outcome measure for years beyond 2014 because a high rate of patient exclusion makes the measure unstable and because the measure is inconsistently administered across providers. CMS has indicated its interest in developing another pain management outcome measure in the longer run.

14 The cost-per-day calculation reflects aggregate costs 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 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.

15 Some differences exist in the diagnosis mix of patients treated by freestanding and provider-based hospices that contribute to the length-of-stay differences observed for these providers. Freestanding providers have a slightly higher share of patients with a neurological primary diagnosis (who tend to have longer stays) and a slightly lower share of patients with a cancer diagnosis (who tend to have shorter stays) compared with provider-based hospices. However, most of the difference in length of stay between freestanding and provider-based hospices reflects differences in length of stay for patients with similar diagnoses. For example, average length of stay for decedents with neurological conditions was 148 days for freestanding providers compared with 111 days for home health–based providers and 89 days for hospital-based providers.

16 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.

17 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 2011 because cost reporting year 2011 is the most recent period for which we have a complete set of claims data. For some hospices, cost-reporting year 2011 includes part of calendar year 2012.

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

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

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

21 Our assumption of full return of overpayments likely understates margins slightly because not all hospices fully return overpayments. For example, a hospice provider last year closed reportedly to avoid repayment of overpayments (Waldman 2012).

22 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 increase Medicare payments by 0.1 percentage point in 2012 and reduce payments by 0.1 percentage point in both 2013 and 2014, according to estimates in the CMS final rules or notices establishing the hospice payment rates for those years.

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