National Advisory Committee
On Rural Health and Human Services

**Rural Implications of Changes to the Medicare Hospice Benefit**
Policy Brief August 2013

***Editorial Note:*** *During its April 2013 meeting in Grand Junction, Colorado, the National Advisory Committee on Rural Health and Human Services discussed challenges and innovations in hospice and palliative care in rural and frontier areas. The Committee met at Hospice and Palliative Care of Western Colorado and visited two of its satellite hospice facilities in northwestern Colorado. In particular, the Committee examined the modifications of the Medicare hospice benefit mandated by Section 3132 of the Affordable Care Act[1] (ACA) in the context of recent changes in utilization patterns of hospice and palliative care in rural and urban areas. This policy brief continues the Committee's series of analyses of ACA provisions which may have rural implications by providing background on the Medicare hospice benefit, describing unique features of hospice care in rural areas, and submitting recommendations to the Secretary based on the outcome of the Committee's deliberations.*

***RECOMMENDATIONS***

1. *The Committee recommends that the Secretary work with the Congress to allow physician assistants and nurse practitioners at rural health clinics to furnish and bill for hospice services (see page 9).*

2. *The Committee recommends that the Secretary examine allowing telehealth consultations to count as face-to-face encounters and allowing nurse practitioners and physician assistants to certify the need for hospice care through face-to-face visits in rural areas (see page 9).*

3. *The Committee recommends that the Secretary examine allowing hospices serving rural areas greater flexibility in fulfilling covered service requirements that takes into account potentially higher costs in rural areas such as for durable medical equipment and pharmaceuticals (see page 10).*

4. *The Committee recommends that the Secretary provide greater flexibility to Critical Access Hospitals (CAHs) in cost-reporting carve outs related to the provision of hospice services so as not to lower the CAHs' cost-based reimbursement (see page 10).*

5. *The Committee recommends that the Secretary consider allowing cost-based reimbursement for hospice services in the upcoming Frontier Community Health Integration Program Demonstration (see page 10).*

6. *The Committee recommends that the Secretary request that the Institute of Medicine evaluate the current status of terminal prognoses and make recommendations concerning both documentation and medical review of such (see page 11).*

7. *The Committee recommends that the Secretary solicit feedback from rural hospices about specific instances of inconsistency among Medicare Administrative Contractors in evaluating patient eligibility for the Medicare Hospice Benefit and work with these parties to improve consistency (see page 11).*

8. *The Committee recommends that the Secretary reexamine disparities in costs incurred in travel (i.e., windshield time) between urban and rural hospice providers given changes in utilization patterns over the past decade (see page 11).*

[1] Affordable Care Act refers collectively to the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

## INTRODUCTION

While the number of hospice providers and hospice utilization in the U.S. have grown rapidly over the past two decades, rural Medicare beneficiaries may still encounter barriers to hospice care access. In rural areas, where residents are disproportionately older, sicker, and lower-income, it is particularly important that hospice and palliative care are universally available and accessible to beneficiaries at the end of life. As the Committee reviewed the unique position of rural hospice providers, it was apparent that changes to the hospice program mandated by Section 3132 of the ACA and recommended by the Medicare Payment Advisory Commission (MedPAC) could affect access to health services for many rural Medicare beneficiaries.

## BACKGROUND ON THE MEDICARE HOSPICE BENEFIT

The Medicare hospice benefit was created in 1983[2] to offer Medicare beneficiaries a choice in their end-of-life care, allowing them to elect palliative instead of curative treatment and receive support from an interdisciplinary care team outside of an intensive care setting. Medicare defines hospice care as "a comprehensive set of services…identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family member."[3] Hospices "are required to provide virtually all the care that is needed by terminally ill patients."[4] Justification of the benefit rested on the premise that such care would be better aligned with patient and family preferences and could reduce costs during a period in life generally associated with high care utilization.[5] The Committee views the hospice benefit as a uniquely valuable supportive service for the terminally ill that is more than simply a cost-saving option for patients at the end of life.

Although relatively few beneficiaries elected hospice care following the implementation of the Medicare hospice benefit, the number of beneficiaries choosing hospice and total Medicare hospice spending have more than doubled since 2000. In FY 2012, enrollment grew to 1.25 million beneficiaries, or 45.2 percent of all Medicare decedents, and spending increased to $14.7 billion.[6] One reason for this increase is that early hospice enrollees were primarily cancer patients following relatively well-established disease progression patterns while the majority of today's hospice patients suffer from non-cancer diagnoses which can have less certain prognoses and lead to longer hospice stays. The increase in hospice spending reflects both the higher number of beneficiaries electing the benefit as well as increased costs per enrollee.[7] Although Medicare spending on the hospice benefit is lower than conventional end-of-life care in the last month of a patient's life, for longer hospice enrollment periods this difference disappears and in

[2] Created by Section 122 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248).
[3] 42 *CFR* §418.3.
[4] 48 FR 56010-56011. Hospice Final Rule published December 16, 1983.
[5] Medicare Payment Advisory Commission. (March 2013). *Report to the Congress: Medicare Payment Policy*. Chapter 12: Hospice Services. p. 266. Citing Government Accountability Office. (2004). *Medicare hospice care: Modifications to payment methodology may be warranted*. GAO-05-42; and Hoyer, T. (2007). The future of hospice. *Caring*. November 6-8.
[6] Chronic Care Warehouse (CCW, 2012).
[7] Chapter 12, MedPAC March 2013 Report.

fact is reversed for stays exceeding six months.[8]

*How the Benefit Works*

Recipients of the hospice benefit must be enrolled in Medicare Part A and be certified by both their attending physician (if any) and a hospice physician as having a terminal prognosis of six months or less to live, should the illness run its normal course. A nurse practitioner (NP), but not a physician assistant (PA) or any provider associated with a rural health clinic, can also serve as the attending provider under the hospice benefit.[9] Upon entry into the hospice program, the patient must establish a written plan of care in consultation with an interdisciplinary group, including a hospice physician, registered nurse, social worker, and pastoral or other counselor.

Hospice care is provided in defined benefit periods. Following an initial 90-day benefit period, patients can be recertified for a second 90-day period. Assuming the patient is still assessed as having fewer than six months to live, the patient can be recertified for an unlimited number of subsequent 60-day benefit periods. Patients may transfer between hospice providers or dis-enroll at any time.

Hospice services include physician and nursing services, hospice aide/homemaker services, social work, counseling, drugs, supplies, therapies, durable medical equipment for palliative care, and other measures normally covered by Medicare. Under the hospice benefit, Medicare reimburses at four levels of care for the palliation and management of terminal illness and related conditions:

1. Routine Home Care: Core hospice services are provided by the interdisciplinary team in the patient's home, an assisted living facility, a boarding home, or a long-term care facility – wherever the patient lives;
2. Inpatient Respite Care: Short-term inpatient care to relieve the family or primary caregiver;
3. General Inpatient Care : Care provided in an acute-care hospital or other setting where intensive nursing and other support is available for patients experiencing, for example, uncontrolled distressing physical symptoms and psychosocial problems; and
4. Continuous Home Care: Care to support the patient and their primary caregiver through brief periods of crisis for 8-24 hours a day. At least 50 percent of care must be provided by a licensed practical nurse or registered nurse.

Routine home care represents about 97 percent of hospice services provided, reflecting the aim of the hospice benefit to make the patient as emotionally and physically comfortable as possible with minimal disruption to normal activities.[10]

[8] Medicare Payment Advisory Commission. (June 2008). *Report to the Congress: Medicare Payment Policy*. Chapter 8: Evaluating Medicare's Hospice Benefit. p. 209.

[9] See §1861(dd)(3)(B) of the Social Security Act, 42 CFR §418.3, and Medicare Benefit Policy Manual, Chapter 9 – Coverage of Hospice Services Under Hospital Insurance.

[10] 78 FR 27850.

*Characteristics of Hospice Patients and Providers*

The average length of stay (ALOS) for hospice patients has increased substantially from 54 days in 2000 to 86 days in 2011. However, median lengths of stay have remained constant around 17 days, indicating that the growth of ALOS is due to a rise in the number of very long hospice stays. Another factor potentially contributing to the rise in ALOS is that approximately 70 percent of hospice patients suffer from non-cancer conditions with a longer ALOS, especially neurological conditions.[11]

Hospice providers are mainly freestanding (69.3 percent), home-health-based (13.3 percent), or hospital-based (16.7 percent). Providers may be government-owned (6.3 percent), not-for-profit (36.5 percent), or for-profit (57.2 percent).[12] Financial margins and costs vary widely by ownership type. Financial margins are usually more positive for hospice providers with longer ALOS. The ALOS for for-profit and freestanding hospice providers is over 20 days longer than for all other types of hospice providers. Hospice costs are usually highest at the beginning of the first hospice benefit period and at the end of life, creating a U-shaped cost curve with highest profitability during the middle portion of the hospice stay. To reflect this cost pattern, MedPAC has recommended instituting a correspondingly U-shaped payment curve.[13]

As might be expected from the patterns in ALOS, the average freestanding, for-profit hospice provider has a positive financial margin of 13.4 percent. The number of for-profit hospices has tripled between 2000 and 2011 as the number of non-profit hospices has decreased by one percent and the number of government-owned hospices has decreased by 13 percent. The number of freestanding hospices has more than doubled over the same period.

## RECENT AND PROPOSED CHANGES TO THE HOSPICE PROGRAM

Prompted by rising costs, increased enrollment, and changing patterns in utilization, diagnosis, and population, several modifications of the hospice program have been proposed. Section 3132 of the ACA requires the Secretary to revise Medicare's payment system for hospice care no earlier than October 1, 2013, following the collection of "additional data and information as the Secretary determines appropriate to revise payments for hospice care." In the rule proposing an update to FY 2014 hospice payment rates, Centers for Medicare and Medicaid Services (CMS) also detailed an option to rebase the Routine Home Care payment rate to address a potential misalignment between actual cost and possibly inflated payment.[14]

Additional changes to Medicare reimbursement for hospice providers include:

1. Quality reporting beginning in FY 2014 – failure to report will result in a two percent reduction in reimbursement[15];

[11] 2010 Hospice Claims Data.
[12] Data on ownership structure from MedPAC analysis of Medicare cost reports, Provider of Services file, and the standard analytic file of hospice claims from CMS as reported in Chapter 12, MedPAC's March 2013 Report.
[13] This recommendation was first made by MedPAC in its March 2009 Report to the Congress (Recommendation 6-1) and continues as a standing recommendation in MedPAC's March 2013 Report.
[14] 78 FR 27823.
[15] ACA Section 3004(c)(2).

2. Phase-out of the budget neutrality adjustment factor over seven years, which involves a 0.6 percent negative adjustment to the annual payment update for FYs 2011-2016; and
3. Starting with FY 2013 and in subsequent FYs, the hospice payment update percentage will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Social Security Act.

The ACA also requires beneficiaries to have a face-to-face visit with a hospice physician or NP prior to recertification for the third and any subsequent benefit period.[16] The ACA also authorized CMS to design a Medicare Hospice Concurrent Care Demonstration Program to test the concurrent delivery of hospice and conventional care over a three-year period.[17] The Committee believes it will be important for the hospice demonstration to include rural participants. If that is not possible, the Secretary should consider a rural hospice demonstration within the Center for Medicare and Medicaid Innovation (CMMI) to test concurrent delivery.

The effect of these new reporting requirements and payment changes on rural providers, which on average have fewer staff and more fragile financial margins, should be carefully monitored. During conversations with hospice providers in Colorado, the Committee heard that rural hospices are concerned about changes to the program which could add pressure to their financial margins. The Committee recommends that the Secretary solicit feedback from rural hospice providers to ensure that the unique situation of those providers is sufficiently understood as the benefit is restructured.

***INFRASTRUCTURE BARRIERS FOR RURAL HOSPICES***

*The infrastructure required to comply with current statue and regulations makes it increasingly burdensome for small isolated communities to have a Medicare certified hospice program. Rural hospices with low patient volume may find it extremely difficult to achieve a viable economy of scale. Moreover, the significant increase in data submissions and the cost of electronic health records (EHRs) necessary to submit the data may make it very challenging for a small, rural hospice program to survive. The Committee heard from clinicians in the frontier area of Mesa County, Colorado regarding the difficulties implementing an EHR system brought to their team; their staff estimated a 50 percent decrease in productivity. The Committee also visited the Hospice Office at Plateau Valley Medical Clinic in Collbran, Colorado where officials reported $100,000 in losses due to regulatory costs in FY 2012. The required infrastructure has prevented the town of Meeker, Colorado (a CAH site) from developing a hospice program.*

**UNDERSTANDING THE UNIQUE LANDSCAPE OF RURAL HOSPICE PROVIDERS**

The geographic coverage of hospice services varies widely across the U.S, in both urban and rural areas. Although in 2011 45.2 percent of all Medicare beneficiaries who died in that year (decedents) elected hospice, that proportion steadily declined moving from urban to rural decedents: while 46.6 percent of urban Medicare decedents elected hospice, 41.4 percent of micropolitan decedents, 40.2 percent of decedents in rural communities adjacent to an urban area, 35.9 percent of decedents in rural areas not adjacent to an urban area, and 30.7 percent of

[16] ACA Section 3132(b)(2).
[17] ACA Section 3140.

frontier Medicare decedents elected hospice.[18] These data and the persistence of these disparities suggest underlying issues in awareness of and access to hospice care among Medicare beneficiaries in rural and especially frontier areas.

More than 25 percent of hospice providers are located in rural areas, which is slightly greater than the share of Medicare beneficiaries living in rural areas.[19] However, the number of rural providers has continued to decrease over the past four years, posting a 1.7 percent reduction in 2011. Over the same period, urban areas have experienced an average annual growth in hospice providers of 3.7 percent.[20] MedPAC in its March 2013 reported an overall positive hospice Medicare margin, the measure of Medicare payment adequacy relative to providers' cost (7.5 percent in 2010). Based on this and several other payment adequacy indicators, as well as the national growth rate of hospice providers (a total of 2.5 percent from 2007 to 2010), MedPAC concluded that payment was adequate for care and recommended that hospice providers receive no update to the hospice payment rates for FY 2014. While the aggregate margin shows positive gains, separating out urban and rural providers shows that the growth of hospice providers in urban areas is not matched among rural hospice providers. The Committee finds that the rural-urban disparity in the growth rate of hospice providers in part may reflect underlying differences in ownership structure and financial health.

***RURAL MEDICARE BENEFICIARIES***

*Rural populations are disproportionately older than their urban counterparts, and this disparity will only increase as Baby Boomers continue to age. The elderly growth rates in non-metropolitan areas are expected to triple from 6 percent in 2000-2010 to 18 percent in 2010-2020.[21] Aside from being older, rural residents have higher rates of age-adjusted mortality, disability, and chronic illness than their urban counterparts.[22] As the elderly comprise a larger percentage of the rural population, access to high-quality end-of-life care in rural areas will become increasingly important.*

*Rural-Urban Differences in Ownership Structure*

The lower growth rate among rural providers is consistent with the lower number of rural for-profit and freestanding hospices. These facility types have primarily driven the recent growth in the number of hospice providers. Table 1 compares tax status and ownership structure between

[18] Chapter 12, MedPAC March 2013 Report. Data from MedPAC analysis of data from the denominator file and Medicare Beneficiary Database from CMS. Urban areas contain a core area with a population of at least 50,000 persons; micropolitan areas contain at least one population cluster of between 10,000 and 50,000 persons; rural areas adjacent to urban areas are rural counties adjacent to urban areas but without a city of at least 10,000 people; rural areas not adjacent to urban areas are rural counties not adjacent to urban areas and without a city of at least 10,000; and frontier areas are counties with no more than six people per square mile.

[19] Chapter 12, MedPAC March 2013 Report. Data from MedPAC Analysis of Medicare cost reports, Provider of Services file, and the standard analytic file of hospice claims from CMS. Of the 3,585 hospice providers in the U.S. in 2011, 985 or 27 percent were in a rural area. According to the 2009 Medicare Beneficiary Annual Summary File cited in Chapter 5 of MedPAC's June 2012 report, 23 percent of Medicare beneficiaries live in a rural area.

[20] *Ibid*.

[21] Economic Research Service. (February 2007). "Nonmetro America Faces Challenges From an Aging Population." (Rural Population and Migration Briefing). U.S. Department of Agriculture.

[22] Jones, CA, Parker TS, Ahearn M, Mishra AK, V Ariyam JN. (August 2009). "Health Status and Health Care Access of Farm and Rural Populations." U.S. Department of Agriculture. Economic Research Service. Economic Information Bulletin No. 57.

urban and rural hospice providers, showing that there are more government-owned hospices in rural areas as well as fewer freestanding and more hospital-based hospice facilities.

**TABLE 1: COMPARISON OF URBAN AND RURAL HOSPICE OWNERSHIP AND MARGINS**

| | Urban | Rural | Average Financial Margins in 2010 |
|---|---|---|---|
| **Ownership Status** | | | |
| For-Profit | 40.0% | 36.9% | +12.4% |
| Non-Profit | 51.2% | 47.5% | +3.2% |
| Government-Owned | 8.9% | 14.3% | N/A |
| | | | |
| **Facility Type** | | | |
| Freestanding | 74.2% | 60.5% | +10.7% |
| Hospital-Based | 9.5% | 22.7% | +3.2% |
| Home-Health-Based | 16.1% | 15.3% | -16.0% |
| Skilled-Nursing-Facility-Based | 0.3% | 0.2% | N/A |
| | | | |
| **Total** | 72.6% | 27.3% | 7.5% |

Source: 2010 Hospice Data Claims and Chapter 12, MedPAC March 2013 report.

Table 1 also shows the financial margins for each hospice provider type which reflect the trend in average cost per day: for-profit hospices receive nearly 25 percent more Medicare reimbursement than non-profit hospices and 33 percent more than government-owned hospices per beneficiary.[23] Higher average costs in hospital-based hospices may be due to higher overhead costs compared to freestanding hospice facilities.[24] However, in many rural communities, hospitals are the only source of health care; indeed, the proportion of hospital-based hospices in rural areas is more than double the proportion in urban areas.

*Rural-Urban Differences in Financial Margins*

Overall, financial margins for rural hospice facilities (5.3 percent) are slightly lower than urban hospice facilities (7.8 percent).[25] The Committee notes that aggregate margins exclude non-reimbursable bereavement and volunteer costs, meaning that hospices often have even lower margins than the data above indicate. The rural-urban difference in financial margins is driven in part by the greater rural prevalence of hospital-based hospices, but rural hospices also receive $17 less per day per beneficiary ($158 versus $141) after adjusting for the wage index.[26]

While rural hospice facilities experience a slightly greater median (17 versus 20 days) and mean (86.7 versus 91.2 days) lengths of stay, which are positively associated with profitability, their

[23] Department of Health and Human Services Office of the Inspector General. (July 2011). "Medicare Hospices that Focus on Nursing Facility Residents."

[24] Chapter 12, MedPAC March 2013 report. Table 12-9. Cost data from MedPAC analysis of Medicare hospice cost reports and Medicare Provider of Services data from CMS.

[25] Chapter 12, MedPAC March 2013 report. Data drawn from MedPAC analysis of Medicare hospice cost reports, 100 percent hospice claims, standard analytical file, and Medicare Provider of Services data from CMS.

[26] SAF Hospice Claims, 2011.

patients also follow different patterns of care. Rural hospice patients are more likely to receive care in their home than urban patients (63.8 versus 53.8 percent) and less likely to receive care in an inpatient setting, either in a hospital (9.8 versus 11.5 percent) or hospice (7.9 versus 16.6 percent). The greater amount of care provided in patients' homes may mean a greater number of visits by rural hospice care providers to patients' homes, longer travel time, and increased expense for hospice employees.

Rural patients are also more likely to receive exclusively routine home care than urban patients (81.2 versus 66.0 percent), and 91.8 percent of rural hospice patients compared to 83.0 percent of urban patients receive any routine home care. Because they receive a greater proportion of their care at this lowest level of intensity, rural patients also have lower average daily resource use than urban patients, although this difference largely disappears as length of stay increases beyond three months.[27] The higher share of routine home care days for rural providers decreases their average per diem reimbursement rate and may mean that proposals to rebase the routine home care payment rate at a lower level could have a disproportionate effect in rural areas.[28]

## DISCUSSION AND RECOMMENDATIONS

Given the more fragile financial margins and lower patient volume in rural areas, rural hospice providers face different challenges from their urban counterparts and one-size-fits-all policy reform may have negative consequences for rural hospice providers. Despite data indicating that hospice provider density in rural areas is comparable to and even higher than in urban areas, rural and frontier Medicare decedents continue to utilize hospice at lower rates than their urban peers. The Committee offers the below set of recommendations to the Secretary to better align the hospice program in rural areas to patterns of care utilization by rural Medicare beneficiaries. At a minimum, as Medicare hospice reform continues, the Committee recommends that rural hospice providers and other stakeholders be included in the conversation.

*Eligibility of PAs and Rural Health Clinic Practitioners to Furnish and Bill for Hospice Services*
Not all physicians, NPs, and PAs are eligible to be attending health care practitioners under the hospice benefit. The Committee recognizes that rural patients who discover their primary care provider is ineligible to act as an attending physician under the Medicare hospice benefit may choose not to enroll in hospice, or dis-enroll from hospice in order to maintain their primary care provider. The Committee supports the Secretary working with the Congress on a statutory change to allow PAs to be considered attending physicians under the Medicare hospice benefit in a similar manner as NPs. In the past year, HHS has taken steps toward addressing regulatory burden challenges for providers while also proposing regulations that would allow clinicians like PAs to practice to the full extent of their training and their individual state scope of practice. The Committee believes the field would benefit from both the Congress and HHS taking the same approach to the hospice benefit. The change may have a larger impact in rural areas, where nearly one in five rural Medicare beneficiaries receives all or some primary care services from an NP or PA.[29] Additionally, the Committee supports the Secretary considering ways to allow NPs

[27] *Ibid*.
[28] See 78 FR 27843-27844 for details on this proposal. In FY 2012, routine home care payment rates would be lowered $18.99 per day, from $153.45 to $134.46.
[29] MedPAC. (January 2013). "Assessing Payment Adequacy: Physician and Other Health Professional Services".

and PAs at rural health clinics to furnish hospice services in a way that will not result in duplicate payment, especially in areas with limited hospice providers.[30]

*Medicare Hospice Concurrent Care Demonstration*

The Committee is interested in the potential of the Section 3140 ACA-authorized demonstration to allow concurrent conventional and hospice care for Medicare beneficiaries to inform hospice care for both urban and rural beneficiaries and measure the cost impact. Such a demonstration might allow for more continuous care in rural areas, especially in cases where beneficiaries must change primary care providers to enroll in the hospice benefit. Alternatively, the Secretary could work with CMMI to fund this demonstration and include rural participation. Hospice and palliative care demonstration projects could provide data on staff requirements and documentation of care. Given the limited resources in rural areas, the Committee anticipates that such demonstrations might suggest greater scope of practice for NPs and PAs.

*Face-to-Face Requirements*

The ACA requires a hospice physician or nurse practitioner to have a face-to-face encounter with a hospice patient prior to the patient's 180th day re-certification, and each subsequent re-certification. This is burdensome for hospice physicians, especially in rural areas. The Committee has been advised that the implementation of this requirement has not resulted in the expected reduction in the number of recertifications anticipated. If this requirement continues to have a negligible effect on re-enrollment rates,[31] the Secretary should work with the Congress to reevaluate the benefits versus the costs of conducting regular face-to-face assessments in rural areas. We recommend that the Secretary explore whether or not the statute provides the flexibility of allowing telehealth consultations to count as face-to-face encounters in rural areas and to allow NPs and PAs to perform the face-to-face visits required for this purpose.

*Covered Service Requirements in Rural Areas*

Hospice-covered service requirements include medical appliances, supplies, and drugs. Rural hospices are often unable to contract with 24-hour pharmacies or more than one durable medical equipment supplier, which may lead to extra costs to procure these items if needed during the weekend or after hours. These increased costs may serve as additional disincentives for hospice providers to move into rural areas, especially if the metropolitan statistical area wage floor is higher than the rural wage floor. The Committee recommends that the Secretary examine allowing hospices serving rural areas greater flexibility in fulfilling covered service requirements that take into account potentially higher costs in rural areas such as for durable medical equipment and pharmaceuticals.

*Critical Access Hospital Cost Reimbursement for Hospice Services*

The Committee has noted previously its concern about how CMS requires CAHs to carve out hospice services in cost reporting and the impact this has on lowering a hospital's cost-based reimbursement rate.[32] The Committee believes this acts a regulatory barrier for CAHs to contract with hospice providers to offer services locally to hospice recipients in their service

[30] See comment request in 78 FR 9230. Medicare and Medicaid Programs; Part II – Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction published February 7, 2013.
[31] See SAF claims from 2009 and 2010 and MedPAC's March 2013 Report, Ch. 12, Table 12-7.
[32] See NACRHHS May 2010 Report.

area. The Committee recommends that the Secretary provide greater flexibility in cost reporting for CAHs to encourage more collaboration between hospice providers and CAHs.

*Cost-Based Reimbursement for Hospice Services in F-CHIP Demonstration*

The Committee finds that the Frontier Community Health Integration Project (F-CHIP) demonstration (discussed in the Committee's September 2012 policy brief) may provide an avenue to explore greater efficiency and accessibility of hospice and other extended care services in rural and frontier communities that could inform future policy (see text box below). The Committee recommends that the Secretary consider allowing for cost-based reimbursement for hospice services in the upcoming F-CHIP Demonstration.

***FRONTIER COMMUNITY HEALTH INTEGRATION PROGRAM DEMONSTRATION***

*Recognizing that hospitals are the primary and often only source of health care in frontier communities, the F-CHIP Demonstration was authorized to identify and revise "regulatory requirements" and "reimbursement policies" under the Medicare programs "to improve access to the range of health care services."*[33] *To be eligible to participate in the demonstration, CAHs must offer home health, hospice, or rural health clinic services. Given the documented challenges rural hospitals face in providing sustainable hospice services, the Committee encourages the Secretary to solicit participation in the F-CHIP Demonstration from low-volume critical access hospitals offering hospice services and apply the policy lessons from this demonstration to similarly situated hospitals around the country.*[34]

*Documentation Burdens*

On its site visits, the Committee heard widespread concern from hospital staff about current documentation burdens and their interference with patient care, taking up as much as one-third of their time. Particularly overwhelming is the obligation to demonstrate that patients are terminally ill on every visit – with failure to document leading to denial of claims. The Committee believes that documentation requirements are not supported by the long literature on terminal illness and as a result impose an undue burden without program benefit. The Committee calls for reconsideration of requirements like nursing care documentation in 15-minute blocks, finding that this imposes a burden on nursing staff that does not produce useful data. The Committee recommends that the Secretary request that the Institute of Medicine evaluate the current status of terminal prognoses and make recommendations concerning both documentation and medical review of such.

*Consistency of Medicare Administrative Contractors*

The Committee heard from hospice providers that inconsistency in evaluation of patient eligibility for the Medicare Hospice Benefit by Medicare Administrative Contractors (MACs) continues to be an issue. These inconsistencies may have a disproportionately significant effect among rural hospices, which generally have more fragile financial margins and less cash on hand to cover delays in reimbursement. The Committee recommends that the Secretary direct CMS to solicit feedback from rural hospices about specific instances of inconsistency between MACs and within the same MAC. It further recommends CMS work with MACs to address issues in evaluation of hospice charges and increase standardization on key issues like terminal prognosis.

[33] Section 123 of the Medicare Improvement for Patients and Providers Act of 2008 (P.L. 110-275).
[34] The Committee is aware that CMS has not yet released the Request for Proposal for the F-CHIP Demonstration.

*Travel/"Windshield Time"*

The Committee understands that CMS has not yet identified cost of care differences between urban and rural providers that arise from the time and expense of travel ("windshield time"). Moreover, discussions with rural providers and with program officials indicate that issue has not been the subject of dedicated or systematic study. One provider the Committee visited documented close to one million miles driven by staff and volunteers in 2012. The stakes are high for rural providers (and likely some urban providers, as well) and Committee recommends that the Secretary task CMS to re-evaluate this issue by doing a careful analysis of the cost of "windshield time" among providers.

*Palliative Care*

The Committee understands that the Medicare hospice benefit is one of many end-of-life care options including long-term care, home health services, nursing facilities, inpatient treatments, and palliative care. However, the Medicare hospice benefit only provides palliative care to its patients, who by definition must be terminally ill, with a prognosis of six months or less to live if the illness runs its normal course. The need for palliative care extends beyond the hospice benefit and that need cuts across a number of existing Medicare payment mechanisms including, but not limited to, the physician fee schedule, skilled nursing care, and home health services. This can be a challenge in rural areas given that access to the full range of palliative care services may be variable and more limited. The Committee believes further study is needed to better understand the relative access of rural Medicare beneficiaries to palliative services.