THE MEDICARE HOSPICE BENEFIT & RECENT CHANGES IMPACTING THE HOSPICE COMMUNITY

The Medicare Hospice Benefit:

- Established in 1983 to provide Medicare beneficiaries with access to high-quality end-of-life care.
- Last year, over 1.5 million Americans and their families benefitted from the hospice care model, a team-oriented approach to medical care, pain management, and emotional and spiritual support tailored to the patient’s needs and wishes during their final days.
- More than 88 percent of hospice patients are Medicare beneficiaries.  
- Medicare pays hospice a flat, per-diem rate that covers all aspects of the patient’s care, including all provider services and drugs as well as all medical equipment and supplies.
- While the number of beneficiaries using hospice has more than doubled since 2000, hospice comprises only 2 percent of total Medicare expenditures, the least of any direct patient service provider under the program.
- According to recent MedPAC data, hospice margins average only 2.8 percent.

Recent Rate Cuts: The hospice community has been subject to several regulatory and legislative changes in recent years. A 2009 CMS rule initiated a seven-year phase out of the Budget Neutrality Adjustment Factor (BNAF), a key element in the calculation of Medicare hospice wage index. Elimination of the BNAF will ultimately result in a permanent reduction in hospice reimbursement rates of approximately 4.2 percent. The Affordable Care Act (ACA) further altered the Medicare hospice rate formula through the introduction of a “productivity adjustment factor,” that will reduce annual hospice payments by an additional 11.8 percent over the next ten years. Hospice is a highly labor-intensive model of care where such productivity gains are not as achievable relative to other areas of our health care system. The Moran Company recently conducted an analysis of the impact of these two cuts on hospice margins over the next decade.

Moran Company Analysis - Estimated Median Profit Margins, 2008-2019 (All Hospices, Urban, and Rural Hospices)

![Graph showing hospice profit margins from 2008 to 2019]

3 - According to MedPAC’s 2010 projection, the average hospice margin is 4.6 percent. We use the 4.6 percent projection and subtract 1.5 percent (costs related to nonreimbursable bereavement services) and an additional .3 percent (costs associated with maintaining statutorily mandated volunteer services) to get 2.8 percent.
4 - The percentage is 2.8% after the statutory annual Market Basket update is taken into account.
PRESERVE AND PROTECT THE MEDICARE HOSPICE BENEFIT
Support the HELP Hospice Act

Action Requested: We are deeply concerned about the effect further modifications to the Medicare hospice benefit will have on quality patient care and access to these valuable services. The hospice community asks that the 112th Congress support the Hospice Evaluation and Legitimate Payment (HELP) Act, legislation to (1) require the Secretary to establish a payment reform demonstration program to test and evaluate any prospective payment revisions to hospice, (2) increase hospice survey frequency to every 3 years, and (3) amend the new face-to-face encounter requirement to reflect operational realities for hospice programs, and the needs of the patients and families they serve. The HELP Hospice Act has been introduced by Senators Wyden and Roberts (S. 722), and efforts for a House companion bill are underway.

1. Sensible Hospice Payment Reform

The ACA included a MedPAC recommendation to transfer hospice payment authority from Congress to the Secretary of Health and Human Services. MedPAC also recommended, and the ACA statute required, the Secretary to collect and analyze extensive data prior to implementing a new payment system for hospice, on or after fiscal year 2014. Noting a lack of reliable, comprehensive data upon which to base a new payment methodology,

The hospice community calls upon Congress to direct the Secretary to pilot any new payment methodology first through a two-year, 15-site demonstration program. This approach would help to overcome the current lack of reliable, comprehensive data upon which HHS can rely to evaluate potential payment methodologies. A pilot program allows for any recommended payment reform schemes to be tested across a representative sample of the hospice community to assess their impact on beneficiary access to hospice services.

COST: $3 million for the 2012-2021 budget forecast period.

2. More Frequent Hospice Surveys

An HHS Office of the Inspector General (OIG) report found that the current certification system for hospice was not providing sufficient oversight relative to other Medicare providers. OIG noted that “the frequency of hospice certification is far different from the certification frequencies required by nursing homes, hospitals, and home health agencies” and recommended regulatory or statutory changes to increase certification frequency. According to the report, the majority of hospices were surveyed within 6 to 8 years (depending upon available resources), while almost 15 percent averaged 3 years past due.

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6- All cost estimates in this document are based on a Moran Company assessment of budgetary implications of the hospice proposal, available upon request.
The hospice community urges Congress to institute a 3-year survey frequency requirement. This recommendation is consistent with the survey industry standard for hospices set forth by accrediting organizations, such as the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO).

COST: No cost under OMB score keep guideline 14.

3. Hospice Face-to-Face Encounter Adjustments

The ACA included the MedPAC recommendation to require a hospice physician or nurse practitioner to have a face-to-face encounter with a hospice patient upon election of the Medicare hospice benefit, before the end of 180-day recertification period and again for each 60-day recertification after that date. The hospice community supports the intent of the face-to-face encounter requirement and is working hard to be in compliance, even as the requirement stretches hospice physician and nurse practitioner resources.

The hospice community is asking that Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants also be allowed to conduct the face-to-face encounter, and that hospice programs be afforded 7 days after the initial election of services to fulfill the requirement. The current limits on who can conduct the face-to-face encounter and the tight timelines specified in the rule for compliance do not reflect the operational constraints of hospice programs, especially for small and rural hospices. Hospices may be forced to turn down certain patients seeking to elect hospice if they feel they will not be able to comply with the present timeline required to conduct the initial face-to-face encounter requirement.

COST: No cost associated with modifications to the face-to-face encounter requirement.

The National Hospice and Palliative Care Organization (NHPCO) is the largest nonprofit membership organization representing hospice and palliative care programs and professionals in the United States. The organization is committed to improving end of life care and expanding access to hospice care with the goal of profoundly enhancing quality of life for people dying in America and their loved ones.

8- OMB Circular A-11: “No increase in receipts or decrease in direct spending will be scored as a result of provisions of a law that provides direct spending for administrative or program management activities.”
Hospice Medicare margins, 2002-2008

Note: Figures are preliminary and subject to change. Margins exclude cap overpayments and non-reimbursable costs.

Source: MedPAC analysis of Medicare hospice claims and cost reports from CMS
Memorandum (March 17, 2011)

TO: Office of Health Policy, NHPCO
FROM: The Moran Company
SUBJECT: Summary of Profit Margin Analysis for Urban and Rural Hospices, 2009-2019

The 2010 Patient Protection and Affordable Care Act (ACA) and the 2010-2011 hospice payment rules have implemented the phase-out of the Budget Neutrality Adjustment Factor (BNAF), the annual hospital market basket adjustment, and the reduction to the market basket update due to a decrease in the productivity factor. The Moran Company estimated the effect of the changes on profit margins for Medicare-certified hospices, particularly hospices that serve patients in rural areas.¹

- We estimate that the median Medicare profit margin for the hospice industry could decrease from 4% in 2008 to -11% by 2019.
- Hospices that serve mostly rural patients would be the most severely affected (profit margin decreases ranging from 0% in 2008 to -16% in 2019).
- We estimate that 66% of hospices could have negative Medicare profit margins by 2019 (61% of moderately rural and 76% of mostly rural hospices).

### Summary of Analysis

Hospices were classified as urban (less than 50% of patient days in a rural county), moderately rural (50-74% rural) or mostly rural (75%+ rural) using the 2008 100% Medicare Standard Analytic Files (Table 1).

Using cost and revenue data from the Hospice Cost reports and the Medicare claims data, we calculated Medicare profit margins per patient day for each hospice and estimated 2009-2019 profit margins based on the three policies affecting hospice rates (Table 2).²

We estimate that median Medicare profit margins for all hospices would decrease from 4% in 2008 to -11% by 2019 when applying the market basket update to costs (Figure 1).³ For urban hospices, median profit margins are estimated to decrease from 6% to -10%. Profit margins are also estimated to decrease significantly for rural hospices (0% to -16% for mostly rural hospices and 9% to -6% for moderately rural hospices). We estimate that the percent of hospices with negative profit margins would increase from 43% in 2008 to 66% in 2019 (Figure 2). The percent

### Table 1: Urban and Rural Composition of Hospices Included in Trend Analysis

<table>
<thead>
<tr>
<th></th>
<th>Number of Hospices</th>
<th>Percent of Hospices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>1,618</td>
<td>76%</td>
</tr>
<tr>
<td>Rural</td>
<td>513</td>
<td>24%</td>
</tr>
<tr>
<td>50-74% Rural</td>
<td>85</td>
<td>4%</td>
</tr>
<tr>
<td>75-100% Rural</td>
<td>418</td>
<td>20%</td>
</tr>
<tr>
<td>Total</td>
<td>2,131</td>
<td></td>
</tr>
</tbody>
</table>

¹ This memorandum summarizes the findings of an October, 2010, study. Please see the complete memorandum for more detail on the methodology employed for this analysis and results.

² Profit Margin = \((\text{Medicare revenue/patient day} - \text{Total reimbursable/bereavement/volunteer costs/patient day}) / \text{Medicare Revenue/patient day}\)

We do not account for hospice repayments associated with the “cap” policy. Additionally, this analysis relies upon Medicare hospice cost reports which may contain errors and variations in the completeness of reporting.

³ We report trends using median profit margins rather than mean profit margins because of considerable variability and incompleteness in cost report data resulting in extreme high and low values.
of hospices with negative margins that service mostly rural areas would increase from an estimated 50% to 76%, and would increase from 39% to 61% for moderately rural hospices.

Table 2: Assumptions for Calculating Changes in Revenue and Costs for Hospice Profit Margin Trend Analysis, 2009-2019

<table>
<thead>
<tr>
<th>Effective Date (October 1)</th>
<th>Hospital Market-Basket Increase</th>
<th>Annual Percent Reduction for BNAF Phase-Out</th>
<th>Estimated Productivity Factor</th>
<th>Annual Change in Revenue</th>
<th>Market Basket Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>2.4%</td>
<td>-1.6%</td>
<td>0.8%</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>2.4%</td>
<td>-1.6%</td>
<td>0.8%</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>2.4%</td>
<td>-1.6%</td>
<td>0.8%</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>2.4%</td>
<td>-1.6%</td>
<td>0.8%</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>2.4%</td>
<td>-0.4%</td>
<td>0.4%</td>
<td>2.4%</td>
<td></td>
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<tr>
<td>2014</td>
<td>2.4%</td>
<td>-0.4%</td>
<td>0.4%</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>2.4%</td>
<td>-0.4%</td>
<td>0.4%</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>2.4%</td>
<td>-0.4%</td>
<td>0.4%</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>2.4%</td>
<td>-0.4%</td>
<td>0.4%</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>2.6%</td>
<td>-0.3%</td>
<td>2.1%</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>2.4%</td>
<td>-0.3%</td>
<td>2.1%</td>
<td>2.4%</td>
<td></td>
</tr>
</tbody>
</table>

1 CBO estimates for 2012-2019; values provided for 2009-2011 are actual market-basket increases.
2 BNAF reduction, 7 year reduction of 4.2%; beginning at 6.1775% in 2010. This reduction is only applied to the wage portion of the hospice rate (68.7%).
3 Productivity reduction- 1.3% for all providers with 0.3% delay to 2013 from 2010 Patient Protection and Affordable Care Act (ACA).

Figure 1: Estimated Median Profit Margins, 2008-2019

Figure 2: Estimated Percent of Hospices with Negative Profit Margins, 2008-2019
EXECUTIVE SUMMARY

OBJECTIVE
To assess, for Medicare hospices certified by State agencies:
1. the timeliness and results of hospice certification surveys performed by State agencies, and
2. the extent of the Centers for Medicare & Medicaid Services (CMS) oversight of the Medicare hospice program.

BACKGROUND
Medicare Part A covers hospice care provided to terminally ill patients. In recent years, this Medicare benefit has grown in terms of patients served, expenditures, and number of hospices.

Organizations that provide hospice care must be certified by State agencies as meeting minimum participation standards prescribed by CMS. CMS uses Federal comparative surveys and annual performance reviews to evaluate State agencies’ survey and certification operations. Certified hospices must undergo recertifications; however, neither law nor regulation specifies the frequency of recertification. Instead, CMS notifies States of the certification frequency for hospices through its annual budget request policy memorandum to the State agencies. For fiscal year (FY) 2005, CMS scheduled hospice certification surveys for every 6 years, but for FY 2006, CMS changed the frequency to every 8 years on average. This change was the result of budget reductions.

Whether 6 years or 8 years, the frequency of hospice certification is far different from the certification frequencies required for nursing homes, hospitals, and home health agencies. While the priority for hospice certification may be lower, CMS did direct State agencies, for FY 2006 surveys, to target 5 percent of the hospices most at risk for having quality problems. Using the results of certification surveys and complaint investigations, CMS has the authority to apply only one enforcement remedy—termination of poorly performing hospices from Medicare.

The report findings are based primarily on analysis of data from CMS’s Online Survey Certification and Reporting system. We analyzed these data for 2,537 hospices that were certified by State agencies and were Medicare providers as of July 5, 2005. We also interviewed staff at CMS headquarters and regional offices, State agencies, and professional organizations knowledgeable about hospice issues.
FINDINGS

Eighty-six percent of hospices were certified within 6 years, as required, while 14 percent averaged 3 years past due. Hospices that were 3 years past due for certification had not been surveyed for 9 years—3 years longer than the CMS standard at the time of our review. Two CMS regions accounted for 56 percent of the past-due hospice certifications: Region V (33 percent) and Region IX (23 percent). Only 24 percent of all certified Medicare hospices are located in these two regions.

Applying an 8-year certification frequency to our hospice data decreased the percentage of past-due certifications from 14 percent to 9 percent. However, because the FY 2006 standard is an average rather than a defined interval, it is possible that a State agency could certify some hospices less often than every 8 years and still meet the requirement.

Health deficiencies were cited for 46 percent of hospices surveyed and for 26 percent of hospices investigated for complaints; many deficiencies related to patient care. The most frequent health deficiencies cited during certification surveys and complaint investigations centered on patient care planning and quality. These deficiencies indicated that written care plans either were not prepared or lacked important elements, or that measures to ensure quality patient care were insufficient. Fifteen percent of hospices surveyed between July 2002 and July 2005 received another citation for the same deficiency cited during a previous survey. Of the hospices with deficiencies cited during complaint investigations, 49 percent were also cited for the same deficiencies during certification surveys over the same period.

CMS and State agencies rarely use methods other than certification surveys and complaint investigations to monitor or enforce hospice performance. CMS rarely includes hospices in Federal comparative surveys or annual State performance reviews. Further, both CMS and State agencies infrequently analyze existing hospice performance data. Finally, hospice deficiency data from certification surveys do not include ratings for scope (how many patients are affected) and severity (extent to which patients’ safety or health is affected), and individual patient assessment data for hospices are not available. For all these reasons, targeting at-risk hospices, as CMS required for FY 2006, may be difficult for State agencies. CMS has not provided State agencies any direct guidance or specific criteria to identify the at-risk hospices. From July
2002 to July 2005, CMS terminated one hospice from Medicare, and few State agencies exercised their own enforcement measures.

RECOMMENDATIONS

To improve oversight of the Medicare hospice program, we recommend that CMS:

**Provide guidance to State agencies and CMS regional offices regarding analysis of existing data and identification of at-risk hospices.** CMS should provide written guidance and/or training that specifies key performance indicators or analysis techniques for hospice data. CMS should also include in its written guidance and/or training how States should identify, using analysis of available data, which hospices are at risk for quality problems. Instituting scope and severity ratings similar to those used for nursing facility deficiency data could provide another method for identifying at-risk hospices. Alternatively, CMS could develop a standard set of indicators for hospice performance, complete data analysis centrally, and ensure that resulting reports are routinely provided to CMS regional office and State agency staffs.

**Include hospices in Federal comparative surveys and annual State performance reviews.** These surveys and reviews allow CMS to ensure that State agencies meet CMS's performance requirements and to understand overall State agency operations.

**Seek regulatory or statutory changes to establish specific requirements for the frequency of hospice certification.** Section 1861(dd)(2)(G) of the Social Security Act allows the Secretary to promulgate other regulatory requirements for hospices. CMS should seek a regulatory change that would specify a fixed certification frequency for Medicare hospices with commensurate funding for staffing and implementation. In lieu of a regulatory change, CMS could pursue a statutory change and related funding. Such regulatory or statutory and related budgetary changes could help to ensure that CMS maintains its certification schedules for hospices.

CMS should also seek to increase the frequency of hospice certifications as part of the regulatory or statutory change. The accrediting organizations, the Joint Commission for the Accreditation of Healthcare Organizations and the Community Health Accreditation Program, have set an industry standard of certification every 3 years for hospices. For
EXECUTIVE SUMMARY

CMS, surveys of hospices are the primary method for gaining information about hospice performance in caring for patients.

**Seek legislation to establish additional enforcement remedies for poor hospice performance.** Currently, CMS’s only enforcement remedy against poorly performing hospices is termination of the hospice from the Medicare program. Our results showed that termination is rarely imposed. Less severe remedies could be effective for addressing performance problems that do not merit termination. A potential array of enforcement measures could include directed plans of correction, directed in-service training, denials of payment for new admissions, civil monetary penalties, and imposition of temporary management.

AGENCY COMMENTS

In its comments on the draft report, CMS concurred with the recommendation to provide greater guidance concerning analysis of existing data and identification of at-risk hospices. To this end, CMS reports exploring and implementing methods to become more efficient in targeting its limited resources toward providers most in need of closer oversight. CMS also concurred with the recommendation to include hospices in annual State performance reviews. However, CMS did not concur with greater inclusion of hospices in Federal comparative surveys, citing budget limitations. Additionally, CMS did not concur with the recommendation that it make a regulatory change to establish frequency requirements for hospice certification. CMS stated that, given resource issues, a statutory change, necessitating congressional action, is more appropriate. Finally, CMS is still considering the last recommendation: to pursue new enforcement remedies for poor hospice performance.

OFFICE OF INSPECTOR GENERAL RESPONSE

We continue to recommend that CMS include hospices in the Federal comparative surveys and set a frequency requirement for hospice certification. We acknowledge that this frequency requirement can be set by a statutory change. Consequently, we changed the recommendation that was included in the draft report to include the option of seeking the requirement through either a statutory change or a regulatory change. We look forward to CMS’s comments on this final report addressing its consideration of establishing additional enforcement remedies for poor hospice performers.
Assessing the Budgetary Implications of Legislation to Amend the Hospice Payment Reform Provisions of the Affordable Care Act

March 2011

The Moran Company
Assessing the Budgetary Implications of Legislation to Amend the Hospice Payment Reform Provisions of the Affordable Care Act

The Medicare hospice benefit offers terminally ill Medicare beneficiaries an alternative to the continuation of end-of-life medical care for terminal conditions. Under this benefit, beneficiaries who elect to forego their regular benefits under Medicare Parts A and B for their terminal conditions become entitled to alternative benefits not available to regular Medicare beneficiaries, including palliative care and psycho-social support services for both the beneficiaries and their families.

Section 3132 of the Affordable Care Act of 2010 (ACA) amended existing hospice program requirements in two ways:

First, subsection 3132(a) directed the Secretary to collect additional data required to develop revisions to the hospice payment policy for “routine home care and other services,” to be implemented no earlier than October 1, 2013. That provision permits, but does not require the Secretary to provide for “…adjustments to per diem payments that reflect changes in resource intensity…during the course of the entire episode…” The Secretary is required to consult with both MedPAC and providers regarding implementation of this policy. The Secretary is required to establish such adjustments in a manner that is budget neutral.

Second, subsection (b) establishes a new patient certification requirement, under which patients being recertified for total hospice episodes in excess of 180 days must have a face-to-face encounter with a physician or nurse practitioner in order to determine eligibility for recertification.

The hospice provider community is presently evaluating legislative changes to the policy of Section 3132 of the ACA. The policy under evaluation has three components:

- It would amend the requirement for face-to-face assessments at recertification by making the timing requirements more flexible and expanding the types of health professionals permitted to conduct the assessments.

- It would require the Secretary to conduct a two-year demonstration of whatever payment policy modifications were developed prior to national implementation. The demonstration would be limited to 15 provider sites that voluntarily enrolled in the program. Payment variation relative to current law would be capped at +/- 5%.

- It would create an additional certification requirement, requiring hospices to be subject to an initial survey by an appropriate regulatory or accreditation body within six months of beginning operations, with follow-up surveys every three years thereafter.

The Moran Company was engaged by the National Hospice & Palliative Care Organization to assess the budgetary implications of the policy under consideration. Our assignment was to evaluate how the Congressional Budget Office (CBO) might “score” this policy, if it were being actively considered in the legislative process.

THE MORAN COMPANY
Our findings are as follows:

- If CBO interprets the provisions related to face-to-face encounters as increasing flexibility for compliance rather than substantively changing the requirement, we believe they will conclude that these provisions will have no effect on the rate of recertifications, and hence will have no budgetary effect.

- CBO’s score of the demonstration provisions will turn on exactly how the language implementing the policy is drafted.

- Under the language we were asked to review, participation in the demonstration would be voluntary, and payment variations would be capped at +/- 5% relative to payments under current law.

- Under that exact policy, we assume that CBO would conclude that selection bias associated with voluntary enrollment decisions would cause total payments to exceed what would be spent under current law, resulting in a positive score.

- Given the very small population of hospices permitted to participate, and the short duration of the demonstration, we estimate that the overall cost to the Medicare program would be approximately $3 million over ten years (2012-2021).

- We do not believe that the expanded survey requirement would be found by CBO to have budgetary effect.

In the balance of this report, we provide the rationale underlying these findings.
Estimating the Effect of the Proposed Policy: Face-to-Face Encounters

We understand the language of the proposed amendments to the face-to-face encounter requirements to establish timelines and methods for compliance that are more flexible relative to the implemented requirement, particularly in rural areas where access to appropriate practitioners may be limited. If CBO interprets the effects of these requirements in this way, we would expect them to conclude that these provisions have no budgetary effect.

Estimating the Effects of the Proposed Policy: Two-Year Demonstration

While the proposed demonstration policy would have the effect of delaying implementation of the new payment policy nationwide by two years, we would not expect CBO to assign a score to this delay in and of itself, because the policy, when implemented, is required to be budget neutral.

CBO’s evaluation of the demonstration provisions would turn on what CBO assumed about the payment policy likely to be implemented in the demonstration. The language of section 3132 is consistent with—but does not require implementation of—a payment policy recommended by the Medicare Payment Advisory Commission (MedPAC), under which payments for routine care services would be increased at the beginning of a hospice episode and prior to death. Under the MedPAC recommended policy, payments would be adjusted to account for variations in service intensity, with offsetting reductions in other periods to maintain budget neutrality. Under this so-called “U-shaped” payment policy, average per diem payments would increase for hospice providers whose length of stay was shorter than average, while average payments per day for providers with above-average durations of hospice care would decrease.

If CBO were to assume that this sort of payment policy would be tested in the demonstration, CBO would be likely to conclude that spending under the demonstration would increase, in 2013 and 2014, to reflect selection bias. Since the demonstration is, as presently drafted, voluntary, it is likely that CBO would conclude that providers who anticipated payment increases under the policy would apply to participate, while those anticipating decreases would decline to apply. If CBO assumed that provider knowledge of outcomes under the policy was perfect, it would score a 5% increase in spending in the 15 participating hospices—the maximum increase permitted under the proposed amendment as presently drafted. Given that there is some degree of uncertainty regarding how individual providers would fare under the policy, it is possible that they would apply a “probabilistic” estimate that the increase might average only 50% of that amount. Applying this logic, our estimates assume that spending on routine care days would increase by 2.5% in 2013 and 2014 in the 15 participating hospices.

To estimate the impact of the demonstration, we developed a model to project payments for routine care days in 2013 and 2014, the years in which the demonstration would be in effect. We project that 88.2 million days of routine care would be provided at an average payment per day of $149.28 in 2013 (adjusted for current law update policy post payment adjustments).
Given the small size of the demonstration, the amount of affected payments is not large. Fifteen providers constitute only 0.44% of the total number of hospice providers recorded in the Medicare Online Survey & Certification Online reporting system (OSCAR) in 2010. Assuming that the 15 providers, in the aggregate, would be of nationally average size, we estimated that routine care payments in 2013 to these providers would be $58 million, and that a 2.5% net payment increase for these providers would result in increased payments of $1.4 million in 2013, and would be slightly higher in 2014.¹

**Estimating the Effects of the Proposed Policy: Survey and Certification Requirement**

With respect to the question of whether more frequent survey and certification activity would reduce or increase spending, it is our opinion that CBO would decline to find a budgetary effect because Scorekeeping Guideline 14 directs CBO not to score lower spending or increased revenues resulting from program management activities.² We also expect that CBO would ignore whatever cost it would estimate for conducting more frequent surveys, since the legislation, as drafted, does not increase the statutory Limitation on Administrative Expenses imposed on CMS. CBO generally proceeds from the assumption that authorizing legislation changes do not bind the appropriations Committees to provide higher funding levels.

**Estimates of Legislation as Presently Drafted**

As presently drafted, our estimate of the likely score of the proposed legislation is as follows:

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<tbody>
<tr>
<td>Increased payments under demonstration ($M)</td>
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<td></td>
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<td>$0</td>
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<td>$3</td>
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As indicated above, the score associated with the demonstration is nominal, totaling only $3 million over the forecast period.

¹ Due to fiscal year timing effect, payments might be slightly lower in 2013, and trail out into 2015. In this presentation, however, we ignore these effects.

**THE MORAN COMPANY**