The **Measures That Matter** in Hospice Care

A Resource for Health Plans, Health Systems, Accountable Care Organizations and Other Risk-Bearing Entities

Produced by an Independent Panel of Healthcare Experts

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Introduction

Over an 18-month period from July 2023 through December 2024, a panel of hospice and value-based care experts met on a recurring basis to identify which hospice measures, out of over 40 readily available, are the most valuable for assessing hospice performance.

The aim of this report is to provide in-depth descriptions of the most important measures and recommend those that stood out as most useful in assessing hospice performances in the context of value-based care.

Through the Value-Based Insurance Design (VBID) Model, CMS began enabling Medicare Advantage plans to develop hospice networks which can have a direct impact on the quality and cost effectiveness of care. While the VBID Hospice Benefit Component was discontinued on December 31, 2024, a full carve-in of hospice into the Medicare Advantage benefit could still occur and would lead to widespread hospice network development activities.

Accountable Care Organizations in the REACH and MSSP models already have hospice carved into their benchmarks and they have begun to guide their patients to preferred hospice partners.

Some hospitals have also begun to analyze hospices based on performance metrics such as HCA Healthcare's *Plus Care Network*. HCA is the largest hospital system in the U.S. operating 186 hospitals.

As health plans, accountable care organizations (ACOs), and other risk-bearing entities begin to identify preferred hospice partners, they will need expert guidance on the best approach for understanding and analyzing hospice performance. Hospice care is complex, and the measures can be difficult to understand.

In recommending measures, we sought to identify measures that were:

- **Readily available** to stakeholders. This limited our focus to publicly available CMS measures, and easy to calculate claims-based measures, while staying away from new complex calculations.
- **Reportable** for most hospices. Some measures, like 30-day readmission rates are only available for about 20% of hospices, while others such as HCI measures are often available for >80% of hospices.
- **Differentiating** between hospices. For each measure, the expert panel reviewed top and bottom deciles, focusing on measures with meaningful differences between averages for top or bottom performers.
- **Unique** in our recommendations. Some measures such as HCI measure 10 on 'Visits at the End of Life' and Hospice Visits in the Last Days of Life (HVLDL) measure such similar outcomes that only one was recommended.

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Chapter 1: Understanding **Live Discharges**

Evaluating the rate of live discharges, with an appreciation for all the nuances, is an important step in creating high-performing hospice networks. Measures related to live discharges are an important indicator of quality but can be difficult to interpret without an understanding of how, when, and why they occur.

In most cases, a hospice patient is discharged from hospice care when they die. However, hospice patients may also be discharged alive for the following reasons:

- **Revocation:** A hospice patient or a representative of the patient may choose to revoke the election of hospice at any time and for any reason. This includes if they decide to pursue treatments that are not included in the hospice plan of care. The election of the hospice benefit is the patient's choice. A hospice program cannot revoke a patient's hospice election.
- **Eligibility:** Medicare coverage of hospice depends on a physician's certification that an individual's prognosis is a life expectancy of six months or less if the terminal illness runs its normal course. But the prognosis is based upon judgement, which introduces some error and improbability. If a hospice determines a patient is no longer terminally ill or has a longer life expectancy, they are no longer eligible and are discharged.
- **Moved from Area:** If a patient moves out of the hospice's service area, they are discharged and may or may not elect hospice in the new area. "Moved from area" includes the patient moving to a facility where the hospice does not have a contract.
- **Transfer:** A patient may transfer between hospice agencies, but only once in each benefit period. A transfer could be patient or provider initiated.
- **Cause:** The hospice determines the patient meets their internal policy regarding discharge for cause. A hospice may discharge a patient in certain situations, such as the safety of the hospice staff, but it may not automatically or routinely discharge patients at its discretion, even if their care will be costly or inconvenient.

The live discharge rate is determined by dividing the number of hospice patients that were *discharged alive* during a period (usually a calendar year) by the total number of hospice dispositions during that same period. The number of hospice dispositions is the sum of live discharges and hospice deaths during the period. A single beneficiary may account for more than one live discharge if they were discharged alive, readmitted, and then discharged alive again.

Live discharge rates, and the breakdown by discharge reason, vary greatly by state, influenced by many factors, including the level of competition and 'churn' in the hospice market. Table 1 shows the overall live discharge rate for select states, as well as the breakdown in live discharges by reason.

***Table 1:** Live Discharge Rates by Reason in 2021. States are highlighted to indicate the highest (red) and lowest (green) rates in the US in 2021.*

HOSPICE STATE	Overall Rate	REVOCATION	NO LONGER ELIGIBLE	MOVED	HOSPICE TRANSFER	FOR CAUSE
ALL STATES	17.7%	35.0%	37.0%	12.0%	14.0%	1.7%
CALIFORNIA	31.3%	40.0%	34.0%	11.0%	14.0%	1.0%
ALABAMA	25.2%	45.0%	35.0%	8.0%	11.0%	1.2%
DISTRICT OF COLUMBIA	25.2%	7.0%	65.0%	10.0%	7.0%	10.0%
NEW YORK	13.2%	28.0%	47.0%	21.0%	3.0%	0.3%
TEXAS	23.8%	34.0%	32.0%	11.0%	19.0%	3.1%
LOUISIANA	19.7%	35.0%	24.0%	18.0%	19.0%	3.6%
MONTANA	14.1%	28.0%	56.0%	3.0%	11.0%	1.0%
VERMONT	10.7%	32.0%	48.0%	3.0%	16.0%	0.0%

What happens to patients after a Live Discharge?

As shown in Table 2, nearly 35% of patients that experienced a Live Discharge in 2021 died within 3 months, and a cumulative 73% died within 12 months, while nearly 27% were still alive 12 months after live discharge.

***Table 2:** 2021 Live Discharges by Death Interval*

	DIED WITHIN 3 MONTHS	DIED WITHIN 6 MONTHS	DIED WITHIN 12 MONTHS	DIED AFTER 12 MONTHS	STILL LIVING	TOTAL
ALL STATES	35%	12%	13%	14%	27%	100%

HealthPivots provided data on which of these same live discharges ended up back in hospice (either the original hospice or a different hospice), as well as how many died without hospice or survived past 12 months. Of all patients in all states that experienced a Live Discharge in 2021:

- 26% were readmitted and died in their original hospice
- 27% were readmitted and died in a different hospice
- 20% died without hospice
- 27% are still alive in 2023

Hospice use patterns after live discharge also vary by state, as shown in Table 3.

***Table 3:** Patient status post Live Discharge in 2021*

HOSPICE STATE	DIES IN SAME HOSPICE	DIED IN OTHER HOSPICE	DIED WITHOUT HOSPICE	STILL LIVING IN 2023	GRAND TOTAL
CALIFORNIA	18%	26%	19%	37%	100%
NEVADA	19%	31%	19%	32%	100%
ARIZONA	21%	32%	16%	31%	100%
DELAWARE	27%	24%	19%	29%	100%
TEXAS	21%	33%	18%	29%	100%
ALL STATES	26%	27%	20%	27%	100%
TENNESSEE	28%	27%	23%	22%	100%
CONNECTICUT	28%	26%	25%	21%	100%
NEW YORK	28%	10%	42%	21%	100%
DISTRICT OF COLUMBIA	32%	15%	32%	20%	100%
WYOMING	27%	26%	28%	19%	100%

Note: 4 of the 5 states (Arizona, California, Nevada, and Texas) with the highest rates of patients "Still Living" were identified by The Centers for Medicare & Medicaid Services (CMS) to undergo enhanced oversight[1] due to growing concerns of fraud and abuse.

When are Live Discharge rates an indicator of poor-quality care?

The Hospice Care Index (HCI) includes four measures related to live discharges. Our expert panel reviewed these measures (and others) and identified three categorical causes of live discharges that may indicate poor quality care, and the measure that tracks each of them.

- **Poorly managed admissions** can lead to early hospice revocations. Patients may revoke due to a lack of understanding that hospice focuses on symptom management, not interventional treatments. Hospices may also discharge patients if they are unknowingly admitted while still scheduled for treatments that aren't palliative. These situations would lead to a higher rate of **Early Live Discharges (HCI Measure 3)**, defined as live discharges within seven days of admission, divided by total live discharges.

- **Poorly managed care** of the sickest patient leading to hospitalization can also lead to live discharges. This is especially true of hospices that do not provide or have arrangements to provide General Inpatient Care (GIP) or Continuous Home Care (CHC). Based on 2024 Medicare fee-for-service claims data, 55% of hospice programs do not bill for any GIP or CHC levels of care, while 33% bill for some GIP care, 12% bill for some CHC care and only 4% bill for both GIP and CHC levels of care. In these cases, hospices may inappropriately initiate the live discharge so the patient can receive emergency department or inpatient care while avoiding having to pay the costs. There are two measures to assess the rate of these discharges:

- **Burdensome Transitions – Type 1 (HCI Measure 5)** tracks the percent of live discharges that are sent to the hospital and re-enrolled in hospice within 2 days of hospital discharge.
- **Burdensome Transitions – Type 2 (HCI Measure 6)** tracks the percent of live discharges that are sent to the hospital within 2 days of hospice discharge and die in the hospital.

- **Admissions of too many long stay patients** or questionably eligible patients can lead to elevated live discharges. The Medicare hospice benefit is only available to Medicare enrollees who are terminally ill with a life expectancy of 6 months or less, if the disease follows its normal course. If a hospice determines a patient is no longer terminally ill or has a longer life expectancy, they are no longer eligible and should be discharged. This increases **Late Live Discharges (HCI Measure 4)**, defined as live discharges more than 180 days after admission, divided by total live discharges. Hospices may pursue long stay patients as the care needs are low leading to higher profit margins, and this can lead to a higher rate of late live discharges.

All these factors, and more, may also lead to higher overall rates of **Live Discharges**, calculated as the live discharges divided by total dispositions (death + live discharges).

Appropriate Live Discharge & Burdensome Transition Rates

Hospice providers are expected to have some live discharges. Even top performing hospices have patients that change their mind about using the hospice benefit, move out of the area, or no longer meet the hospice eligibility criteria. In 2024, the national live discharge rate was 19.0% per the Hospice Monitoring Report[2]. While this does mean that live discharge rates that are very low may indicate the hospice is declining to admit patients that may qualify for the hospice benefit, the consensus is that high live discharge rates are of most concern. Based on our expert panel's consensus, the live discharge rates over 30% are considered high and over 50% are considered excessively high.

Table 4 shows the rates for each live discharge measure we just discussed, broken down by percentiles. Examining the 75th and 90th percentiles offer insight into the performance of the hospices with the worst rates on these measures.

***Table 4:** Live Discharge & Burdensome Transition rates, by decile & quartile (source: 2024 Medicare FFS claims)*

Statistic	% Live Discharges	Early Live Discharges	Late Live Discharges	Burdensome Transitions, Type 1	Burdensome Transitions, Type 2
10th Percentile	10%	0	21	0	0
25th Percentile	15%	3	30	3	0
National Average (Mean)	19%	7	40	8	2
75th Percentile	47%	10	48	12	4
90th Percentile	86%	14	57	18	6

Live discharge rates also vary widely by state, and across hospice organizations. Table 5 compares two very different states. In Florida, which has CON and as a result has a smaller number of hospice programs, no hospices had 'excessively high' discharge rates (>50% live discharges. In California, which has

experienced a boom in new hospice programs, 47% of the hospice organizations in California have excessively high live discharge rates (>50% live discharges) and an additional 22% have rates above 30%.

***Table 5:** Percentage of Hospices in Florida and California with high rates of Live Discharges in 2022*

	# of Hospices with Reportable Data	Average Live Discharge Rates	% Hospices with Rates > 30%	% Hospices with Rates 30% to 50%	% Hospices with Rates > 50%
FLORIDA	48	18%	87%	13%	0%
CALIFORNIA	943	29%	31%	22%	47%

Chapter 1 Summary

Typically, when a patient elects hospice care, they choose a care plan that focuses on controlling symptoms, managing distress, and easing caregiver burden. Most prefer to die in the home setting and avoid nonbeneficial hospitalizations. Live discharges that result in a hospitalization, or a hospital death, are in direct contrast to these goals. They are also very costly and run counter to the aims of value-based care.

Of the five measures discussed in this chapter, the overall rate of Live Discharges and Burdensome Transitions Type 1 & 2 are the most important in understanding the quality of care provided. The HCI measures of Early Live Discharges and Late Live Discharges add additional context, but do not work well as standalone measures as hospices with appropriately low rates of Live Discharges may have a disproportional percent occurring early or late.

- Most important measures from this chapter: Live Discharges (Claims), Burdensome Transitions – Type 1 (HCI Measure 5), Burdensome Transitions – Type 2 (HCI Measure 6).
- Optional measures from this chapter: Early Live Discharges (HCI Measure 3), Late Live Discharges (HCI Measure 4).

Chapter 2: Understanding **Level of Care** and **Care Settings**

Understanding where and when patients are admitted to hospice, the levels of care, and the different care settings is critical to designing a high performing hospice network. The Centers for Medicare & Medicaid Services (CMS) requires hospices be able to provide all four levels of care as a condition of participation[3]. However, an analysis of 2024 Medicare fee-for-service claims data shows that most Medicare-certified hospices are only providing Routine Home Care (RHC) days. Hospices that cannot adequately support patients during a crisis have higher rates of live discharges and costly burdensome transitions.

What are the four levels of care?

- **Routine Home Care** (RHC) is the most common level of hospice care. RHC is provided at the patient's residence, which can include a private home, assisted living facility or nursing facility. Most patients (87.6%) begin hospice care at the RHC level, and RHC days account for 98.7% of all hospice patient days. Hospice staff visit patients about 4 times per week on RHC days, and those admitted at the RHC level receive an average of 78 total days of care.
- **General Inpatient Care** (GIP) is an intensive level of hospice care provided in a Medicare certified hospital, hospice inpatient facility, or skilled nursing facility that has registered nurses available 24 hours a day to provide direct patient care. GIP care is indicated when symptom management or rapid changes in condition cannot be safely and effectively managed in another setting.
- **Continuous Home Care** (CHC), also referred to as "crisis care", is intended for brief periods of crisis to maintain the terminally ill person at home. CHC can be delivered at a private home, within an assisted living facility (ALF), or in a long-term care nursing facility. CHC involves 8-24 hours of visits, which must be predominantly nursing care, in a 24-hour period (from midnight-to-midnight). Utilization of this level of care is very low. A major challenge providers face in providing CHC is having an adequate staff available. In addition, administrative requirements for billing for CHC care are commonly perceived as an obstacle to programs providing this level of care as many patients may have 8 hours of care over 2 calendar days, but that does not qualify for CHC due to the midnight-to-midnight requirement.
- **Inpatient Respite Care (IRC**) is provided in an approved facility on an occasional basis to relieve family caregivers for up to 5 consecutive days incrementally throughout the course of care as the need for respite arises. Respite care is typically provided in a Medicare participating hospital or hospice inpatient facility, or a Medicare or Medicaid-participating nursing facility. The facility providing respite care must have sufficient 24-hour nursing personnel to ensure that patient's needs are met. Respite care may be provided on an occasional basis and may not be reimbursed for more than 5 consecutive days at any one time. Payment for the sixth and any subsequent day of respite care is made at the routine home care rate, and the patient would be liable for the cost of room and board. Respite care cannot be provided to hospice patients who reside in a facility (such as a long-term care nursing facility). Inpatient respite care utilization is very low which may be due to several factors, including unmet patient and family needs, but also lack of bed availability in a hospital or nursing facility, or the requirement that the patient must transfer to a facility to receive respite care.

***Table 6:** Distribution of patients and days by first level of care for 2022*

FIRST LEVEL OF CARE	% OF PATIENTS	DAYS PER PATIENT	% OF DAYS AT RHC	% OF DAYS AT GIP	% OF DAYS AT CHC	% OF DAYS AT IRC
RHC	87.6%	78	99.4%	0.2%	0.1%	0.3%
GIP	12.1%	7	41.0%	58.2%	0.4%	0.5%
CHC	0.1%	16	71.7%	0.9%	27.3%	0.2%
IRC	0.2%	42	87.5%	1.1%	0.0%	11.3%

Access to GIP and CHC care is steadily declining

The Hospice Care Index (HCI) measure gives credit to hospices for provide just one day of either CHC or GIP care **(HCI Measure 1).** The number of hospices billing for any GIP or CHC care is declining. In 2024 only 54% of hospice programs billed for any GIP or CHC days, compared with 82% in 2012 (see Table 7).

***Table 7:** Multi-year trend in GIP and CHC use.*

Year	% Providers with any GIP or CHC	% GIP Patients	GIP Days per GIP Patient	% GIP Days	% CHC Patients	CHC Days per CHC Patient	% CHC Days
2012	82%	21.4%	5.9	1.9%	5.7%	4.9	0.4%
2015	77%	19.8%	5.2	1.6%	4.4%	4.6	0.3%
2018	73%	17.7%	4.7	1.2%	3.5%	4.2	0.2%
2021	61%	15.8%	4.1	1.0%	2.0%	3.7	0.1%
2024	54%	14.7%	4.0	0.8%	1.7%	3.8	0.1%

As seen in Table 7, the overall percent of patients using GIP or CHC is declining, along with the average time a patient receives such care, and the overall percent of hospice days billed at these levels of care. While not every patient requires such care, for those who do, the care provided is important, both for the patient and family, and for alleviation of suffering and prevention of unnecessary hospitalizations.

We recommend Health Plans, ACOs, and other risk bearing entities consider whether their network includes hospices providing CHC or GIP care (**HCI Measure 1**), as well as the overall **% GIP and % CHC** provided, which is calculated from hospice claims by dividing the total number of CHC or GIP service days provided by the hospice within a reporting period by the total number of hospice service days provided during that period.

When is GIP care provided?

For hospice patients who receive GIP care the majority (80%) start at the GIP level (see Table 8). These patients receive an average of 6.6 total days of hospice care. Almost all other patients receiving GIP care begin receiving RHC and are escalated to receive GIP care for acute symptom management that cannot be provided in another setting. These patients receive and average of 74.3 days of hospice care. In 2022, 65% of GIP days were provided in hospices facilities, while 33% were provided in the hospital, and 1.6% were provided in another setting.

***Table 8:** Distribution of GIP patients by initial level of care, including days per patient and percent of GIP days by setting in 2022*

INITIAL LEVEL (ANY GIP)	PATIENTS	TOTAL DAYS PER PATIENT	GIP DAYS PER PATIENT	HOSPICE FACILITY	HOSPITAL	OTHER
RHC	19.7%	74.3	5	76.6%	21.7%	1.7%
GIP	80.1%	6.6	3.9	61.7%	36.8%	1.5%
CHC	0.0%	48.1	5.2	87.5%	12.5%	0.0%
IRC	0.2%	28.6	4	87.7%	8.9%	3.4%
Grand Total	100.0%	20	4.1	65.4%	33.1%	1.6%

Access to freestanding hospice facilities may be at risk.

Our expert panel believes freestanding hospice facilities provide hospice patients with an excellent alternative to receiving care in a nursing facility or hospital and ensure access to GIP care for hospice patients in a community. However, there is significant variation in access to freestanding hospice facilities across markets. Another alternative for GIP in some markets is a joint venture arrangement with a hospital or health system in the community, which provides an integrative care model to enhance continuity of care for the patients needing hospice care services.

***Table 9:** Distribution of GIP patients by initial level of care, including days per patient and percent of GIP days by setting in 2022*

STATE	TOTAL DAYS PER PATIENT	GIP DAYS PER PATIENT	% GIP IN HOSPICE FACILITY	% GIP IN HOSPITAL
UTAH	7.2	2.4	6.7%	85.6%
NORTH DAKOTA	15.5	3.1	21.9%	77.7%
MINNESOTA	27	4.2	27.0%	71.2%
CALIFORNIA	14.3	3.6	27.5%	55.9%
MAINE	21.9	4.4	82.5%	16.1%
ARIZONA	21.4	4.1	83.9%	9.5%
COLORADO	23.1	4	84.1%	11.7%
NEVADA	13	3.8	87.8%	6.8%

As seen in Table 9, in 2022 states ranged from providing 87.8% of hospice GIP days in hospice facilities (Nevada) to only 6.7% of GIP days in hospice facilities. Freestanding hospice facilities require a multi-million-dollar investment but provide an important service to patients and the community. Health Plans and Accountable Care Organizations can ensure the long-term viability of hospice facilities by partnering with the organizations that have made these investments in their communities.

Access to high quality providers and choice of provider may be at risk.

There is a trend toward operators of nursing facilities and senior housing operators starting hospices to provide care solely to their own residents. While there may be some benefit to this level of integration,

this may be limiting beneficiary choice and access to high quality providers. Two examples based on actual data:

- **Hospice A** is owned by a nursing home operator. The majority (82%) of care is delivered in a nursing facility, presumably the facilities they own and operate. Only 65% of caregivers/families would recommend this hospice, which ranks in the bottom 1% nationally.
- **Hospice B** is also owned by a nursing home operator. The majority (93%) of their care is delivered in a nursing facility. Their Burdensome Transition Type 1 rate is 28.3% which ranks in the bottom 1% nationally.

It is unlikely that these nursing home residents are provided with a choice of hospice providers. Health Plans and Accountable Care Organizations should ensure their beneficiaries receive access to high quality providers by partnering with nursing home operators that provide choice to their residents and building high quality networks able to provide care to these settings.

Chapter 2 Summary

While hospice patients may be admitted at any level of care, the progression of their illness may require a change in their level of care. Health Plans, ACOs and other risk bearing entities can improve the quality of care while reducing avoidable (and costly) hospital admissions at the end of life by contracting with hospices that provide GIP and CHC care to theirs patients, and with those that have made significant investments in freestanding hospice facilities or designated units in hospitals and nursing facilities to ensures hospice patients who require general inpatient care can access it.

Health Plans and Accountable Care Organizations can also ensure their beneficiaries receive access to high quality hospices by partnering with nursing home operators that provide choice to their residents and building high quality networks able to provide care to these settings.

- Most important measures from this chapter: CHC/GIP Provided (% of Days) (HCI Measure 1)
- Optional measures from this chapter: GIP % (Claims) and CHC % (Claims)

Chapter 3: Understanding **Visit Frequency & Timeliness**

Evaluating visit frequency and timeliness is important to identifying hospices that are providing the care patients and family require. In fact, visit frequency and timeliness is the focus of four separate HCI measures, as well as Hospice Visits in the Last Days of Life (HVLDL). The following chapter will discuss the importance of visits, what each measure means, and suggest which are the most important.

As discussed in Chapter 2, hospice involves four levels of care, but most care is provided at the routine home care (RHC) level. The measures of visit frequency and timeliness focus on the RHC level of care. Hospice providers receive a fixed daily rate for RHC (per diem payment) that is not tied to the frequency, duration or quality of visits. This could lead to some hospices limiting visits to maximize profits. Hospice organizations may also use lower cost staff such as hospice aides when a more skilled resource is needed.

Which hospice staff members can make a visit?

- **Skilled Nursing (SN)** visits are performed by a registered nurse (RN) or a licensed practical nurse (LPN/LVN). The nurse provides nursing care, physical assessments, regularly communicates with the primary care physician and hospice physician, and makes sure patients have an adequate supply of medications. LPN/LVNs are less costly but must work under the supervision of an RN and have a more limited scope of care. Most measures include LPN visits, but HVLDL does not.
- **Medical Social Services (MSS)** visits are performed by a social worker, who assists in dealing with the difficult emotions related to the illness; helps identify community resources like private care agencies, government resources, and counseling services; or helps with advance care directives.
- **Hospice Aide** visits are performed by a hospice aide, who assists with activities of daily living such as bathing and dressing and can provide companionship and education for patients and family members.
- **Physician or Medical Director** visits are performed by a physician, who is responsible for easing physical symptoms, and management of terminal illness and any conditions related to the illness. If the patient's primary physician is not available, the hospice physician is there to address medical needs. Physician visits are not included in any of the visit measures.

What quality measures relate to visits, and what do they mean?

To ensure providers maintain an appropriate frequency and timeliness of visits, CMS has endorsed several related quality measures as part of The Hospice Quality Reporting Program (HQRP). More detailed information can be found in the CMS Hospice Quality Reporting Quality Measure Specifications User's Manual[4]. These include:

- **Gaps in Nursing Visits (HCI Measure 2)** measures the proportion of hospice stays longer of 30 days or longer who had one or more 7-day periods with no nursing visits. Visits include RN and LPN/LVN visits. Extended gaps in care for hospice patients can be a stressor for the patient and the family, and a high rate of Gaps in Nursing Visits indicates a pattern of insufficient care by a hospice.
- **Nurse Care Minutes per RHC Day (HCI Measure 8)** measures the average number of skilled nursing minutes per RHC day. Visits include RN and LPN/LVN visits. Abnormally low nursing care

minutes per RHC day indicate a program that may not be meeting the needs of patients and their caregivers.

- **Skilled Nursing Minutes on Weekends (HCI Measure 9)** measures the proportion of skilled nursing minutes that occurred on weekends. The measure is limited to RHC days. Visits include RN and LPN/LVN visits. Hospices are required to be prepared to routinely provide care 7 days a week, and this measure is meant to reveal if a program is failing to provide these services on the weekend. Some experts on the panel wondered if poor case management and planning might also lead to higher visits on weekends, which makes this measure more difficult to interpret independent of other measures of a program's performance.
- **Visits Near Death (HCI Measure 10)** measures the proportion of hospice deaths with at least one nursing or social work visit in the final three days of life. The measure excludes patients with fewer than three days of hospice, and those with any non-RHC days in the last three days of life. Visits include RN and LPN/LVN visits. Often, physical symptoms in the final few days of life are major determinants of patient and family experience. This period may also have higher physical and emotional symptoms that the hospice team can help with. A high rate of Visits Near Death (or HVLDL) indicates a program that is actively identifying the needs of patients and caregivers in the final days of life, while an abnormally low rate of Visits Near Death (or HVLDL) is red flag for a program.
- **Hospice Visits in the Last Days of Life (HVLDL)** measures the proportion of hospice deaths with visits from a registered nurse or medical social worker on at least two out of the final three days of the patient's life. The measure excludes patients with fewer than three days of hospice, and those with any non-RHC days in the last three days of life. Visits do not include LPN/LVN visits. The meaning of this measure is similar to Visits Near Death (HCI Measure 10), but requires more care at the end of life, leading to greater differentiation between programs (see Table 10).

Among these measures Visits Near Death (HCI Measure 10) and HVLDL are quite similar. Comparing the two, because HVLDL was more specific, and better at differentiating between programs (see Table 10), the panel endorsed HVLDL as the preferred measure of visits at the end of life. Though the exclusion of LPN/LVN visits is a concern, and the panel would endorse a broader definition of HVLDL visits should the measure ever be updated.

Table 10: *Visit measure distributions by decile and quartile*

STATISTIC	Gaps in Nursing Visits (% of Stays)	Nurse Care Minutes per RHC Day (Minutes/Day)	Skilled Nursing (% of Minutes)	Visits Near Death (% of Hospice Deaths)	Percent Given Visits 2+ of 3 Last Days of Life (HVLDL)
10th Percentile	24	9	5	79	20
25th Percentile	39	10	6	88	40
National Average (Mean)	55	13	9	90	48
75th Percentile	71	15	10	96	70
90th Percentile	83	18	14	98	79

Using visit measures as a proxy for patient/family experience

In addition to the direct meaning of the visit measures as described above, certain visit measures can also serve as proxies for patient and caregiver experience. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures the experiences of patients who died while receiving hospice care, as well as the experiences of their informal primary caregivers already. However, only 53% of hospices have reportable data from CAHPS®. In contrast, data related to visit frequency and timeliness is available for 82% of hospices.

Our panel examined the correlation between each of these visit measures and key CAHPS® hospice measures and found that both Gaps in Nursing Visits (HCI Measure 2) and HVLDL were strongly correlated with multiple CAHPS® measures, such as getting timely help, recommending the hospice, and receiving help for pain and symptoms. The panel was not surprised by these findings, as fewer care gaps would logically reduce the burden on caregivers and ensure the hospice team is successfully managing pain and symptoms in a timely manner. Similarly, identifying the final days of life and providing additional visits would likely lead to better and more timely care and higher patient and caregiver satisfaction.

Nurse Care Minutes per RHC Day (HCI Measure 8) and Skilled Nursing Minutes on Weekends (HCI Measure 9) were not strongly correlated with CAHPS® hospice measures. When discussing Skilled Nursing Minutes on Weekends (HCI Measure 9), our expert panel commented that most hospices utilize 5 days a week, 8 hours a day staffing model. A high rate of visits occurring on the weekend are therefore ad hoc emergency calls, which could be an indicator of poor quality of care delivered Monday through Friday. Our analysis found that hospices that rank in the bottom deciles (fewest minutes on the weekend) and those in the top quartile (most minutes on the weekend) on that measure, had identical CAHPS® scores.

Chapter 3 Summary

Because hospice care is reimbursed by the day, with no specific visit thresholds for RHC days, hospices vary widely in the frequency and timing of visits. Still, providing timely and appropriate care to hospice patients is key. The panel reviewed all five measures reported in HCI and as part of HQRP and found that two measures stood out: Gaps in Nursing Visits (HCI Measure 2) and HVLDL.

This panel endorsed the importance of the care that these measures are focused on. In addition, because both measures are strongly correlated with patient and caregiver satisfaction, they are important proxies for the patient and caregiver experience that are available for many more programs than CAHPS® measures.

Health Plans, ACOs and other risk bearing entities can use these measures to identify strong partners, while also identifying poor performing programs, to build strong hospice networks that provide the right care and meet the needs of patients and caregivers.

- Most important measures from this chapter: Gaps in Nursing Visits (HCI Measure 2), Hospice Visits in the Last Days of Life (HVLDL)
- Optional measures from this chapter: None

Chapter 4: Understanding **Patient & Caregiver Experience**

Evaluating patient and caregiver experience is critical in evaluating hospice performance. To assess this experience, CMS requires hospices to participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey.

The CAHPS® hospice survey is a set of 47 questions and is conducted monthly for all hospices except those with either of the two exemptions:

- **The hospice is new**: Hospices that received their CMS Certification Number (CCN) after January 1 of the data collection year are exempted from participation for that year.
- **The hospice is too small:** Hospices that served fewer than 50 survey-eligible patient/family caregiver pairs are exempt. To be survey-eligible, the caregiver can be a spouse, parent, child, close friend but not a non-familial legal guardian or paid caregiver. The patient must be deceased, and they must have received at least 48 hours of hospice care before death.

CAHPS® hospice survey results are released publicly as both a dataset and as part of CMS' Care Compare website as a set of 8 multi-level measures, and one star rating.

What are the CAHPS® hospice measures?

There are 8 measures in the publicly reported CAHPS® hospice results:

- Communication with family
- Getting timely help
- Treating patient with respect
- Emotional and spiritual support
- Help for pain and symptoms
- Training family to care for patient
- Rating of this hospice (1 to 10)
- Willing to recommend this hospice

Since August 2022, the public results also include a Family Caregiver Star Rating. Each result is for a two-year period, generally ending 9-12 months before the release date. The CAHPS® Hospice Survey results are only reported for hospices with 30 or more completed surveys in the 8-quarter reporting period, with a threshold of 75 completed surveys for the Family Caregiver Star Rating.

Our team of experts discussed CAHPS® scores and identified a desire to recommend measures, or a set of measures, which were differentiating, representative of overall patient and family caregiver satisfaction, and simple to understand.

Which CAHPS® questions are differentiating?

The group reviewed each of the CAHPS® measures and performance deciles and quartiles (Table 11) to determine which CAHPS® measures were differentiating. Two measures—'Emotional and Spiritual Support' and 'Team Treated the Patient with Respect'—stood out as not great at differentiation. For these measures the lowest (or 'worst') decile of hospices had 85% of caregivers giving them the top score for on the question. The other measures had a broader range of scores.

***Table 11:** Visit measure distributions by decile and quartile.*

STATISTIC	Providing emotional support	Help for pain and symptoms	Caregiver training	Providing timely help	Team always communicated well	Caregiver rating	Treating patients with respect	Caregiver recommends hospice
10th Percentile	85	66	66	67	74	72	85	74
25th Percentile	88	70	71	73	78	77	88	80
National Average (Mean)	90	74	75	77	81	81	90	84
75th Percentile	92	79	80	82	85	86	93	89
90th Percentile	94	82	84	86	88	89	95	92
Delta from top to bottom 10%	9	16	18	19	14	17	10	18

Which CAHPS® measures are representative of overall satisfaction?

The team compared each of the measures to see which measures were strongly correlated with one another. The results are shown in Table 12.

***Table 12:** Correlation between each of the 8 CAHPS® hospice measures and the Star Rating*

	Providing emotional support	Caregiver Rating	Caregiver recommends hospice	Treating patients with respect	Help for pain and symptoms	Hospice team communication	Providing timely help	Caregiver training	Star Rating	Correlation Score
Providing emotional support	100%	71%	71%	68%	54%	64%	59%	44%	71%	63%
Caregiver rating	71%	100%	89%	83%	74%	86%	80%	64%	87%	79%
Caregiver recommends hospice	71%	89%	100%	82%	72%	83%	78%	64%	85%	78%
Treating patients with respect	68%	83%	82%	100%	72%	85%	77%	63%	86%	77%
Help for pain and symptoms	54%	74%	72%	72%	100%	79%	74%	72%	83%	73%
Hospice team communication	64%	86%	83%	85%	79%	100%	83%	73%	90%	80%
Providing timely help	59%	80%	78%	77%	74%	83%	100%	64%	86%	75%
Caregiver training	44%	64%	64%	63%	72%	73%	64%	100%	76%	65%
Star Rating	71%	87%	85%	86%	83%	90%	86%	76%	100%	83%

'Willing to Recommend Hospice' and 'Rating of This Hospice' were highly correlated overall (78% and 79% respectively), with one another (89%), and with star rating (87% and 85% respectively). That fact, and the broad definition of these measures, made both measures stand out as potential proxy measures for overall experience. Star Rating also stood out, but that measure requires a higher threshold of completed surveys and therefore missing for many more hospices and is not ideal.

Comparing those two top candidate measures, 'Willing to Recommend Hospice' stood out for its close relationship with an industry standard: The Net Promoter Score.

The Net Promoter Score (NPS) is the most widely adopted metric for measuring customer loyalty and satisfaction as it is used by over two-thirds of Fortune 1000 companies. NPS measures customer perception based on one simple question: "How likely is it that you would recommend [organization/product/service] to a friend or colleague?"

The similarity between 'Willing to Recommend Hospice' and NPS, combined with that measure being a powerful differentiator and highly correlated with the other CAHPS® hospice measures made it the top choice as a single measure to use.

Data limitations: many hospice programs lack CAHPS® data.

The main limitation of using the CAHPS® Hospice Survey data is that the results are not available for many hospices. CAHPS® hospice results are only reported for hospices with 30 or more completed surveys in the reporting period, with a threshold of 75 completed surveys for the Family Caregiver Star Rating. As a result, only 53% of hospices operating in the most recent claims year have reportable data and only 35% have a Family Caregiver Star Rating.

The number of programs missing CAHPS® data varies widely by state (see Table 13). New York and Florida require a certificate of need for hospice programs meaning markets of longstanding, larger hospices. In these states 84-100% of hospices have CAHPS scores. In California, which has experienced an unprecedented boom in new hospice programs in recent years, only 15% of hospices have reportable CAHPS data.

***Table 13:** Visit measure distributions by decile and quartile (CAHPS®; Apr 2022 to Mar 2024)*

State	# of Hospices	# with CAHPS	% with CAHPS
New York	39	39	100%
Florida	57	48	84%
Texas	832	320	38%
California	1,846	282	15%

This limitation should be considered in markets where many hospices lack these measures, and as discussed in Chapter 3 in those cases evaluation of visits measures may overcome this.

Chapter 4 Summary

CAHPS® hospice measures, though not available for all hospice programs, are an important part of building high performing hospice networks, particularly given the availability of these numbers to the public. Of the 8 publicly released CAHPS® hospice measures, 'Willing to Recommend Hospice' stood out to the panel. The measure is highly correlated with most other CAHPS® hospice measures (including the family and caregiver star rating), and the measure is easy to understand.

For hospices that do not have Hospice CAHPS data, it is necessary to use proxy measures, such as the visit measures recommended in Chapter 3 (HCI Measure 2: Gaps in Nursing Visits and HVLDL), and to understand the local hospice market to determine how important it is to evaluate hospices with no CAHPS scores.

ACOs, Health Plans and other key stakeholders that operate in markets with smaller hospice programs would need to make an exception if hospices without reportable CAHPS® hospice survey data play a critical role in ensuring network adequacy. In markets like New York that have CAHPS data for 100% of hospices, organizations may want to consider including additional CAHPS questions like Caregiver Training which was not highly correlated (not redundant) with other measures and was highly differentiating (wide range in scores from upper and lower deciles).

- Most important measures from this chapter: Willingness to Recommend
- Optional measures from this chapter: Star Rating and Caregiver Training if data is widely available in the stakeholder's market

Chapter 5: Understanding **Length of Stay**

The Medicare hospice benefit is only available to Medicare enrollees who are terminally ill with a life expectancy of 6 months or less if the disease follows its normal course. While a length of stay of a few months may be ideal, in practice many hospice patients are admitted and die within days, while others remain on hospice well beyond six months. While variation is natural and expected, measures of hospice length of stay and service are important in identifying high quality hospice partners.

About Very Short Stays

Far too often, providers are hesitant to refer patients to hospice and/or patients and families are hesitant to agree. As a result, many only receive a few days of care. An analysis of 3.4 million Medicare Fee for Service beneficiaries that died on hospice between 2018 and 2022 shows that 30% of hospice deaths received less than one week of hospice and 60% received less than a month of hospice.

Extremely short stays can be problematic for several reasons. Patients and their families are deprived of enough time on hospice to benefit fully. The cost savings of hospice care, which derive from providing hospice instead of costly end-of-life hospitalizations are less likely to be realized.

About Very Long Stays

Patients and caregivers can have a positive experience with hospice at any length of stay, and it is natural that some patients may stay well over six months on hospice. However, unusually high percentages of long-stay patients may indicate that a hospice is admitting patients too early in their disease progression and who may not be terminally ill. In addition, the terminal status of the patient may be related to an acute event, such as an infection, from which they recover. Hospices may be slow to identify the recovery and discharge for extended prognosis.

Extremely long stays can be problematic for several reasons. As discussed in Chapter 1, these hospice programs may have higher rates of live discharges. These hospices may not be serving the entire community, focusing instead on nursing home patients and those living with diagnoses that have relatively longer prognoses.

What measures relate to length of stay?

Our expert panel identified and discussed six measures related to hospice length of stay, most of which are easily calculated using Medicare hospice claims.

- **Median Length of Stay (MLOS)** is calculated from claims as the median number of days hospice patients received hospice services in a given period. MLOS includes all patients, not just deaths and discharges. By using the median rather than an arithmetic mean, the measure is not skewed by very long stay patients.
- **Days per Patient Served (ALOS)** is calculated from claims as total hospice patient days divided by total patients served in that period. It is an important metric in forecasting hospice days but can be skewed by very long stay patients.

- **Mean Discharge Length of Stay (D-ALOS)** represents the average number of days from a patient's admission to hospice until discharge or death, based on claims data. Because it only includes patients who have been discharged, the metric reflects nearly all short-stay patients. However, it can be skewed by a few very long-stay patients and may not fully capture trends in programs with a high proportion of patients still on service at the end of the reporting period. This limitation makes D-ALOS less reliable in assessing programs with excessively long or short lengths of stay.
- **% End of Year Census on Hospice > 180 Days** is calculated from claims as the percent of hospice patients on census on December 31 (or on the last day of the period) who were admitted more than 180 days prior (roughly six months). The measure is specifically aimed at identifying hospices that are too focused on long stay patients.
- **Per-Beneficiary Hospice Spending (HCI Measure 7)** is calculated from claims by CMS and released as one of the HCI measures. Per-beneficiary hospice spending is mostly influenced by days per patient served (ALOS) and is largely duplicative of it. Though hospices with especially high GIP and CHC days will also have higher spending.
- **% Cap Use** is a limit on the total amount of Medicare payments a hospice agency can receive in a given year. Our expert panel raised serious concerns that the aggregate cap is not adjusted by wage index values in Core Based Statistical Areas (CBSAs) and is the same amount ($34,465.34) no matter where the hospice is located in the country. A hospice in a high wage area, such as California, would reach the cap much more quickly because the payment rates are significantly higher (because the wage index value is higher) and fewer days of care can be provided before reaching the cap. A hospice in states with a lower payment rate (and a wage index of less than 1.0) would be able to provide significantly more days of care before reaching the aggregate cap. The hospice in Alabama, using FY 2025 rates, would be able to provide almost 178 days of hospice care before reaching the aggregate cap. The hospice in San Francisco would reach the hospice cap in 100.1 days of hospice care (Table 14).

Table 14: *RHC Rates by Core Based Statistical Areas*

CBSA	Wage Index Value for FY 2025	RHC 1-60 Daily Rate	Days provided before cap
Decatur, AL	0.8	$195	177.8 days
San Francisco-San Mateo-Redwood City, CA	1.8075	$344	100.1 days

What can length of stay measures tell you about a hospice program?

Even among high performing hospice programs, one expects measures of length of stay to vary. Some hospices, especially those owned by or affiliated with hospitals or those with large inpatient hospice facilities, will have shorter lengths of stay. More of their hospice admissions are acutely ill and come directly from the hospital and die soon after. On the flip side, programs with strong outreach to assisted living facilities (ALFs) and nursing homes will have longer lengths of stay because patients in those settings are often identified as eligible for hospice earlier or have a more extended disease trajectory.

Given the expected variation, the expert panel felt length of stay metrics were better suited to identifying problematic hospice programs than at differentiating the best hospices from the good ones. With that in

mind, the aim was to find a set of measures that captured the most important red flags while not being redundant with one another.

Examining these measures, median length of stay (MLOS) was popular with the panel of experts, as it is not easily skewed by outliers, is easy to understand, and can identify programs that either have too many short stay patients, or too many long stay patients. Among the other measures, days per patient served (ALOS) and mean discharge length of stay covered similar territory to MLOS but were subject to skewing by outliers. In addition, % Cap Use, Per-Beneficiary Hospice Spending (HCI Measure 7) and days per patient served (ALOS) measure very similar things and are therefore redundant. The conclusion was that MLOS was the most important measure.

***Table 15:** Visit measure distributions by decile and quartile*

Statistic	Median Length of Stay (MLOS)	Mean Discharge Length of Stay (D-ALOS)	Days per Patient Served (ALOS)	% End of Year Census on Hospice > 180 Days	% Cap Use	Per-Beneficiary Hospice Spending ($)
% Reportable	100%	100%	100%	99%	100%	82%
10th Percentile	14	36	44	6%	31%	$8,799
25th Percentile	23	48	60	22%	44%	$11,732
National Average (Mean)	25	55	71	38%	55%	$16,971
75th Percentile	57	80	99	46%	90%	$19,929
90th Percentile	86	102	117	55%	123%	$24,527

Chapter 5 Summary

Health plans and ACOs should focus on partnering with hospice and palliative care organizations that can increase the percentage of hospice patients that receive an optimal amount of hospice care, both from the patient and family perspective and to avoid excessive end-of-life costs. Among the six measures reviewed, median length of stay (MLOS) was deemed the most informative. The measure, which is easily calculated from hospice claims, can identify hospice programs with excessively long or short lengths of stay, without being skewed by outlier cases. The panel felt this measure was best used to identify hospices with problematic lengths of stay than at identifying the best of the best.

- Most important measures from this chapter: Median Length of Stay (Claims)
- Optional measures from this chapter: None

Conclusion & Other Notable Measures

Our panel discussed many other measures that were not discussed in Chapters 1-5. A representative list includes:

- **Hospice Size and Market Share:** Average Daily Census (ADC) was discussed as an important consideration as hospices below a certain size may not have the resources needed to respond to crises when they arise. Alternatively, the hospice with the leading share of patients in a market could be difficult to exclude from a network, despite poor performance on some measures, as it could create friction with referring providers, patients and caregivers. Our expert panel concluded that health plans, ACOs, and other stakeholders will take size and market share into consideration when designing networks that provide adequate coverage and choice, but that they are not predictors of quality outcomes.
- **Readmissions:** 30-day readmission rates are related to Burdensome Transitions but pertain to patients who have recently been discharged from a hospital, admitted to hospice, and then readmitted to the hospital (usually following a live discharge). Because Burdensome Transitions include all hospice patients, not just those recently discharged from a hospital, it captures more of these events. 30-day readmission rates are only available on 21% of hospices nationally have reportable data.
- **Hospice Item Set (HIS) measures were dismissed** by the expert panel as being non-differentiating. For example, the top decile of hospices on HIS Measure "Asked about Treatment Preferences" had an average score of 100% and those in the bottom decile had an average score of 99%.
- **HOPE:** CMS has developed a new patient assessment tool to replace the Hospice item Set (HIS). The Hospice Outcomes and Patient Evaluation (HOPE) assessments will launch on October 1, 2025. We look forward to assessing how to include this data in our recommendations of Measures That Matter as data becomes available.

Next Steps: Using the Measures That Matter

Health Plans, Accountable Care Organizations, and risk bearing entities can use the insights in this report to identify preferred hospice partners. Seeing hospices side by side with their performance on the Measures That Matter in a sample "report card" can bring this information to life for these stakeholders.

It is important to understand that using the measures identified in this report works best at the extremes. Some hospices have outstanding outcomes and could be designated as preferred hospice partners or centers of excellence. Others perform poorly on several of the Measures That Matter and could be excluded from networks entirely. However, using this data to differentiate between many providers with average quality scores may be putting too much faith in the fidelity of these measures.

In the Sample Quality Report Card below (derived from actual 2024 claims data), 4 hospices stand out for being in the top quartile nationally for caregiver experience, live discharge rates, burdensome transitions and providing CHC & GIP levels of care while 5 perform in the bottom decile nationally on many of those same measures.

Sample Quality Report Card

Hospice	Medicare Average Daily Census (ADC)	% CHC + GIP Days	% Definitely Recommend this Hospice	% w/ Visit in 2 of 3 Last Days of Life	Gaps in Nursing Visits	% Live Discharges	Burdensome Transitions, Type 1	Burdensome Transitions, Type 2	Rank Percent	Hospice Points	Possible Points
Center of Excellence Hospice 1	676	1.99%	92	43.5	63.9	11.7%	0.8	0.4	71.4%	15	21
Center of Excellence Hospice 2	607	1.76%	92	47.2	56.2	9.0%	1.8	0.2	71.4%	15	21
Center of Excellence Hospice 3	486	1.55%	92	47.2	60.3	10.6%	1.5	0.6	71.4%	15	21
Center of Excellence Hospice 4	413	2.79%	92	48.6	64.0	7.9%	0.5	0.3	71.4%	15	21
In Network Hospice 1	96	0.00%	89	79.4	49.0	15.1%	3.2	0.0	57.1%	12	21
In Network Hospice 2	176	0.02%	90	76.4	38.8	29.2%	7.3	2.6	57.1%	12	21
In Network Hospice 3	73	0.26%	87	82.2	69.4	27.7%	1.7	0.8	57.1%	12	21
In Network Hospice 4	52	0.01%	91	76.8	61.8	44.8%	7.0	0.0	42.9%	9	21
Out of Network Hospice 1	74	0.00%	76	43.9	56.3	44.7%	13.9	2.0	23.8%	5	21
Out of Network Hospice 2	305	0.01%	68	43.3	66.1	42.0%	6.0	3.2	19.0%	4	21
Out of Network Hospice 3	51	0.51%	62	47.0	48.4	37.9%	16.8	5.3	14.3%	3	21
Out of Network Hospice 4	71	0.07%	64	19.3	99.1	49.6%	7.1	0.6	9.5%	2	21
Out of Network Hospice 5	48	0.00%	72	36.6	77.3	46.3%	14.5	3.6	9.5%	2	21

High-quality hospice care is completely aligned with the goals of value-based care while low quality care, such as excessively long lengths of stay and burdensome transitions, leads to unnecessary suffering and costs. The saying “rising tides raise all boats” is particularly relevant in this situation. By identifying and rewarding performance on the Measures That Matter, hospices in a market will be incentivized to improve, benefiting the community overall.

As mentioned in the introduction, hospice care is complex, and hospice measures can be difficult to understand. We hope this report has provided some clarity and can simplify the process of identifying preferred hospice partners.

As our expert panel receives feedback, and new measures such as HOPE are released, we anticipate updating these recommendations.

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