Policy option to modify the hospice aggregate cap

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Background: Medicare hospice benefit

- Palliative and supportive services for beneficiaries with terminal illnesses who choose to enroll

- Eligibility criteria:
  - Life expectancy of six months or less if the disease runs its normal course
  - Physician(s) must certify prognosis at outset of each hospice benefit period. Two 90-day periods, then unlimited number of 60-day periods
  - Beneficiary must agree to forgo conventional care for the terminal condition and related conditions

Background: Hospice payment system

- Medicare spending: $17.9 billion (2017)
- Medicare pays a per diem rate for hospice
- 4 levels of care
  - Routine home care (RHC) accounts for 98% of days
    - Higher rate days 1-60; lower rate days 61+
    - Last 7 days of life: Additional payments for nurse and social worker visits
  - General inpatient care (GIP)
  - Continuous home care (CHC)
  - Inpatient respite care (IRC)

Concerns about the hospice payment system

- Aggregate level of payment substantially exceeds cost
  - Commission recommended 2% reduction to FY 2020 base rate (1-year savings of $750M to $2B)
- Payment system has been out of balance by level of care
- Long stays in hospice are more profitable than short stays
- Margins of hospices with disproportionately long stays that exceed the cap are strong and have been increasing
- CMS changes in 2016 and 2020 are improvements, but concerns remain

Hospice aggregate cap

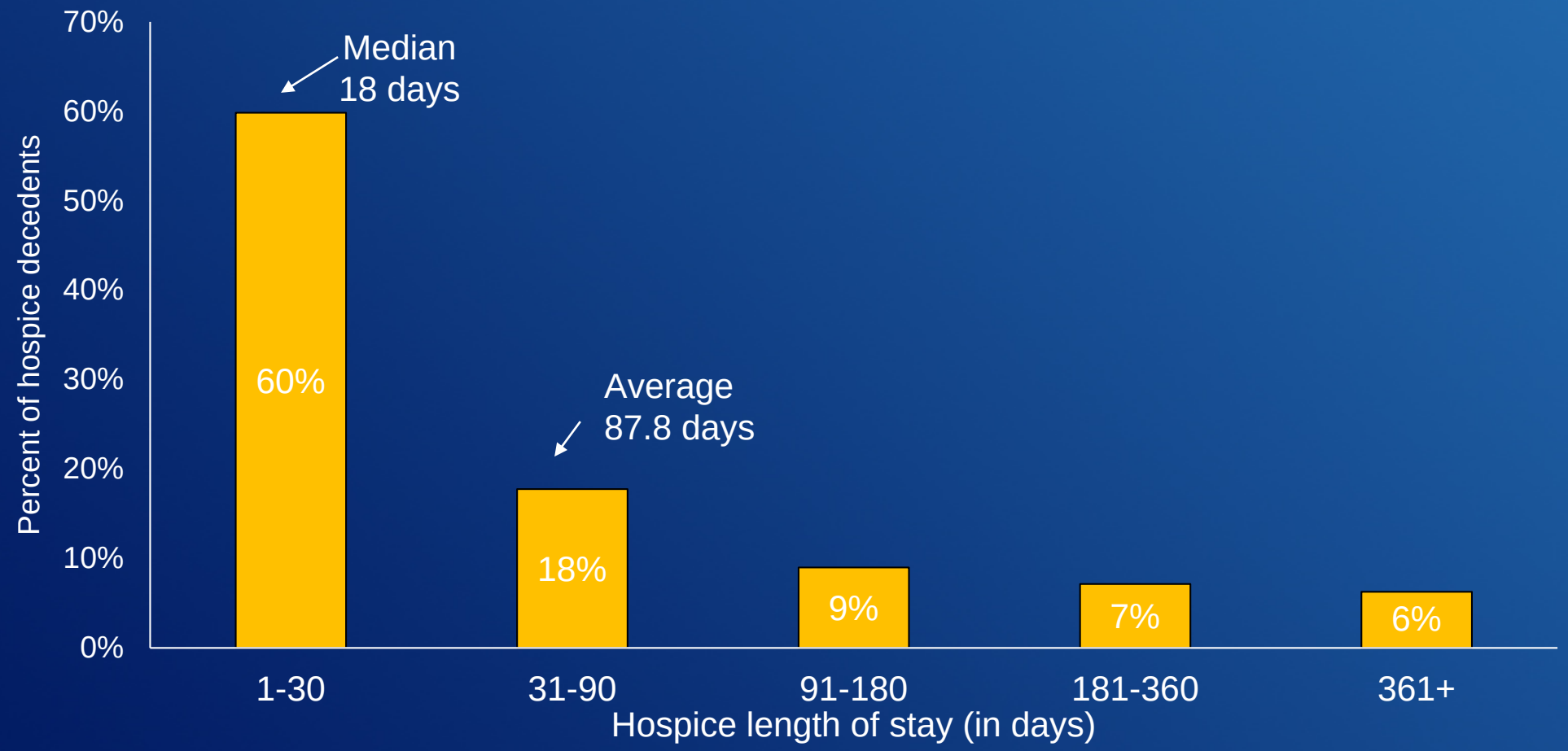
- When the hospice benefit was first established, Congress included an aggregate cap to ensure savings
- Cap limits aggregate payments a hospice provider can receive annually

If:	provider's total payments	>	number of patients	x	cap amount

Then: provider must repay excess to Medicare

- Cap set at $6,500 initially and increased annually for inflation
- FY 2020 cap: $29,965, not wage adjusted

Hospice length of stay for decedents, 2016



Note: Length of stay reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his or her lifetime. Data include decedents who received hospice care at the time of death or prior to death.
Source: MedPAC analysis of the denominator file and Medicare beneficiary data base from CMS.

Illustration of cap calculation

Hypothetical hospice's payments (2016)

Length of stay (days)	Number of patients		Payment per patient	Total payments
30	10	x	$5,605.20 =	$ 56,052
300	10	x	$46,449.60=	$464,496
				$520,548

Hospice's aggregate cap

Number of patients		2016 cap amount	Aggregate cap
20	x	$27,820.75=	$556,415
			$556,415

Hospice is below the cap: total payments ($520,548) < aggregate cap ($556,415)

Note: For illustrative purposes, example assumes this hospice only provides RHC, has a wage index of 1, and does not incorporate the sequester or service intensity adjustment payments in the last 7 days of life. Results preliminary and subject to change.
Source: MedPAC analysis.

Cap functions as a mechanism to reduce payments to hospices with long stays and high margins

- 12.7% of hospices exceeded the cap in 2016
- Overpayments were equivalent to about 1% of total hospice payments to all providers
- Above-cap hospices' Medicare margin in 2016:
  - 20.2% before the return of cap overpayments
  - 12.6% after the return of cap overpayments
- Above-cap hospices' characteristics:
  - Substantially longer stays and higher live discharge rates
  - Disproportionately for-profit, freestanding, urban, and small

Source: MedPAC analysis of Medicare claims and cost report data.

Aggregate cap is stricter in some areas than others because it is not wage adjusted

- Aggregate cap in 2016 was equivalent to average length of stay (ALOS) for RHC of:
  - 204 days for wage index ratio of 0.86
  - 173 days for wage index ratio of 1.00
  - 147 days for wage index ratio of 1.16
- Hospices furnishing care in high wage index areas are more likely to exceed the cap than those in low wage index areas

Note: Wage index ratio is defined as the ratio of the provider's actual payments in cap year / amount that the provider's payments would have been without wage adjustment. Data preliminary and subject to change.
Source: MedPAC analysis of Medicare claims data.

Policy option: Wage adjust and reduce the cap

- Could consider a policy that would wage adjust and reduce the cap to:
  - improve equity of the cap across providers
  - improve payment accuracy and reduce overpayments to providers with disproportionately long stays
  - lessen attractiveness of business model focusing on long stays
  - generate savings for taxpayers and Part A trust fund

Simulation of policies to modify the cap

- Simulated the effect of wage adjusting and reducing the cap
  - Simulated 20% reduction to the cap
  - Illustrative; other amounts could be considered
- Used 2016 data assuming no utilization changes
- Simulated the effect of FY 2020 rebasing before simulating effect of policies to modify the cap

Under policy option, more hospices would exceed the cap, but many would remain under the cap

With a policy to wage adjust and reduce the cap by 20%:

- An estimated 26% of hospices would have exceeded the cap in 2016 (assuming no utilization changes)
  - Above-cap hospices have disproportionately long stays
- Many hospices would have remained substantially under the cap
  - About half of hospices would have been 41% or more below the cap

Source: MedPAC analysis of Medicare claims data and Medicare beneficiary data base.
Data preliminary and subject to change.

Policies to modify the cap would focus payment reductions on providers with the longest stays

Provider quintiles by share of stays > 180 days	2016 Actual Medicare margin	Simulated effect on 2016 Medicare payments of policies to: Wage adjust and reduce the cap
All	10.9%	-3.2%
Lowest quintile	-5.4	0.0
Second quintile	5.8	0.0
Third quintile	14.8	-0.1
Fourth quintile	20.0	-4.5
Highest quintile	15.0	-15.0

Source: MedPAC analysis of Medicare claims and cost report data and Medicare beneficiary data base.
Data preliminary and subject to change.

Effect of policies to modify the cap

- Hospices with disproportionately long stays and high margins would see a reduction in payments, while other hospices would be unaffected
- Effect by category of hospice depends on the prevalence of providers in that category with disproportionately long stays
- For profit and freestanding hospices would experience reduced payments
- Little effect on nonprofit and hospital-based hospices

Source: MedPAC analysis of Medicare claims and cost report data and Medicare beneficiary data base.
Data preliminary and subject to change.

Policy option: Summary

- Wage adjusting and reducing the hospice cap would be an immediate, targeted step that could:
  - Improve equity across providers
  - Increase payment accuracy and reduce excess payments for providers with disproportionately long stays and high margins
  - Likely generate savings for taxpayers and Part A trust fund
- We expect beneficiaries to continue to have good access to hospice care
  - Many providers would remain substantially below the cap
  - To the extent that some providers have entered the sector to pursue revenue generation strategies focusing on long stays, it could lessen the attractiveness of that business model

Next steps

- Questions/clarifications
- Feedback on policy option to wage adjust and reduce cap
- Interest in developing policy option to potential recommendation?