

Assessing payment adequacy and updating payments: Hospice services

Kim Neuman January 16, 2020

меорас

Overview of Medicare hospice, 2018

- Hospice use:
 - Over 1.5 million beneficiaries
 - Over 50% of decedents
- Providers: Over 4,600
- Medicare payments: \$19.2 billion to hospice providers



Summary: Hospice payment adequacy indicators generally positive

Beneficiaries' access to care

- Growth in provider supply
- Growth in volume (use rates, ALOS)
- Positive marginal profits (16%)

Positive

Quality of care

- 7 process measures topped out
- CAHPS survey stable
- OIG identified subgroup of poor performers

Mostly positive; limited measures

Hospices' access to capital

- Continued entry of for-profits
- Sector viewed favorably by investors
- Provider-based have access via parent provider

Positive

Medicare payments and hospices' costs

- 2017 Medicare margin: 12.6%
- 2020 projected margin: 12.6%

Positive



Background: hospice aggregate cap

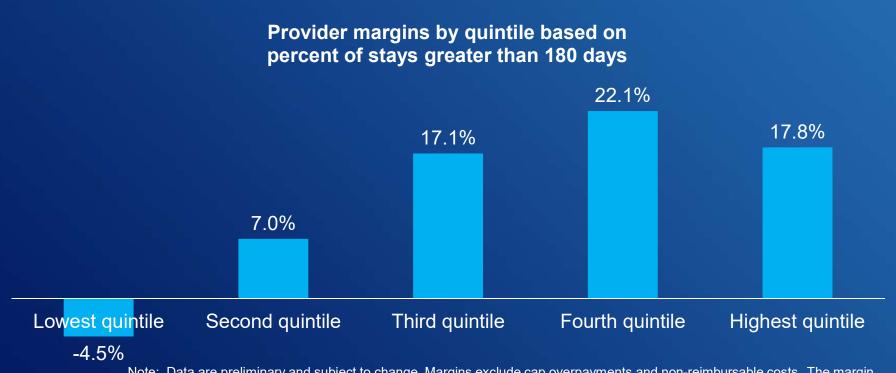
- When the hospice benefit was first established, Congress included an aggregate cap to ensure savings
- Cap limits aggregate payments a hospice provider can receive annually

```
<u>If:</u> provider's > number of x cap total payments > patients x amount
```

Then: provider must repay excess to Medicare

■ FY 2020 cap: \$29,965, not wage adjusted

Hospice margins increase with length of stay



Note: Data are preliminary and subject to change. Margins exclude cap overpayments and non-reimbursable costs. The margin for the highest length of stay quintile dips because some hospices in this category exceed the cap and the repayment of overpayments lowers their margin. Absent the cap, the margin for this group would be about 21 percent.



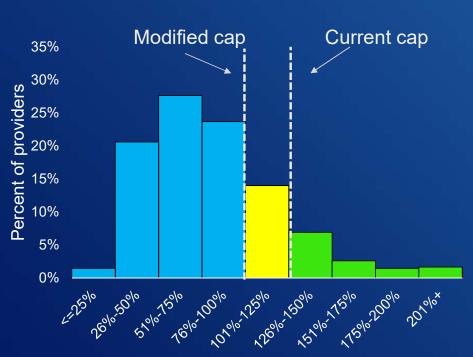
Source: MedPAC analysis of Medicare hospice claims and cost reports.

Policy to modify the aggregate cap

- Cap reduces payments to hospices with long stays and high margins
 - ALOS 276 days, margin 21% before cap in 2017
- Higher rate of exceeding the cap in high wage index areas because the cap is not wage-adjusted
- A policy to wage adjust and reduce the cap by 20% would:
 - Improve equity of the cap across providers
 - Generate savings by focusing payment reductions on providers with long stays and high margins



Simulation of policy to modify the cap



Provider payments as share of modified cap

- Simulation with 2017 data, assuming no utilization changes
- Share of hospices exceeding the cap would increase
 - New above-cap hospices are mostly for-profit (95%) and freestanding (95%), with long stays (ALOS of 254 days) and an aggregate margin of 22% in 2017
- Many hospices remain substantially under the cap
 - Includes mix of provider types with an ALOS of 128 days



Note: ALOS (average length of stay). Data are preliminary and subject to change. Simulation using 2017 data assuming no utilization changes. Average length of stay reflects lifetime length of stay as of the end of calendar year 2017 for all patients treated in cap year 2017. Source: MedPAC analysis of Medicare claims data and the Medicare Beneficiary Database obtained from CMS in October 2019.



Assessing payment adequacy and updating payments: Ambulatory surgical center services

Dan Zabinski January 16, 2020

мефрас

Overview of ambulatory surgical centers (ASCs)

Medicare FFS payments: \$4.9 billion

Beneficiaries: 3.5 million served

Number of ASCs: ~ 5,700

Current law update: 2.6% in 2020

Indicators of payment adequacy are positive

- Access to ASC services increased in 2017:
 - Volume per beneficiary increased 2.2%
 - FFS beneficiaries served increased 0.9%
 - Number of ASCs increased 2.6%
- Medicare payments per beneficiary increased 7.4%
- Access to capital: Good
- Quality: Improvement since 2013; issues with measures remain
- Lack of cost data limits analysis; Commission has recommended that ASCs be required to submit cost data

Data preliminary and subject to change.