



Advising the Congress on Medicare issues

Hospice costs and payments

James E. Mathews

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Medicare's hospice benefit – key points

- Provides beneficiaries with an alternative to intensive end-of-life curative treatment
- Benefit implemented in 1983 on presumption that it would be less costly to Medicare than conventional end-of-life treatment
- Medicare hospice spending = \$10 billion in 2007
- Medicare payment system embodies conflicting incentives

Hospice / non-hospice EOL spending differential – summary of research

- Hospice = lower spending over shorter periods:
 - Lower spending by substituting hospice for inpatient care;
 - Lower absolute spending in each of last 1 – 2 months of life;
 - Lower spending *possible* in 3rd and 4th months before death, but
 - *Higher* Medicare spending for hospice enrollees in each month beginning as early as the 3rd month before death;
- Differences in *cumulative* spending are reduced as hospice length of stay increases;
- No hospice / non-hospice spending differential over last year of life; some evidence suggests hospice use *may* result in *higher* spending.

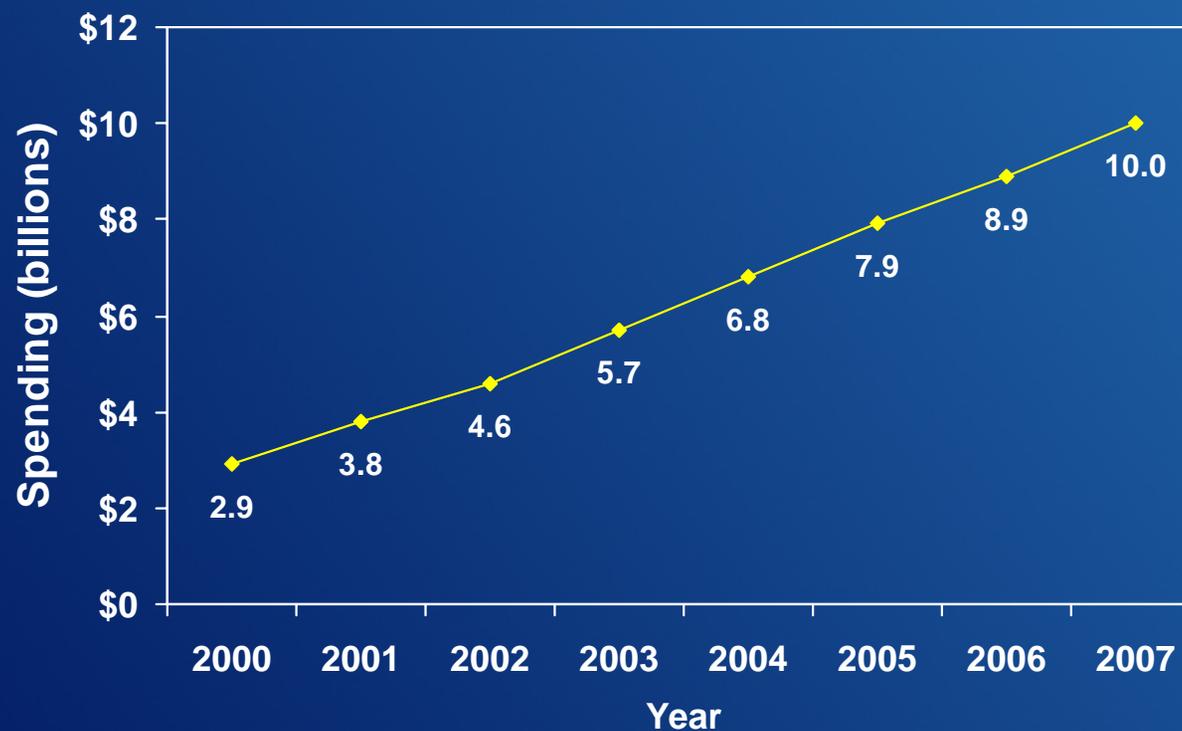
Hospice / non-hospice EOL spending differential – summary of research (cont.)

- The hospice / non-hospice spending differential is not uniform across all terminal diseases;
- Hospice use = lower program spending for shorter hospice stays and/or conditions that typically incur high levels of inpatient care at the end of life (e.g., cancer);
- Hospice use = greater spending for long hospice stays and/or terminal diseases with lower levels of inpatient care (e.g., Alzheimer's disease).

Summary – hospice vs. non-hospice: Medicare financing perspective

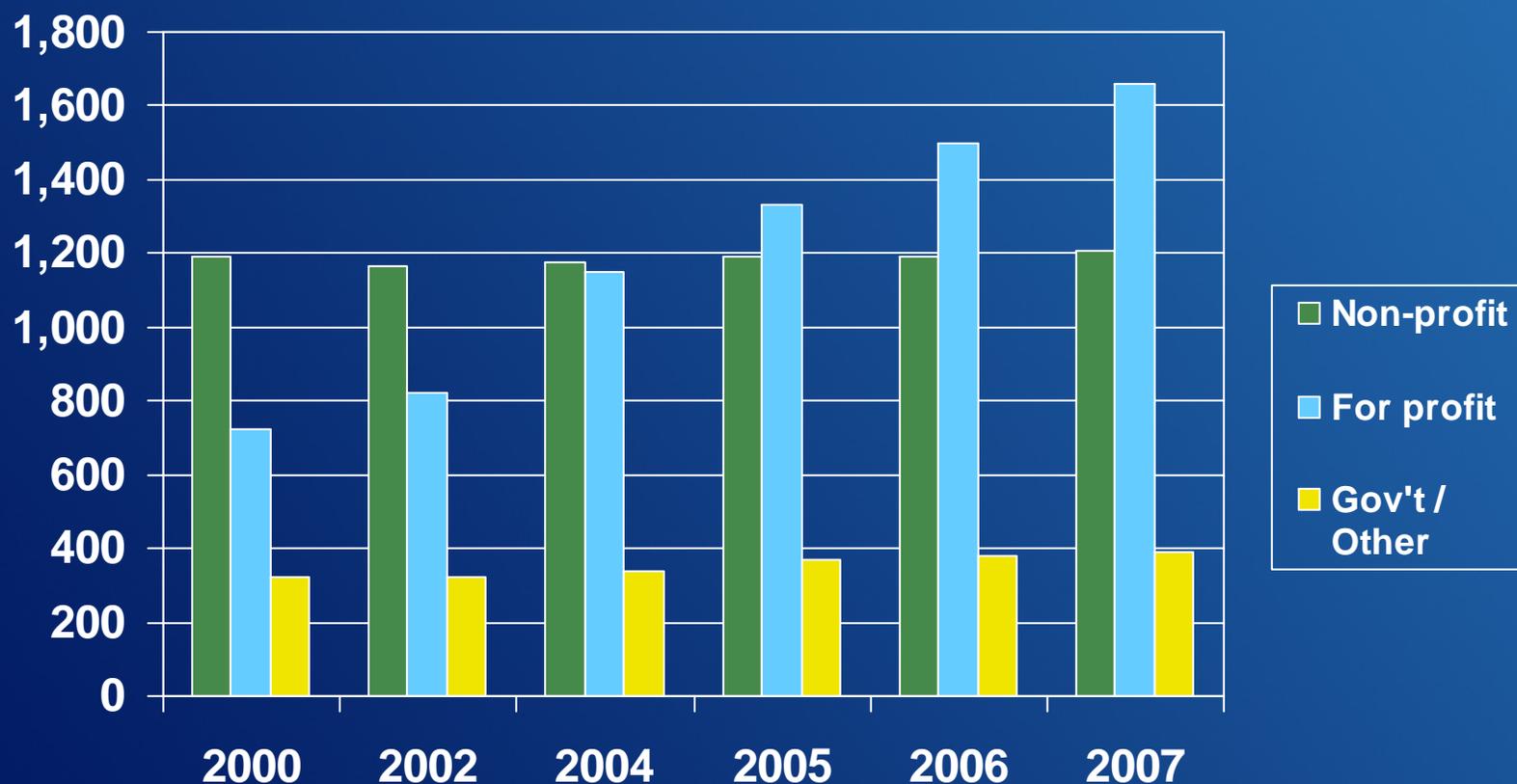
- Hospice enrollment reduces absolute spending only in last two months of life;
- “Net” reduced spending can persist through last six months of life, but spending in months 3 – 6 is higher for hospice enrollees than non-enrollees;
- From Medicare financing perspective, shorter stays result in greatest spending differential.

Hospice spending tripled between 2000 - 2007



Source: Centers for Medicare and Medicaid Services, Office of the Actuary.

Most hospice growth due to for-profit providers, 2000 - 2007



Growth in length of stay accompanies increase in spending, number of hospices

- Mean length of stay increased by over 30 percent between 2000 – 2005;
- Some increase attributable to change in patient mix – some terminal diseases typically have longer LOS than others;
- But patient mix doesn't explain all variation in LOS – some hospices have longer LOS for *all* patients / diagnoses.

Incentives in Medicare's hospice payment system may influence length of stay

- Hypothesis: longer hospice stays more profitable
- Anecdotal evidence:
 - Entry of for-profit hospices in market coincides with increase in LOS
 - Cap hospices = very long LOS, composed mostly of for-profit providers
- Need systematic analysis - margins

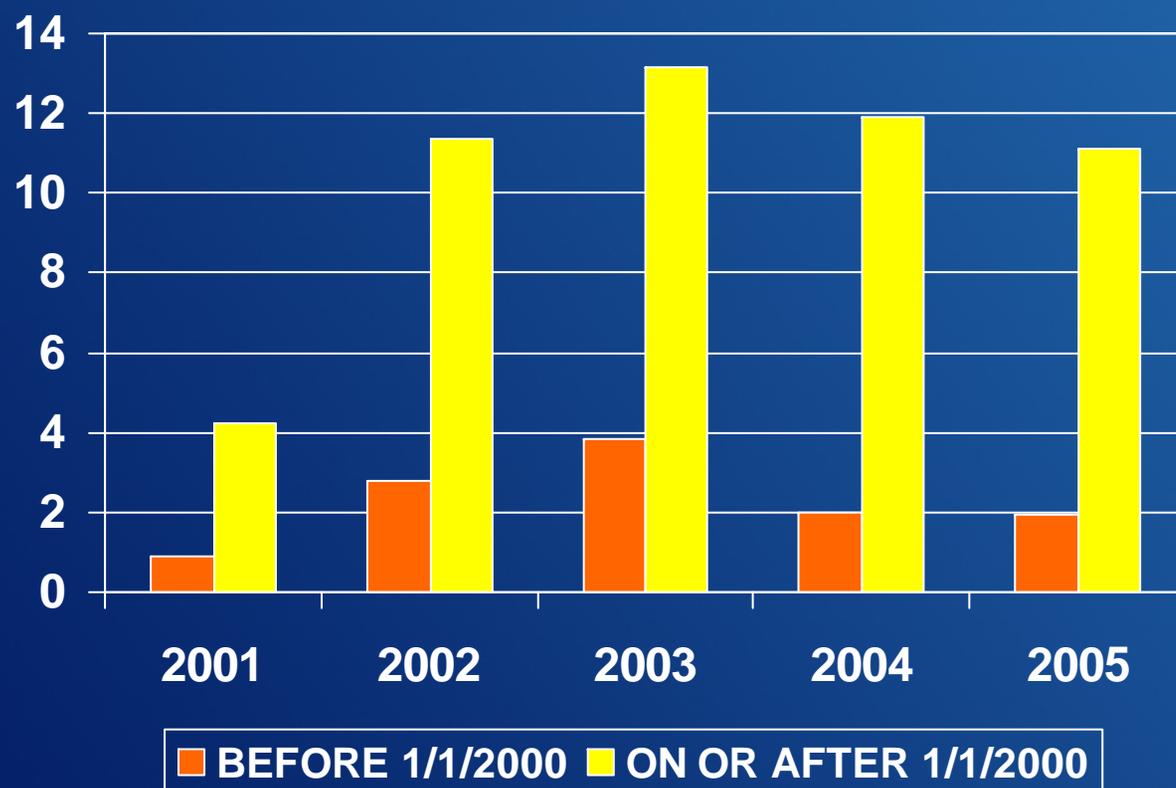
Medicare hospice margins, 2001 – 2005

Category	pct of hospices (2005)	2001	2002	2003	2004	2005
Free-standing	58.9%	5.6%	6.8%	9.0%	6.7%	6.3%
Provider-based*	41.1	-10.5	-7.6	-8.9	-7.5	-5.6
For-profit	43.2	12.0	14.6	15.9	12.4	11.8
Non-profit	47.7	-4.4	-3.7	-2.9	-3.6	-2.8
Urban	64.0	1.4	3.6	4.9	3.6	3.4
Rural	36.0	-1.8	0.1	2.5	0.0	3.3
Non-cap	90.9	N/A	2.1	3.3	1.8	1.5
Cap (incl. overpayments)	9.1	N/A	30.1	23.0	17.4	18.9
All	100	1.0	3.1	4.5	3.2	3.4

*Provider-based includes hospital-based, SNF-based, and HHA-based hospices.

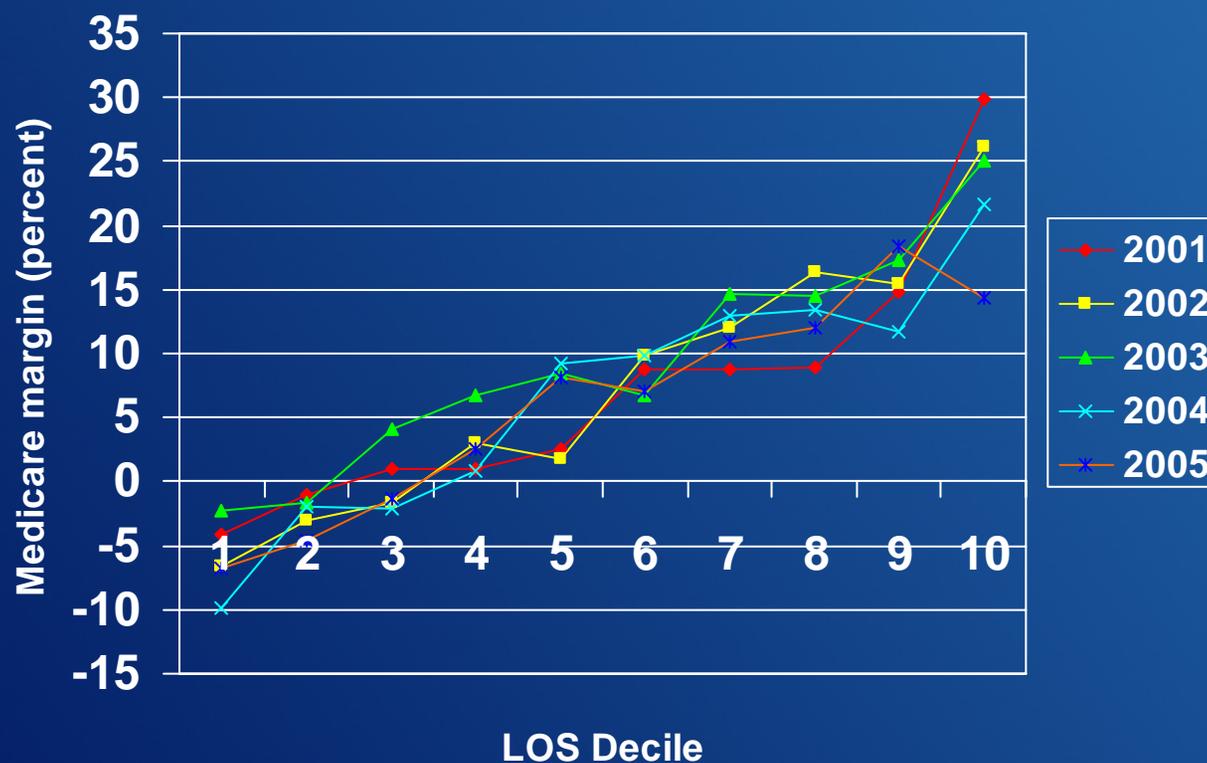
Source: MedPAC analysis of 2001 - 2005 100% hospice claims standard analytical files (SAF) and Medicare hospice cost reports from CMS.

Newer hospices (mostly for profits) have higher margins than established hospices



Source: MedPAC analysis of 2001 - 2005 100% hospice claims standard analytical files (SAF) and Medicare hospice cost reports from CMS.

Hospice margins increase with longer length of stay



Source: MedPAC analysis of 2001 - 2005 100% hospice claims standard analytical files (SAF) and Medicare hospice cost reports from CMS.

Further understanding cap hospice financial performance

- Relatively small number of hospices
- Variation in margins among cap hospices
 - 4.7% at 25th percentile, 28% at 75th percentile
- Cap amount (and provider response) impacts margins
 - Variation in cap amount
 - Variation in response to cap

Summary – Medicare reimbursement incentives: hospice provider perspective

- Hospice episodes are non-linear in cost
- Short hospice stays are less profitable
- Profitability increases with length of stay
 - The hospice cap limits length of stay, and thus profitability
 - Some providers “manage” the cap; others do not

Summary - overall

- Difference between Medicare spending for hospice decedents / other decedents is greatest in 1-2 months before death.
 - Longer use reduces differential.
 - Very long hospice stays result in greater spending for hospice decedents than for others.
- Incentives in payment system drive longer length of stay. Hospice profitability increases with longer length of stay.

Conclusion and next steps

- Beneficiary perspective
 - Quality of care
 - Value of hospice care
- Policy considerations