



Advising the Congress on Medicare issues

Assessing payment adequacy: Hospice

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Medicare hospice benefit

- Provides beneficiaries with an alternative to intensive end-of-life curative treatment
- Provides a broad set of palliative and supportive services to terminally ill beneficiaries who choose to enroll
- In 2008:
 - More than 1 million beneficiaries enrolled
 - 40 percent of Medicare decedents used hospice
 - Medicare spending exceeded \$11 billion

Medicare hospice benefit

- Benefit implemented in 1983 on the presumption that it would be less costly to Medicare than conventional end-of-life care
- Two constraints were placed on the benefit:
 - Eligibility criteria: life expectancy of six months or less if the disease runs its normal course
 - Hospice payment cap: average payments across all patients admitted to a hospice in a year cannot exceed cap amount (\$21,410 in 2007)

Trends in the hospice benefit

- Rapid growth in number of hospice providers (mostly for-profit providers) and hospice users
- Increase in average length of stay, driven by growth in very long stays
- Accountability issues
 - Physician certification of patient eligibility
 - Nursing home / hospice relationships
- Commission recommended in March 2009:
 - Payment system reform
 - Increased accountability
 - More data collection

Assessing adequacy of hospice payments

- Access to care
 - Supply of providers
 - Volume of services
- Quality of care
- Access to capital
- Payments and costs

Supply of hospices has increased, driven by growth of for profits

	2001	2007	2008	Annual change 2001-2007	Annual change 2007-2008
All	2,303	3,258	3,389	6.0%	4.0%
For profit	765	1,637	1,748	13.5%	6.8%
Nonprofit	1,184	1,188	1,197	0.1%	0.8%
Government	354	433	444	3.4%	2.5%
Freestanding	1,196	2,098	2,233	9.8%	6.4%
Home health based	541	592	592	1.5%	0.0%
Hospital based	554	551	545	-0.1%	-1.1%

Note: Figures preliminary and subject to change
 Source: MedPAC analysis of 2009 Provider of Services (POS) data from CMS

Hospice use has grown substantially in recent years

Percent of Medicare decedents using hospice

	2000	2007	2008	Average annual % point change 2000-2007	% point change 2007-2008
All	22.9%	38.9%	40.1%	2.3	1.2
Male	22.4%	35.9%	36.7%	1.9	0.8
Female	23.3%	41.5%	43.0%	2.6	1.5
White	23.8%	40.5%	41.8%	2.4	1.3
Minority	17.2%	29.3%	30.2%	1.7	0.9
<65	17.0%	24.5%	25.0%	1.1	0.5
65-84	24.7%	38.5%	39.3%	2.0	0.8
85+	21.4%	43.5%	45.3%	3.2	1.8

Note: Figures preliminary and subject to change

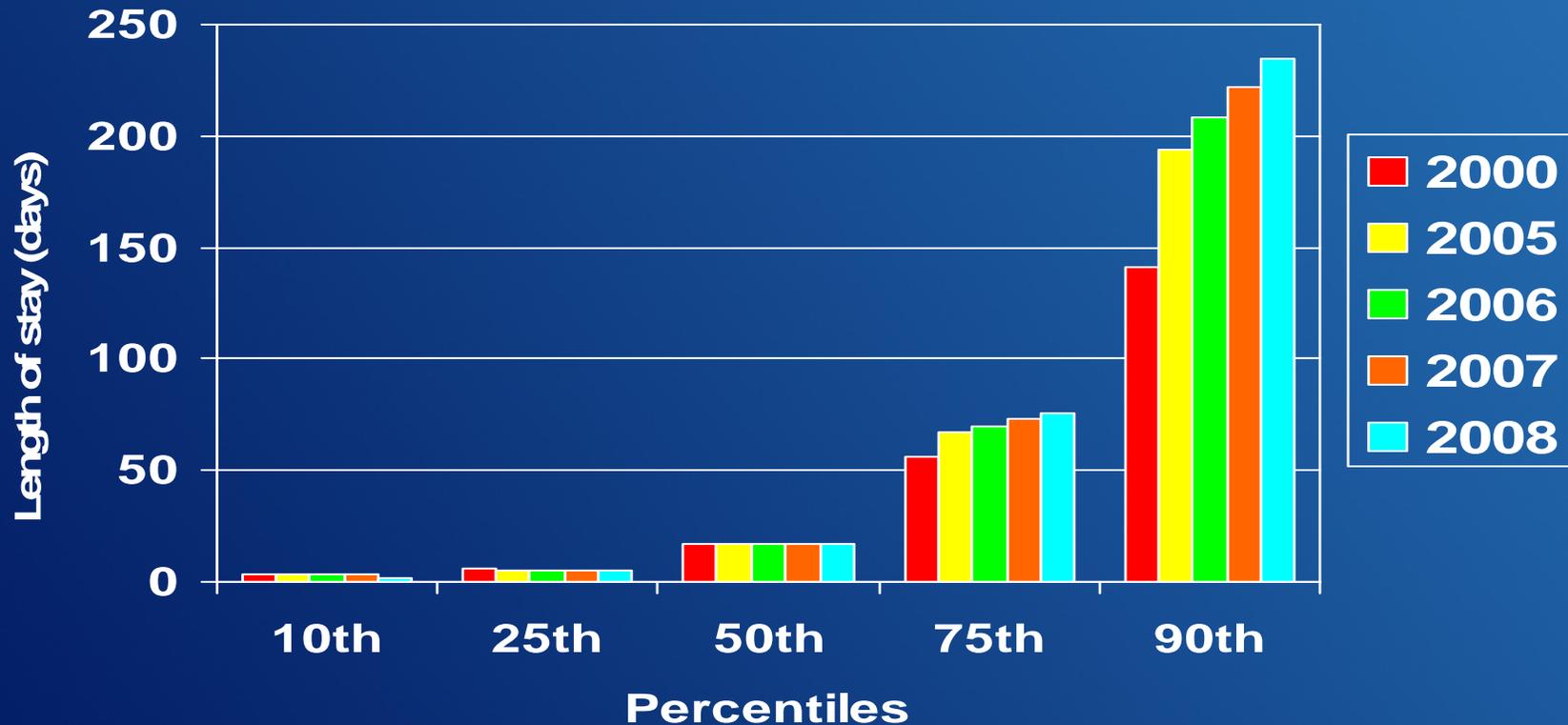
Source: MedPAC analysis of Medicare Beneficiary Database and Denominator File data from CMS

Number of hospice users, average length of stay, and total Medicare spending have increased

	2000	2007	2008	Annual change 2000-2007	Annual change 2007-2008
Medicare hospice spending (billions)	\$2.9	\$10.3	\$11.2	19.8%	8.7%
Number of hospice users	513,000	1,000,000	1,055,000	10.0%	5.5%
Average length of stay among decedents (days)	54	80	83	5.8%	3.8%

Note: Figures are preliminary and subject to change. Length of stay reflects the total number of days the decedent hospice user was enrolled in the Medicare hospice benefit during his/her lifetime.

Long hospice stays have grown longer while short stays remain virtually unchanged



Note: Figures are preliminary and subject to change. Length of stay reflects the total number of days the decedent hospice user was enrolled in the Medicare hospice benefit during his/her lifetime.

Source: MedPAC analysis of Medicare Beneficiary Database and Denominator File data from CMS

Hospice cap

- Number of hospices exceeding the cap: 10 percent in 2007
- Above-cap hospices:
 - Almost entirely for profit providers
 - Very long lengths of stay
 - Substantially more patients discharged alive
- No evidence the cap impedes access to hospice care overall or for racial and ethnic minorities

The hospice cap is unrelated to the use of hospice services across states

Top ten states with highest hospice use rates	Percent of decedents using hospice, 2007	Percent of hospices exceeding the cap, 2007
Arizona	57%	32%
Utah	52%	21%
Florida	52%	5%
Colorado	48%	2%
Iowa	48%	1%
Oregon	47%	2%
Delaware	46%	0%
New Mexico	44%	9%
Texas	44%	10%
Michigan	44%	3%

Note: Figures are preliminary and subject to change.

Hospice quality of care

- Currently, no publicly available quality data covering all hospices
- Surveys sponsored by associations
- CMS initiative
 - Testing 12 hospice quality measures in 7 hospices in NY; scheduled completion date: October 2010

Access to capital is normalizing

- Credit markets are recovering
- Hospice is less capital intensive than some other provider types
- Freestanding hospices
 - Publicly traded hospice chains– strong financial reports and solid access to capital
 - Robust entry of for-profit hospices
 - Access to capital for nonprofits is difficult to discern
- Provider-based hospices have access to capital through their parent institutions

Hospice cost per day by type of provider

Hospice cost per day, 2007

	Average	25th	50th	75th
All	134	103	126	159
Freestanding	128	100	121	150
Home health based	143	105	131	165
Hospital based	168	112	143	187
For profit	121	94	117	147
Nonprofit	148	115	138	173
Above-cap	104	85	102	124
Below-cap	139	107	130	163
Urban	137	105	129	162
Rural	119	99	120	151

Note: Figures are preliminary and subject to change.

Source: MedPAC analysis of Medicare cost reports from CMS

Cost differences across types of hospices reflect differences in length of stay and indirect costs

- Hospices with higher lengths of stay have lower costs per day
- Freestanding hospices have higher lengths of stay than provider-based hospices, and lower costs per day
- But, after taking into account differences in length of stay, freestanding facilities still have lower costs per day than provider-based facilities due to lower indirect costs

Summary

- Supply of providers has grown, driven by growth in for-profit hospices
- Number of hospice users has increased
- Length of stay has increased
- Total spending has increased

Commission's prior recommendations (March 2009)

1. The Congress should direct the Secretary to change the Medicare payment system for hospice to:

- have relatively higher payments per day at the beginning of the episode and relatively lower payments per day as the length of the episode increases,
- include a relatively higher payment for the costs associated with patient death at the end of the episode, and
- implement the payment system changes in 2013, with a brief transitional period.

These payment system changes should be implemented in a budget neutral manner in the first year.

Commission's prior recommendations (March 2009)

2A. The Congress should direct the Secretary to:

- require that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180th-day recertification and each subsequent recertification and attest that such visits took place,
- require that certifications and recertifications include a brief narrative describing the clinical basis for the patient's prognosis (ADOPTED), and
- require that all stays in excess of 180 days be medically reviewed for hospices for which stays exceeding 180 days make up 40 percent or more of their total cases.

Commission's prior recommendations (March 2009)

2B. The Secretary should direct the Office of Inspector General to investigate:

- the prevalence of financial relationships between hospices and long-term care facilities such as nursing facilities and assisted living facilities that may represent a conflict of interest and influence admissions to hospice,
- differences in patterns of nursing home referrals to hospice,
- the appropriateness of enrollment practices for hospices with unusual utilization patterns (e.g., high frequency of very long stays, very short stays, or enrollment of patients discharged from other hospices), and
- the appropriateness of hospice marketing materials and other admissions practices and potential correlations between length of stay and deficiencies in marketing or admissions practices.

Commission's prior recommendations (March 2009)

3B. The Secretary should collect additional data on hospice care and improve the quality of all data collected to facilitate the management of the hospice benefit. Additional data could be collected from claims as a condition of payment and from hospice cost reports.