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 2009:
  - More than 1 million beneficiaries enrolled
  - 42 percent of Medicare decedents used hospice
  - Medicare spending was $12 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 ($22,386.15 in 2008)

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

PPACA hospice provisions

- Payment reform: Secretary may revise the payment system as the Secretary determines appropriate no earlier than fiscal year 2014
- January 2011 accountability measures:
  - Face-to-face physician/NP visit required for recertification of long stay patients
  - Medical review required of hospice claims exceeding 180 days for hospices with many long stay patients
- Additional provisions related to quality reporting (2014), pay for performance (2016), concurrent care demonstration
- Adjustments to the market basket updates beginning in fiscal year 2013

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

	2000	2008	2009	Percent change 2000-2009	Average annual change 2000-2009
All	2,318	3,381	3,476	50%	4.6%
For profit	756	1,744	1,828	142	10.3
Nonprofit	1,198	1,178	1,184	-1	-0.1
Government	364	459	464	27	2.7
Freestanding	1,188	2,257	2,358	98	7.9
Home health based	556	572	569	2	0.3
Hospital based	560	532	528	-6	-0.7

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			Ave. annual % pt change	% pt change
	2000	2008	2009	2000-2008	2008-2009
All	22.9%	40.1%	42.0%	2.2	1.9
<65	17.0	25.1	26.0	1.0	0.9
65-84	24.7	39.4	40.9	1.8	1.5
85+	21.4	45.4	48.0	3.0	2.6
White	23.8	41.8	43.7	2.3	1.9
Minority	17.3	30.4	32.1	1.6	1.7
Urban	29.4	41.7	43.5	1.5	1.8
Rural, adj. urban	19.2	36.2	38.0	2.1	1.8
Rural, nonadj urban	16.7	31.5	33.6	1.9	2.1

Note: Figures preliminary and subject to change

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

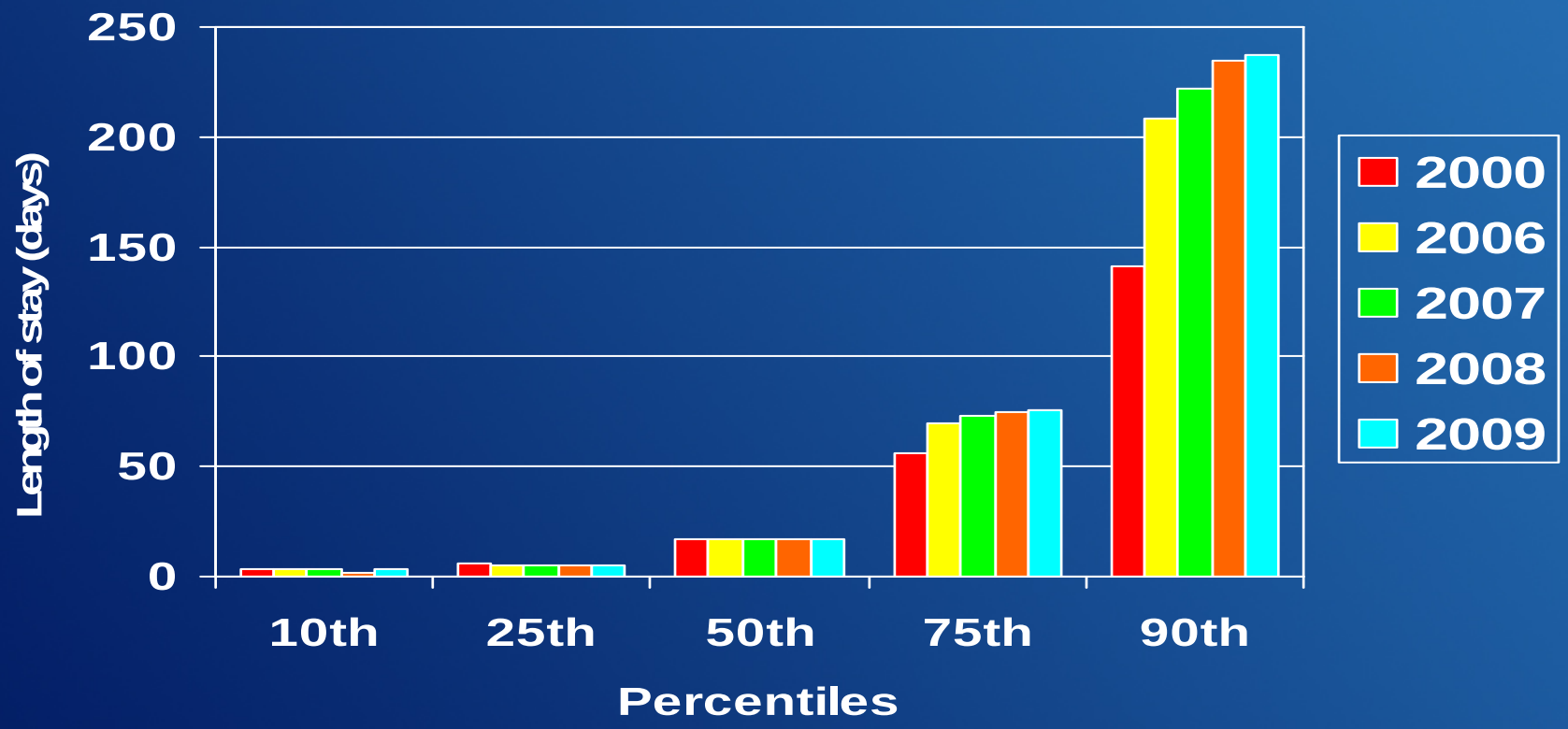
Number of hospice users, average length of stay, and total Medicare spending have increased

	2000	2008	2009	Annual change 2000-2008	Annual change 2008-2009
Medicare hospice spending (billions)	$2.9	$11.2	$12.0	18.4%	7.1%
Number of hospice users	513,000	1,055,000	1,088,000	9.4	3.1
Average length of stay among decedents (days)	54	83	86	5.5	3.6

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 hospice claims data, Medicare Beneficiary Database and Denominator File data from CMS

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

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Hospice cap

- Number of hospices exceeding the cap: 10 percent in 2008
- 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

Hospice quality of care

- Currently, no publicly available quality data covering all hospices
- PPACA requires CMS to publish quality measures in 2012 and hospices to report quality data in fiscal year 2014
- CMS initiative
  - Testing 12 hospice quality measures in 7 hospices in NY

Access to capital is adequate

- Hospice is less capital intensive than some other provider types
- Freestanding hospices
  - Publicly traded hospice chains– strong financial reports and solid access to capital
  - Market entry suggests capital is accessible: Robust growth in the number of for-profit hospices and modest growth of nonprofits
- Provider-based hospices have access to capital through their parent institutions

Hospice cost per day by provider type, 2008

	Hospice cost per day			
	Average	25th percentile	50th percentile	75th percentile
All	$141	$107	$132	$165
Freestanding	135	103	127	158
Home health based	150	109	135	170
Hospital based	175	120	150	193
For profit	127	98	119	153
Nonprofit	156	120	146	181
Above-cap	111	91	110	134
Below-cap	144	110	135	169
Urban	143	109	135	168
Rural	124	102	124	158

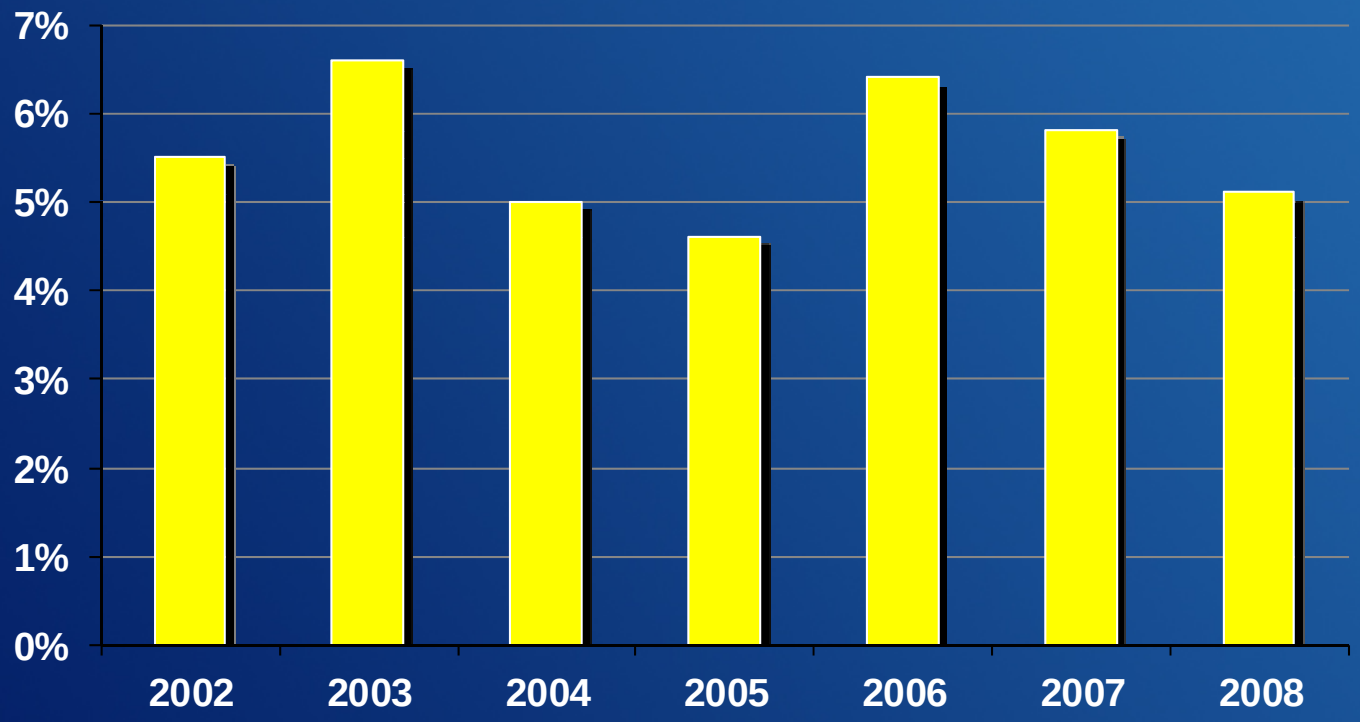
Note: Figures are preliminary and subject to change.

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

Hospice Medicare margins, 2002-2008



Note: Figures are preliminary and subject to change. Margins exclude cap overpayments and non-reimbursable costs.

Source: MedPAC analysis of Medicare hospice claims and cost reports from CMS

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Methodology for estimating margins

- Excluded cap overpayments from hospices' revenues
- Excluded Medicare nonreimbursable costs
  - Bereavement costs
  - Volunteer costs

Margins vary by type of provider

	Percent of hospices	Medicare Margin, 2008
All	100%	5.1%
Freestanding	67	8.0
Home health based	17	2.7
Hospital based	16	-12.2
For profit – all	52	10.0
– freestanding	45	11.1
Nonprofit – all	35	0.2
– freestanding	16	3.8
Urban	69	5.6
Rural	31	1.3

Note: Figures are preliminary and subject to change. Margins exclude cap overpayments (except where noted) and non-reimbursable costs.

Source: MedPAC analysis of Medicare hospice claims, cost reports, and provider of service file from CMS

Margins vary by type of provider (cont.)

	Percent of hospices	Medicare Margin, 2008
ALOS – Lowest quintile	20%	-10.1%
– 2nd quintile	20	0.4
– 3rd quintile	20	7.2
– 4th quintile	20	11.8
– Highest quintile	20	7.5
Below-cap	90	5.5
Above-cap (excl. overpay.)	10	1.0
Above-cap (incl. overpay.)	10	19.0
Percent of patients in NF/ALF		
Lowest quartile	25	-3.3
Highest quartile	25	13.7

Note: Figures are preliminary and subject to change. Margins exclude cap overpayments (except where noted) and non-reimbursable costs.

Source: MedPAC analysis of Medicare hospice claims, cost reports, and provider of service file from CMS

Summary

- Supply of providers continues to grow, driven by for-profit hospices
- Number of hospice users increased
- Length of stay for longest stays continues to grow
- Access to capital appears adequate
- 2008 margin is 5.1%

Commission's prior recommendations (March 2009)

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)

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.