Advising the Congress on Medicare issues

Assessing payment adequacy and updating payments: hospice services

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MEDPAC

Overview of Medicare hospice, 2012

- Hospice use:
  - 1.27 million beneficiaries
  - >46% of decedents
- Providers: > 3,700
- Medicare payments:
  - $15.1 billion to hospice providers
  - $1 billion to non-hospice providers for care unrelated to the terminal condition

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

Commission's findings concerning hospice (March 2009 report)

In depth review in 2008 and 2009 found:

- Trends that suggest new actors entering with revenue generation strategies
- Medicare's hospice payment system does not align well with hospices' provision of care at the end of life, and as a result, long stays are more profitable than short stays
- Accountability issues
  - Physician certification of patient eligibility
  - Nursing home / hospice relationships

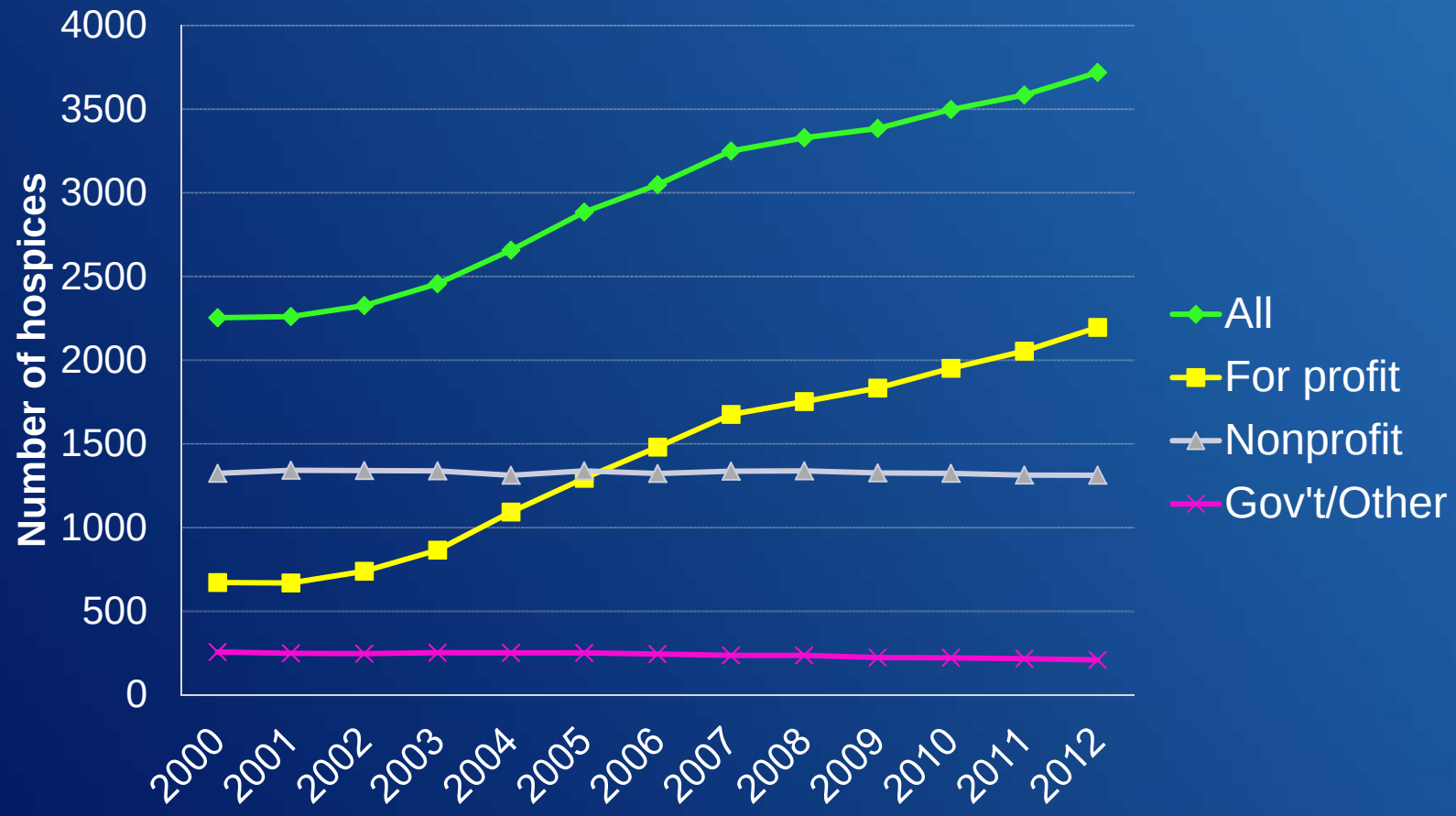
Commission's hospice recommendations (March 2009)

- Payment system reform
  - Per diem payments higher at the beginning and the end of episode, lower in the middle
- Accountability
  - Physician narrative and face-to-face visit requirement
  - Focused medical review of hospices with long stays accounting for an unusually high share of their cases
  - OIG studies
- Additional data reporting to manage the benefit

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-profit hospices



Note: Figures preliminary and subject to change

Source: MedPAC analysis of Medicare cost reports, Provider of Services file, and hospice claims from CMS.

Hospice use continues to grow

	Percent of Medicare decedents using hospice			Average annual % pt change	% pt change
	2000	2011	2012	2000-2011	2011-2012
All decedents	22.9%	45.2%	46.7%	2.0	1.5
Age<85	23.7	40.8	41.9	1.6	1.1
Age 85+	21.4	52.0	53.9	2.8	1.9
White	23.8	47.0	48.5	2.1	1.5
Minority	17.3	35.1	36.4	1.6	1.3
Urban	24.3	46.6	47.9	2.0	1.3
Rural	17.8	40.2	41.9	2.0	1.7

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Note: Figures preliminary and subject to change.

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

Hospice spending grew in 2012 as number of users and average length of stay increased

	2000	2011	2012	Average annual change 2000-2011	Annual change 2011-2012
Medicare hospice spending (billions)	$2.9	$13.8	$15.1	15.2%	9.3%
Number of hospice users	534,000	1,219,000	1,274,000	7.8%	4.5%
Average length of stay, decedents (days)	54	86	88	4.3%	2.3%
Median length of stay, decedents (days)	17	17	18	No change	+1 day

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

Length of stay varies by beneficiary and provider characteristics, 2012

ALOS for decedents varies by:

- Diagnosis (cancer 51 days; neurological 139 days)
- Patient location (home 90 days; nursing facility 112 days; ALF 154 days)
- Ownership (nonprofit 69 days; for-profit 105 days)
- Type of hospice (provider-based 65 days; freestanding 91 days)

Note: Figures are preliminary and subject to change. Length of stay data are for Medicare decedents who used hospice in the last calendar year of life and 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

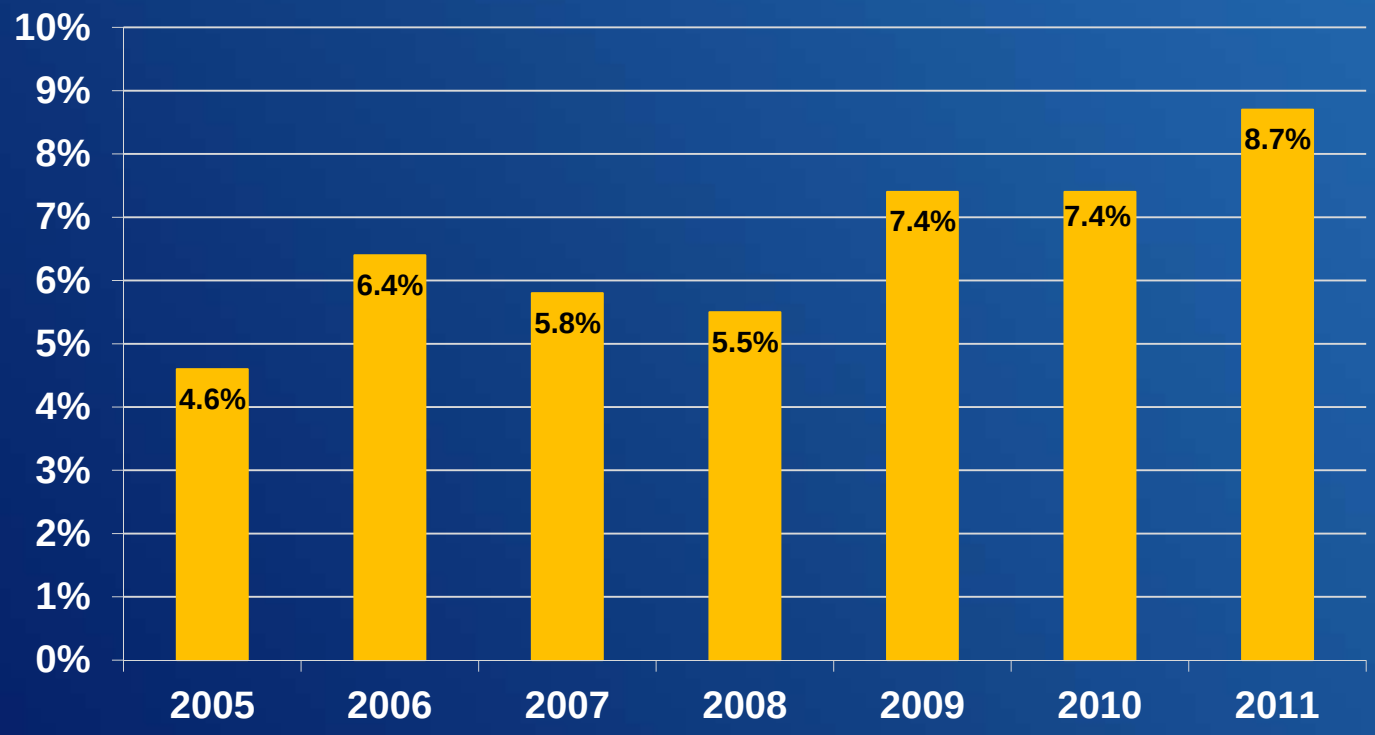
Hospice quality of care

- Currently, no publicly available quality data covering all hospices
- Reporting began in 2013 on two measures: pain management measure and structural measure
- Current measures will be replaced by:
  - 7 process measures collected via standardized instrument (beginning July 2014)
  - Experience of care survey (beginning 2015)
- Publicly reported data not expected before 2017

Access to capital appears adequate

- Hospice is less capital-intensive than some other provider types
- Freestanding hospices
  - Continued strong growth in the number of for-profit freestanding hospices
  - Some publicly-traded chains have acquired other hospices
  - Private equity investment in hospice
  - Less information on access to capital for nonprofit freestanding providers, which may be more limited
- Provider-based hospices have access to capital through their parent institutions

Hospice Medicare margins, 2005-2011



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

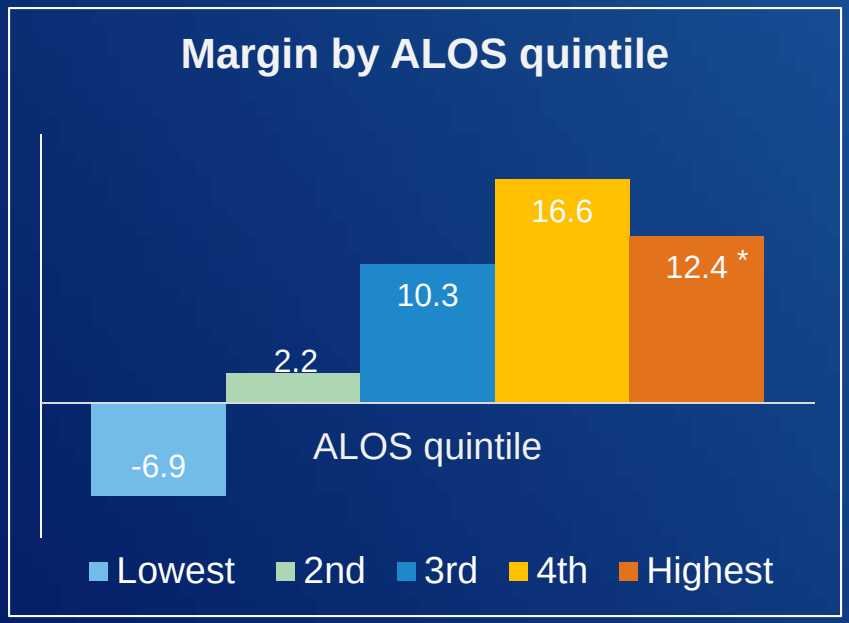
Medicare margins vary by type of provider, 2011

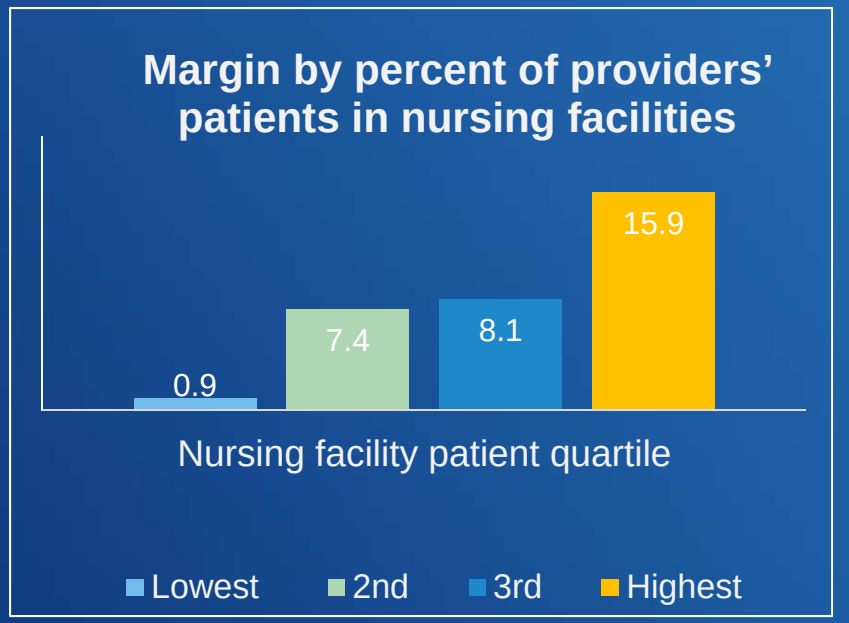
	Percent of hospices	Medicare margin, 2011
All	100%	8.7%
Freestanding	69	11.8
Home-health-based	14	5.0
Hospital-based	16	-15.9
For profit – all	57	14.5
– freestanding	52	15.9
Nonprofit – all	37	2.5
– freestanding	16	6.4
Urban	72	9.0
Rural	28	6.2
Below cap	90.2	9.0
Above cap (exclude/include overpayments)	9.8	4.1/18.4

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.

Medicare margins vary by length of stay and site of service, 2011





* The margin for the highest ALOS 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 more than 18 percent.
Note: Figures are preliminary and subject to change. ALOS (average length of stay). Margins exclude cap overpayments and non-reimbursable costs.
Source: MedPAC analysis of Medicare hospice claims, cost reports, and provider of service file from CMS

Summary

- Indicators of access to care are favorable
  - Supply of providers continues to grow, driven by for-profit hospices
  - Number of hospice users increased
  - ALOS increased
- Quality data are unavailable
- Access to capital appears adequate
- 2011 margin is 8.7%