Future research directions in hospice payment policy

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October 1, 2020

MEDPAC

Overview: Issues and policies for future research

- Hospice aggregate level of payment substantially exceeds cost, while margins vary widely by length of stay
  - Explore site-neutral payment adjustment for long stays

- Outlier utilization patterns among some hospice providers raise program integrity concerns
  - Explore development of compliance threshold

Background: Medicare hospice benefit

Palliative and supportive services for beneficiaries with terminal illnesses who choose to enroll

Eligibility criteria

- Life expectancy: 6 months or less if disease runs its normal course
- Physician(s) certify prognosis at outset of each benefit period
- Two 90-day benefit periods, then unlimited number of 60-day periods
- Beneficiary agrees to forgo care outside of hospice for terminal condition and related conditions

Hospice services covered

- Nurse, social worker, aide, therapist, and physician visits
- Drugs, DME, and supplies
- Short-term inpatient and respite care
- Counseling and bereavement
- Other services for palliation of terminal and related conditions

Note: DME (Durable medical equipment).

Hospice payment system

- Medicare paid $19.2 billion for hospice services in 2018
- Medicare pays a per diem rate for hospice
- 4 levels of care:
  - Routine home care (RHC) (98% of days) and 3 other higher intensity levels of care
- Aggregate cap on total payments to a provider annually
  - If a provider's total payments > number of patients x cap amount ($30,684 in FY 21), then provider must repay the excess

Long stays account for large share of spending

- About 14% of Medicare hospice decedents in 2018 had stays exceeding 180 days
- Nearly 60% of hospice spending in 2018 ($11B) was on behalf of beneficiaries who had stays exceeding 180 days
- Of the $11B, about $7B was for additional hospice care for beneficiaries who had already received at least 180 days of hospice

	Medicare spending 2018
All hospice users	$19.2
Beneficiaries with LOS>180 day	$11.1
Days 1-180	$3.8
Days 181-365	$3.5
Days 366+	$3.8
Beneficiaries with LOS<=180 days	$8.2

Notes: LOS (length of stay). In the chart, LOS reflects the beneficiary's lifetime LOS as of the end of 2018 (or at the time of discharge in 2018 if the beneficiary was not enrolled in hospice at the end of 2018). All spending reflected in the chart occurred only in 2018. Breakout groups do not sum to totals because of rounding.
Source: MedPAC March 2020 Report. MedPAC publications are the definitive reference source for all MedPAC analyses and results.

CMS has taken steps to improve the hospice payment system but issues remain

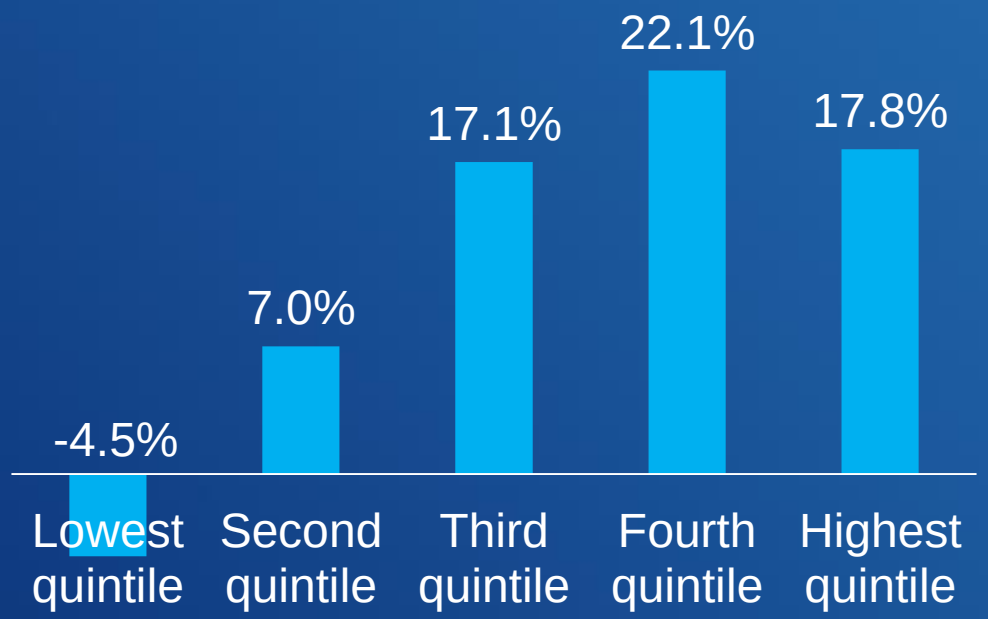
- Long stays in hospice are profitable because per diem payments do not align well with hospice costs
  - Hospices provide more services at the beginning and end of an episode and fewer in the middle
- Until 2016, hospices were paid a uniform rate for each day of RHC
- CMS payment changes
  - 2016: Modified RHC rates (higher for days 1-60, lower for days 61+, additional payments for certain visits in the last 7 days of life)
  - 2020: Rebasing to substantially increase payment rates for other 3 levels of care, and slightly decrease RHC rates (although CMS estimated RHC rates exceeded costs by 18 percent)

Aggregate Medicare margin is strong and providers' margins vary by length of stay

March 2020 report findings

- 12.6% aggregate Medicare margin in 2017
- Margins increase with length of stay
- Aggregate cap provides some check on margins (e.g., in highest quintile)

Margins by provider quintile based on share of stays > 180 days, 2017



Source: MedPAC March 2020 Report. MedPAC publications are the definitive reference source for all MedPAC analyses and results publications

MedPAC recommendation on hospice payment (March 2020)

Two-part recommendation

- No payment update FY 2021
  - Statutory update is 2.4%
- Wage adjust and reduce the aggregate cap by 20%
  - Would focus payment reductions on providers with longest stays
  - But high profit margins would remain for providers with relatively long stays

Provider length of stay quintile	2017 payment-to-cost ratio	
	Actual	Simulated with CMS's FY '20 rebasing and recommendation to wage adjust and reduce cap
Lowest quintile	96%	98%
2nd quintile	107%	109%
3rd quintile	121%	120%
4th quintile	129%	122%
Highest quintile	122%	103%

Note: Simulation based on 2017 data assuming no utilization changes. Data preliminary and subject to change.
Source: MedPAC analysis of Medicare claims and cost report data.

Future research could explore additional payment adjustment for long stays

- Long hospice stays may substitute for other types of care
- Could explore site-neutral payment adjustment for long stays using Medicare home health as payment benchmark
  - Both hospice and home health provide nurse, social worker, aide, and therapy visits
  - With long stays, hospice care occurs earlier in the disease trajectory
  - Role of aide visits increases with hospice length of stay, suggesting that long hospice stays may perform some of the same functions as custodial home care
- Site-neutral payment adjustment would need to account for differences in services covered by hospice and home health

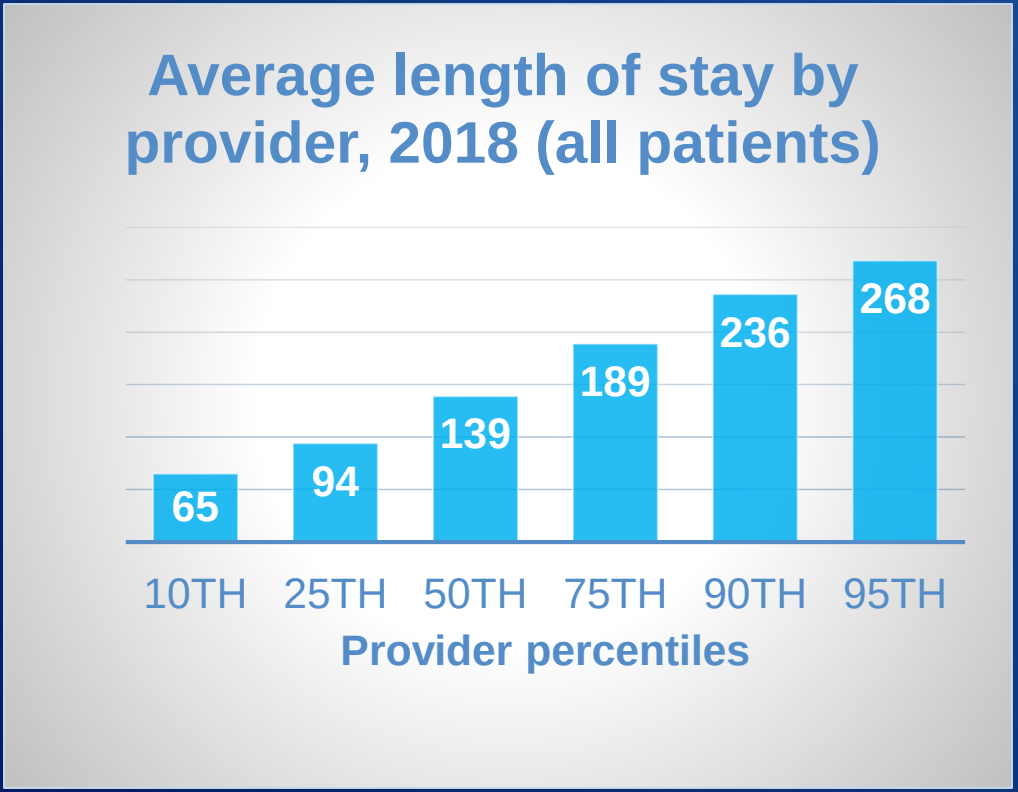
Potential approach to develop site-neutral payment adjustment for long stays

- Use home health per visit payment rates to estimate payment benchmark for hospice visits
- Estimate cost of hospice services not covered by home health using Medicare cost report data
- Combine estimates of visit and non-visit costs to create a site-neutral payment benchmark for long hospice stays
- Compare payment benchmark with actual hospice payments for long hospice stays to create a long stay adjustment factor

Design considerations for site-neutral payment

- What length of stay threshold would trigger site-neutral payment?
- Would payment adjustment apply to the entire stay or only hospice days beyond the threshold?
- For long stays, would there be a period near the end-of-life that is exempt from site-neutral payment?
- How could the policy be structured to:
  - minimize the potential for providers to avoid site-neutral payment by discharging and readmitting patients to hospice
  - treat providers equitably in situations where patients switch hospices and receive care from multiple providers

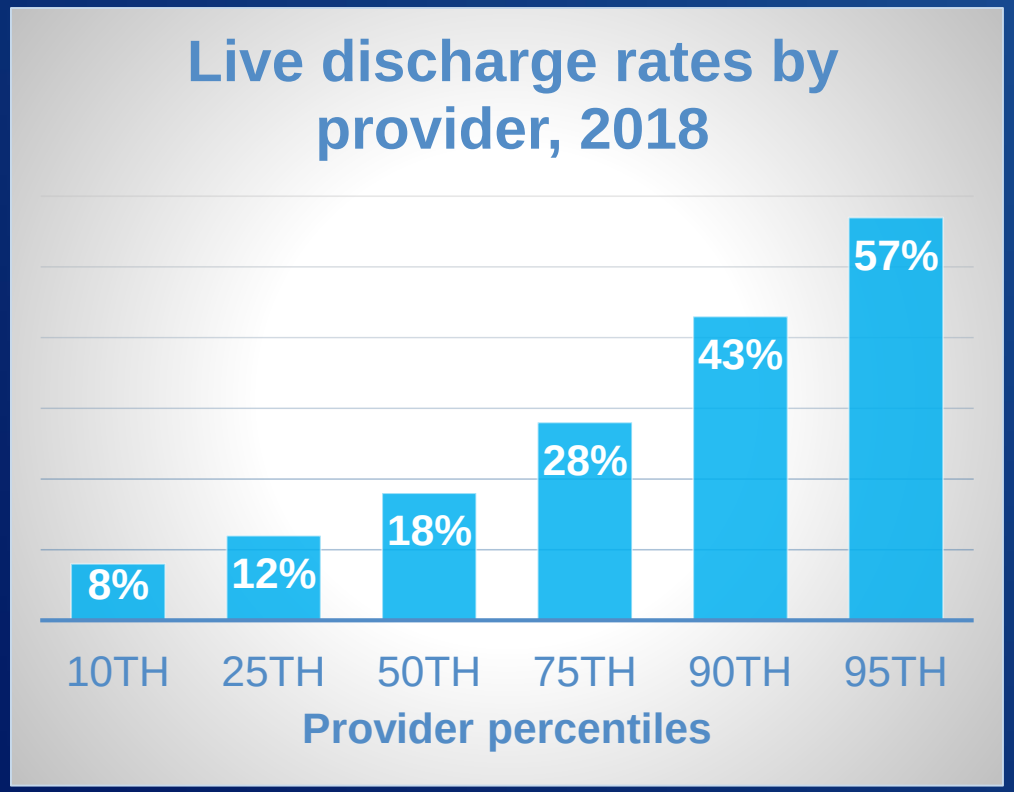
Some hospices have much longer stays than others



- Average length of stay varies by diagnosis and location of care
- Possible to focus on patients likely to have long stays
- OIG has found some providers are not complying with eligibility requirements

Note: Data include providers with more than 30 Medicare patients in 2018. Average length of stay reflects average lifetime length of stay as of the end of 2018 for all patients cared for by the provider in 2018. Data are preliminary and subject to change.
Source: MedPAC analysis of Medicare claims data.

Some hospices have much higher live discharge rates than others



- Providers with unusually high live discharge rates may reflect:
  - Quality of care issues
  - Lack of compliance with eligibility criteria
  - Approach by some providers to minimize aggregate cap liability

Notes: Data include providers with more than 30 discharges in 2018. Data are preliminary and subject to change.
Source: MedPAC analysis of Medicare claims data.

Future research could explore development of compliance threshold for hospice

- Care provided by hospices with outlier utilization patterns differs in comprehensiveness and intensity
- Compliance thresholds in other sectors encourages providers to seek patients most appropriate for that level of care
  Examples:
  - Inpatient rehabilitation facilities: 60% rule
  - Long-term care hospitals: 50% rule, 25-day average length of stay
- Development of compliance thresholds could be explored for hospice to address providers with outlier utilization patterns

Design considerations for compliance threshold policy

- Basis of the threshold (e.g., length of stay, live discharge rates)?
  - If hospice length of stay, what is an appropriate metric (e.g., share of stays exceeding 180 days, average length of stay, or an alternative)?
- At what level should the threshold be set?
- Consequences of not meeting the threshold (e.g., lower payment rate or no longer qualifying as Medicare hospice provider)?
- Time period to which consequence applies (e.g., retrospectively or going forward for a specified period)?

Summary and next steps

- Potential areas for future research
  - Site-neutral payment adjustment for long hospice stays
  - Compliance threshold for hospice providers

- Commissioner feedback to guide future research