Advising the Congress on Medicare issues

Assessing payment adequacy: Hospice

Kim Neuman

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MEDPAC

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:
  - Over 1 million beneficiaries received hospice services
  - 42 percent of Medicare decedents used hospice
  - Medicare spending was $12 billion

Number of hospices and use of hospice have grown substantially

- Number of hospices grew 50% between 2000 and 2009, driven by growth in for-profits
- 42% of Medicare decedents used hospice in 2009, up from 40% in 2008 and 23% in 2000
  - Growth among all racial/ethnic groups and rural/urban areas
- States with most growth in use are not necessarily states with most growth in providers

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

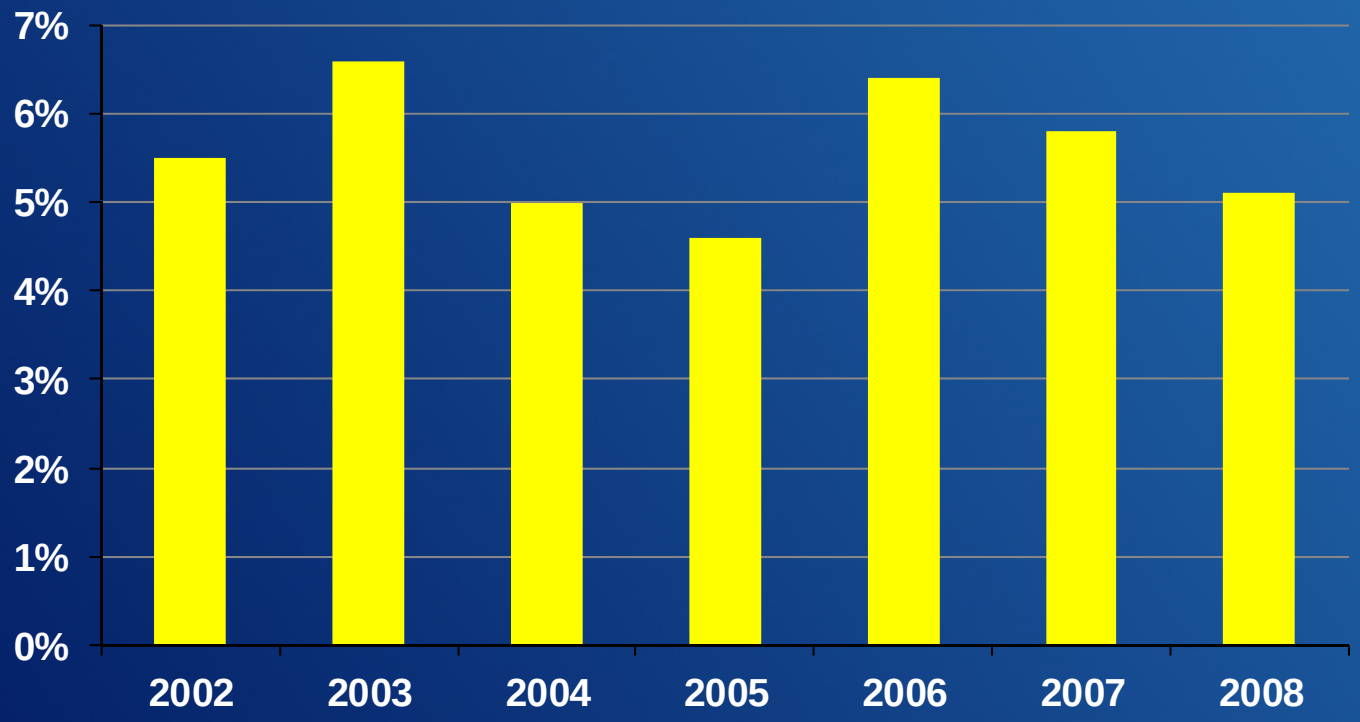
Hospice quality of care

- Currently, no publicly available quality data covering all hospices
- PPACA requires CMS to publish quality measures in 2012. Beginning FY 2014, failure to report quality data will result in a 2% reduction in the annual update.

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 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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2008 margin by hospice characteristics

- Aggregate Medicare margin: 5.1%
- Freestanding margin is higher than provider-based
  (8.0% freestanding; 2.7% home health; -12.2% hospital)
- For-profits have higher margins than nonprofits
  (freestanding: 11.3% for-profit and 3.2% nonprofit)
- Urban margin (5.6%) is higher than rural (1.3%)

2008 margin by hospice characteristics

- Margins increase as length of stay increases
- Margins increase as share of patients in nursing facility and assisted living facility increases
- Methodology for margin calculation:
  - Overpayments to above cap hospices are not counted as revenues
  - Exclude nonreimbursable costs (bereavement and volunteer costs)

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%

Re-print payment reform recommendation that would affect distribution of payments

Reform the hospice payment system to:

- Increase payments per day at the beginning of the episode and reduce payments per day as the length of the episode increases
- Provide an additional end-of-episode payment to reflect hospices' higher level of effort at the end of life

Budget neutral payment change that would redistribute revenues

- Overall, revenues would increase for provider-based, nonprofit, and rural hospices; decrease for others

Re-print recommendation for more OIG scrutiny

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.