Assessing payment adequacy and updating payments: hospice services

Kim Neuman

December 18, 2014

MEDPAC

Overview of Medicare hospice, 2013

- Hospice use:
  - 1.315 million beneficiaries
  - 47.3% of decedents
- Providers: 3,900
- Medicare payments:
  - $15.1 billion to hospice providers

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

MedPAC March 2009 report findings

- Trends that suggest new actors entering with revenue generation strategies
  - Rapid entry of for-profit providers
  - Increase in lengths of stay for patients with the longest stays
  - Longer stays among for-profits than nonprofits for all diagnoses
- 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 and nursing home / hospice relationships

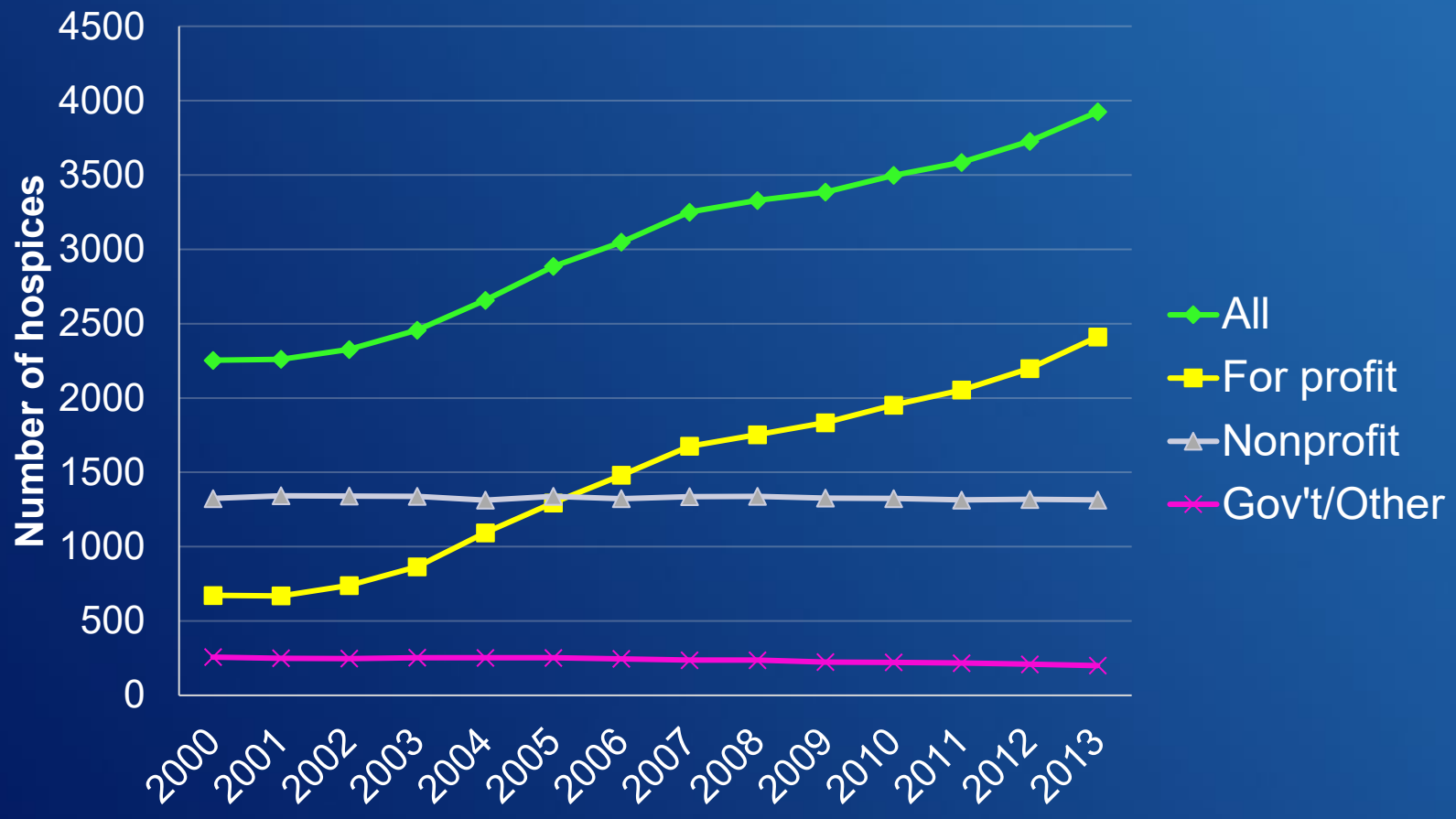
Commission's hospice recommendations (March 2009)

- 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 percentage point change	Percentage point change
	2000	2012	2013	2000-2012	2012-2013
All decedents	22.9%	46.7%	47.3%	2.0	0.6
Age<85	23.7	42.0	42.3	1.5	0.3
Age 85+	21.4	54.0	55.0	2.7	1.0
White	23.8	48.6	49.2	2.1	0.6
Minority	17.3	36.5	37.0	1.6	0.5
Urban	24.3	48.0	48.5	2.0	0.5
Rural	17.8	41.6	42.4	2.0	0.8

MEDPAC

Note: Figures preliminary and subject to change.
Source: MedPAC analysis of Medicare Beneficiary Database and Denominator File data from CMS

Number of hospice users increased and length of stay changed little in 2013

	2000	2011	2012	2013
Medicare hospice spending (billions)	$2.9	$13.8	$15.1	$15.1
Number of hospice users	534,000	1,219,000	1,274,000	1,315,000
Length of stay among decedents (days)				
Average	53.5	86.3	88.0	87.8
25th percentile	6	5	5	5
50th percentile	17	17	18	17
90th percentile	141	241	246	246

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

MEDPAC

Length of stay varies by beneficiary and provider characteristics, 2013

Average length of stay for decedents varies by:

- Diagnosis (cancer: 53 days; neurological :147 days)
- Patient location (home: 89 days; nursing facility: 111 days; assisted living facility: 153 days)
- Ownership (nonprofit: 68 days; for-profit: 105 days)
- Type of hospice (provider-based: 64 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. Diagnosis reflects the primary diagnosis on the beneficiary's last hospice claim.

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

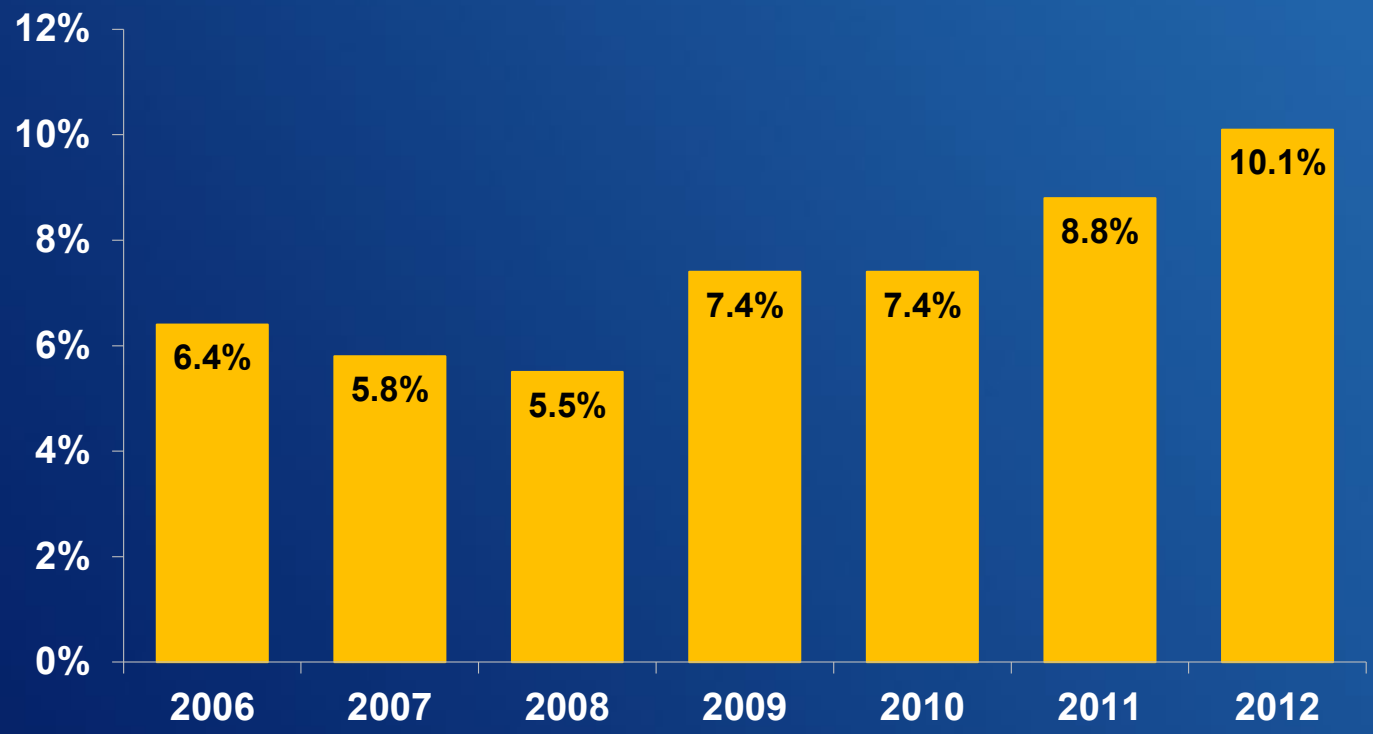
Hospice quality of care

- Currently, no publicly available quality data covering all hospices
- Reporting began in 2013 on two measures: pain management measure and structural measure
- In July 2014, initial measures were replaced by 7 process measures collected via standardized instrument
- Hospice CAHPS survey will begin in 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 (9.6% increase in 2013)
  - Hospice acquisitions by large for-profit hospices and post-acute care providers
  - 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, 2006-2012



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

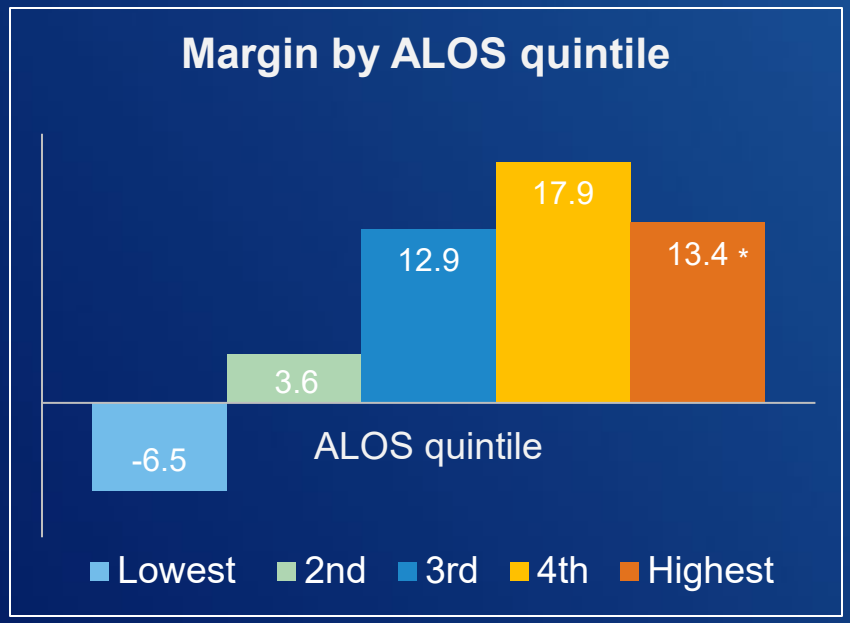
Medicare margins vary by type of provider, 2012

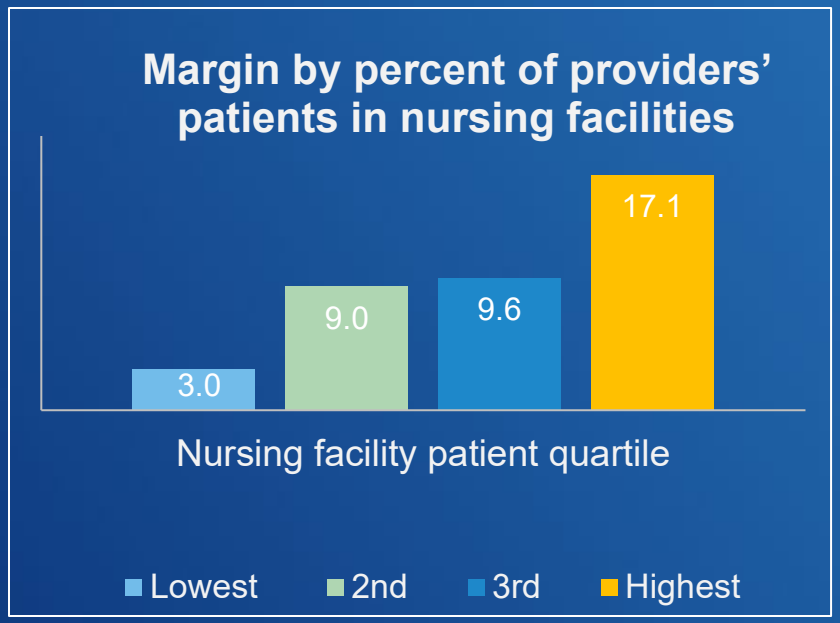
	Percent of hospices	Medicare margin, 2012
All	100%	10.1%
Freestanding	71	13.3
Home-health-based	13	5.5
Hospital-based	15	-16.8
For profit – all	59	15.4
– freestanding	51	16.5
Nonprofit – all	35	3.7
– freestanding	15	7.7
Urban	73	10.3
Rural	27	7.8
Below cap	89.0	10.4
Above cap (exclude/include overpayments)	11.0	5.2/21.3

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.

Medicare margins vary by length of stay and site of service, 2012





* 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 about 19 percent.

Note: ALOS (average length of stay). Figures are preliminary and subject to change. Margins exclude cap overpayments and non-reimbursable costs.

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

2015 margin projection

- 2012 margin: 10.1 percent
- Factors the 2015 projection takes into account:
  - Market basket updates, productivity adjustment and additional legislated adjustment of -0.3 (2013- 2015)
  - Sequester reduces payments reduction beginning April 2013
  - Reduction in wage index BNAF and other wage index changes
  - Additional administrative costs related to new requirements for claims data reporting, quality reporting initiatives, and a revised cost report
- 2015 margin projection: 6.6%
- 2016 policy
  - additional 0.6 percentage point reduction in payments from BNAF phase-out

Note: Figures are preliminary and subject to change.

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 among decedents was stable
- Quality data are unavailable
- Access to capital appears adequate
- 2012 margin is 10.1%
- Projected 2015 margin is 6.6%

Chairman's draft recommendation

The Congress should eliminate the update to the hospice payment rates for fiscal year 2016.

Implications

Spending: decrease relative to statutory update

Beneficiaries and providers: No adverse impact on beneficiaries expected. Not expected to affect providers' willingness and ability to care for Medicare beneficiaries.