Assessing payment adequacy and updating payments: hospice services

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December 10, 2015

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Overview of Medicare hospice, 2014

- Hospice use:
  - 1.324 million beneficiaries
  - 47.8% of decedents
- Providers: >4,000
- 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 and payment reform recommendation

- 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
- The Commission recommended the payment system be changed to have higher per diem payments at the beginning and end of the episode, and lower in the middle

Upcoming payment system changes

- Beginning January 2016, new payment structure for hospice routine home care:
  - Days 1-60: $187 per day
  - Days 61+: $147 per day
  - Last 7 days of life: Additional payments for registered nurse and social worker visits ($39 per hour, up to 4 hours payable per day)
- CMS set payment rates to be budget neutral in aggregate assuming no utilization changes
- Projected to redistribute revenues across providers
  - Increase revenues for provider-based, nonprofit, and rural hospices
  - Decrease revenues for freestanding, for-profit, and urban hospices

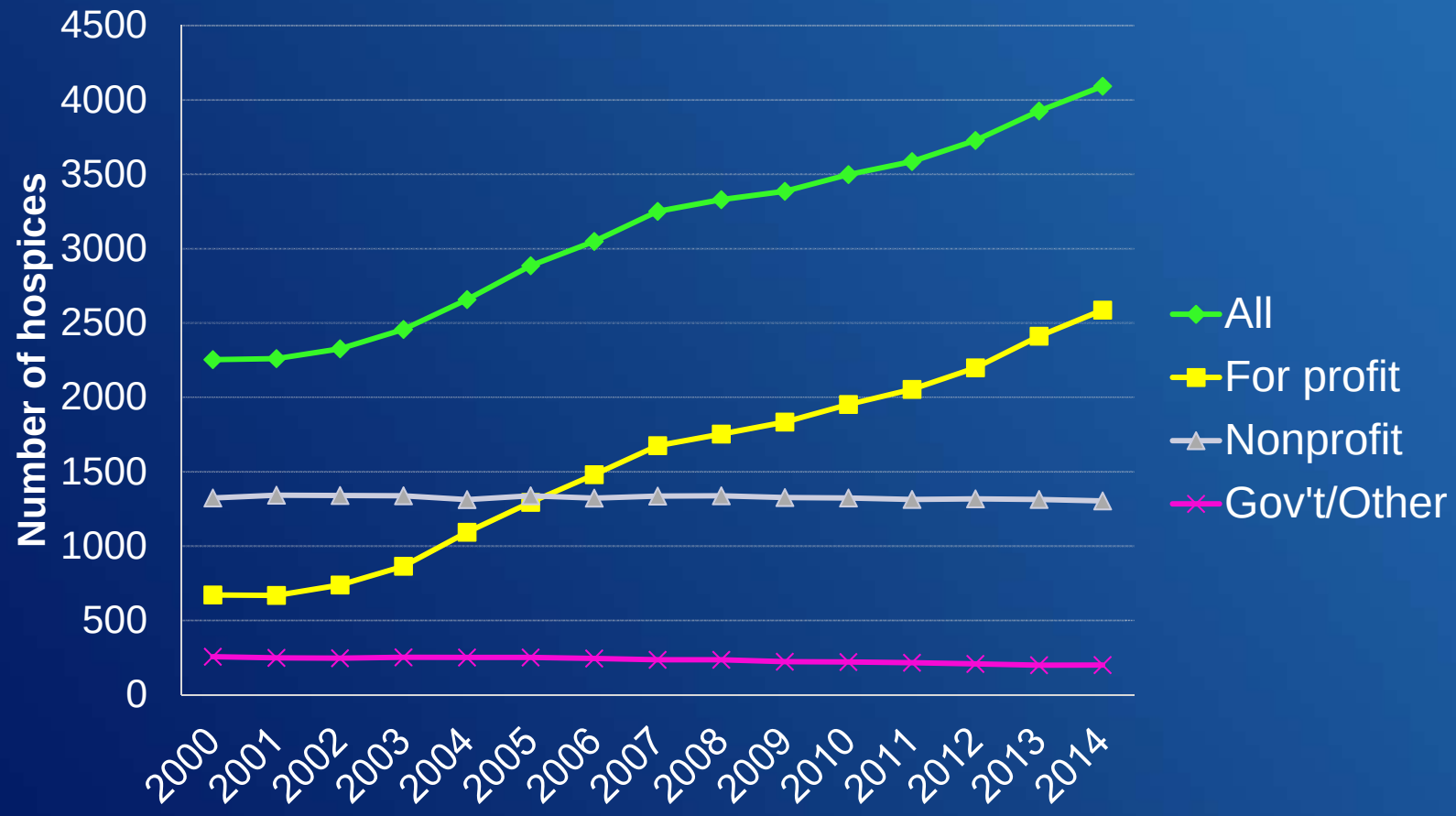
Other changes related to end-of-life care beginning in 2016

- Medicare Care Choices Model demonstration
  - 5-year demonstration to test concurrent palliative and curative care
  - Will involve 140 hospice providers and up to 150,000 beneficiaries
  - For beneficiaries who are hospice eligible but not enrolled in hospice and who meet certain other criteria
  - Hospices will be paid $400 per month per participant to provide palliative and supportive services
- Advanced care planning services will be covered under the physician fee schedule

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	2013	2014	2000-2013	2013-2014
All decedents	22.9%	47.3%	47.8%	1.9	0.5
Age<85	23.7	42.3	42.6	1.4	0.3
Age 85+	21.4	55.0	56.0	2.6	1.0
White	23.8	49.2	49.7	2.0	0.5
Minority	17.3	37.0	37.6	1.5	0.6
Urban	24.3	48.5	48.9	1.9	0.4
Rural	17.8	42.4	42.8	1.9	0.4

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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 2014

	2000	2012	2013	2014
Medicare hospice spending (billions)	$2.9	$15.1	$15.1	$15.1
Number of hospice users	534,000	1,274,000	1,315,000	1,324,000
Length of stay among decedents (days)				
Average	53.5	88.0	87.8	88.2
25th percentile	6	5	5	5
50th percentile	17	18	17	17
90th percentile	141	246	246	247

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, 2014

Average length of stay for decedents varies by:

- Diagnosis (cancer: 53 days; neurological :148 days)
- Patient location (home: 90 days; nursing facility: 110 days; assisted living facility: 154 days)
- Ownership (nonprofit: 67 days; for-profit: 107 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. 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

- No publicly available quality data
- Quality 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 began in 2015
- Publicly reported data not expected before 2017

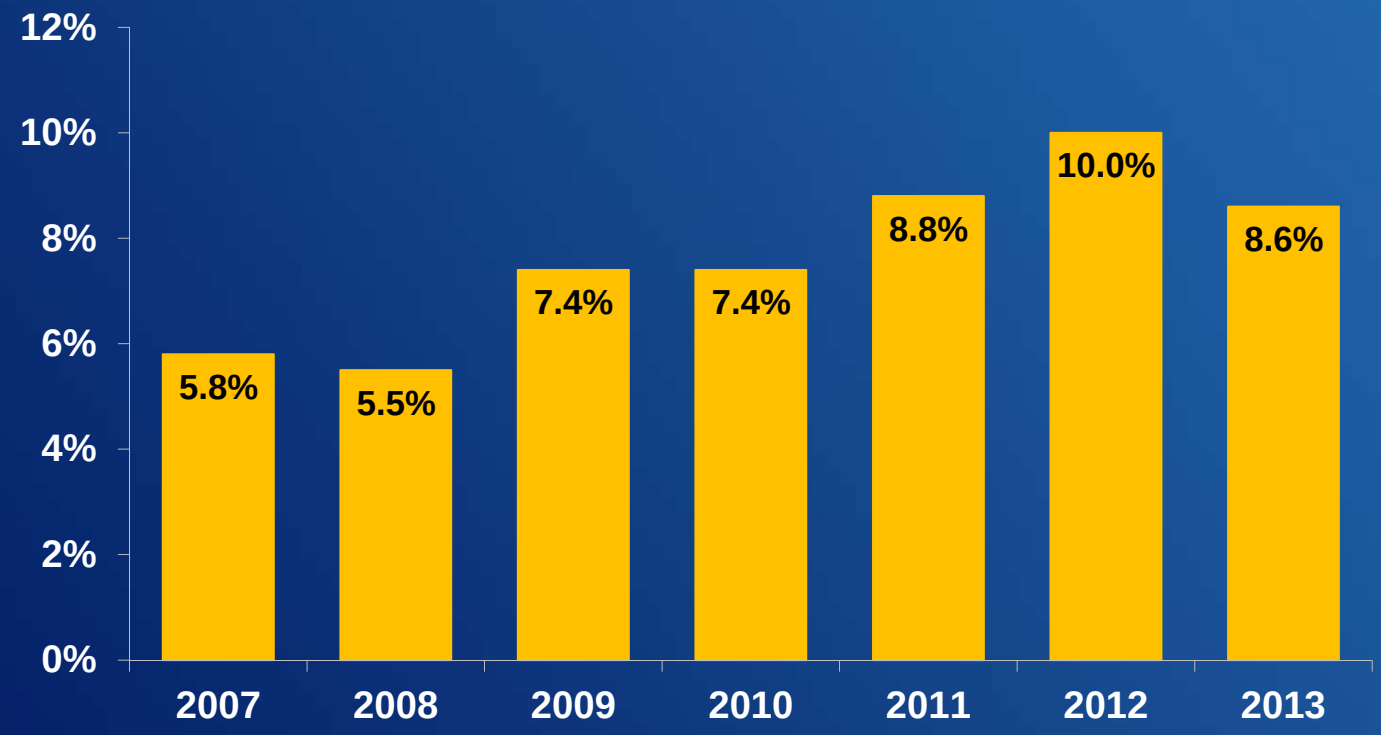
Live discharge rates

- The live discharge rate decreased from 18.4% in 2013 to 17.2% in 2014
- Some providers have substantially higher live discharge rates than their peers
  - Among hospices with at least 50 discharges, about 12% had live discharge rates more than double the national average
  - These providers tended to be for-profit (87%), exceed the aggregate cap (43%), and recent entrants (35%)
  - More common in some states

Access to capital appears adequate

- Hospice is less capital-intensive than some other provider types
- For-profit providers
  - Continued strong growth in the number of for-profit providers (7% increase in 2014)
  - Financial reports suggest the sector is viewed favorably by investors
- Nonprofit providers
  - 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, 2007-2013



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, 2013

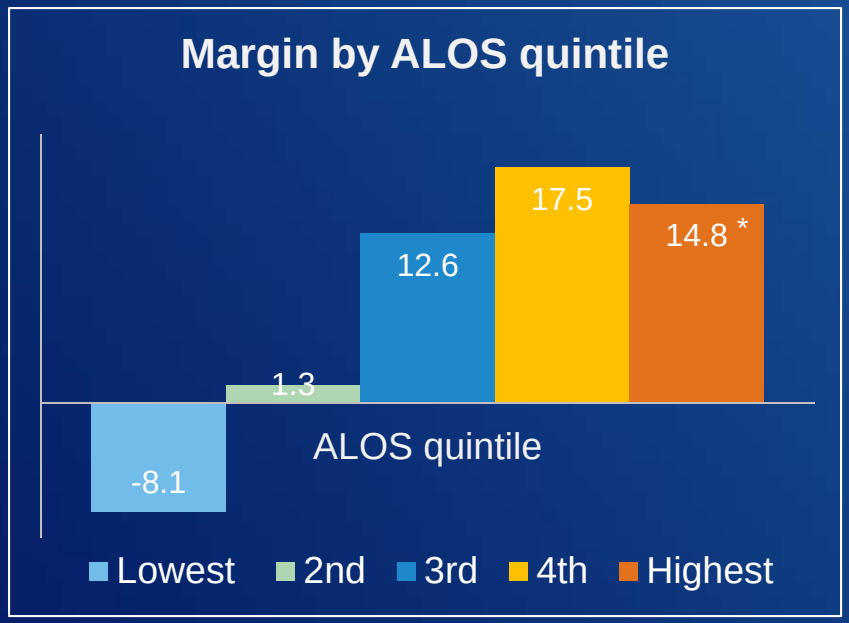
	Percent of hospices	Medicare margin, 2013
All	100%	8.6%
Freestanding	72	12.0
Home-health-based	13	2.2
Hospital-based	14	-16.7
For profit – all	61	14.7
– freestanding	55	15.7
Nonprofit – all	33	1.2
– freestanding	16	5.2
Urban	74	8.9
Rural	26	6.1
Below cap	89.3	8.8
Above cap (exclude/include overpayments)	10.7	7.0/20.2

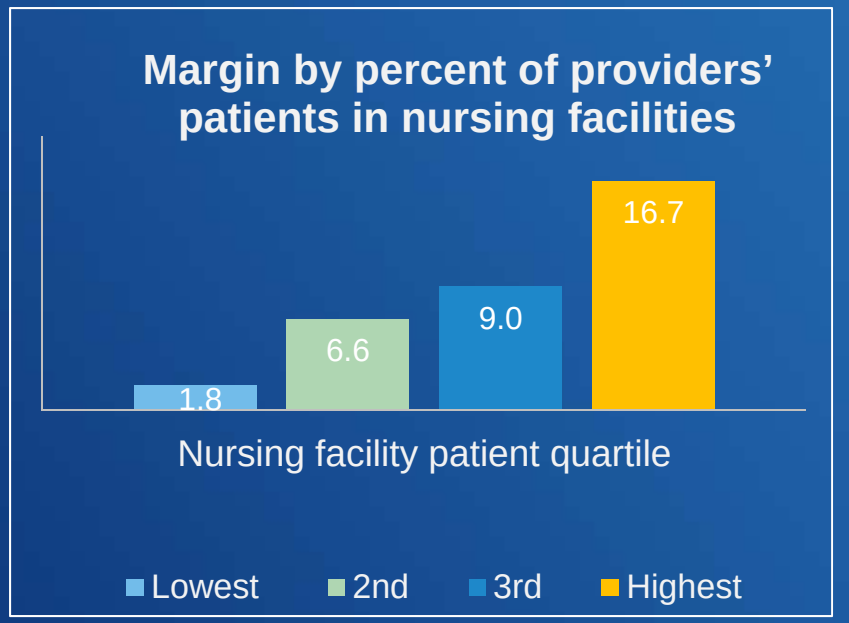
- 2013 marginal profit: 12%

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, 2013





* 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

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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
- 2013 aggregate margin is 8.6%
- 2013 marginal profit is 12%