

Assessing payment adequacy and updating payments: Hospice services

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Background: Medicare hospice benefit

- Palliative and supportive services for beneficiaries with terminal illnesses who choose to enroll
- Eligibility criteria:
 - Life expectancy of 6 months or less if 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

Background: Hospice payment system

- Medicare pays a per diem rate for hospice
- Payments are wage adjusted
- Aggregate cap on total payments to a provider
- 4 levels of care:
 - Routine home care (RHC) (98% of days) and 3 other higher intensity levels of care
- 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

Overview of Medicare hospice, 2018

- Hospice use:
 - Over 1.5 million beneficiaries
 - Over 50% of decedents
- Providers: Over 4,600
- Medicare payments: \$19.2 billion to hospice providers

Hospice payment adequacy framework

Beneficiaries' access to care

- Supply of providers
- Use rates, length of stay, patient days
- Marginal profit

Quality of care

- Admission process
- Visits at end of life
- CAHPS survey

Hospices' access to capital

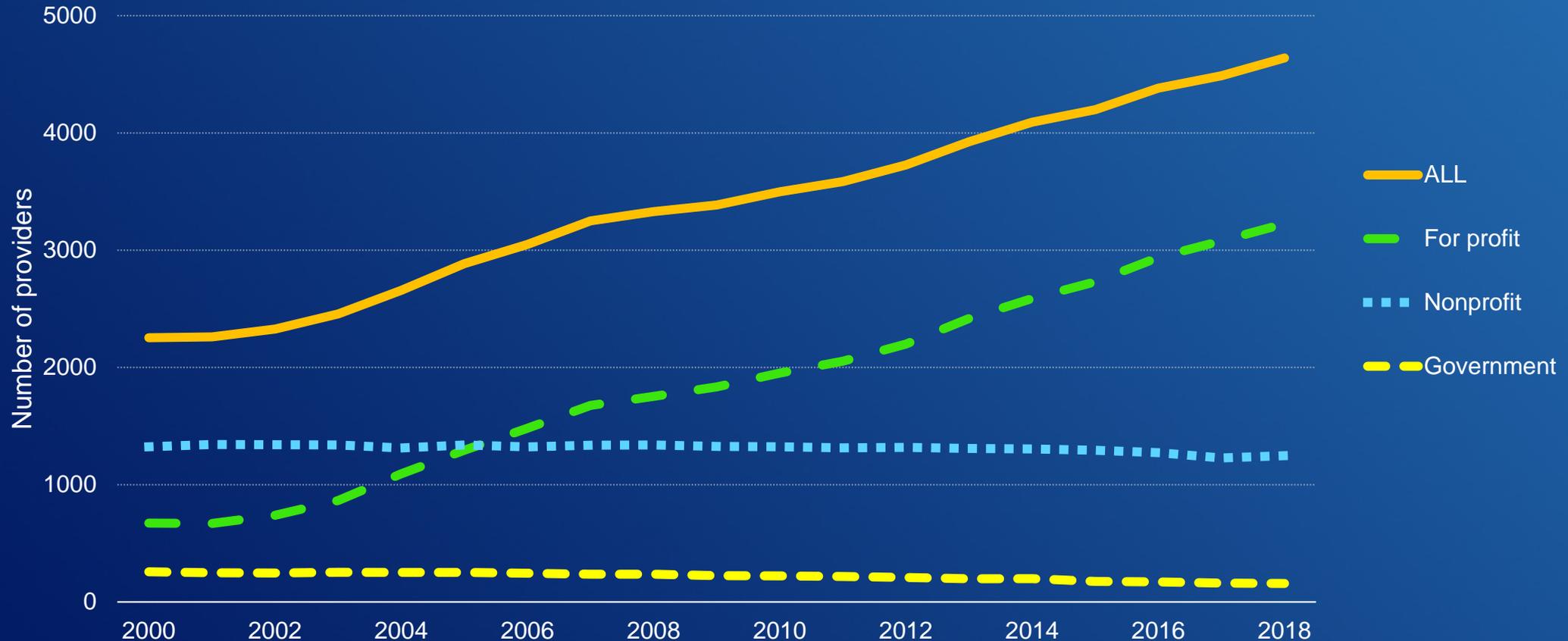
- Provider entry
- Financial reports and mergers and acquisitions

Medicare payments and hospices' costs

- Payments and costs
- Overall Medicare margins in 2017
- Projected overall Medicare margin in 2020

Update recommendation for hospice payment rates

Supply of hospices has increased, driven by growth of for-profit hospices



Hospice use continues to grow

- Share of decedents using hospice before death continues to increase
 - In 2018, 50.7% of decedents used hospice, up from 50.0% in 2017 and 22.9% in 2000
- Average length of stay (ALOS) among decedents increased to 89.6 days in 2018, from 88.1 days in 2017
 - Many beneficiaries have short stays (median of 18 days) while some have very long stays (90th percentile of 253 days)
- Marginal profit -- 16 percent in 2017 -- is a positive indicator of access

Note: Data are preliminary and subject to change. Length of stay data are for Medicare decedents and reflect the total number of days the decedent hospice user was enrolled in the Medicare hospice benefit during his/her lifetime.

Hospice average length of stay among decedents varies by beneficiary and provider characteristics, 2018

Diagnosis

- 53 day - Cancer
- 151 days - Neurological

Patient location

- 93 days - Home
- 106 days - Nursing facility
- 155 days - Assisted living facility

Ownership

- 68 days - Nonprofit
- 110 days - For profit

Type of hospice

- 57 days - Hospital-based
- 70 days - Home health-based
- 92 days - Freestanding

Note: Data 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 reflect 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.

Hospice quality data are limited

- Hospices scored very high on 7 measures related to processes of care at admission
 - Slight improvement on these measures, but most are topped out
- New measure of whether patients received certain visits in last 3 days life
- Hospice CAHPS scores were stable
 - Highest scores: treating patients with respect (91%) and providing emotional support (90%)
 - Lowest scores: pain and symptoms help (75%), caregiver training (75%), timely help (78%)

Note: Data are preliminary and subject to change.

Access to capital appears strong

- Hospice is less capital-intensive than some other provider types
- For-profit providers
 - Continued growth in the number of for-profits (4% increase in 2018)
 - Financial reports suggest the sector is viewed favorably by private equity investors and healthcare companies seeking mergers and acquisitions
- Nonprofit providers
 - Less information on access to capital for nonprofit freestanding providers, which may be limited
 - Provider-based hospices have access to capital through their parent institutions

Note: Data are preliminary and subject to change.

Medicare margins vary by type of provider

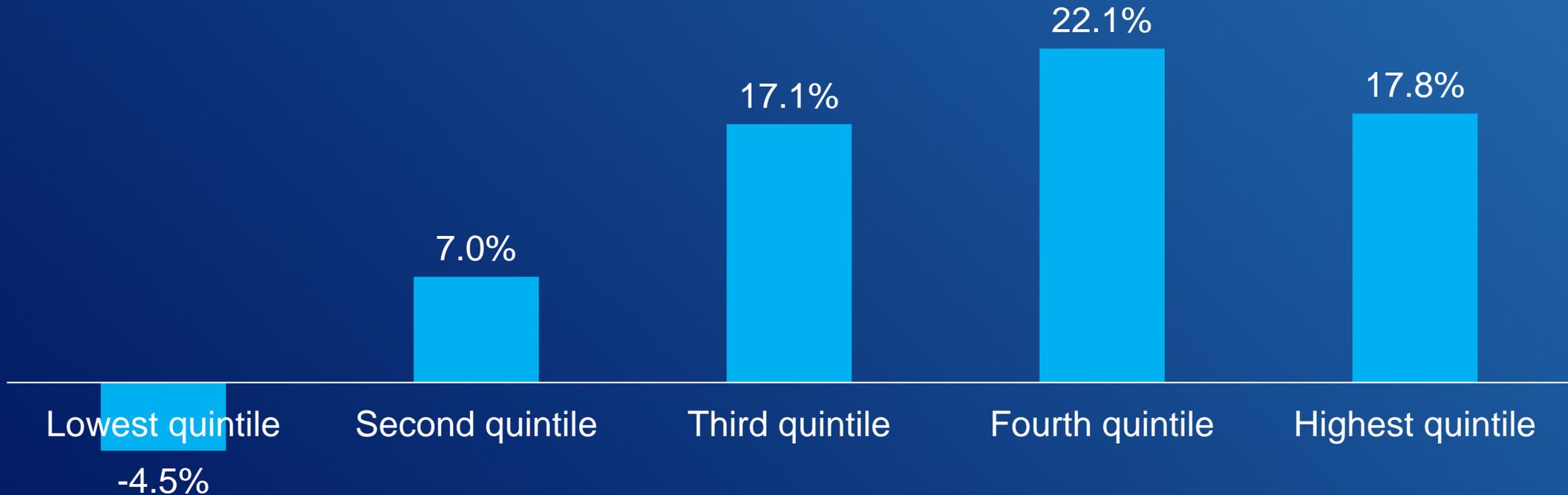
	Percent of hospices 2017	Medicare margin 2017
All	100%	12.6%
Freestanding	78	15.3
Home-health-based	11	8.0
Hospital-based	10	-13.8
For profit	69	20.2
Nonprofit	27	2.5
Urban	80	12.9
Rural	20	8.8
Below cap	86	12.5
Above cap (after return of overpayments)	14	21.2 (13.0)

Note: Data are preliminary and subject to change. Margins exclude cap overpayments (except where noted) and non-reimbursable costs. Percentages may not sum to 100 due to category not shown (e.g., SNF-based hospices and government hospices).

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

Hospice margins increase with length of stay

Provider margins by quintile based on percent of stays greater than 180 days



Note: Data are preliminary and subject to change. Margins exclude cap overpayments and non-reimbursable costs. The margin for the highest length of stay 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 21 percent.

Source: MedPAC analysis of Medicare hospice claims and cost reports.

Summary: Hospice payment adequacy indicators generally positive

Beneficiaries' access to care	Quality of care	Hospices' access to capital	Medicare payments and hospices' costs
<ul style="list-style-type: none">• Growth in provider supply• Growth in volume (use rates, ALOS)• Positive marginal profits (16%)	<ul style="list-style-type: none">• 7 process measures topped out• New measure of care at end-of-life• CAHPS survey stable	<ul style="list-style-type: none">• Continued entry of for-profits• Sector viewed favorably by investors• Provider-based have access via parent provider	<ul style="list-style-type: none">• 2017 Medicare margin: 12.6%
Positive	Positive; limited information	Positive	Positive

Hospice aggregate cap

- When the hospice benefit was first established, Congress included an aggregate cap to ensure savings
- Cap limits aggregate payments a hospice provider can receive annually

If: provider's > number of x cap
 total payments patients amount

Then: provider must repay excess to Medicare

- FY 2020 cap: \$29,965, not wage adjusted

Experience with the hospice cap

- Cap functions as a mechanism to reduce payments to hospices with long stays and high margins
 - 14% of hospices exceeded the cap in 2017
 - Margin of above-cap hospices: 21.2% before and 13.0% after return of cap overpayments
 - ALOS of above-cap hospices: 276 days
 - Other characteristics: Disproportionately for-profit, freestanding, urban, small, and new. Long stays and high live-discharge rates.
- More hospices exceed the cap in high wage-index areas than low wage-index areas because the cap is not wage adjusted

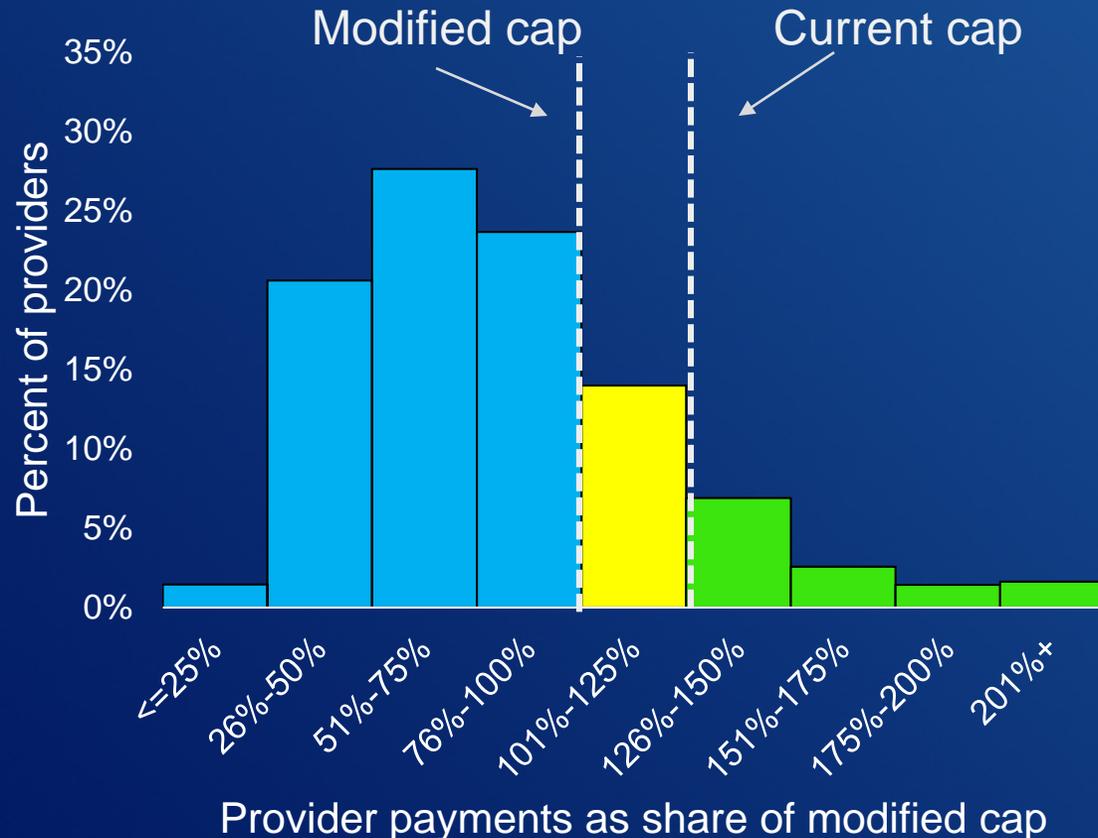
Note: ALOS (average length of stay). Data are preliminary and subject to change. Average length of stay reflects lifetime length of stay as of the end of calendar year 2017 for all patients treated in cap year 2017.

Policy option: Wage adjust and reduce the hospice aggregate cap by 20 percent

Policy objective:

- improve equity of the cap across providers
- generate savings for taxpayers and Part A trust fund
- improve payment accuracy and focus payment reductions on providers with disproportionately long stays and high margins

Under policy option, share of hospices exceeding the cap would increase



- Simulation with 2017 data, assuming no utilization changes
- Share of hospices exceeding the cap would increase
 - New above-cap hospices are mostly for-profit (95%) and freestanding (95%), with long stays (ALOS of 254 days) and an aggregate margin of 22% in 2017
- Many hospices remain substantially under the cap
 - Includes mix of provider types with an ALOS of 128 days

Note: ALOS (average length of stay). Data are preliminary and subject to change. Simulation using 2017 data assuming no utilization changes. Average length of stay reflects lifetime length of stay as of the end of calendar year 2017 for all patients treated in cap year 2017. Source: MedPAC analysis of Medicare claims data and the Medicare Beneficiary Database obtained from CMS in October 2019.

Policies to modify the cap would focus payment reductions on providers with the longest stays

Provider quintiles by share of stays > 180 days	Simulated percent change in payments from cap policy option
All	-2.8%
Lowest quintile	0.0
Second quintile	0.0
Third quintile	-0.1
Fourth quintile	-4.0
Highest quintile	-13.6

Payment reductions focused on providers with longest stays

Note: Data are preliminary and subject to change.

Source: MedPAC analysis of Medicare claims and cost report data and Medicare beneficiary data base from CMS.

Effect of policy option to modify the cap

- Most providers would not be effected by policy option
- Affected providers are those with long stays and high margins, mostly freestanding and for-profit providers
- Policy option would improve equity of cap across geographic areas with different wage indices
- CMS should monitor utilization patterns among providers (e.g., live discharge rates)