Advising the Congress on Medicare issues

Medicare hospice policy issues

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Roadmap

- Background
- Hospice payment reform
- Hospices with high live discharge rates
- Hospice in nursing facilities

Commission's prior analysis on hospice

- Analyses found over the period from 2000-2007:
  - Medicare hospice spending more than tripled
  - Number of hospice patients nearly doubled
  - Number of providers grew by ~45%, mostly for-profits
  - ALOS increased ~50% due to growth in very long stays
  - Higher profit margins among hospices with longer stays
  - For-profits had longer stays than nonprofits
- Panel of hospice physicians and staff gave reports of:
  - Lax admission and recertification practices at some hospices
  - Concerns about financial arrangements between some hospices and nursing homes

Commission's prior analysis on hospice

- Evidence that the payment system is not well matched with the intensity of care throughout an episode
  - Medicare makes a flat payment per day (whether a visit is provided or not), while hospice visit intensity is greater at the beginning and end of the episode
  - As a result, long stays are more profitable than short stays

Commission's prior recommendations on hospice

Commission recommendations (March 2009):

- Payment system reform (U-shaped curve)
- Increased accountability (physician narrative, face-to-face recertification visit, focused medical review, OIG studies on hospice/nursing facility issues)
- More data collection (claims, cost report)

More than half of hospice spending in 2011 was for patients with stays exceeding 180 days

	Medicare hospice spending 2011 (billions)
All beneficiaries using hospice	$13.8
Beneficiaries with LOS>180 days	7.9
Days 1 to 180	2.6
Days 181+	5.3
Days 181 to 365	2.5
Days 366 to 730	1.9
Days 731+	0.8

- Medicare spent about $2.7 billion on additional hospice services for patients who had already received at least 1 year of hospice

Note: LOS (length of stay). Figures are preliminary and subject to change

Source: MedPAC analysis of Medicare claims data and common Medicare enrollment file from CMS.

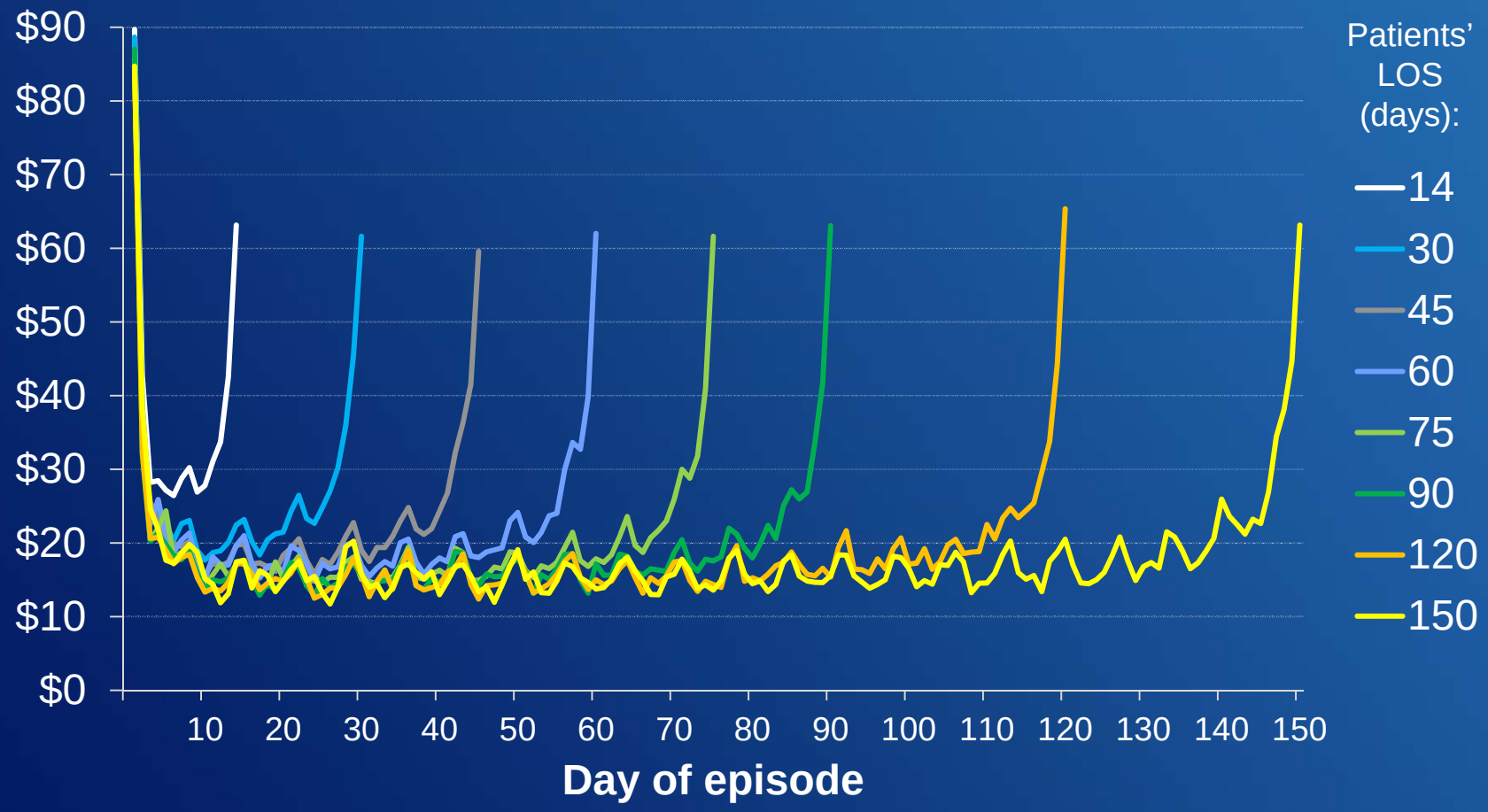
Hospice payment reform

- Commission's recommendation:
  - Per diem payments higher at the beginning and end of episode, lower in middle
  - Budget neutral in the first year
- PPACA gave CMS the authority to revise the payment system in 2014 or later as the Secretary determines appropriate
  - CMS is researching payment reform, considering additional data collection (e.g., DME, supplies, drugs), and considering cost report changes

Claims data are available to estimate the labor cost of visits

- Claims data are available on date and length of:
  - Hospice visits for 6 types of staff (nurses, aides, social workers, PT, OT, and ST)
  - Social worker phone calls
- Using BLS data on wages and benefits, we can estimate labor cost of visits per day and map out the trajectory of the U-shaped curve

The average labor cost of visits per day follows a U-shaped trajectory



Note: Data only include routine home care days for patients discharged deceased. Visit time data on which the estimates are based include time spent caring for the patient and exclude documentation and travel time. Figures are preliminary and subject to change.

Source: MedPAC analysis of Medicare claims data and common Medicare enrollment file from CMS, and wage and benefits data from BLS.

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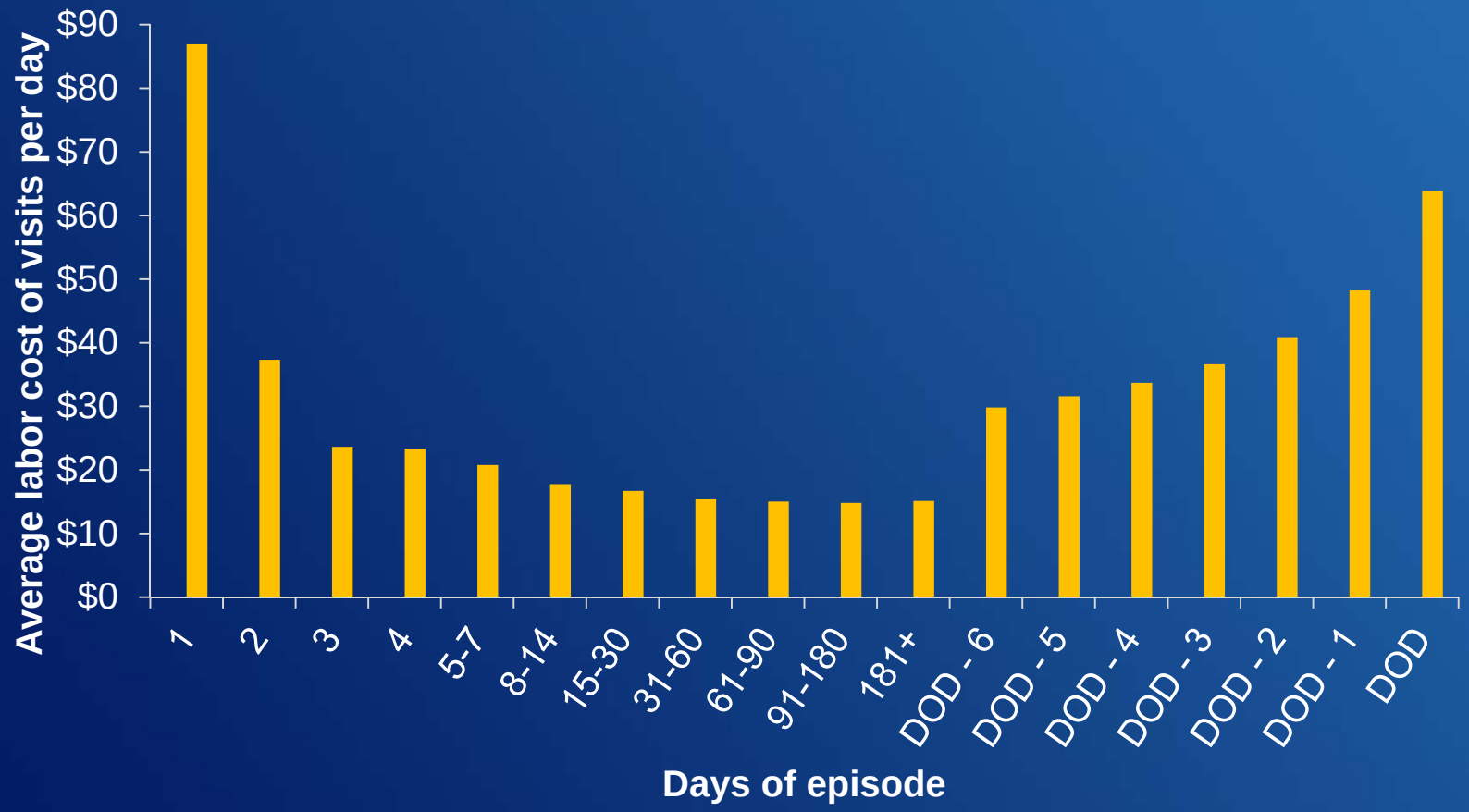
Average labor cost of visits per day across all patients



Note: DOD (Date of death). Only routine home days are included in the analysis. Figures are preliminary and subject to change

Source: MedPAC analysis of Medicare claims data and common Medicare enrollment file from CMS, and wage and benefits data from BLS.

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Initial step on payment reform is possible with current data

- The labor cost of visits data can be used to adjust the hospice payment rate
- These data do not include non-labor services (e.g., drugs, supplies, and DME) and chaplain visits
- The 6 types of staff for which we have visit data account for 68% of hospices' direct costs
- Therefore, initially we adjust only this portion (68%) of the per diem rate by the u-shaped curve and keep the remainder (32%) flat

Illustrative example of potential revised payment system

Days	Relative weight	Per diem payment rate adjusting 68% of base rate ($153)	Percent change from current rate
1 to 7	1.97	$255	66%
8 to 14	1.01	155	1%
15 to 30	.95	148	-4%
31+	.86	139	-10%
Each of last 7 days	1.15 add-on to applicable weight above	$120 add-on to applicable rate above	68 % - 144% depending on LOS

Note: LOS (length of stay). Payment rates under illustrative model apply to routine home care only. Payment add-on for the last seven days applies for patients discharged deceased. Payment rates are rounded to nearest dollar. Figures are preliminary and subject to change

Source: MedPAC illustrative example of payment reform model.

Impacts of illustrative payment model by length of stay

Provider quintile: share of cases > 180 days	Percent change in payments (all hospices)	Actual 2010 margin (freestanding)	Estimated 2010 margin w/ illustrative model (freestanding)
Lowest	6.7	-1.2	4.2
Second	2.9	5.9	7.9
Third	-0.3	12.2	11.7
Fourth	-2.0	15.6	13.7
Highest	-3.7	17.1	13.8

- Under the illustrative model, payments would increase by more than 2% for the majority of provider-based (70%), nonprofit (61%), and rural (52%) hospices

Note: Figures are preliminary and subject to change

Source: MedPAC analysis of the effects of illustrative payment model based on analysis of hospice claims, Medicare common enrollment file, and provider of services file from CMS.

Conclusions on payment reform

- Effects of illustrative payment model are in the expected direction, but modest
- Larger changes in payments might be needed to eliminate the higher profitability of long stays
- But, a first step in that direction is possible now with current data
- Additional changes could be considered later if additional data (e.g., data on non-labor costs or chaplain visits) become available

Live discharge analysis: Background

- Not every live discharge should be prevented
- Many potential reasons
- Concern with providers seeking patients with very long stays
  - High rates of live discharge among some providers may indicate questionable business practices

Live discharge rates

- In 2010, 14% of hospice episodes among all beneficiaries (1.2M episodes) ended in live discharge

Live discharge rate by provider, 2010	1st quartile	11%
	2nd quartile	17%
	3rd quartile	25%
	4th quartile	38%

Source: Acumen analysis of Medicare claims data.

- For-profit hospices 20% more likely than non-profit hospices to discharge patients alive
- Above-cap hospices 2x as likely as hospices below the cap to discharge patients alive

Long stays in hospice tied to long survival post-discharge

- 1/3 of all live discharges spent 180+ days in hospice before discharge
- Most patients in hospice 180+ days before discharge had long survival post-discharge
  - 73% alive at 180 days; 56% alive 1 year later
- Patients alive 1 year after discharge spent an average 213 days in hospice before discharge
  - $1.2B in Medicare payments for first episode
- Patients discharged alive from above-cap hospices ~20% more likely to be alive 180 days after discharge

Spending

- For patients with long stays before discharge, average post-discharge spending is less than the hospice payment rate
  - Average payment rate for hospice = $156 / day
  - Spending after hospice for patients who were in hospice 180+ days before discharge = $70 / day
- Data supports ensuring that patients are appropriate candidates for hospice before admission and throughout long episodes

Live discharge summary

- Key findings:
  - Long stays before discharge tied to long survival post-discharge
  - Findings support ensuring that patients are appropriate candidates before admission and throughout long episodes
  - High rates of live discharge among some providers may indicate questionable business practices

OIG recommended a reduction to hospice payment rate in nursing facilities

OIG study of hospices that focus on nursing facility patients (2011) found:

- These hospices are more likely to be for-profit and treat patients with diagnoses likely to have long stays and have a less complex service mix
- OIG recommended:
  (1) CMS monitor these hospices
  (2) CMS reduce the payment rate for hospice in nursing facilities
- In making the 2nd recommendation, OIG raised the issue of duplicate payment for aide services in nursing homes

Hospices provide more aide visits in nursing facilities than the home

- Nursing facility residents receive more aide visits from hospice staff than patients at home
- Not clear why this occurs since nursing facility residents have access to assistance with activities of daily living through nursing facility staff
- If comparable amounts of aide visits were provided in the two settings, the average labor cost of all types of visits combined would be 4 to 7 percent lower in nursing facilities than the home

Potential policy option on payment for hospice in nursing facilities

- Could consider reducing a portion of the hospice payment rate in nursing facilities based on estimates of the labor cost of visits in the two settings assuming equal provision of aide visits
  - This would yield a reduction to the hospice payment rate in nursing facilities in the range of 3% to 5%

Summary

- Medicare spending on long hospice stays is substantial
- PPACA medical review provision should be implemented
- Initial step on hospice payment reform is possible with current data
- Hospices with high live discharge rates warrant monitoring
- Payment reduction for hospice care in nursing facilities could be considered