Reforming Medicare's hospice benefit

Kim Neuman, James E. Mathews,
and Zach Gaumer

January 9, 2009

MEDPAC

Medicare’s hospice benefit – key points

- Two tenets:
  - Provides beneficiaries with an alternative to intensive end-of-life curative treatment
  - Benefit implemented on presumption that it would be less costly to Medicare than conventional end-of-life treatment
- Medicare payment system embodies incentives that may undermine second assumption, and doesn’t provide incentives for appropriate timing of hospice admission

MEDPAC

Medicare's hospice benefit – trends

- Length of stay increasing
  - 62 to 82 day ALOS, 2000 – 2006, stays at 90th percentile > 212 days in 2006
  - Long stays are getting longer
  - Long stays more profitable than short stays
- For-profit hospices have longer LOS; nearly all new hospices since 2000 are for-profit
- Lack of oversight may contribute to trends

MEDPAC

Policy areas / draft recommendations presented in November 2008

- Payment system reform
  - Change payment stream from linear to U-shaped
- Accountability
  - More hospice accountability
  - More FI oversight
  - OIG studies
- Need for more information
  - Cost reports
  - Claims

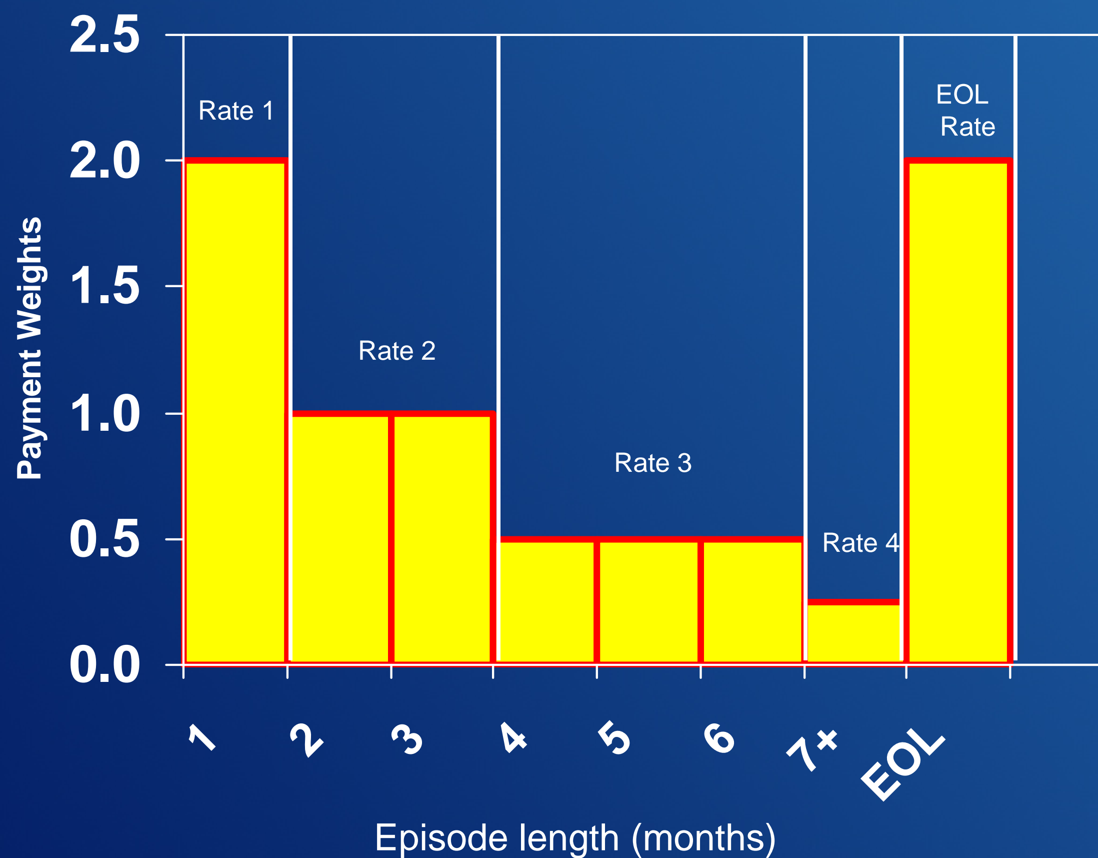
MEDPAC

Payment system reform: payments should follow "U-shaped" curve

- Payments are set higher at the start of the episode, then decline over time
- An end-of-episode payment would be made after the patient's death
- Structure creates incentive for hospices to more carefully screen patients for appropriate admission

MEDPAC

Model of intensity-adjusted payment system



MEDPAC

Characteristics of intensity-adjusted payment system

- Home care only
- Payment still made on a per-diem basis, but varies over time
- Budget-neutral to current law – redistributes payments as a function of length of stay
- End-of-episode payment rate = payment rate at beginning of episode

Impacts on payments; percent change relative to current system

Share of cases over 180 days (quintile)	Percent difference in payments, larger intensity adjustment	Percent difference in payments, smaller intensity adjustment
Lowest	24.1	16.6
Second	10.3	7.0
Third	0.8	0.6
Fourth	-9.6	-7.1
Highest	-10.9	-6.6

Impacts on payments; percent change relative to current system (continued)

Hospice type	Percent difference in payments, larger intensity adjustment	Percent difference in payments, smaller intensity adjustment
Urban	-0.4	-0.3
Rural	2.8	2.2
Provider-based	10.9	7.8
Free-standing	-3.2	-2.3
For-profit	-5.0	-3.2
Non-profit	4.1	2.5

MEDPAC

Impacts on payments; percent change relative to current system (continued)

Hospice type	% of hospices w/ payment decrease > 2 percent	% of hospices w/ payment change between -2 and +2 %	% of hospices w/ payment increase > 2 percent
Total	34	8	58
Urban	37	9	55
Rural	28	7	65
Free-standing	45	9	46
Provider-based	14	6	79
For-profit	50	9	41
Non-profit	20	7	73

MEDPAC

Benefits of this approach

- Consistent with program goals (providing appropriate hospice care at the end of life)
- Ensures adequate resources at key periods in hospice episode (admission / death), more closely parallels hospices' cost function
- Provides incentives for appropriate length of stay

Accountability

- Hospices with long average length of stay, focusing on the longest stays
- Hospice admissions from nursing facilities

Some hospices' admissions practices result in long stays getting longer

- The length of long hospice stays has been increasing
- Top 20% of hospices with the longest stays have on average 34% of stays exceeding 180 days, compared to 14% percent among all other hospices
- Hospices with very high nursing home caseload have longer lengths of stay and are more likely to be for-profit

MEDPAC

Potential causes of growing length of stay

- Input from expert panel
- Provider response to incentives in payment system
  - Profitability of long stays may encourage some hospices to seek such patients
  - Nursing homes are potentially a referral source for long-stay hospice patients
- Insufficient adherence to Medicare Local Coverage Determinations (LCDs)
  - May reflect insufficient physician engagement in hospice patient’s care
  - May reflect inadequate training in EOL care

Data needs

- Claims
  - Have historically indicated only days of service
  - CMS collecting some info on visits
- Cost reports
  - Information not standard across all hospice types (free-standing, hospital-based, HHA-based)
  - Some information lacking on all hospice cost reports (e.g., revenues)

Conclusions

- Given incentives, the following changes are needed:
  - Payment system changes
  - Additional accountability controls, focused most on hospices with very long stays
  - Additional data

MEDPAC