MEDPAC

Advising the Congress on Medicare issues

Assessing payment adequacy and updating payments: Hospice services

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Presentation roadmap

1. Overview of hospice
2. Payment adequacy analysis
3. Chair's draft recommendation
4. Nonhospice spending for beneficiaries in hospice

Overview: 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) certifies prognosis at outset of each hospice benefit period: two 90-day periods, then unlimited number of 60-day periods
- Beneficiary agrees to forgo conventional care for the terminal condition and related conditions
- Hospice benefit is carved out of MA and paid by FFS*

Note: FFS (fee-for-service), MA (Medicare Advantage).
*Under the CMS Innovation Center's value-based insurance design model hospice benefit component, some MA plans are responsible for the provision of hospice care to their enrollees. A CMS evaluation report indicates about 20,000 beneficiaries received hospice through their MA plan in 2022. See: https://www.cms.gov/priorities/innovation/data-and-reports/2023/vbid-2nd-eval-report.

Overview: Hospice payment system

- Medicare FFS pays a daily rate for hospice
  - Payment is made regardless of whether hospice furnishes services on a given day
- Routine home care is the most common level of care (>98% of days)
  - $218 per day (days 1–60); $172 per day (days 61+) in FY 2024
- Three other levels of care (general inpatient care, continuous home care, and inpatient respite care) are paid higher daily rates
- Aggregate cap on total payments to a provider in a year
  - If FY 2024 total payments > $33,494 × number of patients, then hospice must pay back the overage to Medicare

Note: FFS (fee-for-service), FY (fiscal year).

Overview: Hospice services, 2022

- Hospice utilization
  - Over 1.7 million Medicare beneficiaries used hospice
  - 49% of Medicare decedents
- Visits: 3.9 visits per week on average
- Length of stay (decedents): Median 18 days, average 95 days
- Providers: 5,900 hospices
- Medicare payments: $23.7 billion

Note: FFS (fee-for-service).
Source: MedPAC analysis of Medicare hospice claims and Medicare enrollment file from CMS.

Payment adequacy framework: Hospices

Beneficiaries' access to care

- Supply of providers
- Hospice use, length of stay, visits
- FFS Medicare marginal profit

Quality of care

- CAHPS® survey
- Visits at the end of life

Access to capital

- Provider entry
- Financial reports and mergers and acquisitions

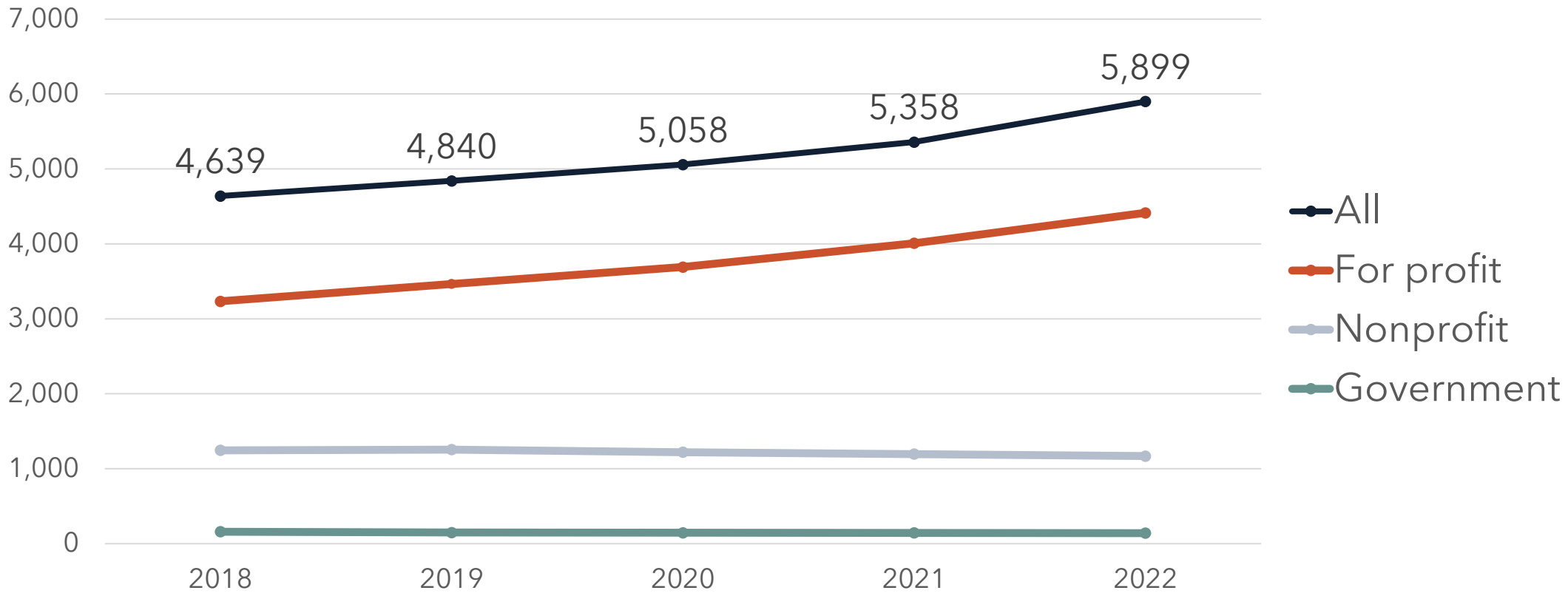
FFS Medicare payments and costs

- 2021 FFS Medicare margin
- 2024 projected FFS Medicare margin

Update recommendation for hospice base rates

Note: FFS (fee-for-service), Consumer Assessment of Healthcare Providers and Systems® (CAHPS®).

Supply of hospices increased 10% in 2022, driven by entry of for-profit providers



Note: Data on ownership type is missing in 2022 for more hospices than usual due to a temporary pause in updating the Provider of Services file.
Source: MedPAC analysis of Medicare hospice claims data, Medicare cost reports, and Provider of Services file from CMS.

Share of decedents using hospice increased in 2022, after declining during the pandemic

- In 2022, 49.1% of decedents used hospice, up from 47.3% in 2021
- Use increased for all subgroups examined (age, gender, race/ethnicity, FFS/MA, rural/urban, dual-eligible beneficiaries, ESRD)
- During the pandemic, the rate of hospice use declined from 51.6% in 2019 to 47.3% in 2021
  - Reflects that decedents with COVID-19 are more likely to die in the hospital than home
- Rate of hospice use in 2022 was affected by COVID-19 surge in January 2022

Note: FFS (fee-for-service), MA (Medicare Advantage), ESRD (end-stage renal disease).
Source: MedPAC analysis of data from the Common Medicare Enrollment file and hospice claims data from CMS.

Access: Indicators of hospice access to care were positive in 2022

Utilization increased

- Share of decedents using hospice: +1.8 percentage points
- Number of hospice users: +0.4%
- Total number of hospice days: +2.0%

Length of stay (LOS) increased

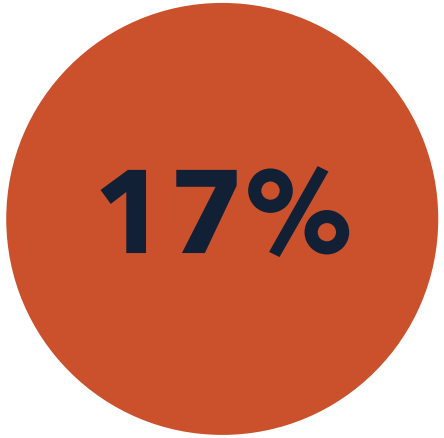
- Average LOS: +3 days to 95.3 days
- Median LOS: +1 day to 18 days

Visits were stable

- Average visits per week: +0.1 to 3.9 visits/week, but still below 2019 level

Note: "Length of stay" reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during their lifetime.
Source: MedPAC analysis of Medicare hospice claims and Medicare enrollment file from CMS.

Access: Hospices have a strong financial incentive to serve beneficiaries



FFS Medicare marginal profit, 2021

- Marginal profit = how much the revenue from treating an additional Medicare patient exceeds the variable cost of treating that patient
- Marginal profit of 17% indicates hospices have a strong incentive to treat Medicare patients

Note: FFS (fee-for-service). To make a conservative estimate of hospices' FFS Medicare marginal profit, we use a broad definition of variable costs.
Source: MedPAC analysis of Medicare cost reports.

Quality: Hospice quality indicators were stable in 2022

CAHPS scores were stable

- 5 measures were unchanged
- 3 measures declined 1 percentage point

Processes of care at admission increased

- Composite of 7 processes of care at admission increased slightly but was generally topped out

End-of-life visits were stable

- Visits in the last 7 days of life by nurses and social workers were stable in 2022, but below 2019 level

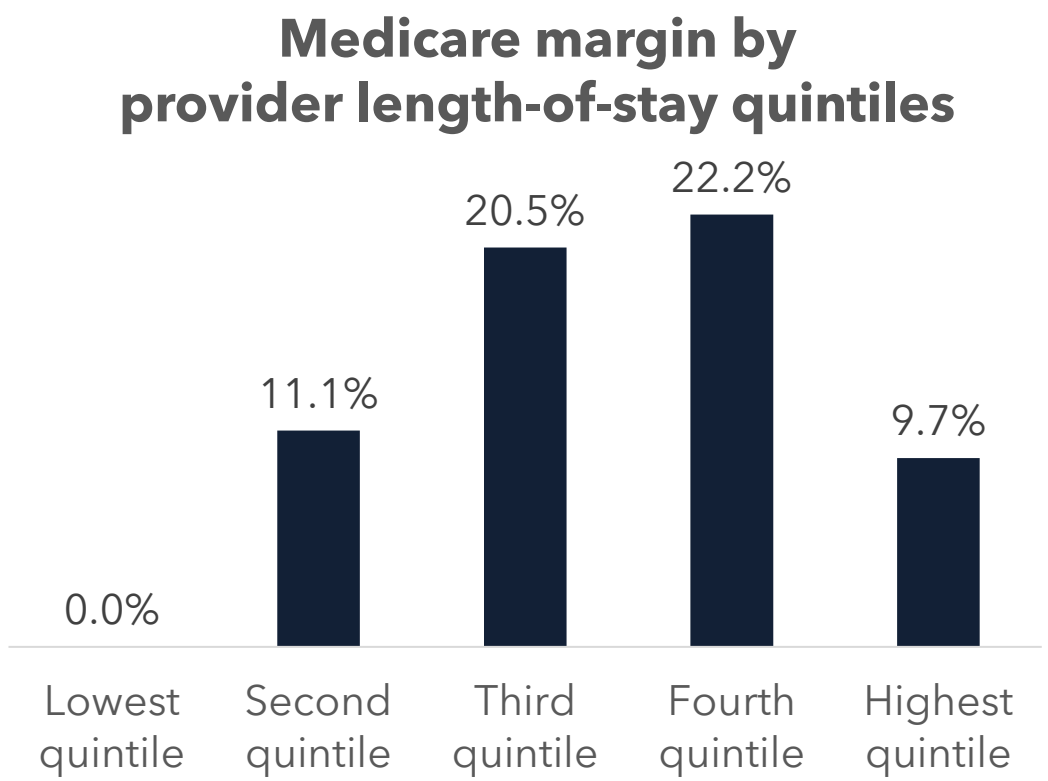
Note: CAHPS (Consumer Assessment of Healthcare Providers and Systems).
Source: MedPAC analysis of CAHPS, Hospice Item Set, and claims data from CMS.

Access to capital appears positive

- Hospice is less capital intensive than some provider types
- Continued growth in the number of for-profit providers (at least 10% in 2022)
- Financial reports suggest the sector is viewed favorably by investors and other health care companies
- Less information on nonprofit freestanding providers' access to capital
- Provider-based hospices have access to capital through their parent institutions

Overall margin is strong and varies by provider type

Provider type	Share of providers	2021 FFS Medicare margin
All	100%	13.3
Freestanding	84	15.5
Home health based	8	10.9
Hospital based	7	–15.6
For profit	75	19.2
Nonprofit (NP)	22	5.2
NP freestanding	12	8.5
Urban	84	13.4
Rural	16	12.3



Note: FFS (fee-for-service). Margins exclude cap overpayments and nonreimbursable costs. Provider length-of-stay quintiles are based on the providers' share of stays exceeding 180 days.
Source: MedPAC analysis of Medicare hospice claims, cost reports, Provider of Service file, and Common Medicare Enrollment file from CMS.

Summary: Hospice payment adequacy indicators

Beneficiaries' access to care

- Increase in provider supply
- Increase in share of decedents using hospice, number of hospice users, total days of care
- Increase in length of stay
- Slight increase in visits per week
- FFS Medicare marginal profit: 17%

Positive

Quality of care

- CAHPS quality scores are stable
- Visits at the end-of-life were stable in 2022, but below 2019

Stable

Access to capital

- Continued entry of for-profit providers
- Sector viewed favorably by investors
- Provider-based hospices have access via parent provider

Positive

FFS Medicare payments and costs

- 2021 FFS Medicare margin: 13.3%

Positive

Note: FFS (fee-for-service), CAHPS (Consumer Assessment of Healthcare Providers and Systems).

Nonhospice spending: Significant spending occurs outside the hospice benefit for hospice enrollees

- Hospices are responsible for all care that is reasonable and necessary for palliation of the terminal condition and related conditions
  - Unrelated services are covered by FFS or Part D
- CMS has said it expects "virtually all" care needed by the hospice patient would be covered by the hospice, but significant spending occurs outside of hospice
  - In FY 2022, spending outside of hospice amounted to about $1.5B in program payments and $200M in cost sharing (CMS 2023)
- To understand what is driving spending outside of hospice, we conducted interviews with 12 hospice providers in 2022 and 2023

Note: FFS (fee-for service), FY (fiscal year).
Source: CMS. 2023. FY 2024 hospice proposed rule. Available at https://www.govinfo.gov/content/pkg/FR-2023-04-04/pdf/2023-06769.pdf.

Nonhospice spending: Interviews suggest variation in what services are classified as related

- Hospice clinicians determine what services are related
- Most hospice respondents described a similar approach:
  - Classifying as related treatments for all conditions that contribute to the terminal prognosis
- Views varied on whether certain types of care (e.g., diabetes care, treatments for injuries from falls) are typically related or unrelated
- Treatments typically unrelated: Several respondents cited eye and thyroid conditions; a number of other conditions were cited by at least one respondent

Note: "Related services" mean services that are related to the hospice beneficiary's terminal condition or related conditions.
Source: MedPAC interviews with hospice clinicians and administrative personnel in 2022 and 2023.

Nonhospice spending: Interviews suggest many factors contribute to nonhospice spending

- Hospices facilitate appropriate service use and billing by:
  - Educating patients and families
  - Reaching out to other providers and pharmacies
- Related services may be billed outside of the hospice benefit due to:
  - Unsuccessful education/outreach by hospice providers
  - Information flow/coordination challenges: A nonhospice provider may not know a beneficiary is in hospice; a hospice may not realize a beneficiary sought outside services; it may be easier for a pharmacy to bill Part D than the hospice
  - Unbundling of hospice benefit by some hospice or nonhospice providers
- Hospices generally do not receive Medicare claims data on the specific nonhospice services that their patients receive (unless there is an audit)

Note: "Related services" means services that are related to the hospice beneficiary's terminal condition or related conditions.
Source: MedPAC interviews with hospice clinicians and administrative personnel in 2022 and 2023.

Nonhospice spending: Possible policy directions for further consideration

- Administrative approaches
  - Create more concrete definition of *related*; efforts to facilitate more information flow across providers, pharmacies, and Part D
- Bundled payment approach
  - Unrelated services could be bundled into the hospice benefit with an increase to the base rate
- Payment penalty approach
  - A payment penalty could apply to hospice providers whose patients have high nonhospice spending compared with other hospices

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