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Eli's Hospice Insider

Keep Your Eye On These Hospice Hot Spots

Half of hospice spending goes to long-stay patients, stats show.

MedPAC thinks hospices are getting paid more than enough under Medicare, and that they don't need a pay raise in 2016. So says the influential advisory body to Congress in its annual set of recommendations sent to lawmakers this month.

The **Medicare Payment Advisory Commission** points out that profit margins actually increased for hospices in 2012 from 8.8 percent to 10.1 percent. However, MedPAC projects a margin of only 6.6 percent in 2015 including the sequester.

The availability of hospice services also seems to be adequate, given the increasing number of providers, MedPAC contends in the report. From 2012 to 2013, the number of hospices increased 5 percent to 3,925. That growth was all in the for-profit sector; the number of non-profits actually declined slightly in that time period.

Stats: About one-third of Medicare-certified hospices were non-profit in 2013, MedPAC points out. That compares to more than half the provider population being non-profit back in 2000.

High margins and rapid growth are only two of the areas for concern that the advisory body outlines in its report. MedPAC offers a laundry list of red flag areas for consideration to policymakers crafting payment reform and value-based purchasing, lawmakers considering legislation, and regulators and medical reviewers targeting areas for oversight. Those areas include:

Length of stay. Both long and short LOS are problematic, MedPAC noted. The longer a LOS, the more profitable it is. Longer stays lead to hospices exceeding their per-patient caps and higher rates of live discharge. "More than half of Medicare hospice spending in 2013 was for patients with stays exceeding 180 days," MedPAC highlights.

LOS has skyrocketed since 2000, along with patients with non-cancer diagnoses, MedPAC notes. "Currently, a substantial amount of Medicare hospice spending is devoted to long-stay patients, who are more profitable than other patients under the current payment system," the report says. "Because the misalignment of the current payment system creates a number of problems (e.g., distorts the distribution of payments across providers, makes the payment system vulnerable to patient selection, and results in program integrity concerns), improvements to the payment system are needed as soon as possible."

Short LOSs are also a concern, because patients don't get to fully benefit from hospice services. Patients enroll in their last week of life for about one-quarter of episodes, according to MedPAC.

Care for patients with advanced illnesses or multiple chronic conditions "is oftentimes fragmented and uncoordinated and does not take into account the individual's overall needs," MedPAC observes. "Also, many patients do not receive adequate information about their condition, prognosis, and treatment options to enable them to make decisions based on their goals and preferences."

Note: LOS held steady from 2012 to 2013.

SNFs and ALFs. "In 2013, average length of stay was higher among Medicare decedents whose main care setting was an assisted living facility (ALF) (152 days) or a nursing facility (111 days) rather than home (89 days)," MedPAC notes. "Length-of-stay differences across settings are most pronounced among patients with longer stays."

Further: "Even among patients within the same diagnosis group, hospice patients in ALFs had markedly longer stays

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compared with other settings," MedPAC says. That "warrants further monitoring and investigation in CMS's medical review efforts," the advisory body warns.

MedPAC references several high-profile **HHS Office of Inspector General** reports that have investigated hospice provision in SNFs and ALFs.

Utilization & spending. In 2013, 47.3 percent of Medicare decedents used hospice compared to 22.9 percent in 2000. Policymakers should encourage hospice use, but only for eligible patients, the report cautions.

Hospice users were up 3.2 percent to 1.3 million in 2013, and spending actually decreased 0.1 percent to $15.1 billion. However, MedPAC points out that spending is way up from 2000. "Between 2000 and 2012, Medicare spending for hospice care increased dramatically more than 400 percent, from $2.9 billion in 2000 to $15.1 billion in 2012," it says. More beneficiaries electing hospice and growth in LOS for patients with the longest stays drove that increase, MedPAC says.

Levels of care. MedPAC knocks hospices for furnishing only one level of care. Nearly 98 percent of hospice days in 2013 were for routine home care (RHC). About 1.7 percent were General Inpatient (GIP). 0.4 percent continuous home care (CHC), and 0.3 percent inpatient respite care.

According to the **Centers for Medicare & Medicaid** Services, "a sizable share" of hospice providers did not furnish GIP (21 percent), CHC (57 percent), or inpatient respite care (26 percent) to any hospice patient discharged in 2012, MedPAC chides. Small hospices were more likely than large hospices not to provide the various levels of care.

Target: "The lack of provision of the four levels of care among larger hospices ... raises questions about whether these providers have the capacity or willingness to furnish these services," MedPAC notes. "CMS has indicated that it intends to monitor utilization patterns of the four levels of care and refer providers with aberrant patterns to Survey and Certification, or other parts of CMS responsible for program integrity, for further investigation. While this concern is an important issue for providers of all sizes, those with large patient populations that do not provide these levels of care merit the most immediate scrutiny."

Quality reporting: "It might be useful to beneficiaries choosing a hospice provider if there were information in quality reporting or transparency initiatives as to whether a provider has a history of not furnishing these levels of care to any patients," MedPAC adds.

Live discharges. As highlighted by the OIG and high-profile newspaper reports recently, high rates of live discharges are under the microscope. "A high rate of live discharges could indicate that a hospice provider is not meeting the needs of patients and families, and so they choose to revoke their hospice election," MedPAC suggests. "A high rate of live discharges could also signal that the provider is admitting patients who do not meet the eligibility criteria."

In 2012, about 17.5 percent of hospice discharges were live discharges. Ten percent of providers had a live discharge rate of roughly 29 percent or more at least double the rate of the median provider. "Above-cap hospices had particularly high live-discharge rates," MedPAC points out.

Non-cancer patients. Patients with non-cancer diagnoses have much longer average LOSs, MedPAC points out. "Medicare decedents in 2013 with neurological conditions and debility or adult failure to thrive had substantially higher average lengths of stay (147 days and 116 days, respectively) than those with cancer (53 days) and heart or circulatory conditions (81 days)," MedPAC says.

"Use of nonspecific diagnoses debility and adult failure to thrive as a hospice primary diagnosis had grown substantially since 2002," MedPAC notes. But that's now going back down, since CMS no longer allows hospices to report those diagnoses as primary as of Oct. 1, 2014.

In anticipation of the change, hospices had already reduced those codes' usage 9 percent in 2013 versus 16 percent in 2012.

Visits in the last days of life. Like live discharges, visits in the last days of life has received considerable attention

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from the popular press recently. About 14 percent of hospice decedents who received routine home care did not receive any skilled visits from hospice staff in the last two days of life in 2012, CMS noted in its 2015 final rule.

Data: The share of RHC patients who did not receive a skilled visit in the last two days of life varied across providers, MedPAC continues. "For example, nearly 5 percent of hospices furnished no skilled visits in the last two days of life for more than 50 percent of their routine home care patients."

"The last days of life tend to be some of the most service-intensive days of a hospice stay," MedPAC says. "Variation in the provision of skilled visits in the last days of life across providers raises questions about whether some providers are meeting the needs of patients and families during this period."

CMS may want to use this data in public quality reporting or in a value-based purchasing system, MedPAC suggests.

Geographic differences. Much of the industry's growth has been concentrated in areas known for high risk of fraud and abuse. California, Texas, Ohio and Arizona saw growth numbers that far outstripped most areas in 2013 (see story, cover).

Above-cap hospices. Hospices that exceed their caps are suspect in MedPAC's eyes. For example, "above-cap hospices have substantially longer lengths of stay than other hospices," the report notes. "About 42 percent of patients receiving care from above-cap hospices in 2012 had stays exceeding 180 days compared with about 20 percent of patients treated by below-cap hospices."

Between 2011 and 2012, the share of hospices exceeding the cap grew from 9.8 percent to 11 percent, reversing the trend seen since 2009 of a declining share of hospices exceeding the cap. Among hospices that exceeded the cap, the average amount over the cap was larger in 2012 than in 2011 ($510,000 compared with $424,000).

CMS hopes its new self-reporting requirement for caps with its first deadline that occurred on March 31 will help ease this problem area.

Note: The report is at http://medpac.gov/documents/reports/Mar15_EntireReport.pdf the hospice chapter begins on p. 283.

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