# Medicare Financing of Hospice and Palliative Care

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# My Background

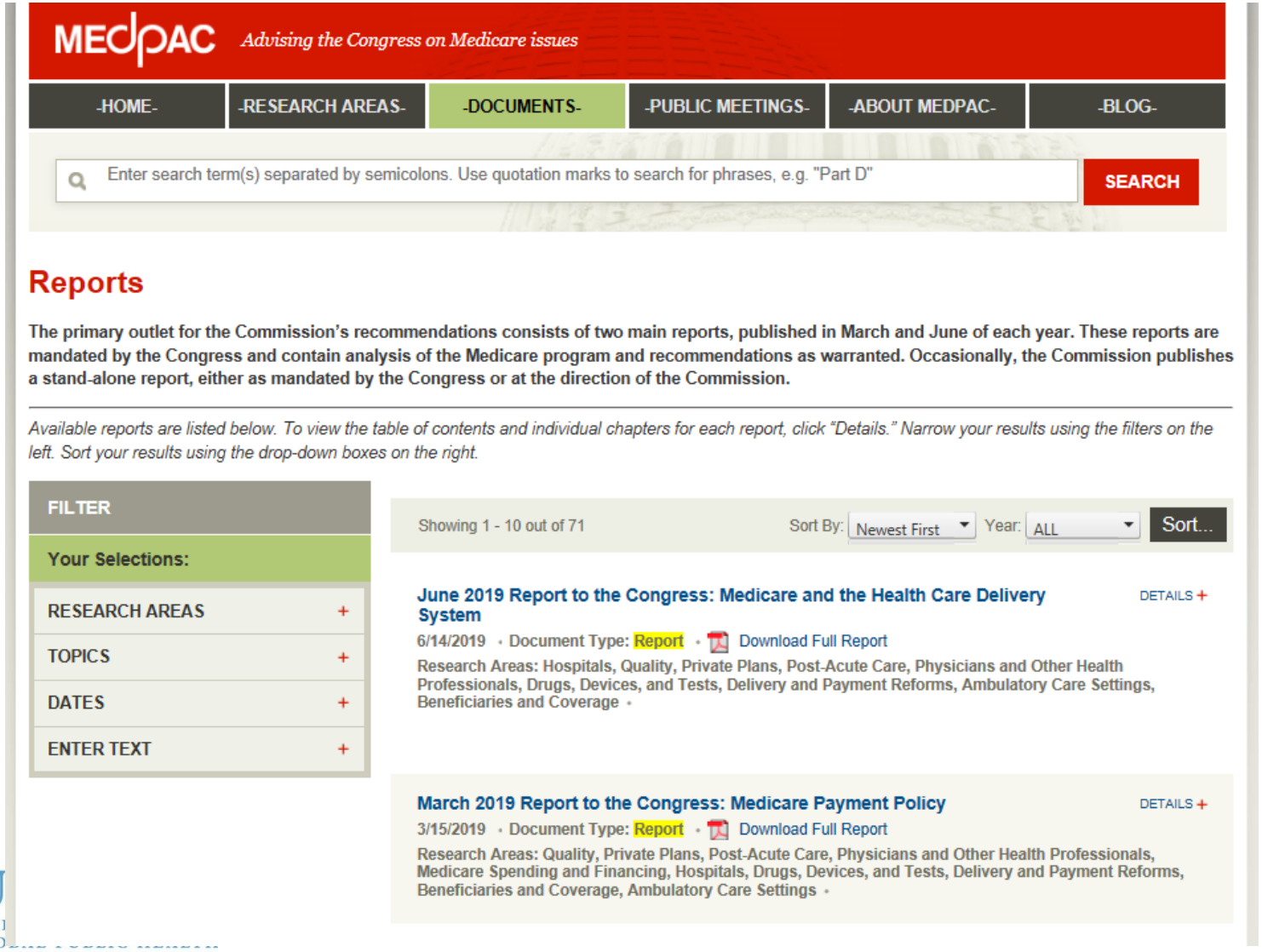
- Long-standing interest in health care use at the end of life
  - Research assistant on CMS-funded National Hospice Study (1980-1982)
  - PhD in Economics, University of Wisconsin, 1987
- Professor at UNC-Chapel Hill since 1989
  - Lots of work on Medicare use and payment, but not much focus on hospice *per se*
- Two stints as a Senior Advisor at the Office of the Assistant Secretary for Planning and Evaluation (ASPE), Dept. of Health & Human Services
  - 2011-2012 (Health and Aging Policy Fellow)
    - Participated in analyses contributing to hospice reimbursement reform mandated under the Affordable Care Act and implemented in 2016
  - 2018-Current
    - Providing support for the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

# Topics Covered Today

- Medicare hospice benefit: history and basics
- Medicare Care Choices Model
- PTAC review of stakeholder-submitted proposals to promote palliative care and end of life care for Medicare FFS beneficiaries
- New/emerging CMMI payment models
  - Primary Care First
  - Serious Illness Population

# Medicare Hospice Benefit (1):

## Medicare Payment Advisory Commission (MedPAC) Reports are Very Informative



# Medicare Hospice Benefit (2): Overview

- The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill with a life expectancy of six months or less.
- When beneficiaries elect to enroll in the Medicare hospice benefit, they agree to forgo Medicare coverage for conventional treatment of their terminal illness and related conditions.
- In 2017:
  - Nearly 1.5 million Medicare beneficiaries (including more than half of decedents) received hospice services from 4,488 providers
  - Medicare hospice expenditures totaled about $17.9 billion.

# Medicare Hospice Benefit (3): Payment Categories and Rates

**TABLE 12–1** Medicare hospice payment categories and rates

| Category | Description | Base payment rate, FY 2019 | Share of hospice days, 2017 |
|---|---|---|---|
| Routine home care* | Home care provided on a typical day: Days 1–60 | $196 per day | 31.6% |
| | Home care provided on a typical day: Days 61+ | $154 per day | 66.4 |
| Continuous home care | Home care provided during periods of patient crisis | $42 per hour | 0.2 |
| Inpatient respite care | Inpatient care for a short period to provide respite for primary caregiver | $176 per day | 0.3 |
| General inpatient care | Inpatient care to treat symptoms that cannot be managed in another setting | $758 per day | 1.4 |

Note: FY (fiscal year). Payment rates are rounded in the table to the nearest dollar. The routine home care payment rate has two levels: one for the first 60 days of hospice care and one for days 61 and beyond. If there is a break in hospice care that is more than 60 days, the day count resets to 1 when the patient re-enters hospice. Payment for continuous home care (CHC) is an hourly rate ($41.56 per hour, with a maximum payment per day equal to about $997) for care delivered during periods of crisis if care is provided in the home for 8 or more hours within a 24-hour period beginning at midnight. In addition, a nurse must deliver more than half of the hours of this care to qualify for CHC-level payment. The above rates are 2 percentage points lower for hospices that do not submit the required quality data. The percentages may not sum to 100 percent due to rounding.
*In addition to the daily rate, Medicare pays $42 per hour for registered nurse and social worker visits (up to four hours per day) that occur during the last seven days of life for beneficiaries receiving routine home care (which is referred to as the service intensity adjustment).

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2018. *Update to hospice payment rates, hospice cap, hospice wage index, and the hospice pricer for FY 2019*. Manual System Pub 100–04 Medicare Claims Processing, Transmittal 4086, July 13.

# Medicare Hospice Benefit (4): Key Ongoing Challenges and Approaches

- Extremely long stays for some beneficiaries
- Role of hospice in nursing homes
- High rates of live discharges
- Whether reimbursement rates are sufficient to cover appropriate care
- Continued high frequency of short stays

# Medicare Hospice Benefit (5): Extremely Long Stays for Some Beneficiaries

- Approaches so far: ACA provisions
  - Face-to-face requirement: ACA required a hospice physician or nurse practitioner to have face-to-face encounter with hospice patients prior to 180th day recertification & subsequent recertifications.
  - Lower RHC payment after 60 days (except for service intensity adjustment in last 7 days)
- But high margins for hospices:
  - With very long stays
  - For-profit vs. non-profits

**TABLE 12–16** Hospice Medicare margins by length of stay, 2016

| Hospice characteristic | Medicare margin |
|---|---|
| Average length of stay | |
| Lowest quintile | –5.4% |
| Second quintile | 5.8 |
| Third quintile | 15.1 |
| Fourth quintile | 19.2 |
| Highest quintile | 16.0 |
| Share of stays >180 days | |
| Lowest quintile | –5.4 |
| Second quintile | 5.8 |
| Third quintile | 14.8 |
| Fourth quintile | 20.0 |
| Highest quintile | 15.0 |

Note: Margins for all provider categories exclude overpayments to above-cap hospices. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports, Medicare Beneficiary Database, 100 percent hospice claims standard analytical file, and Medicare Provider of Services file from CMS.

# Medicare Hospice Benefit (6): Role of Hospice in Nursing Homes

- Hospice care is undoubtedly an important component of quality care for nursing home residents at the end of life.
  - But hospice was originally intended as primarily a home-based benefit.
  - Marginal contribution of care from hospices paid externally from the nursing homes is unclear.

**TABLE 12-17**

**Hospice Medicare margins by providers' share of patients residing in facilities, 2016**

| Hospice characteristic | Medicare margin |
|---|---|
| Share of patients in nursing facilities | |
| Lowest half | 8.1% |
| Highest half | 13.5 |
| Share of patients in assisted living facilities | |
| Lowest half | 5.8 |
| Highest half | 13.7 |

Note: Margins for all provider categories exclude overpayments to above-cap hospices. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports, Medicare Beneficiary Database, 100 percent hospice claims standard analytical file, and Medicare Provider of Services file from CMS.

# Medicare Hospice Benefit (7): High Rate of Live Discharge

**TABLE 12–12** Rates of hospice live discharge and reported reason for discharge, 2013–2017

| Category | 2013 | 2015 | 2016 | 2017 |
|---|---|---|---|---|
| Live discharges as a share of all discharges, by reason for live discharge | | | | |
| All live discharges | 18.4% | 16.7% | 16.9% | 16.7% |
| No longer terminally ill | 7.8 | 6.9 | 6.8 | 6.5 |
| Beneficiary revocation | 7.3 | 6.3 | 6.4 | 6.4 |
| Transferred hospice providers | 2.0 | 2.1 | 2.1 | 2.1 |
| Moved out of service area | 0.9 | 1.0 | 1.2 | 1.4 |
| Discharged for cause | 0.4 | 0.3 | 0.3 | 0.3 |
| Providers' overall rate of live discharge as a share of all discharges, by percentile | | | | |
| 10th percentile | 9.3% | 8.4% | 8.3% | 8.3% |
| 25th percentile | 13.2 | 12.0 | 12.2 | 12.6 |
| 50th percentile | 19.4 | 18.4 | 19.1 | 19.3 |
| 75th percentile | 30.2 | 29.6 | 31.3 | 31.8 |
| 90th percentile | 47.2 | 50.0 | 53.3 | 53.0 |

Note: Percentages may not sum to total due to rounding. "All discharges" includes patients discharged alive or deceased.

Source: MedPAC analysis of the 100 percent hospice claims standard analytical file, Medicare hospice cost reports, and Medicare Provider of Services file from CMS.

# Medicare Hospice Benefit (8): Are Reimbursement Rates Sufficient?

- Issue of great importance to MedPAC and CMS
- Topic of recent deliberation for MedPAC
- MedPAC Recommendation (2019 March Report to Congress):
  - For 2020, the Congress should reduce the fiscal year 2019 Medicare base payment rates for hospice providers by 2 percent
  - Questions?

# Medicare Hospice Benefit (9): Continued High Frequency of Short Stays

- Median hospice episode is 18 days
  - 25% of hospice users have stays of less than 7 days
- Medicare does not formally offer a palliative care benefit
  - Must forego regular Medicare benefits to access hospice services
  - Some efforts (e.g., care coordination) are not comprehensive
- Two specific approaches undertaken
  - Payment for physician visit for advance care planning starting in 2016
  - The Medicare Care Choices Model demonstration

# Medicare Physician Payment for Advance Care Planning (ACP)

- Ideally, ACP would be initiated before need for palliative or hospice care occurs.
  - So long run effects may not be evident for a while.
  - Rate of hospice use among decedents receiving ACP is higher than the overall rate of hospice use for decedents (data not shown)

**TABLE 12–6** Use of hospice among decedents who received an advance care planning visit, 2016

| | Share of beneficiaries who received advance care planning visit in 2016 |
|---|---|
| Died in 2016 | 8.4% |
| Used hospice | 5.0 |
| Did not use hospice | 3.5 |
| Died in 2017 | 7.3 |
| Used hospice | 4.4 |
| Did not use hospice | 2.9 |

Note: Numbers may not sum to totals due to rounding.

Source: MedPAC analysis of data from the denominator file, the Medicare Beneficiary Database, and Medicare claims data from CMS.

# Medicare Care Choices Model (1): Goals of the Demo

- MCCM is a five year demonstration (2016-2020) in 140 hospices
  - Offers hospice-eligible beneficiaries the option of receiving supportive services from a hospice while continuing to receive conventional care.
  - Targets specific diagnoses (advanced cancer, congestive heart failure, chronic obstructive pulmonary disorder, HIV/AIDS)
  - MCCM intended to test whether beneficiaries would be willing to elect supportive palliative care from hospice providers and effect on:
    - Quality of care
    - Cost of care
    - Whether beneficiaries will subsequently choose to enroll in the Medicare hospice benefit.

# Medicare Care Choices Model (2): Payments

- Under MCCM, care is directed by the referring nonhospice provider, and the hospice provider plays a supportive role.
  - Hospice providers are paid $400 per month ($200 per half month)
  - Supportive services include care coordination, symptom management, counseling, in-home nurse and aide visits, and other services determined to meet the patient's needs.
- Two points:
  - Patient does not need to drop curative health services.
  - This payment rate is low relative to what the provider would get if the patient transferred to hospice.

# Medicare Care Choices Model (3): Initial Experience/Findings

- First evaluation:
  - https://innovation.cms.gov/Files/reports/mccm-fg-firstannrpt.pdf
- Findings to date:
  - Enrollment lower than expected (though part of problem was requirement that enrollees be in Medicare FFS for 12 months prior to enrollment)
  - About half of enrollees were referred by physician offices
  - 37 hospices withdrew by Dec 2017
  - Enrollees had an average of 10.6 encounters per month (75% were in person)
  - Too early to assess impact on costs

# Proposals Submitted to PTAC Focusing On Serious Illness Population:

- Two proposals deliberated by PTAC on 3/26/18:
  - Patient and Caregiver Support for Serious Illness (PACSSI) submitted by American Academy of Hospice and Palliative Medicine (AAHPM)
  - Advanced Care Model (ACM) Services Delivery and Advanced Alternative Payment Model submitted by Coalition to Transform Advanced Care (C-TAC)
- Review team slide decks available at link.

# PACSSI Proposed Model: Summary Description

- Suggested five-year demonstration of payment for palliative care services for beneficiaries with:
  - Serious, potentially life-limiting illnesses; or
  - Multiple chronic conditions with functional limitations
- Participating beneficiaries must meet detailed diagnostic, functional status, and healthcare utilization criteria in one of two clinical complexity "Tiers"
- Payment includes:
  - Two different tier-based monthly care management payments
  - Two different financial incentive tracks

# ACM Proposed Model: Summary Description

- Payment for palliative care services to Medicare beneficiaries who:
  - Meet at least 2 of 4 screening criteria
  - Physician affirms they would not be surprised if patient died within 12 months
- Covered services:
  - Palliative/comfort-based care and promotion of evidence-based, disease-modifying treatments that align with patient's personal preferences;
  - Comprehensive care coordination and case management of beneficiary's total healthcare needs (curative and palliative);
  - Advanced care planning;
  - Shared decision-making between the advanced illness beneficiary (and caregivers and family) and the ACM care team; and
  - 24/7 access to a clinician
- Services delivered by:
  - An ACM care team that includes a Registered Nurse (RN), licensed social worker, and provider with board-certified palliative care expertise. ACM teams may also include other clinicians practicing within their scope of licensure and non-clinicians.
  - Participating physicians and other eligible clinicians

# PTAC Report to the Secretary on PACSSI and ACM

- Joint PTAC Report to the Secretary on 5/7/2018:
  - PTAC concluded both proposals have merit and recommended limited–scale testing with the highest priority.
  - "PTAC wishes to underscore that the need for palliative care services for Medicare beneficiaries is urgent and that such care can only be effectively provided with changes to Medicare payment policy such as those proposed in these two models."
- Report provides excellent summary and points

# Secretarial Response to PTAC Report

- HHS Secretary Response to several models including PACSSI and ACM: Letter from Alex Azar 6/13/2018.
  - I am particularly interested in the two serious illness models proposed by the Coalition to Transform Advanced Care (C-TAC) and the American Academy of Hospice and Palliative Medicine (AAHPM).
  - We agree with PTAC that a payment model that establishes incentives to provide optimal care for seriously ill beneficiaries should be tested by CMS, and Innovation Center staff have met with submitters and other stakeholders about both proposed models.
  - While it is unlikely that all of the features of any proposed model would be tested as proposed, HHS is clearly benefitting from PTAC's comments and recommendations as we explore designing a future payment model for seriously ill beneficiaries.

# Key CMS/CMMI Links for Models Addressing Serious Illness Care

- PTAC announcement: https://www.thectac.org/2019/04/cmmi-announces-new-serious-illness-payment-model-based-on-c-tac-proposal/

- Primary Care First (webinar slides available at link): https://innovation.cms.gov/initiatives/primary-care-first-model-options/

- SIP Webinar (July 24 webinar slides not yet posted): https://innovation.cms.gov/resources/pcf-seriously-ill-population-webinar.html

# Questions or Discussion?

- Many thanks to the *NC Institute of Medicine Task Force on Serious Illness Care* for the important work you are doing!