Hospice Economics: Where Can We Position Ourselves? (ACO’s and beyond)

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Where should the focus of hospice and palliative care be in our healthcare universe?
In an infinite Universe:
  – focus is entirely on the patient.

In a finite Universe:
  – focus is on the patient with the understanding there are others in line for our services.

So…”It’s always about the money.” Because to get the ethical questions right, you have to get the economic questions right.

Money is just a representation of resources. If it makes it easier, substitute the word energy, food or resources for money.
**General Fund**

- Help pay children's healthcare
- Help people quit smoking

**Federal Fund**

- Tobacco companies raised prices as soon as mandate was voted in. Profits went to tobacco industry.

**Projected sales decrease of 1.2% Actual 8.1%**

**State has to find revenue from other source for SCHIP**

**Medicaid Loss 2009, 2010, 2011**

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**State’s Tobacco Tax Revenue Drops as Cigarette Sales Fall**

Last year, cigarette sales in California dropped by 8.1%, the largest one-year decline in the past 10 years, according to the state Board of Equalization, the Sacramento Bee reports.

The bill estimates that 9.72 million packs of cigarettes were sold in California last year, down from 2.8 billion packs sold in 1990 (Calisi, Sacramento Bee, 7/26).

According to the California Department of Public Health, the percentage of smokers in California also has declined by nearly 50% since 1985 (Halo, Los Angeles Times, 7/27).

**Higher Prices Per Pack**

The federal per-pack tax on cigarettes increased by 62 cents last year, bringing the total tax to $1.01 per pack. In California, a package of cigarettes now costs an average of $5.95 (Sacramento Bee, 7/26).

In addition to a higher sales tax, cigarette manufacturers also raised their product prices by an average of 4.2% between fiscal year 2008 and FY 2009 to compensate for a drop in demand (Los Angeles Times, 7/27).

**Good News for Public Health, Bad News for Health Programs**

California’s decline in cigarette sales could have a positive effect on public health because smoking has been linked to cancer, emphysema, heart disease and other medical conditions.

However, the drop in sales also means that the state is collecting less in tobacco tax revenue. During the most recent fiscal year, the state received $376 million in cigarette tax revenue, down from the $471 million it collected in the previous fiscal year (Sacramento Bee, 7/26).

California’s tobacco tax revenue helps fund health education programs, early childhood education, breast cancer research and other state programs (Hat, Orange County Register, 7/27).

Diane Levin—chief deputy director of First 5 California, which uses tobacco tax revenue to fund early childhood health and education programs—said she expected the decrease in cigarette sales and tax revenue. Levin added that her organization is developing strategies to do more with less funds (Sacramento Bee, 7/26).
Medicaid Benefit Contractions 2009

- Podiatry Benefits
- Vision Benefits
- Dental Benefits
- Chiropractic Care

- Decrease pay by 10% to healthcare providers
- Limit covered patient visits to 10 per year
- Restrict coverage to 6 prescriptions per month excluding lifesaving medicines
- Initiate copays: $5.00/office, $50.00/ER, $100.00/day hospital

Other Moral Questions?
(Unintended Consequences/Moral Hazard)

- Doesn't associating tobacco tax with SCHIP mean we need new smokers?
- Where do we recruit new smokers to pay for SCHIP?
- Does helping a smoker quit truly lower the cost of healthcare?

Older Children
Young Adults
WHO – Ranking the World’s Healthcare Systems

The World Health Organization (WHO) ranked the health systems of its 191 member states in its World Health Report 2010. It provided a framework and measurement approach to examine and compare aspects of health systems around the world. It developed a series of performance indicators to assess the overall level and distribution of health in the populations, and the responsiveness and financing of health care services. It was the organization’s first ever analysis of the world’s health systems.
Chart 2 - Total Expenditures on Health as a Percentage Share of GDP, OECD Countries, 2006

Source: OECD Health Data 2008.
Note: For the United States the 2006 data reported here do not match the 2006 data point for the United States in Chart 1 since the OECD uses a slightly different definition of "total expenditures on health" than that used in the National Health Expenditure Accounts.
Methodology
Rankings are based on index of 5 factors

- Health (50%): disability-adjusted life expectancy
  - Overall or average: 25%
  - Distribution or equality: 25%
- Responsiveness (25%): speed of service, protection of privacy, and quality of amenities
  - Overall or average: 12.5%
  - Distribution or equality: 12.5%
- Fair financial contribution: 25%
Hi Hospice and How to fit in and be a Part of the Economic Solution

Pyramid Scheme

FDA TO RETOOL FOOD GUIDE PYRAMID, CITING CONSUMER CONFUSION
National Health Care and Medicare Spending
Eliminating Waste in US Healthcare

Figure. Proposed “Wedges” Model for US Health Care, With Theoretical Spending Reduction Targets for 6 Categories of Waste

Chart 1-4. Medicare's share of total spending varies by type of service, 2009

Note: SCHIP (State Children's Health Insurance Program). Personal health spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Totals may not sum to 100 percent due to rounding. "Other" includes private health insurance, out-of-pocket spending, and other private and public spending.


Chart 1-10. FFS program spending is highly concentrated in a small group of beneficiaries, 2007

Note: FFS (fee-for-service). Excludes beneficiaries with any group health enrollment during the year. Spending data reflect revised 2007 Medicare Current Beneficiary Survey Cost and Use files from CMS.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use files.
Chart 1-9. Medicare spending is concentrated in certain services and has shifted over time

Total spending 2000 = $227 billion

<table>
<thead>
<tr>
<th>Service</th>
<th>2000</th>
<th>2010</th>
<th>Percent change 2000-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital</td>
<td>39%</td>
<td>12%</td>
<td>-81%</td>
</tr>
<tr>
<td>Home health</td>
<td>1%</td>
<td>4%</td>
<td>335%</td>
</tr>
<tr>
<td>Physician fee schedule</td>
<td>18%</td>
<td>12%</td>
<td>-33%</td>
</tr>
<tr>
<td>Other hospital</td>
<td>4%</td>
<td>5%</td>
<td>25%</td>
</tr>
<tr>
<td>DME</td>
<td>2%</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>Managed care</td>
<td>10%</td>
<td>6%</td>
<td>-40%</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>5%</td>
<td>5%</td>
<td>0%</td>
</tr>
</tbody>
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Chart 11-8. Medicare hospice use and spending grew substantially from 2000 to 2009

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Beneficiaries in hospice</td>
<td>13,000</td>
<td>1,055,000</td>
<td>1,088,000</td>
<td>9.4%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Medicare payments (in billions)</td>
<td>2.9</td>
<td>11.2</td>
<td>12.0</td>
<td>18.4</td>
<td>7.1</td>
</tr>
<tr>
<td>Average length of stay among decedents (in days)</td>
<td>54</td>
<td>83</td>
<td>86</td>
<td>5.5</td>
<td>3.6</td>
</tr>
<tr>
<td>Median length of stay among decedents (in days)</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Note: Average length of stay is calculated for decedents who received hospice care at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime.

Source: MedPAC analysis of the denominator file, the Medicare Beneficiary Database, and the 100 percent hospice claims Standard Analytic File from CMS.
Chart 11-12. Long hospice stays are getting longer, while short stays remain virtually unchanged, 2000 and 2009

Note: Data reflect hospice length of stay for Medicare decedents who used hospice at the time of death or before death. 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 the denominator file and the Medicare Beneficiary Database from CMS.

Chart 11-15. Medicare margins are higher among hospices with more long stays, 2008

Note: Margins exclude overpayments to hospices that exceed the cap on the average annual Medicare payment per beneficiary. Margins are calculated based on Medicare allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports and 100 percent hospice claims Standard Analytic File from CMS.
Part II: Hospice Economic Opportunities

*Five Payment Models: the Pros, the Cons,*

Minnesota Medicine
Goal: Higher Value - Better Quality

1. Fee for Service
2. Pay for Coordination
3. Pay for Performance
4. Episodic or Bundled Payments
5. Comprehensive Care/Total Cost of Care Payments

Goal of CMS ACO Program

CMS Shared Savings Program established in the Patient Protection and Affordable Care Act (“PPACA”) with the goal to provide:

Three Part Aim

1. Better care for individuals
2. Better health for populations
3. Lower growth in Medicare expenditures
Pioneer ACO Program

- Offered by the Center for Medicare & Medicaid Innovation ("CMMI")
- Designed for health care organizations that are already experienced in coordinating care for patients across care settings
- Allows these provider groups to move more rapidly from a shared savings payment model to a population-based payment model

Pioneer ACO Footprint
Beneficiary Alignment

- Patients aligned prospectively with the ACO based on the plurality of outpatient evaluation and management ("E&M") billings
  - Primary care activity and certain specialties activity
    - Nephrology, Oncology, Rheumatology, Endocrinology, Pulmonology, Neurology, and Cardiology
  - Minimum requirement of 15,000 aligned beneficiaries
    - 5,000 beneficiary minimum in rural areas
- Participating PCPs must be exclusive to one ACO
  - Specialists are not required to be exclusive

Beneficiary Alignment

- Once a beneficiary is aligned to an ACO, they may opt out of Medicare sharing data with the ACO
  - Patients who opt out of information sharing are included in an ACO's quality and cost results
- Beneficiaries aligned prospectively
  - Retrospective adjustments for decedents, patients moving out-of-network, patients who lose their Medicare coverage or enroll in a Medicare Advantage plan
- Patients retain unrestricted choice of providers
  - No authorizations required for services
Subcommittee Structure

Aim and Primary Drivers

Best Health, Best Care, Best Experience

Care Delivery Models

Care Coordination

Patient Engagement

Information Technology and Analytics

Alignment of Incentives
### Years One and Two

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing</td>
<td>Providers bill normally and receive standard fee-for-service payments</td>
</tr>
<tr>
<td>Comparison</td>
<td>Total cost of care for ACO beneficiaries is compared to a benchmark based on historical costs of the aligned population</td>
</tr>
<tr>
<td>Bonus</td>
<td>If total expenses are less than target, and if <em>quality metrics are achieved</em>, a portion of the savings is returned to the ACO</td>
</tr>
<tr>
<td>Distribution</td>
<td>The ACO is responsible for dividing the savings among ACO participants</td>
</tr>
</tbody>
</table>

### Quality Measures

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Caregiver Experience</td>
<td>7 individual measures (6 composite) based on CAHPS</td>
</tr>
<tr>
<td>Care Coordination/ Patient Safety</td>
<td>6 individual measures (EHR adoption double weighted)</td>
</tr>
<tr>
<td>Preventive Health</td>
<td>8 measures (immunizations, vaccinations, screenings, tobacco cessation)</td>
</tr>
<tr>
<td>At Risk Population</td>
<td>12 measures (5 composite diabetes measures and 2 composite coronary artery disease measures)</td>
</tr>
</tbody>
</table>
Year Three

Payment Option

• Must achieve quality targets as well as a minimum 2% annual savings in years one and two to receive population-based payments in year three

CMMI’s AIM is that 100% of Pioneer ACOs generate sufficient cost savings and quality improvements to qualify for population-based payments in year three

Fee For Service (FFS)

Strengths:
• Emphasizes productivity,
• Flexible

Weaknesses:
• No incentive to delivery efficient or prevent unnecessary care.

Incentivizes delayed or no palliative or hospice referral.

Opportunities:
• Physician education
• Direct marketing to the public.
• 30 Day readmissions: ACP, Medication reconciliation and AIM
Pay For Coordination: Pays groups or systems for coordination of services.

Strengths:
• "Pays for support services that would not be paid under the traditional FFS model."
• Intended to reduce unnecessary and inefficient care.

Weaknesses:
• Patient and family expectations regarding services

Opportunity: MEDICAL HOMES

PEARL. – The medical home concept was designed to provide as many services as possible by bringing the patient to the medical home. The demographics we deal with need that care brought to them.
Pay for Performance - payment or financial incentive associated with achieving defined or measurable Goals.

Strengths:
• System coordination of care
• Care is outcome driven

Weakness:
• Incentives to avoid high risk patients or discharge noncompliant patients.
• Increases administrative time versus direct patient care

Opportunity:
• ACOs – discharge palliative/medical coordination
• Value Based Purchasing – Nursing Homes

**PEARL:** P4P is disease driven. ACOs and NHs work like P4P but they are comprehensive care.
Episodic or Bundled Payments – single payment for a group of services related to a condition for multiple providers in multiple settings. “Episodic Case rate”

Strengths:
• improves coordination of care
• flexibility
• incentivizes efficiency
• billing simplicity
• clear accountability for an episode of care

Weaknesses:
• Clarity of episodic services
• May limit patient choice
• No incentive to prevent care
• “Cherry picking”

Opportunity:
• Most Episodic Care is Obstetric or Surgical.
• Palliative opportunity exists in defining goals of care before and after a procedure.
Comprehensive/"Total Care" Payment – risk adjusted payment for complete care of a group of patients over a predetermined period of time.

Benefits:
• Highly flexible
• Opportunity for innovation
• Incentive for efficient care delivery
• Requires vision of the continuum
• Emphasis on keeping the patient healthy and respecting patient choice. “Don’t let the patient get sick in the first place.”

Weaknesses:
• Requires sophisticated health systems
• May limit application to larger healthcare models
• Emphasis on population versus individual health
• Avoidance of high-risk patients
• Decreases patient choice
• Real or “perceived” that care is withheld.
Sharp HealthCare’s Transitions Program:

1. Pre-hospice concurrent care model
   a) “When is the patient going to start using the hospital as a tool to manage their condition?”
   b) Moves to a proactive versus reactive model of medical and psychosocial care
2. Took advantage of Capitated contracts
3. Aligned incentives
4. Started with “low lying fruit”

Soon to be published:

1. Decreased PRIMARY ER visits and Hospitalizations by 94% / decreased home health utilization
2. Saved $27,000.00…
Increased hospice referrals

3. For Transitions patients moved our median LOS for Transitions CHF patients on hospice.

<table>
<thead>
<tr>
<th>Year</th>
<th>Median LOS</th>
</tr>
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<tbody>
<tr>
<td>2009</td>
<td>34</td>
</tr>
<tr>
<td>2010</td>
<td>47</td>
</tr>
<tr>
<td>2011</td>
<td>66</td>
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Conclusion:

- Be sure you are actually helping
- Know what your data means
- Be prepared for an evolving system
- Position ourselves to be part of the solution