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Bringing Transparency to Healthcare

MYTH BUSTERS

Market Intelligence Reveals New Insights to Old Growth Measures

By looking deeply into the CMS Chronic Conditions Data Warehouse, Excel Health challenges the hospice industry to consider new approaches to measuring key growth indicators and new ways to position hospice benefits in the value-based care economy.

Truth or Consequences *How Obsolete Calculations Misrepresent the Facts of Hospice Growth*

Many industry watchers say that hospice utilization is receding. One claim is that a primary industry growth indicator, represented as the rate of hospice elections among Medicare beneficiaries, is stagnant at best and declining at worst.

However, through investigation of newer and more accurate market intelligence, Excel Health has proven that recent assumptions about the health of hospice in America are erroneous. Outdated calculation methodologies distort the role hospice providers play in the emerging value-driven care continuum.

Moreover, changes in hospice length of stays are the direct product of changing Medicare demographics and referral patterns, involving patients with more complex, multi-dimensional disease states. As a result, Excel Health believes that the time has come for a more innovative and accurate approach to traditional indicators of industry norms and vitality.

Myth vs. Reality

Myth	Reality
Hospice utilization is declining.	Hospice utilization grew by almost 1 full percentage point in 2016 over 2015.
Physicians understand the value of hospice.	Many physicians are unaware of the role hospice can play in improving the patient experience and reducing healthcare costs.
Most hospice referrals come from hospitals.	Hospice referrals come from all care settings, two-thirds of which are not inpatient.
Hospice is mainly for cancer patients.	Hospice has seen a tenfold increase in Alzheimer patients and those with multiple chronic comorbidities.
For-profit hospices drive more utilization of services due to longer lengths of stay.	Many factors other than tax status of the organization must be considered when predicting hospice utilization trends.

The purpose of this paper is to help hospice providers understand why the traditional approach to calculating utilization rates, as a means of predicting industry trends, no longer provides a true picture of the industry. We will also expose data-driven realities that conflict with long-held assumptions about hospice in America.

At Excel Health, we are focused on providing greater transparency in healthcare by making the CMS Chronic Conditions Data Warehouse easily accessible and consumable to all healthcare providers through its market intelligence platform. By arming hospice leaders with more accurate and timely information than once thought possible, Excel Health is delivering relevant facts, drawn from CMS' most recent 2017 data, to help hospice organizations better understand true hospice trends and achieve their missions.

It has been said that knowledge is power. With insight into intelligence that enables a more complete understanding of industry dynamics and facts, hospices will have the power to thrive in an increasingly complex and rapidly shifting healthcare delivery environment.

The Emerging Importance of Value-Based Care

As Congress, the Medicare Payment Advisory Commission and CMS continue to grapple with concerns over the sustainability of the Medicare program, payment reform initiatives have surged in importance.

Researchers concluded that if 1,000 additional Medicare beneficiaries enrolled in hospice for 15 to 30 days prior to death, the Medicare program could save $6.4 Million.[1]

Hospital performance is measured through the Value Based Purchasing program, rewarding high performing institutions based on total performance scores that measure the quality of patient care and outcomes. At the same time, CMS has also instituted penalties for hospitals with high readmission rates suggestive of poor quality outcomes for certain chronic conditions.

The end goal is simple – elevate quality of care while reducing Medicare expenditures. Because of this, it comes as no surprise that hospitals have a vested interest in improving post-acute care and selecting the partners most likely to contribute to their own success.

Additionally, beginning in 2017, physicians are being motivated to submit quality data under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to qualify for future payment incentives and avoid penalties in 2019. Thus physicians also have a vested interest in preserving higher quality, lower cost service delivery directions.

As the industry moves inexorably towards even more aggressive payment reform initiatives, particularly for physicians and institutional providers, the availability of effective post-acute care options becomes more and more essential to the realization of their own quality and cost-reduction mandate.

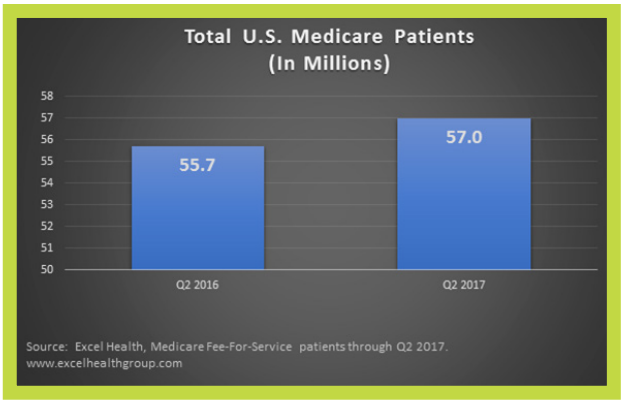
Clearly hospices are in the enviable position of being able to effectively deliver on both quality and cost objectives. In a 2013 analysis of hospice enrollments and costs, researchers concluded that if 1,000 additional Medicare beneficiaries enrolled in hospice for 15 to 30 days prior to death, the Medicare program could save $6.4 Million.[1]

Not incidentally, those same beneficiaries would have also been spared 4,100 days of hospitalization at the end of life. Pursuing avenues of care that produce these results is a worthwhile endeavor for all.

[1]2013, March. Hospice Enrollment Saves Money For Medicare And Improves Care Quality Across A Number Of Different Lengths-Of-Stay www.healthaffairs.org

New Demographics Require a Fresh Approach to Metrics

It's no surprise that the number of Medicare beneficiaries is growing. Thanks to the greying of America, there were approximately 57 million Medicare beneficiaries at the close of the second quarter of 2017, as reported by Excel Health.



That is up from 55.7 million beneficiaries a year earlier, contributing to a 2% year-over-year growth rate for the last four quarters. Most of this growth is directly attributable to the fact that nearly 10,000 baby boomers reach the age of 65 and qualify for Medicare every day. The result is that the average age of a Medicare beneficiary continues to drop.

The traditional hospice utilization calculation, number of hospice patients as a percent of total beneficiaries, fails to consider this changing concentration of potential patients along the Medicare age continuum.

The massive introduction of baby boomers to the ranks of Medicare beneficiaries has created a record number of younger enrollees who are unlikely to become eligible for hospice benefits until much later in life.

At the opposite end of the spectrum are older beneficiaries for whom the need for end-of-life care becomes much more probable. And, because eligibility for hospice services remains unchanged, beneficiaries must be in the last stages of life to qualify for the benefit.

Because of these prevalent demographic shifts and changes in patient clinical characteristics, it has never been more important for hospice providers to gain access to detailed data to understand how changing market conditions are impacting service delivery, current operating results and expectations for future success.

By having a more accurate and complete picture of the patient population and service providers in the communities they serve, hospice leaders will be better equipped to make more informed business decisions that will produce revenue growth, improve the hospice experience for patients and simultaneously play a meaningful role in improving the Medicare cost curve.

Why Miscalculations Lead to Misconceptions

To truly understand and predict the future of the hospice industry, it is important that we further investigate new ways to capture and report on traditional growth indicators. It is equally important that hospice organizations have access to insightful data to underscore their unique ability to assist key constituencies in their communities, as they work to navigate the changing reimbursement models driving the value-based care economy.

Myth #1

Reality

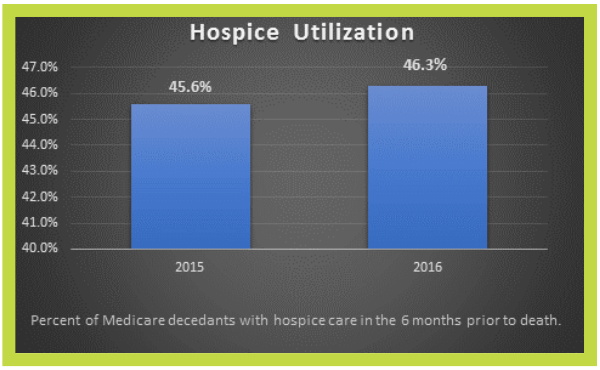
Hospice utilization is declining

Hospice utilization is growing. To get an accurate picture of hospice use, we must look at Medicare mortality rates and differentiate between those deceased beneficiaries who did and those who did not receive hospice services. Because of the age curve, this is the only realistic approach to getting a true picture of hospice utilization.

The traditional way of measuring hospice utilization boils down to dividing the total number of hospice beneficiaries by the total number of Medicare beneficiaries. This exercise produces a measure suggestive of a trending decline in hospice utilization. However, if we use the mortality rates made available by CMS through the Excel Health portal, we see an increasing percentage of Medicare beneficiaries dying with the hospice benefit.

To illustrate the point, hospice utilization, as measured by decedents who received hospice care increased nearly a full percentage point from 45.6% in 2015 to 46.3% in 2016.

In fact, the most recent Excel Health Hospice Industry Utilization Report reveals a 5.6% increase in total hospice patient admissions in Q2 2017 when compared to the Q2 2016, and an average 5% quarter over quarter growth for the last four quarters.



The average hospice patient is 85 years old. Given the significant expansion in the number of lives covered by Medicare and the increasing number of younger beneficiaries who have not yet reached old age, it is no surprise that we need to adopt a new, more accurate way of calculating utilization rates that reflect the true market dynamics driving the demand for hospice services.

Myth #2
Reality

Physicians understand the value that hospice brings to their patients and practices

Many physicians are uninformed about the benefits that hospice care can bring to terminal patients and how it can positively impact performance measures.

Like it or not, physicians are the gatekeepers for nearly every modality of care; however, many fail to broach the subject of hospice to their dying patients until it is almost too late for the patient or family to get meaningful benefit from hospice care. This not only prevents the patient and family members from experiencing the many benefits hospice offers, but also causes physicians to miss out on opportunities to positively impact their quality measures and the quality of their patients' lives.

Physicians must take a fresh look at how hospice care can impact their own performance results, particularly in the view of hospitals that end up receiving their patients who do not elect hospice, and for whom repeated, and very costly, end-of-life hospitalizations are the norm. The reality is that patients who are frequently readmitted at the end of life have a lower quality of remaining life. Hospital readmissions also do nothing to improve physician and hospital quality performance.

To reshape old perceptions, hospice providers must be prepared to present meaningful data and quantifiable results to demonstrate the value they bring to the patients of their physician referral sources. By educating physicians using factual, easy to understand data, such as hospice utilization rates versus their peers, hospices can help physicians to better understand the cost and quality implications of not recommending hospice care.

Myth #3
Reality

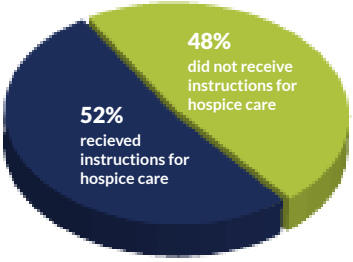
Most hospice referrals come from hospitals

Hospice referrals have multiple points of origin

Hospice organizations have long coveted relationships with hospitals. Historically, this is where they believe most referrals originate. Excel Health believes that this misconception has been fed, in part, by presentation of partial Medicare claims data that represents only a portion of the opportunity for hospices to measure their markets. For example, Part B institutional claims, which include hospitals and skilled nursing facilities, represent only one-third of all Medicare claims. What about the other two-thirds?

To gain significant market share, all hospices must understand the discharge behaviors of all potential referral sources of hospice patients. Accessing the full data set that provides this market intelligence is the only reliable way to gain the complete picture of growth opportunities in the hospice's service area. And, that means being able to access Part B claims data as well as Part A claims data.

Hospice Patients Discharged from Hospital Inpatient Setting



Source: Excel Health Medicare Fee-For Service Claims data through 2016. Patients receiving hospice care within 30 days of discharge from hospital inpatient setting

> *"Hospitals are trying to improve their post acute strategies, but have only recently begun to realize the existence of the discharge planning gap. In many cases, it is our customers who are helping hospitals improve by sharing our unique discharge data and implementing programs to ensure hospice patients are captured during discharge."*
> *—Ian Juliano, founder and CEO of Excel Health*

Upon deeper analysis of the full data set, which includes all of Medicare institutional and physician claims, Excel Health has demonstrated that patients often enter hospice without an immediately prior hospitalization. Furthermore, on a national basis, almost half (48%) of hospice patients enter hospice care within 30 days of inpatient discharge without instructions from discharge planning to get hospice care. This means that someone else is making the hospice referral.

Still, a significant number of patients are entering hospice following an encounter outside of a hospital, in many cases with an individual physician or non-physician practitioner in the physician's private practice. Hospice providers that have access to physician private practice claims data, like the data accessed through Excel Health, will have a distinct advantage identifying and partnering with the practitioners most likely to refer to hospice.

Myth #4
Reality

Hospice is mainly for cancer patients

The array of typical hospice terminal diagnoses has changed. As hospice began more than three decades ago, the vast majority of hospice patients were referred with end-stage neoplasms, or cancer.

Multiple chronic conditions, including neurological diseases with specific end of life complications, are now far more likely to be represented as the terminal diagnosis than neoplasms.

The origins of the myth are easy to trace. In the 90's, 75% of hospice patients had a primary diagnosis of cancer with a predictable trajectory of decline.

> *In a 2017 publication by the Health Policy Team at NHPCO, dementia was identified as a top diagnosis comprising of 16.5% of hospice patients.*[2]

But, during the last decade, there has been more than a tenfold increase in dimentia as the primary terminal hospice diagnosis. In a 2017 publication by the Health Policy Team at NHPCO, dementia was identified as a top diagnosis comprising of 16.5% of hospice patients.[2]

Today, more than 70% of Medicare beneficiaries have multiple morbidities, which together with general frailty and significant cognitive impairment, complicate care at the end of life and make it far more difficult for a physician to predict when a patient is likely to die.

This certainly can have the effect of complicating the development of a terminal prognosis that "fits" with Medicare's expected six-month trajectory between a patient's hospice election and his or her death. These facts present both a challenge and an opportunity for hospices.

Patients with multiple morbidities have been shown by researchers to be more likely to experience aggressive care at the end of life, punctuated by more frequent ER visits, increased hospitalizations and more days in intensive care.

Research has also shown that most patients would prefer to forego this intensity and receive care that is less intensive and more comfortable. In order to bridge the gap and to identify patients who are or are about to become appropriate for hospice care, hospice providers must help physicians and other practitioners who are caring for complex patients to understand when hospice becomes the best choice for treatment of the patient.

[2] 2017, October. National Hospice and Palliative Care Organization Facts and Figures: Hospice Care in America. www.nhpco.org

With the use of Excel Health's claims data that includes patient concentrations by zip code and performance data by major diagnostic category, hospices can hone in on the facilities and physicians most likely to be treating persons who are or will soon become hospice eligible. And, from there, the educational activity and trusted advisor relationship can commence.

Myth #5
Reality

For-profit tax status equates to longer hospice lengths of stay

Length of a hospice stay is primarily dependent on two factors: the timeliness with which patients are identified as appropriate for hospice and referred, and the complexity of the patient's array of combinate diseases.

Some researchers have attempted to prove that the size and tax status of a hospice organization is a preeminent driver of length of stay. Ergo, with a higher profit motivation, these hospices are more likely to admit patients who revoke or are discharged for lack of ongoing terminal status and less likely to be on service for very short periods of time. Put another way, some researchers theorize that for-profit hospices are more likely to prematurely admit patients and keep them on service longer. The theory may seem logical at first blush, but the most recent Excel Health data supports a cogent argument to the contrary.

In fact, Excel Health's most recent data, from the second quarter of 2017, puts this theory in substantial doubt. When comparing states with high proportions of for-profit providers to those with a higher percentage of not-for-profit hospices, average length of stay is still comparable to the national average.

New Insights Shed New Light on Current Hospice Trends and Future Expectations

The entire post-acute care community is now sharing the responsibility to provide more accountable value-based care. This presents enormous opportunity for hospices able to access recent and complete data to present a more accurate depiction of current industry metrics and market dynamics, that can be acted upon by hospitals and physicians with patients who would benefit from hospice services, both in terms of quality of care and overall Medicare program cost.

By accessing the Excel Health data set, hospice organizations can now use mortality rates to accurately depict hospice utilization rates in their coverage areas. They can also better predict length of stay by referral source and diagnostic category. And importantly, hospices with the data to share will be those that successfully position themselves as trusted post-acute care advisors to their community referral sources.

To learn more about how your organization can access Excel Health market data, visit www.excelhealthgroup.com or speak to one of our Data Experts @ sales@excelhealthgroup.com or 678.813.1590.

About Excel Health

Excel Health enables healthcare providers to thrive in the new paradigm of value-based care. With access to complete Medicare Part A and Part B data, delivered 90-120 days after each quarters' end (over 1.25 billion claims annually), Excel Health has put the most current, comprehensive, and robust medical databases in the world at your fingertips in our easy to use Home Health and Hospice portals. Our goal is for care networks to be constructed and providers selected based on care efficacy (superior outcomes) and care efficiency (reduced utilization). The potential of our suite of on-demand, cloud-based data solutions to profoundly impact healthcare and patient lives is immediately evident in our client success stories. For more information, please visit: http://www.excelhealthgroup.com or to see a demonstration email us at sales@excelhealthgroup.com.