VNAA Principles
Refinement of the Medicare Hospice Payment Methodology

Introduction: The Visiting Nurse Associations of America (VNAA), on behalf of nonprofit, community-based hospice providers, supports the need for refinements to the Medicare hospice payment methodology to reduce or eliminate problems that have become evident in the current system. Unanticipated shortcomings and vulnerabilities in the Medicare payment system have created incentives for providers to admit long stay patients with relatively low service needs while simultaneously threatening patient access by underpaying for persons with short stays and those with particularly high patient care resource needs.

Notwithstanding the current Medicare payment system's shortcomings, the hospice benefit has become an increasingly valuable part of the Medicare program. It affords millions of beneficiaries a choice to accept a humane and caring alternative to futile and often painful curative care at the end-of-life. It also has created a more efficient means for Medicare to meet the needs of terminally ill patients. Getting the Medicare payment system to more accurately support the needs of hospice beneficiaries is crucial to the continuation and enhancement of this mode of care. Hospice payment reform is an opportunity to align resource allocation and payment incentives in the Medicare program to ensure hospice is offered at the right time, to the right people, at the right price.

Problems in the Current Payment System: The number of Medicare hospice patients who have long lengths of stay has been increasing dramatically each year as are Medicare payments driven by such very long stays. This is due to the strong financial incentive in the current Medicare hospice payment system to admit long stay patients with relatively low service needs. The Medicare hospice program pays one of four flat, per-diem rates for each day a Medicare patient is in the hospice benefit, regardless of the services needed or provided. Thus, the longer the Medicare hospice stay and the fewer services patients require, the greater the profit potential.

Conversely, the Medicare payment system fails to recognize that the current daily rate system does not cover the full cost for short lengths of stay. Nonprofit hospices admit patients who are referred to hospice late in their end-of-life experience while many other providers do not. Sometimes this means only a few days of hospice care prior to death, and often less than three weeks. Such late referrals give the hospice very little time to put in place the kind of comprehensive hospice support system needed for these very sick patients. Short stay patients concentrate a large amount of cost over very few days but Medicare reimburses the same per diem rates for very short and very long stays.

VNAA members continue to accept short stay patients knowing that it will be challenging to care for them both from a service and Medicare payment perspective. If higher Medicare payments for longer stay patients do not help cross-subsidize short stay patients, the hospice will take a loss and be in jeopardy unless charitable donations can offset uncompensated costs. The capacity of a nonprofit hospice to generate enough charitable donations to offset uncompensated costs is limited. Moreover,

as the incentives in the current system drive some hospices to avoid shorter stay patients and maximize profits by concentrating on long stay and low service intensity patients, hospices that take all patients will increasingly be unable to offset their losses on short stay patients with longer stay patients.

Thus, the implications of the current Medicare system is that overpayment for long stay cases will drive Medicare payments continually higher while underpayment for short stay cases will make it more difficult for hospices that take such patients to remain financially viable. Access problems and financial instability of full service hospices are inevitable but are an unacceptable outcome of the current Medicare hospice payment system and thus the need for reform is urgent.

Principles for Payment Reform:

1. **Redistribute Payments in a Budget Neutral Manner.** Problems in the current Medicare hospice system will not be fixed by cutting payments. That would only exacerbate the problems of hospice access and level of service. The reform of the payment system should reallocate existing dollars in a budget neutral fashion to fully recognize the legitimate costs of caring for eligible Medicare hospice patients. A properly functioning hospice benefit will achieve cost savings by reducing or eliminating the wasteful and futile end-of-life expenses hospice patients chose to forego.

2. **Build on the Current Hospice Payment System**. The current hospice payment system, while flawed in some respects, enjoys many advantages in its relative simplicity and blending of both prospective and service-specific payment structure. Any changes that are made over the foreseeable future should be built on the existing model rather than a more complicated and untested model.

3. **Recognize All the Necessary Costs the Current Program.** There are important and required aspects of hospice care that are not recognized in hospice cost reporting and/or are not separately identified in billing. These include bereavement services, spiritual counseling services, volunteer training services and patient medications. VNAA members report that failures to fully recognize these services in cost reporting and billing is already leading to reductions in the level of service in one or more of these areas.

4. **Consider Payment Modifications that Will Enhance the Value of the Hospice Program to Consumers, Referral Sources and the Medicare Program.** The Medicare hospice program is already one of the most highly valued services among patient families and is increasingly valued by physicians and other referral sources. It would be prudent to identify those aspects of the hospice program that are most valued and needed by patients, families, caregivers and referral sources and assess ways in which hospice payment reform could create incentives for improved value to beneficiaries and other stakeholders.

5. **Base Payment Reform Decisions on Data Not Supposition.** While the limited data currently available combined with field reports have been useful in identifying shortcomings in the payment system and suggesting areas for reform, they lack the level of detail, reliability, and validity to accurately redistribute resources within the payment system. In general, long stay patients are overpaid while short stays are underpaid but the question is by how much, for what services and in which cases?

6. **Anticipate Behavioral Effects of Payment Change to Avoid Perverse Incentives.** While anticipating the behavioral changes that will result from payment system changes is challenging and often controversial, the failure to do so risks creating incentives that can be extremely damaging to patients and to the integrity of the program.

7. **Maintain the Existing Hospice Cap as Long as Needed.** The current annual, per capita cap on hospice payment is a necessary safeguard under the existing payment system. Absent this cap there is no effective payment safeguard against agencies from chasing the incentives for longer and more profitable stays to the point of abuse. Improved methods of calculating and applying the cap in ways that are more predictable should be explored. Only if different methodologies in the reformed system extinguish the incentives for longer and unnecessary stays, should elimination of the hospice cap be considered.

8. **Hospice Payment Reforms Should Be Considered in the Context of All Other Changes in Hospice Policy and the Overall Medicare Policy Environment.** It is important that payment policy changes not be developed in isolation from other changes in hospice coverage and eligibility policy which may be implemented contemporaneously. It is also critical that the changes impacting the overall healthcare system be considered. For example, how will hospice payment changes interact with the possible bundling of hospital and post-acute Medicare payments, the evolution of accountable care organizations (ACOs) and the growth of chronic care management.

9. **Create Incentives for Use of Appropriate Level of Care.** The underlying principle of the hospice program is that care is best provided in a home-based setting. The program also recognizes the occasional need for inpatient care and respite care in institutional settings. The payment levels for inpatient and respite care must be carefully examined to ensure that inappropriate incentives to provide this level of care do not exist while providing adequate compensation for both inpatient general and respite care.

10. **Create Incentives for the Appropriate Use of Home-Based versus Inpatient Hospice Care.** The underlying principle of the hospice program is that care is best provided in a home-based setting. The program also recognizes the occasional need for inpatient care and respite care in institutional settings. The payment levels for inpatient and respite care must be carefully examined to assure that there is a neutral to marginally negative incentive for the use of care in an institutional setting while providing adequate compensation for both inpatient general and respite care.

11. **Consider the Differences in Cost Between Care in Private Residence versus Congregate Care Facilities.** The aggressive marketing of hospice services in some areas suggests that the costs of providing hospice care in congregate care facilities is lower than that in private residences, thus creating an incentive to recruit patients in nursing homes, assisted living facilities or other congregate care facilities. The payment system should address any differentials in payment that may be creating perverse incentives.

12. **Recognize the Special Needs of Patients Lacking Homes or Caregivers.** The current payment system assumes both the availability of a suitable home for the hospice patient to

receive care and the presence of an able and willing caregiver in the home. Fortunately this is generally the case. But as the value of hospice is increasingly recognized by physicians, hospices face an increasing number of referrals from patients who are homeless and/or have no suitable caregivers or who have caregivers that are burned-out. These are among the most heart-rending situations a hospice faces and the current payment system does not have an approach that really fits this situation. We believe a special payment level should be created that would support the provision of alternative home-based care in hospice houses for the homeless and additional personal support services for such Medicare beneficiaries lacking a family caregiver.

13. **Minimize Burden on Providers**. The revised payment system should minimize new administrative burdens on hospices by making changes as consistent as possible with existing data collection, reporting and billing systems. Where this is not possible, the payment system should reflect the additional one-time or continuing costs of additional provider activities.

14. **Consider and Minimize any Differential Impact on Small or Critical Access Providers**. Changes in the payment system should consider the impact on small providers that have more limited administrative capacity and must spread overhead costs over fewer patients. Changes that would create any disproportionate impact on smaller providers should be minimized. Changes that would threaten the financial viability of hospices that are the sole safety net provider should also be minimized or off-set with special payment adjustments to the break-even point.

15. **Payments Should be Adjusted to Accommodate Any Significant and Valid Differences in the Costs of Providing Services, Such as Labor Market Costs**. Any payment amount or payment cap that is subject to significant and valid cost differences based on geographic location should be adjusted based on a valid measure of relative costs. This would, at a minimum, include labor market costs. These cost factors should be measured in a manner specific to hospice services.

16. **The Structure of the Payment System Should Accommodate Value-Based Purchasing.** The structure of the revised hospice payment structure should accommodate the possibility of future pay-for-performance or other value-based payment initiatives. It is important that quality and outcome measurements be integrated with all services in the healthcare system, including hospice. Although outcome measurement in hospice will require considerable development before it is sufficiently advanced and standardized to allow for the adoption of value based purchasing, it would be prudent to consider how adaptable the revised system would be to such outcome-based adjustments.

17. **Discourage the Excessive Proliferation of Hospice Programs**. Many of the problems that are currently experienced in hospice are due, in part, to the proliferation of hospice programs in some areas far in excess of demand. This proliferation results in predatory competition, provider induced demand, unethical or illegal referral practices, selective admissions practices and excessive billing. Although the capacity of the payment system to address all of these problems in isolation from other policy and enforcement action is limited, the payment system should consider ways to reduce the capacity of marginal, unscrupulous providers to become profitable while hospices that have proven themselves as reliable Medicare partners are penalized.

18. **Testing the System Prior to a Phase-in Implementation.** Too often the pressure for change and delays in policy development results in untested changes being implemented precipitously. Given the particular sensitivity of issues surrounding the end-of-life, hospice payment changes should be tested on a pilot basis, and only when perfected, phased-in over several years.

Conclusion

VNAA is eager to work with the Centers for Medicare and Medicaid Services (CMS), the Medicare Payment Advisory Commission (MedPAC) and relevant congressional staff to develop changes in the Medicare hospice payment system that will assure appropriate access to this important service while assuring the integrity of the benefit. We believe the principles articulated above should be used to evaluate whether proposed refinements to the payment system will meet these goals and provide the

Issue: The number of Medicare hospice patients who have long lengths of stay has been increasing dramatically each year along with Medicare payments driven by very long stay patients. The current Medicare Hospice payment system creates a strong profit incentive for long stay patients with relatively low service needs by paying one of four flat, per-diem rates for each day a Medicare patient is in hospice, regardless of the services provided. Thus, the longer the Medicare hospice stay with few services required, the greater the profit potential. Conversely, the Medicare payment system fails to recognize that the current daily rate system does not cover the full cost for short lengths of stay.

Background: There is agreement in the hospice community and by MedPAC that the first and last several days of hospice care are the most expensive. Moreover, the entire overhead associated with the admission and discharge of a patient cannot be absorbed with only a few days of payment at the current Medicare per diem rates. Thus, a stay that only consists of a few days to a couple weeks is typically underpaid as a simple matter of Medicare payment structure.

Nonprofit hospices admit patients who are many times referred to hospice late in their end-of-life experience. Sometimes this means only a day or two of hospice care prior to death, and often less than three weeks. Nonprofits "pull out all the stops" to make a quality end-of-life experience possible, but this concentrates a huge amount of up front costs over very few days of care. Nonprofits continue to accept such short stay patients knowing that it will be challenging to care for them both from a service and payment perspective. But, if longer stay patients do not help cross-subsidize short stay patients, the hospice will take a loss.

Thus, the implications of the current Medicare system is that overpayment for long-stay cases will drive Medicare payments continually higher while underpayment for short stay cases will make it more difficult for hospices that take such patients to remain viable, potentially creating an access problem for short-stay hospice patients. Agencies that are driven to maximize profits will continue to drive Medicare cost higher with longer lengths of stay and nonprofit hospices that accept short stay patients will come under increasing financial pressure, particularly in markets where other hospices are aggressively admitting predominantly longer stay patients.

MedPAC's Proposed Solution: MedPAC has recommended that payments be increased for the beginning and ending days of hospice stays while maintaining budget neutrality by reducing payments in the middle of hospice stays. This "U" shaped redistribution of payments would reduce the incentives for excessively long stays while better compensating shorter stays on which many hospices lose money. While a more sophisticated change to the payment system that more precisely matched daily payments to patient characteristics and related costs would be preferable, the data needed to develop such a system does not exist and would take years to collect. Thus the "U-shaped" redistribution of payment concept, i.e. simply adding dollars to the beginning and ending of hospice stays while removing an equal number of dollars from the middle of stays is one simple solution that can be implemented without extensive data collection.

The VNAA Reaction to the "U-Shaped" Redistribution: VNAA is supportive of this approach in principle. It would begin to eliminate the high profits associated with excessively long stays and reduce the losses associated with short stays. For example, an average stay of about three weeks would benefit from additional payments for the first and last week, and would stand to lose relatively little for

the seven days of payment in between. However a stay of a year would not gain enough from increased payments for the first and last week to offset the reduced payments for 50 weeks of care in between. Thus the financial incentive to increase average length of stay would be dampened while shorter stays would be more appropriately compensated.

However, the example given above is very general. How much will payments be increased at the beginning and end and how much of a reduction in the middle? Until there is sufficient clarity in the details and a statistically sound impact analysis, VNAA can only support the concept in general terms.

VNAA Suggestions for Implementation of the U-Shaped Redistribution:

- Assure that the dollars moved in the U-shaped redistribution as accurately as possible reflect average actual costs of the beginning and ending based on a statistically valid sample of non-profit and for-profit providers.

- Before implementing the redistribution, simulate the impacts of proposed redistribution on hospice stays of various lengths, locations, ownership types and sizes and fine tune the distribution specifics to assure adequate payment for necessary care.

- Require that redistributive payment changes are actually budget neutral and restore dollars to the system promptly if they are not.

- Address issues of fraud and abuse in hospice to protect the good actors in the hospice community from unfair and illegal competition during the period of payment reform.

- Finally, given need for prompt payment reform and the limitations of the data now available, begin these changes promptly but phase them in over several years. The inherent logic of the U-shaped distribution suggests that some measure of this change could be phased-in very soon, if it were implemented in stages. Most payment policy change impacts include a level of uncertainty because it is so difficult to predict accurately changes in provider behavior as they respond to such changes. This is compounded in the case of hospice by a very limited data base.

  VNAA suggests CMS begin some modest movement to the "U" shaped redistribution as a way both to move more quickly to a better payment distribution and to gather better information on impacts and other data needed to determine the most effective ultimate payment redistribution details. Such a gradual approach could be done on a national basis which would also test whether the "U" shaped improvement in payment distribution impacts some of the other hospice peculiarities sited by MedPAC, such as the differences in the number of hospices and lengths of stay betweens states. This would also allow CMS time to collect better data and perform more detailed impact studies allowing the policy to be "fine-tuned" along the way.

Conclusion: The VNAA, on behalf of its nonprofit hospice members, lends its support to a reform of the Medicare hospice payment system based on the MedPAC concept of the "U-shaped" distribution. It does so based on its understanding that such a change would be budget neutral, based on sound statistical analysis of the best data available, simulated to prevent adverse impacts and phased-in to allow for adjustments to assure the intended effect of accurate payment for Medicare hospice services.

VNAA believes that implementation of the U-shaped distribution is one of a number things CMS could and should do to assure integrity to the Medicare hospice benefit and restore equity and accuracy to the hospice payment system. Other recommendations related to Medicare hospice payment are included in the list below.

VNAA Recommendations for Hospice Payment Reform:

- Modify the Medicare hospice cost report to better capture the full and accurate cost of providing hospice services to Medicare patients. This would include capturing costs by type of visits and diagnosis as well as separately tracking costs for pharmacy, bereavement services and overhead costs specific to Medicare patients.

- Maintain the current hospice cap as a barrier to excessive profiteering through pursuing a long-stay business strategy.

- Impose a moratorium on certification of new Medicare Hospices until payment, quality and program integrity reforms can be put in place.

- Consider a temporary cap on the percentage of total Medicare revenue that can come from long-stay cases as an additional program payment safeguard.

- Restore the Hospice Budget Neutrality Adjustment.

- Provide Wage Index parity for hospices providing services in areas where hospitals have been reclassified to higher labor cost areas.