Medicare Hospice Payment Reform:
VNAA Reactions to the "U" Distribution

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.

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.