REPORT OF THE HHFMA HOSPICE REFORM TASK FORCE
January 14, 2009

The Home Care and Hospice Financial Managers Association (HHFMA) established a task force to design a proposal for modernization of the Medicare hospice benefit reimbursement structure. The reasons for the effort are twofold. First, there is a widespread belief among hospice providers that the existing payment model does not adequately and fairly reimburse providers for the range of services supplied to the current Medicare patient population. Second, the Medicare Payment Advisory Commission (MedPAC) has already initiated efforts to encourage Congress to reform the existing payment model based on its impression that certain hospices have "high" profit margins and that certain patient groups may leave providers with reimbursements that are not reasonably related to the cost of the resources used for those patients.

At the outset, the Task Force agrees that the current reimbursement model needs reform and modernization. However, the ability to modify the current model is limited by the availability of reliable data on many elements of hospice costs. Accordingly, the Task Force is very supportive of an effort to improve hospice cost data in order to allow future consideration of alternative reimbursement model reforms than referenced herein.

The HHFMA task force is composed of 15 members representing the provider and consultant communities. It is chaired by Robert J. Simione, an HHFMA Advisory Board member. A full listing of the task force membership is attached

INITIAL ANALYSIS

The first action of the task force was to evaluate the existing system. The consensus is that the current reimbursement model retained many of the merits of its original design, but also had weaknesses that needed to be addressed. The task force concluded that the existing payment model possessed the following positive and negative attributes.

PRO

1. The per diem payment model is simple to understand and administer.
2. The per diem model offers predictability on the payment amounts.
3. The model allows for a provider to manage costs within a reasonably known budget while presenting an opportunity to secure a potential margin/profit.

4. The bundling of payment for the full range of hospice services works well to achieve simple, overall care management.
5. The payment method is consistent regardless of the patient's length of stay.
6. The use of a four level payment rate reflects, to a degree, the varying intensity of resource use for a particular patient.
7. Limited or nonexistent copayments/coinsurance for beneficiaries avoids roadblocks to hospice care access.
8. The payment rates do not discriminate on the basis of the patient's place of residence.
9. The use of an annual aggregate cap controls overall hospice spending thereby reducing the risks of overutilization and abuse.

CON

1. The payment model may be too simple.
2. Payment rates have not been updated to reflect changes in services and supply costs.
3. Payment rates do not adjust adequately to reflect service resource intensity.
4. The payment rates do not adjust for differences in patient service utilization within the four levels of payment.
5. Ancillary costs for such items as drugs, radiation treatments, chemotherapy, and DME are not sufficiently considered in the payment rates.
6. The absence of an outlier payment is unfair to providers that care for high cost patients.
7. Certain services such as volunteers and bereavement counseling are not subject to reimbursement.
8. The payment model may create incentives for providers to discriminate in favor of long stay patients.
9. Copayment amounts are a nuisance to establish and collect.
10. The site of the patient's residence does not affect payment rates even though there may be significant differences in costs.
11. The amount of the annual cap is inconsistent with changes in the scope of the hospice benefit, including coverage for non-cancer patients and the extension of covered benefit periods, and advances in medical science that have extended the lives of patients.
12. The cap creates a potential risk of retroactive liability after costs have been incurred.
13. State Medicaid payment to the hospice for dual-eligibles residing in nursing facilities at 95% of the rate for bed and board is insufficient and unnecessary in contrast to direct payment to the nursing facilities.

The task force recognizes that the positive and negative attributes of the current payment model overlap and that some components possess both attributes. To resolve these potential conflicts in the analysis and recommendations, the task force suggests the application of several guiding principles.

PRINCIPLES

1. A wholesale replacement of the existing payment model is not feasible at this time. Rather than a re-engineering of hospice payment, a refinement of the existing model will provide the opportunity to retain the model's existing strengths while addressing its weaknesses.
2. The model should remain simple to understand and administer.
3. No refinements should negatively impact on a patient's access to hospice care.
4. All refinements should be evidence-based and supported by reliable data.
5. A reform of the hospice reimbursement method should be done in conjunction with, rather than in isolation from, any reforms on the scope of the hospice benefit and any change in the standards for determining benefit eligibility.
6. Refinements to the hospice reimbursement model should be designed to achieve a reasonable payment system without regard to the budget neutrality of the changes.
7. Any reimbursement model must appropriately and adequately reflect the use of hospice resources in patient care and variations thereof among hospice patients and providers.

In line with these principles, the HHFMA Hospice Reform Task Force recommends the following:

Overall Payment Model

Recommendation: The structure of the current simple, four level per diem payment model should be continued with adjustments primarily focused on the Routine Home Care per diem as referenced below. A case mix adjustment model like the DRGs in the inpatient hospital payment and HHRGs in the home health service payment should not be considered at this time.

Rationale: With over 90% of hospice covered days subject to the Routine Home Care per diem, the priority for action is on this component. Further, there are indications that the varying costs of caring for the range of hospice patients necessitates the consideration of a payment adjustments that reflect the differences in service intensity and/or administrative costs Currently, there is a wide range in patient lengths of stay and service utilization within their hospice care.
The use of a case mix adjustment model like DRGs or HHRGs is not feasible at this time. A case mix adjustment model:

1. requires significant data for accurate payment distribution that is not currently available

2. adds complexity to the payment model with likely results of increased administrative costs with no certainty of offsetting or corresponding gains for patients

3. is difficult to devise in a way that recognizes the uniqueness and variation of the needs of individual patients and their families as well as the location of service.

4. poses risks to access to care if developed and implemented without a high level of accuracy and proper incentives.

Routine Home Care Per Diem

Recommendation: The Routine Home Care per diem should be adjusted to increase payment rates at the beginning of a patient's hospice care to reflect higher service and administrative. An additional payment adjustment should be made in consideration of the increased service and administrative costs that occur preceding the death of the patient.. All cost variables should be considered including the intensity of services, pharmaceuticals, medical supplies, bereavement counseling, and administrative costs. The payment differentials should be based on audited data that adequately evaluates differences in resource use. Payment rates should remain in a bundled form with no "carve-outs" for any class of costs.

Rationale: There is preliminary evidence that hospices experience a greater intensity of service and higher costs at the start of care and during the period preceding the patient's death. Further, the range in the length of stays of hospice patients is significant with some patients on service for a few days and others for well in excess of six months. As such, the use of a single per diem rate throughout the length of stay unfairly reimburses hospices for short stay patients, encourages overutilization with potentially premature admissions, and discourages the admission of short stay patients. "Carve-outs" of certain classes of costs such as drugs and medical supplies adds unnecessary complexities to the payment model.

Site of Care Adjustment

Recommendation: A site of care adjustment should be investigated and evaluated. Consideration of such adjustment should include cost and resource use differences in rural and urban areas, congregate living residences, and nursing facilities. No adjustment should be instituted unless the payment differences can be empirically justified based on audited data.

Rationale: There is an intuitive-based perception that the site of care of a hospice patient impacts on the cost of care for that patient. The cost variations may be related to transportation expenses, the availability of unpaid informal caregivers, differences in service provision, and other factors. Currently, there are suspicions that patients cared for in a nursing facility residence receive less service from the hospice than those residing in a private residence. At the same time, there may be higher costs associated with the care of hospice patients residing in nursing facilities that need to be evaluated and investigated before any payment policy changes are implemented. There has been no detailed in-depth study to date that comprehensively evaluates care cost differences that are site of care based. While the task force believes that such differences may exist, it also does not support the institution of a payment adjustment until a full evaluation of data is performed and the extent of those differences can be safely established.

Medicaid Pass-Through

Recommendation: Medicaid should pay the room and board rate directly to the nursing facility for all dual-eligible patients in nursing facilities. Alternatives to the 95% rate should be evaluated to ensure that Medicare beneficiaries residing in nursing facilities have full access to hospice services.

Rationale: There is no sensible basis for continuing to require that a hospice administer the Medicaid payment for Medicaid and the nursing facility. This adds administrative costs for all parties, delays payment to the nursing facility, and may incentivize favoritism of certain hospices by nursing facilities that seek higher payment rates from the hospice. At he same time, the existing 95% payment rate should be re-evaluated to determine if there is any rationale for its continuation in comparison to a full payment. Hospices should not bear the expense of subsidizing Medicaid for an unwarranted payment rate reduction.

Continuous Care Per Diem

Recommendation: The Continuous Care per diem should be increased to reflect actual staffing and service costs.

Rationale: Providing the extended hours of professional and non-professional staffing in a continuous care case represents a cost to the hospice that is often far in excess of the existing payment rate. Patients needing such care are at one of the most crucial points in their hospice service and inadequate payment rates should not be a barrier to access to such care.

General Inpatient Per Diem

Recommendation: Maintain the current payment method and rate.

Rationale: The current reimbursement for general inpatient days is sufficient provided it is properly managed. There is no known difficulty in finding inpatient providers willing to accept payment levels within the existing rate.

Respite Care

Recommendation: The level of payment for respite care should be evaluated and addressed to the extent that data demonstrates that rates are inadequate in relation to the costs of respite care and the accessibility of respite services.

Rationale: Respite care is a vital hospice service that is not fully utilized because costs of the care may exceed the reimbursement rate. However, consistent with the task force's guiding principal, it withholds a specific recommendation beyond studying the issue until the evidence and data can be fully evaluated.

Annual Hospice Cap

Recommendation: Retain some form of annual aggregate payment cap. Evaluate the appropriateness of the computation of the current cap amount, its annual updating method, and its application to individual hospices.

Rationale: The hospice cap provides a budget/cost benchmark that helps control unnecessary and inappropriate growth in Medicare spending. However, there are indications that the currently calculated cap does not adequately represent the scope of the hospice benefit nor is it fairly applied in circumstances where patients are served in more than one cap year. In the last several years, an increasingly greater proportion of hospices have been impacted by the annual cap.
The cap has not changed in its calculation method or application since the inception of the hospice benefit in 1983 while there has been a significant change in the scope of the benefit, a change in the patient population served in hospice, and advances in medical science that has lead to the extension of patients' lives. Further, the use of a single nationwide cap has been raised as a concern by such parties as the Medicare Payment Advisory Commission.

CONCLUSION

The Task Force offers these recommendations for consideration by the HHFMA Advisory Board and Workgroup. Upon such consideration and any modifications to this report, HHFMA will forward this report to the Hospice Association of America (HAA) for its consideration and action.