NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE

Reject Efforts to Reduce the Hospice Aggregate Cap

BACKGROUND

At its enactment in 1982, the Medicare hospice benefit and payment structure were extremely innovative – hospice providers were paid prospectively set rates to provide an array of services based on individual patient care needs. In addition, Congress imposed an "aggregate cap" (CAP) designed to limit spending under hospice to what would otherwise have been spent under Medicare absent hospice coverage. The CAP was set at a single national rate of $6500 (with provision for an annual update) but no adjustment based on wage variation by locality. The $6500 value was roughly equivalent – for the time -- to the cost of providing care to hospice cancer patients in the final 40 days of life (the average length of stay and predominant type of patient cared for under the hospice demonstration). Use of a flat national CAP rate has resulted in inequities, particularly for areas of the country with high labor costs. The CAP is applied in the aggregate on a hospice by hospice basis, but a "lifetime limit" equal to the value of the CAP follows the patient while on hospice care. Roughly 13 percent of hospices currently exceed the CAP.

The hospice population has changed significantly over time – the majority of patients today have a non-cancer diagnosis (many with advanced neurological disorders) and multiple comorbidities. For these patients, it is much more challenging to arrive at an exact six-month prognosis. In keeping with these changed patient characteristics the average length of stay on hospice care has increased to just under 90 days.

In early 2020, the Medicare Payment Advisory Commission (MedPAC) approved a recommendation that Congress enact legislation to wage adjust the CAP and cut the CAP value by 20 percent. MedPAC provided no analysis supporting the appropriateness of the CAP cut except that it would change financial incentives and potentially reduce long lengths of stay. MedPAC estimates that the number of hospices that exceed the CAP would roughly double as the result of these changes.

A deep cut to the hospice CAP is a crude tool to change hospice financial incentives and fails to take into consideration the many factors that contribute to variations in patient care needs. These factors include a more complex patient population for whom establishing an accurate six-month prognosis can be challenging, as well as greater variation in overall patient mix. The proposal also fails to consider alternatives, such as budget neutral changes to the hospice payment system that could increase payments to hospice providers that incur high costs when patients first enter hospice care and those that have a high percentage of very short stay patients (which are also costly to serve).

While there is some merit to wage-adjusting the CAP to reflect variation in labor costs, this change will redistribute hospice spending throughout the county. Moving to a wage-adjusted rate without a phase-in could have significant negative impact on areas of the country with lower labor costs; this could precipitate changes in admission patterns that limit access to care for vulnerable hospice patients, including patients with Alzheimer's or other neurological disorders.

What Congress Should Do:

- Consider wage adjusting the CAP to address wage variation and make this change on a budget neutral basis, but phase the adjustment in over multiple years pact, wage adjustment of the CAP should be phased in over time to minimize the potential impact on access to care and to allow the most negatively impacted areas of the country to adjust. Finally, Congress should limit variation in the wage index applicable to the CAP (creating a "floor" and a "ceiling") so as to protect hospice providers from the significant swings that can accompany wage index changes from year to year to ensure the CAP value remains more consistent.
- Reject MedPAC's recommended CAP cut of 20 percent and seek a more thorough analysis of an appropriate amount for the hospice CAP that includes consideration of variation in patient mix.
- Examine budget neutral payment changes that address the hospice payment system's continuing shortcomings relative to long lengths of stay.

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