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MedPAC Targets Length of Stay to Curb Rising Costs

Reforms will revamp payments, accountability, and data collection

Hospice providers may soon have a whole new payment structure -- and it could mean a big drop in reimbursement.

The Medicare Payment Advisory Commission'sextensive review of Medicare's hospice benefit has found that the program offers few effective controls to prevent long lengths of stay or increased costs, staffers reported at a Nov. 6 public meeting.

Crux: The Medicare hospice benefit is supposed to provide patients with an alternative to costly and intensive end-of-life curative treatment, but the payment system contains incentives that push hospice providers to seek out patients who will require a longer stay, MedPAC staff found. Between 2000 and 2006, the number of patients using Medicare's hospice benefit grew from 513,800 to 942,500 -- an 83-percent jump, and Medicare spending tripled.

Potential solution: Staffers want MedPAC's Commissioners to restructure the hospice reimbursement system to "ensure that the level and structure of payments are sufficient to ensure appropriate hospice care for Medicare beneficiaries who elect this benefit." The group's main goals are to decrease Medicare spending while pushing for a high standard for patient care, says **Janet Neigh**, hospice VP for the National Association for Home Care & Hospice.

MedPAC's staffers reported three key areas for reform: payment system, accountability, and data collection.

Providers Must Scrutinize Length of Stay

Because long-stay patients are more profitable, the average length of stay for hospice patients has increased, MedPAC contends. The top 10 percent of patients stayed in hospice for an average of 144 days in 2000, but that number grew to 212 days by 2005. That means hospice providers may be enrolling and recertifying patients who aren't eligible for the benefit or that they are passing over short-stay patients in favor of more lucrative long-stay patients, MedPAC worries.

New way: MedPAC's staffers propose that the restructured payment system should reimburse providers along the hospice "cost curve," which would mean reducing reimbursement beginning in the second month of the stay and then at regular intervals through the length of the stay. Because the group found costs to be higher at the beginning and end of the stay, providers would receive an increased payment after the patient's death.

Why it would work: The budget-neutral restructure would cut the number of long stays by forcing hospice providers to carefully screen patients, and it would make shorter stays more profitable, staffers say.

Potential drawback: While shorter lengths of stay would appeal to providers more, this change "might result in later starts of care for expected long-stay patients," Neigh notes. For example, a provider might delay a start of care for a hospice patient until enrolling him would be more profitable. Also, providers could screen out long-stay patients who desperately need services.

Crucial: Any hospice restructure must "keep together current services' holistic package," Neigh urges. NAHC and other industry associations, including the National Association for Hospice Access and the American Academy of Hospice & Palliative Medicine, released a joint statement delivered during the comment period at the Nov. 6 meeting. It said the groups' main goal is to make sure "that future patients and families can access, in all service settings, the high quality care that hospice has come to symbolize."

The statement also encouraged commissioners to make sure the recommendations meet patients' needs and match payments in the most cost-effective manner. NAHC has been working with MedPAC to provide expert guidance and

perspective to the group.

Providers Need More Training & Incentives

Extensive evaluation of the Medicare benefit found that too many hospices suffer from a lack of physician engagement, inadequate charting, lack of physician or staff training, and financial incentives to enroll ineligible patients, MedPAC contends.

New way: Potential reforms would require a physician or advanced practical nurse to recertify patients after 180 days and every 120 days thereafter, a brief explanation of clinical basis for the prognosis included in all certifications, and greater enforcement of local coverage determinations.

The feds hope these changes would give hospices greater accountability and government oversight -- making it difficult to falsely enroll patients just for the financial reward long-stay patients bring.

But providers fear more red tape erecting barriers to access for patients.

CMS Must Collect More Data

The Centers for Medicare & Medicaid Services has started collecting data on hospice visits, but in the past CMS has only collected a minimal amount of data, making it difficult for MedPAC to recommend ways hospice providers can cut costs on a day-to-day basis. And even with CMS's new data collection attempts, not every visit will be counted.

Staffers want CMS to gather information on all hospice visits and providers, including the duration of visits and cost reports. To both create a standard for and speed up data collection, the group discussed creating national coverage determinations to replace local ones.

The more information MedPAC has on how hospice providers operate on an individual level, the greater its opportunity to spot trends and pinpoint how the Medicare benefit can be more efficient and cost effective.

What to expect: MedPAC's commissioners are considering the staffers' recommendations and will discuss them again in future meetings. A vote isn't expected until at least January.