Eli's Hospice Insider

Reimbursement: Which Sounds Worse - A Cap Reduction Or An Across-The-Board Rate Cut?

MedPAC thinks a cap reduction is better.

The **Medicare Payment Advisory Commission** seems determined to persuade Congress to cut hospice payment rates, one way or another.

In past years, MedPAC has recommended hospice rate freezes and even cuts. But this year, the influential advisory body to Congress also will urge lawmakers to reduce the hospice aggregate cap amount by 20 percent and to freeze hospice payment rates for 2021.

In its March report to Congress, MedPAC will include both a rate freeze and cap cut recommendations in order to curb the high profit margins of hospices with long-stay patients, commissioners indicated in a Dec. 6 meeting. While commissioners will officially vote on the recommendations next month, they cleared the way for a streamlined expedited vote in the most recent meeting.

MedPAC staffer **Kim Neuman** pointed to an array of statistics showing that for-profit hospices with long average lengths of stay are raking in profits under the current Medicare payment system.

For example: Hospices' overall Medicare profit margin in 2017, the most recent year available, was 12.6 percent. But above-cap hospices had a 21.2 percent profit margin before returning cap overpayments. The cap is set at $29,965 for 2020.

Above-cap hospices also have higher live discharge rates, MedPAC found.

"In other words, MedPAC is connecting over-cap hospices to characteristics MedPAC has previously associated with bad behavior," observes the **Visiting Nurse Associations of America** in its member bulletin.

MedPAC's number crunching shows a 20 percent reduction to the hospice cap should result in about 2.8 percent lower hospice payments overall. One reason commissioners are so keen on the cap reduction idea is because it would concentrate those cuts on hospices with long-stay patients, which also are usually more profitable.

Running 2017 numbers through the change shows that hospices with the highest 20 percent of stays would see a 13.6 percent reduction in payments, while those in the lowest two quintiles would see no payment reduction; the middle quintile a slight 0.1 percent reduction; and the next-to-highest 20 percent a 4 percent reduction.

Given hospices' double-digit margins, commissioners indicated that the advisory body might want to endorse an even bigger cap reduction. "What if the cap were reduced by 30 percent or 40 percent?" asked Commissioner **Bruce Pyenson**, a consulting actuary at **Milliman Inc.** in New York City. "The 20 percent sounds like a great number, but ... if anything, we could be more aggressive about the cap," Milliman urged in the meeting.

The alternative: If MedPAC didn't take up a cap reduction recommendation this year, it instead would have likely endorsed a 3 percent or so rate cut, MedPAC Executive Director **James Mathews** revealed in the meeting. "Last year, we made a recommendation of a minus 2 percent update," Mathews noted. "Given the improvement in financial performance and the stability of other measures, we might have been ... talking about a minus 3 percent across-the-board update this year." Hospices' profit margins increased from 10.9 percent in 2016 to 12.6 percent in 2017, and are forecast to be 12.6 percent again in 2020.

Instead, the 20 percent cap reduction "has the same aggregate effect on hospice revenues as a 3 percent across-the-board [cut] ... but has the benefit of targeting that reduction on those providers that have the longest length of stay and are more profitable," Mathews said.

Bottom line: "Hospice payment rates may be higher than needed to ensure appropriate access to care," Neuman said in her meeting presentation.

Industry Opposes Cap Reduction

"A reduction of 20 percent is a blunt instrument for changing provider incentives, and fails to address other incentives - such as further refinement to adequately address costs associated with short-stay patients - that may be indicated by MedPAC's data on margins and length of stay," the **National Association for Home Care & Hospice** says in a letter to the commission. "MedPAC should conduct a more thorough study of the hospice cap before moving forward," the trade group urges.

The **National Hospice & Palliative Care Organization** "continues to be concerned about the unintended consequences of the draft recommendation to reduce the aggregate cap on beneficiary access and quality of hospice care," the trade group says in a release. The change could lead to shorter lengths of stay, among other problems.

"Without reliable data, it is unclear how such reductions would lead to Medicare savings, increase access to care, or lead to higher quality of care," NHPCO CEO **Edo Banach** says in the release. "NHPCO shares MedPAC's goals, but this approach appears overly broad and likely to lead to a decrease in hospice access for patients and families."

Recommendation: "In the short term, we urge MedPAC to use a targeted approach that will have a higher likelihood of rewarding high quality, punishing low quality, and increasing access," Banach says.

"We strongly disagree with an overall reduction to the cap of any amount, or percentage, for the specific purpose of targeting certain groups of providers," criticizes consulting firm **The Health Group** in Morgantown, West Virginia. "The cap was originally established for purposes of ensuring that spending for hospice patients would not exceed Medicare spending if those patients had received curative instead of hospice care. An arbitrary reduction to the cap directly contradicts the purpose of the cap, will impact providers outside of the target group, and reduce access to hospice care for individuals who would otherwise qualify for hospice services," the firm says in its electronic newsletter.

Instead: "Efforts to address claims for non-qualifying hospice care should be the responsibilities of the MAC or other claim reviewing authorities, and should be based on the specific beneficiary's condition and prognosis, not inappropriately addressed through an overall reduction to the cap," The Health Group argues.

If anything, the current cap may be too low, NAHC contends. "Given that the current cap value is based on care of cancer patients in the 1980s, it fails to account for current end-of-life practices and treatments for terminally ill cancer patients," the trade group says in its letter to MedPAC. "Further, the cap does not address costs associated with care of patients with a variety of other terminal illnesses (and comorbidities) served by hospice today. To the extent that the cap does not account for these costs, the current cap value may create disincentives to serve certain types of patients, and perpetuate limitations on access to care."

Another proposed change to the cap, wage index application, could compound the problem for some providers (see story, p. 14), the industry representatives add.

Watch for: Commissioners will officially vote on the hospice rate freeze and cap recommendations in the body's January meeting, and its resulting annual report to Congress will go to lawmakers in March.