Proposal for 2009 Hospice Interim Reform

During the past two years the National Alliance for Hospice Access has been working with Members of Congress and their staffs to try to resolve critical problems confronting independent and rural hospices operating throughout the country. These problems, rooted in conflicting federal hospice laws, are forcing many hospices to close their doors, face financial ruin, or limit hospice care or access in critical areas of the country.

In working with the Hill, NAHA has received valuable feedback from Members and staff. The Hospice 2009 Interim Reform proposal outlined below incorporates that guidance and many important suggestions, resulting in a plan that is fiscally sound, improves hospice access for those eligible, and ensures hospice patients receive uninterrupted care.

2009 Hospice Interim Reform:

- ✓ **Restoring Access to Health Care for the Terminally Ill**
- ✓ **Saving Medicare Billions of Dollars**

Medicare is facing a financial crisis that will soon reverberate through not just health care, but the entire economy.

One part of the solution to that crisis is hospice care, a respected benefit which also saves Medicare $2,300 per patient. That translates into billions of dollars in Medicare savings annually. The hospice industry, however, is being decimated by outdated and conflicting policies that are forcing law abiding hospice providers into bankruptcy and threatening end-of-life care for thousands of terminally ill Medicare beneficiaries.

NAHA has developed a four-part interim solution to this problem that would improve access to hospice care, improve payment accuracy and save Medicare billions of dollars.

The Problem

There are three immediate problems facing the hospice community that must be, and can be, solved in 2009.

1) The first immediate problem is a conflict in the Medicare statute that has the perverse effect of providing qualified beneficiaries with an unlimited right to hospice care, but arbitrarily caps reimbursement to hospices for providing that care. *In 1998, Congress removed any limitation on individual length of stay in hospice, recognizing that many patients would be on service beyond the six month average target in the law. At the same time Medicare expanded eligibility by developing objective Local Coverage Determinations for non-cancer patients, whose life expectancy is far less predictable. Medicare did not, however, adjust the aggregate cap on reimbursement when it expanded coverage. Hospices that continue to care for patients who live longer than the expected six months are subject to retrospective government demands that they refund to Medicare the payment received for providing those services, even though their patients are qualified. The hospice is faced with untenable alternatives: (a) deny care to patients who live longer than expected: (b) borrow funds to pay back Medicare; (c) declare bankruptcy; or (d) manipulate the system to treat some patients differently than others.*

2) The second related problem is that the eligibility standards, called Local Coverage Determinations (LCDs), used by CMS to determine whether a patient qualifies for hospice care do not work as intended*. While end of life prognoses are inherently uncertain, especially for non-cancer patients, the LCD's which define whether hospice services are reasonable and necessary are badly*

flawed and are increasingly viewed as having no predictive value for patient length of stay. They were not developed in a scientific manner and have never been tested empirically. Yet by law, they still determine whether hospice services are "necessary and reasonable." At the same time, an increasing number of hospices and physicians appear to be ignoring Medicare's LCD's and developing their own eligibility criteria. In practice, there are now hundreds of different hospice eligibility standards around the country. This eligibility problem results in patient access and length of stay that varies widely, and higher total Medicare costs. Nationally, less than 50% of Medicare decedents receive a hospice choice and 75% of hospice users receive far fewer days of hospice care than intended, while 10% of hospice users stay far longer than intended and consume 50% of hospice dollars.

3) The third problem is a decision made last year by CMS to unilaterally cut hospice reimbursement rates as a cost-saving device*.*

Combined, these problems create a crisis. They deny treatment to terminally ill patients who qualify for and deserve care under Medicare. They force hospices to make decisions that are not in the best interests of them or of their patients and their families or of Medicare. They waste Medicare dollars that could otherwise be devoted to budget savings or better services.

The Solution

This problem can be addressed through a four-part interim solution that would improve access to hospice care, standardize eligibility, reform the reimbursement cap process, improve payment accuracy AND generate billions of dollars in Medicare savings.

1) ***Congress must direct CMS to introduce evidence-based National Coverage Determinations (NCD's) to improve the accuracy of eligibility decisions.*** *By improving accuracy, CMS could reduce hospice spending by $1 billion annually. Clarifying eligibility could generate another $1 billion in savings by increasing legitimate hospice access to 60% from 40% currently, thereby achieving the savings that naturally occur from hospice care as opposed to the cost of traditional institutional care.*

2) ***Congress must authorize reforms of the reimbursement cap system by replacing it with a pay as you go system that would reduce per diem reimbursement rates for long lengths of stay, and in turn provide relief to those hospices that have received demands from CMS for back payments for the 2006, 2007 and 2008 audit years.*** *These reforms would eliminate any provider incentive for longer stays, and eliminate CMS' administrative burden and credit risk associated with enforcing the cap and trying to collect overpayments from hundreds of small hospices two years after the fact. Importantly, these reforms could save Medicare an additional $1.6 billion over the next five years and improve patient access to cost-effective end-of-life care.*

3) ***Congress must authorize an updated hospice reimbursement program that increases funding for the first five and last five days of patients' stays and decreases funding for patient stays that exceed 180 days.*** *This would improve payment accuracy and patient access, and would be budget neutral*

4) ***Congress must repeal CMS' arbitrary and unilateral hospice reimbursement cut, which CMS refers to as a Budget Neutrality Adjustment Factor (BNAF).*** *This cut has no merit or basis in sound fiscal policy and it reduces the quality of health care services. Savings from the introduction of evidence-based NCDs would more than fund repeal of this cut.*

The CMS-induced economic crisis in the hospice industry and the overlaying national recession make it imperative that Congress act with all due haste to restore the hospice program to policy and fiscal solvency and protect patients' access to cost-effective end-of-life care. Taking these steps now will give CMS the time needed to study and address the larger and more structural problems with health care delivery at the end of life.