

**Assessing the
Budgetary
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the Affordable Care
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THE MORAN COMPANY

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The Medicare hospice benefit offers terminally ill Medicare beneficiaries an alternative to the continuation of end-of-life medical care for terminal conditions. Under this benefit, beneficiaries who elect to forego their regular benefits under Medicare Parts A and B for their terminal conditions become entitled to alternative benefits not available to regular Medicare beneficiaries, including palliative care and psycho-social support services for both the beneficiaries and their families.

Section 3132 of the Affordable Care Act of 2010 (ACA) amended existing hospice program requirements in two ways:

First, subsection 3132(a) directed the Secretary to collect additional data required to develop revisions to the hospice payment policy for “routine home care and other services,” to be implemented no earlier than October 1, 2013. That provision permits, but does not require the Secretary to provide for “...adjustments to per diem payments that reflect changes in resource intensity...during the course of the entire episode...” The Secretary is required to consult with both MedPAC and providers regarding implementation of this policy. The Secretary is required to establish such adjustments in a manner that is budget neutral.

Second, subsection (b) establishes a new patient certification requirement, under which patients being recertified for total hospice episodes in excess of 180 days must have a face-to-face encounter with a physician or nurse practitioner in order to determine eligibility for recertification.

The hospice provider community is presently evaluating legislative changes to the policy of Section 3132 of the ACA. The policy under evaluation has three components:

- It would amend the requirement for face-to-face assessments at recertification by making the timing requirements more flexible and expanding the types of health professionals permitted to conduct the assessments.
- It would require the Secretary to conduct a two-year demonstration of whatever payment policy modifications were developed prior to national implementation. The demonstration would be limited to 15 provider sites that voluntarily enrolled in the program. Payment variation relative to current law would be capped at +/- 5%.
- It would create an additional certification requirement, requiring hospices to be subject to an initial survey by an appropriate regulatory or accreditation body within six months of beginning operations, with follow-up surveys every three years thereafter.

The Moran Company was engaged by the National Hospice & Palliative Care Organization to assess the budgetary implications of the policy under consideration. Our assignment was to evaluate how the Congressional Budget Office (CBO) might “score” this policy, if it were being actively considered in the legislative process.

Our findings are as follows:

- If CBO interprets the provisions related to face-to-face encounters as increasing flexibility for compliance rather than substantively changing the requirement, we believe they will conclude that these provisions will have no effect on the rate of recertifications, and hence will have no budgetary effect.
- CBO's score of the demonstration provisions will turn on exactly how the language implementing the policy is drafted.
- Under the language we were asked to review, participation in the demonstration would be voluntary, and payment variations would be capped at +/- 5% relative to payments under current law.
- Under that exact policy, we assume that CBO would conclude that selection bias associated with voluntary enrollment decisions would cause total payments to exceed what would be spent under current law, resulting in a positive score.
- Given the very small population of hospices permitted to participate, and the short duration of the demonstration, we estimate that the overall cost to the Medicare program would be approximately \$3 million over ten years (2012-2021).
- We do not believe that the expanded survey requirement would be found by CBO to have budgetary effect.

In the balance of this report, we provide the rationale underlying these findings.

Estimating the Effect of the Proposed Policy: Face-to-Face Encounters

We understand the language of the proposed amendments to the face-to-face encounter requirements to establish timelines and methods for compliance that are more flexible relative to the implemented requirement, particularly in rural areas where access to appropriate practitioners may be limited. If CBO interprets the effects of these requirements in this way, we would expect them to conclude that these provisions have no budgetary effect.

Estimating the Effects of the Proposed Policy: Two-Year Demonstration

While the proposed demonstration policy would have the effect of delaying implementation of the new payment policy nationwide by two years, we would not expect CBO to assign a score to this delay in and of itself, because the policy, when implemented, is required to be budget neutral.

CBO's evaluation of the demonstration provisions would turn on what CBO assumed about the payment policy likely to be implemented in the demonstration. The language of section 3132 is consistent with—but does not require implementation of—a payment policy recommended by the Medicare Payment Advisory Commission (MedPAC), under which payments for routine care services would be increased at the beginning of a hospice episode and prior to death. Under the MedPAC recommended policy, payments would be adjusted to account for variations in service intensity, with offsetting reductions in other periods to maintain budget neutrality. Under this so-called “U-shaped” payment policy, average per diem payments would increase for hospice providers whose length of stay was shorter than average, while average payments per day for providers with above-average durations of hospice care would decrease.

If CBO were to assume that this sort of payment policy would be tested in the demonstration, CBO would be likely to conclude that spending under the demonstration would increase, in 2013 and 2014, to reflect selection bias. Since the demonstration is, as presently drafted, voluntary, it is likely that CBO would conclude that providers who anticipated payment increases under the policy would apply to participate, while those anticipating decreases would decline to apply. If CBO assumed that provider knowledge of outcomes under the policy was perfect, it would score a 5% increase in spending in the 15 participating hospices—the maximum increase permitted under the proposed amendment as presently drafted. Given that there is some degree of uncertainty regarding how individual providers would fare under the policy, it is possible that they would apply a “probabilistic” estimate that the increase might average only 50% of that amount. Applying this logic, our estimates assume that spending on routine care days would increase by 2.5% in 2013 and 2014 in the 15 participating hospices.

To estimate the impact of the demonstration, we developed a model to project payments for routine care days in 2013 and 2014, the years in which the demonstration would be in effect. We project that 88.2 million days of routine care would be provided at an average payment per day of \$149.28 in 2013 (adjusted for current law update policy post payment adjustments).

Given the small size of the demonstration, the amount of affected payments is not large. Fifteen providers constitute only 0.44% of the total number of hospice providers recorded in the Medicare Online Survey & Certification Online reporting system (OSCAR) in 2010. Assuming that the 15 providers, in the aggregate, would be of nationally average size, we estimated that routine care payments in 2013 to these providers would be \$58 million, and that a 2.5% net payment increase for these providers would result in increased payments of \$1.4 million in 2013, and would be slightly higher in 2014.¹

Estimating the Effects of the Proposed Policy: Survey and Certification Requirement

With respect to the question of whether more frequent survey and certification activity would reduce or increase spending, it is our opinion that CBO would decline to find a budgetary effect because Scorekeeping Guideline 14 directs CBO not to score lower spending or increased revenues resulting from program management activities.² We also expect that CBO would ignore whatever cost it would estimate for conducting more frequent surveys, since the legislation, as drafted, does not increase the statutory Limitation on Administrative Expenses imposed on CMS. CBO generally proceeds from the assumption that authorizing legislation changes do not bind the appropriations Committees to provide higher funding levels.

Estimates of Legislation as Presently Drafted

As presently drafted, our estimate of the likely score of the proposed legislation is as follows:

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2012-2021
Increased payments under demonstration (\$M)		\$1	\$2								\$3
Net change in mandatory spending	\$0	\$1	\$2	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$3

As indicated above, the score associated with the demonstration is nominal, totaling only \$3 million over the forecast period.

¹ Due to fiscal year timing effect, payments might be slightly lower in 2013, and trail out into 2015. In this presentation, however, we ignore these effects.

² See OMB Circular A-11 Appendix A: SCOREKEEPING GUIDELINES.
http://www.whitehouse.gov/sites/default/files/omb/assets/a11_current_year/app_a.pdf