National Hospice and Palliative Care Organization

Policy Alert

MedPAC Issues March 2023 Report to Congress: Medicare Payment Policy

To: *NHPCO Provider and State Members*
From: *NHPCO Policy Team*
Date: *March 16, 2023*

Summary at a Glance

On March 15, 2023 the Medicare Payment Advisory Commission (MedPAC) released its March 2023 Report to the Congress: Medicare Payment Policy. The hospice chapter provides MedPAC's analysis of the current state of hospice – beneficiary access to care, quality of care, and Medicare spending and margins. MedPAC found "generally positive indicators of payment adequacy and strong margins" and, therefore, concluded the chapter with the following recommendations for Congress:

- "For fiscal year 2024, the Congress should update the 2023 Medicare base payment rates for hospice by the amount specified in current law and wage adjust and reduce the hospice aggregate cap by 20 percent."

Base rate recommendation: MedPAC is deferring to CMS to follow the statutory updates to the hospice payment rates and the cap amount for FY 2024. The rates, and their percentage increase from FY 2023, will be announced in the FY 2024 Hospice Wage Index proposed rule, due to be published in the Federal Register in the coming days.

Cap recommendation: MedPAC noted the rationale for the Commission's March 2023 cap recommendation is "with the range of financial performance across providers and the existence of the hospice aggregate cap, there is the potential to focus payment reductions on providers with disproportionately long stays and high margins." NHPCO continues to highlight the unintended consequences of the MedPAC recommendations on beneficiary access and quality of care delivered by hospice providers.

Note: Providers should remember MedPAC is an advisory body that makes recommendations to Congress. Even with a unanimous vote in favor of any recommendation, including modifications to the hospice aggregate cap, Congress must adopt the necessary legislative changes to put these recommendations into effect.

The March 2023 report includes MedPAC's analyses of payment adequacy in fee-for-service (FFS) Medicare and reviews the status of Medicare Advantage (MA) and the prescription drug benefit (Part D). For payment updates, MedPAC recommends:

Medicare Provider Type	Positive MedPAC Recommended Payment Updates	0% Payment Updates	Negative Payment Updates
Outpatient Dialysis	1.8%		
Physicians	1.45%		
Hospitals – IPPS	1.0%		
Hospitals – OPPS	1.0%		
Hospices	In line with statutory update – percentage to be released with FY 2024 Proposed Hospice Wage Index rule		
Ambulatory Surgery Centers		0%	
Inpatient Rehabilitation Facilities			-3.0%
Skilled Nursing Facilities			-3.0%
Home Health			-7.0%

The summary of the hospice chapter (PDF) of the MedPAC March 2023 Report to Congress follows.

1. Hospice and Patient Demographics

A. ***Growth in providers:*** In 2021, 5,358 hospices submitted claims and provided care to Medicare beneficiaries, a 5.9 percent increase from 2020. For-profit hospices accounted for all of the net increase in the number of hospices, continuing a more than decade-long trend of substantial market entry by for-profit providers.

B. ***Volume of services:*** The number of beneficiaries using hospice services at the end of life continued to increase.

Medicare decedents served by hospice:

Numbers

- 2020: 1.72 million beneficiaries used hospice
- 2021: 1.71 million beneficiaries used hospice*

Percentages

- 2020: 47.8 percent of Medicare decedents used hospice
- 2021: 47.3 percent of Medicare decedents used hospice

Length of Stay:

Average lifetime length of stay:

- 2020: 97.0 from
- 2021: 92.1 days (similar to pre-COVID)

Median length of stay: In 2021, dropped from 18 days to 17 days

**These estimates are based on Medicare paid hospice claims, which excludes hospice care paid for by a small number of MA plans participating in the CMMI hospice MA VBID hospice model

TABLE 10–4 **Hospice use rates were stable or declined in 2021, following the 2020 increase**

	2010	2019	2020	2021	Average annual percent change 2010–2019	Change 2019–2020	Change 2020–2021
Hospice utilization among Medicare decedents							
Number of Medicare decedents (in millions)	1.99	2.32	2.73	2.73	1.7%	17.6%	–0.1%
Number of Medicare decedents who used hospice (in millions)	0.87	1.20	1.31	1.29	3.6	9.0%	–1.3%
Average lifetime length of stay among decedents (in days)	87.0	92.5	97.0	92.1	0.7	4.8%	–5.1%
Median lifetime length of stay among decedents (in days)	18	18	18	17	0 days	0 days	–1 day
Medicare utilization and spending for all hospice users (not limited to decedents)*							
Total spending (in billions)	$12.9	$20.9	$22.4	$23.1*	5.5	7.4	2.8*
Number of Medicare hospice users (in millions)	1.15	1.61	1.72	1.71*	3.8	6.6	0.0*
Number of hospice days for all hospice beneficiaries (in millions)	81.6	121.8	127.8	127.6*	4.6	4.9	–0.1*

C. Cost growth

Between 2018 and 2020, hospice cost growth was generally modest. Average cost per day for:

- Routine home care
- General inpatient care
- Inpatient respite
- Continuous home care
- Average cost per day for routine home care, the level of care that accounts for more than 98 percent of hospice days, increased 0.5 percent between 2018 and 2019 and 1.2 percent between 2019 and 2020. In contrast, average cost per day for general inpatient care, inpatient respite care, and continuous home care, which are provided relatively infrequently, rose substantially in 2020.

D. Medicare aggregate margins

The aggregate margin, which is an indicator of the adequacy of Medicare payments relative to provider costs. Hospice margins are presented through 2020 because of the data lag required to calculate cap overpayment amounts.

- 2019: 13.4%
- 2020: 14.2%

For 2022, the Commission projects a Medicare aggregate margin of about 8%.

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TABLE 10–11 **Hospice Medicare aggregate margins by selected characteristics, 2016 to 2020**

Category	Share of hospices 2020	2016	2017	2018	2019	2020
All	100%	10.9%	12.5%	12.4%	13.4%	14.2%
Freestanding	83	14.0	15.3	15.1	16.2	16.7
Home health based	9	6.2	8.1	8.4	9.6	11.2
Hospital based	8	–16.7	–13.8	–16.5	–18.4	–18.2
For profit	73	17.9	20.0	19.0	19.2	20.5
Nonprofit	24	2.2	2.5	3.8	6.0	5.8
Urban	83	11.4	12.9	12.6	13.6	14.3
Rural	17	6.3	8.9	10.3	11.5	13.5
Patient volume (quintile)						
Lowest	20	–3.1	–1.1	–3.1	–4.5	–2.1
Second	20	6.2	6.7	5.6	6.2	4.9
Third	20	11.2	13.8	13.8	13.5	14.2
Fourth	20	13.1	15.2	14.0	15.8	17.9
Highest	20	11.1	12.5	12.7	13.9	14.4
Below cap	81	10.7	12.6	12.5	13.8	14.8
Above cap (excluding cap overpayments)	19	12.6	12.1	10.1	10.0	7.7
Above cap (including cap overpayments)	19	20.2	21.9	21.8	22.5	22.8
Share of stays > 180 days						
Lowest quintile	20	–5.4	–4.5	–3.0	–2.5	–0.4
Second quintile	20	5.8	7.0	8.5	10.3	11.8
Third quintile	20	14.8	17.1	16.8	19.9	20.0
Fourth quintile	20	20.0	22.1	20.8	22.8	24.1
Highest quintile	20	15.0	17.8	17.6	13.4	13.4
Share of patients in nursing facilities and assisted living facilities						
Lowest half	50	4.8	6.3	6.1	6.6	7.5
Highest half	50	16.2	18.1	17.3	18.7	18.9

Note: Margins for all provider categories exclude overpayments to above-cap hospices, except where specifically indicated. Medicare aggregate margins are calculated based on Medicare-allowable, reimbursable costs. Margin by hospice ownership status is based on hospices' ownership designation from the Medicare cost report. The rural and urban definitions used in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census).

Source: MedPAC analysis of Medicare hospice cost reports, Medicare hospice claims data, and Medicare Provider of Services file from CMS.

2. Beneficiary Access to Care

MedPAC found many of the trends from 2020 and the COVID-19 pandemic continued into 2021. Hospice use among Medicare decedents decreased from 2020 (47.8% to 47.3%). This continued decline from pre-pandemic use rates is due to the growth in deaths outpaced growth in the number of hospice users in 2021. The following table depicts the increase in hospice utilization by beneficiary type, age, race/ethnicity, sex, and county. It should be noted the data released by MedPAC in the table below compares patients who elected hospice in that race or ethnicity to the total of Medicare

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decedents for that race or ethnicity. The share of decedents using hospice by race and ethnicities was fairly stable from 2020. White decedents saw the only decline among race and ethnicity groups (-0.8%) and Hispanic decedents saw the largest increase in use (1.1%); however, white decedents maintain the largest share of decedents using hospice by race or ethnicity (50.0%) and saw the smallest decrease in 2020.

TABLE 10–3

Share of decedents using hospice declined overall in 2021 but increased for some beneficiary groups

	Share of Medicare decedents who used hospice					
	2010	2019	2020	2021	Average annual percentage point change 2010–2020	Percentage point change 2020–2021
All decedent beneficiaries	43.8%	51.6%	47.8%	47.3%	0.4	–0.5
FFS beneficiaries	42.8	50.7	47.2	47.2	0.4	0.0
MA beneficiaries	47.2	53.2	48.7	47.4	0.2	–1.3
Dually eligible for Medicaid	41.5	49.3	42.3	42.1	0.1	–0.2
Not Medicaid eligible	44.5	52.4	49.8	49.2	0.5	–0.6
Age						
<65	25.7	29.5	26.5	25.0	0.1	–1.5
65–74	38.0	41.0	37.3	35.8	–0.1	–1.5
75–84	44.8	52.2	48.3	47.8	0.4	–0.5
85+	50.2	62.7	59.0	60.8	0.9	1.8
Race/ethnicity						
White	45.5	53.8	50.8	50.0	0.5	–0.8
Black	34.2	40.8	35.5	35.6	0.1	0.1
Hispanic	36.7	42.7	33.2	34.3	–0.4	1.1
Asian American	30.0	39.8	36.0	36.3	0.6	0.3
North American Native	31.0	38.5	33.5	33.8	0.3	0.3
Sex						
Male	40.1	46.7	42.9	42.1	0.3	–0.8
Female	47.0	56.3	52.7	52.5	0.6	–0.2

3. *Telehealth:*

In response to the COVID-19 Public Health Emergency (PHE), CMS modified the hospice conditions of participation to permit hospice providers to furnish services using telecommunication systems during the PHE, under certain circumstances. However, hospices are unable to report on the use of telehealth services on Medicare claims (with the exception of social worker phone calls, which have historically been reported on claims). Although MedPAC recommended the inclusion of telehealth on hospice claims in 2022, MedPAC did not make this recommendation this year.

4. *Quality of Care:*

Due to the pandemic, CMS suspended collection of hospice quality data submitted by providers (the Hospice Item Set and the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®)

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Hospice Survey) for the first two quarters of 2020. These data for 2020 is not used to inform conclusions of quality of care. Although it is hard to assess, hospice quality appears to be stable.

Scores on the Hospice Consumer Assessment of Healthcare Providers and Systems® were stable. Scores for the composite of seven processes of care at admission were "so high and unvarying that meaningful distinctions and improvement in performance can no longer be made." After a modest decline in 2020, in-person visits at the end of life were stable. CMS also launched a new claims-based quality measure, the Hospice Care Index (HCI) based on 10 indicators, that identifies outlier patterns of care among hospice providers.

CAHPS ® Percent of Providers by Star Rating Score

- 1 Star – 1%
- 2 Star – 14%
- 3 Star – 36%
- 4 Star – 39%
- 5 Star – 10%

TABLE 10–8 **Scores on hospice CAHPS quality measures and hospice star ratings**

	Prior period (January 2018 – December 2019)	Most recent period (April 2019 – December 2019; July 2020 – September 2021)
Share of respondents giving a top rating on:		
Providing emotional support	90%	90%
Caregiver rates hospice 9 or 10	81	81
Caregiver recommends hospice	84	84
Treating patients with respect	91	90
Help for pain and symptoms	75	75
Hospice team communication	81	81
Providing timely help	78	78
Caregiver training	76	76
Percent of providers by star rating score		
1 star	N/A	1%
2 star	N/A	14
3 star	N/A	36
4 star	N/A	39
5 star	N/A	10

Note: CAHPS (Consumer Assessment of Healthcare Providers and Systems®), N/A (not available). The CAHPS scores in the eight listed domains reflect the share of respondents who reported the "top-box"—meaning the most positive survey response across all providers.

Source: CAHPS data from CMS.

5. MedPAC Recommendation to Wage Index the Cap and Reduce It By 20%

The basis for MedPAC's recommendation to wage index and reduce the aggregate cap by 20 percent is to target "providers with disproportionately long stays and high margins." NHPCO has and will

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continue to disagree with this approach as the length of stay issue is most often caused by the types of diseases with more difficult disease trajectory and the precision of the prognosis being more difficult. MedPAC acknowledges there are certain diagnoses that contribute to a significantly longer length of stay.

MedPAC goes on to say "there is evidence suggesting that some hospices are inappropriately using live discharges as a way to limit their cap liabilities. CMS and OIG should monitor this type of behavior under current policy and any changes under a policy to reduce the cap. In addition, there could be merit in considering a payment penalty for hospices with unusually high rates of live discharges. For example, live-discharge rates could be included in a compliance threshold policy, as discussed in the MedPAC March 2021 report."

In NHPCO's ongoing advocacy with MedPAC, NHPCO has also emphasized how reducing the aggregate cap could have the unintended consequence of not having the hospice benefit as an option in rural or underserved areas or electing hospice very late in the disease process. Both deny or delay care to beneficiaries who most need care and support at the end of life. MedPAC provided Table 11-12 below to simulate the number of hospices who would exceed the aggregate cap with an implemented wage index and 20 percent reduction in the cap amount. It is of note, the number of rural hospices exceeding the cap would go from 4.2 percent to 17.3 percent and the projection for all hospices exceeding the cap would go from 18.6 percent to 33.5 percent.

NHPCO does not support MedPAC's recommendation to modify the hospice aggregate cap. After reviewing the full report with associated recommendations– including increases to hospital payments – NHPCO believes MedPAC is relaying a message to Congress, and to all Americans, they encourage care to be provided in acute care settings while discouraging person-centered care in less costly settings like in the home. NHPCO shares MedPAC's goals to reduce overall health care costs and improve quality, but this hospice payment policy recommendation is overly broad, especially in light of the strain put on providers by the COVID-19 pandemic.

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TABLE 10–12

Simulated share of hospice providers exceeding the aggregate cap in 2020 under a policy to modify the aggregate cap

	2020 share of providers exceeding the cap	
	Actual	Simulation of modified cap policy
All	18.6%	33.5%
Freestanding	21.7	38.6
Home health based	4.4	13.3
Hospital based	0.7	3.2
For profit	24.6	43.0
Nonprofit	2.1	8.4
Urban	21.3	36.7
Rural	4.2	17.3

Note: This analysis simulates the effect of a policy to wage adjust and reduce the cap by 20 percent using 2020 data. The simulation assumes no changes in utilization in response to the policy. Although we are not able to incorporate potential behavioral changes in our simulation, it is possible that some providers might respond to cap changes by adjusting their admissions practices to remain under the cap.

Source: MedPAC analysis of Medicare claims data for hospice providers.

Providers should remember MedPAC is an advisory body making recommendations to the Congress. Even with a unanimous vote in favor of the modifications to the hospice aggregate cap or any other recommendation, Congress must adopt the necessary legislative changes to put these recommendations into effect.

For questions about this Policy Alert, please reach out to regulatory@nhpco.org with MedPAC in the subject line.

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