MedPAC Draft Recommendation for Hospice Eliminates Rate Update

Source: NAHC, December 11, 2023

Late last week, the Medicare Payment Advisory Commission (MedPAC) held a meeting to discuss their draft recommendations for various Medicare programs for their upcoming annual report to Congress, which will be released in March 2024 (*slides from the hospice discussion can be found **HERE***). The Chair's draft recommendation for the Medicare hospice program, which most commissioners indicated support for, is:

- ***"For FY2025, to eliminate the update to the 2024 Medicare hospice payment rates"***

A formal vote on the recommendation will be taken at the January 2024 MedPAC meeting.

In response to the MedPAC recommendation and discussion, **NAHC President William Dombi stated**, "NAHC disagrees with MedPAC's recommendation not to update hospices' payment rates for FY025. Hospices are still facing historically high costs across a number of areas, and CMS has failed to accurately account for real inflation in their reimbursement rates. We will continue to inform MedPAC about the true financial landscape for hospices, to ensure providers' payment supports high-quality care. We are pleased however to see that MedPAC has left out their prior recommendation to reduce the aggregate cap by 20%. NAHC has long believed this policy change would negatively impact access to hospice care for some of the most vulnerable patients and families. NAHC recently met with MedPAC to discuss important research that shows how problematic the cap cut could be, as well as new data highlighting the financial value of hospice to the overall Medicare program. The commissioner's discussions about non-hospice spending and quality-of-care in the program are important areas that need further exploration, and we will work with our members to educate MedPAC on their real-world implications."

Recommendation not to update hospices' payment rates

MedPAC's recommendation not to increase hospices' payment rates next year is based on what they see as overall stability and financial strength in the program, as reflected in metrics they believe are proxies for such stability. These include

growth in the number of hospices, increases in hospice utilization by beneficiaries, increases in hospice episode lengths-of-stay, hospice providers' steady access to capital, and hospices' Medicare margins. MedPAC staff indicated that based on their analysis of these metrics, they do not believe the recommendation would negatively impact access to hospice care or willingness or ability of hospice providers to care for beneficiaries. It is important to remember that while MedPAC makes recommendations, CMS and Congress are not obligated to act on them. To that end, in four of the last five years, MedPAC has recommended that Congress either eliminate hospices' payment update, or actually reduce it by 2% (this was the recommendation in 2019); Congress never acted on those proposals, however.

NAHC is disappointed that MedPAC is not recommending any payment update for hospices in FY2025. We feel this position does not account for the ongoing financial challenges hospices are facing, including increased across-the-board costs as a result of a challenging labor environment, coupled with overall high levels of general inflation that have increased costs of supplies, drugs, wages, and other items essential to the delivery of high-quality hospice care. Further, unlike many other Medicare provider types (such as hospitals), most hospice care is financed by federal health care programs (predominantly Medicare and Medicaid). As a result, hospice providers are unable to shift costs to other payers to help offset losses under Medicare. Even hospices that have significant commercial contracts have very limited pricing power and are forced to accept rates set by the payer.

Most of the increased cost factors attributable to inflation will not recede quickly and will represent a new base for hospice spending. These concerns are exacerbated by how CMS has also failed to accurately forecast inflationary impacts on the market basket upon which hospice payment rates are based. As detailed in NAHC's comment letter to CMS on the FY2024 Hospice Payment rule, in recent years CMS' forecasts have fallen far short of actual cost inflation, resulting in a cumulative shortfall of 3.7% for 2021 and 2022. This gap between the forecast and actual measured inflation matters greatly, as it essentially gets "locked into" hospice rates going forward, which perpetuates a distorted picture of hospices' true cost environment.

NAHC will continue to educate MedPAC, Congress, CMS and others on the financial realities hospices face, and will advocate for fair and accurate payment policies that are necessary to support the provision of high-quality care at the end-of-life.

Removal of recommendations to wage-adjust and reduce the aggregate cap by 20%

It is very notable that MedPAC's draft recommendation this year *does not* include the previous four years' recommendations to wage-adjust and reduce the aggregate cap by 20%.

While NAHC believes that Congress should consider wage-adjusting the cap to address wage variation, this change should be phased in over time to minimize the potential impact on access to care and to allow the most negatively impacted areas of the country to adjust.

NAHC disagrees strongly however with MedPAC's recommendation to reduce the cap by 20 percent, and has advocated against this change for years. A 20% cap cut is a blunt tool that would negatively impact access to care by introducing disincentives to serve patients that have a more unpredictable disease trajectory. Also, by disincentivizing hospice care for certain kinds of patients, a large untargeted cap reduction could result in increased *overall* Medicare outlays, as those individuals who might have received cost-saving hospice care end up utilizing more expensive and aggressive care such as hospital, ER, and nursing home services. Research, including the seminal NORC analysis the NAHC and NHPCO co-commissioned earlier this year, has shown that hospice use by Medicare beneficiaries is associated with major savings to the overall Medicare program. Additional academic research has highlighted how policy recommendations intended to reduce longer hospice stays, including MedPAC's cap cut proposal, are or could have a chilling effect on hospices feeling comfortable taking care of patients with non-cancer terminal illnesses. This is a scenario that not only has negative quality-of-life impacts for dying beneficiaries, but also contributes to increased overall spending to Medicare.

NAHC has met with MedPAC multiple times and shared the above-referenced research and data. We hope and believe that our advocacy contributed in some way to MedPAC leaving the cap cut changes out of their draft recommendation this year. We know that MedPAC is taking a closer look at the cap's impact on beneficiary outcomes (as highlighted in their recently revealed multi-year hospice research work plan), and so expect that we will see more data come out based on their own internal analyses of some of the highlighted issues.

Non-hospice "unrelated" spending for beneficiaries on the Medicare hospice benefit

MedPAC staff also presented on the growing level of Medicare spending for hospice beneficiaries that occurs outside of the hospice benefit itself (so-called "unrelated" spend, because of the perception that it is "unrelated" to the terminal illness and related conditions). In FY2022, this spending outside of hospice amounted to $1.5 billion. To better understand what is driving this spending and its growth, MedPAC conducted in-depth interviews with 12 hospices in 2022 and 2023. More detail on these interviews and MedPAC's future directions on "unrelated" spend will be included in the March 2024 Report to Congress, but on during the presentation last week, MedPAC staff highlighted a few important issues and ideas, including:

- Hospices sometimes have different understandings and cultural interpretations of what services qualify as "related" or "unrelated"

- One potential driver of unrelated spend is the fact that hospices generally do not receive claims data on the specific non-hospice services that their patients receive, and so it can be nearly impossible for hospices to know when or where a patient under their care seeks out non-hospice services.
- While hospices strive to educate patients, families, and other community providers about what is covered and not covered by the hospice, and when a patient or family should reach out to the hospice if there are concerns, it can be difficult to ensure this education reaches all relevant parties or "sinks in" enough to help prevent seeking out unhelpful non-hospice services.
- It is important to determine if the growth in unrelated spending is influenced partly by hospices inappropriately trying to avoid paying for services that they should in fact be responsible for covering.

MedPAC staff presented three different potential policy proposals for the Commissioners' consideration intended to address unrelated spending growth, including:

- **Administrative solutions**, including requiring CMS to create more concrete and clear definitions of "related" and "unrelated" and building systems-level fixes to facilitate more accurate and timely information-sharing across hospice and non-hospice providers and suppliers
- **A bundled payment approach to hospice**, whereby the unrelated services could be bundled into the hospice benefit with an increase to providers' base payments to account for the increased accountability for covering the unrelated services.
- **A payment penalty approach,** in which hospices with high levels of unrelated spending have a penalty imposed on them, presumably through a payment reduction of some sort.

It is important to note that the MedPAC commissioners discussion on the unrelated spending issue was very nuanced, and many of them expressed opinions that indicated they believe the dichotomy between "related" and "unrelated" is very fuzzy, and not reflective of the current clinical environment in which many treatments can be both palliative and disease-focused simultaneously. Some felt the split is potentially unhelpful, with the important mention that it creates difficulties for hospices trying to decide what to cover in service of honoring their patients wishes' and improving their quality-of-life. Most commissioners appeared to nominally support the administrative solutions presented (ie CMS clarifying "related" vs "unrelated" etc), while there was disagreement about both the bundled payment approach and the payment penalty idea. Some commissioners felt a bundled benefit would be more seamless and smooth for patients and families, while others were concerned about the ability of smaller hospices to cover the unrelated services, even with increased payments.

<u>Other important information from the hospice discussion</u>

- **2021 Medicare margins were 13.3%** (2021 is most recent year they have accurate margins for, given the lag associated with getting cap calculations)

- **Projected Medicare margin for 2024 is 9%** (last year they projected 2023 Medicare margins at 8%)
- Unrelated to the payment update discussion, there was a lot of **concern expressed by commissioners during the discussion about the state of quality in the hospice program**. Some commissioners lamented how far behind they believe hospice is in regards to quality measurement and reporting. A number of other commissioners also highlighted what they see as troubling quality-of-care scores across the hospice landscape (they cited data that is in the draft congressional report on CAHPS scores and the large number of hospices with low CAHPS Star ratings)

MedPAC is clearly taking an intense interest in the hospice program from many different angles. Their ambitious research workplan for the program over the coming years includes hospice's impact on overall Medicare spending; The effect of the cap on beneficiary outcomes; Non-hospice "unrelated" spending; and EoL care for beneficiaries with ESRD. NAHC will continue to engage with MedPAC on all of these issues and more, to ensure they are aware of the realities of the hospice care delivery environment.