National Hospice and Palliative Care Organization

Policy Alert

MedPAC Issues March 2024 Report to Congress: Medicare Payment Policy

To: NHPCO Provider and State Members
From: NHPCO Policy Team
Date: March 15, 2024

Summary at a Glance

On March 15, 2024 the Medicare Payment Advisory Commission (MedPAC) released its March 2024 Report to the Congress: Medicare Payment Policy. The Hospice services 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 "positive indicators of payment adequacy and strong margins" and, therefore, made the following recommendations to Congress:

- "For fiscal year 2025, the Congress should eliminate the update to the 2024 Medicare base payment rates for hospice."

Base rate recommendation: MedPAC is deferring to CMS to follow the statutory updates to the hospice payment rates and the cap amount for fiscal year (FY) 2025. The rates, and their percentage increase from FY 2024, will be announced in the FY 2025 Hospice Wage Index proposed rule, due to be published in the Federal Register in the coming weeks.

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

The March 2024 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 2025 payment updates, MedPAC recommends the following:

Medicare Provider Type	MedPAC Recommended Payment Update[1]
Outpatient Dialysis	1.8%
Hospitals – IPPS	1.5%
Hospitals – OPPS	1.5%
Physicians	1.3%
Hospices	**0%**
Skilled Nursing Facilities	-3.0%
Inpatient Rehabilitation Facilities	-5.0%
Home Health Care	-7.0%

The summary of the hospice chapter (PDF) of the MedPAC March 2024 Report to Congress follows.

1. Hospice and Patient Demographics

A. ***Growth in providers:*** In 2022, 5,899 hospices submitted claims and provided care to Medicare beneficiaries, a 10.1 percent increase from 2021. For-profit hospices drove the increase of hospice providers as nonprofit and government providers saw decreases from 2021 to 2022.

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

- 2022: 1.72 million beneficiaries used hospice
- 2021: 1.71 million beneficiaries used hospice

Percentages

- 2022: 49.1 percent of Medicare decedents used hospice
- 2021: 47.3 percent of Medicare decedents used hospice

Length of Stay:

Average lifetime length of stay:

- 2022: 95.3
- 2021: 92.1 days

Median length of stay: In 2022, increased from 17 days to 18 days.

[1] Recommendations are based on current law.

TABLE 9–3 **Hospice use increased in 2022**

					Average annual percent change		Percent change
	2010	2019	2021	2022	2010–2019	2019–2021	2021–2022
Hospice use among Medicare decedents							
Number of Medicare decedents (in millions)	1.99	2.32	2.73	2.64	1.7%	8.4%	–3.5%
Number of Medicare decedents who used hospice (in millions)	0.87	1.20	1.29	1.30	3.6	3.9	0.2
Average lifetime length of stay among decedents (in days)	87.0	92.5	92.1	95.3	0.7	–0.2	3.5
Median lifetime length of stay among decedents (in days)	18	18	17	18	0 days	–0.5 days	1 day
Medicare use and spending for all hospice users (not limited to decedents)*							
Total spending (in billions)	$12.9	$20.9	$23.1*	$23.7*	5.5	5.1*	2.7*
Number of Medicare hospice users (in millions)	1.15	1.61	1.71*	1.72*	3.8	3.2*	0.4*
Number of hospice days for all hospice beneficiaries (in millions)	81.6	121.8	127.6*	130.2*	4.6	2.4*	2.0*

Note: Lifetime length of stay is calculated for decedents who were using hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during their lifetime. Total spending, number of hospice users, number of hospice days, and average length of stay displayed in the table are rounded; the percentage change columns for number of hospice users and total spending are calculated using unrounded data.
*These estimates are based on Medicare-paid hospice claims, which exclude hospice care paid for by Medicare Advantage (MA) plans participating in the Center for Medicare & Medicaid Innovation hospice MA value-based insurance design hospice model beginning 2021. According to CMS contractor evaluation reports, 9,630 MA beneficiaries in 2021 and 19,065 MA beneficiaries in 2022 received hospice paid for by MA plans (Eibner et al. 2023, Khodyakov 2022).

Source: MedPAC analysis of data from the Common Medicare Enrollment file and hospice claims data from CMS.

C. ***Cost growth***

MedPAC indicates that hospice cost per day growth may be moderating. Between 2022 and 2021, hospice costs per day increased by 3.7 percent. Comparatively, hospice costs per day increased by 4.3 percent from 2020 to 2021. Hospice costs vary substantially by average length of stay, as well as provider type. MedPAC found that providers with longer length of stays have lower average costs per day. MedPAC estimates the following average total costs per day by provider type in 2022:[2]

- All hospices: $162
- Freestanding: $155
- Home health based: $180
- Hospital based: $251
- For profit: $143
- Nonprofit: $195
- Urban: $163
- Rural: $149

[2] See MedPAC March 2024 Report, Chapter 9, Table 9-9.

D. ***Medicare aggregate margins***

The aggregate margin is an indicator of the adequacy of Medicare payments relative to provider costs. Hospice margins declined from 14.2 percent in 2020 to 13.3 percent in 2021.

For 2024, MedPAC projects a Medicare aggregate margin of approximately 9 percent.

TABLE 9–10

Hospice providers' FFS Medicare aggregate margins by selected characteristics, 2017–2021

Category	Share of hospices 2021	2017	2018	2019	2020	2021
All	100%	12.5%	12.4%	13.4%	14.2%	13.3%
Freestanding	84	15.3	15.1	16.2	16.7	15.5
Home health based	7	8.1	8.4	9.7	11.2	10.9
Hospital based	8	–13.8	–16.5	–18.4	–18.2	–15.6
For profit	75	20.0	19.0	19.2	20.5	19.2
Nonprofit	22	2.5	3.8	6.1	5.8	5.2
Urban	84	12.9	12.6	13.6	14.3	13.4
Rural	16	8.9	10.3	11.5	13.5	12.3
Patient volume (quintile)						
Lowest	20	–1.1	–3.1	–4.5	–2.1	–4.4
Second	20	6.7	5.6	6.2	4.9	3.1
Third	20	13.8	13.8	13.5	14.2	13.3
Fourth	20	15.2	14.0	15.8	17.9	15.5
Highest	20	12.5	12.7	13.9	14.4	14.0
Below cap	81	12.6	12.6	13.8	14.8	14.0
Above cap (excluding cap overpayments)	19	12.1	10.3	10.0	7.7	2.5
Above cap (including cap overpayments)	19	21.9	21.8	22.5	22.8	21.8
Share of stays > 180 days						
Lowest quintile	20	–4.5	–3.0	–2.5	–0.4	0.0
Second quintile	20	7.0	8.5	10.3	11.8	11.1
Third quintile	20	17.1	16.8	19.9	20.0	20.5
Fourth quintile	20	22.1	20.8	22.8	24.1	22.2
Highest quintile	20	17.8	17.6	13.4	13.4	9.7
Share of patients in nursing facilities and assisted living facilities						
Lowest half	50	6.3	6.1	6.6	7.5	7.1
Highest half	50	18.1	17.3	18.7	18.9	17.6

Note: FFS (fee-for-service). 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

Hospice use increased in 2022 among Medicare decedents, following a decline in 2020 and 2021 due to the coronavirus (COVID-19) pandemic. However, hospice utilization among Medicare decedents still has not reached pre-pandemic levels, and COVID-19 continued to adversely impact hospice utilization in 2022. MedPAC found that months with the highest number of deaths during the pandemic had the lowest hospice use rates, which is consistent with previous pandemic patterns of deaths outpacing growth in the number of hospice users.

The following table depicts the increase in hospice utilization by beneficiary type, age, race/ethnicity, sex, and location. It should be noted that the data released by MedPAC in the table below compares patients who elected hospice in the group (e.g., age, location, race) to the total of Medicare decedents for that group.

The share of decedents using hospice saw an increase across all races and ethnicities in 2022. Hispanic decedents saw the largest increase (4.1%) in use among race and ethnicity groups; whereas, White decedents, which experienced a slight decrease in utilization in 2021, saw the smallest increase in 2022 (1.6%). However, hospice utilization continues to be lower for non-White decedents.

TABLE 9–2

In 2022, share of decedents using hospice increased overall and across all beneficiary subgroups

	Share of Medicare decedents who used hospice					
	2010	2019	2021	2022	Average annual percentage point change 2010–2021	Percentage point change 2021–2022
All decedent beneficiaries	43.8%	51.6%	47.3%	49.1%	0.3	1.8
FFS beneficiaries	42.8	50.7	47.2	49.1	0.4	1.9
MA beneficiaries	47.2	53.2	47.4	49.2	0.0	1.8
Dually eligible for Medicaid	41.5	49.3	42.1	44.2	0.1	2.1
Not Medicaid eligible	44.5	52.4	49.2	50.9	0.4	1.7
Age						
<65	25.7	29.5	25.0	26.6	–0.1	1.6
65–74	38.0	41.0	35.8	37.7	–0.2	1.9
75–84	44.8	52.2	47.9	49.4	0.3	1.5
85+	50.2	62.7	60.8	61.8	1.0	1.0
Race/ethnicity						
White	45.5	53.8	50.0	51.6	0.4	1.6
Black	34.2	40.8	35.6	37.4	0.1	1.8
Hispanic	36.7	42.7	34.2	38.3	–0.2	4.1
Asian American	30.0	39.8	36.2	38.1	0.6	1.9
North American Native	31.0	38.5	33.8	37.1	0.3	3.3
Sex						
Male	40.1	46.7	42.1	43.8	0.2	1.7
Female	47.0	56.3	52.5	54.3	0.5	1.8
Beneficiary location						
Urban	45.6	52.8	48.5	50.2	0.3	1.7
Micropolitan	39.2	49.7	45.1	47.2	0.5	2.1
Rural, adjacent to urban	39.0	49.5	44.9	47.8	0.5	2.9
Rural, nonadjacent to urban	33.8	43.8	39.9	42.1	0.6	2.2
Frontier	29.2	36.2	33.0	35.2	0.3	2.2

Note: FFS (fee-for-service), MA (Medicare Advantage). For each demographic group, the share of decedents who used hospice is calculated as follows: The number of beneficiaries in the group who both died and received hospice in a given year is divided by the total number of beneficiaries in the group who died in that year. "Beneficiary location" refers to the beneficiary's county of residence in one of four categories (urban, micropolitan, rural adjacent to urban, or rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes (UICs). This chart uses the 2013 UIC definition. The frontier category is defined as population density equal to or less than six people per square mile and overlaps the categories of residence. Yearly figures presented in the table are rounded, but figures in the columns for percentage point change were calculated using unrounded data. Analysis excludes beneficiaries without Medicare Part A because hospice is a Part A benefit.

Source: MedPAC analysis of data from the Common Medicare Enrollment file and hospice claims data from CMS.

3. Quality of Care

Quality of care metrics were stable from 2021 to 2022 with a slight increase of in person visits, but still below 2019 levels. Scores on the Hospice Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) were stable. Eighty one percent of caregivers rated the hospice either 9 or 10 in the most recent period (January 2021 to December 2022). There was a slight decrease in the number of caregivers giving hospices the top rating in: treating patients with respect, help for pain and symptoms, providing timely help, and caregiver training in the most recent period.

From January 2021 to December 2022, the Hospice Care Index (HCI) identified "15 percent of providers with data were outliers on at least 3 of 10 measures, and 2 percent were outliers on at least half of the measures."[3] For nurse and social worker in-person visits in the last days of life, the visits have been stable for 2021 and 2022 but have not returned to pre-pandemic levels.

MedPAC reiterates its support for outcomes measures for hospice, specifically the Hospice Outcomes & Patient Evaluation (HOPE) tool.

MedPAC highlights concerns with high rates of live discharges as indicative of poor quality or program integrity issues. The top reasons for live discharges in 2022 were "beneficiary revocation" and "beneficiary not terminally ill" which were stable from 2021.

TABLE 9–7 **Scores on hospice CAHPS® quality measures and hospice star ratings**

	National performance	
	Prior period (July 2019 – December 2019; July 2020 – December 2021)	Most recent period (January 2021 – December 2022)
Share of caregivers rating the hospice a 9 or 10	81%	81%
Share of caregivers who would definitely recommend the hospice	84	84
Share of caregivers who give top ratings on:		
Providing emotional support	90	90
Treating patients with respect	91	90
Help for pain and symptoms	75	74
Hospice team communication	81	81
Providing timely help	78	77
Caregiver training	76	75

Note: CAHPS® (Consumer Assessment of Healthcare Providers and Systems®). 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. The "previous period" covers July 2019 to December 2021, excluding the first half of 2020, when hospices' quality reporting requirement was suspended due to the coronavirus pandemic.

Source: CAHPS data from CMS.

MedPAC indicates that very short lengths of stays are an opportunity for quality improvement. The Commission highlights a variety of causes for short lengths of stay:

[3] See MedPAC March 2024 Report, Chapter 9, page 277.

- "Physicians are reluctant to have conversations about hospice or tend to delay such discussions until death is imminent;
- some patients or families may prefer to exhaust all other treatment options before enrolling in hospice; and
- financial incentives in the FFS system may encourage increased volume of clinical services (compared with palliative care furnished by hospice providers."[4]

MedPAC references a variety of current and completed CMS demonstration projects as potential ways to address the short lengths of stay.

4. MedPAC Recommendation

MedPAC recommends to not increase hospice payment rates for FY 2025 in consideration that "current payment rates are sufficient to support the provision of high-quality care without an increase to the base payment rates."[5] Based on 2022 third quarter projections, current law would increase hospice payment rates by 2.8 percent (market basket rate of 3.1% minus 0.3% productivity adjustment).

MedPAC's recommendation is a change from previous years with the removal of its prior recommendation to wage index and reduce the aggregate cap by 20 percent. NHPCO advocated against this recommendation, and we are happy to see MedPAC move away from its recommendation to reduce the aggregate cap. NHPCO 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.

5. Nonhospice Spending for Beneficiaries Enrolled in Hospice

In FY 2022, approximately $1.5 billion was spent on nonhospice services for hospice enrollees. The breakdown of key areas where nonhospice spending occurred is provided below:

- Medicare Part A and B: $833 million
  - Physician services: $472 million
  - Outpatient services: $150 million
  - Hospital inpatient services: $145 million
- Medicare Part D: $623 million

MedPAC interviewed providers to better understand relatedness, hospice efforts to educate patients and families, and hospice efforts to work with providers and pharmacies to ensure correct billing. MedPAC highlighted the Program for Evaluating Payment Patterns for Electronic Report (PEPPER) and the Patient Notification of Hospice Non-Covered Items, Services, and Drugs as current policy approaches to address nonhospice spending. Providers indicated there are limitations with these approaches. MedPAC considered the below approaches to address nonhospice spending:

- **Administrative approach**: Potential options could be a definition for relatedness or better information flow across providers and pharmacies to alert a patient has elected hospice

[4] See MedPAC March 2024 Report, Chapter 9, page 278.
[5] See MedPAC March 2024 Report, Chapter 9, page 263.

- **Payment approach**: Potential options could be expanding the bundle of services provided by hospices to include unrelated services.
- **Payment penalty approach**: A potential option could be penalizing hospice providers above a certain threshold of nonhospice spending.

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.

In November 2023, MedPAC introduced a new hospice workplan which included a focus on hospices' effect on Medicare spending; effect of hospice aggregate cap; non-hospice spending for beneficiaries enrolled in hospice; and end-of-life care for beneficiaries with end-stage renal disease (ESRD). NHPCO has provided comments to MedPAC on this new workplan.

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

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