



*Advising the Congress on Medicare issues*

# Hospice: MedPAC workplan

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# Today's presentation

- 1 Background on hospice
- 2 Workplan for ongoing and new projects
- 3 Commissioner discussion and questions

# Background on hospice benefit

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- Palliative and supportive services for beneficiaries with terminal illnesses who choose to enroll
- Eligibility criteria:
  - Life expectancy of 6 months or less if disease runs its normal course
  - Physician(s) certifies prognosis at outset of each hospice benefit period: two 90-day periods, then unlimited number of 60-day periods
- Beneficiary agrees to forgo conventional care for the terminal condition and related conditions
- Hospice benefit is carved out of MA and paid by FFS\*

\*Under the CMS Innovation Center's value-based insurance design model hospice benefit component, some MA plans are responsible for the provision of hospice care to their enrollees.

# Hospice payment system

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- Medicare FFS pays a daily rate for hospice
  - Payment is made regardless of whether hospice furnishes services on a given day
- Routine home care is the most common level of care (>98% of days)
  - \$218 per day (days 1-60); \$172 per day (days 61+) in FY 2024
- Three other levels of care (general inpatient care, continuous home care, and inpatient respite care) are paid higher daily rates
- Aggregate cap on total payments to a provider in a year

**Note:** FY (fiscal year)

# Snapshot of hospice, 2021

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- Hospice utilization
  - 1.7 million Medicare beneficiaries used hospice
  - 47% of Medicare decedents
- Length of stay among decedents:
  - Median 17 days, average 92 days
- Hospice visits
  - Average of 3.8 visits per week total, with 1.8 nurse, 1.7 aide, and 0.3 social worker visits per week
- Medicare payments to hospice providers: \$23 billion

# Overview of MedPAC's current and future work on hospice

Project	Description
Hospices' effect on Medicare spending	We have contracted with Urban Institute to conduct a study of the effect of hospice on Medicare spending (updating our prior 2015 research)
Effect of hospice aggregate cap	MedPAC staff conducting analyses of aggregate cap's effect on beneficiary outcomes
Nonhospice spending for beneficiaries enrolled in hospice	Interviews conducted with hospice providers about factors contributing to nonhospice spending
End-of-life care for beneficiaries with end-stage renal disease (ESRD)	New project to interview clinicians, providers, and stakeholders about end-of-life care (e.g., palliative care and hospice) for beneficiaries with ESRD

# Effect of hospice on Medicare spending: Background

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- Most important benefit of hospice is its effect on patient care
  - Hospice offers patients option to receive end-of-life care focused on quality of life and to die at home or in another location consistent with their preferences
- When the hospice benefit was enacted, it was presumed that the benefit would reduce net Medicare spending
- Hospices' effect on Medicare spending is influenced by many factors:
  - What spending would be in the absence of hospice
  - Timing of hospice admission and length of hospice stay
- Hospices' net effect on Medicare spending does not affect our assessment of beneficiary access to care or the adequacy of Medicare hospice payment rates
  - Topic of general interest to policymakers and stakeholders

# Effect of hospice on Medicare spending: Literature findings are mixed

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- Assessing effect of hospice on spending involves methodological challenges
- MedPAC contractor (in 2015) using multiple methodologies concluded hospice did not result in net aggregate Medicare savings
  - Concluded while hospice saved for some beneficiaries (e.g., cancer patients), it did not save in aggregate due to long stays among beneficiaries with noncancer diagnoses
- Subsequently, additional studies have reported varied results. For example:
  - A working paper concluded that for-profit hospice enrollment led to large Medicare savings for some beneficiaries with dementia (Gruber et al. 2023)
  - Study sponsored by industry groups concluded hospice saved 3% in the last year of life, with savings for long stays across all diagnoses (NORC 2023)

**Sources:** Direct Research. 2015. *Spending in the last year of life and the impact of hospice on Medicare outlays* (updated August 2015). Report prepared by Direct Research for MedPAC; Gruber et al. 2023. *Dying or lying? For-profit hospices and end of life care*. NBER Working Paper No. 31035; NORC at the University of Chicago. 2023. *Value of hospice in Medicare*.



# Effect of hospice on Medicare spending: Literature findings are mixed (cont'd)

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- Mixed findings from other researchers; for example, some studies found hospice was associated with:
  - higher or no difference in Medicare spending in the last 6 or 12 months of life for beneficiaries with dementia (Zuckerman et al. 2015\*, Aldridge et al. 2023)
  - lower Medicare spending in the last 6 or 12 months of life for beneficiaries with cancer (Zuckerman et al. 2015\*, Hung et al. 2020)
  - higher Medicare spending in the last 12 months of life for hospice enrollees with dementia, heart failure, and COPD who had stays over 30 days (Hung et al. 2020)
  - higher Medicare spending in the last year of life for beneficiaries who resided in nursing facilities (Gozalo et al. 2015)

\*Zuckerman et al. reported no statistically significant difference in spending for hospice patients with stroke or heart failure that resided in the community, but hospice was associated with higher spending for those in nursing facilities.

**Note:** COPD (chronic obstructive pulmonary disease). Studies included are examples of varied findings in the literature and are not an exhaustive list

**Sources:** Zuckerman et al. 2015. *Hospice use, hospitalization, and Medicare spending at the end of life*. Journals of Gerontology: Social Sciences; Aldridge et al. 2023. *Health care costs associated with hospice use for people with dementia in the US*. Health Affairs; Hung et al. 2020. *Associations between end-of-life expenditures and hospice stay length vary by clinical condition and expenditure duration*. Value Health; Gozalo et al. 2015. *Changes in Medicare costs with the growth of hospice care in nursing homes*. New England Journal of Medicine.

# Effect of hospice on Medicare spending: Workplan

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- Contracted with the Urban Institute to study the effect of hospice on Medicare spending
  - Literature review and assessment of methodological approaches and challenges
  - New data analysis with multiple methodologies, using recent data through 2019 and including Part D spending
  - Results expected in fall of 2024

# Hospice aggregate cap: Background

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- Cap limits annual aggregate payments to a hospice provider
  - FY 2024 cap = \$33,494 x number of patients served (not wage adjusted)
- Hospices that exceed the cap have long lengths of stay and high margins
  - In 2020, we estimated 18.6% of hospices exceeded the cap. Their Medicare margin was about 23% before and 8% after return of cap overage
- Each year since March 2020, the Commission has recommended that the cap be wage adjusted and reduced by 20%
  - Would make cap more equitable across providers and focus payment reductions on providers with longest stays and high margins

**Note:** FY (fiscal year).

# Hospice aggregate cap: Workplan

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- Ongoing project:
  - MedPAC staff is examining whether the hospice cap policy affects patient outcomes
  - Looking at admission, discharge, and mortality patterns by type of patient across the cap year and across providers
- Previously, we have looked at length of stay and live discharge rates
  - Like others, we have found that hospices that exceed the cap have longer stays and higher live discharge rates
- We are currently conducting an analysis of mortality rate data
  - A paper recently reported a 2 percentage point increase in hospice patients' likelihood to die in the next year due to cap pressure (Gruber et al 2023)
  - We will report back findings from our data analysis

# Nonhospice spending for beneficiaries enrolled in hospice: Background

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- Medicare's payment to hospices is intended to cover all care for palliation of the terminal condition and related conditions
- Services for unrelated diagnoses are covered by FFS and Part D
- CMS has not generally defined related vs. unrelated services, but CMS has stated it expects "virtually all" care needed by the terminally ill individual would be provided by the hospice
- Spending on nonhospice services for hospice enrollees:
  - \$1.4B in program payments and \$200M in cost sharing in FY 2022 (CMS 2023)
  - Amount of nonhospice spending varies across hospice providers (MedPAC 2022)

**Note:** FY (fiscal year).

**Sources:** CMS. 2023. FY 2024 hospice proposed rule. Available at <https://www.govinfo.gov/content/pkg/FR-2023-04-04/pdf/2023-06769.pdf>; MedPAC. 2022. *Report to the Congress: Medicare payment policy.*

# Nonhospice spending for beneficiaries enrolled in hospice: Stakeholder interviews

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- Within the last year, a contractor and MedPAC staff conducted interviews with 12 hospice providers about factors contributing to nonhospice spending
- Topics:
  - How hospices determine whether a service is related
  - Certain conditions and/or types of services commonly considered unrelated
  - Factors that contribute to nonhospice spending for beneficiaries in hospice
  - Hospices' strategies to address service use outside the benefit
  - Experience with CMS's new "addendum" policy that gives beneficiaries the right to request a list of services that the hospice considers unrelated
  - Policies that could address the issue of spending outside the benefit

# Nonhospice spending for beneficiaries enrolled in hospice: Interview findings and next steps

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- Lack of concrete CMS guidance on related vs. unrelated services
- Variation in hospice providers' interpretation of policy and behavior
- Technological and logistical issues in some cases
  - E.g., nonhospice provider may not know a beneficiary is in hospice; easier for some nonhospice providers to bill as they normally do than to bill hospice; hospice may not know that a beneficiary seeks nonhospice care
- Little impact of new addendum: providers report few requests for it
- Next step: March report will include discussion of interview findings

# End-of-life care for beneficiaries with ESRD: Background

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- Decedents with ESRD have lower hospice use rates than other decedents
  - In 2021, 28% of Medicare decedents with ESRD used hospice compared with 47% of all Medicare decedents
- In the 2024 proposed rule, CMS reported hearing anecdotal reports that beneficiaries believe they cannot receive dialysis once they elect hospice
- CMS indicated that the hospice benefit would cover dialysis if the hospice determines that it is beneficial for a patient's symptom control
- Hospices are paid a per diem rate for all hospice services; cost of dialysis provided under hospice benefit would be responsibility of the hospice

**Note:** ESRD (End-stage renal disease)

**Source:** CMS. 2023. FY 2024 Hospice Proposed Rule available at <https://www.govinfo.gov/content/pkg/FR-2023-04-04/pdf/2023-06769.pdf>.



# End-of-life care for beneficiaries with ESRD: Workplan

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- New project to examine the issue of hospice and palliative care for beneficiaries with ESRD
  - Literature review on end-of-life care for beneficiaries with ESRD
  - Interview clinicians and providers (e.g., nephrologists and hospices) and stakeholders about beneficiaries' end-of-life care, including programs that provide kidney palliative care
  - Data analysis examining hospice use patterns among ESRD beneficiaries
  - Consider any implications for beneficiaries' access to care and Medicare payment policy

# Next steps

- March report chapter will include discussion of findings from stakeholder interviews on nonhospice spending
- Any questions on the workplan?
  - Hospices' net effect on Medicare spending
  - Hospice aggregate cap and beneficiary outcomes
  - Nonhospice spending for beneficiaries in hospice
  - End-of-life care for beneficiaries with ESRD
- Other issues related to the workplan that we should consider?



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