Regulatory Alert

March 15, 2024

TO: CHAPCA Members

FROM: CHAPCA Regulatory Team

RE: MedPAC Releases March 2024 Report to Congress

Every March 15, the Medicare Payment Advisory Commission (MedPAC) releases the MedPAC Report to the Congress, with chapters on each provider type in Medicare, including payment adequacy and analyses of other issues. The Report to the Congress was submitted to Vice President Kamala Harris as President of the Senate and The Honorable Mike Johnson, Speaker of the House.

The hospice chapter provides data on hospice utilization in Medicare, a special section on spending outside the benefit, and a recommendation to the Congress for FY 2025. Here are the main takeaways from the chapter.

1. **Growth in hospice providers:** In 2022, there was a 10% increase in the number of providers, for a total of 5,899 providers caring for Medicare beneficiaries. MedPAC also states that in 2022, "much of the growth in the number of hospice providers was concentrated in California and Texas. Between 2021 and 2022, the growth in the number of providers in California and Texas combined (about 20%) exceeded the growth in the number of hospices excluding these two states."
    a. **California:** Between 2021 and 2022, there were 342 additional hospices in California.
    b. **Texas:** Between 2021 and 2022, there were 75 additional hospices in Texas.

    MedPAC goes on to say that "the rapid entry of providers in California has led to program integrity efforts by the state. California placed a moratorium on new hospice licenses in 2022 and bolstered its state laws governing hospice referral and patient enrollment practices (California Legislature 2021)."

    MedPAC also referenced the provisional period of enhanced oversight for newly enrolled hospices in Arizona, California, Nevada, and Texas. In those four states, CMS will conduct medical review before making payments on these providers' claims. CMS has also launched a pilot project to review hospice claims following an individual's first 90 days of hospice care.

TABLE 9-1

Increase in total number of hospices driven by for-profit providers

Category	2018	2019	2020	2021	2022*	Average annual percent change 2018–2021	Percent change 2021–2022*
All hospices	4,639	4,840	5,058	5,358	5,899	4.9%	10.1%
For profit	3,234	3,436	3,691	4,008	4,414	7.4	10.1
Nonprofit	1,245	1,255	1,220	1,195	1,169	–1.4	–2.2
Government	159	148	146	143	141	–3.5	–1.4
Freestanding	3,701	3,936	4,189	4,511	4,919	6.8	9.0
Hospital based	453	429	413	396	383	–4.4	–3.3
Home health based	463	456	437	434	421	–2.1	–3.0
SNF based	22	19	19	17	17	–8.2	0.0
Urban	3,762	3,974	4,196	4,505	5,006	6.2	11.1
Rural	871	859	853	845	827	–1.0	–2.1

Note: SNF (skilled nursing facility). The providers included in this analysis submitted at least one paid hospice claim in a given year. Some categories do not sum to total because of missing data for some providers. 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). Type of hospice reflects the type of cost report filed (a hospice files a freestanding hospice cost report or the hospice is included in the cost report of a hospital, home health agency, or skilled nursing facility).
*In 2022, data on ownership status, type of hospice, and rural and urban location are missing for more providers than usual due to a temporary pause in CMS's updating of the Provider of Services file data for hospices in 2022. While the total number of hospices providing care to Medicare beneficiaries in 2022 (5,899) is not affected by this issue, the table may understate the number of hospices in any ownership, hospice type, or urban/rural subgroup in 2022.

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

2. **Growth in Patients Served:** In 2022, beneficiaries on Medicare who died comprised 49.1% of all Medicare decedents who used hospice. See Table 9-2 for additional details. MedPAC continues to reference the impact of COVID 19 on hospice utilization.

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

	Share of Medicare decedents who used hospice					
	2010	2019	2021	2022	Average annual percentage point change 2010–2021	Percentage point change 2021–2022
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. **Other data points:**
    - **Percentage of Medicare decedents who used hospice in 2022:** 1.30 million.
    - **Percentage of all Medicare beneficiaries who used hospice in 2022:** 1.72 million.
4. **Total spending (in billions):** $23.7 billion

   Length of stay:
    - 10th percentile: 2 days
    - 25th percentile: 5 days
    - 50th percentile (median): 18 days
    - 75th percentile: 84 days
    - 90th percentile: 275 days

5. **Quality of care:**

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.

6. **Special Focus Program:** MedPAC provided details on the implementation of the Hospice Special Focus Program (mandated by the Consolidated Appropriations Act, 2021) and expects to implement it in the fourth quarter of 2024. In the chapter, MedPAC confirms that CMS will identify the poorest-performing hospices based on an algorithm that reflects the following quality indicators:
    - condition-level deficiencies identified in surveys,
    - substantiated complaint allegations,
    - a claims-based measure of outlier patterns of care, and
    - performance on the hospice CAHPS survey, including the share of caregiver respondents who gave bottom ratings for
        - pain and symptom management
        - getting timely help
        - overall rating of the hospice
        - the share who would not recommend the hospice.
    - Hospices selected for the Special Focus Program will be subject to more frequent surveys, every 6 months over an 18-month period. MedPAC states that "these providers could face termination from the Medicare program if they are found to have additional serious deficiencies or complaints that meet certain criteria while being surveyed during the Special Focus Program."

7. **High rates of live discharge:** MedPAC states that in 2022, "the aggregate rate of live discharge (that is, live discharges as a share of all discharges) was 17.3%, close to the 2021 rate of 17.2%.

Reason for Live Discharge	Percentage
Beneficiary revocation	6.1%
No longer terminally ill	6.1%

In the endnotes, MedPAC calls attention to the increase in the rates of live discharge, stating "A CMS contractor found that rates of live discharge—due to beneficiary revocations and to beneficiaries no longer being terminally ill—increase as hospice providers approach or surpass the aggregate cap (Plotzke et al. 2015). The contractor's report suggested that this pattern could reflect hospice-encouraged revocations or inappropriate live discharges and thus merit further investigation."

8. **Margins:** The aggregate margin for hospice providers was 13.3%, down a small amount from the 14.2% margin in 2020. A more complete discussion of margins can be found on page 282 of the hospice chapter.
9. **Nonhospice spending for beneficiaries enrolled in hospice:** During the meetings of MedPAC commissioners in the fall and winter of 2023/2024, there was significant discussion about Medicare spending outside the hospice benefit after the beneficiary has elected hospice.

Type of Spending	2022
Total spending outside the benefit	$1.5 billion
Parts A and B	$883 million
Physician services	$472 million
Outpatient services	$150 million
Hospital inpatient services	$145 million
Cost sharing for beneficiaries	$197 million
Part D spending outside the hospice benefit	$623 million
Cost sharing for beneficiaries	$68 million

Possible policies for addressing nonhospice spending for beneficiaries in hospice:

- **A.** Administrative approaches could be considered to **clarify financial responsibility** for services and promote information flow.
- **B.** Expand the bundle of services for which hospices are responsible to **include services unrelated to the terminal condition**, with an increase to the hospice base payment rates to account for additional services.
- **C.** Nonhospice spending above a specified threshold could be **subject to a penalty** that would reduce their hospice payments by a certain amount. A penalty policy would place some financial risk on providers, but less risk than a bundled policy. Nonetheless, a penalty might help counter financial incentives for some providers to shift services from hospice to FFS Medicare or a Part D plan.

10. **Recommendation:** For fiscal year 2025, the Congress should eliminate the update to the 2024 Medicare base payment rates for hospice.