Eli's Hospice Insider

Hospice: MedPAC Fails To Face Rural Patients' Difficulties Accessing Hospice

Plus: Cap cut would hurt vulnerable patients, expert warns.

A long-term problem is finally seeing a little attention from the Medicare Payment Advisory Commission.

Reminder: In its Jan. 13 meeting, MedPAC commissioners voted to approve two hospice recommendations for 2023: 1) Congress should eliminate the update to the 2022 Medicare base rates for hospice and wage-adjust and reduce the hospice aggregate cap by 20 percent, and 2) the Department of Health and Human Services should require that hospices report telehealth services on Medicare claims.

But commissioners' discussion of the recommendations wasn't necessarily cut and dried. For one, multiple MedPAC members were critical of the Commission's official take on access to hospice services.

MedPAC's position is that due to the increase in the number of hospices (up 4.5 percent in 2020, to more than 5,000 hospices), an increased number of users (up 6.6 percent in 2020), an increased average length of stay (to 97.0 days in 2020), and the relatively high profit margin of 13.4 percent in 2019, access is fine.

Plus, "financial reports suggest the sector is viewed favorably by investors," the MedPAC presentation for its Dec. 9, 2021 meeting noted.

But "so many of our rural hospitals don't have access to hospice care," protested Commissioner **Lynn Barr** in the December meeting. "So I'm just wondering … what do we have to do to fix that?" Barr heads up Caravan Health, "which guides and supports more than 200 health facilities … in value-based payment models, such as accountable care organizations (ACOs)," according to the MedPAC website. Many of those are rural facilities.

Barr pointed to one data point as indicative of the problem. About one-third of frontier rural beneficiaries who die use hospice care, while about half of urban ones do, according to MedPAC. "I don't want to pay everybody else more, but we should somehow address it, I think," Barr said.

"Hospice is unique in that it is an elected service at the end of life and it does reflect a number of different cultural and personal and religious attitudes," pointed out MedPAC staffer **James Mathews**. "It is maybe more nuanced than to say … utilization among different populations reflect automatic disparities that need to be addressed," Mathews responded. "We have seen people who live in frontier areas … have a propensity to be independent and not rely a lot on this kind of benefit, necessarily," he suggested. "So there's a lot more to it than simply the raw utilization numbers for this benefit."

MedPAC Chair **Michael Chernew**, a health care policy professor at Harvard Medical School, discussed the Commission's guiding philosophy. "We are trying to find a balance between making sure that access is generally adequate and not overpaying, on average," he told Barr. "When we find particular areas where we think we need something … we are trying to find other mechanisms by which we can solve those problems, instead of having the entire fee schedule be pushed by the group that may be the one that you might care about the most."

Barr didn't necessarily concede, however. "The for-profit people are not going to go to these rural areas, and so there's a supply issue as well, right?" she responded. "I hope we can address it at some point. I don't think it's all cultural," she

concluded in the December meeting.

In the January meeting, MedPAC staffer **Kim Neuman** highlighted that in 2020, about 23,000 frontier beneficiaries died. Of those, 7,700 - about a third - received hospice "If frontier decedents had the same hospice use rates as urban decedents, we estimate an additional 3,600 frontier decedents would have used hospice in 2020," Neuman said.

"Many factors influence hospice use such as patient preferences, disease type and progression, and provider preferences and referrals," Neuman said. "So it's uncertain how much these types of factors versus access factors account for lower hospice use in frontier areas. In the future, we plan to continue to monitor and gather information on hospice use in frontier areas and other rural areas."

As in the December meeting, Barr wasn't ready to acquiesce. "I have concerns about hospice … that the payment rates are not adequate for home visits in rural areas," Barr said. "So I know that we have a peanut butter approach that we're going to make recommendations, and I do support the recommendations for the aggregate of hospice providers, but I do feel we have to look at the lack of access and consider that that's being caused by the fact that it is unprofitable for them to get to these remote areas, and that's why there's less access overall," Barr persisted.

Nevertheless, the commissioners approved the recs for the rate freeze and cap cut and adjustment by a unanimous vote. They also unanimously voted to urge HHS to adopt telehealth claims reporting requirements.

Expert: Geographic Wage Adjustment May Equal Discrimination

While the telehealth measure is fairly welcomed by hospices and their representatives, the freeze and cap cut recommendations are not.

The National Association for Home Care & Hospice "continues to strongly oppose rate reductions to both home health and hospice base payment rates," the trade group said after the January vote. "NAHC will continue to work with the Congress to educate them on the realities of high-quality home-based care provision, and ensure that payment policy protects access to necessary home health and hospice services in every community," it pledged.

"MedPAC continues to focus on hospices exceeding the cap without researching the underlying causes of the increase in the number of hospices exceeding the cap," criticizes consulting and accounting firm The Health Group in Morgantown, West Virginia. The Commission expects access, which is already in controversy, to remain unchanged even though the freeze and cap cut would reduce Medicare hospice spending by up to $750 million in 2023 and up to $10 billion over the next five years, the firm points out in its electronic newsletter.

"The facts clearly indicate that the cap has not kept pace with the changing underlying terminal diagnosis of terminally ill hospice patients," The Health Group maintains. "Over-cap hospices continue to increase, now at 19 percent" according to MedPAC's data. "An across-the-board reduction to the cap merely represents a simple approach to reducing total Medicare payments to hospices serving Medicare program beneficiaries," the firm criticizes.

And "while a wage-adjusted cap makes sense, the implementation of such a change becomes extremely important as rural hospices could be significantly impacted," The Health Group warns. "Any negative impact on rural hospices is in direct conflict with MedPAC's recent focus on rural hospice providers," it says.

Bottom line: "The cap for certain geographies is significantly inadequate, thereby creating a discriminatory payment limitation for certain providers," The Health Group contends.

Stay tuned for MedPAC's March report to Congress, which will include the approved recommendations and more supporting data.