Oppose Additional Reductions To The Hospice Aggregate Cap

HOSPICE IS A UNIQUE HEALTH CARE SUCCESS STORY

Access to the Medicare Hospice Benefit (MHB) is one of the greatest successes of the American health care system. By serving more people, with more diverse diagnoses, and in communities across the entire country, scaling the MHB has meant that the most vulnerable beneficiaries have greater access to person-and family-centered, holistic care that can help alleviate the suffering and stress of a serious terminal illness.

Hospice saves families and the health care system money. Recent academic research has demonstrated that *"hospice is associated with lower total health care expenditures across all payers [including Medicare] and families, primarily owing to lower spending for inpatient care"*.[1]

The hospice patient population has changed significantly over time. The majority of patients today have a non-cancer illness (many with advanced neurological disorders). These conditions have more unpredictable courses, which makes it much more challenging to accurately predict the exact six-month prognosis that the MHB requires.

THE HOSPICE AGGREGATE CAP

- The hospice aggregate "cap" is an annual limit on the total aggregate payment that any individual hospice can receive in a year. If hospices exceed the cap amount set by CMS, they must repay the excess to the Medicare program. For FY2022 the aggregate cap value is $31,297.61.
- The cap is set at a single dollar value nationwide (it is not wage adjusted to reflect local wage values), has always been a component of the MHB, and it has always served as a cost containment mechanism unique to hospice.

Medpac Recommendation To Cut Cap By 20%

- In early 2020, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress wage-adjust and cut the cap value by 20%, which would cause many more hospices to exceed the cap.
- MedPAC provided no analysis supporting the appropriateness of the cap cut except that it would change financial incentives and potentially reduce long patient stays on the MHB.

Cutting The Cap By 20% Will Make It Harder For Some Of The Most Vulnerable Patients To Get Hospice

While the recommendation is an attempt by MedPAC to address outlier hospice program utilization, this **overly blunt proposal is problematic for a number of reasons, including:**

- **Patient access to care could be significantly reduced:** a 20% cap cut would create disincentives to serve patients that have a more unpredictable disease trajectory[2], such as those with dementia and organ failure, thereby disenfranchising entire categories of patients' access to the hospice benefit.
- **It could further exacerbate health disparities in hospice access and utilization:** The individuals most likely to have their access to hospice impacted by the cap reduction (those with dementia and other neurological diagnoses) are also more likely to be from medically underserved communities that already have lower rates of hospice utilization.[3]
- **It may result in increased overall spending by Medicare:** Any proposal that could limit hospice use, such as the cap reduction, may result in increased overall spending for Medicare, as patients who might have been served by cost-saving hospice instead utilize more expensive and aggressive care such as hospital, ER, and skilled nursing facility services. Recent research has shown that hospice use by Medicare beneficiaries is associated with significantly lower total health care costs across all payers, including Medicare.[1]

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CONGRESS HAS ALREADY TAKEN ACTION TO REDUCE THE CAP

- In the *Improving Medicare Post-Acute Care Transformation Act of 2014* (IMPACT Act), Congress changed the methodology for how the aggregate cap is calculated each year.[4] Whereas prior to 2016, the cap amount was updated annually by a measure of inflation in overall medical costs, **the IMPACT Act mandated that, for the years 2016-2025, the cap instead be updated by the annual payment update percentage (APU) for hospices,** which is based on a separate measure of hospital market basket costs. In the *Consolidated Appropriations Act of 2021*, Congress extended through 2030 this requirement to use the APU methodology for the hospice cap,[5] and again extended it through 2031 in the *Consolidated Appropriations Act of 2022*.
- This **methodology change has already reduced the hospice cap and produced savings.** In 2014, the Congressional Budget Office's (CBO) IMPACT Act analysis found that the change would ***"reduce direct spending by… reducing the caps on payments for beneficiaries receiving hospice services."*** [6] In its estimate of the impact of the Consolidated Appropriations Act of 2022, CBO estimated that extending the APU cap methodology from 2030 to 2031 would produce **savings of $594 million for that single year**.[7]

  Additionally, it appears that **the change is already contributing to an increase in the number of hospices exceeding the cap.** MedPAC estimates that the percent of hospices exceeding the cap increased from 12.3% in 2015 (pre-IMPACT Act implementation) to 19% in 2019 (3 years post-IMPACT Act implementation)[8]
- Based on analysis that assumes average APU updates and average inflationary growth, NAHC estimates that the IMPACT Act cap methodology change alone will have reduced the cap by nearly 20% by 2031 (See "Medicare Hospice Benefit - Aggregate Cap Amount") compared to what it would have been without the methodology change.

WHAT CONGRESS SHOULD DO

- Reject MedPAC's recommended cap cut of 20% and seek a more thorough analysis of an appropriate amount for the hospice cap that includes consideration of variation in patient mix.
- Work with CMS to develop targeted policy solutions designed to address program integrity concerns in hospice focused on genuine fraud and abuse of the MHB.

[1] *Association Between Hospice Enrollment and Total Health Care Costs for Insurers and Families, 2002-2018.* (Feb 2022). https://jamanetwork.com/journals/jama-health-forum/fullarticle/2788935?resultClick=1

[2] Dobson DaVanzo & Associates Report: *Summary of Findings: Analysis of the Impact of Medicare Patient and Hospice Characteristics on the Aggregate Cap* (2021).

[3] *Racial and Ethnic Differences in Hospice Use and Hospitalizations at End-of-Life Among Medicare Beneficiaries with Dementia* (June 2022). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793176?resultClick=1

[4] *The Improving Medicare Post-Acute Care Transformation Act of 2014* (P.L. 113-185). Section 3(d): https://www.congress.gov/113/plaws/publ185/PLAW-113publ185.pdf#page=19

[5] *The Consolidated Appropriations Act, 2021* (P.L. 116-260). Section 404: https://www.govinfo.gov/content/pkg/BILLS-116hr133enr/pdf/BILLS-116hr133enr.pdf#page=1821

[6] CBO Estimate of the Statutory Pay-As-You-Go Effects for H.R. 4994, the IMPACT Act of 2014: https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/costestimate/hr4994pm00.pdf

[7] CBO Estimate for H.R. 2471, the Consolidated Appropriations Act, 2022, as Cleared by the Congress on March 10, 2022: https://www.cbo.gov/system/files/2022-03/HR2471_As_Cleared_by_the_Congress.pdf#page=4

[8] MedPAC March 2022 Report to the Congress, Chapter 11: https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch11_SEC.pdf#page=22

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