Background

What is the hospice aggregate cap? The aggregate cap was designed to put a ceiling on Medicare expenditures for hospice services for all Medicare patients served over the course of a year. The cap was originally set and implemented based on 40% of the cost of care for a cancer patient in the last six months of life, and it remains calculated based on this original cancer-focused amount. However, as awareness of the benefits of hospice for people with many different kinds of serious illness has grown, hospice providers now care for patients with a variety of non-cancer diagnoses with differing lengths of stay. Today, while there are patients that are on service for longer than 6 months as a result of the unpredictability of their decline, the vast majority of hospice patients have an average length of stay of 180 days or less, and a full 75% of stays are under 87 days[1].

Hospice cap cut: In recent years, some stakeholders have suggested reducing the aggregate cap across-the-board as a way to slow spending and address program integrity. This is a complex policy issue that has had no hearings or congressional review. As an untargeted pay for it will have negative unintended consequences impacting vulnerable populations.

Cutting the Hospice Aggregate Cap Would Have Significant Impact on Hospice Patients, Families, and Caregivers

Reducing the hospice cap will:

- **Limit hospice access and delay care for many appropriate and eligible patients, particularly those with neurological conditions and other non-cancer diagnoses:** Any patient with an illness that has a more unpredictable trajectory and is therefore harder to predict with total certainty when they will die could result in a hospice provider's hesitancy to enroll them in their program – not because they do not want to provide these patients care, but because they would have legitimate fears that the costs of caring for these patients would exceed the cap, which would require repayments to CMS that make it harder to stay in business and continue serving their community. Additionally, patients and providers in rural areas would be disproportionately impacted by a cap cut, further exacerbating the pre-existing access issues in these geographies.

- **Exacerbate health disparities in hospice access and utilization**: Hospices concerned about their cap status may admit fewer or refuse to admit patients with diagnoses that tend to result in longer lengths of stay, especially those with Alzheimer's Disease and related dementias (ADRD). These patients are more likely to be from medically underserved communities who already have lower rates of hospice utilization and poorer end-of-life care outcomes.

- **Reduce overall hospice utilization:** Imposition of a cap cut will not improve quality control or contribute to better patient care, nor will it contribute to better hospice eligibility determinations. However, a blunt reduction in the cap would stall years of progress that have seen a growing number of people appropriately served by this compassionate care. A recent paper analyzing a MedPAC recommendation to cut the cap by 20% found that "*Relative to hospices which would remain below the proposed reduced cap, hospices which would be affected by the policy change tend to have higher portions of care-days for older, minority patients, those receiving care at home, those with chronic and neurological conditions, and those discharged alive*."[2]

- **Increase overall Medicare spending:** Any policy proposal that could limit hospice use may result in increased overall Medicare spending, as patients who would otherwise have been served by cost-saving hospice instead will 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.[3]

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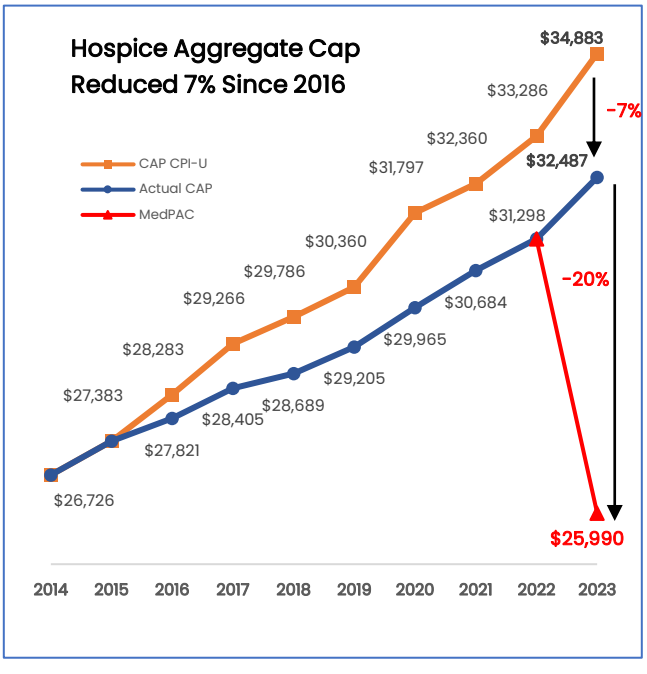
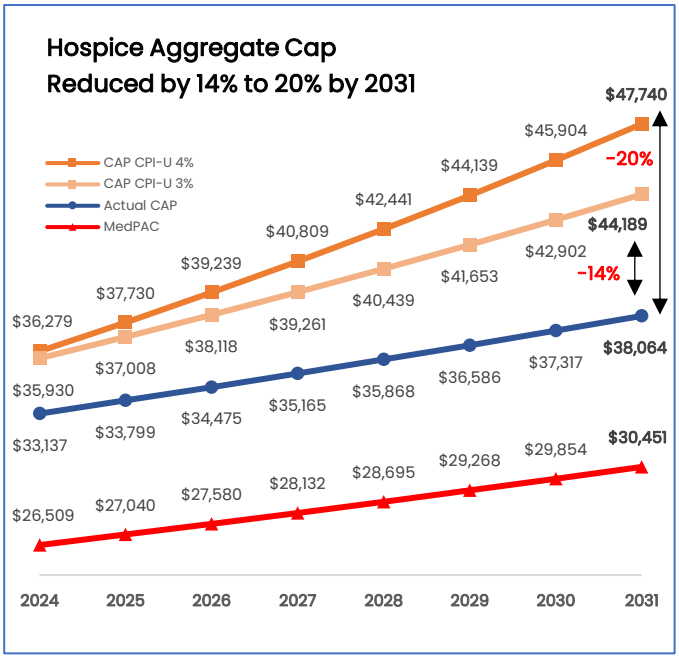
[1] MedPAC March 2022 Report to the Congress, Chapter 11: https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch11_SEC.pdf
[2] Dobson DaVanzo & Associates Report: *Summary of Findings: Analysis of the Impact of Medicare Patient and Hospice Characteristics on the Aggregate Cap* (2021).
[3] *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

Congress has Already Taken Action to Reduce Hospice Spending Through Policy That Lowers the Aggregate Cap.

Change in the calculation of the cap amount: Beginning in 2016, as a part of the IMPACT Act, Congress changed the cap update factor to the hospice annual payment update percentage (APU) instead of the annual measure of medical care inflation (CPI-U). This calculation has slowed the growth in the hospice cap and has threatened access to hospice[4]. The **hospice cap has already been reduced by 7% since 2016** as a result of this change and is projected to be **reduced by 20% in 2031, generating major savings for Congress** *(CBO has estimated that a single year extension of the APU cap methodology produced savings of $594 million*).[5]

An additional 20% cut to the cap would further reduce the cap by as much as 16% by 2031





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 illness.

- **Only about half of the people with Medicare who die each year access any hospice at all**, and far too many patients are on hospice for *extremely short* periods of time[6]. We should be working on solutions to increase the percentage of beneficiaries who receive hospice and ensure that the care they receive is of the highest quality possible.

  The increase in the overall rate of people using hospice AND the increase in average length of stay (LOS) is in large part due to the fact that **many more eligible individuals with non-cancer terminal diagnoses are being appropriately served**. In 2020, 76% of hospice patients had a non-cancer diagnosis compared to 48% in 2000. These patients, many of whom have organ failure or dementia/other neurological illnesses, have more unpredictable disease courses, which often means it is **harder to accurately predict when they will die**. This does not mean that these patients are automatically ineligible for Medicare hospice coverage. CMS and Congress have both repeatedly acknowledged the challenges of predicting when death will occur for hospice patients[7], and have taken policy actions that identify **the physician as the trusted source** for this difficult eligibility prognosis[8].

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[4] *Evaluation of Federal Policy Changes to the Hospice Benefit and Use of Hospice for Persons with ADRD* (May 2022): https://jamanetwork.com/journals/jama-health-forum/fullarticle/2791963

[5] 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

[6] CMS hospice data: https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/medicare-hospice

[7] CMS, *Hospice Care Enhances Dignity And Peace As Life Nears Its End*, CMS Pub. 60AB, Transmittal AB03-040: https://bit.ly/2DB9JtY

[8] *Consolidated Appropriations Act, 2001* (P.L. 106-645). Section 322: https://www.congress.gov/106/plaws/publ554/PLAW-106publ554.pdf#page=503