Hospice Workgroup Meeting 3

Hospice Workgroup Need Methodology

Meeting Notes: 08/04/2025

Meeting Introduction and Roll Call Jeanne-Marie Gawel welcomed attendees and conducted a roll call and welcomed everyone to the 3rd hospice workgroup meeting (00:00:00). She reminded participants that meeting materials are posted on the website a week in advance and set ground rules, including muting phones when not speaking, introducing oneself before speaking, and avoiding substantive comments in the chat (00:05:35). She also stated that the meeting was being recorded and transcribed using Gemini AI (00:07:07).

Purpose of Need Methodology for Hospice Services Vishal Mundlye outlined the purpose of the need methodology for hospice services, which is to support the Certificate of Need program by examining current utilization patterns and forecasting future utilization and capacity (00:07:07). This methodology helps regulate the supply of hospice services and requires continuous monitoring of trends due to factors like population demographics and care settings. He explained that the session would cover the basic building blocks and nuances of the methodology, quantitative and qualitative challenges, MHCC's suggestions, and open discussion for ideas (00:08:29).

Data Sources and Need Projection Workflow Vishal Mundlye detailed the three-step workflow of the need methodology, which begins with data collection from various sources, including hospice mortality data from MHCC's annual survey, population mortality and projections from the Department of Planning, and national hospice use rates from the Medicare Payment Advisory Council report (00:08:29). Step two involves applying arithmetic functions and considerations, such as the volume threshold, to the data. The final step leads to the need projection and determination of target capacity for the next five years, with need defined by hospice mortality (00:09:57).

Hospice Need Methodology Finer Aspects Vishal Mundlye explained that need projections are organized by jurisdictions, dividing Maryland's 23 counties and Baltimore City into five planning regions. He clarified that the hospice utilization rate is defined as the total number of deaths in hospice divided by total Medicare deaths within a jurisdiction (00:11:08). The projections are for age groups 35 and older, a change implemented in 2013 due to low hospice patient percentages under 35, and the forecast model shifted from a fixed to a median volume threshold, which adapts annually with utilization (00:12:36).

Volume Threshold and Need Recognition Vishal Mundlye provided an example of need projections from 2019, based on 2014 data, to illustrate how the volume threshold operates (00:13:55). He explained that even if a net need is identified, it is only recognized if it crosses the median volume threshold, derived from the median of hospice deaths (00:15:49). For instance, Allegany County showed a net need, but it was not recognized as it did not exceed the threshold, whereas Baltimore City and Prince George's County did (00:13:55).

Discussion on Age Group for Projections Carlos Graveran questioned the use of the 35 and older age group for projections, noting that other states use Medicare data for 65 and older and that younger patients rarely pursue hospice care until late stages (00:15:49). Vishal Mundlye acknowledged that other states vary, with some using all ages and others 35 and plus and stated that they plan to model the impact of different age groups (00:17:13). Cordt Kassner agreed that it would be valuable to model all deaths versus 35 plus versus 65 plus to assess the impact on net need and potential county openings for additional hospices (00:18:34).

Impact of COVID-19 on Data and Historical Data Concerns Monica Escalante raised concerns about adjusting data for the drastic spike with COVID-19, which Vishal Mundlye assured would be addressed in upcoming slides (00:11:08). Cordt Kassner also expressed concern that using 2010-2014 data for 2019 projections felt dated and highlighted that incorporating COVID-19 impacted years (2019-2022) into the methodology would significantly alter the numbers. Vishal Mundlye confirmed this was a valid concern and they had thoughts on correcting it (00:21:10).

Quantitative Challenges in Existing Methodology Vishal Mundlye outlined quantitative challenges, including the methodology's failure to incorporate current year capacity, leading to projections for the current plus four years. He noted that the methodology does not consider staffing levels, team-based care, or length of stay, which are crucial for high-touch healthcare delivery, nor does it account for migration patterns. Furthermore, there is a problem of underestimation of target capacity and gross need, as actual deaths in 2019 exceeded projected capacity in 11 jurisdictions and projected gross need in 16 jurisdictions (00:22:47) (00:29:11).

Discussion on Capacity and Staffing Flexibility Carlos Graveran provided operational insight, explaining that hospice capacity is highly flexible and adjusted day-to-day based on need, rather than staffing up in anticipation of future demand (00:24:09). He emphasized that financially, hospices cannot sustain significant excess capacity, contrasting it with the fixed infrastructure of hospitals, and warned that using capacity as a primary variable for determining need would lead to inaccurate assumptions (00:25:39). Vishal Mundlye acknowledged this feedback as valuable and noted that he is in the preliminary stages of modeling these aspects (00:26:49).

Maryland's Hospice Utilization Rate Cathy Hamel asked about the assumed utilization rate, noting Maryland's historical struggle with low hospice utilization due to factors like

academic beds and research potential, questioning if this was factored into the model (00:26:49). Vishal Mundlye confirmed that recent MedPAC findings suggest the number of hospices does not directly impact access, aligning with their understanding (00:27:56). Cordt Kassner provided more recent data, indicating that Maryland's hospice utilization rate was 47.7% in 2024, ranking 37th nationally, while the national average was 50.6% (00:40:56). Peggy Shimoda added that Maryland has shown a consistent and faster increase in utilization compared to many states (00:42:14).

Inconsistencies in Data Definition Monica Escalante raised a concern about the inconsistency in data definitions, where hospice utilization is defined as total deaths in hospice as a percentage of Medicare deaths, yet other projections use data for those 35 and older. She suggested that using 65 plus across the board for consistency would be cleaner. Vishal Mundlye acknowledged observing these inconsistencies, including mathematical ones, and stated that they plan to resolve them (00:31:46).

Qualitative Challenges in Existing Methodology Vishal Mundlye detailed qualitative challenges, including the overdue review of the state health plan and methodology, which should occur every five and three years, respectively. The existing methodology does not account for provider performance, quality indicators, special needs populations (racial, ethnic, urban/rural, children), patient choice, or market concentration. However, the commission indirectly addresses special populations through health equity and character competence clauses in Certificate of Need guidance (00:33:11). Cordt Kassner highlighted the importance of quality indicators, noting their emphasis from Medicare and a recent white paper on hospice and palliative medicine, suggesting Maryland could set a precedent by integrating them into the methodology (00:34:42).

MHCC's Ideas for Future Methodology Improvements Vishal Mundlye presented MHCC's ideas for the future state of the methodology, emphasizing patient choice, quality, and measurable outcomes. He proposed exploring the incorporation of meaningful process and outcome measures, such as the hospice care index, and developing mechanisms to quantify special needs populations, potentially through a weightage factor for underutilization (00:36:24). Other ideas include lowering or eliminating age group restrictions, incorporating social vulnerability or area deprivation index data to analyze the interplay of demographics with hospice utilization, and including staffing fluctuations and average annual growth rate to account for variability. He also suggested incorporating length of stay as a meaningful metric (00:37:53).

Discussion on Impact of Certificate of Need Openings Carlos Graveran revisited Peggy Shimoda's earlier question about the impact of opening the Certificate of Need in Baltimore City and Prince George's County, stating he was unaware of data directly showing that additional hospices significantly impact utilization (00:43:24). Stacy Howes reported that utilization did increase in Prince George's County (24% to 32-33%) and Baltimore City (27% to 42.9%) from 2020 to 2022 but did not have data on whether this was due to new hospices or existing ones (00:49:00). Carlos Graveran suggested comparing this to overall state

increases and integrating hospice earlier into hospital care mixes to increase utilization (00:45:52).

Quantifying Special Populations and Medicaid Utilization Cordt Kassner asked for more detail on quantifying special populations and needs, noting variations in hospice use rates based on race, socioeconomic status, and urban/rural factors (00:45:52). Monica Escalante suggested that tracking Medicaid funds utilization in hospice care would be beneficial for providers.

Hospice Data Platforms and Medicaid Utilization Monica Escalante inquired about hospice data platforms, and Cordt Kassner suggested Health Pits, Trella, and Hospice Analytics as primary options that use Medicare claims to analyze hospice impact. Peggy Shimoda recommended examining the Medicaid hospice utilization rate, noting it was around 2% previously, which is among the lowest in the country and an area for potential improvement, especially for underserved communities (00:59:57). Vishal Mundlye affirmed that he has begun exploring this for a future discussion with Medicaid, confirming that their initial findings indicated a 2.5% utilization rate compared to a national average closer to 5% (01:01:29).

Medicaid Omission and Age Demographics in Hospice Care Cathy Hamel proposed running a scenario to assess the impact of omitting Medicaid from benefits on need and its distribution in high-need areas like Baltimore City and County (01:01:29). Becky Miller supported looking into Medicaid utilization, but also suggested coupling it with age considerations, as younger individuals often use Medicaid, and older users are typically in skilled nursing facilities, which adds complications like room and board pass-throughs that deter hospice use (01:03:42). Becky Miller further questioned the methodology's current use of an age 35 and above baseline, and a potential shift to age 25, when a significant population choosing hospice is 65 plus (01:04:44).

Hospice Death Data and Patient Residency Saqra McKay asked whether the hospice death numbers include out-of-state residents who passed away in Maryland, noting that their facility observed this trend. Vishal Mundlye clarified that the death data in surveys is recorded based on the patient's county of residence, and the current methodology does not specifically track migration (01:02:25). They mentioned the need to implement checks and balances for this in the future (01:03:42).

Action Items

Suggestions for the commission from the Workgroup:

1. Run a modeling on the need methodology outcomes per the current age criteria and compare results with:
    a. Elimination of age restriction
    b. 65 and above age
    c. Inspect other states and their age criteria
    d. Check national benchmark using MedPAC
2. Run a modeling on the Need Methodology outcomes per the current Compound Annual Growth Rate (CAGR) criteria and compare with Average Annual Growth Rate (AAGR) criteria to capture annual fluctuations in utilization owing to events such as COVID-19, etc.
3. Members pointed out that there is an inconsistency between the Commission's definition of Hospice use and actual Hospice Use Rate calculation. Hospice use rate as defined by the Commission is Total Medicare Hospice deaths as a percent of Total Medicare Deaths within a given jurisdiction; however the survey data considers 'deaths across all payer sources' as the Numerator for Hospice use rate. The workgroup tasked the commission with clarification of the definition as well as exploration of utilization data by payers such as Medicare, Medicaid and others to calculate the utilization.
4. With need projections for 2019 recognizing a positive need in Baltimore City and Prince Georges County, the workgroup would like the commission to analyze impact of opening the Certificate of Need on utilization patterns across both the counties from 2019 and beyond broken down by Age, Gender, Race and Ethnicity, length of stay, jurisdictions, facility, payers as well as Revenues and Expenses.
5. Members of the workgroup support the integration of quality measures into the need methodology. The commission will brainstorm over the exact structure, process and outcomes measures that make sense for the Hospice industry including providers, patients and overall care delivery. The commission would model different scenarios to integrate quality measurement within the need methodology framework.
6. Members of the workgroup support exploration of a mechanism to quantify for special needs populations including aspects such as race, socioeconomic status, and urban/rural factors within the need methodology. The commission would model different scenarios to integrate special need quantification within the need methodology framework.
7. Members of the workgroup support exploration of a mechanism to quantify the integration of population migration (in-state, intra-jurisdictional and out of state) within the need methodology. The commission would model different scenarios to integrate population migration within the need methodology framework.

8. Members of the workgroup affirmed their trust in the data sources used within the existing methodology; however they also suggested exploring other longitudinal data sources including claims and third party sources such as 'Health Pivots', 'Trella Health' and others.

Considerations:

1. Members of the workgroup pointed out month over month staffing and capacity fluctuations leading to annual fluctuations. They were concerned that use of staffing and capacity as a variable in need methodology might give false or misleading outcomes. The commission would review and inspect considerations from other states as well national guidance if any around using these variables in Hospice need calculation
2. Members of the workgroup realize that increasing utilization and designing a robust need approximation mechanism remain the primary objectives behind the updating of the need methodology; however they also urged the Commission to look for ways to integrate Hospice Care in Hospital settings early on.
3. While the workgroup members acknowledged that MD Hospice had a shorter length of stay (LOS) they also voiced their concerns about a shorter LOS of less than 6 days being clinically complex and hence labor intensive.
4. Members of the workgroup suggested exploration of factors such as academic medical center beds and research programs and their effects if any on Hospice utilization as part of the Need Methodology.