MEDPAC Medicare Payment Advisory Commission

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June 2, 2017

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: File code CMS-1675-P

Dear Ms. Verma:

The Medicare Payment Advisory Commission welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services proposed rule entitled, "Medicare Program; FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Report Requirements," *Federal Register*, Vol. 82, No. 84, p. 20750 (May 3, 2017). We appreciate your staff's ongoing efforts to administer and improve the payment system for hospice, particularly given the many competing demands on the agency staff's resources.

We address the following proposals or issue discussed in the proposed rule:

- proposed payment update,
- accounting for social risk factors in quality metrics, and
- hospice quality measurement and related initiatives.

Proposed fiscal year (FY) 2018 hospice payment update

CMS has proposed a payment update of 1.0 percent for hospice services for FY 2018. This proposal is in accordance with the Medicare Access and CHIP Reauthorization Act of 2015, which specified a hospice update of 1.0 percent in FY 2018.

Comment
We recognize that CMS is required by statute to propose an update of this amount. However, we note that MedPAC recommended that the Congress eliminate the hospice payment update for FY 2018. In our March 2017 report to the Congress, we concluded that indicators of payment adequacy for hospice providers are generally positive. In 2015, the number of hospices increased about 2.6 percent because of continued entry of for-profit providers. The number of beneficiaries enrolled in hospice increased about 4 percent. Average length of stay declined slightly because of a

decrease in length of stay for patients with the longest stays. Access to capital appeared adequate. The aggregate Medicare margin was 8.2 percent in 2014 and we projected a 2017 aggregate Medicare margin of 7.7 percent. Based on our assessment of these payment adequacy indicators, we concluded that hospices should be able to accommodate cost changes in 2018 without an update to the 2017 base payment rate.

Accounting for social risk factors in quality metrics

CMS has been reviewing reports prepared by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine on the issue of accounting for social risk factors in CMS's value-based purchasing and quality reporting programs, and considering options on how to address the issue in these programs. CMS has also been monitoring and awaiting results from the National Quality Forum's (NQF) 2-year trial period in which quality measures seeking endorsement are assessed to determine whether risk adjustment for selected social risk factors is appropriate. At the end of the trial, NQF will issue recommendations on the future inclusion of social risk factors in risk adjustment for these quality measures. As CMS continues to consider the analyses from these reports and await the results of the NQF trial on risk adjustment for quality measures, the agency seeks public comment on whether and how to incorporate social risk factors in Medicare programs, including the Hospice Quality Reporting Program.

Comment
In December 2016, ASPE released the "Social Risk Factors and Performance Under Medicare's Value-based Purchasing Programs" report to the Congress mandated by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. The report provides empirical analysis of the effects of six social risk factors (i.e., dual eligibility, residence in low-income areas, Black race, Hispanic ethnicity, rural residence, disability) on the nine Medicare quality payment programs (not including hospice). The report included two main findings:

1. Beneficiaries with social risk factors had worse outcomes on quality measures, regardless of the providers they saw, and dual eligibility status was the most powerful predictor of poor outcomes.
2. Providers that disproportionately served beneficiaries with social risk factors tended to have worse performance on quality measures, even after accounting for their beneficiary mix.

ASPE found that clinical risk factors (age, gender, medical comorbidities) had a substantial effect on quality measure results. They also found that dual eligibility status is independently associated with worse outcomes, and dually enrolled beneficiaries are more likely to see lower-quality providers. However, providers serving a high proportion of beneficiaries with social risk factors tended to perform worse in part due to the patient population, and in part due to the provider's poor performance overall.

ASPE simulated the effect of three different potential policy solutions to account for social risk factors in each of the Medicare programs.

- Adjust quality and resource use measures
- Stratify providers into groups by proportion at-risk
- Create separate payment adjustments

MedPAC has generally supported the second solution of using peer grouping or stratification.[1] This approach is straightforward to implement, since no additional measure-level research is needed (i.e., working with measure developers to run new risk-adjustment models). The stratification approach also does not minimize incentives to improve for providers with high shares of beneficiaries with social risk factors, and does not "mask" provider performance. Instead, providers would compare their unmasked performance (the rate would still have been adjusted for differences in patient age, sex and comorbidities) with providers with similar risk factors.

Hospice quality measurement and reporting initiatives

Although CMS did not make a proposal, the agency indicated it is continuing to work on developing a patient assessment instrument for hospice. CMS also noted that the agency continues to explore the development of quality measures in two areas: potentially avoidable hospice care transitions and access to the different levels of hospice care.

Comment
As we have stated previously, we support efforts to develop a patient assessment instrument for hospice. We believe a patient assessment instrument would offer the opportunity to gather more detailed clinical information on hospice patients (e.g., patients' symptom burden), which could facilitate the development of more meaningful quality measures and could also be helpful for payment policy purposes. In using elements of a patient assessment instrument to calibrate payments, Medicare would need to ensure that such elements were not unduly subject to provider manipulation.

We also support efforts to develop measures of potentially avoidable hospice care transitions and access to all levels of hospice care. MedPAC has raised concern about hospice providers with substantially higher live discharge rates than their peers. An unusually high rate of live discharge could signal a problem with quality of care (e.g., that a hospice provider is not meeting the needs of patients and families) or program integrity (e.g., that a provider is admitting patients who do not meet the eligibility criteria). We believe that a measure of potentially avoidable hospice transitions that includes live discharges would be valuable. In addition, the Commission has raised concern about some hospice providers not providing patients with access to all levels of hospice care. The hospice Conditions of Participation require that hospice providers have the capacity to provide all four levels of hospice care. MedPAC has urged CMS to investigate providers that have a history of not providing all levels of care. In addition, it may be useful to beneficiaries and their

[1] Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC.

families when choosing a hospice to know if the provider has a history of not furnishing a particular level of care.

MedPAC appreciates the opportunity to comment on this proposed rule. The Commission also values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, MedPAC's Executive Director at (202) 220-3700.

Sincerely,

Francis J. Crosson, M.D.
Chairman

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