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Glenn M. Hackbarth, J.D., Chairman
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June 25, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: File code CMS-1609-P

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) hospice proposed rule for fiscal year 2015, published in the Federal Register on May 8, 2014. We appreciate your staff's efforts to improve Medicare's hospice payment system, especially considering the competing demands on the agency and the limited resources.

Our comments focus on five areas:

- 1. Payment system reform.** We are disappointed that CMS did not take action to revise the hospice payment system for fiscal year 2015. We believe that there is ample evidence that the current payment system is misaligned with hospices' costs and that an initial step to revise the hospice payment system should occur in 2015.
- 2. Program integrity.** We are very supportive of CMS' efforts to identify aberrant care or utilization patterns among hospice providers and urge CMS to use its data on individual providers to target program integrity scrutiny where it is most warranted.
- 3. Hospice and Part D.** With respect to coordination of drug coverage between hospices and Part D plans, we agree that mechanisms such as prior authorization or other procedures should be in place to ensure that the appropriate party – either the hospice or the Part D plan - pays for needed drugs for hospice enrollees. However, we are concerned that the current prior authorization process established through subregulatory guidance is administratively burdensome for hospice beneficiaries and families and does not ensure that hospice beneficiaries maintain timely access to needed drugs. We urge CMS to suspend the current Part D prior authorization process for hospice enrollees and issue a

regulatory proposal to establish an improved prior authorization process consistent with our comments as soon as possible.

4. **Filing timeframes for notices of election and termination/revocation.** With respect to CMS' proposals related to timeframes for filing notices of election and notices of termination/revocation, we are supportive of these proposals.
5. **Hospice aggregate cap.** We are concerned that CMS' proposal for hospices to file a self-determined cap calculation and remit overpayments within 150 days of the close of the cap year as currently structured would not achieve CMS' stated goal of better safeguarding the Medicare trust fund. We offer suggestions for an alternative approach to achieve that end.

Hospice payment system reform

In the proposed rule, CMS did not make any proposals to revise the hospice payment system or discuss payment models it may be considering for the future.

We are disappointed that CMS has declined to use the authority granted under the Patient Protection and Affordable Care Act of 2010 (PPACA) to make revisions to the hospice payment system in 2015. We believe that there is currently ample evidence that the payment system is misaligned with hospices' costs and that an initial step to revise the payment system is possible with existing data. In March 2009, the Commission recommended that the hospice payment system be revised to better match hospices service patterns throughout an episode (i.e., moving from a flat per diem payment to one where the payment is higher at the beginning and end of the episode (in the last days of life) and lower in the middle) (MedPAC 2009).¹ Analyses of Medicare claims data by both MedPAC and CMS' contractor, Abt Associates, demonstrate that hospice visits are generally more frequent at the beginning and end of a hospice episode, and less frequent in the middle (MedPAC 2013, Plotzke et al. 2012).^{2,3} In addition, our June 2013 Report to Congress provided an illustrative example of a revised hospice payment system to demonstrate that payment changes are possible now using existing data.

For a number of reasons, it is important that CMS take an initial step to revise the hospice payment system as soon as possible. Improving payment accuracy is important given the substantial amount of Medicare hospice spending devoted to long-stay patients, who are more profitable than other patients under the current payment system. In 2012, Medicare spent nearly \$9 billion, more than half of all hospice spending that year, on patients with stays exceeding 180 days. Reforming the

¹ Medicare Payment Advisory Commission. 2009. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC.

² Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC.

³Plotzke, M., B. Morefield, T.J. Christian, et al. 2012. *Medicare Hospice Payment Reform: Hospice Study Technical Report*. Prepared under contract to the Centers for Medicare & Medicaid Services. Cambridge, MA: Abt Associates, Inc.

payment system as the Commission has recommended would also address concerns about payment for very short stays, which may currently be reimbursed at levels below their cost (due to the high visit intensity of these stays and the fewer days over which to spread fixed costs). Modifying the payment system would help make payments more equitable across providers, decreasing payments to providers who have disproportionately long stays and high margins and increasing payments to providers who have shorter stays and lower margins. Improving the hospice payment system is also important from a program integrity perspective. Financial incentives under the current payment system may have spurred some providers to pursue business models that enroll patients likely to have long stays who may not meet the hospice eligibility criteria.

Program integrity

In the proposed rule, CMS identified several program integrity issues related to hospice care as a precursor to potentially revising the payment system in the future. Program integrity issues identified include: (1) some providers with high rates of not providing skilled visits in the last days of life, (2) some providers not providing general inpatient care or continuous home care, (3) some providers with high rates of live discharges, and (4) concerns about Medicare expenditures on non-hospice services for beneficiaries enrolled in hospice.

In terms of program integrity, we are very supportive of efforts to identify aberrant care or utilization patterns among providers. We urge CMS to use the data on individual providers discussed in the proposed rule to target program integrity scrutiny toward those providers where it is most warranted.

We share CMS' concern about the program integrity issues identified in the proposed rule. The data on the lack of skilled visits in the last days of life for some beneficiaries, and the variation in this across providers, is troubling. This type of data could be valuable to beneficiaries and families as they choose a hospice provider and we urge CMS to consider including this type of data for individual hospice providers in its quality reporting or transparency initiatives. We also intend to give some thought to whether the absence of skilled visits in the last days of life might be a useful measure for a value-based purchasing payment adjustment. We share CMS' concern that some providers may not have the capacity to provide all the levels of hospice care (e.g., general inpatient care, continuous home care, and inpatient respite care), as required by the conditions of participation. We support efforts to investigate this through the survey and certification process and any other means available. If these efforts need to be prioritized, we suggest they focus first on the largest providers who furnish no general inpatient care or no continuous home care to any patient (since it seems unlikely that a large patient population would include no patients who need these levels of care). We also believe that the high rates of live discharges and non-hospice spending for patients of certain hospices warrants further scrutiny in program integrity efforts. In addition to the program integrity issues identified in the rule, we believe hospice length of stay should be a continued focus of program integrity efforts. As we recommended in March 2009, we

believe providers with unusually long stays compared to their peers should be subject to focused medical review.

Hospice and Part D

For beneficiaries enrolled in hospice, drugs related to the terminal condition and related conditions are covered through the hospice benefit and drugs that are unrelated to these conditions are covered by Medicare Part D. Effective May 1, 2014, CMS required Part D plans to put all drugs on prior authorization for their members who are enrolled in hospice in an effort to ensure that the appropriate party is paying for drugs for hospice enrollees. In the proposed rule, CMS expressed concern that hospice services are possibly being unbundled, pointing out that gross drug costs under Part D for hospice enrollees exceeded \$400 million in 2012. In the proposed rule, CMS discussed and sought comment on processes it is considering to facilitate the coordination of payment between hospices and Part D plans, but did not make any proposals.

The Commission agrees that mechanisms such as prior authorization or other procedures should be in place to ensure that the appropriate party – either the hospice or the Part D plan - pays for needed drugs for hospice enrollees. However, we are concerned that the current prior authorization process established through subregulatory guidance is administratively burdensome for hospice beneficiaries and families and does not ensure that hospice beneficiaries maintain timely access to needed drugs. Furthermore, we are concerned that no regulatory proposals were made related to the prior authorization process for 2015. We urge CMS to suspend the current Part D prior authorization process for hospice enrollees and issue a regulatory proposal to establish an improved prior authorization process as soon as possible. As we discuss in more detail below, we believe that an improved prior authorization process should not be administratively burdensome for hospice beneficiaries and families and should ensure that hospice beneficiaries obtain timely access to needed drugs even in the event of a dispute between the hospice and Part D plan over financial responsibility.

As hospices are responsible for providing comprehensive, holistic care for the terminal condition and related conditions, we would expect that drug coverage for hospice enrollees would predominantly be the responsibility of the hospice, but with Part D coverage available when a particular patient has a need for a particular drug unrelated to these conditions. As a general principle, we believe the prior authorization process should involve communication between the hospice and Part D plan to work out which entity has financial responsibility for needed drugs for a hospice beneficiary, without burdening the beneficiary and family to be involved in these coverage determinations.

To improve the prior authorization process, we believe that CMS should require the hospice and the Part D plan to coordinate their coverage at the outset of hospice care, with the hospice communicating to the Part D plan any drugs it believes are the responsibility of Part D and why, and the Part D plan determining whether it agrees. When both the hospice and Part D plan agree that Part D should cover a particular drug for a particular hospice patient, we believe that an

exception to the prior authorization should be put in the Part D plan's system even before a prescription is presented at the pharmacy. Although this timing may not always be feasible, we believe it should be the goal in order to make the process as seamless as possible for the hospice beneficiary and family.

To settle any disputes between the hospice and Part D plan over who has financial responsibility, we believe that an independent review entity or an alternate means of dispute resolution should be available. But, a hospice beneficiary's access to needed drugs should not be held up while a determination is made about who is financially responsible. In situations where the hospice and the Part D plan disagree, CMS may want to consider requiring a hospice to pay for a drug it believes is covered by the Part D plan and establish processes for dispute resolution and payment reconciliation to ensure that the appropriate party ultimately pays for the drug. Burden on the hospice beneficiary and family to initiate and participate in any dispute resolution process should be minimized.

It is also important that CMS establish a requirement that ensures that beneficiaries who revoke their hospice election have access to Part D drugs. When a beneficiary revokes hospice, Part D regains responsibility for covering all outpatient drugs (regardless of whether they are related to the terminal condition) and the beneficiary-level prior authorization on Part D drugs should be removed. Because time lags exist in the transmission of revocation information from the hospice to CMS and then from CMS to the Part D plan, there is potential for delays in beneficiaries' access to medications. Given this, a requirement should be established to ensure that beneficiaries who revoke hospice are able to obtain timely access to Part D drugs, even if CMS has not officially transmitted the hospice revocation information to the Part D plan. CMS has issued guidance in the form of a frequently asked question (FAQ) stating that Part D plans should accept a copy of the beneficiary's hospice revocation or certain other information provided by the hospice as evidence that the beneficiary is no longer enrolled in hospice. We urge CMS to codify this requirement in regulation.

Filing timeframes for notices of election and termination/revocation

CMS has proposed requiring hospices to submit to CMS a notice of hospice election and notice of hospice termination/revocation for its patients no more than 3 calendar days after the effective date of the action. In addition, CMS proposed that hospices that do not file the notice of election within 3 days after the hospice election date would not receive payment for any days prior to filing the election.

We support these proposals. Prompt filing of notices of elections and notices of termination/revocation is important so that CMS, Medicare Advantage plans, and Part D plans are aware that a beneficiary has entered hospice or is no longer in hospice, and can make changes to their systems to ensure services are paid for appropriately and services that should be covered by hospice are not paid for by other entities. Given that almost all of these notices are filed electronically, we believe that 3 days should be more than a sufficient amount of time for filing.

Hospice aggregate cap

Currently, the Medicare contractors calculate the hospice aggregate cap calculations 16 months to 24 months after the close of the cap year. In the proposed rule, CMS reported that both the percentage of hospices exceeding the aggregate cap and the amount of dollars over the cap grew in 2012. CMS stated that to better safeguard the Medicare trust fund, demands for cap overpayments should occur sooner. CMS proposed to require hospice providers to file a self-determined cap calculation within 150 days of the close of the cap year and to remit payment for any overages at that time. The Medicare contractors would reconcile all payments at the final cap determination. Hospices that fail to file the self-determined cap calculation within this timeframe would have payment suspended in full or part until the cap calculation is filed.

We understand the desire to collect a portion of cap overpayments earlier, especially for hospices with large overages. However, we are concerned that this proposal as currently structured would not be effective in achieving CMS' goal of better safeguarding the Medicare trust fund. As we discussed in our March 2012 Report to Congress, a large lag time is needed between the close of the cap year and the date at which the aggregate cap calculation is performed to accurately estimate whether a hospice exceeded the cap and by how much (MedPAC 2012).^{4,5} Early calculation of hospice cap liability (within 150 days of the close of the cap year) will underestimate the amount of money owed by a hospice found to exceed the cap, and will not identify the full set of hospices that exceed the cap for the cap year. The proposal to require the hospice to perform its own cap calculation within 150 days of the close of the cap year is also vulnerable to gaming because a hospice could choose to perform its cap calculation immediately after the close of the cap year when the estimated liability would be lowest or nonexistent.

If CMS wishes to collect a portion of cap overpayments earlier, we believe a more effective approach would be for CMS to make its contractors responsible for performing an initial, earlier cap calculation. Under such an approach, clear processes and timeframes should be established to ensure that the contractors eventually collect the full overpayments (not just the initially calculated amount) from all hospices that exceed the cap (both those found to exceed the cap at the early calculation and those found to exceed the cap when the calculation is performed at later dates). If this approach raises workload concerns for the CMS contractors, CMS could consider establishing criteria to target earlier cap calculations to those providers where it would be most valuable (e.g., for those hospices with lengths of stay in excess of a certain threshold, or with a history of exceeding the cap).

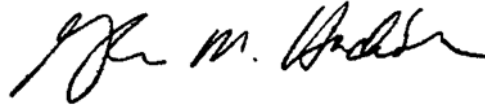
⁴ Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC.

⁵ This is due to how the cap calculation handles beneficiaries who continue to receive hospice care after the close of the cap year.

Marilyn Tavenner
Administrator
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If you have questions about any of the issues raised in our comments, please contact Mark Miller, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with a long horizontal stroke at the end.

Glenn M. Hackbarth, J.D.
Chairman