

June 27, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Suite 314-G
Washington, DC 20201

RE: File code CMS-1449-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, published in the Federal Register on May 10, 2013. The proposed rule made several proposals related to the hospice quality reporting program and provided an update on CMS' efforts in the area of payment reform research and enhanced data collection. 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. We also appreciate your staff's work on revising the hospice cost reports, which will facilitate future refinements to the near-term payment system reforms we support in this letter.

Our comments focus on three areas:

1. **Payment system reform.** We are very appreciative of CMS' research efforts in the area of hospice payment system reform, but we are concerned that CMS has not taken action to improve the hospice payment system in fiscal year 2014. We believe that there is ample evidence that the current payment system is misaligned with hospices' costs and that an initial step to improve the hospice payment system is possible now using available data.
2. **Site-of-service adjustment for nursing facilities.** We share CMS' concern about potential duplication of payment for aide services provided to hospice patients in nursing facilities. Analyses we conducted in our June 2013 Report to the Congress suggest that a payment reduction may be warranted for hospice care in nursing facilities due to the overlap in responsibilities between hospices and nursing facilities.
3. **Quality reporting.** In general, we support the direction of the hospice quality reporting program proposals. We agree that data collection should be halted on the current pain

management outcome measure due to concerns about its validity. We support the addition of a hospice item set to facilitate standardized data collection and a hospice experience of care survey, but at the same time we raise a number of issues that CMS will need to address in conducting such a survey to ensure that it produces viable results.

Hospice payment system reform

In the proposed rule, CMS provided an update on its research efforts on hospice payment system reform, but made no proposal for payment changes in fiscal year 2014. CMS indicated that its contract researcher, Abt Associates, continues to conduct research on a variety of hospice issues related to payment system reform. CMS noted that they are exploring several payment reform models, such as a tiered model (i.e., flat per diem payments for patients who enter hospice in the last 5 days of life and U-shaped per diem payments for all other hospice patients) or a short-stay add-on approach (which would maintain a flat per diem payment but provide a fixed add-on payment for patients with short stays similar to the home health low utilization payment amount add-on).

We appreciate the extensive efforts CMS has made to research hospice payment reform issues and consider further data collection. The research that CMS has sponsored, as well as some of the payment models they are contemplating, affirms that there is a U-shaped component to hospice visit patterns. Nonetheless, we are concerned that CMS has declined to use the authority granted under the Patient Protection and Affordable Care Act of 2010 (PPACA) to begin improving the hospice payment system in fiscal year 2014. We believe that there are clear problems with the existing hospice payment system and that sufficient data exist to begin making improvements to the payment system in fiscal year 2014.

There is substantial evidence that the current hospice payment system is not well aligned with providers' costs. 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).^{1,2} Because Medicare makes a flat payment for each day of routine home care while hospice visit intensity is higher at the beginning and end of the stay, long hospice stays are more profitable for providers than short stays. This misalignment in the payment system results in hospices with longer stays having substantially higher profit margins than hospices with shorter stays.³

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

²Plotzke, 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.

³ For example, among freestanding, below-cap providers, hospices in the quintile with the highest share of patients with stays exceeding 180 days had a margin exceeding 16 percent compared to a margin of -1 percent for hospices in the quintile with the fewest long-stay patients.

For a number of reasons, it is important that an initial step to improve the hospice payment system be taken as soon as possible. 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. In addition, 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 2011, Medicare spent nearly \$8 billion, more than half of all hospice spending that year, on patients with stays exceeding 180 days. Modifying the current payment system also 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.

The Commission recommended in March 2009 that the hospice payment system be revised to reflect the U-shaped pattern of hospice visits throughout an episode. As we described in our June 2013 Report to the Congress, we believe sufficient data exist to begin improvements to the hospice payment system now, with additional refinements possible as more data become available. In that report, we used Medicare claims data on hospice visit minutes and BLS data on wages and benefits to demonstrate how the labor cost of hospice visits changes over the course of a hospice episode, generally following a U-shaped pattern. Based on that analysis, our June 2013 report provides an illustrative example of a revised payment system that could be implemented now using available data. Since we lack data on non-labor items like drugs, supplies, and durable medical equipment, we adopted an approach that used the data on hospice visits from the claims to adjust a portion (68 percent) of the hospice payment rate for the U-shaped pattern of care and kept the remainder of the payment (32 percent) flat.⁴ Simulating the effects of this approach on provider profitability, we found that it would reduce but not entirely eliminate differences in hospice profitability by length of stay. As expected, providers that tend to have fewer patients with very long stays would see an increase in payments and those that have a disproportionate amount of patients with very long stays would see a decrease in payments. Overall, we believe that our illustrative approach demonstrates that it is possible to make changes to the payment system now that would be an improvement over the current system.

One of the concerns that CMS raised in the proposed rule with respect to payment reform relates to the diagnosis information on hospice claims. CMS stated that it is unable to determine whether case-mix adjustment for a revised payment system is necessary because of issues with the completeness and accuracy of diagnosis information reported on the claims. CMS provided several clarifications on how hospices are to report diagnosis information on the claims and noted that in the future with better diagnosis information it intends to examine whether case-mix adjustment is appropriate. We support CMS' efforts to obtain better diagnosis information, but we urge the agency not to delay payment reform on this account. To date, research has found that hospice length of stay, not diagnosis, is the predominant driver of hospice visit intensity. We believe a U-shaped payment model - without a diagnosis adjustment - would be a substantial

⁴ The 68 percent is based on the share of hospice direct costs accounted for by the six types of staff for which hospice visits are reported in the claims data.

improvement over the current payment system. In our view, diagnosis-based case-mix adjustment is a second order issue that could be contemplated in the future if later data were to suggest it had potential to improve payment accuracy.

Site-of-service adjustment for hospice payment in nursing facilities

In the proposed rule, CMS discussed, but did not propose, a possible payment reduction for hospice routine home care furnished in nursing facilities due to concerns about duplicative payment. CMS found that hospice aides provided more minutes of care to hospice patients in nursing facilities than patients at home or at assisted living facilities. CMS indicated that it would expect hospices to provide fewer, not more, aide services to patients in nursing facilities due to the presence of a paid caregiver. CMS stated that hospice aide visits in nursing facilities may be replacing, rather than supplementing, aide services provided by nursing facility staff. CMS noted that it would not be appropriate for Medicare to pay for duplicative services, raising the possibility of a downward adjustment to the payment rate for routine home care in nursing facilities. CMS noted that, under current law, any change to payment rates would have to be budget neutral.

We share CMS' concerns about potential duplicative payment when hospice care is provided in nursing facilities. In our June 2013 Report to the Congress, we found that hospices provide fewer nurse visits, but more aide visits, to patients residing in nursing facilities compared with patients at home. The greater aide visits in nursing facilities raised concerns about duplicative payment since the nursing home room and board fees paid largely from Medicaid funds or by patients and families explicitly cover aide services provided by nursing facility staff. We conducted analyses that estimated what the labor cost of hospice visits would be for patients in nursing facilities compared with patients at home if hospices *did not* provide more aide visits in nursing facilities. Under a conservative assumption that hospices provide equivalent amounts of aide visits in the two settings, our analysis found that hospice visit costs (for all types of visits combined) would be lower for patients in nursing facilities than patients at home. Overall, these analyses suggested that a payment reduction in the range of 3 to 5 percent may be warranted for hospice care in nursing facilities. As CMS pointed out, current law would require any reduction to the hospice payment rate in nursing facilities to be made in a budget neutral manner. In the future, as the Commission continues to examine the issue of duplicative payment for hospice care in nursing facilities, a question that we may consider is whether the Secretary should be given the authority to make a site-of-service adjustment in the nursing facility setting in a non-budget neutral manner.

Hospice quality reporting program

The proposed rule made several proposals concerning the hospice quality reporting program, including the discontinuation of one current quality measure and future implementation of a standardized hospice item set and a hospice experience of care survey.

Discontinuation of the current pain management quality measure

Under the hospice quality reporting program, hospices are required to collect data on two quality measures in calendar year 2013. The first is a structural measure in which a hospice indicates whether it tracks at least 3 quality measures related to patient care. The second is a National Quality Forum (NQF)-endorsed outcome measure related to pain management (NQF #0209). This measure reflects the percent of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours. CMS proposed to drop NQF #0209 from the quality reporting program, citing concerns that the measure is unstable due to a high rate of patient exclusion and that the measure is inconsistently administered across providers because it is not well aligned with the process of care. In proposing to halt collection of this measure, CMS indicated its interest in developing another pain management outcome measure in the longer-run. As an alternate proposal, CMS raised the possibility of continuing to include NQF #0209 in the hospice quality reporting program until a better pain outcome measure is developed.

We agree that serious issues have been identified with NQF #0209 that suggest this measure is not useable for the hospice quality reporting program. Given the administrative resources involved in collecting data for specific quality measures, it does not serve the interests of the Medicare program or its beneficiaries to require providers to expend resources on the collection of a quality measure found to have serious deficiencies. As a result, we believe that this measure should be dropped from the Medicare hospice quality reporting program. We urge CMS to quickly develop a sound pain management outcome measure. Symptom management is one of the fundamental aspects of hospice care and the development of a sound measure to gauge hospices' performance on pain management should be a priority.

Hospice item set and additional quality measures

CMS proposed to implement a standardized item set to collect additional quality measures beginning in July 2014. The purpose of the item set would be to ensure that hospice quality data are collected consistently across providers. The item set would include seven quality measures recently endorsed by NQF. The seven quality measures are all process measures (i.e., measures focus on pain screening, pain assessment, dyspnea screening, dyspnea treatment, documentation of treatment preferences, addressing beliefs and values (if desired by patient), and provision of a bowel regimen for patients treated with an opioid).

We agree that it is important that hospice quality information be collected in a standardized manner and support the adoption of a hospice item set. We believe that the long-run objective should be to have a small, focused set of measures, including outcomes measures, that gauge how well hospice providers meet the goals of hospice care such as the effectiveness of symptom management and whether patients receive care consistent with their preferences. We recognize that the current state of hospice quality measurement does not permit the inclusion of outcomes measures at this time. Nonetheless, we believe that it is important to get started on standardized quality measurement for hospice care and the process measures included in the draft item set are a

reasonable first step. In the future, as more research is done that examines the extent to which process measures are linked to outcomes, we urge CMS to periodically reevaluate the benefits of the various process measures included in the item set as well as new measures that may be developed. We also suggest CMS closely monitor hospices' aggregate performance levels on the process measures and propose deleting or suspending data collection for "topped-out" measures where hospices' performance scores are so high among the vast majority of hospices that there is little room for improvement.

Hospice experience of care survey

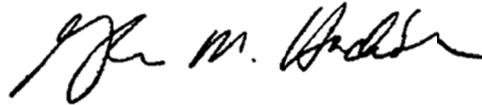
CMS has also proposed to require hospice providers (except for very small providers) to participate in a hospice experience of care survey beginning in 2015 under the hospice quality reporting program. Hospices would be required to contract with a CMS-approved vendor to administer the survey. The survey would collect information from the patient's informal caregiver after the patient's death focusing on questions that the informal caregiver would be well positioned to answer such as how well the provider communicated with the patient and family.

In general, the Commission believes that there is a role for experience of care surveys to play as part of multi-domain efforts to measure health care quality that focus primarily on outcomes, but also include a few carefully chosen clinical process and, when necessary, structural measures. With respect to hospice, the Commission supports efforts to develop an experience of care survey, but notes that there are special challenges associated with such a survey for hospice care that will require careful attention. Different from a patient experience of care survey, the hospice experience of care survey will collect information from the patient's informal caregiver (family or friend) following the patient's death. This raises a number of important issues such as: how long after the patient's death should the survey be fielded to allow time for the caregiver to grieve and still have a good recollection of the details of care, how will the surveyed individual be chosen when the patient had multiple caregivers, and are there characteristics of the informal caregiver (e.g., the caregiver's level of involvement in patient care) that might affect survey responses? With hospice care provided in a variety of settings (patients' homes, nursing facilities, assisted living facilities, hospice facilities, and hospitals), additional questions arise such as to what extent are the same survey questions appropriate across settings and are survey responses correlated with the setting of care? Also, with any survey, there will be questions about the response rate and to what extent response bias occurs.

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 prominent initial "G" and a long, sweeping underline.

Glenn M. Hackbarth
Chairman