

May 26, 2016

Andrew Slavitt, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Re: File code CMS-1652-P

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services proposed rule entitled Medicare Program; FY 2017 Hospice Wage Index and Payment Rate Update and Hospice Quality Report Requirements, *Federal Register*, Vol. 81, No. 82, p. 25498 (April 28, 2016). 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
- proposed new quality measures and related initiatives
- monitoring the new payment system and other data analysis

**Proposed fiscal year (FY) 2017 hospice payment update**

CMS has proposed a payment update of 2.0 percent for hospice services for FY 2017. This proposed update is based on the statutorily required formula of market basket minus productivity minus an additional 0.3 percentage point mandated reduction.

*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 2017. In our March 2016 Report to the Congress, we concluded that indicators of payment adequacy for hospice providers are generally positive. In 2014, the number of hospices increased more than 4 percent because of continued entry of for-profit providers. The number of beneficiaries enrolled in hospice increased modestly, and average length of stay held steady. Access to capital appeared adequate. The aggregate Medicare margin was 8.6 percent in 2013 and we projected a 2016 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 2017 without an update to the 2016 base payment rate.

**Proposed new quality measures and related quality initiatives**

For FY 2017, CMS has proposed the addition of several new quality measures: two measures of the percentage of routine home care (RHC) patients receiving hospice visits when death is imminent and a composite process measure that aggregates performance across seven existing measures of care processes at admission.

The proposed measures of visits when death is imminent are:

- percentage of RHC patients receiving at least one visit from registered nurses, physicians, nurse practitioners, or physician assistants in the last three days of life
- percentage of RHC patients receiving at least two visits from medical social workers, chaplains or spiritual counselors, licensed practical nurses, or hospice aides in the last seven days of life

The proposed composite process measure is:

- percentage of hospice patients who received all seven care processes at admission consistent with existing guidelines

The composite measure would aggregate performance across these seven existing measures: pain screening, pain assessment, dyspnea screening, dyspnea treatment, provision of bowel regimen for patients receiving an opioid, documentation of treatment preferences, and addressing patient's beliefs and values if desired by patient. CMS states that when looking at each of the seven process measures separately hospices score high (90 percent or above). In contrast, when looking at the seven processes collectively, only about 68 percent of hospice patients on average receive all seven processes of care appropriately at admission.

CMS also states that the agency may consider replacing the current hospice item set, which it uses to collect hospice quality reporting data, with a hospice patient assessment instrument. CMS notes that the hospice item set relies on retrospective chart abstraction whereas a patient assessment instrument would collect data concurrent with care provision. A patient assessment

instrument could give CMS greater capacity to collect information on clinical aspects of patients' care such as symptom burden, functional status, and patient, family, and caregiver preferences. It would also permit CMS to continue to collect process measure information like that collected through the hospice item set.

*Comment*

We support the addition of the proposed quality measures for FY 2017. A very important function of hospice is to provide appropriate clinical and psychosocial support throughout a patient's hospice stay. The last days of life are a period where patients often have the highest need for symptom management and other supports. Therefore, we believe quality measures that gauge the extent to which hospices are providing visits to patients in the last days of life are valuable. This information could be useful to hospice patients and families as they choose a hospice provider, as well as to the Medicare program as it monitors the performance of providers.

We also support the use of a composite process measure aggregating hospices' performance across seven individual process measures at admission. Performance on this composite measure is lower than on the individual process measures. To the extent that there is more variation across hospices in the composite measure than the individual measures, it may offer more information than currently available to differentiate performance across providers.

Although we support the quality measures CMS has proposed, we believe in general that it is best to have a small number of meaningful quality measures. We would suggest as CMS considers measures in the future, the agency revisits existing measures to ensure that they are providing value and to consolidate measures where possible. In general, we believe that outcomes measures would be preferable to process measures. We recognize that the development of outcomes measures for hospice is particularly challenging, but we urge CMS to pursue outcomes measures to the extent possible. For example, CMS has previously stated an interest in developing a patient reported pain measure and we support such efforts.

We also believe measures of hospice live discharges merit further exploration. Providers with substantially higher rates of live discharge than their peers may signal a problem with quality of care or program integrity. An unusually high rate of live discharge could indicate that a hospice provider is not meeting the needs of patients and families or is admitting patients who do not meet the eligibility criteria.

CMS has indicated that the agency is considering developing a patient assessment instrument for hospice. We agree that a patient assessment instrument could be valuable from the perspective of capturing more meaningful quality data (e.g., on symptom burden), as well as providing more detailed clinical information that might be useful for payment policy.

### **Monitoring the new payment system and other data analysis**

CMS discusses its plans to monitor the effects of the hospice payment system changes. CMS states that its contractor Acumen will perform real-time monitoring of changes in hospice utilization and service provision by tracking a wide range of data on a monthly and annual basis. CMS indicates that this monitoring will be used to track effects of the new payment system as well as identify potential program vulnerabilities or fraud and abuse. The measures CMS indicates it will track include:

- number and share of beneficiaries electing hospice (overall and by demographic group, geographic area, and terminal condition)
- total payments for hospice care (overall and by level of care)
- proportion of days of hospice care by level of care
- prevalence of live discharges and readmissions overall and around timeframes that affect payment rates
- average length of episodes/stays
- volume and payment for nonhospice services during hospice stays
- several different measures of the provision of hospice visits on average and during various portions of the episode

The proposed rule also includes a discussion of patterns of care that may signal program integrity concerns among some providers. CMS finds about \$1.1 billion in spending on nonhospice services during hospice enrollment in FY 2014 (about \$900 million in Medicare spending and about \$200 million in beneficiary cost-sharing) and expresses concern about potential unbundling of the hospice benefit. CMS analyzes data for individual providers on a number of dimensions such as length of stay, live discharges, quantity of visits provided, and amount of nonhospice spending for patients enrolled in hospice. Focusing on the 10 percent of hospices with the highest amounts of nonhospice spending during hospice election, CMS finds that these providers also had higher lengths of stay and higher live discharge rates than other hospices. CMS states that this pattern may suggest that some hospices may be using the benefit inappropriately as a long-term care benefit. CMS indicates that the agency is working to improve monitoring of hospices and plans to analyze data as they become available to determine if additional regulatory proposals to reform or strengthen the hospice benefit are warranted.

### *Comment*

MedPAC supports CMS' efforts to conduct real-time monitoring of hospice utilization, service delivery, and payments. We believe it is important to monitor for any effects of the new payment system on beneficiaries. We also agree that there is a need to monitor for any unintended program vulnerabilities that may arise under the new payment system. In some other sectors, we have observed behavioral responses by providers to new payment systems that increase aggregate payments or distort patterns of care. Having a monitoring system in place will permit the agency

to address such issues as expeditiously as possible should they occur.

The patterns of care that CMS has identified in the proposed rule, consistent with our work looking at aberrant patterns of care among some hospice providers, raise concerns that some providers appear to be using the hospice benefit as a long-term care benefit and pursuing revenue generation strategies. We commend CMS for its intent to improve monitoring of hospices and would urge the agency to focus its program integrity efforts on those providers where the data suggest scrutiny is most warranted.

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,

A handwritten signature in black ink that reads "Francis J. Crosson M.D." The signature is written in a cursive, flowing style.

Francis J. Crosson, M.D.  
Chairman