MEDPAC Medicare Payment Advisory Commission

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June 2, 2015

Andy 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-1629-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 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Report Requirements, *Federal Register*, Vol. 80, No. 86, p. 25832 (May 5, 2015). 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.

For fiscal year 2016, CMS has proposed to modify the structure of the payment rates for routine home care (RHC). We support these changes as a positive step toward better aligning hospice payments with the u-shaped pattern of hospice visits throughout an episode.[1] Because the changes are modest and incremental, they leave room for additional changes in future years based on further data and experience. We view the proposed changes as being in the spirit of the Commission's March 2009 recommendation for payment reform and urge CMS to move ahead expeditiously with implementing these payment changes for fiscal year 2016. With respect to the additional payments for certain hospice visits in the last seven days of life, the Commission urges CMS to permit these payments for hospice patients in nursing facilities because regardless of setting we would expect hospice patients to have increased needs for nursing support and symptom management in the last days of life. The remainder of this letter provides more detailed comments on CMS's payment reform proposal.

[1] As the Commission's and CMS's research has shown, hospice visit intensity follows a u-shaped pattern (more visits at the beginning and end of a hospice episode and less in the middle). Medicare's current flat per diem payment does not align well with this pattern of care.

Payment reform proposal

CMS has proposed a new structure for RHC payments, which entails a higher base rate for RHC during the first 60 days of an episode ($188) and a lower base rate for days 61 and beyond ($147). In addition to the per diem payments, CMS has proposed to make additional payments, referred to as a service intensity adjustment (SIA), for certain skilled hospice visits that occur during the last seven days of life. In particular, CMS has proposed to pay an additional $39 per hour for registered nurse and social worker visits that occur during the last seven days of life (up to 4 hours will be payable per day). To be eligible for the SIA payments, the patient must be receiving the RHC level of care, must be discharged deceased by the hospice, and must not be receiving care in a nursing facility.

The payment structure that CMS has proposed – a higher rate for the first 60 days, a lower rate for days 61 and beyond, and additional payments in the last seven days of life tied to the provision of skilled visits – would begin to better align payments with the u-shaped pattern of hospice visits throughout an episode. In our view, the proposed changes are in the spirit of the Commission's March 2009 recommendation to move away from the flat per diem payment to one that is higher at the episode's beginning and end and lower in the intervening period.

The misalignment of payments and costs under the current flat per diem payment has resulted in a number of issues.

- Long stays in hospice are more profitable than short stays because Medicare pays the same rate for each day in the episode while hospice visits tend to be most frequent at the beginning and end of the episode and less frequent during the intervening period.
- The current hospice payment system is vulnerable to patient selection. A hospice that wishes to do so can focus on patient populations likely to have long stays and high profitability.
- Substantial profit opportunities within the current payment system may have spurred for-profit provider entry into the hospice field and led some providers to pursue revenue-generation strategies such as enrolling patients likely to have long stays who may not meet the hospice eligibility criteria.
- Short stays, because of their high visit intensity, may currently be reimbursed at levels below their cost under the current flat per diem payment.
- The substantial profit opportunities from long stays and the less favorable reimbursement for short stays has led to wide variation in margins across providers based on the length of stay of their patients.[2]

For these reasons, we urge CMS to move expeditiously to finalize and implement these proposed changes to the RHC rates for fiscal year 2016. Although the payment changes included in this proposal would generally have a modest impact on providers (as reflected in CMS's impact

[2] Comparing hospice providers based on the percent of their patients' stays exceeding 180 days, the average margin in 2012 ranged from –7 percent for hospices in the lowest quintile to 18.3 percent for hospices in the second-highest quintile. Hospices in the highest length-of-stay quintile had a 13.7 percent average margin after the return of cap overpayments, but without the hospice aggregate cap, these providers' margins would have averaged 20.3 percent.

analysis), these changes would begin to address some of the negative consequences that have resulted from the misalignment between payments and costs under the current flat per diem payment system.

RHC base rates for days 1-60 and days 61 onward

A number of possible structures could be contemplated to better align hospice payments with the u-shaped pattern of visits that occur during an episode. We believe CMS's proposal to establish two base rates for RHC – a higher rate for the first 60 days and a lower rate for days 61 and beyond – is a reasonable initial approach. By establishing two base rate categories (days 1-60 and days 61 and beyond), CMS has proposed an approach that is straightforward to implement and that has the effect of increasing payments in the beginning portion of the episode and reducing payments later in the episode.

Since visit intensity is typically high in the first few days of the episode, declines rapidly in the first week, and flattens out by day 60, the choice of a single payment rate for the first 60 days of the episode represents a conservative step to moderately increase payments for the initial portion of the episode. Whether the higher base rate for the first 60 days of the episode, in conjunction with the establishment of the SIA payments for the last seven days of life, does enough to address concerns about the adequacy of reimbursement for very short stays and overpayments for very long stays remains to be seen. But, the proposed changes leave room for the establishment of finer base rate categories in future years should data and experience suggest they are warranted. For these reasons, we support CMS's proposal for a higher base rate for days 1 to 60 and a lower base rate for days 61 and beyond. We also caution against any changes to the proposed structure that would lengthen the period for the initial payment rate (e.g., days 1-90) because that would result in a lower initial payment rate and represent a smaller increase in reimbursement for shorter stays.

Hospice days follow the patient

Another important aspect of the design of the RHC payment structure is how breaks in hospice enrollment or transfers to a different hospice provider affect the RHC payment rates. For purposes of determining which RHC base rate applies, CMS has proposed that the episode day count would follow the patient if he or she switches providers or has a break in hospice enrollment of 60 days or less. For breaks in hospice enrollment of more than 60 days, CMS has proposed that upon re-enrollment the patient would begin a new episode and the hospice would be eligible for the higher RHC base rate for days 1-60. We agree that these policies are warranted to minimize financial incentives for hospice patients to be disenrolled and re-enrolled, or transferred between hospice providers, for the purposes of obtaining the higher base rate. We think that a break of more than 60 days is a reasonable threshold for triggering a new episode, and we do not believe this threshold should be shorter.

The proposed rule does not describe how hospice days will be counted for beneficiaries in existing hospice episodes that continue thru October 1, 2015 and beyond. Based on the data used to established the payment rates from Table 16 (which includes more than 15 million episode days

that are beyond the 365-day mark), it appears that the patient's episode day count on October 1, 2015 will be based on the total number days included in that episode prior to that date (taking into account CMS's policy that the episode days generally follow the patient and breaks of more than 60 days trigger a new episode). We believe this is the most sensible approach as it matches the payment with the appropriate period in the episode. Conceptually, we do not believe it would be appropriate to reset all hospice patients' episodes to day 1 on October 1, 2015 since patients in long stays would not require the higher base payment rate associated with the first 60 days of the episode. Another approach might be to allow patients in existing stays to remain under the prior single base rate system. However, this would perpetuate concerns about payments being misaligned with costs for the longest-stay patients. We believe that setting the new RHC payment rates beginning on October 1, 2015 for existing patients based on the actual episode day count is the preferable approach.

Service intensity adjustment for the last seven days of life

The Commission agrees that additional payments during the last seven days of life are appropriate in light of the higher patient need and visit intensity that typically occurs during this period. At the same time, data published by CMS and its contractor, Abt Associates, raise concern that some hospice patients are not receiving skilled visits at the end of life, and that this occurs disproportionately among some hospices. Given this, we believe that structuring additional payments in the last seven days of life to be based on the amount of registered nurse and social worker visits actually furnished to the beneficiary is sensible. It creates incentives for hospices to provide appropriate care in the last days of life.

CMS has proposed to exclude the nursing facility setting from the SIA payment, citing an OIG report that recommended CMS reduce the payment rates for hospice care in nursing facilities. While we agree that providing hospice care in a nursing facility is less costly than in a patient's home, we believe an SIA payment should be permitted in the nursing facility setting. Regardless of setting, we would expect hospice patients to have an increased need for nursing support to manage their symptoms in the last days of life. Thus, it is appropriate to permit an SIA payment in the nursing facility setting.

We believe the issue of the cost of furnishing hospice care in nursing facilities would be more appropriately addressed through an adjustment to the RHC payment rates for patients in nursing facilities. Analysis from our June 2013 Report to the Congress suggests that the RHC rates paid in nursing facilities should be lower than in the home due to the overlap in responsibilities between the hospice and the nursing facility staff. However, we recognize that the Secretary would need additional statutory authority to reduce the RHC payment rates for nursing facility patients in a non-budget neutral manner.

Budget neutrality

CMS has proposed RHC payment rates for fiscal year 2016 that it estimates are budget neutral based on hospice utilization in the most recently available claims data (fiscal year 2014). As part of this process, CMS estimated the amount of payments that would be made for the SIA assuming utilization in 2016 were the same as in 2014. CMS then reduced the RHC base rates for days 1-60 and days 61 and beyond by two SIA payment budget neutrality factors (SBNFs) to account for the expected amount of SIA payments that will occur during those periods of the hospice episode. CMS has proposed to continue to make the SIA payments budget neutral in future years through annual determination of the SBNFs based on the most current and complete fiscal year utilization data available at the time of rulemaking.

We support the proposal to annually recalculate the SBNFs. This step has some similarity to annual recalibrations that occur in other payment systems. The amount of hospice visits furnished in the last seven days of life may increase in the future in response to the additional payments available for these visits through the SIA, as well as the increasing attention being paid to the lack of visits at the end of life as a potential indicator of poor quality. We support the annual recalculation of the SBNFs as one way to mitigate potential increases in aggregate payments that might otherwise result if visits in the last seven days of life increase in the future.

Even with the annual recalculation of the SBNFs, it is possible that aggregate hospice payments could increase depending on how hospice providers respond to the payment changes. In some other sectors, we have observed behavioral responses by providers that increased aggregate payments following the adoption of new payment systems that were intended to be budget neutral. In the future, the Commission intends to monitor the trends in aggregate payments following adoption of these payment changes and would consider additional policies to address a substantial behavioral response should it occur.

Quality measure development

In the proposed rule, CMS discussed several areas it intends to focus on for future quality measure development, including patient-reported pain outcomes, claims-based quality measures (e.g., skilled visits in the last days of life, burdensome transitions of care for patients in and out of hospice, and rates of live discharges), responsiveness of hospices to patient and family needs, and hospice team communication and care coordination. As we discussed in our March 2015 Report to the Congress, we believe that claims-based quality measures such as visits in the last days of life and rates of live discharge could be promising sources of information on the quality of hospice care and merit further exploration. The Commission also believes that to the extent possible quality measurement should focus on outcomes. Although this is particularly challenging with hospice, a pain outcome measure is one such measure that might be possible and we strongly encourage CMS to pursue this.

MedPAC appreciates the opportunity to comment on these important proposals to reform the hospice payment system. 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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