

June 4, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington DC, 20201

RE: CMS-1754-P

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements" in the *Federal Register*, vol. 86 no. 70, p. 19700 (April 14, 2021). We appreciate CMS's ongoing efforts to administer and improve the payment system for hospice services, particularly given the many competing demands on the agency's staff.

The Commission's comments are organized into three sections: the update for fiscal year (FY) 2022, rebasing of the labor shares, and hospice quality proposals.

Proposed update to the FY 2022 payment rates and aggregate cap

CMS has proposed an update of 2.3 percent to the FY 2022 hospice payment rates and hospice aggregate cap amount, as required by statute.

Comment

We recognize that CMS is required by statute to propose an increase to the FY 2022 base rates and aggregate cap of 2.3 percent. However, in our March 2021 report to the Congress, the Commission recommended no update to the FY 2021 payment rates for FY 2022 (i.e., hold the payment rates for FY 2022 at the FY 2021 levels) and wage adjust and reduce the hospice aggregate cap by 20 percent.¹

¹ Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

In the March 2021 report, the Commission found that indicators of access to care were positive, and the aggregate Medicare margin was strong. The number of hospice providers, number of beneficiaries enrolled in hospice, days of hospice care, and average length of stay increased in 2019. The rate of marginal profit was 16 percent in 2018. As the number of for-profit providers increased by 6 percent in 2019, access to capital appeared strong. The aggregate Medicare margin in 2018 was 12.4 percent, and the projected 2021 margin is 13 percent.

Given the aggregate Medicare margin in the industry and the other positive payment adequacy indicators, the Commission concluded that the aggregate level of payments could be reduced and would still be sufficient to cover hospice providers' costs and preserve beneficiaries' access to care. In light of substantial variation in financial performance across providers, we developed a two-part recommendation. The Commission recommended (1) no update to the FY 2021 payment rates for FY 2022 for all providers and (2) the hospice aggregate cap be reduced by 20 percent as a way to focus payment reductions on providers with particularly high margins. The recommendation would also wage adjust the hospice aggregate cap to make it more equitable across providers. Overall, this recommendation would bring aggregate payments closer to costs, would lead to savings for taxpayers, and would be consistent with the Commission's principle that it is incumbent on Medicare to maintain financial pressure on providers to constrain costs.

Proposed rebasing of the hospice labor shares

For FY 2022, CMS proposes to rebase and revise the labor shares for the four levels of hospice care based on 2018 Medicare hospice cost report data, as shown in the below table. The proposed rule notes that the current labor shares for hospice routine home care and continuous home care are based on home health data and have been unchanged since 1984. The labor shares for hospice general inpatient care and inpatient respite care are based on skilled nursing facility data and have been unchanged for more than 30 years.

	Proposed labor share	Current labor share
Continuous home care	74.6%	68.71%
Routine home care	64.7%	68.71%
Inpatient respite care	60.1%	54.13%
General inpatient care	62.8%	64.01%

Comment

We support CMS's proposal to rebase the labor shares for the four levels of hospice care based on 2018 Medicare hospice cost report data. It is appropriate that the hospice labor shares be based on data for hospice providers, rather than home health agencies and skilled nursing facilities. Basing the hospice labor shares on recent Medicare cost report data for hospice providers will improve payment accuracy.

Hospice quality proposals

The hospice proposed rule contains several proposals related to the hospice quality reporting program.

CMS is proposing to remove from public reporting the seven individual hospice item set measures related to processes of care at admission because they are topped out. CMS states that providers will continue to report data on the seven measures because they form the basis of a composite measure that reflects the share of patients for whom the hospice performed all seven activities appropriately.

CMS is proposing to report two new claims-based quality measures in 2022. The first is the Hospice Care Index and the second is the Hospice Visits in the Last Days of Life measure.

- ***Hospice Care Index (HCI)***: The HCI would identify providers with aberrant patterns of care based on hospice providers' performance across ten measures. The ten measures include four related to the provision of visits to hospice patients, four related to aspects of live discharges, one that reflects Medicare hospice spending per beneficiary, and one that gauges whether the provider furnished any high-intensity care (continuous home care or general inpatient care). In general, providers receive a score of 1 on a measure, unless their performance is in the worst 10 percent, in which case they receive a score of 0. Scores on the ten measures are summed to arrive at the HCI score. The highest possible score is a 10, meaning the provider's performance was not an outlier on any of the 10 measures.
- ***Hospice Visits in the Last Days of Life (HVLDDL)***: The HVLDDL measure indicates the hospice provider's proportion of patients who have received in-person visits from a registered nurse or medical social worker on at least two out of the final three days of the patient's life. This measure replaces an existing measure that examines the share of patients that received at least one visit in the last three days of life by a physician, nurse practitioner, registered nurse, or physician assistant.

For public reporting of the HCI and HVLDDL, CMS is proposing to use two years of data. CMS states that by using two years of data, the agency could report data for more providers than if one year of data were used, and those additional providers tend to have lower-than-average performance on these measures.

CMS is proposing to create star ratings for hospice providers based on the Consumer Assessment of Healthcare Providers and Systems[®] (CAHPS[®]) Hospice Survey. Hospice CAHPS surveys family members of deceased hospice patients about the care the hospice provided. Currently, CMS reports on Care Compare hospice providers' CAHPS scores in eight areas: (1) communication with family, (2) getting timely help, (3) treating patient with respect, (4) emotional and spiritual support, (5) help for pain and symptoms, (6) training family to care for the patient, (7) survey respondent's rating of the hospice, and (8) survey respondent's willingness to recommend the hospice. CMS is proposing to calculate an overall star rating for a hospice provider by weighting scores on each of the first six measures as a 1.0 and scores on measures 7 and 8 each as 0.5.

The proposed rule also includes an update on CMS's interest in developing future quality measures. As part of the new hospice patient assessment instrument currently under development (referred to as the Hospice Outcomes & Patient Evaluation), CMS is developing three candidate outcome measures related to symptom management: timely reduction of pain impact, reduction in pain severity, and timely reduction of symptoms. CMS stated that a technical expert panel (TEP) reviewed these measures and thought they were viable measures of hospice quality, and the agency continues to develop all three measures. The agency also indicated interest in developing additional claim-based measures in the future—for example, measures of hospice quality related to hospice services on weekends, transitions after hospice live discharge, Medicare expenditures per beneficiary (including the share of non-hospice spending during hospice election, and the share for hospice care prior to the last year of life), and post-mortem visits.

Comment

We support the removal of the seven process measures from the hospice quality reporting program, but we also urge CMS to consider removing the Comprehensive Assessment Measure, which is a composite of the seven process measures. Under CMS's proposal, the seven individual measures would no longer be displayed on the Care Compare website, but providers would still be required to report the seven measures for the purposes of calculating the composite measure. However, scores on the composite measure are very high (ranging from 85.6 percent at the 25th percentile to 97.8 percent at the 75th percentile in 2019), suggesting the composite measure is of limited utility for distinguishing provider quality.² Retiring the composite measure would reduce burden because providers would no longer need to report the seven underlying measures. According to the Commission's principles, Medicare quality programs should include population-based measures (such as outcomes, patient experience, and value), and quality measurement should not be unduly burdensome for providers. Therefore, CMS should retire process measures that are topped out and weakly correlated with health outcomes of importance to beneficiaries and the program.

We support CMS's development of the HCI. We believe that a measure that can help identify providers with aberrant patterns of care would be valuable for hospice patients and families. The HCI focuses on several areas where the Commission, CMS, and others have expressed concern about providers with unusual utilization patterns such as high live-discharge rates or burdensome

² Ibid.

transition following live discharge, lack of visits at the end-of-life or other important periods (e.g., weekends), providers that furnish no high-acuity care, and providers with very high spending per patient. To the extent that a hospice provider is an outlier across several of these dimensions, it raises concerns about the care provided by that hospice.

CMS has proposed using two years of data to construct the HCI measure and HVLDL measure because it would permit CMS to display data for a greater share of small providers, and those additional providers for whom data would be available tend to have below-average performance. The Commission, over the years, has noted that small hospices as a group tend to have substantially higher live-discharge rates than large hospices and suggested that measurement efforts should seek to provide data on small providers' performance to the extent feasible. We believe CMS's proposal to use two years of data for the HCI and HVLDL is a reasonable approach to address these issues.

With respect to the technical aspects of the HCI live-discharge measures, we suggest CMS explore approaches to ensure that providers with very low overall live-discharge rates are not flagged as having unusual utilization patterns by these measures. There are four live-discharge measures: early live discharge (first 7 days), late live discharge (days 180+), live discharge followed by hospitalization and readmission to hospice, and live discharge followed by death in the hospital. As currently constructed, the denominator of each measure is total live discharges. With this denominator, it may be possible that a provider with a very low overall rate of live discharge could be identified as being an outlier (for example, because among the very small share of the provider's patients with a live discharge, most of the live discharges occurred after 180 days). An alternate denominator for these measures—all discharges—would be one potential approach to ensure that providers with very low rates of live discharge are not identified as outliers in these measures.

While we believe there is value in a measure that identifies providers with aberrant patterns of care, we believe it is very important to have additional measures that can distinguish hospice providers that furnish high-quality care. We support CMS's current efforts in this direction, including the proposed development of star ratings based on the hospice CAHPS survey and CMS's efforts to develop the candidate outcome measures about pain and symptom management. Hospice CAHPS provides patient experience-of-care information (as reported by a family member of the deceased hospice patient) on a variety of issues of importance to patients and families (e.g., treating patients with respect, provision of timely help, symptom management, emotional and spiritual support, communication with and training of family). A star rating that provides an overall assessment of providers' performance across these areas will be a valuable addition to the hospice quality reporting program. We also support CMS's efforts to develop outcome measures related to pain and other symptom management during a hospice episode. Symptom management is one of the fundamental goals of hospice care, and being able to distinguish providers with high- and low-quality performance has the potential to be very meaningful for hospice patients and families.

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The Commission values the ongoing cooperation and collaboration between CMS and our 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 James E. Mathews, the Commission's Executive Director, at 202-220-3700.

Sincerely,

A handwritten signature in black ink, appearing to read "m. chernew", with a long horizontal line extending to the right from the end of the signature.

Michael E. Chernew, Ph.D.
Chair

MC/kn