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June 14, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: File code CMS-1714-P

Dear Ms. Verma:

The Medicare Payment Advisory Commission welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services proposed rule entitled “Medicare Program; FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Report Requirements,” *Federal Register*, vol. 84, no. 80, p. 17570 (April 25, 2019). 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’s resources.

We comment on the following proposals or requests for comment:

- proposed fiscal year (FY) 2020 hospice payment update
- proposed rebasing of continuous home care, inpatient respite care, and general inpatient care
- proposed changes to the hospice election statement and requirement for an addendum
- wage index

Proposed FY 2020 hospice payment update

CMS has proposed a payment update of 2.7 percent for hospice services for FY 2020. This proposal is in accordance with statute, which specifies an update equal to the hospital market basket less productivity.

Comment

We recognize that CMS is required by statute to propose an increase to the FY 2020 base rates of 2.7 percent. However, in our March 2019 report to the Congress, the Commission recommended that the Congress reduce the aggregate level of payment to hospices for FY 2020 by 2 percent.¹ In that report, we found that the aggregate Medicare margin in 2016 reached 10.9 percent—the highest level in more than 10 years. In addition, indicators of access to care are positive: the number of providers, number of beneficiaries enrolled in hospice, days of hospice care, and average length of stay increased in 2017. The rate of marginal profit for Medicare patients was 14 percent in 2016, indicating that providers have a financial incentive to serve additional Medicare patients. As the number of for-profit providers increased by 5 percent in 2017, access to capital appears strong. The projected 2019 margin is 10.1 percent. Given the aggregate Medicare margin in the industry and our other positive payment adequacy indicators, we concluded that the aggregate level of payments could be reduced by 2 percent in 2020 and would still be sufficient to cover providers' costs and preserve beneficiaries' access to care. This recommended reduction to the base payment rates would bring aggregate payments closer to costs, lead to savings for beneficiaries and taxpayers, and 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 continuous home care, inpatient respite care, and general inpatient care

CMS has proposed using hospice cost report data to rebase the payment rates for three levels of care: continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIP). The rebasing would increase the payment rates for these three levels of care based on estimates of their costs from the cost report data. CMS proposes to reduce the payment rates for the fourth level of care, routine home care (RHC), so that the changes are budget neutral overall according to the agency's estimates.

The estimated cost by level of care and proposed payment changes are shown in Table 1. The proposed FY 2020 payment rates reflect rebalancing of the payment rates by level of care and all other adjustments including the annual update of 2.7 percent, the wage index standardization factor, and the service intensity adjustment budget neutrality factor. The payment rates for CHC, IRC, and GIP are proposed to increase by 41 percent, 155.5 percent, and 35.5 percent respectively. CMS indicated that the proposed RHC payment rates were reduced by 2.71 percent to offset the additional costs the agency estimated would be incurred due to the increased rates for the other three levels of care. However, the FY 2020 RHC rates are proposed to be about the same as the actual FY 2019 payment rates because the annual update of 2.7 percent largely offsets the reduction to the RHC payment rates associated with rebasing the other three levels of care.

¹ Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Table 1: Estimated cost and the Secretary’s proposed changes to payment rates by level of care

	Percent of days in 2018	FY 2019 estimated average cost per day	Actual FY 2019 payment rate	Estimated FY 2019 budget neutral payment rate^b	Proposed FY 2020 payment rate including annual update and other adjustments	Proposed percent change in payment rates from FY 2019 to FY 2020
Continuous home care ^a	0.2	\$56.80	\$41.56	\$56.80	\$58.58	41.0%
Inpatient respite care	0.3	\$457.61	\$176.01	435.82 ^c	\$449.78 ^c	155.5%
General inpatient care	1.3	\$994.45	\$758.07	\$994.45	\$1,027.43	35.5%
Routine home care days 1–60	98.2	\$171.89	\$196.25	\$190.93	\$195.65	–0.3%
Routine home care days 61+		\$118.95	\$154.21	\$150.03	\$154.63	0.3%

Note: FY (fiscal year).

^a Cost/payment rate per hour

^b Estimated FY 2019 budget neutral payment rate reflects CMS’s estimate of what FY 2019 payment rates would have been if the payment rates for CHC, IRC, and GIP had been rebalanced in line with their estimated costs and the RHC payment rate had been adjusted downward to maintain budget neutrality.

^c CMS adjusted the IRC payment rate downward by 5 percent to account for the 5 percent coinsurance.

Source: CMS FY 2020 Hospice proposed rule.

Comment

We support CMS’s efforts to rebalance the payment rates by level of care to ensure that payments are closer to the estimated cost of each level of care. As we noted in our March 2019 report to the Congress, the cost report data suggest that the payment rates by level of care are out of balance. Like CMS, over the years, we have heard anecdotal reports from providers that the payment rates for the three less frequently used levels of care—CHC, IRC, and GIP—are below providers’ costs. Although the hospice conditions of participation require providers to have the capacity to provide all four levels of care, both CMS and MedPAC have noted that some providers do not furnish certain levels of care. Increasing the payment rates for these three levels of care to be in line with their estimated cost is an appropriate step to promote access to these services.

However, the rebalancing of the payment rates would do little to address the substantial overpayments for RHC. The statute requires CMS to implement these changes in a budget-neutral manner in the first year they are implemented. Because RHC accounts for the vast majority of hospice spending, CMS estimates that only a small adjustment to the RHC rates is needed to offset the increased rates for the other three levels of care. Although we recognize that CMS lacks current statutory authority to reduce the RHC payment rates below a budget-neutral level, we are concerned that the proposed RHC rates remain substantially above the estimated cost for that level of care.

Budget neutrality

To estimate a budget-neutral adjustment to the RHC payment rates, CMS uses the most complete historical data available. By using these historical data, CMS assumes there will not be an increase in use of the three levels of care that are proposed to experience substantial payment increases. If the share of hospice days accounted for by the three levels of care increases in FY 2020, the payment changes would not be budget neutral and would instead increase Medicare spending.

For several reasons, we believe it is likely that use of the three levels of care will increase in response to the payment changes. First, as it has been noted, some providers currently do not furnish all levels of care, although they are required to have the capacity to do so. The increased payment rates for the three levels of care may encourage these providers to begin furnishing these levels of care. The increased payment rates may also encourage some providers that currently provide these levels of care to do so more frequently. In addition, the OIG has found that some providers inappropriately furnish GIP care to patients who do not meet the criteria.² Higher payment rates could increase the likelihood that some providers will inappropriately provide more GIP care. We encourage CMS to consider a prospective adjustment to the payment rates to maintain budget neutrality or to seek authority from the Congress to adjust the payment rates in the future if aggregate payments increase as a result of these payment changes.

Payment rate for inpatient respite care (IRC)

We urge CMS to examine the cost report data for IRC to assess whether its average cost per day estimate is being affected by high-end outliers. In our March 2019 report to the Congress, we estimated the average and percentile distribution of IRC cost per day using data for cost report year 2016. We found a substantial difference between the average (\$442) and median (\$312) IRC cost per day. Further analysis of the data suggested that the average was being skewed by high-end outliers. To explore this, we estimated the IRC average cost per day excluding the observations below the 10th percentile and above the 90th percentile. With that exclusion, our estimate of the IRC average cost per day declined to \$370, which was still above the median, but closer to it.

Last year, the FY 2019 hospice proposed rule included information on the distribution of IRC cost per day in FY 2016 using several different approaches to editing the data for outliers. With each approach, CMS reported a substantial difference between the average and median IRC cost per

² Office of Inspector General. 2016. *Hospices inappropriately billed Medicare over \$250 million for general inpatient care*. OEI-02-10-00491. Washington, DC: OIG

day. (In contrast, the median and average cost were much closer for the other levels of care.) The FY 2020 proposed rule does not provide information on the percentile distribution of IRC cost per day so it is difficult to ascertain whether high-end outliers are affecting CMS's estimate of the average cost per IRC day.

We urge CMS to examine the cost report data to determine if high-end outliers are an issue for IRC, and if so, to utilize an approach for establishing the IRC payment rate that mitigates the effect of outliers (e.g., employing further edits or using the median instead of the average). Given the large payment increase (155.5 percent) that is being proposed for IRC, it is particularly important to ensure that the increase is not inappropriately driven by outliers.

GIP and the skilled nursing facility setting

We are concerned about the proposed increase in the payment rate for GIP in the skilled nursing facility (SNF) setting and urge CMS to maintain the current GIP payment rate in that setting. In past years, we have heard concerns from some providers about potential overpayments for GIP in the SNF setting. These providers have stated that it costs less to contract for GIP with a SNF than with a hospital. These concerns about potential overpayments for GIP in the SNF setting were raised about the existing GIP rate, prior to the proposal to increase the GIP rate for FY 2020.

Medicare FFS payment rates provide an example of the difference in payment amounts received by SNFs and hospitals. The average Medicare payment per day for a SNF is roughly \$500, while for an inpatient hospital patient it is more than \$2,000. These relative payment rate differences are for SNF care and inpatient hospital care, not for hospice care in these settings. However, the magnitude of the difference in level of payment these providers receive suggests that hospice providers would likely face different costs to contract with these two types of providers.

We urge CMS to hold off on increasing the GIP payment rate in the SNF setting at this time. Although GIP in SNFs is relatively uncommon today, an increase in the payment rate for GIP of 35.5 percent would likely make providing GIP in SNFs quite profitable and could create incentives for more hospice providers to furnish GIP in SNFs. An OIG study identified several concerning patterns related to GIP in the SNF setting.³ OIG found that GIP stays were billed inappropriately more frequently in SNFs than in a hospital or an inpatient hospice facility. In addition, the OIG found that beneficiaries receiving GIP in a SNF received less intense care than GIP patients in other settings. About 32 percent of hospice patients receiving GIP in a SNF received subcutaneous or intravenous treatments compared with 70 percent of GIP patients in a hospital or inpatient hospice facility. It is uncertain whether these differences in treatment patterns reflect differences in patient needs or differences among these settings in the capacity to provide services. Regardless, it is another indicator that GIP care in the SNF setting tends to be less resource intensive and less costly than in a hospital or hospice facility.

³ Office of Inspector General, op cit.

Proposed changes to the hospice election statement and requirement for an addendum

The hospice benefit covers services for palliation of the terminal condition and related conditions. CMS has stated that “we continue to expect hospices to adhere to the long-standing policy to provide ‘virtually all’ care during a hospice election as articulated in the 1983 Hospice Care proposed and final rules as well as most recently in FY 2019 Hospice Wage Index and Payment Rate Update final rule.” In the proposed rule, CMS describes a number of anecdotal reports it has received of some hospice providers not furnishing patients with services that fall within the scope of the hospice benefit. To provide patients and families with more information on what is covered by hospice, CMS is proposing changes to the hospice election statement and a new requirement for an addendum to the election statement.

Specifically, CMS proposes that the hospice election statement be revised to include: information about the comprehensive nature of the Medicare hospice benefit, a statement that in rare situations there may be some services unrelated to the terminal condition that would not be covered by the hospice benefit, and a notification of the right to request an addendum to the election statement with more information on non-covered services. That addendum would include a written list and rationale for the conditions, items, drugs, or services that the hospice has determined are unrelated to the terminal condition and not covered by the hospice benefit. The addendum would also provide beneficiaries with information on the availability of the Beneficiary and Family Centered Care–Quality Improvement Organizations (BFCC–QIOs) as a resource to assist beneficiaries with appeals. CMS also proposes permitting non-hospice providers furnishing services to hospice patients to request the addendum.

Comment

We support these changes to the hospice election statement and the requirement for an addendum. The anecdotal reports of some hospice providers not furnishing services that should be within the scope of the benefit are concerning. It is very important that beneficiaries and their families have an understanding of what is covered by the hospice benefit and have information on what resources are available to appeal decisions by hospice providers if they have concerns or disagree with coverage determinations made by their hospice provider. We also agree it would be beneficial to permit non-hospice providers treating hospice patients to request the addendum (as this would promote communication and may lessen the potential for duplicate payments).

Wage index

Historically, CMS has calculated the hospice wage index values using the pre-floor, pre-reclassified wage index values from acute care hospitals. In response to stakeholder comments on certain aspects of the wage index values and their impact on payments, the FY 2020 proposed rule requested feedback regarding the wage index used to adjust hospice payments and suggestions for possible updates and improvements to the geographic adjustment of payments to hospice providers.

In response to CMS's request for feedback on the current wage index system, we wish to reiterate our recommendations on wage index reform included in the Commission's 2007 report to the Congress.⁴ We recommended that the Congress repeal the existing hospital wage index and instead implement a market-level wage index for use across other prospective payment systems, including certain post-acute care providers. Specifically, our recommended wage index system would:

- use wage data from all employers and industry-specific occupational weights,
- adjust for geographic differences in the ratio of benefits to wages,
- adjust at the county level and smooth large differences between counties, and
- include a transition period to mitigate large changes in wage index values.

Two significant research evaluations commissioned by the Secretary concluded that the Commission's proposed wage index system would be an improvement over Medicare's current hospital wage index system.^{5,6} Although the wage index system we proposed did not evaluate the use of the calculated index for hospice providers, since the hospice payment system uses the unadjusted wage index values from acute care hospitals, we contend this change would more fully reflect input prices, automatically adjust for occupational mix, reduce circularity, and reduce large differences between adjoining areas compared with the current system.

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 James E. Mathews, MedPAC's Executive Director at (202) 220-3700.

Sincerely,



Francis J. Crosson, M.D.
Chairman

⁴ Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC.

⁵ Institute of Medicine. 2011. *Geographic adjustment in Medicare payment, Phase I: Improving accuracy. Second edition*. Washington, DC: The National Academies Press.

⁶ MaCurdy, T, T. DeLeire, K. Lopez de Nava. et al. 2009. Revision of Medicare Wage Index. Final Report, Part I. and MaCurdy, T, T. DeLeire, K. Lopez de Nava. et al. 2010. Revision of Medicare Wage Index. Final Report, Part II. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/CMS1237065.html>