MEDPAC | Medicare Payment Advisory Commission

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May 28, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244–1850

Attention: CMS-1810-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 2025 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements" in the *Federal Register*, vol. 89 no. 66, p. 23778 (April 4, 2024). 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.

Our comments focus on four issues:

- the update to the fiscal year (FY) 2025 hospice payment rates,
- the proposed Hospice Outcomes & Patient Evaluation Assessment Instrument,
- the proposed changes to the hospice wage index, and
- the request for information on payment mechanisms for high-cost palliative care services.

Proposed update to the FY 2025 hospice payment rates

CMS proposes an update of 2.6 percent to the FY 2025 hospice payment rates.

Comment

We recognize that CMS is required by statute to propose a 2.6 percent increase to the hospice payment rates for FY 2025. However, in our March 2024 report to the Congress, the Commission recommended the elimination of the update to the FY 2024 payment rates for FY 2025.[1] Our assessment of indicators of payment adequacy for hospices—beneficiary

[1] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

access to care, quality of care, provider access to capital, and Medicare payments relative to providers' costs—were positive. In 2022, the number of providers climbed 10 percent and the share of Medicare decedents using hospice, the total number of beneficiaries receiving hospice care, and the total days of hospice care all increased. Among decedents, average length of stay and median length of stay also increased. Aggregate Medicare marginal profit was 17 percent in 2021. Access to capital appeared adequate given the substantial growth in the number of for-profit providers and reports of continued investor interest in the sectors. The 2021 Medicare aggregate margin was over 13 percent. Based on these positive indicators of payment adequacy, the Commission concluded that current payment rates are sufficient to support high-quality care without an increase to the base payment rates in 2025.

Hospice Outcomes & Patient Evaluation Assessment Instrument

CMS proposes to implement a new hospice patient assessment instrument, referred to as the Hospice Outcomes & Patient Evaluation (HOPE) Assessment Instrument, beginning October 1, 2025. The HOPE instrument is intended to replace the current Hospice Item Set (HIS), which hospices use to report certain patient-level data for the hospice quality reporting program. The HOPE instrument would expand the number of timepoints during the hospice episode when data are collected. In addition to collecting data at admission and discharge, the HOPE would also collect certain data at up to two visits that occur during the first 30 days of a hospice stay. The proposed HOPE instrument would also collect information in a number of domains that are not currently available in the HIS such as symptom impact on the patient (e.g., pain, shortness of breath, anxiety, nausea, vomiting, diarrhea, constipation, agitation); reassessment of symptom impact; neuropathic pain at admission; whether death is imminent; comorbidities; and skin conditions. CMS proposes two new quality measures based on the HOPE instrument: timely reassessment of (1) pain symptom impact and (2) other symptom impact among patients who were initially assessed with moderate or severe symptom impact.

Comment

The new HOPE assessment instrument offers the opportunity to collect additional information about the symptoms and care needs of hospice patients and could help with the development of improved quality measures. Current quality measures for hospice care are limited. The aim of hospice is to provide palliative and supportive services at the end of life that effectively manage a patient's symptoms and care in a manner that is consistent with the patient's preferences. Measuring how effectively a hospice delivers this type of care is not straight forward. The Hospice Consumer Assessment of Healthcare Providers & Systems® (CAHPS®) survey seeks to provide this type of information, asking bereaved family members after the patient's death about how well the hospice met the patient's and family's needs in several domains (e.g., symptom management, providing timely help). Adoption of the HOPE instrument would provide information on patients' symptom impact and hospices' management of symptoms from another perspective, collecting data on symptoms from the perspective of the patient where possible (or alternatively, from the perspective of the patient's family or observation of hospice staff) at the beginning of the stay and at up to two points in the first 30 days of the stay.

With the implementation of a new patient assessment instrument, it will be important to ensure the accuracy of the assessment data through oversight and monitoring. If assessment data are used to measure quality or to adjust payments, it can create incentives for providers to report data in ways that are favorable to providers. For example, in other sectors like post-acute care, the Commission has observed that because provider reported data on patients' functional status is used to adjust payments and calculate quality metrics, providers have an incentive to report patient functional status data in ways that raise payments and appear to improve performance.[2] Although the HOPE instrument (appropriately) does not include functional status measures, there may be other provider reported measures in the instrument that could create similar issues, especially if in the future the agency considered using provider reported data from the HOPE instrument to adjust payments or calculate outcome measures. Thus, oversight and monitoring of the HOPE data is important to ensure its utility. As the Commission has discussed more broadly, in overseeing the implementation of a patient instrument like the HOPE instrument, CMS should consider the following:

- Focus on items with **high inter-rater reliability** that are less subject to differential coding practices and monitor inter-rater reliability periodically after the tool is implemented.
- Implement a **strong audit plan** to ensure sufficient and continual monitoring of the data as it is collected. The Commission has previously stated that under such audits, meaningful penalties, such as civil monetary penalties, could be imposed on providers whose data submissions are either inaccurate or not supported by adequate documentation.[3] In addition, conditions of participation could be expanded to require sufficient documentation in the medical record to support the data from the assessment tool.

Proposed FY 2024 hospice wage index

Since 1998, CMS has used general acute care hospital wage data to develop the hospice wage index. For FY 2025, CMS proposes to continue to use the unadjusted inpatient prospective payment system (IPPS) wage index (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index"), with a hospice-specific national floor.

CMS also proposes to:

- update the hospice wage index with newer wage data and Office of Management and Budget (OMB) delineations,
- continue its policy of capping the wage index decrease that a provider can experience in a given year at 5 percent, and

[2] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[3] Medicare Payment Advisory Commission. 2019, *op cit*.

- implement the 5 percent cap on wage index decreases at the county level for those counties that switch core-based statistical areas under the new OMB delineations

Comment

The Commission supports CMS's annual process to update the hospice PPS wage index with newer wage data and OMB delineations. The Commission also supports having a policy to cap the wage index changes a provider can experience in a given year. We continue to urge CMS to apply a cap to the wage index increase that a provider can experience in a given year as well.

However, the Commission has long been concerned with flaws in the wage indexes Medicare uses to adjust provider payments to reflect geographic differences in labor costs.[4] To improve the accuracy and equity of Medicare's wage index systems for IPPS hospitals and other providers (such as, but not limited to hospices), Medicare needs wage indexes that are less manipulable, more accurately and precisely reflect geographic differences in market-wide labor costs, and limit how much wage index values can differ among providers that are competing for the same pool of labor. In the Commission's June 2023 report to the Congress, we recommended that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in a new Medicare wage index system for hospitals and other types of providers that:

- Uses all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;
- Reflects local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
- Smooths wage index differences across adjacent local areas.

We urge the Secretary to use existing authority to adopt the Commission's recommended approach for hospices.

Payment mechanism for high-intensity palliative care services

In this proposed rule, CMS indicates that it has received anecdotal reports from beneficiaries and families that they have been told that certain high-cost services (such as dialysis, radiation, blood transfusions, and chemotherapy) are not available in hospice, even when the services are for symptom management. CMS has stated that the hospice benefit would cover these palliative services if the hospice clinician determined that they would be beneficial for symptom management (because they are not intended to be curative). Last year, CMS asked for comment on access to high-intensity palliative services and reported that commenters stated that Medicare's current bundled per diem payment for hospice care is not reflective of the increased expenses associated with higher-cost palliative treatments.

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

In this year's proposed rule, CMS seeks comment on a number of issues related to payment for high-intensity palliative care services for hospice enrollees. For example, the agency seeks comment on what specific financial risks or costs are of particular concern to hospices that would prevent the provision of higher-cost palliative treatments and what would address those risks. The agency also asks if there should be parameters around when palliative treatments should qualify for a different type of payment, if CMS should consider defining palliative services more specifically with regard to high-cost treatments, if there should be documentation that all other palliative measures have been exhausted prior to billing for a payment for a higher-cost treatment, and if there should be separate payments for different types of higher-cost palliative treatments or one standard payment for any higher-cost treatment.

Comment

Access to hospice care for beneficiaries with high-cost palliative care needs is an important issue. At the Commission's November 2023 public meeting, the Commission discussed the issue of hospice use among decedents with end-stage renal disease (ESRD). Substantially fewer decedents with ESRD use hospice than Medicare decedents overall (29 percent vs. 49 percent in 2022).[5] Some researchers and stakeholders have pointed to concerns about terminating dialysis as being one of many factors that may contribute to lower hospice use rates among decedents with ESRD. However, CMS has stated that dialysis would be covered under the hospice benefit if the hospice clinician determines it is for palliative purposes, with the dialysis treatments paid for by the hospice. To examine this issue further, the Commission plans to conduct research about access to hospice and end-of-life care for beneficiaries with ESRD, interviewing clinicians; hospice providers; ESRD facilities, including programs that provide palliative kidney care; and other groups.

Conclusion

We appreciate the opportunity to comment on these important policy proposals. The Commission values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues, and we look forward to continuing this relationship.

If you have any questions, or require clarification of our comments, please do not hesitate to contact Paul Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair

[5] Medicare Payment Advisory Commission. 2024, *op cit.*