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Jim Mathews, Executive Director
Medicare Payment Advisory Commission
425 I Street, N.W.
Suite 701
Washington, DC 20001

Re: **MedPAC Proposed Modifications to the Hospice Aggregate Cap**

Dear Director Mathews:

As follow-up to the verbal comments we provided at the October 4th MedPAC public meeting, I submit written comments on behalf of the National Hospice and Palliative Care Organization (NHPCO). NHPCO is the largest membership organization representing the entire spectrum of not-for-profit and for-profit hospice and palliative care programs and professionals in the United States. Comprised of almost 4,000 hospice locations with more than 57,000 hospice staff and volunteers, as well as 46 state organizations. NHPCO is committed to improving end-of-life care and expanding access to hospice care with the goal of creating an environment in which individuals and families facing serious illness, death, and grief will experience the best that humankind can offer.

Our comments focus on the potential impact of the proposed changes to the hospice aggregate cap that were presented by MedPAC on October 4th**.**

Comparison of Hospice Savings to Non-Hospice Spending

Before turning to the merits of MedPAC's proposed changes, we have a fundamental observation regarding the very concept of a cap. To the extent that the cap serves to reduce access to person-centered interdisciplinary care and/or drives people to more expensive care settings, the cap needs to be fundamentally rethought.

What evidence or data do we have now to substantiate the aggregate cap as compared to the costs Medicare would bear absent hospice? Congress initially included an aggregate cap to ensure savings on hospice care, as compared to the cost of providing care to a Medicare beneficiary in the last year of life without the use of hospice. Hospice is relied on as a cost saving measure because it prevents avoidable hospitalizations and procedures that are unnecessary or unwanted, and it better aligns with the patient's goals and preferences.

There are multiple studies that support the claim that hospice care utilization results in cost savings to Medicare.[1,2] Instead of attempting to limit hospice participation, which would be an

[1] Amy S. Kelley, Partha Deb, Qingling Du, Melissa D. Aldridge Carlson, and R. Sean Morrison (2013). Hospice Enrollment Saves Money for Medicare And Improves Care Quality Across A Number of Different Lengths-Of-Stay. *Health Affairs*, *32*. doi: 10.1377/hlthaff.2012.0851
[2] Taylor DH Jr1, Ostermann J, Van Houtven CH, Tulsky JA, Steinhauser K. (2007). What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program? *Social Science & Medicine*. doi: 10.1016/j.socscimed.2007.05.028

unintended consequence of reducing the aggregate cap, there should be focus on ensuring the timely enrollment of qualified patients into hospice. The hospice program not only provides patients and family's person-centered care, it provides *cost savings* to Medicare. As discussed by Amy Kelley, MD and her colleagues in the Health Affairs study cited above, "Medicare costs for patients enrolled in hospice were significantly lower than those of nonhospice enrollees across all periods studied: 1–7 days, 8–14 days, and 15–30 days, the most common enrollment periods prior to death, as well as 53-105 days, the period previously shown to maximize Medicare savings." We look to MedPAC to guide us to reliable data that assesses the impact of the cap on costs to Medicare and specifically whether it currently functions to produce savings for Medicare today.

Access to High Quality Hospice Care

We are concerned about creating a new barrier to beneficiary access to high quality hospice care by implementing the proposed changes to the aggregate cap. While we are supportive of wage indexing the cap in the abstract, we need further evidence to be assured that wage indexing will not harm beneficiaries in rural and underserved areas. We firmly believe that a 20% reduction to the cap on top of the wage index will impose harmful, unintended consequences on patients and are therefore strongly against this proposed policy change.

MedPAC's October 4th presentation states that modifications to the cap would reduce payments to hospices with disproportionately long stays and high margins, while "other hospices would be unaffected." The last part of this claim is inaccurate. There are many nonprofit hospices that operate in underserved and rural areas that would be negatively impacted by these modifications.

We heard from the hospice provider community on the proposed modifications and include a portion of the comments below:

"The impact will be most felt in our CCN with minimal census. For small organizations with lower censuses, the impact of the 20% decrease in cap will potentially be dramatic and result in a risk too great to allow continued operation. The issue represented there of course is reduced access." ***Hospice Provider from Delaware***

"We are strongly against a 20% cut to cap. Our organization handles higher acuity patients, which is tough on staff- reducing cap means serving a higher acuity case mix with a worry about whether we will go over the cap. Not sure how less-savvy providers would handle that. Additionally, with the funding decreases to the both the 1st 60 days of care and the 61+ days of care for FY2020, this would pinch providers who are doing what CMS just asked the community to do - appropriately serve eligible patients, even when their length of stay (LOS) is longer. A balanced case mix is crucial for a hospice to maintain, and while very long LOS should be drawn down, a 20% cut is extreme…" ***Hospice Provider from Illinois***

"The proposed changes are looked at and applied in the aggregate, however since providers do not operate in every market, this sort of broad-spectrum change would arbitrarily injure providers and in turn the communities they serve. Finally, the cut is far greater than 20%, and the hospice cap credit would no longer support the spirit of the hospice benefit which currently

indicates eligibility with a prognosis of 6 months or less." ***Hospice Provider Operating in Multiple Service Areas***

As substantiated by these comments, reducing the aggregate cap would negatively impact the ability of the hospice provider to serve patients who require both short and long stays. We understand that MedPAC staff proposed the changes to the aggregate cap to target "bad actors"[3] by "reduc(ing) overpayments to providers with disproportionately long stays and high margins." MedPAC should not use the aggregate cap to reduce payments to providers with a patient mix with more long stays or to specifically lessen the "attractiveness of business models focusing on long stays." This is not a business model issue – it reflects the market and the reality that the determination of the six-month prognosis is not precise for many diagnoses. Reducing the aggregate cap could have the unintended consequence of not having the hospice benefit as an option or electing hospice very late in the disease process. Both deny or delay care to beneficiaries who most need care and support at the end of life.

Has MedPAC considered alternative proposals, e.g. indexing the cap based on reported quality measures? We would like to work with MedPAC to further analyze the impact of this alternative approach. We believe this could possibly change the behavior that MedPAC is trying to target and might better align with the intent of the proposed changes presented at the October 4th, 2019 meeting.

Access to quality hospice care will also be impacted by one important nuance of the proportional method applied during the hospice aggregate cap calculation that was not considered during the October 4th presentation. In the case in which a beneficiary received care from more than one hospice, each hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in that cap year, *using the best data available at the time of the calculation*. Those calculations are updated by the MAC and further adjustments may be made for up to 3 years after the first percentage of days adjustment.

A hospice must be vigilant about checking the Common Working File to determine whether the patient has had hospice from another provider previously. Sometimes it is from a competitor in the same geographic area or care from a hospice in another state several years previous, when the patient was discharged for a disease plateau. A hospice who is working to manage their cap exposure could be surprised that the percentage of cap applied to their hospice is only a fraction of the total cap, since the aggregate cap amount is applied proportionally among all the hospices that provided care. If the aggregate cap is wage indexed, this could negatively impact providers with shorter length of stays that share in the cap with another provider.

With the above points in mind, we challenge MedPAC to look at this issue more holistically. MedPAC should stay true to the original intent of Congress that the Medicare hospice benefit aggregate cap ensures savings to the Medicare program, while encouraging individual providers to continue to expand access to all beneficiaries - regardless of diagnosis or location.

[3] "Bad actors" is language from the October 4th MedPAC public meeting. http://www.medpac.gov/docs/default-source/default-document-library/october-2019-transcripts.pdf?sfvrsn=0

Thank you for your consideration of these comments. NHPCO is committed to working with MedPAC on this important issue and we look forward to working with MedPAC staff to analyze proposals on access to care and the quality of hospice care.

Sincerely,

Edo Banach, JD
President and CEO