June 18, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1718-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (CMS-1714-P)

Dear Administrator Verma:

ElevatingHOME and VNAA submit the following comments on the *FY2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements*. We appreciate CMS' positive hospice payment update but offer additional recommendations to support patients and caregivers at the end-of-life. Of critical importance, ElevatingHOME urges CMS to provide additional funding and technical assistance to support interoperable health IT infrastructure so that all members of the interdisciplinary care team have access to the information and support they need.

ElevatingHOME is a new industry organization, launched in 2017, to unify America's for-profit and not-for-profit home-based health (home health and hospice) care providers and to advocate for high-quality, affordable care. ElevatingHOME was formed by the leadership of the Visiting Nurse Associations of America (VNAA) with leaders and stakeholders from across the country. ElevatingHOME's mission is to align, unify, and strengthen the home-based care industry.

Our specific comments on the proposed rule follow--

A. Proposed Rebasing of the Continuous Home Care, Inpatient Respite Care and General Inpatient Care Payment Rates for FY 2020

CMS proposes to rebase general inpatient care (GIP), inpatient respite care (RHC), and continuous home care (CHC) to more accurately reflect the costs of providing these levels of care in a manner which remains budget neutral.

Response: ElevatingHOME and VNAA agree that these levels of care are more costly to provide than routine homecare (RHC) and appreciates the effort to reimburse accordingly. We agree that every hospice needs to have the capacity to provide all four levels of care. The ability to meet this requirement

requires extensive planning, coordination, and communication within the agency and across multiple community stakeholders. The data reflecting underutilization of these levels of acuity is consistent across time at the national level but does show variation at the agency level. In 2014, Abt Associates demonstrated that hospices were more likely to provide GIP care if they were in operation for 20 or more years, larger, and located in the Northeast.[1] The OIG report subsequently reported that hospices that did not provide GIP were more likely to be for-profit. The explanation from CMS for the rebasing as a response to reports of the inability to secure contracts with facilities to provide GIP or IRC are concerning. Most agencies who do not operate free-standing facilities have pass-thru contracts with local hospitals and nursing facilities. These arrangements are a community-benefit and in the best interest of the facilities and hospices to coordinate efforts for the community members. Given the relationship between the for-profit status and lack of GIP care, the question of profit as motivation to avoid making such contracts must be considered. In the instance of pass-thru contracts, no real value will be gained by the hospice agencies.

An alternative explanation for the low use of GIP, IRC, and CHC is the concentrated, and intentional use audits on these stays. Since the release of a 2015 OIG report on the utilization of hospice GIP in 2012, there has been a national focus on auditing the use of all acuity levels other than RHC, based on the largely unsubstantiated accusation of widespread fraud. This scrutiny delays payments undercuts the clinical decision of the physician and care team, and either leaves patients with unmet need or places organizations in fiscal jeopardy and ultimately suppresses the use of these much-needed levels of care. Although increased reimbursement for these more resource-intense levels of care is welcomed, the effort to increase use of these levels of care with this incentive is incomplete. Auditing practices must be aligned with the desire to provide these services to patients in need. If national utilization does increase in the next several years, entities examining only the fiscal implications of their use must embrace the stated goal of CMS and support the upward trend, not deny more claims and punish the industry.

C. Proposed Election Statement Content Modifications and Proposed Addendum to Provide Greater Coverage Transparency and Safeguard Patient Rights

CMS proposes revisions to the Election Statement to improve transparency of the potential for unrelated medical care and products to be billed separately from the hospice benefit.

Response: ElevatingHOME and VNAA support the goal of increased transparency and the complex nature of unrelated medical care, services, and products in hospice. We request additional information from CMS about the proposed process. We support the suggested language for addition to the election statement before the start of care and the need to make detailed information on what, if any, care, services, or products are identified as unrelated after the completion of the full interdisciplinary assessment is completed and the plan of care is created.

[1] Abt Associates. Medicare Hospice Payment Reform: Analyses to Support Payment Reform. (May 2014). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/May-2014-AnalysesToSupportPaymentReform.pdf.

However, we are concerned about the confusing language in the rule regarding the process, timeline, and requirements of the detailed list intermittently referred to as "the addendum." A thorough reading of the rule reveals numerous inconsistencies. The description of this part of the proposed rule starts by stating that this information is "to be available on request," does not need to be complete until the plan of care is complete and is not a required part of communication to the providers. Further in the rule, all these items change. At one point, the language in the rule states that the detailed list must be completed on admission, provided in duplicate for the patient/family to sign with the signed acknowledgment maintained in the chart as a "condition for payment," and sent actively to all providers of care, services, or products involved. These steps are highly problematic.

The list of care, services, or products, which may be determined as unrelated to hospice care, cannot be determined at the time of election. This is part of the interdisciplinary care process, requiring input from numerous professionals and complete patient, family, and home assessments. Efforts to make this list available immediately on admission in a detailed format are contradictory to the hospice philosophy of interdisciplinary planning. Attempts by the nurse to identify this list on admission will be artificial at best and place patients at greater risk for making an election decision based on incomplete or erroneous information.

The difference between "available on request" and a "condition of payment" is significant in practice. If these lists are intended to be distributed on paper, signed by a beneficiary, shared with all non-hospice members of the care team (physicians, DME providers, pharmacies, etc.), updated with every change, and maintained as a condition of billing, the estimates of staff burden are completely inadequate. The ability to update, print, and obtain signatures alone will take a minimum of two days. Hospice staff do not carry printers to patient homes, and changes in the plan of care require input from a minimum of two members of the interdisciplinary group (IDG). This will not occur during the visit when a change to the plan of care is identified for consideration. Further, the related/unrelated decision is significant and best accomplished with the entire IDG.

We support the spirit of transparency reflected in this proposal but have grave concerns about the contradictory descriptions of the process for documenting and sharing the details of unrelated care, services, or products. We request clarity about this process and an opportunity to comment on the revisions before future implementation.

D. Request for Information Regarding the Role of Hospice and Coordination of Care at End-of-Life

CMS seeks input regarding alternative payment models and end-of-life care.

Response: ElevatingHOME and VNAA appreciate the opportunities to discuss alternatives to the traditional fee-for-service model for end-of-life care. In designing new payment models, consistency with the fundamentals of hospice will be critical. The current hospice benefit is the role model for holistic, patient-driven care, encompassing family members of the beneficiaries' choosing. It is mindful of the communities of people, the physical environment of choice, and the spiritual, psychosocial, and emotional components of being human. Changes to the payment structure must enhance these ideals. Concerns about eroding payment in risk-sharing arrangements are grounded in the patterns of many

payment models where savings are realized based on reducing days of service and types of care. Discussions about new payment models for end-of-life care will be successful when they embrace the original ideals of holistic care, minimize the application of "care unrelated to the terminal condition," and provide structural support to the continuum of care needs individuals progress through during the evolution to active dying. Timely and adequate payment are structural necessities to ensuring Medicare beneficiaries receive enhanced end-of-life services with new payment models. We recommend that if alternative arrangements are going to be examined, they are tested and evaluated before large-scale changes being introduced directly.

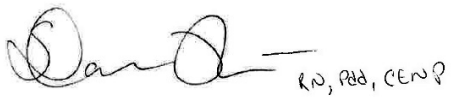
E. 2. a. Claims-Based and Outcome Quality Measure Development for Future Years

CMS seeks further development of outcomes measures for quality evaluation.

Response: ElevatingHOME and VNAA fully support the development of outcomes measures to evaluate hospice quality and appreciate the recognition of the strengths and weakness of claims-based measures. Recognizing the complexity of defining measures for outcomes in hospice, we agree with both the desire to measure transitions in care and the need to carefully define inclusion and exclusion criteria, as well as framing when a transition is positive or negative. It is valuable to track high rates of live discharge and excessive use of emergency departments or hospital admissions other than GIP days. These measures must be nuanced enough not to label these events as poor care automatically. We support the continued partnership with the National Quality Forum to vet and evolve well-developed measures with minimal chance of unintended consequences.

ElevatingHOME and VNAA appreciate the opportunity to offer comments on the hospice proposed rule, as well as offering comments on solutions to improve the hospice care benefit. ElevatingHOME and VNAA welcome the opportunity to serve as a resource. Please contact Danielle Pierotti, RN, Ph.D., CENP, Vice President, Quality and Research at dpierotti@elevatinghome.org or 202-508-9429.

Best regards,



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