



June 26, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1675-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (CMS-1675-P)

Dear Administrator Verma,

ElevatingHOME submits the following comments on the *FY2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements*. We appreciate CMS' positive hospice payment update and offer here 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 an 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 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.

II. E. Trends in Medicare Hospice Utilization

CMS reiterates that hospices are to report all diagnoses codes on hospice claims, whether related to the terminal prognosis or not.

Response: ElevatingHOME agrees that all providers should be aware of their billing responsibilities regarding a hospice patient and encourages CMS to support hospice providers to ensure that hospices are connected into the electronic health records and other patient health information databases to receive all needed information. To that end, CMS should support and fund an interoperable health care system and additional education systems so that all providers are aware of the patient's hospice election and are further guided to communicate with the hospice provider. This is not meant to suggest additional regulation or requirements; rather tools to ensure that providers who support hospice patients better understand Medicare coverage of services.

III. A. Monitoring for Potential Impacts-ACA Hospice Reform

1.a. Length of Stay and Live Discharges: Hospice Length of Stay

CMS reports that the rates for both *length of stay* and *total lifetime length of stay* are similar between FY 2015 and FY 2016. *Average lifetime length of stay* is consistent over the same time period.

Response: ElevatingHOME strongly recommends that CMS continue data collection of hospice length of stay over an episode and over the lifetime. However, data collection must focus on patterns of hospice utilization and not an individual's use of services over the lifetime. Data collection is meant to support payment and policy alignment, not to monitor patient-level use of services.

1.a. Length of Stay and Live Discharges: Live Discharges

CMS documents that approximately half of live discharges in FY 2016 were because the individual was no longer terminally ill.

Response: ElevatingHOME recommends that CMS continue data collection on live discharges and patient's revocation of the benefit. CMS should monitor the care plans of patients who are discharged live to see if the medical condition improved during the episode. The care plans will also identify a patient's next steps, including if a facility placement followed the live discharge or if new hospice services were put in place.

Further, ElevatingHOME requests additional information from CMS about the high rate of live discharge, as well as more information about their discharge rate methodology. We are concerned that CMS' analysis does not take into account the full scope of data included in the patient's care plan. Instead, CMS' presentation of the data does not acknowledge other possible reasons for live discharge rates and, instead, give the appearance of high rates of fraud. The data presented does not illustrate all reasons for live discharge that could include hospices discharging for those no longer eligible, patients that move out of a hospice service area to be closer to families or loved ones and other benign reasons.

However, a high proportion of live discharges because a patient was no longer terminally ill could indicate that patients are being enrolled who are not terminally ill or who do not need end-of-life care. But this could also indicate that patients are underserved at home before they reach hospice and have experienced a decline in health and function that—absent high quality care at home—could be terminal. With support and intervention, a patient's trajectory towards death is halted and a live discharge is possible because the patient is no longer terminally ill.

ElevatingHOME also supports guardrails of program integrity measures to filter out high quality providers and allow enforcement efforts to focus on curbing inappropriate admissions. These program integrity measures include:

Low rates of long length of hospice stay (180 days +)¹

Low rates of live discharge (appropriate definition and how the calculation is made)²

Certification of Terminal Illness compliance (fully meets the requirements for certification and recertification)³

¹https://www.pepperresources.org/portals/0/Documents/PEPPER/HOSPICE/Hospice_PEPPER_training_2016.pdf

²https://www.pepperresources.org/portals/0/Documents/PEPPER/HOSPICE/Hospice_PEPPER_training_2016.pdf

³ <https://oig.hhs.gov/oei/reports/oei-02-10-00492.asp>

Low percentage of “leakage” (those who have elected hospice who end up getting services outside of the benefit from other providers)⁴

Policymakers should develop and implement monitoring and pre-payment review for hospices with continuing to fall outside of these data metrics.

Other aspects of a hospice program integrity include: vital areas of education and outreach jointly developed and conducted by CMS, Medicare contractors and national industry organizations could complement and strengthen program integrity efforts.

Education and re-education of members about compliance of hospice regulations in an effort to break through falsely held common beliefs not in compliance.

Education from the industry to patients and their families

Education from the industry to physicians on latest regulatory changes

Education and re-education from CMS to MACs and auditors and surveyors on current regulations and their appropriate application

Additionally, a joint certification for hospice program compliance could also be useful to complement and strengthen program integrity efforts. This certification could lead to potential lessening of audits or review.

1.b. Skilled Visits in the Last Days of Life

After analyzing the first year of data on utilization of services, CMS reports a very small increase in the number of patients receiving skilled visits in the last days of life has occurred with the implementation of Service Intensity Add-on (SIA).

Response: ElevatingHOME applauds CMS’ continued interest in supporting patients in the last seven days of life. We support their goal of aligning payment structures to ensure that all patients get the skilled visits they need at the end of life—and the SIA attempted to do this. However, while there has been a small positive increase in the number of patient’s receiving skilled services at the end of life, patients are receiving similar levels of care when compared to before the SIA payment implementation. As such, it does not appear that the new SIA policy resulted in the desired shift in utilization.

ElevatingHOME asks CMS to refine the model to increase the number of patients who receive skilled services in the last seven days as additional incentives or policy alignment are needed. ElevatingHOME strongly supports CMS’ goal that patients and caregivers receive the level of care necessary during the critical last days of life and encourages additional policy development in this area. These incentives should include a focus on high level coordination of advanced practice nurses and social workers providing care. While the current CMS analysis shows that hospice providers are not inappropriately overusing the service intensity payment, far too many hospice patients are not receiving skilled visits in the last seven days of life. ElevatingHOME encourages CMS to focus on educating hospice providers on continuing increased usage as quality improvement efforts and better care for hospice patients. Additionally, ElevatingHOME stands ready to support CMS on their outreach efforts in this area.

⁴ <https://oig.hhs.gov/oei/reports/oei-02-10-00492.asp>

1.c. Non-Hospice Spending

CMS continues to monitor hospice spending for duplicate payments, with a particular focus on Part D drug spending.

Response: Federal policy must prioritize hospice patients receiving needed medications in a timely and effective manner, regardless of the payer and without additional burdens on the patient or caregiver.

ElevatingHOME urges CMS to convene stakeholders, patient groups and hospice providers in the planning process when designing any new or revised benefit and payment structures on drug payment (and potential duplicate payments), and to develop an appropriate on-ramp to allow hospice providers, pharmacists and other participating providers to adjust their administrative systems allowing for data-sharing to best align accurate and non-duplicative prescribing and billing practices.

Alignment and transparency across *all* providers is vital for improving appropriate prescription drug utilization. At end-of-life, hospice patients may require a wide range of prescription drugs, in addition to other maintenance drugs. Restrictions or burdensome utilization management strategies should not be used to curb perceived duplicate payment for drugs. These structures delay needed prescriptions for very vulnerable patients—and dramatically increase the paperwork burden on providers, diverting them from patient care.

Further, many providers—including prescribing providers, pharmacists, plans, as well as hospices—deliver prescription drugs to hospice patients. Each of these providers has a different process for filling prescriptions; there is no centralized coordination mechanism. Yet only hospices are subject to a financial penalty when there is evidence of duplicate payments.

2.B.2. Proposed Hospice Payment Update Percentage

CMS proposes a hospice payment update percentage for FY 2018 of 1%.

Response: ElevatingHOME supports a positive payment update for FY2017. However, the update does not appropriately keep pace with the cost of providing hospice care to beneficiaries. The payment update does not match the increasing costs associated with data collection requirements and reporting, technology, workforce and training. For example, a 2015 Pricewaterhouse Cooper's cost trend report⁵ cited that increasing technology costs account for 2% growth in administrative costs alone, per year. VNAA strongly encourages CMS to revisit the payment update to account for the underlying and growing costs of providing high-quality hospice care and meeting the new reporting requirements from CMS.

ElevatingHOME urges CMS to revisit this proposed payment update to account for the growing costs of providing high-quality hospice care. The payment update must be sufficient to cover the burden on providers of meeting CMS' new reporting requirements, as well as necessary investments in technology, workforce and training. When combined with program integrity safeguards, an adequate payment increase will ensure that Medicare beneficiaries receive high quality care and that taxpayer funds are

⁵ <http://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/pwc-hri-medical-cost-trend-2015.pdf>

used appropriately. Additional funds should be designated to support hospice providers with interoperable health information technology.

2.C. Discussion and Solicitation of Comments Regarding Source of Clinical Information for Certifying Terminal Illness

CMS solicits comments on the certification and eligibility determinations prior to election of the hospice benefit.

Response: ElevatingHOME applauds CMS on the recognition that the terminal diagnosis is complex and not an exact science. Patients, with the support of their families, *choose* hospice after careful consideration—the role of the certifying provider is to agree that patients are reasonably at the end of their life.

There must be no unreasonable delay between certification of terminal illness, the election of benefit and a patient receiving services. Patients need immediate services once they have elected hospice and cannot wait for burdensome pre-approval processes for certifying terminal illness *prior* to the election of hospices. No process should be proposed that will increase the time between a patient choosing hospice and receiving services. This puts patients at risk particularly in light of the short median length of stay in hospice.

To alleviate any potential delay in accessing services, ElevatingHOME has developed a recommendation that CMS establish a “grace period” for reviewing terminal certification. The grace period will begin when the patient, who is reasonably deemed as terminal by the certifying physician per current standards, elects to have hospice services. Once the election is made, the patient will have immediate access to hospice services. A grace period of 10 business days will start allowing the hospice team to gather more information, assess, care for, and plan for the patient needs. Patients who have died during this time period will have their terminal status confirmed without the submission of further documentation. More detailed documentation and supporting evidence can be submitted on those with longer LOS.

It is also important to acknowledge that the multi-disciplinary hospice team, including the hospice physicians and nurses, are trained in end-of-life care, as well as on the rules Medicare hospice eligibility. Their training and scope make them uniquely positioned to support the certification of terminal illness. CMS must invest in an interoperable health care system that supports all members of the health care team and supports the hospice team as the center of the patient’s care.

2.D.7 Measures Concepts Under Consideration for Future

CMS identified two high priority areas for development:
Potentially avoidable hospice care transitions
Access to levels of hospice care

Response: ElevatingHOME supports the continued development and testing of quality measures for hospice providers.

Specifically, ElevatingHOME supports the measure on potentially avoidable transitions. The underlying goal of the hospice benefit is about supporting patient choice and dying in the place they are most comfortable. Transferring locations is inconsistent with this core goal and should be treated as an adverse occurrence.

In addition, ElevatingHOME also supports the measure on access to levels of hospice care. As noted above, the goal of the hospice benefit is support a patient in the location of their choice. Access to levels of care is a critical component of avoiding transfers and honoring patient choice.

Hospice is about meeting patient needs and goals, staying in the location of choice AND receiving the care needed go hand in hand. These measures support this critical goal. In addition, as quality measures are deployed for public reporting, it is important to educate patients and the public about what they mean, and what can be inferred about the quality of the hospice providers.

2.D.8.d New Data Collection and Submission Mechanisms Under Consideration: Hospice Evaluation & Assessment Reporting Tool (HEART)

CMS is in the early stages of developing a hospice patient assessment tool which would provide quality data necessary for HQR requirements.

Response: ElevatingHOME supports the development and implementation of a patient assessment tool for hospice beneficiaries that is patient-specific and reflects a patient's plan of care and end-of-life decisions. The tool must reflect the interdisciplinary nature of hospice care, and be usable and used by all members of the care team, including non-physician and nurse providers (e.g., social workers; chaplains).

A uniform patient assessment tool should collect additional data and inform payment and risk adjustment methodologies, and can support measures of social and economic status and spiritual guidance in quality reporting programs.

It is important to also consider the goal of a uniform post-acute assessment tool that includes hospice and all post-acute settings. ElevatingHOME is committed to ensuring that all patients are placed in the most appropriate setting of their choosing. Policies such as the IMPACT Act are making significant strides in the development of a patient assessment across all settings. The HEART tool should be carefully aligned with and integrated into the full care continuum. However, the HEART tool must be hospice-specific and reflect the unique nature of hospice care, the interdisciplinary team (including non-medical providers), and the unique choices and decisions facing hospice patients and their families.

We appreciate CMS' acknowledgement that stakeholder engagement is critical to the development and implementation of this assessment tool. CMS should roll out the implementation of the HEART tool with a small pilot first to test and get feedback from all stakeholders.

2.D.11 CAHPS Hospice Survey Participation Requirements for the FY 2020 APU and Subsequent Years

CMS proposes 8 survey-based measures for the CY 2018 data collection period and for subsequent years including:

Hospice Team Communication

Getting Timely Care

Treating Family Member with Respect

Getting Emotional and Religious Support

Getting Help for Symptoms

Getting Hospice Care Training

Rating of Hospice

Willingness to Recommend Hospice

Response: ElevatingHOME supports the adoption of the new survey measures. In particular, we support that CAHPS Hospice Survey scores for a given hospice be displayed as “top-box” scores, with the national average top-box score for participating hospices provided for comparison. This will allow hospice providers to understand their measures and identify areas for improvement.

2.D.14 Public Display of Quality Measures and other Hospice Data for the HQRP

CMS announces that reporting to the Hospice Compare Website is anticipated in the summer of CY 2017.

Response: ElevatingHOME supports quality benchmarking and transparent reporting for hospice providers. As quality reporting is still new for hospice providers, CMS should provide more than 30 days for hospices to review their preview report. Sufficient time is needed by the hospices to work out any issues with data submission and to report in an accurate and timely manner. ElevatingHOME recommends a minimum of 60 days for hospices to review their preview report.

VI. Request for Information on CMS Flexibilities and Efficiencies

CMS invites comment on regulatory, subregulatory, policy, practice and procedural changes to reduce unnecessary burdens for clinicians, provider and patients/families, and to increase quality of care, reduce costs, improve program integrity, and make the health care system more effective.

Response: ElevatingHOME envisions home-based care providers as an integral and critical component of high-quality health care delivery models. ElevatingHOME advances the principles across the care continuum that health care starts at home, that the home is a lower-cost setting for care delivery, and that outcomes are often best at home. Of special significance to hospice services, the foundation of hospice care recognizes that patients choose to die at home. ElevatingHOME is committed to working with CMS to develop and implement innovative solutions to keep patients in the center of care at home. ElevatingHOME’s initial recommendations include:

Bridging care between treatment, palliative care and hospice

Palliative care and hospice are important steps on the continuum of care for patients and caregivers during advanced illness and end-of-life. Patients increasingly choose palliative care and hospice, and support for the programs continue to grow.

Yet Medicare payment policy does not support a seamless path between services for patients and caregivers, resulting in a paperwork burden, delays in care, and complexity for patients. ElevatingHOME supports reforms that will help ease this complexity and result increased use and appropriate payment of these critical end-of-life services. To accomplish this goal, CMS must pursue data-driven payment reforms. Initial steps include:

- Data collection on patients who seek concurrent curative and palliative care outside the traditional Medicare benefit. These data will provide information on how and why these patients engage curative care in addition to hospice care, and what the complimentary services are.
- Administrative action to enhance information exchange between all Medicare providers regarding a beneficiary’s hospice election and a transparent system to coordinate claims processing and provider responsibility.

- Enhance care in the last seven days by aligning payment structures to appropriately incentivize high levels of coordinated care; specifically, by the nurse practitioners, social workers and registered nurses.

Education of patients and families about the role of hospice and end-of-life care

Additional education is needed to support patients and families and to ensure that they are aware of the services available to them. Studies have shown that caregivers reported the first discussion of the illness being incurable and of hospice as a possibility occurred within 1 month of the patient's death in many cases (23.5% and 41.1%, respectively).⁶ Additionally, the Family Evaluation of Hospice Care (FEHC) showed that family member perceptions of the quality of end-of-life care did not vary by length of stay but rather the perception of being referred “too late” was associated with unmet needs, higher reported concerns, and lower satisfaction. These results suggest that family members' perception of the timing of hospice referral—not the length of care—is associated with the quality of hospice care.

CMS can support patient end-of-life choices by:

- Developing a sustained information campaign and hospice specific materials for patients and caregivers.
- Providing incentive payments to providers for having end-of-life conversations.
- Supporting State Health Insurance Programs (SHIPs) and other Medicare benefit counselors to provide patients and caregivers information about what Medicare covers.

ElevatingHOME appreciates the opportunity to offer comments on the Hospice proposed rule, as well as offering comments on solutions that would improve the hospice care benefit. ElevatingHOME welcomes the opportunity to serve as a resource. Please contact Joy Cameron, vice president of policy & innovation at jcameron@elevatinghome.org or 571-527-1536.

Best regards,

A handwritten signature in blue ink, appearing to read "Joy M. Cameron", with a long horizontal line extending to the right.

Joy M. Cameron
Vice President, Policy & Innovation

² <http://online.liebertpub.com/doi/abs/10.1089/jpm.2005.8.1176>