



June 18, 2019

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1714-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: Medicare Program; FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

Dear Administrator Verma:

The National Partnership for Hospice Innovation (NPHI) is pleased to submit the following comments on the CMS proposed rule CMS-1714-P, entitled *Medicare Program; Hospital FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements*. NPHI is a collaborative of many of the nation's most innovative, community-based, not-for-profit hospice and palliative care providers that serve as a critical safety net in communities across the United States. In coming together, we work to identify, enhance, and spread the best practices in which our members are engaged.

NPHI members have decades of experience in providing the highest-quality hospice and palliative care to those facing the final stages of their lives. Of the almost 4,500 hospice providers in the United States, only 27 percent are not-for-profit,¹ but they serve the sickest and most vulnerable patients in our communities and refuse to turn any patient away regardless of their terminal condition or ability to pay, while still providing a comprehensive scope of care to meet each patient's goals, values, and wishes during their last stage of life. Many of our programs have their own inpatient units, serve patients who have no caregivers themselves and have a multitude of special programming all of which play a critical role at the end-of-life for those who have no alternative supports and who could otherwise go without care during this vulnerable time.

This commitment to serve as essential and high-quality safety net providers for those in our communities who need hospice care is not only fundamental to our mission, but also distinguishes us as leaders in hospice whose innovative programs reflect the original intent of the Medicare Hospice Benefit (MHB). Our members are longstanding and integrated members of their communities and many have participated in the delivery of the MHB since its inception and are committed to the mission and improvement of the MHB.

TRENDS IN MEDICARE HOSPICE UTILIZATION

Overall Comments

¹Medicare Payment Advisory Commission. 2019. "Hospice Services." *Report to the Congress: Medicare Payment Policy*. http://medpac.gov/docs/default-source/reports/mar19_medpac_ch12_sec.pdf?sfvrsn=0.

NPHI continues to applaud CMS for the depth and breadth of data presented in the FY2020 and 2019 Wage Index rules and urges CMS to use these data to target outlier hospice programs, rather than creating more regulatory burdens on all hospices in order to attempt to achieve the same outcome. We believe a goal of a focused, data-driven program integrity strategy, rather than the imposition of more processes on all providers, is aligned with the Administration's focus on regulatory relief and its *Patients Over Paperwork* initiative.

There is compelling evidence of systemic problems in the oversight of the MHB by the Medicare Administrative Contractors (MACs) and related contractors, and we submitted comments regarding this concern for the FY2016, FY2017, FY2018, and FY2019 Hospice Wage Index and Payment proposed rules. These problems have created an unintended but material strain on the nation's finest hospice programs, including NPHI's members, that provide excellent hospice and palliative care to Medicare beneficiaries and abide by statutory and regulatory rules.

Current challenges with the lack of a sufficient data drive program integrity strategy

Claims for Medicare hospice benefits are routinely denied on improper grounds.

Although the relevant statutes and regulations condition the receipt of hospice benefits only upon certification by two physicians that the beneficiary is terminally ill, i.e., is not *expected* to live more than six months if the illness runs its normal course, MACs are routinely denying claims based on an overly simplified conclusion that the documentation fails to show the "continuous decline" of the patient's condition, as clinically defined by the MAC reviewers. The standards applied for continuous decline are most often not apparent nor clinically supportable in determining terminal illness. Although physicians do indeed evaluate declines related to the primary diagnosis and comorbidities to inform prognostication, the clinical judgment made by a physician that the patient remains terminally ill (as opposed to chronically ill) is not negated by a period of stability or the finding that one or another of the descriptions included in the hospice local coverage determinations (LCDs) is not applicable in any particular case.

As noted above, the "decline requirement" neither appears in, nor is consistent with, applicable statutes and regulations, but the practical effect of this "as applied" standard for the terminally ill patient and the hospice provider is either (a) cessation of hospice care in the patient's final days, weeks or months, or (b) extraordinary financial risk due to the assumption by the hospice of the full costs of hospice care if the MAC denies payment but the hospice does not abandon the patient and family in time of incredible need. Administrative appeals to the ALJ level now take *years*, while these patients often have only days, weeks or months to live.

Current audit practices have a chilling effect on beneficiaries' access to high-quality hospice care.

Not-for-profit hospices are being disproportionately affected by the MAC and other contractor audit activity because larger, more established hospice programs often have higher average daily census counts. The ongoing and potential damage to these not-for-profit entities does not benefit Medicare, its beneficiaries, or high integrity hospice providers.

MedPAC has reported that not-for-profit hospices average only a "breakeven" financial performance on their Medicare cost reports. This breakeven is drastically optimistic, as most not-for-profit programs have

additional expenses for their robust volunteer and bereavement programs that are carved out of their financial performance as reported by the Medicare cost reports.

Clearly, these hospices cannot afford the direct and indirect costs associated with audits and appeals, despite their desire to "prove innocence" and demonstrate they are conducting their programs with the utmost integrity.

The audits are creating a "chilling effect," which particularly affects the admission of patients who 'fail to die on time' or patients transferred to an inpatient unit who are not demonstrating extreme distress, but who nonetheless clinically qualify for a GIP level of care. At present, these include 1) patients who are medically appropriate for hospice according to physician review, but who may be relatively more likely to clinically stabilize or survive for several months, and 2) patients who, according to a physician, would benefit from an inpatient stay to improve symptom control but who do not have a consistently dramatic need for continuous skilled nursing care to avoid more expensive hospitalization.

As we will discuss later in our comments, these trends in oversight that are now moving to GIP disproportionately impact our members and are not aligned with CMS' stated intent in this proposed rule to increase access to GIP and the other non-RHC levels of care. In addition to data-driven scrutiny, NPHI recommends a clinical evaluation by CMS and relevant stakeholders of the local coverage determinations (LCDs) which are long past due for revision and are being overly relied upon by CMS contractors.

Examples of Data Presented in the FY2019 Rule That Could Be Considered for Program Integrity Targeting

Length of Stay and Live Discharges

Table 6 in the proposed rule² shows significant variation in the rate of live discharges between the 10th and 90th percentile of hospice providers. Some live discharges are appropriate – patients may move or change their mind about seeking curative treatment over the course of a hospice stay. Some patients also might genuinely no longer be eligible for the benefit – though the application of a "rule of thumb" standard regarding continuous decline cannot be the only tool used to judge this eligibility. Regardless, there are certainly hospice providers who are using live discharge as a tool to control costs or whose high rate of live discharges could be a sign of other poor behavior. What we would like CMS to note is that there is a large difference in the percentage of live discharges by programs in the 95th or even 90th percentile – and we would ask that CMS use this as an indicator for medical review. Pairing this data with analysis of Part A spending outside of the hospice benefit would likely enhance targeting.

CMS also focuses a lot of the discussion on long length of stay – once again, NPHI believes that if there are too many beneficiaries who have a long length of stay, that can be a sign of problematic behavior. However, we would encourage CMS to increase their focus on the *short* lengths of stay in hospice. The median length of stay in hospice has remained relatively constant at 18 days --- NPHI believes this indicates the need to focus on hospice access. We note that the increased *average* length of stay warrants attention but should not be CMS' only focus.

Non-Hospice Spending During Hospice Election Period

²<https://www.federalregister.gov/d/2018-08773/page-20942>

In this section, CMS notes: “...we continue to conduct ongoing analysis of non-hospice spending during a hospice election and the results of our analysis seem to suggest the unbundling of items and services that perhaps should have been provided and covered under the Medicare hospice benefit.”³ NPHI wants to stress that this point is key – if services that should be provided under the hospice benefit show up as “post-live discharge” costs to original Medicare, this is a critical data point for program integrity. In other words, our providers are paying the FFS Medicare costs to the hospital for related services, but our competitors often discharge alive. We also recommend (and discuss in depth later in this letter) that CMS revisit and clarify what should be covered by the hospice – there is inconsistency on this point across hospice providers as well as inconsistent enforcement. This clarification would enhance care for patients and families, allow for easier comparison of programs, and allow for increased program integrity efforts based on this data point.

Initial Analysis of the Revised Hospice Cost Report Data

NPHI supports the changes to the cost reports that were implemented and are now proposed. It is critical that the accurate costs of running a hospice program be reflected in the cost report, including the cost of services like bereavement and volunteer program administration which are required parts of the benefit but not reimbursed. It is a differentiator as to who offers robust services and being able to accurately capture how much money is spent on these critical services, as well as on increased clinical services, can also be used as differentiators in future iterations of tools like *Hospice Compare*.

We request that CMS continue education on the cost reports and changes in expectations as to how they should be completed. We would be happy to partner with CMS and other stakeholders on these efforts and, once again, we applaud CMS for its efforts to obtain more accurate data on this critical aspect of hospice operations.

In addition, we would recommend that the allocation of overhead methodology must be amended to more accurately reflect the cost of administration of the hospice program. Currently if a hospice organization operates comprehensive programs supporting the seriously ill and bereaved and their philanthropy program (such as thrift shops), their organizational overhead is taken out of the hospice cost calculation and distributed across these other programs. This is a flawed approach, since almost none of those overhead costs would actually be eliminated if all of those associated business lines closed. The audited financials of each organization distribute overhead in an accurate manner and this should be collected on the cost report.

Finally, NPHI believes it is vital to analyze and understand the impact of chain affiliation and ownership status on the quality of hospice care provided to Medicare beneficiaries and their families. We understand that the hospice cost reports currently gather some data regarding chain affiliation, but also that these data are often unreliable.⁴ We urge CMS to take steps immediately to improve the accuracy and validity of cost report data on chain hospice affiliation and ownership.

³<https://www.federalregister.gov/d/2018-08773/page-20946>

⁴David Stevenson, Emily Krone, Robert Gambrel, Laurie Meneades, and Haiden Huskamp, *Tracking the Impact of Ownership Changes in Hospice Care Provided to Medicare Beneficiaries*, prepared for the Office of Disability, Aging, and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation (ASPE), January 2017. <https://aspe.hhs.gov/basic-report/tracking-impact-ownership-changes-hospice-care-provided-medicare-beneficiaries-final-report>

PROPOSED PAYMENT RATE REBASING, WAGE INDEX CHANGES, AND MARKET BASKET UPDATE

Summary of proposal

CMS proposes to make four changes to the Medicare hospice payment rates starting in FY 2020:

1. Increase rates for Continuous Home Care (CHC), Inpatient Respite Care (IRC), and General Inpatient Care (GIP), such that the resulting rates cover approximately 100% of the estimated average costs of providing these levels of care.
2. Decrease the rate for both Routine Home Care (RHC) levels of care by 2.71% to offset the proposed increases in the other rates to maintain program budget neutrality.
3. Change the hospice wage index methodology to standardize it with the hospital inpatient prospective payment system (IPPS) wage index by eliminating the current 1-year lag between changes to the IPPS and hospice wage indices. CMS instead would use the pre-floor, pre-reclassified hospital wage index from the current fiscal year as the basis for the hospice wage index.
4. Increase all hospice payment rates by 2.7% to reflect projected increases from FY 2019 to FY 2020 in the costs of hospice care (3.2%) less a mandated productivity adjustment factor (-0.5%).

Comments

NPHI appreciates and supports the proposed payment rate rebasing, wage index changes, and market basket update for FY2020. We applaud CMS for its recognition that appropriate payment to cover all 4 levels of care is crucial to encouraging holistic and high-quality hospice care. NPHI strongly supports increasing payment for the non-RHC levels of care because of our view that the other levels of care are critical parts of the hospice benefit and are underutilized, and we are thrilled that CMS is recognizing this gap and proposing action to close it.

We are pleased to offer the follow specific comments.

Concerns regarding unintended consequences of rate increases

Most of our members have their own inpatient units, whether freestanding or standalone within a hospital or SNF in leased space. Building GIP units requires huge philanthropic investments from our communities and our development of these units speaks to the value our members bring and their commitment to community integration. We have the following concerns about the consequences of the rate increase that we would request that CMS monitor closely:

- **Inappropriate use of higher intensity services.** We recognize and agree with CMS' concern that insufficient payment rates for high-cost services may be disincentivizing appropriate use of GIP and the other non-RHC levels of care. We also caution that payment rate increases of this magnitude could incentivize some hospice providers to inappropriately use higher intensity services when patients would be more appropriately served with less costly services. Further, it

could incentivize hospice in institutional settings when a patient is more appropriately served in the home.

- **GIP increases benefits to hospitals and nursing homes:** We appreciate CMS' acknowledgement that GIP is expensive and may not be used when it could be because of the cost of running a freestanding facility or providing that care via a hospital lease or bed contract. Higher GIP and IRC rates may encourage more hospitals and nursing homes to take hospice patients. Most or all GIP and IRC reimbursement in hospitals and SNFs is turned over to the facilities. While the increase gives hospices more opportunity to hold back a portion of these funds to cover services the hospice continues to provide, the negotiating leverage will likely remain with the facilities.
- **Accelerated development of GIP facilities by for-profit hospice providers:** For-profit hospice providers with access to capital will likely conclude that it is profitable to build more facilities for GIP, especially in nursing facilities, which will only incentivize the use of inpatient hospice further as they seek to maximize return on investment.

CMS should examine if the GIP rate increase has the intended effect of securing more contracts and closely monitor post-live discharge costs to original Medicare. Most of the money from those contracts are already passed through – we do not want an environment where GIP is delivered at a bigger loss. If there is an increase in the number of GIP units (which we anticipate based on this change) we would want CMS to engage in appropriate oversight of those services (see comments below on GIP scrutiny). We would value a discussion as to what factors might be considered.

Concern regarding the intention to support GIP by a rate change in conflict with current scrutiny

While CMS's stated intent of the rebasing is to increase the provision of the non-RHC levels of care, we believe that the current intense scrutiny on the GIP level of care from CMS' contractors is inconsistent with an incentive structure to encourage more GIP. Our programs are reporting a proliferation of "Target, Probe, and Educate" (TPE) audits related specifically to GIP. Given that GIP is only 1.5%⁵ of the percentage of overall care and CMS' recognition in this proposed rule that there are barriers to its provision, this scrutiny seems out of proportion to the current proposal. We are concerned that while the intent of this rule and the payment bump is to increase access to GIP and the other levels of care, the ongoing scrutiny by CMS contractors will nullify that intent.

NPHI asks that CMS closely monitor the appropriateness of its contractors' scrutiny of GIP utilization and work with us and other stakeholders to clarify appropriate GIP utilization and provide more transparency around the review and audit standards that the agency's contractors are using. From our perspective, we are seeing patterns where the contractors are pulling high numbers of charts, particularly those with a length of stay of 5 days or more (which is not a statutory or regulatory standard for GIP), and then have a high error rate. If our members are going to be judged based on their error rate, CMS needs to closely monitor the error rate of their contractors. For example, one of our member programs that has two freestanding inpatient units reported having 80 claims pulled for a TPE audit and ultimately 79 of the claims were paid. This is typical among our members and since many of them provide *more* GIP, these audits disproportionately impact them. We strongly believe in program integrity but, in line with CMS'

⁵NHPCO Facts and Figures: Hospice Care in America, 2017 Edition.
https://www.nhpc.org/sites/default/files/public/Statistics_Research/2017_Facts_Figures.pdf

Patients Over Paperwork initiative, we want to be sure it is appropriate and not burdensome as is the current state of affairs.

Furthermore, all of our programs that have received an audit have chosen the “Educate” option. When they meet with the auditors for education, *our program medical directors have provided education of the auditors*. This underscores that 1) the auditors are not properly trained on what to look for which is leading to a burdensome process with a high contractor error rate; and 2) that further education on what GIP should look like is needed. We would be thrilled to partner with CMS on clarification and guidance around GIP care in collaborative manner outside of the TPE process.

Continuous Home Care (CHC) and Inpatient Respite Care (IRC) Rates

NPHI supports the increase in rates for CHC and IRC as well. We believe these changes will make respite care more available and feasible to deliver. With regard to CHC, we recommend operational changes make it easier to administer, specifically allowing it to be provided on a rolling 24-hour basis rather than only on a midnight-to-midnight basis, which would allow the proposed payment rate change to have a larger impact. While such an operational change would greatly help to make CHC more accessible from an administrative perspective, we also recommend that CMS evaluate other changes that may need to be made to the structure of CHC to increase its viability.

Routine Home Care (RHC) and Margins

While we understand that to maintain budget neutrality, the payment rates for the RHC level of care had to be reduced, we underscore that further cuts to the RHC rates would significantly challenge the programs of NPHI. The proposed cut is already threatening the viability of many of our programs even with the proposed increase in rates for the other levels of care. The hospice community is also still negatively impacted by sequestration over many years. In order to sustain current care goals and market-based wage and salary programs, an increase in overall reimbursement is required.

Many of the hospices who are members of NPHI are founding hospice programs in their communities. They share CMS' goal for high-quality hospice care. Many have participated over the years in writing standards to ensure appropriate care. They have developed comprehensive and innovative services funded by philanthropy in order to continue to meet the original intention of the MHB, for example to continue funding robust bereavement services. This infusion of philanthropy dollars also enhances the hospice experience of the Medicare beneficiary – for example, research has documented that spouses of well supported hospice patients who receive robust grief support have less morbidity and mortality that matched subjects. We believe it would be a travesty for health policy to support programs with less breadth and depth, but scale over these comprehensive programs.

NPHI members invest in a wide range of services across the continuum of a beneficiary's needs—from greater commitment of resources for nursing care at the bedside to greater spending on bereavement services to support families—that align with the intent of delivering high-quality hospice. As a result of these types of investments in the patient and family experience and commitment to delivering

comprehensive, high-value care, not-for-profit hospices often operate at **significantly lower margins** (2.7% in 2016 as opposed to the 16.8% margin of for-profit providers, as measured by MedPAC in 2019).⁶

With many of our members operating at these razor-thin margins, the current payment rates undermine their financial viability and sustainability. Our members are operating under growing administrative burdens, which place further financial pressures on their ability to meet the needs in their communities. For instance, one NPHI member has estimated that the regulatory requirements promulgated in the past five years cost the program over \$3.5 million annually, a startling 2 to 3 percent of their overall budget. This underscores the difficult fiscal environment our members are operating under, and the critical need to address unnecessary hurdles so that high-quality hospices can focus on the provision of care.

We urge CMS to consider increasing the market basket update to support these comprehensive care goals and hospice best practices. While payment rates are an immediate issue to maintain our financial viability and beneficiary access to comprehensive care, NPHI is, at the same time, committed to moving to a value-based system that pays for high-quality, appropriate, and efficient care.

Wage Index

Summary of Proposal

In the early years of the MHB, the hospice wage index was based on a stagnant hospital wage index. In subsequent years this was updated based on how hospital wage indices changed year over year. It is currently calculated using the prior year's pre-floor, pre-reclassified hospital wage index because, as dictated by regulation, it represents the most recently finalized hospital wage index data available at the time that the hospice payment rule is promulgated.

In the interest of using more up-to-date wage data, CMS is proposing to align the hospice wage index with the same timeframe used by the hospital IPPS system and other payment systems. This means that CMS would use the FY2020 pre-floor, pre-reclassified acute care hospital wage index in calculating FY2020 hospice payment rates. CMS has indicated this will result in more consistency and parity in the wage index methodology used by Medicare across provider types. CMS has also requested input from stakeholders on the wage index used to adjust hospice payments and suggestions for possible updates and improvements to the geographic adjustment of hospice payments.

Comments

NPHI supports eliminating the lag year and recognizes the value in having wage index consistency across provider types to enhance the ability of all employers in a given area to compete for staff from the same labor pool. Elimination of the lag year also provides some potential for hospices to provide input to local hospitals when proposed wage index values appear to undervalue the cost of labor in a geographic area.

However, there are significant issues related to parity that come into play relative to the wage index that are not addressed by this change. While consistency in use of the wage index has some value, a much greater concern for hospices relates the ability to compete with other providers that draw from

⁶ Medicare Payment Advisory Commission. 2019. "Hospice Services." *Report to the Congress: Medicare Payment Policy*. http://medpac.gov/docs/default-source/reports/mar19_medpac_ch12_sec.pdf?sfvrsn=0.

the same labor pool. While the same data are used to establish the basic wage index values applicable to most provider types, hospitals receive special consideration in a number of ways, including that they are permitted to seek geographic reclassification from their assigned geographic area (thereby receiving higher wage adjustments to their payments). Hospice providers are not afforded these same options yet must compete for the same types of caregiving professionals.

Another major concern is that wage index values, at some times and in some localities, are subject to significant year-to-year swings. This volatility has a disproportionate impact on not-for-profit hospice programs that have smaller operating margins and therefore less ability to absorb large cost swings. In a year where there is an overall cut to the RHC rates, many of our members are going to have to absorb significant cuts: for example, one program is going to undergo a negative 6% cut due to the combination of the RHC rate cut and their wage index change. Elimination of the lag year allows hospices a much shorter period of time to adapt or adjust their financial expectations and absorb the impact of negative wage index swings, particularly swings under which the wage index value for an area drops precipitously.

Given these concerns, NPHI recommends that CMS should take action to develop and implement a wage index model in line with the system recommended by the Medicare Payment Advisory Commission (MedPAC) in 2007⁷; this model should be consistent across all provider types so that all types of providers have a level playing field from which to compete for personnel. Additionally, the model should incorporate some means by which providers are protected against substantial payment reductions due to dramatic reductions in wage index value from one year to the next.

Finally, all providers should be guaranteed that their wage index value does not drop below the rural wage index value applicable in the state of operation. This is a rare but significant for the programs impacted. A recent analysis demonstrated 61 CBSA's in 24 States fall below their State's rural wage index. 220 hospice programs are impacted with greater than a .02 level of difference, and only 33 CBSA's have a greater than .03 difference. With regards to the lack of a rural floor, we are most concerned about these areas. Each of these 33 CBSA's have a HPSA designation signifying professional staffing shortages. Certainly, those challenges must be addressed. Providing a rural floor begins to address the wage disparity that may be contributing to that HPSA issue.

PROPOSED ELECTION STATEMENT CONTENT MODIFICATIONS AND PROPOSED ADDENDUM TO PROVIDE GREATER COVERAGE TRANSPARENCY AND SAFEGUARD PATIENT RIGHTS

Comments on Services Unrelated to the Terminal Illness and Related Conditions

CMS outlines in this section their longstanding assertions that they have defined “related” and “unrelated” with clarity and provide examples from the Medicare Ombudsman. NPHI supports the intent of the benefit to be holistic and to cover substantially all of the patient and family needs. However, the members of NPHI frequently find that they cover more services, drugs, etc. as “related” than most competitors in their markets. **While we appreciate CMS’s intent around having flexibility to**

⁷MedPAC, June 2007 Report to the Congress, Chapter 6: An alternative method to compute the wage index. http://www.medpac.gov/docs/default-source/reports/Jun07_Ch06.pdf?sfvrsn=0

define the care plan, the continued insistence that CMS is clear in its guidance around “related’ and “unrelated” is not borne out in practice.

Examples like those from the Medicare Ombudsman’s office are helpful in underscoring this issue. These examples highlight exactly the point that *there is a lack of clarity around this issue and that the guidance needs to be updated and more specific.* The agency’s acknowledgement that they receive frequent requests for clarification underscores this reality. Some hospices, exemplified by those represented by NPHI, cover as much as related as possible since that is CMS’ intent and is aligned with their organizational mission and values. Others take advantage of the gray space and manipulate the system. The example of a patient not receiving a walker is one that we all find out of line with the intent of the MHB. However, what if the patient wanted an electric scooter? CMS has coverage determinations for medical necessity determinations to qualify for electronic scooters in the rest of the Medicare program. That discussion around coverage standards is warranted for the hospice benefit as well.

CMS also uses confusing language across this section, for instance discussing services “related to the terminal *diagnosis*” when the current standard is that hospices should cover medications and services “related to the terminal *prognosis*.” This inconsistency with language contributes to the overall confusion. Finally, as with data around live discharges, if CMS is seeing trends for outliers in coverage—for example, programs who do not cover walkers or inhalers for COPD—we wonder why those programs are not audited.

In short, there are clear differences in what programs offer and as CMS moves toward consideration of the hospice benefit in Medicare Advantage or increasing incentives in other care delivery models (i.e., ACOs) to utilize hospice, this lack of consistency amongst providers as to what hospice is will only continue to grow.

In order to address this issue, we recommend first and foremost that CMS gather hospice stakeholders and work to develop more standardized definitions of related and unrelated in order to promote consistency of delivery across the benefit. We would recommend this workgroup to complete this work prior to the development of any new tools or documentation around relatedness.

Comments on the Proposed Election Statement Content Modifications and Proposed Addendum

NPHI strongly opposes the proposed addendum and election statement content modifications. While we appreciate CMS’s desire to increase transparency for patients and families, we feel strongly that this proposal only serves to increase burden and will not accomplish the stated goals. We propose instead that CMS conduct an evaluation of current practices in disclosure of unrelated costs and make a new proposal based on best practices. In addition, we reiterate our proposal from above about the creation of a CMS-stakeholder working group to inform more standardization around related and unrelated. We stand ready to assist.

We have the following specific concerns with the addendum and election statement as proposed:

- NPHI members believe that the presence of a written addendum could chill hospice admissions. While in theory it may seem that patients and families should be discontinuing services that are not appropriate for a hospice plan of care, many patients and families are reluctant to let go of services like maintenance medications. Our members are concerned that the addendum could

cause undo confusion and thus deter patients from electing hospice or maintaining their enrollment, which could have the impact of shortening lengths of stay or increasing revocations or live discharges.

- Obtaining signatures from patients or their legal representative can already be challenging; especially if the patient is not able to make his or her own decisions, it can take substantial time to track down the legal representative for signature. Adding an additional signature, particularly for every change in the plan of care, would be hugely burdensome and we do not see how it would benefit the patient and family. This is also not common practice in other Medicare programs; for example, when the home health plan of care is changed, a signature is not required. The signature appears to only acknowledge receipt of the addendum, but not whether there was true education on what hospice covers. This suggests that the proposed process would only create an incentive to get the paperwork done rather than truly working with the patient and family on what an appropriate plan of care looks like.
- NPHI is unclear on how CMS would know whether a patient and family has requested the addendum. Our assumption is that they would draw this conclusion based on the medical record, but if CMS is expecting a specific form for the request, it is not clear in the rule.
- Given heightened scrutiny in hospice, we would have grave concerns that auditors would use these forms as a mechanism to justify payment denials. If there is no clear standard around “unrelated,” these potential audits could be numerous and add to the already increasing number of audits. Furthermore, certain medications are often only discovered later on in the hospice-patient relationship; patients or families often do not share all medications being taken. Would hospices be automatically liable to be served with an ADR if this occurred? We would CMS to develop specific protections to prevent these outcomes.
- Would the addendum apply only to items/drugs/services the beneficiary was receiving prior to electing hospice? What about requests for items/drugs/services made after a beneficiary is on service? The proposed addendum seems to only arise when there is a determination of a new illness or condition, but if the goal is clarity about what is covered by hospice, addendums would need to be executed each time a request is denied even if the patient and family have been educated on that choice and accepted it.
- The addendum is not built into any hospice workflows and to do so, EMR modifications would be necessary as well as additional full time employees. These modifications would be costly in both personnel time and money.
- The timeframes proposed are not feasible. There is no provided definition of “immediately” and 48 hours is too short a turnaround for the initial form. Given the other issues outlined here, we hesitate to propose alternatives because we firmly believe CMS needs to reconsider their approach to this issue.
- While we appreciate CMS’s desire to increase transparency and communication with non-hospice providers, complaints about this process are not reported from our providers’ community partners.

Once again, we appreciate and support the intent behind this proposal, but we believe that as proposed it would only serve as a burden and a source of potential confusion for patients and families.

RESPONSE TO THE REQUEST FOR INFORMATION (RFI) REGARDING THE ROLE OF HOSPICE AND COORDINATION OF CARE AT THE END-OF-LIFE

Summary of the Proposal

CMS seeks information on the interaction of the hospice benefit and various alternative care delivery models, including Medicare Advantage (MA) plans, Accountable Care Organizations (ACOs), and other future models designed to change the incentives in providing care under traditional FFS Medicare. They also seek information on the impact of alternative delivery and payment models implemented outside of the Medicare program on the provision of hospice care and any lessons learned that CMS should consider for the future design of the Medicare Hospice Benefit, including how hospice under FFS Medicare relates to other treatment options; how it impacts the provision of a spectrum of care for those that need supportive and palliative care before and after hospice eligibility; and whether rates of live discharge are a reflection of the current structure of Medicare FFS.

Comments

NPHI believes that hospice and other home-based, holistic care models are a critical part of the future of the health care delivery system. Furthermore, our members are engaging in and excited to continue to build their capacity to engage in alternative payment models and value-based contracts with payers. One of the founding tenets of the National Partnership for Hospice Innovation is to serve as an organization that supports innovative, not-for-profit hospice providers as they deliver the best hospice care as well as work toward participation in value-based payment arrangements with CMS and private payers. Through our 40-year experience with an interdisciplinary team that is paid on a capitated basis, we believe that innovative hospice providers are particularly well positioned to offer and partner on care upstream of hospice.

We recommend that CMS engage hospice stakeholders in a broader conversation on all of the issues on which they seek input in this RFI. To fully provide feedback to CMS on the questions outlined here, we feel that a series of meetings to discuss these questions would be valuable as CMS considers its next steps. We reiterate our recommendation around coming together to discuss definitions around “related” and “unrelated.” NPHI is open to taking on more risk if the incentives align but want to be sure there is an equal playing field in terms of definitional clarity.

Comments on hospice integration into ACOs and Medicare Advantage

Many of our member programs are already offering palliative and supportive care programs upstream of hospice as well as engaging in other opportunities like PACE or home-based primary care. Many of our eligible members plan to participate in CMMI’s Primary Care First model (particularly the SIP track) due to their comfort managing these very sick patients and our belief that we can contribute to lowering the total cost of care.

Private payers are implementing a range of palliative and supportive care programs that range from telephonic case management to whole programs across all lines of business. We have a number of members participating in those networks and entering into case rate arrangements in order to deliver support from the interdisciplinary team. NPHI and its members have been also been very engaged with CMMI as they consider the parameters for the 2021 VBID demonstration track that will test hospice as a part of the Medicare Advantage program. We would hope that any carve-in or other relationships to manage the care of those with serious illness recognizes the role that hospices can take in taking on more responsibility for the seriously ill patient population. Given the movement by payers toward delegating risk to providers in other sectors of the Medicare and private payer world (i.e., through ACOs), we hope that hospices are given the opportunity to move in that direction with appropriate quality guardrails. We ask that CMS considers the following as they look at hospice in the Medicare Advantage and the ACO programs:

- **Ensuring the quality and integrity of the hospice benefit:** Hospice is a comprehensive, interdisciplinary benefit that meets all of the patient’s physical, psychological, spiritual and familial needs related to the terminal prognosis. The hospice interdisciplinary team (IDT) includes physicians, nurses, social workers, chaplains, volunteers, and other professionals as required by the patient and their families. It is an end-of-life “bundle,” which is the responsibility of the hospice to manage. We believe there are many opportunities for that bundle to be managed upstream of traditional hospice parameters. However, we are concerned that MA plans may treat hospice like they have home health care, reimbursing for piecemeal visits instead of the comprehensive home care benefit. In such a scenario, it is easy to imagine a plan paying for something traditionally thought of as end-of-life care like pain therapy, but giving little consideration to services outside the medical realm, such as spiritual and emotional counseling that it is so important to patients and families during this period. CMMI has been responsive to this concern. We want to work with CMS as they consider parameters and ramifications of a broader carve-in environment to ensure that the quality and integrity of the benefit are not only maintained but strengthened.
- **Administrative burden:** CMS needs to be mindful of the administrative burden on both providers and payers that comes with a transition to value-based care. Hospices manage the benefit and all of the associated costs (once again, the definition of associated costs needs clarification for consistency). If the hospice benefit were to permanently become a part of the Medicare Advantage program, it would likely add another level of “care management” (i.e., utilization management) to an existing managed hospice benefit. Our concerns would revolve around the timeliness of hospice admissions which must happen efficiently and compassionately. More than one-third of hospice patients die within a week of electing hospice, and more than half die within two weeks. If MA plans or other payers require preauthorization for hospice care, it will delay admission to hospice care. If hospices had to seek authorizations for services and constantly negotiate, manage and process claims from each of several payers including MA plans with whom they contract, it would significantly increase the cost and administrative burden and have a deleterious impact on patient care. CMMI has been responsive in their consideration around this concern related to the VBID demonstration. However, if the hospice benefit were to move into Medicare Advantage permanently or guidelines were to be given to ACOs around working with hospice, we would request consideration and guidance around utilization management processes as well as how to support the administrative transition would be warranted.

- **Ensuring beneficiary access to the hospice of the patient's choice:** The selection of a hospice is one of the most important decisions a family can make at the end of their loved one's life. Hospice staff and volunteers are in the home on a regular basis, interacting with the patient and family, providing comfort and compassionate care when it is needed most. In both Medicare Advantage and ACOs, one of the tools for management of costs and quality is narrowing networks. While we understand that reality, we also want to be sure that our members are judged not only on the price at which they offer to deliver services but also based on the quality of the care they receive and for providing the *right services*. CMS has previously excluded home-based care providers like home health from health plan's network adequacy requirements, but we encourage thoughtful consideration as to how these requirements – both in the MA context and the ACO or other narrow network construct – can be adjusted for home-based care.
- **Incentives:** We encourage continued work with the stakeholder community on how to make sure that the incentives align in alternative payment arrangements so that hospices can be paid appropriately for care. We also hope that CMS works to continue to define differentiators in service requirements between hospice and other supportive services in order to ensure appropriate payment for the appropriate service intensity along a patient's care continuum. Finally, we want to note the continued conflict in incentives between hospitals that have some alternative payment arrangements and still receive FFS payments. Our providers will find success in keeping patients out of inpatient settings and emergency departments. When those goals do not align with those of hospital partners, setting us up for success in alternative payment arrangements becomes much more challenging.

Quality Measurement Development and Areas for Increased Attention

In order for hospice and other supportive care services to be truly integrated into value-based payment models, we need to do definitional work around what metrics indicated quality hospice and palliative care. We know a lot of work is going on in this space both by CMS and our stakeholder partners along as within our own organization and we look forward to continued work together. While this work is ongoing, we recommend that CMS also consider:

- Adding a mandatory claims code that allows for payers (CMS, ACOs, and health plans) to see the time of day visits are made. As we have evaluated differentiators between high- and low-quality hospice care, true 24/7 availability comes up as a critical factor but currently is not able to be measured.
- Developing standards for bereavement services and monitoring for their implementation and execution. Currently, the overhead spent by a not-for-profit hospice is 2.5x higher than bereavement care in a for-profit program – we see this as a signal of greater investment in this crucial part of the benefit. If there were enforceable standards around bereavement services, this discrepancy would decrease, and this service would better address the needs of families and caregivers.
- Enforcement of the conditions of participation, including the 5% volunteer threshold, adherence to the cap, and utilization of all four levels of care. We look forward to continuing to work with CMS on measures related to all levels of care and avoidable transitions to bolster this effort.

Comments on relation between live discharges and FFS Medicare structure

As outlined in other portions of this letter, we believe that there is a correlation between the enforcement of the Medicare Hospice Benefit as it exists today and live discharges. We wanted to delve further into the following recommendations

- *Define “related” and “unrelated” and levy penalties against those providers who do not take on appropriate services.* It is not uncommon for many of our competitors to discharge a hospice patient and justify it as a beneficiary revocation (when in fact, the beneficiary is told they have to revoke because their care won’t be covered) or due to the beneficiary going to a “non-contracted facility.” In the latter case, these hospices are not attempting to maintain contracts with that facility or with all the providers who work at said facility in order to keep that type of discharge as an option. **We reiterate our recommendation that CMS bring together a stakeholder workgroup to clarify “related” and “unrelated” costs.** In our own analysis, there is a huge discrepancy between the costs to Medicare Part A post-live discharge incurred by patients who were at a not-for-profit hospice versus a for-profit hospice. We found that Part A costs in the first 7 days post-discharge were almost 45% higher in 2017 for patients discharged from for-profit hospices compared to those discharged from not-for-profit hospices. This data suggests that for-profit hospices are indeed discharging expensive patients alive so that those costs are incurred by Medicare FFS instead of the hospice. Additionally, not-for-profit hospices spend over 7 times as much on contracted inpatient care as for-profit hospices, indicating that not-for-profit hospices are following through on their responsibilities to provide the care patients need. All of these trends point toward the need for clarification accompanied by more targeted enforcement in this arena.
- *Recognize that not all long lengths of stay are a sign of aberrant behavior and consider long length of stay in context.* The hospice benefit utilizes a “risk corridor” approach, where longer length of stay patients offset significant losses from short-term patients. A much higher percentage of hospice patients receive care for less than one week (25%) than live longer than a year. There also is an aggregate spending cap that assures program cost savings if a hospice serves many patients with long lengths of stay, based on estimated costs as if the patient was not in hospice. This cap is applied as a ceiling of payment for every hospice in America, ensuring that there is a mechanism to address risk associated with too many long length of stay patients. Therefore, a singular focus on “long length of stay” patients alone is not a fruitful approach to saving money for the Medicare Trust Fund because it is antithetical to the Congressional construct of the Medicare Hospice Benefit and because such focus redundantly addresses a category of patients that CMS should already address through the spending cap. We would encourage CMS to focus appropriate enforcement such that hospice oversight does not revolve around whether a patient dies “on time” but rather is looking at a very sick patient and how to support the patient and family through the end of life. NPHI looks forward to working on this idea with CMS both in the context of the hospice benefit and through dialogue around supporting care for those with advanced and serious illness.

We want to be sure there is a clear recognition of the role hospice can play in reducing the total cost of care at the end of life, and a corresponding payment structure that rewards hospices for doing so. The move toward more accountability in the health care system overall should reward high performing and high-quality hospices and we look forward to working with CMS on how to achieve these goals.

UPDATES TO THE HOSPICE QUALITY REPORTING PROGRAM (HQRP)

Claims-Based and Outcome Quality Measure Development for Future Years

Summary of Proposal

CMS is “not proposing any claims-based or outcome measures at this time. However, we are soliciting public comments and suggestions related to ideas for future claims-based and outcome measure concepts and quality measures in the HQRP that could also be tied to the goals of the Meaningful Measures initiative.”

Comments

NPHI believes that the rates for all claims-based measures should be displayed along with state and national averages for each measure, so users have a frame of reference for an individual hospice’s published rates in addition to the rates for nearby hospices they may be considering.

Update on Claims-Based Measure Development

Summary of Proposal

As discussed in previous years’ rulemaking, CMS has identified two high-priority areas it seeks to address by claims-based measure development: potentially avoidable hospice care transitions and access to levels of hospice care. CMS notes that the potentially avoidable hospice care transitions concept was developed as a measure under consideration called “Transitions from Hospice Care, Followed by Death or Acute Care,” which was reviewed by the NQF-convened Measures Application Partnership (MAP) in December 2018. CMS acknowledges that, as a result of the MAP not supporting the measure as then specified, it is revisiting the potentially avoidable hospice care transitions measure. The MAP recommended that CMS reconsider the exclusion criteria for the measure, including adding an exclusion to allow for patient choice and shortening the timeframes for the measure. Lastly, CMS notes that the access to levels of hospice care measure concept as currently specified could result in hospices providing higher levels of care when it is not required by the plan of care or expected by CMS.

Comments

NPHI is a member of the MAP and did not support the measure as it was specified when presented to the MAP in late 2018, and we appreciate CMS’s effort to take seriously the MAP’s suggestions for revising the measure. As detailed in our comment letter to CMS dated April 25, 2018, our concerns included the following:

- The proposed specifications mix together quality of care and program integrity measurement and the purpose of the measure should be more clearly defined—is it a measurement of the quality of care provided by a hospice or a program integrity measurement of a hospice’s compliance with program requirements?

- Discharges initiated by the patient should be excluded from the measure.
- The measurement period for discharges followed by an inpatient hospital admission should be shortened from 7 days to 1 day, and for discharges followed by death from 30 days to 7 or 14 days, to maximize the link between hospice quality and the subsequent adverse event.
- Discharges to certain types of inpatient settings, such as Veterans Health Administration and inpatient psychiatric hospitals, should be excluded from the measure.
- The risk adjustment methodology for the measure should include the language spoken at home, measured at the hospice level. Cultural preferences will affect patients’ and families’ decisions about whether to remain in hospice. Language spoken at home may be a reasonable proxy to capture differences across hospices in the cultural composition of their patient populations.
- The risk adjustment methodology should include a variable indicating the presence of a State Certificate of Need (CON) law in the hospice’s service area.
- The risk adjustment methodology should include presence or absence of a patient “DNR” code since this could affect a hospice’s rate of deaths within 30 days following discharge.

We look forward to continuing to work with CMS to address these concerns and reiterate our thanks to CMS for listening carefully and taking seriously our and other stakeholders’ input in the process of developing this important measure concept.

Concerning the measure concept of Access to Levels of Care, we urge CMS to publish rates for all four levels of care for each hospice, along with the corresponding state and national averages for further context.

Update on the Hospice Assessment Tool

Summary of Proposal

CMS seeks public comment on the name for the revised hospice assessment tool.

Comments

We suggest the name Hospice Assessment Tool (HAT).

CAHPS Hospice Survey Participation Requirements for the 2023 APU and Subsequent Years—Data Source

Summary of Proposal

As part of its *Patients Over Paperwork* initiative, CMS solicits comments about the CAHPS Hospice Survey questionnaire. Specifically, CMS seeks comments regarding suggested changes, additions or deletions to

the instrument that would improve its value to hospices for quality improvement and consumers for selecting a hospice.

Comments

First, we **strongly** suggest that there should be a “not applicable” response option available for each question, so that the survey is reflective of the actual care that a patient required, as opposed to generalizing hospice care as a one size fits all. Questions such as “How often did your family member get the help he or she needed for trouble breathing” or “How often did your family member get the help he or she needed for constipation” are difficult for family members to answer if their loved one did not experience issues with those symptoms. In addition, the question “How often did your family member get the help he or she needed from the team for feelings of anxiety or sadness” also set the expectation that their loved one experienced those emotions. Questions should be reworded to better identify the unique needs of individual patients and experiences. A “not applicable option” for current questions could be implemented as stopgap measure to allow caregivers to identify the questions which do not apply to them rather than being forced to answer inaccurately. Questions regarding instruction on care of the patient make a huge assumption regarding direct care involvement of the survey respondent. This needs to be clarified.

Second, we recommend that the total number of survey questions be decreased. The current survey instrument is time-consuming to complete, especially for grieving families, which we believe contributes to a low response rate. Identifying the key 1 or 2 questions in each survey domain would improve the overall response rate, which will then provide an improved picture of the quality of care provided by the hospice.

Third, we strongly believe that the Hospice CAHPS survey risk adjustment methodology should include a variable that captures the cultural differences in patients’ and families’ perceptions of their care experience. For example, published studies indicate that Chinese speakers are culturally less likely to choose extremes (low or high) on surveys.⁸ Additionally, the way the rating question is worded (“what number would you give this hospice” rather than a more explicit question indicating what that rating means) makes it more likely that a Chinese-speaking person will give us an 8 rather than a 9 or a 10. One of our member hospices found that their rating of care began decreasing after they initiated a program serving predominantly Chinese-speaking families and when they examined the scores, they found that respondents from that program were less than half as likely to rate the hospice with a 9 or 10. When they looked at the individual surveys and they found that the vast majority of those ratings less than 9 or 10 were 8s. They also found that those who rated the hospice an 8 were very satisfied with our care. Upon further inquiry they found that “8” is a lucky number in Chinese culture and that those who reported 8s were likely intending to indicate a high level of satisfaction. We urge CMS to re-institute risk adjustment of CAHPS results based on a Chinese or another language spoken at home, which we understand was adjusted for until 2017 when this was changed due to low numbers of surveys requiring this adjustment. For programs like the one in this example that are greatly impacted by this cultural preference, it seems only fair that this case mix adjustment be re-implemented.

⁸ Rui Wang, Brian Hempton, John P Dugan, Susan R Komives. Cultural Differences: Why Do Asians Avoid Extreme Responses? Survey Practice, Vol. 1, Issue 3 (September 30, 2008). [10.29115/SP-2008-0011](https://doi.org/10.29115/SP-2008-0011).

Update to Quality Measures to be Displayed on Hospice Compare in FY 2019--“Hospice Visits When Death Is Imminent” Measure Pair

Summary of Proposal

CMS states that this measure pair assesses whether the needs of hospice patients and their caregivers were addressed by the hospice staff during the last days of life. Measure 1 of the pair assesses the percentage of patients receiving at least 1 visit from a registered nurse, physician, nurse practitioner, or physician assistant in the last 3 days of life. Measure 2 assesses the percentage of patients receiving at least 2 visits from social workers, chaplains or spiritual counselors, licensed practical nurses, or aides in the last 7 days of life. The agency reiterates its decision that Measure 1 meets established standards for reliability, validity, and reportability, and therefore will be publicly reported in FY 2019. However, it has determined that Measure 2 currently does not meet readiness standards for public reporting and has decided not to publish Measure 2 at this time.

Comments

While we support CMS’s decision to delay public reporting of Measure 2 until it is determined to meet public reporting standards, we also are disappointed because we believe the complete measure pair will provide the most meaningful quality of care information to Medicare beneficiaries and families. The 24/7 availability of the interdisciplinary team of hospice care professionals is always important, but absolutely critical for patients and families in the final days of life. While we suggest refinements to the specifications of Measure 2 below, we are strongly supportive of it being published along with Measure 1 as soon as it is found to meet the established standards for reliability, validity, and reportability. Measures 1 and 2 were developed as a pair of quality indicators and should be reported as such, as soon as practicable.

Concerning the specifications for Measure 2, we offer the following recommendations. First, we suggest that the list of providers whose visits would count toward the measure numerator should include RNs as well as LPNs. Many of NPHI’s member programs use only RN-level nursing staff, but the current specifications would not count visits by RNs between the last 7 and last 3 days of life. The current specification unfairly penalizes hospices that do not employ LPNs, only RNs. Second, the measure should be able to capture instances when a patient or family is offered but declines home visits by hospice staff in the last 7 days of life. Our experience is that oftentimes families wish to spend their final days together without non-family members coming into the home. If a hospice has been successful in managing symptoms and is available 24/7 by phone for support or to provide visits if the family wishes, then families should have the right to limit visits in the final days and the hospice should not be penalized for supporting that decision. One way to operationalize this would be to implement a skip logic for the measure two specification, where the hospice could report that it called and offered the family each of the services captured in Measure 2 and the family declined.

Display of Publicly Available Government Data on the Hospice Compare Website

Summary of Proposal

CMS proposes to post information from publicly available government data, in addition to the data from the Medicare Public Use Files (PUFs) or other CMS sources, to the Hospice Compare website as soon as

FY 2020. Illustrative examples of possible data sources include the U.S. Census Bureau, Centers for Disease Control and Prevention, and National Institutes of Health.

Comments

In general, we support the presentation on Hospice Compare of a limited amount of informative data, but we strongly urge CMS to seek input from a range of hospice providers and Medicare beneficiary advocates in what data will be displayed. The website should include clear and simple text describing how to interpret the data shown. It would be preferable not to show additional data rather than display more data without clear explanations and a context for understanding the information being displayed.

CONCLUSION

We appreciate the opportunity to provide these comments and we look forward to working with CMS on these issues. Please do not hesitate to contact either Mollie Gurian, NPHI Chief Strategy Officer, at mgurian@hospiceinnovations.org or John Richardson, NPHI Chief Data and Quality Officer, at jrichardson@hospiceinnovations.org with any questions or follow-up inquiries.

Sincerely,



Tom Koutsoumpas
President and CEO
National Partnership for Hospice Innovation