June 20, 2016

Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
P.O. Box 8010  
Baltimore, MD 21244-8010

Attention: CMS-1652-P

Dear Mr. Slavitt:

Since 1982, the National Association for Home Care & Hospice (NAHC) has been the leading association representing the interests of hospices, home health, and home care providers across the nation, including the home caregiving staff and the patients and families they serve. Our members are providers of all sizes and types -- from the small rural agencies to large national companies -- and including government-based providers, nonprofit voluntary hospices, privately-owned companies and public corporations. As such, we welcome the opportunity to comment on CMS-1652-P: Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (proposed FY2017 hospice payment rule).

The proposed FY2017 hospice payment rule contains a number of changes that will impact hospice financial, quality and operational concerns. NAHC has conducted analysis and received considerable input from the stakeholder community on the proposed rule, and this letter provides general and specific comments about the proposals CMS has put forth, including implementation concerns. We appreciate your consideration of this input.
Background

Trends in Medicare Hospice Utilization

In the proposed rule CMS provides data monitoring utilization of hospice services and other issues. We note that the FY2016 and FY2017 proposed hospice payment rules the Office of the Actuary anticipated annual spending growth for hospice at 8% and 7%, respectively, and that the FY2016 proposed rule estimated spending for FY2013 at $15.3 million and the FY2017 proposed rule estimates FY2015 spending at $15.5 million. These findings reflect a general downward trend in growth, and essentially flat growth in outlays in recent years. These trends are supported by data in the Medicare Payment Advisory Commission’s (MedPAC) March 2016 Report to Congress showing flat growth in hospice spending over recent years despite an increase in the number of patients served. (It should be noted that use of other statistical methods indicate an actual decline in the number of patients served in recent years.)

Regardless of the statistical approach, Medicare hospice utilization growth is slowing substantially. We understand that a variety of factors are likely contributors to this trend, but believe that finer detail related to hospice utilization trends would help stakeholder to discern whether the trends reflect positively on action by CMS and hospice programs, reflect reduced access to care for eligible patients that could benefit from hospice services, and/or reflect denied claims resulting from medical review and systems processing issues. Further, in recent years CMS has indicated its intent to refer hospice programs to program integrity (PI), survey and certification, and other areas of CMS for review but the outcome of those referrals has not been released.

CMS also provides background on hospice diagnosis coding and reporting of diagnoses on claims. These issues have been discussed in proposed and final hospice payment rules over the last several years as CMS has sought greater accuracy in coding and reporting of all appropriate diagnoses on hospice claims. CMS notes in the proposed FY2017 rule that 63% of claims have at least two diagnoses, and many of those include three or more. This is a dramatic change over CMS’ initial reports that the vast majority of hospice claims included only one diagnosis. NAHC supports CMS’ efforts to underscore the importance of including all appropriate diagnoses on hospice claims, and most recently the inclusion of a new “target area” on the April 2016 Hospice PEPPER Report that addresses the percent of claims submitted with a single diagnosis. As a result of inclusion of this target area, some hospices have discovered that their Electronic Medical Record (EMR) settings remained incorrect and that only a single diagnosis was flowing through to their hospice claims. Based on these reports, we anticipate that as a direct result of the 2016 PEPPER, CMS will see a further increase over time in the percent of hospice claims that include multiple diagnoses.

Hospice Payment Reform: Research and Analyses

Pre-hospice Spending
As part of the preamble to the proposed rule, CMS discusses recent analysis conducted for MedPAC finding that use of hospice appears to modestly raise end-of-life costs across all diagnoses. CMS conducted its own analysis evaluating pre-hospice spending as an initial step in determining whether patients have different resource needs prior to hospice based on the principal diagnosis reported on the hospice claim. CMS found that patients with the longest lengths of stay (who tend to have Alzheimer’s/neurological conditions and are more difficult to establish a prognosis for) had lower pre-hospice Medicare spending in comparison with patients with shorter hospice lengths of stay (patients with terminal cancer). Following admission to hospice, Medicare spending for Alzheimer’s disease and other neurological disorders tended to be higher than for patients with terminal cancer. Patients with Alzheimer’s/neurological disorders had a significantly longer average length of stay.

The hospice benefit was developed using data related to patients with terminal cancer. Over the last 30 years, the patient mix under hospice care has changed dramatically. A patient electing hospice care has access to an array of different types of services as part of the hospice “bundle” but different diagnoses require different mixes of services both prior to and upon election of hospice. Some of the services offered as part of the hospice “bundle” (homemaker and hospice aide) are not generally offered under Medicare, so prior to hospice election a patient needing such services is likely to be paying for them out of pocket or may be securing them through Medicaid or long-term care insurance. In fact, hospices report experiencing a marked increase in the number of dual-eligible patients being served (due most likely to the Medicaid expansions) and more patients being served by hospice and Medicaid waiver services simultaneously. The cost of these services prior to hospice would not be included in CMS’ data tracking Medicare spending prior to election of hospice.

MedPAC data (MedPAC, June 2013, Report to Congress: Medicare and the Health Care Delivery System) indicates that hospice patients in nursing facilities (a larger proportion of which have neurological conditions as their principal diagnosis) receive more hospice aide services and fewer nursing services than patients living at home. We believe that it is likely that this variation in service is due, at least in part, to the different mix of care needs depending upon a hospice patient’s diagnosis(es). These higher volume personal care and supportive services for neurological conditions (relative to lower frequency of nursing services) were likely not financed under Medicare but are covered under hospice when they are necessary to support the delivery of effective hospice services.

CMS is monitoring pre-hospice spending to determine whether a case-mix based payment system can and should be developed for hospice. However, additional study (MedPAC, 2012, Report to Congress: Medicare Payment Policy) indicates that length of stay is a greater driver of hospice costs than terminal diagnosis. These findings raise questions as to whether pursuit of a case-mixed based system is necessary or advisable. NAHC believes it is most appropriate for CMS to consider payment refinements that help to incentivize appropriate timing on enrollment for hospice. This focus on reducing the high percentage of very short stay hospice episodes was recently cited by MedPAC commissioners as a person-centered improvement that also promises further reduction in Medicare expenditures.

Non-hospice Spending
In recent years CMS has tracked spending outside of hospice while patients are on service in an attempt to determine whether “unbundling” of care responsibilities is occurring under the hospice benefit.

Hospice patients retain the right to receive services under Medicare for conditions unrelated to the terminal illness. This right is guaranteed by law and must be protected. However, as part of the provider agreement under Medicare, certified hospice providers agree to supply all services that are covered under the hospice benefit if they are reasonable and necessary for the palliation and management of the terminal/related condition(s), reasonable and necessary in the hospice plan of care, and arranged for by the hospice. Coverage of hospice-related services outside of hospice is inappropriate and we support efforts to protect against this. In order for providers to do their part, CMS systems must provide timely information related to a patient’s eligibility/ineligibility for these services.

Accuracy of patient status in the Common Working File (CWF) is a key element in ensuring that care that has been waived by the patient when he/she elects hospice (curative services for the terminal/related conditions) is not covered/financed under Medicare Parts A, B, or D. As became evident in discussions during 2013 and 2014 on Part D expenditures for hospice patients, patient hospice status is not always updated in the CWF on a timely basis. To address this issue, CMS required, beginning in October 2014, that hospice Notices of Election (NOE) and Notices of Termination/Revocation (NOTR) be filed within the 5 days following admission/revocation of hospice. While we understand that the 5 day timely filing requirement has created a strong incentive for hospice providers to submit their NOEs in a more timely fashion, the current requirement that hospices use Direct Data Entry (DDE) to meet this requirement has created tremendous challenges for hospices, the Medicare Administrative Contractors (MACs) and, ultimately, CMS, and been extremely detrimental to hospices financially and operationally. In terms of concerns for the Medicare program, use of DDE to submit NOE has diminished the potential effectiveness that the timely filing requirement might otherwise have in providing for more timely updates of patient hospice status in the CWF. We recently received communication indicating that, in response to information supplied by NAHC, CMS is pursuing an avenue by which hospices may be permitted to submit NOE and related transactions via Electronic Data Interchange (EDI). We are hopeful that this effort can be pursued in a timely fashion. In the interim, CMS should continue to make changes so as to minimize NOE/NOTR processing challenges and lost revenue.

We note that data tracked by CMS indicates that Medicare spending outside of hospice has declined, due in large part to reductions in Part D spending for hospice patients (a reduction of more than $100 million between CY2012 and FY2014). This is a positive development and is attributable to significant efforts by all stakeholders to support prior authorization of specific categories of drugs. We believe, based on the commitment and efforts of hospice providers and others, that this trend will continue.

Elimination of inappropriate spending under Parts A and B is a more complex challenge as many non-hospice providers lack understanding of the interaction of Part A and B services and the hospice benefit. We applaud efforts by some of the Medicare Administrative Contractors (MACs) to educate providers under Parts A and B about coverage rules when a patient is on hospice care, and suggest that CMS
encourage all of the MACs to pursue this type of educational effort. As noted above, lack of timely data on patient hospice status in the CWF is a factor that contributes to inappropriate Medicare spending outside of hospice that is difficult for the hospice provider to control, so we believe that accelerating efforts to permit electronic submission of NOE/NOTR (as referenced above) will have a direct impact on these outlays in the future.

**Live Discharge Rates**

CMS continues to track hospice live discharges and notes that between 2006 and 2014, live discharge rates have declined from 20.4% to 17.4%. CMS also has found that the live discharge rates of an extremely small number of hospices skew the data for the overall average live discharge rate. We strongly recommend that the data from these outlier providers be excluded from overall averages, and that action be taken to investigate these providers individually.

Continued analysis of live discharge rates is of value, particularly where it provides data identifying potentially problematic patterns of care. NAHC also supports the expansion of the live discharge target areas that were included in the 2016 Hospice PEPPER report; hospice providers benefit from being able to compare their own patterns of live discharge with those of their peers in the state, MAC jurisdiction, and nationally. We support an even finer breakdown of hospice live discharge data as part of the PEPPER and have recommended such to the TMF Health Quality Institute for future consideration as there are a variety of reasons for live discharge due to the different circumstances that may apply. We suspect the culture of the region where care is being provided in some cases impacts a hospice’s live discharge rates. For instance, a hospice serving those in an urban area with one or more research hospitals in the area may have a higher discharge rate than a rural provider. Likewise, hospices operating close to state lines may have a greater live discharge rate because the local hospital and concentration of non-hospice healthcare providers is located across state lines and the states do not allow the hospice to contract for services. This is also a contributing factor to hospices that have low or no utilization of the GIP level of care.

Greater detail on a hospice’s live discharge rate broken down by type of live discharge and as compared with other hospice providers will allow hospices to conduct more meaningful analysis of their live discharge patterns and address any particular areas of concern. Finally, because live discharge can be such a complex issue, NAHC continues to have concerns about use of live discharge rates as a publicly-reported measure -- there is significant potential for the public to misunderstand the significance or meaning of a live discharge measure.

**Skilled Visits in the Last Days of Life**

CMS continues to track visits delivered by hospice providers while patients are in the final days of life. This is considered an important domain relative to palliative and hospice care and is an important element related to care quality for these patients and families.
Continued tracking of the delivery of skilled visits in the last days of life is of value to hospice providers and consumers. We do note, however, (as outlined in our comments related to the Visits at the End of Life paired measure (below)) it is important that CMS and hospice providers recognize the importance of honoring the wishes of patients and family members relative to the types and frequencies of visits in the last days of life. These preferences must be addressed through some means so as not to create a conflict for hospices between honoring patient/family wishes and risking lower quality scores.

**Monitoring for Impacts of Hospice Payment Reform**

CMS outlines a lengthy list of factors that it will be monitoring as data related to the payment system changes becomes available.

NAHC fully supports CMS’ planned oversight of the impact of hospice payment reform on hospice providers, patients, and overall patterns of care. We have received anecdotal reports indicating that some hospice providers with a high proportion of short-stay patients are receiving less revenue than was previously the case. We urge CMS to examine this area closely and if it can be determined that these hospices are being negatively impacted by some aspect of the payment changes that CMS identify some means for addressing this.

**Proposed Updates to the Hospice Quality Reporting Program (HQRP):**

CMS indicated there are no current HQRP measures that address care beyond the hospice initial and comprehensive assessment period, nor do any current HQRP measures relate to the assessment of hospice staff visits to patients and caregivers in the last week of life. NAHC supports the inclusion of measures that address care throughout an individual’s entire hospice stay. CMS is proposing two new measures be added to the HQRP. CMS believes the first of the two measures -- Hospice Visits When Death is Imminent Measure Pair (paired measure) -- will encourage hospices to visit patients and caregivers and provide services that will address their care needs and improve quality of life during the patients’ final days. We applaud CMS for recognizing the value all of these disciplines bring to the quality of hospice care. We also caution CMS against creation of an environment that drives unnecessary visits and shifts the focus of hospice care from holistic care delivered by an interdisciplinary team to a visit model. Holistic care delivered by an interdisciplinary team is the essence of the hospice philosophy, and we have received feedback from some hospices that an internal review of their visit data reveals that many visits in the last days of life are provided by social workers and bereavement coordinators helping patients and families through the grief process and working through the transition. As more family members are coming in during the patient’s last days there is a need for more education and support which volunteers can also help to provide and reinforce. We note that bereavement coordinators and volunteers are not part of the disciplines included in the measures and encourage CMS to consider their inclusion in future measure development.

Regarding visits that are included in Measure 1, a visit for purposes of quality must be defined. We believe that visits counted for quality purposes are not the same as those counted for claims/payment.
purposes. There are many care processes delivered by hospice team members that are not tracked on claims or paid for by Medicare. For instance, quality visits should include post mortem visits, social worker phone calls, NP visits that are part of nursing services, NP visits that are attending physician visits or under which physician services are provided by a non-attending hospice-employed NP, and volunteer visits if the volunteer is providing care as a specific hospice discipline. However, this is not how the measure numerator was defined in the NQF Measures Under Consideration (MUC15-227). Since the measure has not been finalized, CMS must include detailed instructions of what constitutes a visit for each of the disciplines with examples and how the measure outcome(s) will be calculated. We also noted that some hospices believed that the paired measure outcomes would be calculated only for the last three days of life or last seven days of life with the physician, physician assistant, NP, RN, and LPN visits included in the three-day outcome calculation. We suggest clarification from CMS indicating that all disciplines that are part of this paired measure are likely to be included in the calculation of the outcome(s) from this paired measure. We also strongly encourage CMS to conduct more research on the type of visits provided at the end of life and develop a clear rationale as to whether such visits should be counted or not for purposes of this measure. This rationale must be shared with hospice providers so that they have a better understanding of the logic used in development of the measure, and thereby resulting in more accurate data to CMS.

Because patients have the right to refuse services from the various interdisciplinary group (IDG) members and it is not uncommon for them to exercise this right, it is important that any outcomes calculated from this measure that would be publicly reported be risk-adjusted to reflect this. In addition, patients with shorter lengths of stay will have a different cadre of visits than patients with a longer length of stay (i.e. 60 days compared to short length of stay of less than 7 days), and publicly-reported quality outcomes should be risk adjusted for this, as well.

The second of the two proposed measures is the Hospice and Palliative Care Composite Process Measure, a process measure that addresses the percentage of hospice patients who received care processes consistent with existing guidelines. The outcome calculation of the composite process measure should be risk-adjusted to reflect the fact that hospices may not be able to deliver all seven care processes when serving a patient with an extremely short length of stay. Otherwise, an unintended consequence of Measure 2 is that the hospice is incentivized to complete all seven processes as opposed to identifying and addressing the patient’s and caregiver’s immediate needs for short length of stay patients. For instance, a patient may require intense symptom management for dyspnea and possibly pain at the time of admission, thus the hospice intensely focuses its efforts in these areas at the time of admission and then the patient dies the same day he/she elects hospice care or within a few days afterwards. The patient’s immediate needs as identified in the initial assessment should drive the processes delivered to the patient and family and when those processes are delivered. For very short length of stay patients it may not be reasonable to expect that all seven processes have been delivered.

In general, the public does not understand the difference between a process measure and an outcome measure. Therefore, we believe consumers should be provided information about the difference between a process measure and an outcome measure. Additionally, the general public will likely not be
able to draw a conclusion between a hospice’s performance on the composite measure and the overall care that can be expected from the hospice as the measure only addresses processes during the admission and comprehensive assessment period. While we are not suggesting that this measure is not valuable (because we do believe it is of value to hospice providers and some key hospice stakeholders) we want to point out that public reporting of this measure will be most meaningful to consumers if CAHPS hospice survey data is publicly reported simultaneously. Without the CAHPS hospice survey outcome(s) it will be difficult for the consumer to put the process measure data into context. NAHC also strongly supports the Medicare Payment Advisory Commission’s (MedPAC) comments urging timely development of hospice outcomes measures, as well as routine efforts by CMS to eliminate measures that are no longer considered to effectively measure quality.

**Comprehensive Patient Assessment Instrument**

Overall, NAHC and HAA support a comprehensive patient assessment instrument provided that instrument is developed in conjunction with providers and end-of-life care experts. We thank CMS for this opportunity to provide comment on such an instrument. It is important to allow comments from stakeholders and the public at several points throughout the development process. NAHC urges CMS to test any tool(s) in the hospice provider community allowing for necessary revisions realized during the testing period to be made prior to full implementation.

Again, the premise of the hospice philosophy is holistic care delivered by an interdisciplinary team. NAHC cannot stress enough the importance of ensuring that this premise not be violated. It is important for any comprehensive assessment patient instrument in hospice to be comprised of a physical, psychosocial, and spiritual component. All core members of the IDG should be able to document within the tool. Any outcomes generated by the tool need to be risk adjusted:

- To reflect the patient’s right to refuse or defer some IDG services
- For short lengths of stay
- To account for situations where attending physicians refuse to give orders aligned with identified patient needs and patient preferences (i.e. effective use of narcotics for patients with history of substance abuse, use of narcotics with ‘street value’, etc.)

CMS indicated in comments that two time points would be used for this instrument – admission and discharge. While these time points allow for calculation of outcome measures, we believe it is important to measure care throughout the entire course of care, not just at admission and discharge. We understand patient assessment instruments are utilized by other providers and may be attractive for use in hospice to allow for comparisons across provider types, but strongly recommend that CMS assess the platforms and methodologies to determine whether they are appropriate for use in the hospice setting.

Because hospices follow somewhat different processes depending on the patient’s site of service, CMS should consider this in development of the instrument, as well as the level of care the patient is receiving, and possibly modify questions based on these factors. Settings include the patient’s home, hospice inpatient unit, nursing home, assisted living facility, and hospital. Given that the assessment will
be completed by different staff than are currently completing the HIS Admission and Discharge records and that the assessment will be more lengthy than the current HIS, CMS must ensure that its estimate of increased costs to hospice programs accurately reflect the higher costs associated with skilled disciplines. The instrument should, of course, be tested and revised as necessary prior to full implementation with input from hospice experts and stakeholders. NAHC stands ready to assist as appropriate.

We note that CMS (with increased frequency) references and considers hospice as part of the post-acute care continuum. While we do not believe hospices provide the same type of care or to the same population as post acute care providers, we recognize that CMS may look to quality initiatives utilized with PAC providers and apply these to hospice. We warn CMS that comparing the findings of these measures across provider types would not be comparing like providers and the unique components of the hospice philosophy may be lost or left unconsidered.

One area common to hospices and PAC providers alike is patient preferences. We stress the importance of including patient preferences in the instrument and recommend that one of the outcome measures calculated be whether these preferences were observed throughout the patient’s course of care.

Should the instrument go so far as to prescribe standardized tools (i.e. pain scales, symptom management assessment tools, etc.) it is important that CMS preserve the integrity of the hospice philosophy by allowing hospice IDG members to individualize assessments and care based on their best clinical judgment and this requires that they be able to use this clinical judgment to determine the best assessment tool to utilize. Again, any comprehensive patient assessment tool must be tested and revised as necessary prior to full implementation.

Public Reporting

CMS plans to publicly report all seven HIS measures on a CMS Hospice Compare Web site. The CMS Hospice Compare Web site is on target to be implemented in spring/summer 2017. We provided some comment on the public reporting of the two new proposed quality measures above. We believe that CAHPS Hospice Survey data would be most helpful for consumers in drawing conclusions about the quality of hospice care and the experience that should be expected. Therefore, NAHC encourages CMS to include CAHPS Hospice Survey Data as soon as possible in public reporting or potentially even wait to publicly report HIS data until CAHPS data is available. Hospice providers have raised concerns about the current ease with which the HIS data can be manipulated to secure a better score. Waiting to publicly report HIS until CAHPS measures are available would -- at least in part -- reduce the impact that such manipulation might have on scores.

Star Ratings

We understand that provider quality star ratings usually are developed and available for public viewing soon after the provider type compare website and corresponding quality measures are available for public viewing. For hospice this could mean the implementation of star ratings as soon as summer of 2018. It makes sense that CMS and its quality contractors will look to the star rating methodologies of
other providers when developing and implementing the star ratings. We note that some measures used to determine star ratings on the fee-for-service side utilize a “bell” curve to rank providers’ quality performance. We caution that putting hospice star ratings on a bell curve as is used for some measures under home health and other provider types may be misleading to the consumer and may misrepresent the quality of care provided by a particular hospice. Most consumers familiar with star ratings do not expect that the “product” will be rated in the state or nationally according to a pre-determined distribution that guarantees some providers will rank very low regardless of how well they have performed. Further, having some measures ranked according to a bell curve while other rankings are based on a traditional scoring method (as is done for some providers under fee-for-service) will create further confusion for consumers.

We also encourage CMS to include CAHPS hospice survey measures in any star rating developed for hospices and to ensure that all components of the hospice interdisciplinary team are reflected, specifically bereavement services and volunteer programs. As mentioned previously in these comments risk adjusting for individualized care is a must, i.e. very short lengths of stay, patient right to refuse some IDG services, etc.

We appreciate the opportunity to comment on the proposed rule, CMS’ insights, and proposed changes for the Medicare hospice program. Changes that CMS is contemplating related to assessment and public reporting of hospice quality are of great interest to us and to the stakeholders that we represent, and we look forward to continuing discussions with representatives of your agency as the process continues. Please feel free to contact us if we can be of assistance in any way.

Sincerely,

Theresa M. Forster
Vice President for Hospice Policy & Programs