June 29, 2015

Mr. Andrew Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–1629–P
P.O. Box 8010
Baltimore, MD 21244–8010

Dear Mr. Slavitt,

NHPCO appreciates the opportunity to comment on CMS 1629-P, Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements; Proposed Rule. NHPCO is the largest membership organization representing the entire spectrum of not for profit and for profit hospice and palliative care programs and professionals in the United States. We represent over 4,000 hospice locations and more than 70,000 hospice professionals in the United States, caring for the vast majority of the nation’s hospice patients. The organization is committed to improving end-of-life care and expanding access to hospice care with the goal of creating an environment in which individuals and families facing serious illness, death, and grief will experience the best that humankind can offer.

Executive Summary

Overall, NHPCO applauds CMS’s proposal to establish a two-tiered payment system for the hospice Routine Home Care (RHC) level of care. We believe that it addresses concerns about higher service utilization and costs in the first days and weeks of care and appropriately supports providers during that time. We also support the proposal to establish a “Service Intensity Add-on” (SIA) payment for certain skilled services provided to patients nearing the end of life, specifically the last 7 days of life. However, we strongly object to CMS’s proposal to exclude from the SIA those hospice patients dying in skilled nursing facilities or nursing facilities (SNFs/NFs) and we urge CMS to include patients in those settings for the SIA payment. Beneficiaries dying in these settings need the same intensive support of an RN or social worker as patients in their own homes, and should not be discriminated against because of their location of care.
We note that CMS continues to contend that “virtually all” care and services for terminally ill patients are related to the terminal prognosis and should be provided by the hospice. NHPCO strongly asserts that determinations of “relatedness” must be made on a case by case basis, as CMS has stated previously, and it is the role and responsibility of the hospice medical director or hospice physician to determine what is related to the terminal prognosis, and what is not. Earlier in 2015, NHPCO launched an initiative to provide support and assistance to hospice providers and clinical staff in making determinations about relatedness, and has promoted the use of the “terminal prognosis” language and an algorithm for provider use. We urge CMS to avoid blanket assertions or assumptions about which services are always related to a patient’s terminal prognosis.

Aside from NHPCO’s views on the merits of CMS’s proposals, which are discussed in detail below, the changes in payment policy and methodology put forth in the proposed rule pose significant infrastructure and procedural implementation questions and challenges that remain unresolved, and it will require time and effort to develop, test and put in place all of the necessary processes and changes. Therefore, NHPCO strongly recommends a comprehensive and time-limited test or “dry run” of the new payment system mechanisms, within the Medicare and Medicaid systems and hospices, before it is fully implemented in the hospice community.

A. Hospice Payment Reform Research and Analyses

The proposed rule outlines the research and analyses CMS has conducted pursuant to the Affordable Care Act (“ACA”) requirement to undertake hospice payment reform. In particular, CMS details its identification of non-hospice Medicare spending on hospitalizations, drugs, DME and diagnostic services for beneficiaries during a hospice election. CMS expressed concern about “unbundling” of the hospice benefit, and that many of these expenses were for items and services that might have been related to the terminal prognosis and should have been provided by the hospice. CMS also identified high rates of live discharges among some hospices and expresses concern that hospices may be admitting individuals who do not meet eligibility criteria.

NHPCO Comments

1. Unbundling

NHPCO shares CMS’s concern about any inappropriate unbundling of the hospice benefit and has undertaken efforts to help providers identify and cover all items and services that are related to the terminal prognosis, and to ensure that beneficiaries understand the scope and structure of the hospice benefit.
began its work on “relatedness” because there have been varied interpretations of what should be considered “related to the terminal illness and related conditions” over the years, and providers needed both clearer guidance and a framework within which to make “relatedness” decisions. We welcome the opportunity to continue working with CMS to educate all providers about the hospice benefit, and establish mechanisms to ensure that beneficiaries are able to access their benefits and that services are billed appropriately. However, hospices alone are not responsible for this, nor can they prevent billing by other providers outside the hospice benefit. CMS needs to help educate other providers and beneficiaries, and make infrastructure changes to flag and prevent inappropriate billing.

**Non-hospice spending:** We note that in the CMS description of why services would be paid outside the hospice benefit, the reasons given point only to the hospice “incorrectly classifying conditions as unrelated… not communicating and coordinating the care and services needed to manage the needs of the hospice beneficiary, or deliberately, to avoid costs.” While we acknowledge that these are possible, CMS fails to consider that it was other providers, not hospices, billing Medicare for these services, and that there are a myriad of reasons that a non-hospice provider bills inappropriately. They may lack awareness of the beneficiary’s hospice election, they may fail to understand the hospice benefit and its requirements, or they may want to continue to bill “like they always have” without regard to billing changes that take effect when the patient elects hospice.

Our members also report that many non-hospice Medicare providers have stated that the non-hospice providers are not required to check for a hospice election and they continue to get paid by Medicare, so they don’t intend to change their billing practices. NHPCO will continue to work to help hospices better communicate and coordinate with all providers involved with a hospice patient’s care, and to try and ensure that services are billed appropriately, but hospices cannot dictate whether, or from whom, a beneficiaries seeks care, nor can they control billing by other providers. We began discussions with CMS on this issue in 2014, and provided CMS with a list of suggestions for addressing these concerns. We look forward to continuing those discussions in hopes of finding workable solutions.

**Initiative for Terminal Prognosis:** Since the rather vague references that appeared in the Federal Register preamble of the 1983 final rule establishing the Medicare hospice benefit, there has been almost no guidance or attention given to the issue of “relatedness.” Over the last two rulemaking cycles, however, the discussion on “relatedness” is mentioned and refers back to the 1983 final rule and even then proposed no new guidance. As NHPCO has talked with providers
over the last several years, we realized that a more systematic approach was needed to determine diagnoses and conditions that should be considered related.

It is with that systematic approach in mind that NHPCO launched an initiative to help providers walk through the process of making decisions about relatedness to the terminal prognosis. An algorithm for that decision making process has been created and was shared with CMS earlier this year. These are clinical determinations and, as CMS has acknowledged, they must be made on a case by case basis, so a central component of the algorithm is the key role of the hospice physician or medical director, who has the role and responsibility for making decisions about whether treatments and medications are related to the terminal prognosis, and whether they continue to be reasonable and necessary for the palliative management of the terminal illness. Many hospices have begun using this algorithm with great success, as a way to better operationalize the decision-making process. While hospices can do a better, and more consistent, job of classifying conditions, as related or unrelated, hospices cannot prevent or control all non-hospice spending for beneficiaries enrolled in hospice.

**Part B expenditures:** Another element of the perceived “unbundling” of the hospice benefit is the amount of Part B expenditure after the hospice election. Hospices can make further efforts to communicate to beneficiaries the need to allow the hospice to coordinate care they receive, and they can increase their communication with physicians about the hospice election and facilitate attending physician communication about goals of care and appropriateness of treatments and medications after the hospice election. However, it is not reasonable to expect that the hospice alone will be able to control the Part B billing of a physician office or the physician’s orders for labs or other treatments after the hospice election. CMS has the responsibility to take action with respect to other providers and its own infrastructure and systems in order to address this issue.

**Part D expenditures:** Another component of the “unbundling” involves payments by Part D for medications after the hospice election. Over the last two years, NHPCO has worked intensely with CMS and other stakeholders to address concerns about Part D payments after the hospice election, which resulted in the CMS memo to Part D plan sponsors and to hospices on July 18, 2014, requiring a prior authorization for four classes of medications. These drugs are covered by Part D only when the hospice indicates it has made a determination that the drug is not related to the patient’s terminal illness. Even since that memo was issued and a standardized form was approved for use, concerns remain and confusion continues among Part D plan sponsors, pharmacies, and hospices about the process and its enforcement. We believe that in many circumstances, the
hospice is attempting to “do the right thing” and the communication process with the pharmacy or the Part D sponsor is confused or lacking. Further efforts are needed to continue to clarify this process for hospices, beneficiaries, pharmacies, and other providers.

2. Case Studies

NHPCO appreciates the work of Acumen in detailing the care and services often associated with four specific diagnoses common among enrolled hospice patients. It is important to note, in each of the case studies, that the picture of related drugs, DME, Part A and Part B services is not black and white. In some cases, the examples of expenditures outside the hospice benefit may not be the hospice’s doing, but rather a function, as we have stated earlier, of systems that do not indicate the hospice election to other Medicare providers and/or allow for overlaps in billing, or a lack of provider awareness of the impact on billing and reimbursement once the beneficiary has elected hospice.

3. Live Discharges

Like CMS, NHPCO is concerned about the rising incidence of live discharges, and agrees that attention should be paid to this development. We also concur that the live discharge rate should never be expected to be zero, since there are many instances where patients stabilize, move out of the service area or are in other situations where a live discharge is appropriate.

Patients have the right to revoke their hospice election at any time, and revocation, which is a form of live discharge, should be evaluated separately. This is now possible with the separate occurrence code 42. While other forms of live discharge should be the primary focus of CMS’s ongoing analysis, it also is important to identify providers with high revocation rates to ensure that patients are not unduly “encouraged” to revoke their hospice benefits, whether for costly care or for other reasons.

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NHPCO Recommendations (continued)

2. CMS should undertake education of hospitals, physicians and other providers so that they better understand the coverage of services for beneficiaries enrolled in hospice under the Medicare hospice benefit, and the need to coordinate care with the hospice.

B. Proposed Routine Home Care Rates and Service Intensity Add-on

A. Two Tiered Routine Home Care Rate

In response to the ACA requirement to implement revisions to the methodology for determining hospice payment rates, CMS is proposing to establish a two-tiered model for Routine Home Care ("RHC") days. Hospices would be paid one rate for a beneficiary's first 60 days of hospice care and a lower rate for subsequent days in hospice care. The count of days would follow the patient, whether they remained in the same hospice or changed hospices, unless there was a 60 day lapse in hospice enrollment. If the patient re-enrolled in hospice after a 60 day or greater gap, the patient would be eligible for the higher rate for another 60 days.

NHPCO Comments

NHPCO is supportive of the proposal for a two tiered payment rate for RHC and believes that payment of a higher rate during the first 60 days of care reflects the service intensity identified by CMS and its contractors in claims data. We hope that this differential payment structure will help address the high cost of care, services and medications for patients who are in hospice for only a short time.

We are, however, concerned that this payment differential could incentivize providers to target and admit larger numbers of short stay patients, and to discharge, or decline to admit, patients whose hospice care would be paid at the lower rate. Our providers have communicated that the admission of a patient is time-consuming and labor intensive, no matter whether the patient has been served by another hospice or not. We encourage CMS to monitor the utilization at each tier of the routine home care rate, and discharges of patients around the 60th day of hospice care, to identify any effects this new payment system may have on access and quality of care.

We also have a number of questions and concerns about how the two tiered rate would work, outlined below:
Day Count and Effective Date for Implementation

1. **Responsibility for determining the count of days:** It’s unclear in the proposed rule whether hospices will simply bill a routine home care day and CMS will determine the count of days for the patient and pay at the appropriate rate, or if hospices will be responsible for determining the patient day count and billing at the correct rate. NHPCO believes that CMS should be responsible for determining the count of days, making every effort to accurately count the days of care, based on information available, either in the Common Working File (CWF) or from other sources.

2. **Timely and accurate day count data:** Regardless of who is responsible for determining the day count for patient billing, access to timely and accurate data regarding the day count is essential. A number of factors make this challenging, and we have serious concerns about the ability of CMS, the state Medicaid offices, or hospices to make the necessary system changes, and undertake the education and training to be ready to implement the new billing system by October 1st.

3. **Basis for day count:** We assume, but ask CMS to clarify in the final rule, that the count of days for determining the appropriate RHC payment rate is based on all days in hospice, not just days billed at the RHC rate. Similarly, what about days of care that were provided but aren’t billable?

4. **Start date for the day count:** There is confusion and concern about the start date for the day count. NHPCO requests clarity in the final rule for the start date for the day count – does it start on the effective date of the election statement, or on the first day of payment? The question arises from the concerns expressed by our members that if a Notice of Election (NOE) is returned to the provider or otherwise not accepted by the MAC, the time lag could be as long as three weeks, and the hospice would have a significant number of unbillable days.

5. **Untimely filing of Notice of Termination/Revocation:** If a hospice is delayed in filing a Notice of Termination/Revocation ("NOTR") or has not submitted its final claim, the days that a beneficiary was served by a previous program may not be “visible” to a new hospice admitting the patient because only days that were billed are in the FISS system. If the patient chooses to elect care from another hospice and the NOTR or final bill from the first hospice have not been completed, the new hospice will
have no knowledge of the day count and cannot post the Notice of Election (NOE). This is an example of why we believe that CMS should be responsible for the count of days, rather than individual hospices.

6. **Days used:** The FISS system should be able to calculate “days used” by referencing the NOTR date rather than the final claim for purposes of determining the day count and appropriate billing. How will CMS address this concern?

7. **Day count when more than one hospice is involved:** CMS has indicated that the count of days follows the patient, and for patients who are discharged and readmitted to the same or a different hospice within 60 days of that discharge, the day count would start back where they were at discharge. If the patient moves to be closer to family or is discharged by one hospice and elects hospice care from another hospice, the second hospice will have the same initial admission and services expenses and may not, depending on the day count, ever receive the higher level of reimbursement. NHPCO remains concerned about the inequities for the second hospice and requests that CMS continue to monitor the incidence of this issue and whether it has any effect on access to hospice care.

8. **Patient transfers:** Currently, if a patient transfers from one hospice to another, both entities may bill on the day of transition. NHPCO requests clarity in the final rule to ensure that this day counts as one day, rather than two, even when two entities are billing for that day.

9. **Reconciliation and recoupment:** Regardless of who is responsible for determining the day count, if payments made to the hospice are later found to have been at the wrong rate because of missing or inaccurate information on the day count, what will be the process for reconciliation and recoupment, and over what time period might this occur?

10. **Implications for budgeting and planning:** If access to a timely and accurate day count, and a fair and speedy reconciliation process, aren’t available, it will have serious implications for a hospice’s budgeting and planning process.

11. **Effective date of implementation:** How will the new two tiered rate system be applied to patients in hospice on the effective date? NHPCO requests clarity from CMS on how the new two tiered payment system will be applied for patients enrolled in hospice on the implementation date. Will it be implemented only for patients admitted on or after the effective
date, with current patients continuing to be billed at current rates until they die or are discharged? Will the day count for all patients currently on service have to be determined and payment made at the appropriate rate after the implementation date?

### NHPCO Recommendations

1. CMS should be responsible for determining the day count for hospice patient billing, and should clarify and answer the questions noted above regarding the day count.
2. NHPCO recommends that CMS provide clarity on how current patients will be impacted on the implementation date of the new two-tiered RHC payment system.

### B. Service Intensity Add-On Payment

In addition to moving to a two-tiered RHC rate, CMS also is proposing to establish a “Service Intensity Add-On” (SIA) payment that would be available to hospices in addition to the RHC rate when they provide visits involving certain skilled services to patients during the last week of life. SIA payments would be equal to the Continuous Home Care (CHC) hourly rate and would be available for up to 4 hours of care per day. CMS would make the payments based on a retrospective review of claims after a hospice patient’s death, and the SIA payments would be available only if:

- the day was billed at the RHC level,
- the day was during the last 7 days of the patient’s life, and the beneficiary was discharged dead,
- direct patient care was provided by a hospice RN or social worker (as defined in the hospice regulations), and
- the patient is not in a skilled nursing facility or nursing facility.

In order to maintain budget neutrality, CMS also is proposing to establish a SIA payment budget neutrality factor (SBNF), which would be calculated and applied annually to reduce the RHC rate, based on utilization of the SIA payments.

### NHPCO Comments

NHPCO is supportive of CMS’s proposal to provide SIA payments, and agrees that patient and family needs typically intensify as the patient nears death, and hospice costs increase in order to meet these needs. We appreciate that the SIA payments would be available regardless of the beneficiary’s length of stay in
hospice, and given that over 30 percent of hospice patients die within 7 days of electing hospice, we believe this will assist in absorbing the high cost of caring for these short stay patients. However, we do have concerns that the availability of SIA payments could also have the unintended consequence of incentivizing “brink of death” hospice care, and we urge CMS to monitor trends in short hospice stays. And, as noted below, we have significant concerns about the exclusion of hospice patients dying in skilled nursing facilities or nursing facilities (SNFs/NFs) from SIA payments.

**SIA payments for patients in NFs and SNFs:** NHPCO strongly objects to CMS’s proposal to exclude SIA payments for patients who otherwise meet the criteria but who die in SNFs/NFs. Medicare beneficiaries who are in SNFs/NFs have just as much need (if not more), and are just as deserving of skilled services at the end of their lives. To withhold SIA payments for services in these settings is discriminatory and, we believe, inconsistent with the Medicare Conditions of Participation, which require that hospices providing care to SNF/NF residents provide services at the same level and to the same extent as those services would be provided if the SNF/NF resident were in her or her own home.¹

CMS fails to even provide a rational reason for not allowing SIA payments for beneficiaries dying in SNFs/NFs. In the proposed rule, CMS cites an OIG report that addressed concerns about certain hospices that had a high percentage of their patients in nursing facilities, and that these patients tended to have longer lengths of stay and required less complex care. The OIG recommended that CMS modify the reimbursement system to reduce incentives for hospices to seek out beneficiaries in nursing facilities. However, CMS should address any concerns about hospices with high percentages of nursing home residents in a more targeted fashion, and not by targeting certain beneficiaries and imposing disincentives to provide skilled care to hospice patients in SNFs/NFs during their final days of life.

As CMS has noted, at the end of life patient needs typically surge and more intensive services are warranted, and this is no less true of patients in SNFs/NFs. In fact, the needs of some SNF/NF patients may be even greater than those in traditional home settings, where one or more caregivers are often present around the clock. While the SNF/NF continues to be responsible for the patient’s personal care needs, the facility isn’t responsible for providing the skilled level of care for these hospice patients or for providing needed care for their families. Therefore, NHPCO strongly objects to this proposed discriminatory treatment of patients and families based on the location of services.

¹ 42 CFR §418.112(c)(5).
Disciplines appropriate for SIA: NHPCO also supports the identification of RNs and social workers as the appropriate disciplines for the SIA payments. RNs because of their training and expertise in assessment, which typically is required at greater frequency as the patient nears the end of life, and social workers for providing a skilled level of support for the patient and family at this difficult time.

Clarifications needed: In addition to the concern noted above, NHPCO also requests that CMS clarify in the final rule several issues related to the proposal for SIA payments:

1. The proposed rule states that SIA payments would be equal to the CHC hourly payment rate. Does CMS propose to calculate payments based on 15 minute increments, as is the case with CHC?

2. Please clarify that SIA payments would be available for hospice patients residing in assisted living and similar types of facilities, as well as hospice residences, provided the hospice care was billed at the RHC rate and the visits otherwise qualify for the SIA payment.

3. NHPCO assumes that if a patient, during the final week of life, receives direct patient care from a RN or social worker on the 3rd through 7th days prior to death but then requires hospice general inpatient care or continuous home care for the final two days of life, the hospice would still receive SIA payments for days 3-7 prior to death, when the hospice was billing the RHC rate. Please confirm in the final rule that SIA payments would be made under these circumstances.

4. NHPCO assumes that if a patient’s last 7 days spanned the end of one month and the beginning of the next, CMS would “look back” after the patient’s death and process whatever SIA payments the hospice qualifies for, regardless of whether the days were in one month or two. Please confirm in the final rule how SIA payments will be made under these circumstances.

SIA Payment Budget Neutrality Factor: There are some concerns with the calculation and application of the SBNF outlined below:

1. CMS proposes to make SIA payments only for direct patient care provided by a RN or social worker, and the current claim forms only allow reporting of skilled nursing visits, without distinguishing between visits by RNs vs. LPNs or
other nurses. How did CMS calculate the proposed FY2016 SBNF for adjusting RHC rates when there is no data on RN-specific visits?

2. The timeframes for the SBNF aren’t clear. CMS states that they will use a full year of SIA utilization data to set the SBNF. If so, what payment year will the SBNF be applied to?

3. We note that CMS proposes to use a budget neutrality factor for each of the two proposed RHC rates. Since the statute requires budget neutrality but does not specify how it is to be achieved, we recommend that CMS adopt one SBNF adjustment that can be used across the full spectrum of RHC days. NHPCO believes that having two different SBNF calculations is too complex and for ease of implementation and hospice understanding, we recommend calculating and apply only one.

NHPCO Recommendations

1. CMS should provide SIA payments for hospice patients dying in SNF/NF settings. As noted in our comments, all Medicare beneficiaries need and are entitled to the same level and type of services during their final days, regardless of the setting in which they spend those days.

2. Once the full year of SIA utilization data is available for analysis and the budget neutrality adjustment is set, clarify how the adjustment would be applied to the payment year.

3. Establish one SBNF for both RHC rates, rather than a separate SBNF for each level of RHC. This will provide ease of implementation and understanding among hospice providers.

4. CMS should clarify the questions and comments raised above.

C. Proposed FY 2016 Hospice Wage Index and Rates Update

NHPCO has no comments.

D. Alignment of the Inpatient and Aggregate Cap Accounting Year with the Federal Fiscal Year

Currently the accounting year for the inpatient and aggregate cap is November 1 to October 31. CMS proposes to align the cap accounting year for both the inpatient and aggregate cap with the federal fiscal year for FYs 2017 and later, in order to eliminate timeframe complexities associated with counting payments and
beneficiaries differently from the federal fiscal year, and help hospices avoid mistakes in calculating their aggregate cap.

**NHPCO Recommendations**

1. We support this alignment as we believe it will help eliminate confusion and misunderstandings. CMS should ensure that there is information available to hospices on the transition to the new accounting year time frames.
2. We note that CMS has removed the March 31 due date in §418.308. We request that CMS provide early notice on the due date for the “aggregate cap determination” each year as the removal of this due date may be a source of confusion for hospice providers.

**E. Proposed Updates to the Hospice Quality Reporting Program**

1. **Proposed Policy for Retention of HQRP Measures Adopted for Previous Payment Determinations**

   CMS has proposed that measures are automatically adopted for all subsequent years’ payment determinations, unless CMS proposes to remove, suspend, or replace the measures.

   **NHPCO Comments**

   NHPCO supports this proposal. We agree that measures should be systematically reviewed on a regular schedule to ensure that the measures included in the HQRP are able to distinguish performance among hospices, do not result in unintended consequences, and have demonstrated potential to improve care. We also urge CMS to use sufficient data collected over an adequate period of time to inform the decision-making process for retaining, removing, suspending or replacing a measure.

   The burden placed on hospices in terms of expenditure of financial and human resources in implementation of, and ongoing compliance with, HQRP requirements is significant. This burden needs to be taken into consideration by CMS in deciding to make changes in HQRP requirements. Both current and new measures should be thoroughly evaluated and tested before removal from or introduction to the HQRP. We recommend that measure data from the first two quarters after implementation not be used for evaluation; that a minimum of a year of data after implementation be used in the evaluation process; and that the evaluation process should be comprehensive, including not only the
psychometric properties of the measure, but evidence of the measure’s relationship to meaningful patient/family outcomes, as well as consideration of the effect of implementation of the measure on hospice practice.

NHPCO Recommendations

1. NHPCO supports this proposal.
2. Both current and new measures should be thoroughly evaluated and tested before removal from or introduction to the HQRP.
3. We recommend that measure data from the first two quarters after implementation not be used for evaluation; that a minimum of a year of data after implementation should be used in the evaluation process.
4. We recommend that the evaluation process should be comprehensive, including not only the psychometric properties of the measure, but evidence of the measure’s relationship to meaningful patient/family outcomes, as well as consideration of the effect of implementation of the measure on hospice practice.

2. HQRP Quality Measures and Concepts Under Consideration for Future Years

CMS has identified several high priority concept areas for future measure development:

- Patient reported pain outcome measure that incorporates patient and/or proxy report regarding pain management;
- Claims-based measures focused on care practice patterns including skilled visits in the last days of life, burdensome transitions of care for patients in and out of the hospice benefit, and rates of live discharges from hospice;
- Responsiveness of hospice to patient and family care needs;
- Hospice team communication and care coordination.

NHPCO Comments

a. Patient reported pain outcome measure: Because pain management is a fundamental aspect of hospice practice and embodies patient-centered care, NHPCO supports the development of a patient reported outcome measure related to pain. To be truly useful for accountability and quality improvement, as well as public reporting, this measure should provide a means for evaluation of hospices’ performance in pain management. We remind CMS that a reduction in pain intensity is not equivalent to pain management. Pain
management occurs over time and effective management frequently requires the coordinated efforts of the interdisciplinary team.

We also remind CMS that a patient reported outcome measure should reflect the patient’s voice and goals for care. Correct pain management integrates patient choice for the desired level of treatment with the care process by incorporating the patient’s own pain goals and perception of his or her own degree of comfort into the pain management process. Likewise, a measure that truly evaluates pain management is based on patient perception not clinician judgment.

b. **Claims based measures:** While the identified measure areas do focus on important aspects of hospice care, claims do not provide sufficient information to adequately represent hospice practice. Consequently, claims data cannot appropriately be used to inform the creation of performance measures that improve quality of care. For example, there are multiple reasons for a patient to be discharged alive from hospice. Some of these reasons stem from the uncertainty inherent in prognostication of terminal illness and that hospice care is a choice made by patients and families, who are free to change their minds. And, some live discharges stem from questionable organizational practices. Claims data do not distinguish between appropriate and inappropriate reasons for live discharge and, consequently, a performance measure related to rates of live discharge based on claims data cannot provide meaningful distinctions in performance among hospice providers. Moreover, performance measures should guide and promote the quality of direct care received by hospice patients and families. Performance measures should not be implemented as a means to discourage or correct undesirable organizational practices that have been identified from trends in payment.

### NHPCO Recommendations

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c. Responsiveness of hospice to patient and family care needs; and Hospice team communication and care coordination: In the development of quality measures for these focus areas, NHPCO requests that CMS be especially mindful of provider burden in measure implementation. We also ask that CMS consider demonstrated evidence of a link to quality care as a criterion in the development of these measures.

3. Form, Manner, and Timing of Quality Data
   a. Proposed Policy for New Facilities to Begin Submitting Quality Data

   CMS proposes that responsibility for HQRP data reporting for new hospices begins on the date they receive their Certification Number (CCN).

   NHPCO Comments

   NHPCO supports the proposed requirement. We agree that this policy will allow sufficient time for hospices to establish processes for collection and submission of HIS data. To avoid potential discrepancies between CMS and hospices’ expectations for initiation of HIS record submission, we ask that CMS provide clarification on how the date the CCN number is received will be verified.

   NHPCO Recommendation

   1. NHPCO supports this proposed requirement and asks that CMS provide clarification in the final rule on how the date the CCN number is received will be verified.

   b. Proposed Data Submission Timelines and Requirements for FY 2018 Payment Determination and Subsequent Years

   CMS proposes that hospices must submit the appropriate HIS records within 30 days of each patient’s admission date and discharge date.

   NHPCO Recommendations (continued)

   3. Discipline specific codes: The interdisciplinary nature of hospice care is not adequately reflected in claims data. Consequently, current hospice claims data cannot effectively inform quality of care and should not be used as the basis for performance measures for hospice.
NHPCO Comments

NHPCO supports the proposed requirement. We concur that timely submission of HIS data is necessary in order to facilitate CMS evaluation of the data and the eventual evaluation of hospice’s performance on the quality measures.

c. Proposed HQRP Data Submission and Compliance Thresholds for the FY2018 Payment Determination and Subsequent Years

CMS has proposed a compliance goal of 90% compliance for meeting the submission deadlines for HIS admission and discharge records. The penalty for non-compliance is a 2% reduction in the market basket increase in subsequent years. The compliance threshold will be phased in incrementally over a period of three years as follows:

a. 2016 – 70% threshold, below 70% - 2% penalty for FY 2018
b. 2017 – 80% threshold, below 80% - 2% penalty for FY 2019
c. 2018 – 90% threshold, below 90% - 2% penalty for FY 2020

NHPCO Comments

NHPCO supports the establishment of data submission and compliance thresholds for FY2018 payment determinations and for subsequent years. We believe that the proposed phase-in timeline is reasonable and feasible for hospices to achieve compliance with the proposed submission percentage thresholds.

In addition, NHPCO asks that CMS consider removing the completion deadline requirements for HIS Admission and Discharge records. The completion deadlines add to hospices’ administration burden for HIS and do not facilitate compliance with submission deadline requirements. The implementation penalties for non-compliance with HIS submission deadlines will ensure that hospices implement reliable processes for collection and submission of HIS data if they have not already done so.

NHPCO Recommendations

1. NHPCO supports the establishment of data submission and compliance thresholds.
2. NHPCO requests that CMS consider removing the completion deadline requirements for HIS Admission and Discharge records.
4. **HQRNP Reconsideration and Appeals Procedures for the FY 2016 Payment Determination and Subsequent Years**

CMS proposes to use QIES and CASPER to communicate about compliance with reporting requirements and to publish a list of hospices that successfully meet reporting requirements on the HQRNP website.

**NHPCO Comments**

NHPCO supports CMS’ additions to the communications method regarding annual notification of compliance with HQRNP reporting requirements. The use of CASPER Reporting for the dissemination of compliance notifications and the publication of a list of compliant hospices on the HQRNP website offers an additional means for hospices to confirm compliance with HQRNP requirements and will help facilitate timely reconsideration requests when appropriate.

In addition, NHPCO requests that CMS consider revision of the criteria for granting an extension to include non-compliance related to technological problems. In some, albeit rare, circumstances a hospice may have collected HIS data and attempted to submit the HIS records, but failed to submit due to technological difficulties without understanding or realizing that submission was unsuccessful. Such a hospice made a good faith effort at compliance, yet incurs the same penalty as a hospice that neither collected nor submitted HIS data.

**NHPCO Recommendations**

1. NHPCO supports additions to the communications method regarding annual notification of compliance with the HQRNP reporting requirements.
2. NHPCO requests that CMS consider revising the criteria for granting an extension to include non-compliance related to technological problems.

5. **Public Display of other Hospice Information**

CMS plans to make provider-level feedback reports available through CASPER sometime in CY 2015. CMS anticipates that providers would use the quality reports as part of their Quality Assessment and Performance Improvement (QAPI) efforts.

CMS is required to establish procedures for making any quality data submitted by hospices available to the public and plans to develop a CMS Compare website for hospice. CMS states that it is essential that the data
made available to the public be meaningful and that comparing performance between hospices requires that measures be constructed from data collected in a standardized and uniform manner. To that end CMS plans to establish the reliability and validity of the quality measures prior to public reporting in order to demonstrate the ability of the quality measures to distinguish the quality of services provided.

**NHPCO Comments**

NHPCO strongly supports CMS’ creation of provider level quality reports in CY2015 as a way for hospices to have additional information related to their performance on the HIS quality measures to inform their QAPI efforts. We also strongly support establishing the scientific soundness of the quality measures through systematic and rigorous analysis and evaluation of the submitted data prior to release of any reports that present hospices’ performance on the measures.

We recommend, however, that CMS not begin public reporting until results from measures derived from both HIS data and the CAHPS Hospice survey data are available. While the concept of hospice has fairly wide public recognition, knowledge about hospice practice is minimal among the public. Few will be familiar with the processes behind the measures derived from HIS data and even fewer will be able to understand the relationship of those processes to quality of care. Additionally, the HIS derived measures are very limited in scope and fall far short of presenting a comprehensive picture of hospice services. For these reasons, CMS should not consider creation of the Hospice Compare website and public posting of quality measure results until analysis of CY 2015 and CY 2016 HIS and CAHPS Hospice data has been completed and accompanying educational material has been developed that explains hospice practice as an aid to interpretation of the results.

**NHPCO Recommendations**

1. NHPCO supports the creation of provider level quality reports so that hospices have additional information related to their performance.
2. NHPCO recommends that CMS not begin public reporting until results are in from measures derived from both HIS data and the CAHPS hospice survey data are available.
3. NHPCO recommends that CMS not consider the creation of the Hospice Compare website and public posting of quality measure results until CY2015 AND CY2016 HIS and CAHPS data have been completed and educational materials are developed.
F. Clarification Regarding Diagnosis Reporting on Hospice Claims

In the Hospice Wage Index for FY 2013 Notice, CMS stated that hospices should report on hospice claims all coexisting or additional diagnoses related to the terminal illness, not just the principal diagnosis, but that they should not report coexisting or additional diagnoses unrelated to the terminal illness. However, in the current proposed rule, CMS sets forth what it describes as a “clarification” that hospices are now to report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual, and that this would include reporting of any mental health disorders and conditions that would affect the plan of care. CMS also notes that ICD-10 Coding Guidelines state that diagnoses should be reported that develop subsequently, coexist, or affect the treatment of the individual.

In support of this new requirement, CMS indicates that there is “anecdotal evidence” that some hospices are inappropriately unbundling the hospice benefit and telling other providers to bill Medicare for services as “unrelated” and receive reimbursement from Medicare Parts A, B or D.

In this section CMS also addresses the issue of “related to the terminal condition” and states that longstanding, preexisting, chronic, stable and controlled conditions and disease states, as well as comorbidities, are included in the bundle of hospice services because “hospices are required to provide reasonable and necessary services for both palliation and management of all conditions that contribute to a terminal prognosis.”

NHPCO Comments

1. Concerns with Unbundling

As noted previously in this comment letter, NHPCO shares CMS’s concern about any inappropriate unbundling of the hospice benefit, and is committed to continue working to help providers understand the scope of the hospice benefit and how to identify those conditions related to the terminal prognosis. We agree that care coordination is a key component of good care, and that hospices need to be aware of all conditions affecting a hospice patient, whether or not they are related to the terminal prognosis. However, hospices are only one piece of the puzzle and they, alone, are unable to control every aspect of a patient’s care.

Anecdotal reports from non-hospice providers: NHPCO has provided CMS with a detailed list of suggestions for ways that hospices and other providers
could better work together to provide optimal end of life care to beneficiaries who have elected the hospice benefit, and ways for CMS to better facilitate this goal. CMS cites “anecdotal reports” from non-hospice providers stating that hospices have sometimes instructed them to report services as unrelated to the terminal condition, so that they could bill outside of the hospice benefit, even when the non-hospice provider felt the condition was related to the terminal condition. This is distressing to hear, and if true, we hope it is a rare exception, but we also hear reports from our member hospices of the converse situation; that non-hospice providers sometimes tell the hospice that they have billed, or intend to bill, as “unrelated” a service that the hospice believes is related to the terminal condition. The non-hospice provider may find it easier, or financially advantageous, to bill Medicare rather than coordinate with the hospice, or they may not be willing to concede any control over the patient’s care. In any event, NHPCO is concerned that CMS seems to be undertaking substantial regulatory changes based on what CMS admits is merely anecdotal reports.

NHPCO is concerned that CMS is holding hospice providers alone solely responsible for all claims filed on behalf of beneficiaries who have elected hospice, and yet hospices often do not know, and are not in control of, whether or how other providers bill, and for what services, nor can hospices control whether and when a beneficiary sees a non-hospice provider. Better education and guidance for hospices, as well as other providers and beneficiaries will help address this problem, but we encourage CMS to establish systems in claims processing so that other providers are immediately aware of the patient’s hospice election and are guided to coordinate with the hospice and to bill appropriately.

2. Related to the Terminal Prognosis

NHPCO continues to be concerned with CMS’s interpretation of what is related to the terminal prognosis, and strongly asserts that this is a clinical determination that must be made on a case by case basis, by the hospice physician in consultation with the patient’s attending physician. In the proposed rule, CMS indicates that “longstanding, preexisting, chronic, stable and controlled conditions and disease states as well as comorbidities” are included in the bundle of hospice services. We strongly disagree that any such blanket statement regarding relatedness is appropriate or consistent with the statute.

**Pre-existing and chronic conditions, including mental health diagnoses:**
Some preexisting and chronic conditions may contribute to a particular patient’s terminal prognosis, and in other cases they may not. Similarly, some mental health conditions, particularly depression or anxiety that develop during the patient’s terminal illness, may be related to a patient’s terminal prognosis, or they
may not. The cause and impact of a mental health (or any other) diagnosis has to be determined on a case by case basis, and expecting global adherence to general rules is unreasonable. In addition, the impact of any comorbid diagnosis may vary based on the individual length of prognosis. How a comorbid diagnosis would be managed, and its effect on a patient's prognosis, may vary depending on whether the individual's prognosis is 5 days versus 5 months. Again, this requires individualized clinical determinations by the hospice physician, who has specific knowledge, expertise and experience and is in the best position to make these determinations. Just as we asserted with respect to Part D coverage of drugs, there is no drug that one could say would always be related to a patient's terminal prognosis, and no drug that one could say would never be related. A hospice physician needs to make the determination of what is related to the terminal prognosis based on each individual patient's clinical condition.

“*Affect patient care*”: We also want to be clear that just because a diagnosis or condition may “affect patient care” or “affect the management and treatment of the individual”, does not infer that condition is related to the terminal prognosis. It is important for the hospice to be aware of all conditions affecting the patient’s care, and the hospice may be involved in coordinating that care, but that does not make the condition related to the terminal prognosis. Hospice patients may, for example, continue to have need for treatments for other medical conditions that do not impact the terminal prognosis, or need to continue dental care or allergy medicines. The hospice needs to be aware of that, and those services may even affect how the hospice provides palliative management of the patient’s terminal condition (for example, the hospice might prescribe different drugs to avoid an interaction), but if those conditions don’t affect the patient’s prognosis they are not the hospice's responsibility.

### 3. Reporting all Diagnoses on the Claim

Hospices have questions and concerns about the requirement to report all diagnoses on the claim form, and NHPCO requests further guidance regarding the scope of diagnoses they’re expected to identify. The existence of a diagnosis doesn’t indicate the severity of disease, or its effect on prognosis. The diagnoses that a hospice will be aware of, and that will be relevant to their hospice care, will vary depending on the patient’s time in hospice and their condition on admission.

**Short stay patients**: With so many patients in hospice for a week or less, hospices are managing actively dying patients – in fact, NHPCO data shows that over 30% of patients died in the first seven days of care, and by 14 days, over
40% of patients have died.\textsuperscript{2} For these short stay patients, hospices often have limited information about the patient's medical history other than their terminal diagnosis. Other contributing conditions, and additional diagnostic information often isn't relevant to the patient's palliative care needs during their final days of life. For these short stay patients, hospices should not be expected to obtain the patient's extensive medical history in order to report all diagnoses that may be present, but rather to collect any and all medical history information relevant to the patient and their palliative care needs. Hospices should also make a good faith effort to report diagnoses as they are known, but not be required to add diagnoses to the final claim after the patient has died.

\textbf{Additional diagnosis information obtained late:} The initial and comprehensive assessments are snapshots in time, and initially they are based on information provided within very short time frames. If the patient later develops additional diagnoses, or the hospice becomes aware of additional diagnoses during an update to the comprehensive assessment and the care plan is revised, the hospice should only be required to report these diagnoses on the claim form for the next monthly billing cycle. It should be noted that there are some historical diagnoses that are no longer relevant to the patient's current disease state. Hospices should not be required to report these on the claim form.

\textbf{Comprehensive assessment:} As the hospice conducts the first comprehensive assessment, required by regulation to be completed within five days of admission, the interdisciplinary team gathers as much information as possible on the medical history and current active diagnoses of the newly admitted patient. There may be other diagnoses that surface in the first weeks of care, based on additional information from the attending physician and other medical information. That information would be added as an update to the comprehensive assessment along with changes to the plan of care to reflect the individual patient's changing needs. The patient's comprehensive assessment is updated at least every two weeks and reviewed by the IDG.

\textbf{Differentiating related from unrelated diagnoses:} If CMS expects hospices to report all diagnoses, whether related to not, we must be able to distinguish between related and unrelated by using a modifier, or another mechanism, that indicates diagnoses that the hospice has determined are unrelated. Providers have concerns that MAC medical review and other audit contractors will not be able to distinguish between related and unrelated on the claim, and will make their own determinations about relatedness or otherwise take action on the erroneous assumption that the hospice is responsible for all diagnoses.

\textsuperscript{2} NHPCO Facts and Figures, 2014. The data includes patients who were discharged alive, but discharges are rare for short stay patients.
regardless of relatedness. NHPCO believes it is important that anyone reviewing the claim be able to identify the diagnoses determined by the hospice as not being related to the terminal prognosis.

**ICD-10 Implementation:** NHPCO has concerns about the burden of implementing this new significant requirement at the same time that hospices are having to transition from using ICD-9 to ICD-10 codes. Particularly for the many small hospices, such massive changes in coding requirements will be overwhelming, and the risk of inadvertent errors is high.

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**NHPCO Recommendations**

1. Implement specific training for hospices regarding the coding requirements as they relate to hospice processes, such as the update of the Comprehensive Assessment and the review/revision of the Plan of Care.
2. Establish a mechanism for hospices to indicate on the claim those diagnoses that have been determined to be unrelated to the terminal prognosis.

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**G. Readiness for These Changes by October 1st**

As noted above, NHPCO is supportive of many of the proposed changes, and looks forward to working with CMS and assisting its members in implementing them. However, the proposed rule leaves unanswered many key questions, and until CMS finalizes this proposed rule, sometime in August, hospices and their software and other vendors are unable to even begin preparing for any changes with certainty. We have significant concerns about the ability of CMS, the MACs, state Medicaid agencies, and hospices to be able to put in place and test the system changes, and conduct the necessary education and training in order for these changes to be implemented on October 1, 2015 without considerable problems. This is particularly worrisome given the extremely high percentage of hospice patients who are Medicare beneficiaries and therefore the dependence of hospice providers on the reliability of Medicare claims payment. Significant disruptions, or glitches, in Medicare payments could have a catastrophic effect on many hospices, particularly smaller providers.

**Medicaid**

Since the Social Security Act requires that Medicaid “payment for hospice care be in amounts no lower than the amounts, using the same methodology,” used under Medicare, the changes in Medicare hospice payment rates also will affect Medicaid programs in the 49 states that have a
Medicaid hospice benefit. Making changes in 49 different state Medicaid systems will take time and effort, and although patients covered under the Medicaid hospice benefit account for a small percentage of all patients, it is not insignificant.

In our discussions with state leaders, they report that many if not most state Medicaid agencies, are unaware and unprepared to make changes in the hospice reimbursement system at the state level. We also believe that many State Medicaid plans don’t currently have systems that would allow hospice providers to view a patient’s history in hospice in order to determine the count of days and bill at the correct RHC rate. Given CMS’ statement in the Regulatory Impact Analysis in the proposed rule that “This proposed rule only affects Medicare hospices, and therefore has not effect on Medicaid programs”, we do not believe CMS has adequately considered this issue.

**NHPCO Recommendations**

1. We urge CMS to undertake testing and a “dry-run” of the changes proposed in this rule, prior to implementation, even if this requires a delay in the implementation date. We request this “dry run” in light of the magnitude and significance of these changes in Medicare requirements, for CMS, for software vendors, and for hospices.

2. We urge CMS to reach out to Medicaid staff and to state Medicaid agencies during the rulemaking process to assess their ability to implement these changes in accordance with the timeframes set for implementation.

3. As soon as the rule is finalized, CMS should immediately communicate the changes to state Medicaid programs and provide whatever assistance possible to help them implement these changes, working to assure that all systems are operational before implementation.

**NHPCO Comments on Regulatory Text**

Part 418 – HOSPICE Care
Subpart G – Payment for Hospice Care

§ 418.302 Payment procedures for hospice care
(b) * * *

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3 Social Security Act §1902(a)(13)(B).
(1) ** * **

(i) *Service intensity add-on.* Except as provided in paragraph (b)(1)(ii) of this section, routine home care days that occur during the last 7 days of a hospice election ending with a patient discharged as “expired” are eligible for a service intensity add-on payment. Such payment must be equal to the continuous home care hourly payment rate, as described in paragraph (e)(4) of this section, multiplied by the amount of direct patient care provided by a RN and/or social worker, up to 4 hours total per day.

(ii) Routine home care days provided to patients residing in a skilled nursing facility (SNF) or a long-term care nursing facility (NF) are not eligible for the service intensity add-on payment.

**NHPCO Comment:**

As noted in detail above, we strongly disagree with CMS' proposal to not allow SIA payments for patients residing in a SNF or NF and recommend that routine home care days provided to patients residing in a skilled nursing facility (SNF) or long-term care nursing facility (NF) should be eligible for the service intensity add-on payment.

(e) ** * **

(1) Payment is made to the hospice for each day during which the beneficiary is eligible and under the care of the hospice, regardless of the amount of services furnished on any given day (except as set out in paragraph (b)(1)(i) of this section).

§ 418.306 Annual update of the payment rates and adjustment for area wage differences.

(a) *Applicability.* CMS establishes payment rates for each of the categories of hospice care described in § 418.302(b). The rates are established using the methodology described in section 1814(i)(1)(C) of the Act and in accordance with section 1814(i)(6)(D) of the Act.

(b) *Annual update of the payment rates.* The payment rates for routine home care and other services included in hospice care are the payment rates in effect under this paragraph during the previous fiscal year increased by the hospice payment update percentage increase (as defined in sections 1814(i)(1)(C) of the Act), applicable to discharges occurring in the fiscal year.

(1) For fiscal year 2014 and subsequent fiscal years, per section 1814(i)(5)(A)(i) of the Act, in the case of a Medicare-certified hospice that submits hospice quality data, as specified by the Secretary, the payment rates are equal to the
rates for the previous fiscal year increased by the applicable hospice payment update percentage increase.

(2) For fiscal year 2014 and subsequent fiscal years, per section 1814(i)(5)(A)(i) of the Act, in the case of a Medicare-certified hospice that does not submit hospice quality data, as specified by the Secretary, the payment rates are equal to the rates for the previous fiscal year increased by the applicable hospice payment update percentage increase, minus 2 percentage points. Any reduction of the percentage change will apply only to the fiscal year involved and will not be taken into account in computing the payment amounts for a subsequent fiscal year.

(c) Adjustment for wage differences.
Each hospice’s labor market is determined based on definitions of Metropolitan Statistical Areas (MSAs) issued by OMB. CMS will issue annually, in the Federal Register, a hospice wage index based on the most current available CMS hospital wage data, including changes to the definition of MSAs. The urban and rural area geographic classifications are defined in § 412.64(b)(1)(ii)(A) through (C) of this chapter. The payment rates established by CMS are adjusted by the Medicare contractor to reflect local differences in wages according to the revised wage data.

NHPCO Comment:

We note that §418.306(c) references the definitions of “Metropolitan Statistical Areas (MSAs) issued by OMB.” That language has been replaced by Core Based Statistical Areas (CBSAs). Is this an opportunity to make a correction in the language in this section of the regulations?

We note that there is also language in this section that states that CMS will issue the hospice wage index “in the Federal Register,” when language in the proposed rule specifically states that the hospice wage index is located in Addendum A and located on the CMS website. Is this an opportunity to make a correction in the regulatory language above regarding the hospice wage index?

§ 418.308 [Amended]
4. Section 418.308(c) is amended by removing the phrase “(that is, by March 31st)”.

NHPCO Comment:

This change references the annual filing of the aggregate cap determination with the appropriate MAC. NHPCO requests that the filing deadline be published
early and often so that providers are not confused about the requirement or its deadline.

NHPCO stands ready to discuss our comments for further clarification and to work with CMS in whatever ways possible as we move toward the final rule and beyond. Thank you for the opportunity to comment.

Sincerely,

J. Donald Schumacher, PsyD
President and CEO