National Hospice and Palliative Care Organization

June 26, 2017

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

Attention: CMS-1675-P

Dear Administrator Verma,

The National Hospice and Palliative Care Organization (NHPCO) appreciates the opportunity to comment on **CMS 1675-P, Medicare Program; FY 2018 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 hospice and palliative care programs and professionals in the United States. We represent over 4,000 hospice locations and more than 59,000 hospice professionals in the United States, caring for the vast majority of the nation's hospice patients. NHPCO 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

Data: NHPCO has reviewed CMS data on non-hospice spending in Parts A, B and D after a beneficiary's hospice election and welcomes the opportunity to collaborate with CMS to identify solutions to these challenging issues. Included in our recommendations is a request for more data on Part D expenditures outside the hospice benefit, including classes of medications or more specific categorization, volume of Part D payments by state, and location of care.

Sources of clinical information: NHPCO has reviewed the CMS discussion on the sources of clinical information to inform the hospice physician's decision on eligibility. Hospice providers now gather clinical information from a variety of sources, and that data and its detail is variable and case-specific. NHPCO believes that the requirement in the Medicare hospice Conditions of Participation, the skills of the hospice team in assessing eligibility, and medical review by the Medicare Administrative Contractors are all important components of the hospice's assessment for eligibility practice. No additional changes in the requirements are warranted.

Quality reporting: NHPCO believes that claims data alone cannot appropriately be used to inform the creation of performance measures that improve quality of care. Hospice performance measures should guide and promote the quality of direct care received by hospice patients and families. If CMS decides to pursue the development of claims based measures, paired measures that capture the complexities of patterns of utilization should be developed. In addition, when CMS is developing the Hospice Evaluation and Assessment Reporting Tool (HEART), NHPCO encourages CMS to comprehensively gather input from hospice providers about what should and should not be included in the tool, use rigorous and thorough pilot testing, provide clear data definitions and phase in implementation.

Request for Information – Reducing Regulatory Burden for Hospices: NHPCO is pleased to submit a robust list of regulatory burden issues that hospice providers encounter every day and look forward to ongoing dialogue about possibilities for reducing burden.

NHPCO is pleased to offer comments on various components of the proposed rule, as outlined below.

1. Hospice Payment Reform: Research and Analyses

A. Non-Hospice Spending – Part A and B

In recent years, CMS has raised concerns about the level of Part A and B spending associated with hospice patients that occurs outside the hospice benefit. NHPCO has worked with CMS to educate providers, and has suggested other actions for better insuring that services are provided and billed as they should be, although a certain level of non-hospice Part A and B spending will always be appropriate. In the proposed rule, CMS provides analysis on the decrease in spending after the hospice election for Parts A and B. We are pleased to see the 25% decrease in billed Part A and B services over the last five years. NHPCO continues to be willing to work with CMS to ensure that services are billed appropriately. While the implementation of the Notice of Election/Notice of Termination or Revocation process for hospice providers has led to more timely notification of a beneficiary's hospice election, and lowered the volume of non-hospice spending, there continues to be a lack of awareness about hospice election by some providers, and its impact on their claims submissions. Hospice providers regularly find that hospitals do not check a patient's hospice enrollment when a patient is being admitted to the hospital, and there are few opportunities for the hospital and the hospice to communicate about the patient's hospice election and how that impacts the hospital admission and the care provided.

NHPCO will continue to work to educate hospices on communicating with other providers and with beneficiaries about the need to coordinate all care through the hospice. In addition, NHPCO is committed to communicating with other provider organizations to increase awareness and provide additional education about the hospice benefit works and how it interfaces with other provider types.

NHPCO Recommendation

NHPCO welcomes the opportunity to collaborate with CMS to take action to educate other Medicare provider types to increase understanding of benefits coverage and claims processing after a beneficiary has elected hospice. In addition, we encourage CMS to investigate options for preventing the non-hospice Medicare provider from billing without checking the Common Working File and notifying the hospice for a determination as to whether or not the care is related to the terminal prognosis.

B. Non-Hospice Spending – Part D and Maintenance Medications

CMS also has raised concern in recent years about the volume and pattern of Part D spending on hospice beneficiaries for drugs that CMS believes may be covered under the hospice benefit, or may no longer be medically necessary or appropriate for the patient. Unlike the decrease in Part A and B spending, CMS has noted an increase in Part D spending on a category of drugs it refers to as "maintenance drugs." Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes. These categories include beta blockers, calcium channel blockers, corticosteroids, and insulin.

Maintenance drugs for beneficiaries under a hospice election are not subject to the Part D Prior Authorization process that is in place for four categories of drugs most likely to be associated with a patient's terminal prognosis. As CMS notes, after a hospice election, many maintenance drugs, as well as drugs used to treat or cure a condition, are typically discontinued as the focus of care shifts to palliation and comfort measures. However, this transition often happens over time, and typically depends on the length of the patient's prognosis as well as other factors. There are maintenance drugs that are appropriate to continue as they may offer symptom relief for the palliation and management of the terminal illness and related conditions, and therefore should be covered under the hospice benefit, not Part D. And some maintenance drugs may be completely unrelated to the patient's terminal prognosis but still medically appropriate, at least for some period of the patient's hospice election, and should continue to be covered under Part D.

NHPCO and its members have spent significant time and resources on assisting providers in determining whether a treatment or medication is "related to the terminal prognosis" and therefore is the hospice's responsibility, and on communicating with patients and families about discontinuing medication that is no longer necessary or appropriate. In addition, we have been in dialogue with CMS about this issue for more than two years. Much progress has been made in helping providers determine what diagnosis or medication is related to the terminal prognosis. The reduction in Part D spending for the four classes of medications characterized as "common palliative medications" is a part of that work.

While there has been improvement in reducing some Part D spending, NHPCO is commenting below on other issues that impact Part D spending after the hospice election.

1. **Medication review:** The hospice physician, and the team that works with him or her, should be allowed to care for their patients in a professional manner on a case-by-case/patient-by-patient basis, rather than applying any blanket policy. The goal for every hospice physician is to determine the right drugs for the right reasons at the right time. Medication review, which happens on an ongoing basis, is required in the Medicare Hospice Conditions of Participation, as cited below.

   > ***§ 418.106 (a) Standard: Managing drugs and biologicals***
   > The hospice must conduct a medication review to "ensure that drugs and biologicals meet each patient's needs."

   That review includes an evaluation of which drugs should be discontinued, which drugs are related to the terminal prognosis and should be continued and provided by the hospice, and which drugs, if any, are considered unrelated to the terminal prognosis but are still medically necessary and appropriate. The issue of pharmaceutical management for hospice patients is not how many nor what type of medications, but the right medications at the right time for the right reason, to give optimal care to dying people appropriate to the stage of their dying process. This decision-making is squarely within the realm of the hospice physician and his/her clinical judgment.

2. **Impact of short length of stay:** CMS cites a median length of stay of 18 days in hospice. Many hospices report that 50% or more of their patients are under care for less than two weeks. Those patients have different symptoms and pharmaceutical needs from patients who may be under care for a few months. For patients with short stays, there may be little opportunity to discontinue medications, but also more limited opportunity for Part D spending outside the hospice benefit. For those with longer stays, the focus is on medication review, on-going evaluation of efficacy and medication discontinuation. There is not an appropriate "one size fits all" approach regarding medication prescribing, and each patient's individual situation must be considered, including the length of their prognosis.

3. **System concerns:** There are persistent system issues beyond the control of the hospice that continue to disrupt the Part D-Hospice interaction. CMS implemented CR8877 in October 2014, which requires hospices to file a Notice of Election (NOE) to provide timely notification to all Medicare Part A, B and D providers that a patient has elected the Medicare hospice benefit, and from the beginning of implementation all stakeholders, including CMS, noted system shortcomings and an antiquated infrastructure which limited the efficiency and timeliness of data entry and retrieval. A high priority issue when the NOE process was adopted was to communicate the hospice election to Part D plans through the MARx system. System issues with this process continue, and information entered in the Common Working File is not being shared with the MARx system in a timely way.

   Hospices continue to cite problems based on not having a consistent and accessible contact point at the individual Part D plan who has proficiency in the process for communicating the hospice election, or who can assist when there are questions or a need for additional information. In

addition, some pharmacies regularly continue to bill Part D as the payer of choice, even after the hospice has communicated, either through the NOE/NOTR process or directly with the pharmacy, that the hospice is responsible for payment for drugs for a beneficiary after the hospice election. Hospices can educate and make requests, but they have a very limited ability to control how pharmacies bill for the prescriptions they fill. Some nursing home pharmacies fill prescriptions for nursing home residents using Part D, even after the hospice has provided hospice enrollment information and instructions to bill hospice. In addition, in many cases, patients and families often continue to refill long-standing prescriptions on file with the pharmacy, or receive prescriptions on auto-refill, outside the control of the hospice.

NHPCO Recommendation

In addition to the data shared about Part D spending in the proposed rule, NHPCO recommends that CMS make more data available to NHPCO and other stakeholders. The medication data could include classes of medications or more specific categorization, volume of Part D payments by state, and location of care. If more data on questionable Part D payments is available, NHPCO and its partners can develop additional targeted education can be developed and more targeted follow up can occur.

C. Initial Analysis of Revised Hospice Cost Report Data

NHPCO notes that CMS is conducting initial analysis of the revised hospice cost report and that these analyses "may inform future work that could include such refinements to hospice payment rates." Given the newness of this process, NHPCO is concerned that the data in the revised cost report may not be of high quality, and is also concerned that the data in the cost report has never been audited for accuracy. As such, we have little confidence in the data submitted by free-standing hospice providers and its accuracy and completeness accuracy. On a related note, early reports on the hospice schedules in provider-based cost reports indicate significant questions about the accuracy and usability of that hospice cost data as well.

Education continues to be needed for hospices and individuals responsible for cost report preparation. NHPCO believes that cost reports are being submitted with significant errors and have been accepted by the MACs. Level 1 edits, which test the format of the data to identify error conditions that must be corrected for cost report acceptance, should be enhanced so that the provider may make corrections before submitting to the MAC. Increased review by the MAC for the basic elements of a cost report submission would reduce the number of unacceptable cost report submissions and put cost report preparers on notice that the quality of a cost report submission is expected and is being reviewed.

NHPCO Recommendation

CMS should require MACs to conduct audits of hospice cost report data and communicate their findings to providers for correction and improved accuracy. Only after at least one year of audits should cost report data be used to inform refinements to hospice payment rates.

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

CMS has raised concerns about the source of clinical information the hospice medical director (or hospice physician designee) relies on to support his or her certification that the individual is terminally ill. CMS solicits comments for possible future rulemaking to amend the regulations to specify that the patient's referring physician's and/or acute or post-acute care facility's medical records would have to serve as the basis for the initial hospice eligibility determination, and that they would have to be obtained and reviewed prior to the patient's election of the hospice benefit. CMS also solicits comments on amending the regulations to specify that documentation of an in-person visit by a hospice physician could be used to support initial eligibility determinations, only if needed to augment the clinical information from the referring physician or facility's medical records.

NHPCO shares CMS's interest in ensuring that all patients referred to hospice are appropriately assessed to determine their eligibility, and we are committed to confirming that only eligible patients are admitted to hospice. However, we have concerns about these proposed changes. If, as seems to be the case, CMS's goal is to address ongoing concerns with long stay patients and the admission of patients who are chronically ill but should not be certified as being terminally ill, we don't believe these changes would be effective and would only add to hospices' already burdensome administrative load. And if the regulatory changes suggested in the proposed rule were implemented, we believe they would adversely affect access to hospice care for many beneficiaries, particularly the large percentage (35.5%[1]) of hospice patients who die within 7 days of being admitted to hospice. Start of care will be delayed to patients, and some patients will never get the care they need at the very end of life. For patients with a longer length of stay, we support using the other safe guards already in place to ensure continuing eligibility.

CMS specifically solicits comments on current processes used by hospices to ensure comprehensive clinical review to support certification and any alternate suggestions for supporting clinical documentation sources. NHPCO expects you will get comments from many hospices providing such feedback, based on their own experiences in providing care to their patients. Below are some examples of the situations and challenges hospices currently face, and explanations of why the regulatory changes CMS has suggested would be very problematic for patients, families, hospices, and other healthcare providers.

[1] NHPCO Facts and Figures: Hospice Care in America. Alexandria, VA: National Hospice and Palliative Care Organization, September 2015.

A. Reliance on the referring physician's medical records for initial hospice eligibility determination

CMS states that the majority of hospice referrals come from family physicians, who have often cared for patients with chronic illnesses for long periods of time, and have knowledge of the patient's values, family issues and communication style. CMS also refers to the Local Coverage Determinations (LCDs) of the Medicare Administrative Contractors (MACs) that may assist the attending physician and hospice medical director in determining hospice eligibility, and notes that documentation of the indicators in the LCDs likely would not exist without some degree of long term monitoring by a physician, and that this information would typically be found in the referring physician's and/or acute care or post-acute care facility's medical records.

It would be ideal if patients referred for a hospice evaluation were always accompanied by clear and complete medical records documenting their clinical history and progression of their disease state. It would be ideal if they all had physicians who had known them well over a long period of time and who wanted to remain involved in their care. Unfortunately, patients often present to hospices under very different circumstances. For example, beneficiaries' health care providers' records may focus on medical management and curative care, not providing the needed picture of progressive decline over time. Or, some records might support the patient's eligibility, but the hospice is unable to access those records in a timely fashion. And yet these patients have been referred to hospice, are terminally ill, often imminently dying, and they and their families are in need of timely provision of the medical and psychosocial services that hospice can provide.

Patients are referred to hospice from a variety of sources and they present with a variety of different clinical circumstances. Requiring a hospice to always track down, obtain, and review the medical records of another provider, which may or may not include information relevant to determining their current prognosis, is neither necessary nor appropriate. Hospices are already responsible for ensuring that clinical information to support the prognosis is in the medical record. This would simply be another item the hospice would have to check off their list in order to admit a patient.

1. **Content of the medical record:** A referring physician's or facility's medical record may have a detailed description of the patient's last routine physical, or about the acute episode that brought the patient to the facility. However, the medical record often does not contain relevant information on functional status or details about cognitive status. The record may not provide the record of progressive decline, but rather provides a series of clinical vignettes with medical information.

   The hospice, per current regulations, collects clinical information as a part of the hospice's assessment of eligibility must include this in the medical record to support the certification. Whether it's from the referring physician's/facility's medical records or the hospice's own assessment, the certification of terminal illness must include clinical information that supports the terminal prognosis, and the certifying physician must provide a narrative explanation of the clinical findings that support the determination that the patient has a life expectancy of six months or less.

2. **Reasonable attempts to obtain records:** Hospices should, and typically do, make significant efforts to obtain records of past medical history. The current process of hospice providers is to seek as much clinical information as possible (i.e., recent history and physical, facility discharge summary, medication profile, etc.) from the family and from referral sources at the time of referral and during the hospice evaluation and admission process. However, delays in identifying the appropriate sources of patient records or the receipt of records should not delay a terminally ill patient's admission to hospice, where a clinical assessment has been completed and eligibility has been reviewed and certified. A delay in receiving prior clinical records, under this scenario, could result in delay of services, death prior to admission, and unnecessary suffering due to lack of symptom management and support.

3. **Timely receipt of records:** To our knowledge, there are no federal or uniform state requirements for physicians and health care facilities to provide requested medical records within a specified amount of time, and hospice providers often experience significant delays in obtaining requested clinical information, even from the provider who referred the patient to hospice. Hospice providers report that requests for some records require multiple phone calls and follow up that can drag on for weeks.

   Some physician offices refuse to release records without a signed authorization from the patient, which also may result in delays. The hospice may meet with the patient to discuss hospice care and begin assessing whether the patient is eligible, and obtain a signed release of information authorization. This is then submitted to the office of referring physician and/or other physician, the hospice staff may then review the available clinical information with the hospice medical director as part of the process to determine whether the patient can be certified as terminally ill. The hospice physician may also speak with the referring physician or facility. The hospice nurse may then go back to the patient's home or the facility to admit the patient. In this scenario, if the hospice has to wait to admit the patient until after they have received and reviewed medical records from the referring physician's office, the delay in admission may mean that the patient never receives hospice care or admission is unnecessarily delayed.

4. **EMR Interoperability and Practical Access to Patient Records:** The hospice provider's ability to access patient information from another healthcare provider's EMR is often challenging. Lack of interoperability of health information is a factor in many of the delays in hospices receiving clinical information from other healthcare providers. Communication gaps and data-sharing challenges are pervasive in healthcare, persisting between different providers, hospitals and payers, and even various departments within a health system.

   Many providers do not have the ability to securely transfer medical information electronically through a secure email pathway or similar option. Thus they rely on fax communication, which is secure, but is cumbersome and outdated. In addition, physician offices and acute care facilities were provided incentives to utilize EHR /EMRs. Post-acute care providers have never been provided

incentives to move to EHR/EMR. Some providers are still on paper, which makes provision of medical records burdensome and takes more time.

5. **Reality of hospice lengths of stay:** A review of the latest data confirms an enduring trend of short lengths of service for hospice patients. More than 35 percent of patients die within 7 days, 50 percent die within 18 days and more than 67 percent die within 30 days of admission. Approximately 90 percent of hospice patients die within 180 days. Hospices report that in some areas, the hospice length of stay is decreasing, as healthcare providers delay the referral or the patient wishes to try one last treatment. No eligible hospice patient should be denied a day of care when the hospice physician feels they have sufficient clinical information to support their certification and admission, because the hospice hasn't been able to obtain and review a chart or record from a referral source. If CMS is concerned about the small percentage of long stay hospice patients, requiring review of medical records prior to admission will not address this.

6. **Sources of Referrals:** CMS states that "in general, the majority of hospice referrals do come from family physicians who have often cared for patients with chronic illnesses for long periods of time. These providers are in the unique position of understanding and identifying the individualized progression of the patient's illness and recognizing when the condition becomes terminal." In fact, it is typically not a family physician with a long-term relationship with the patient who is the source of the majority of referrals. Data collected by NHPCO show that the source of the largest number of referrals is the hospital (46%), followed by all physicians (19%). Additional data from a hospice software vendor corroborates that hospitals are the most frequent referral source. We do not believe that the majority of hospice referrals come from family physicians, but rather hospitals and the hospitalist physicians employed by hospitals. Patients are also referred by specialist physicians who may have long or short term familiarity with a single aspect of the patient's medical history, and sometimes family members contact hospices directly.

   Multiple studies also have shown that physicians outside of the primary care role often act as hospice referral sources. Among hospitalized nursing home residents, hospitalists were significantly more likely than other types of physicians to refer to hospice.[2] Likewise, regions with primary care physicians who are more heavily involved in end-of-life care have lower hospice enrollment rates.[3] Many other healthcare professionals may have unique knowledge of an individual and may play a part in determining an appropriate hospice referral. Finally, research suggests that many primary care doctors lack appropriate end-of-life education and may not fully understand eligibility criteria for hospice.[4]

[2] Ankuda, C., Mitchell, S., Gozalo, P., Mor, V., & Teno, M. J. (2016). Who Refers to Hospice? A Comparison of Referral Rates by Whether the Attending Physician is Hospitalist, Non-Hospitalist General Practitioner, or Specialist (SA517B). Journal Of Pain & Symptom Management, 51(2), 392-393. doi:10.1016/j.jpainsymman.2015.12.275.

[3] Ankuda, C.K., Petterson, S.M., Wingrove, P., & Bazemore, A.W. (2017). Regional variation in primary care involvement at the end of life. Annals of Family Medicine, 15(1), 63-67.

[4] Snyder, S., Allen, K., Hazelett, S., & Radwany, S. (2011). Primary Care Physician Knowledge, Utilization, and Attitude Regarding Advance Care Planning, Hospice, and Palliative Care: Much Work Remains (757). *Journal Of Pain & Symptom Management*, *41*(1), 307.

B. Sources of Clinical Information Relied on by the Hospice Physician

CMS solicits comments on the current processes hospices use to evaluate patients referred to hospice, and ensure that patients who are certified as terminally ill and admitted to hospice have been appropriately assessed. Hospice providers offer the following information about the sources of clinical information and their strengths and weaknesses:

- Clinical information about the referred patient may come from a variety of sources, including the referral source (physician, hospital, SNF) or from non-referral sources, such as other physicians, specialists, hospitals, SNFs, rehabilitation facilities, or any other health care provider that may have seen the patient recently.
- Records from these referral sources often, by themselves, do not capture progressive decline, because patients have been in and out of multiple hospitals, have multiple specialists caring for them, and have resided in more than one location. The referring physician may only be able to provide documentation of what has very recently transpired, cannot provide evidence of decline over time, and makes the referral based on the acute episode.
- Clinical information is obtained by the hospice nurse during the assessment for possible hospice admission, where the nurse functions as "eyes and ears" for the hospice medical director or hospice physician. This often provides the most up-to-date and accurate clinical information regarding indicators used for assessing eligibility for hospice, such as functional status, cognitive status, nutritional status, palliative performance scores (PPS), or other indicators. Clinical information from non-hospice/non-palliative care providers does not consistently contain appropriate documentation on indicators necessary for assessing eligibility.
- If documentation from a referring physician or health care provider is poor, or doesn't include information relevant to assessment of the patient's hospice eligibility, it shouldn't delay or prevent access to hospice services if the hospice team can appropriately assess the patient. This often includes verbal discussions between the hospice physician and the referring physician or other physicians, which should be documented in the medical record.

C. Skills of the hospice clinical team

The Medicare hospice benefit, from the start, has involved a team-based approach to care delivery. The important, and specialized, skills of the hospice physician and the hospice nurse in assessing patients who are referred for hospice services should be recognized. Hospice clinicians have particular expertise in terminal disease at end of life. Hospice care is a specialty, and hospice clinicians are more attuned and skilled at assessing patients and identifying the signs and symptoms that indicate a terminal prognosis, than other types of health care providers. Through a comprehensive physical and functional assessment, they can validate referral information, determine the patient's true clinical status, and

doi:10.1016/j.jpainsymman.2010.10.236 & Ogle, K. S., Mavis, B., & Wyatt, G. K. (2002). Physicians and Hospice Care: Attitudes, Knowledge, and Referrals. *Journal Of Palliative Medicine*, *5*(1), 85-92. doi:10.1089/10966210252785042).

communicate the necessary and relevant information to the hospice medical director making a decision about eligibility.

Non-hospice health care providers typically focus on treating or managing acute or chronic conditions - and they assess and document accordingly. Clinician assessment outside of hospice care is focused on disease management and curative care and, consequently, a patient's status related to disease trajectory or individualized symptom management needs may not be well documented. Often, these healthcare providers recognize that a patient has likely entered the terminal phase of an illness or may be approaching end of life, and make the decision to refer to hospice at this point. They do not often document the patient's decline or all of the signs and symptoms needed to support a six month prognosis and determination of eligibility for hospice services. It is the assessment by hospice clinical team, particularly hospice nurses, that provides the comprehensive information needed.

Ultimately, for the hospice, it is the hospice medical director who bears the responsibility for determination of eligibility, using their clinical judgment. The medical director has primary responsibility for the medical component of the hospice's patient care program and a critical component of their role is evaluation of each patient for terminal prognosis and subsequent eligibility. The medical director relies on multiple sources of information related to the clinical status of referred patients, including records from other healthcare providers. Input from the hospice clinical team, in particular the hospice nurse, is a fundamental component of the comprehensive picture of the patient's clinical status required to make the determination of eligibility.

Hospice nurses are uniquely qualified to provide information to guide and inform the determination of eligibility. Hospice nurses' entire caseload consists of patients with a limited life expectancy. Hospice nurses are trained to assess a patient holistically with specific knowledge of end-of-life disease presentation. In addition to clinical judgement, hospice nurses' comprehensive assessment frequently utilize functional and symptom assessment tools (e.g., the Karnofsky Performance Status Scale, Palliative Performance Scale, ECOG Scale and other specialized symptom management scales) to evaluate a patient's function and symptom status. These tools are not typically used in primary care settings.

D. <u>Concerns about admission of patients who are not terminally ill</u>

CMS has expressed concerns that some patients admitted to hospice are chronically ill but do not meet hospice eligibility criteria. NHPCO shares this concern. Providers admitting, or recertifying, patients who are not terminally ill should be subject to audits and investigations of their practices.

However, with a median length of stay of 18 days, hospices report that the larger concern is the increasing number of patients with very short lengths of stay, especially 7 days or less. These Medicare beneficiaries most need symptom management, care and support at the end of life and could receive even less hospice care, or none at all, if these proposed changes were implemented. For those patients for whom there is a question about a longer length of stay, the hospice face-to-face encounter requirement and the new hospice payment methodology, which pays a lower rate for routine home care

(RHC) after 60 days of care, both address the long stay issue. If there is a concern about hospices with a high percentage of patients with a length of stay over 180 days, implement the IMPACT Act provision to target hospice providers where this is an issue.

NHPCO Recommendation

NHPCO believes that the existing regulations are sufficient for addressing the various issues of clinical information to inform that medical prognosis and offer the following recommendations:

- The regulations at 418.22(b) specify that the clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record. Hospices receive clinical information from a variety of sources, and the sources and details are case-specific. There is no need for additional requirements. The MAC medical review process should be used to identify hospices that may not be meeting the currently established regulatory guidelines. **No change is warranted.**

- The new payment model, which pays RHC at a lower rate at day 61 and after, as well as the face-to-face requirement prior to the third benefit period, are both intended to appropriately curb long stay issues in hospice.

- CMS should implement the IMPACT Act provision for 100% medical review for hospices with a high percentage of patients with a length of stay greater than 180 days. Use mechanisms already available to identify providers who admit patients who are not terminally ill, rather than make sweeping changes to the regulations that will be burdensome to all, and will adversely affect access to hospice care.

E. In-person visits from hospice medical director

CMS is soliciting comments on amending the regulations at §418.25 to specify that documentation of an in-person visit from the hospice medical director or the hospice physician member of the interdisciplinary group could be used as documentation to support initial hospice eligibility determinations, only if needed to augment the clinical information from the referring physician/facility's medical records.

CMS seems to be suggesting that in order for a hospice to admit a patient for whom they haven't been able to obtain and review medical records from a referring physician or facility, the hospice would have to send a physician for an in-person visit to "augment" the information they have obtained, in order to support a certification of terminal illness. Given physician shortages and the time that would be required to send a physician to a patient's home, particularly in rural areas and on short notice, this is simply untenable and will delay access to care.

NHPCO asserts that hospice physicians currently use their clinical judgment to make decisions about when an in-person visit is necessary to gather additional information about the referred patient to determine hospice eligibility. Every hospice has had beneficiaries referred where there is a question about their eligibility. In such cases, whatever clinical data can be obtained from the referral source is reviewed. The hospice nurse makes an assessment visit, and reports back to the hospice physician with any questions about eligibility. The hospice physician can then determine whether an in-person visit is necessary to conduct an additional assessment and determine eligibility.

NHPCO Recommendation

The hospice is already responsible for insuring that the medical record includes clinical information and other documentation to support the prognosis, including a physician narrative explaining the clinical findings supporting a life expectancy of six months or less. The hospice physician should use his/her clinical judgment to determine whether an in-person visit is necessary to gather additional clinical information about a referred patient to inform eligibility and admission to hospice. There is no need for an addition to regulations to require this visit, or to specify the case-specific circumstances where this may be necessary. **No change is warranted**.

3. Proposed Updates to the Hospice Quality Reporting Program (HQRP)

A. Inclusion of Social Risk Factors in Risk Adjustment for Quality Measures

A key principle in quality measurement is that providers should only be held accountable for what they can control. Accounting for various characteristics inherent in healthcare providers' case mix that may influence quality measure results, including social factors, is intended to "level the playing field" and ensure accurate interpretation of results.

Determination of factors that influence provider performance on quality measures and subsequent adjusting of measure scores according to the degree of influence of those factors (i.e., risk adjustment) is one approach used to ensure fairness when comparing performance across providers. Other approaches include risk stratification and exclusion.

There is no need to account for patient factors for structural measures as putting necessary structures in place is within the control of healthcare providers. The same is largely also true for process measures. In contrast, performance on outcome measures can be influenced by factors other than quality of care such as patient demographics, comorbidities, disease trajectory status, and social factors.

1. Applicability of social factors for hospice

Hospice providers should be able to perform care processes equitably for all patients regardless of social factors. Consequently, social factors cannot be identified as influencing hospice performance on process measures.

It is possible that patient and/or family caregiver social factors might influence outcomes and subsequent performance on quality outcome measures for hospices. Consideration of customary social factors and utilization of standard statistical methods should reveal which social factors might be relevant for hospice.

In addition to determining the influence of social risk factors, the appropriateness and feasibility of taking social risk factors into account for hospice need to be considered. If CMS decides to take social risk factors into account in calculating quality measure scores, it would be important to avoid the unintended consequences of disincentivizing hospices to admit patients and families with identified social risk factors or sanctioning provision of less than best possible care for them.

2. **Other influences on quality measure scores**

The unique features and conditions of hospice care mean that factors other factors are likely to be stronger influences on patient and/or caregiver outcomes than social factors. Of these other factors, length of service is the most important.

Very short stay patients (i.e., patients who on admission are likely to die within a few days) and their families often have urgent and/or complex needs. In these situations the hospice should make assessing and meeting patient/family needs the priority and, consequently, and may not address all of the aspects of care that are more relevant to patients who are not imminently dying. Safeguards are needed to ensure that concerns about a hospice's performance on quality measures do not supersede meeting the needs of imminently dying patients and families who may be in crisis upon admission to hospice. Additionally, that length of stay (LOS) was identified as a risk factor for the measures derived from Hospice CAHPS® data is evidence of the need for consideration of LOS for other hospice outcome measures.

Other risk factors that may influence outcomes are not distributed randomly among hospice providers, but tend to be clustered in certain hospices patient populations and/or service areas. These factors may not uniformly influence all outcomes, but may be specific to particular outcome measures. For example, performance on a quality measure related to timeliness of care provision is likely to be influenced by long distances and drive time inherent in some hospices service areas.

3. **Method for accounting for risk factors**

If any social factors are identified as significant influences on outcomes, risk adjustment consistent with the approach used for the Hospice CAHPS® should be used. For LOS and other factors risk stratification is the most appropriate and useful method as this approach is the more transparent and readily understood for public reporting. Just as Nursing Home Compare includes the "Percentage of High-Risk Long-Stay Residents Who Have Pressure Sores" and the "Percentage of Low-Risk Long-Stay Residents Who Have Pressure Sores," Hospice Compare could present results of outcome measures for short stay and long stay hospice patients.

NHPCO Recommendations

1. CMS should employ standard statistical methodology to identify the influence, if any, of the usual social factors used in risk adjustment.
2. CMS should account for length of service (LOS) in the HQRP in recognition that the hospices must take a different approach to measure data collection when addressing urgent patient/family needs must be the priority.
3. CMS should employ risk adjustment for any social factors identified as significant and utilize risk stratification for other factors, such as length of service (LOS).

B. <u>Two new claims-based measures</u>

While the identified measure areas do focus on important aspects of hospice care, claims alone do not provide sufficient information to accurately represent the complexity of hospice practice for these two topics. Consequently, claims data cannot adequately inform the creation of performance measures related to transitions (i.e., live discharges) and access (i.e., utilization of GIP and CHC levels of care) that that can improve quality of care without probable unintended consequences.

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.

Hospices currently have a vehicle for monitoring both of the identified priority areas, namely the Program for Evaluating Payment Patterns Electronic Report (PEPPER). PEPPER includes detailed information on live discharges and provision of General Inpatient (GIP) level of care. According to the CMS user guide for PEPPER, "a hospice can use PEPPER to compare its claims data over time to identify areas of potential concern and to identify changes in billing practices." The analyses in PEPPER are designed to identify areas within the hospice benefit which could be at risk for improper Medicare payment – not quality. The overlap and redundancy of the two proposed claims based measures with current CMS efforts related to program integrity and payment is unnecessary.

1. Priority Area 1: Potentially avoidable hospice care transitions

Claims data do not capture the complexity and multifaceted nature of hospice care delivery related to live discharges. There are multiple reasons for a patient to be discharged alive from hospice. 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.

Also, composition of patient populations served varies greatly across hospices. Setting a national ceiling benchmark for live discharges that is both meaningful and fair would be extremely difficult. And, when used in public reporting could create the impression that live discharges are not

appropriate. In addition, a quality measure focused on not exceeding a threshold for live discharges could easily have the unintended consequence of encouraging hospices from discharging patients who are appropriate for discharge; or, could make hospices reluctant to admit patients with diagnosis that are more difficult to prognosticate, thus denying access to hospice care for these patients.

2. **Priority Area 2: Access to levels of hospice care**

As with live discharges, claims data do not sufficiently reflect the factors which determine appropriate provision of the various levels of hospice care. Patient needs vary greatly, even for patients with similar principle diagnoses and disease trajectories. It is necessary to know patient acuity to evaluate appropriate GIP and CHC utilization, but acuity information not available in claims data. Or, a low rate of provision of GIP might indicate excellence in care management – and a hospice with high degree of proficiency in handling symptoms in the home setting and anticipation of needs before symptoms get out of control could be penalized for not meeting the threshold set for GIP utilization.

3. **Approach to measure development**

If, in spite of the deficiencies in the use of claims data for hospice quality measures, CMS decides move forward with development of the two proposed measures, an attempt should be made to base the measures on interdependent patterns of care. For example, a paired measure that looks at a pattern of live discharge and readmission within a short timeframe would demonstrate cost avoidance instead of provision of meeting patient needs with provision of appropriate care. Claims based measures that are paired in this way are advantageous compared with measures focused on simple rates of live discharges or provision of levels of care. Paired measured focused on related patterns of utilization would be both fairer to hospices that are employing appropriate practices and would promote appropriate access to care for hospice patients.

NHPCO Recommendations

1. NHPCO believes that claims data alone cannot appropriately be used to inform the creation of performance measures that improve quality of care and that hospice performance measures should guide and promote the quality of direct care received by hospice patients and families. Therefore, CMS should not pursue development of quality measures based on claims data.
2. If despite the significant shortcomings of hospice claims data, CMS decides to pursue the development of claims based measures, paired measures that capture the complexities of patterns of utilization should be developed.

4. **<u>High priority concept areas for future measure development</u>**

It is important that quality measures reflect the holistic and comprehensive care provided by hospice and recognize that the patient and family are the unit of care. CMS should continue to

utilize the work of the Measure Applications Partnership (e.g., the Performance Measurement Coordination Strategy for Hospice and Palliative Care from 2012) and NQF in determining priority areas for measure development.

Some important areas of practice with potential for quality measurement are:

- Access to the healthcare team on a 24-hour basis with a goal of providing timely and appropriate intervention
- Psychological and psychiatric aspects of care—managing anxiety, depression, delirium, behavioral disturbances, and other common psychological symptoms
- Care planning—establishing and periodically reviewing patient/family/caregiver goals
- Timely communication of patients' goals across all providers
- Cost of care

C. New Data Collection and Submission Mechanisms Under Consideration: Hospice Evaluation & Assessment Reporting Tool (HEART)

NHPCO concurs with CMS that the utilization by hospices of a standardized assessment instrument has the potential to provide data that can be used to inform both quality reporting and payment refinements. NHPCO also is committed to active participation in the discussions and development of any data collection mechanisms that CMS may be considering.

NHPCO asks that CMS ensures that the hospice patient assessment tool:

- Truly reflects the holistic and comprehensive nature of hospice care (including physical, psychosocial, and spiritual components).
- Recognizes the importance of an individualized approach to care.
- Includes the patient's and family's right to refuse or defer offered services. Care delivered in various settings (including the nursing home, assisted living facility, hospital, hospice facility as well as in the patient's home) is recognized and accommodated.
- Recognizes that assessment must be interdisciplinary and is the foundation of documentation that guides care on an ongoing basis. Data gathered through assessment must easily and readily be usable for the development and updating of the plan of care.

1. Need for accommodate patient/family needs

The cornerstone of hospice practice is individualization of care based on the particular needs of each patient and family. As stated earlier, patient/family needs for those patients who are imminently dying at the time of admission are often different and more intense than for patients who are anticipated to have a longer length of service.

While instituting a standardized patient/family assessment has many potential benefits, the implementation of HEART places these particularly vulnerable patients and their families at risk for

significant negative unintended consequences. If to be in compliance, hospices are required to complete all HEART components for all patients, patient and family priorities may be subordinated to hospices' performance for patients with very short lengths of stay. Requiring completion of all HEART data elements regardless of patient status would impel hospices to focus on ensuring full data collection for HEART at the expense of addressing urgent patient and family needs for patients who are close to death on admission to hospice care.

Initial assessment of patients who on admission are likely to die within hours or days, and their families, should allow for and facilitate focus on immediate and complex needs in order to provide individualized care that best meets those needs. This means that a flexible approach is critical in the implementation of HEART. Hospices should have the leeway to utilize only those aspects of assessment that are most relevant to specific patient/family needs for patients who are close to death on admission.

2. Potential burden

a. Patients and families

In addition to the unintended consequence discussed above, implementation of HEART poses risk for substantial burden for patients who are close to death on admission and their families. These individuals are often in crisis and have needs that must be addressed immediately in order for hospice care to be delivered efficiently and effectively. Requiring completion of all of the HEART data elements for these patients and their families has the potential to be both burdensome and cause unnecessary delay in initiating care. Hospices should have discretionary ability to complete HEART data elements that are most germane to patients who are close to death, and delay or ignore those with little or no relevance.

b. Hospice providers

The impact of implementation of HEART on hospice providers cannot be underestimated. Chart review and other processes are needed to ensure accurate completion of the HIS data collection, which currently requires substantial resources - in many cases full time staff. Implementation of HEART will increase this burden significantly. Ideally, this burden could be minimized by efficiencies built into the EMR software, which will require substantial time to design, implement and test.

Hospice software vendors will need ample time to create and thoroughly test the incorporation of HEART into their EMR software. And, equally critical, hospice providers will need ample time for implementation and training for HEART and the use of the software well in advance of its use for data collection and data submission to CMS. Staff training is vital to successful HEART implementation and needs to be provided to all clinical staff involved in patient assessment. While CMS educational materials are useful for staff responsible for HQRP, many hospices have found the level of detail is too much and too time consuming for use with staff who need to juggle patient care responsibilities and training. Consequently, hospices have had to develop

their own training materials and education sessions which creates additional burden to an already burdensome multi-step process.

NHPCO Recommendations

1. In the continuing development of HEART, CMS should:
   a. Systematically and comprehensively gather input from hospice providers related to what should and what should not be included in the assessment tool. Because of the complexity, magnitude, and importance of this project, we ask that CMS consider going beyond the usual means (e.g. Technical Advisory Panels) and employ as widespread processes for gathering provider input as possible.
   b. Employ rigorous and thorough pilot testing before the patient assessment tool is implemented
   c. Provide clear data definitions that can be readily understood
   d. Phase in implementation using a dry run or similar approach
   e. Provide thorough and ongoing education and support for hospices, including streamlined educational materials for use in training clinical staff.
2. CMS should allow adequate time (e.g., a year or more) for vendors to incorporate HEART into hospice EMR software; for hospices to initiate and thoroughly test HEART; and, to train staff and ensure their competency in its use.
3. CMS should allow hospices to have the discretion to utilize only those aspects of HEART that are most relevant to specific patient/family needs for patients who are close to death on admission.

D. Hospice Compare

Presentation of hospice performance on quality measures: NHPCO commends CMS commitment to developing the necessary systems for transparent public reporting of hospice quality data and that the data made available are meaningful. We also draw attention to the necessity of ensuring that public reporting maximizes value and utility for the end user.

1. Inclusion of CAHPS® Hospice Survey measures

NHPCO fully supports the inclusion of CAHPS® Hospice Survey measures in Hospice Compare in 2018 and the display of measure scores based on eight rolling quarters of data. We believe that the HIS quality measures alone will not provide a useful and comprehensive picture of the quality of hospice care, nor will most of the public who have not had experience with hospice be readily able to relate the care processes to quality hospice care. We believe that the inclusion of the Hospice CAHPS® results is essential if Hospice Compare is to provide a meaningful reflection of hospice care quality. These measures should be added to Hospice Compare as soon as possible, ideally with the first refresh in 2018.

2. Equivalence and potential bias

a. Display of CAHPS® quality measure results

NHPCO is concerned that there are some important statistical considerations that should be addressed in the display of CAHPS® quality measure results in Hospice Compare. Analysis of missing data is needed to determine how well CAHPS® Hospice survey results are likely to reflect quality of hospice care.

Two factors influence the degree of missing data for the CAHPS® Hospice survey. The first of these factors is the eligibility requirements for determining which family caregivers are included in the administration of the survey. These eligibility requirements (the most significant of which is that only caregivers of decedents who died 48 hours or more following the last admission to hospice care are surveyed) mean that some proportion of a hospice's census is not included in CAHPS® Hospice survey administration. The second factor is the response rate for the survey. CAHPS® Hospice survey results can be calculated only for completed surveys. Response rates are variable, but it is rare to have 100% of surveys completed and a response rate of 30 – 40% is not unexpected. This means that a substantial portion of a hospice's census is not included in CAHPS® Hospice results.

These results should be examined at the national level to determine how well CAHPS® Hospice survey results represent the totality of hospice care quality and provided at the organization level to each hospice to assist with interpretation of results for use in QAPI activities.

b. Hospices that are not included in public reporting may be disadvantaged.

Hospices that do not meet the threshold of 20 stays for the HIS measures denominator and/or the Hospice CAHPS® threshold of 50 survey eligible deaths or 30 completed surveys will not be included in all or part of public reporting. This means that provider quality information will not be available for all hospices.

Consequently, consumers using the CMS Hospice Compare to search for Medicare approved hospice providers may be more likely to seriously consider only those hospices for which quality information is presented. This creates a fairness issue for those hospices without quality information in Hospice Compare simply due to the volume of patients served and their length of service.

E. <u>Star rating system</u>

The importance of the star rating system for Hospice Compare cannot be understated. A significant proportion of hospice patients are imminently dying when admitted to hospice care (one third of hospice patients die within seven days of admission). The families of these patients are often in crisis and do not have the time or emotional resources to thoroughly investigate the hospices that may be available to them. Many of these families are likely to rely solely on star ratings in choosing a hospice. In addition, much of the public and referrers as well have only a vague idea of the even the basic

components and features of hospice practice and are poorly equipped to evaluate the relative importance of quality measure scores. Consequently, the vast majority of users of Hospice Compare are likely to rely on star ratings in Hospice Compare.

This means that it is essential that the methods used for calculation of the star rating system are consistent and fair. A normative approach, such as used for Home Health Compare, in which the same score might earn five stars one quarter and four stars the next quarter would be confusing to the public and not truly indicative of hospice performance. Instead, we recommend that CMS should establish cut points or benchmarks based on a full year of national level data and calculate the star summary ratings based on performance scores in relation to the benchmark scores.

NHPCO adopted a similar approach for its Family Evaluation of Care (FEHC) comparative reporting. After many years of basing comparative reporting on percentiles that fluctuated each quarter, NHPCO created stable benchmark scores for each FEHC quality indicators for an entire reporting year. Hospices found having stable benchmark scores for comparison to be far more useful for setting goals and tracking performance improvement. We believe a similar approach that offers stability for comparison of a hospice's performance relative to other hospices for HQRP measures will prove equally useful for hospices and the public alike.

NHPCO Recommendations

1. CMS should conduct ongoing analysis of the demographics and other characteristics (e.g., age, gender, diagnosis, geographic area, care setting, etc.) for those patients whose caregivers a) are not included in Hospice CAHPS® administration; or b) do not complete a survey. This information at a minimum should be shared with hospice providers so it can be used to inform their quality improvement efforts and development of strategies to improve survey response rates. CMS should also consider including these results in Hospice Compare to provide consumers with an idea of the degree that Hospice CAHPS® survey respondents may differ from themselves.
2. NHPCO recommends that CMS create a means to counterbalance the potential negative consequences for those hospices for which quality information is not included in public reporting. Simply stating that insufficient data were not available to include a hospice in Hospice Compare is not adequate to offset the effect of the lack of quality measure results.
3. CMS should take a criterion approach to constructing the star rating system in Hospice Compare.

F. Emergency Extensions/Exemptions

NHPCO supports the CMS proposed extension from 30 to 90 days for the period of time to submit a request for an extension or exception for quality reporting purposes and its application to both HIS and CAHPS. We concur that this change hospice enhances fairness for providers where acts of nature or a systemic problem with the CMS data collection system prevents compliance with HQRP requirements and will maximize participation in HQRP.

4. Request for Information - Reducing Regulatory Burden for Hospices

In addition to requesting comment on the proposed rule, CMS also has issued a Request for Information regarding ideas for regulatory, subregulatory, policy, practice, and procedural changes that would reduce unnecessary burdens for clinicians, other providers, patients and their families. CMS has stated that this could include elimination or streamlining of reporting, monitoring and documentation requirements, aligning Medicare and Medicaid requirements and processes, and operational flexibility that would enhance patient care and better support the physician-patient relationship.

In recent years, hospices have been faced with substantially increased regulatory burdens, based on new regulations and subregulatory guidance, changes required by hospice payment reform, additional quality reporting obligations, and increased audit activity. While some of these changes are positive, hospices report that they are facing many regulatory burdens that take valuable staff time away from patients and are not increasing the quality of care provided. So we very much appreciate the Trump Administration's interest in soliciting feedback from providers and taking steps to eliminate or simplify duplicative, excessive, antiquated and contradictory regulatory requirements.

The list below identifies many areas where regulatory relief is needed for the hospice community.

1. Hospice Payment Policy Issues

- **Hospice Notice of Election Issues** – ***CMS should continue to work as quickly as possible toward allowing electronic filing of the Notice of Election (NOE) so that providers can minimize keying errors when entering beneficiary data through Direct Data Entry (DDE***). The current DDE system has created significant problems with the accuracy and efficiency of getting data entered on each hospice patient, which has resulted in claims being denied for care that has been appropriately provided*.*

- **Notice of Termination/Revocation Issues** – ***CMS should ensure that beneficiaries' termination or revocation of their hospice benefit is immediately available in the Common Working File (CWF) so their access to full Medicare services can be available the same day as the termination or revocation.*** Currently, hospices report that lags in updating the CWF result in delays in beneficiaries' access to Medicare benefits outside the hospice benefit.

- **Part D** – ***CMS should take steps to ensure that the information submitted by the hospice through the Notice of Election process to the Common Working File (CWF) is accessible by the Part D plan sponsor through the MARx system timely.*** Part D plan sponsors report that currently they do not

get timely access to information on the Part D subscriber's hospice election, and therefore Part D plans may inadvertently pay for medications that the hospice should have provided under the hospice benefit. Timely notification will improve this process.

- **Part D** – ***CMS should ensure that Part D plans identify a designated hospice contact at the plan who has knowledge about the plan's hospice medication coverage process.*** Hospices report that they have had great difficulty identifying a contact at a Part D plan who can provide guidance about the communication of medication coverage information for the beneficiary who has elected hospice or assist with resolving issues that arise.

- **Part D Recoupment** – ***CMS should develop a model notice letter to clarify the request for recoupment and repayment.*** Hospice providers are confused by the multiple processes, requirements, and lack of standards for the recoupment of payments for drugs that should have been paid for by the hospice. Clarification in the letter could include the retrospective period to be evaluated in the hospice drug review, response time for the recoupment request, and details about the drugs and patients, along with the recoverable amounts.

- **Sequential billing** – ***CMS should explore options to eliminate sequential billing for hospice.*** While the ability to count a beneficiary's days in hospice and track benefit periods is essential to accurate payment, CMS's sequential billing requirement causes significant problems for hospices. The implementation of the Notice of Election (NOE)/Notice of Termination or Revocation (NOTR) process has complicated the sequential billing issues, particularly when the patient revokes or is discharged, or when a patient changes hospices. Because bills must be submitted sequentially, if the first hospice has not submitted a NOTR or final claim, the second hospice is unable to bill. Typically, this causes the second hospice's NOE to be submitted late. The second hospice must have an exception request approved in order to submit claims and receive reimbursement. If there is any change in the hospice election, where the patient revokes, chooses another hospice or is discharged from the hospice for any discharge reason, sequential billing issues mean that there are circumstances that often require significant time and third parties to settle.

- **Eliminate provider liable days for hospice when there are claims processing issues outside the hospice's control** – ***CMS should provide additional manual instruction when retroactive Medicare or Social Security Disability is determined.*** There are many beneficiaries that have to wait months or years to have their Social Security Disability approved. By the time the application is approved, the patient is eligible for retroactive Medicare. Hospices must have a valid election statement, certification of terminal illness, recertifications and even face to face visits that line up with the date of Medicare eligibility.

  When the Medicare is approved retroactively to the date of hospice admission, this may work out if the hospice "assumed" Medicare would be approved and completed the certification requirements. But if the retroactive Medicare starts at some point after hospice admission, the dates of the

certification of terminal illness will not line up with the start of Medicare. This means that the hospice will not be paid for <u>any</u> of the care that they provided up to the date of retroactive Medicare. There is no way for a hospice to plan for or control the date of retroactive eligibility for Medicare. We recommend that if a hospice has made a good faith effort to comply with the certification/recertification requirements, all claims should be paid with no penalty to the hospice.

- **<u>Hospice and skilled nursing facility care</u>** – ***CMS should consider ways to address the current incentives for patients to be admitted for skilled nursing facility benefits following hospital discharge, even when hospice care would be more appropriate and would be of more benefit to the patient and family.*** Upon discharge from the hospital, families are often overwhelmed with the care required for a terminally ill patient and cannot envision caring for them at home. And the current Medicare system provides financial incentives for such patients to be admitted for skilled nursing facility benefits until they are exhausted, by which point the patient may have died without the benefit of hospice care. CMS could explore ways to allow hospice care for these patients, which will likely result in fewer readmissions to the hospital. Hospice staff can assist in transferring the patient to their home. Receiving the appropriate care will also decrease expenses associated with rehabilitation, medications, and other aggressive tests that are not appropriate or wanted.

2. <u>Other Hospice Policy Issues – Staffing and Coding Concerns</u>

- **<u>Eliminate the regulatory interpretation that a dietitian engaged by the hospice must be a W-2 employee of the hospice</u>** – The Medicare statute includes dietary counseling in the list of hospice core services, and requires that hospices provide "substantially all" of such services directly through employees. However, it is extremely uncommon for hospice patients to have dietary needs that would require the skills of a dietitian. The dietary needs of most hospice patients are not unique or complex and the vast majority of dietary counseling in hospice can be done by nurses, which is allowed under the Medicare Hospice Conditions of Participation. CMS should issue guidance that a hospice could contract for the occasional services of a dietician, as needed, while still being in compliance with the requirement to provide "substantially all" dietary counseling services directly.

- **<u>Allow hospice to contract with nurses for the provision of continuous home care (CHC) and require hospice training as a part of the contractual obligation</u>** – ***CMS should allow contracting for nursing services under the CHC level of care.*** The Medicare statute requires hospices to provide "substantially all" nursing services directly through employees, and CMS has interpreted this to preclude hospices from using contracted nurses to provide CHC. However, hospices have a difficult time staffing for continuous home care (CHC) because patients' need for this level of care is variable and intermittent. It is not feasible for a hospice to directly employ CHC nursing staff if they are not needed on a regular and consistent basis. As a result, many hospices provide little or no CHC. The provision of nursing services in CHC is a small part of the hospice's overall nursing services. The pattern of need for CHC fits with PRN staffing, not staffing by regular employees for most hospices. CMS should issue guidance that hospices can contract with nurses who have been trained in hospice

care to provide CHC services, as needed, while still providing "substantially all" nursing care through their employees. This would better allow hospices to provide this level of care and meet the needs of patients.

- **Allow continuous home care (CHC) to be provided for a minimum of 4 hours in a 24 hour period, beginning and ending at midnight** – ***CMS should change the minimum of 8 hours in a 24 hour period to 4 hours in a 24 hour period for CHC.*** Hospices find that many of their patients could use CHC services toward the end of the day. As currently structured, if a patient needs CHC after 4:00 pm the hospice cannot bill for it since there is an 8 hour minimum in a 24 hour period that begins and ends at midnight. Making an adjustment in the minimum time requirements would increase the options for hospices to assure that this level of care is delivered to patients who need it.

- **Workforce issues for social workers** – ***To address workforce shortages, CMS should add flexibility to the requirement for social worker supervision by someone with an MSW.*** The 2008 Medicare Hospice Conditions of Participation, at § 418.114(b) require that social workers with a BSW or baccalaureate degree in psychology, sociology or other field related to social work must be supervised by an MSW. Hospice providers report great difficulty in identifying and hiring MSW-trained social workers to supervise hospice social workers with undergraduate degrees. A hospice social worker with a certain amount of hospice experience (2-3 years) should be experienced enough to forgo ongoing weekly clinical supervision, other than for consultation on challenging patient/family situations. With this level of experience, social work supervision could be more flexible, with reduced frequency.

- **Reinstate dementia codes for hospice patients currently eliminated** – ***CMS should reinstate all diagnosis codes for senile dementia while following current ICD-10 coding guidelines.*** Among current hospice patients, there remains a subgroup who present with some form of senile dementia (classified as F03, Unspecified dementia) where no underlying condition has been identified. Non-hospice providers can report a code from F03 as primary and be paid for the claim. However, this code is not approved for use in hospice. We wholeheartedly support proper and complete coding for diagnoses. However, hospices are put in the untenable position of inaccurately reporting a patient's dementia diagnosis because of the list of codes not allowed. We request that CMS allow all dementia diagnoses in the list of eligible diagnoses for hospice patients.

- **Confusion over location of care codes -- Q5003 and Q5004** – ***CMS should review manual guidance about location of care codes for NF and SNF patients.*** Confusion continues about the appropriate use of the two locations of care Q codes for patients residing in nursing homes. In some states, there is no NF designation in nursing home beds. For hospices in those states, reporting the SNF designation is the only option, which impacts the target area data on the PEPPER report. For most providers, guidance is not clearly understood by those applying codes on claims and the wrong code is often used. For many hospice providers, this is a distinction without a difference and makes location of care comparisons between providers meaningless, and data about hospice care in NFs

and SNFs difficult to analyze with accuracy.

- **QIO and Hospice** – ***CMS should further clarify the role of the QIO's decisions when a beneficiary or their family appeals the hospice's intent to discharge the patient from hospice care.*** In 2013, CMS made changes to Chapter 9 of the Benefit Policy Manual at 260.6.2 regarding the effect of a QIO determination on continuation of care. However, hospice providers report that there is still significant confusion about the effect of the QIO medical director's determination when a beneficiary or their representative appeals a decision for a beneficiary's discharge from hospice. While Chapter 9 is clear, more education of QIOs and hospices is needed to clarify the decision of the QIO and the responsibility of the hospice to accept or reject it.

3. Hospice Audit Issues

- **Education** – ***CMS should provide additional training for audit staff on hospice eligibility and hospice regulations.*** Hospice providers report that auditors have a lack of understanding about the hospice benefit and hospice regulations and often cite the hospice for issues that are clearly allowed in the hospice regulations. Examples include audit findings citing the hospice for the following: days of care denied because the hospice patient had no hospitalizations or emergency department visits (not a requirement for hospice); days of care denied because the patient was not homebound (not a requirement for hospice); or the patient lived more than 180 days after admission (not prohibited for hospice), so all care after 180 days was denied. Having to expend time, effort and money challenging such inappropriate audit findings is frustrating and administratively burdensome.

- **Disagreements about medical necessity** – ***CMS and its contractors should follow the established waiver of liability provisions for audit findings that the patient is not "terminally ill."*** While done under the auspices of "fraud", the majority of these audit findings reflect only disagreement between the clinical judgment of the hospice medical director and the audit agency regarding medical necessity. Congress has established an applicable waiver of liability provision, which is consistently disregarded. Section 1879(g) of the Social Security Act requires Medicare to pay for hospice services despite a determination that a patient is not "terminally ill" when both the individual and the hospice "did not know, and could not reasonably have been expected to know, that payment would not be made…."[5] Congress specifically added section 1879(g) to the Act to extend this waiver protection to determinations that a patient is not terminally ill.

- **Auditors should follow audit response deadlines** – ***CMS should ensure that government auditors are subject to, and follow, established audit deadlines in reporting audit findings.*** Established audit response deadlines for hospices are onerous but regularly enforced, yet deadlines for the audit contractors are non-existent or unenforced. A hospice provider typically is given 15 days, 30 days or 45 days to respond to audit requests, while contractors may take 2 years to issue their findings to the hospice, leaving them in financial and legal limbo.

[5] *See* Act § 1879(a) and (g)(2).

- **Needless appeals** – ***Audit entities should provide a meaningful review of medical record documentation and sufficient clinical rationale to support claim denials.*** Hospices report that they frequently have to spend time and resources needlessly appealing audit "findings" where the denials are based on boilerplate language or invented standards. For example, ZPICs deny serial claims with little more than the unsupported conclusion that "beneficiary did not meet hospice criteria", with no specifics provided. Such denials often go unchecked as appeal contractors uphold claims denials with boilerplate recitations of the law, with no application of the legal requirements to the particular patient's condition or the documentation provided. This is inconsistent with guidance in Medicare Claims Processing Manual, chapter 29, §290.4. In the instances when a clinical rationale is provided, reviewers will often "invent" standards to deny payment, claiming that a patient must exhibit "rapid deterioration" or have a "Do Not Resuscitate Order" to qualify for hospice. Neither is a requirement for hospice eligibility

- **Audit contractors fail to follow legal standards that could provide protection for hospices from undue burden** – ***CMS should ensure that contractors follow legal standards for waiver of liability and ensure that CMS' directive to limit review to the initial reasons for review is followed.*** Contractors routinely fail to follow legal standards without any recourse for the hospice. In addition to the waiver of liability provisions mentioned above, contractors also ignore CMS' directive to limit their review to the initial reasons a claim was denied.[7]

- **Duplicative medical review audits** – CMS should take steps to ensure that medical review audits are not duplicative. Uncoordinated and duplicative medical review audits have led to contradictory decisions and place hospices in "double jeopardy". While hospices are expected to coordinate multiple audits from multiple contractors (MICs, ZPICs, MACs, SMRCs, CERTs), similar expectations are not imposed on contractors. ZPICs will request records for claims that have been previously reviewed by the MAC and deemed appropriate, or are otherwise in the process of being adjudicated. Hospices are left having to defend themselves twice. This lack of coordination leads to mixed messages, divergent outcomes, and confusion and additional burden for the hospice.

  Hospices also get caught in the middle of differences of opinion between MIC contractors and State Medicaid Programs. Numerous State Medicaid Programs have instituted prior authorization processes that involve a contemporaneous evaluation of hospice appropriateness based on requested clinical documentation. Like hospices, these State Medicaid programs are making a real time evaluation of clinical appropriateness, yet MICs can disregard such determinations and second guess clinical decision making up to 5 years later. Hospices bear the financial burden of these contradictions, and may be asked to repay the cost of care they provided and that their own State Medicaid agency approved.

- **Medicaid Integrity Contractor (MIC) Audits** – ***CMS should require that the Medicaid Integrity Contractors (MICs) be educated about eligibility requirements for Medicaid hospice patients in the***

[7] CMS, *Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims*, SE1521 (April 18, 2016).

State(s) at issue, including pediatric patients. Hospice providers report that claims are being denied arbitrarily for any days past six months, even when the benefit isn't limited to six months, the patient continues to be eligible, and that eligibility is reflected in the hospice's medical record. Likewise, auditors regularly engage in "Monday morning quarterbacking," deciding to arbitrarily pay for care only during the last six months of a patient's life, ignoring the preceding months of decline, including the patient's admission, which was supported by the clinical judgment of multiple physicians. In addition, some auditors are requiring documentation of clinical indicators that are not necessarily found in hospice patients or relevant to their prognosis, such as evidence of pressure ulcers, trips to the hospital, and weight loss.

4. Leakage Issues

- **Part A Leakage – Hospital Admission/Discharge –** ***CMS should place a flag in the hospital claims processing system so that hospitals will know, in a timely fashion, when a beneficiary has elected hospice.*** Beneficiaries sometimes arrive at hospitals and are admitted for acute care services without anyone realizing they are hospice patients. This process will decrease the amount of Medicare Part A hospital expenditures after the patient has elected the Medicare hospice benefit, and lead to better care coordination.

5. Health Information Technology

- **Telehealth -- C*MS should allow and encourage greater use of telehealth to provide services to hospice patients*.** Expanded availability of telehealth services would be especially beneficial for patients who need physician services in remote areas. In addition, many patients could benefit from quicker and easier interaction with hospice staff, who could assess symptoms and support caregivers, providing additional contacts to the in-person visits already scheduled and determine whether an in-person visit is necessary.

6. Rural Hospice Issues

- **Critical Access Hospital (CAH) Contracting for GIP –** ***CMS should provide additional clarity for CAHs to allow hospices to contract with CAHs for GIP care without the cost of those contracts adversely affecting the CAH's payment rate.*** Some rural hospices report that CAHs decline to contract with hospices in the area because of concern that by accepting the hospice GIP rate for a day of care, it will be included on the CAH's cost report and impact their hospital payments in the coming year.

- **Telehealth –** ***As noted above, CMS should encourage and facilitate greater use of telehealth for hospice patients in rural areas to increase access to physician specialists and support caregivers.*** Hospice providers report significant windshield time for very scarce physician resources and believe that additional support to patients through telehealth is important.

7. Local / National Coverage Determinations

- **Update the Local Coverage Determinations (LCDs)** – ***CMS and the Medicare Administrative Contractors (MACs) should review hospice LCDs and ensure that they have updated information on prognostication and guidelines for terminal prognosis.*** CMS and the MACs should also ensure that the LCDs continue to be used as guidelines, rather than as strict legal/mandatory requirements.

8. Medicaid

- **Update the State Medicaid Manual** – ***CMS should update the State Medicaid Manual, Section 4305, which has not been updated since October 1990.*** Since there have been a number of substantive statutory and regulatory changes to the Medicare hospice benefit since 1990, State Medicaid agencies and hospice providers in all parts of the country are confused and frustrated by the language in several subparts of the hospice section of the State Medicaid Manual which continues to reflect old Medicare provisions that have been changed. Particularly in light of increased Medicaid Integrity audits and State Medicaid audits, it is increasingly important that the State Medicaid Manual has clear and up-to-date guidance to hospice providers so that no confusion exists and audits are efficiently and properly conducted using the correct legal standards.

  We propose the following changes so that the State Medicaid Manual instructions are consistent with Medicare requirements and greatly ease administration of the hospice benefit. Our proposed additions are underlined; deleted text shows as strike through.

  a. **State Medicaid Manual §4305.1 – Physician Certification**: The manual provision currently requires obtaining written certification within 8 days after care is initiated, which is the old Medicare certification requirement. This was revised following a statutory change in the Balanced Budget Act of 1997 (BBA), which eliminated the specific time frames, and CMS now allows for **verbal certification within two days after the initiation of hospice care when a written certification cannot be obtained in that time period, and requires written certification to be obtained before the claim is filed.** Nonetheless, because the old Medicare provision is still in the State Medicaid Manual, hospices are cited in Medicaid audits for failing to comply with it.

     Recommendation: The State Medicaid Manual should be updated to also state that if the hospice does not obtain a written certification within two days after the initiation of hospice care, a verbal certification may be obtained within these 2 days, and a written certification obtained before the hospice submits a claim for payment. If these requirements are not met, no payment can be made for days prior to the certification.

  b. **State Medicaid Manual §4305.3 - Election, Revocation, Discharge and Change of Hospice**
     Currently, there is no provision in the Medicaid manual for a patient to be discharged from hospice. Medicare regulations have been revised and now include two reasons that a patient

may no longer receive hospice services -- revocation and discharge. The revocation is characterized as the patient's choice; the discharge is hospice-initiated. The State Medicaid Manual should be revised as follows:

Suggested additions to manual text:
"§4305.4 - An individual or representative may revoke the election of hospice care at any time. To revoke the election of hospice care, the individual must file a document with the hospice that includes a signed statement that the individual revokes the election for Medicaid coverage of hospice care and the date that the revocation is to be effective. The individual forfeits coverage for any remaining days in that election period. ~~if the benefit is broken into periods. If it is not or no periods are left, the revocation is permanent.~~ An individual may not designate an effective date earlier than the date that the revocation is made.

Upon revoking the election of Medicaid coverage of hospice care for a particular election period, an individual resumes coverage of any Medicaid benefits for which they are eligible. An individual may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible."

CMS should add a section on discharge, consistent with Medicare provisions:

A hospice may discharge a patient if 1) the patient moves out of the hospice's service area or transfers to another hospice; or 2) the hospice determines that the patient is no longer terminally ill; or 3) the hospice determines under a policy set by the hospice that the patient should be discharged for cause.

c. State Medicaid Manual §4305.4 - Requirements for Coverage

Current language: The current provisions describe requirements under the old Medicare Conditions of Participation, which were significantly revised in 2008, including detailed requirements regarding the initial and comprehensive assessment, as well as the development of the initial plan of care. Because Social Security Act section 1902(o) defines "hospice care" by reference to the Medicare definition in section 1861(dd), and this includes development of a plan of care by the physician and other members of the interdisciplinary group, the Medicaid requirements should be the same as those under Medicare. Given that 90% of hospice patients are covered by Medicare, it would eliminate confusion and increase compliance if the Medicaid and Medicare requirements regarding assessment and care planning were consistent.

Recommendation: Add the following underlined language to §4305.4 so that the initial and comprehensive assessment, as well as the initial plan of care, for Medicaid hospice patients mirrors the requirements for Medicare hospice patients.

Initial and comprehensive assessment: The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care is complete (unless the physician,

patient, or representative requests that the initial assessment be completed in less than 48 hours). The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care.

Initial plan of care: The RN, in consultation with the other members of the IDG, considers the information gathered from the initial assessment as they develop the plan of care and the group determines who should visit the patient/family during the first 5 days of hospice care in accordance with patient/family needs and desires and the hospice's own policies and procedures. All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group, (composed of a nurse, physician, medical social worker and pastoral or other counselor), in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.

Remove the following language as it is out of date with Medicare Conditions of Participation and current practice:
~~In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member (nurse, physician, medical social worker or counselor) before writing the initial plan of care.~~

~~At least one of the persons involved in developing the initial plan must be a nurse or physician. This plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care. The other two members of the basic interdisciplinary group must review the initial plan of care and provide their input to the process of establishing the plan of care within two calendar days following the day of assessment.~~

NHPCO is eager to engage in further dialogue about the issues discussed in this letter, including ways that CMS can reduce regulatory burden for hospice providers. We look forward to continuing collaboration with CMS on these and other hospice issues.

Sincerely,

Edo Banach
President and CEO