NHPCO Talking Points
FY2018 Proposed Rule
June 7, 2017

The Centers for Medicare and Medicaid Services (CMS) published the FY2018 Hospice Wage Index Proposed Rule on May 3, 2017. NHPCO has been hard at work analyzing the proposed rule and gathering feedback from providers about the implication of the rule for the hospice community.

Comments on the proposed rule are due to CMS no later than June 26, 2017. While comments may be submitted by mail, the submission method of choice is to submit them online at www.regulations.gov. Enter the number of the proposed rule, CMS–1675–P, and find the listing for “Medicare Program: FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements”

There will be a “Comment Now” button, which you will click to enter your comments. Follow the instructions to submit. NHPCO recommends that you save your comment letter on agency letterhead and pdf the document before uploading it to Regulations.gov. When submitting electronically, the due date is June 26, 2017 at 11:59 pm.

NHPCO Talking Points

How to read this document: We have organized this document into topic areas so that readers can easily follow the discussion of important issues in the proposed rule. For each topic area, the text in black is taken directly from the FY2018 proposed rule, followed by a box with red, italicized text with NHPCO talking points.

1. Non-Hospice Spending – Part A and B

Non-hospice spending for Part A and Part B items and services has decreased each year since we began reporting these findings. Overall, from FY 2012 to FY 2016 non-hospice Medicare spending for Parts A and B during hospice election declined 25 percent. However, there continues to be a non-trivial amount of non-hospice Parts A and B spending on beneficiaries under a hospice election, and we will continue to monitor data regarding this issue.

Overarching Concern:
Non-hospice spending after the hospice election continues to be a “non-trivial” issue, according to data provided in the proposed rule. While the implementation of the Notice of Election/Notice of Termination or Revocation process for hospice providers has impacted the volume of non-hospice spending, there continues to be a lack of awareness about hospice election and its impact on other providers’ claims submissions.
2. **Non-Hospice Spending – Part D and Maintenance Medications**
   
a. CMS has noted an increase in Part D spending on a separate category of drugs referred to as maintenance drugs. Maintenance drugs for beneficiaries under a hospice election are not subject to the Part D Prior Authorization process. 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, 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. *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.*

   **NHPCO Talking Points:**
   
   - There are persistent system issues beyond the control of the hospice, that continue to disrupt the Part D-Hospice interaction.
     - **CR8877** implemented on October 1, 2014 requires hospices to file a Notice of Election to provide timely notification to all Medicare Part A, B and D providers that a patient has elected the Medicare hospice benefit.
       - Lack of a consistent and accessible contact point at the individual Part D plan that has proficiency in dealing with the process for communicating the hospice election.
       - Pharmacies continue to bill Part D as the payer of choice, even when the hospice has communicated payment responsibility for drugs for a beneficiary after the hospice election.
       - Maintenance medications are on automatic refills for patients.
     - For maintenance medications that are clearly not related to the terminal prognosis, who should pay for those medications? [Hospices should cite examples of patients where the maintenance medications are not related to the terminal prognosis.]

b. In our ongoing analysis of non-hospice spending, we remain concerned that common palliative and other disease-specific drugs for hospice beneficiaries that should be covered under the Part A Medicare hospice benefit are instead being covered and paid for through Part D. Based on our own analysis as demonstrated in the data provided above and similar analyses conducted by the Office of the Inspector General (OIG) regarding Part D drug expenditures for Medicare hospice beneficiaries, *we believe that Medicare could be paying twice for drugs that are already covered under the hospice per diem payment by also paying for them under Part D.*

   **NHPCO Talking Points:**
   
   - The issue seems to be a lack of awareness or action on the part of the Part D plan to take notice of the NOE/NOTR notification within the CWF. It is often difficult for a hospice to change the payer from Part D to the hospice, especially since the fall back is to charge Part D.
3. **Quality Improvement Organization Review**

We encourage hospices to educate beneficiaries regarding the comprehensive nature of the hospice benefit. Although it should be rare, if any conditions are identified by the hospice as unrelated to the terminal illness and related conditions, we further encourage hospices to inform the beneficiary (or representative) at or near the time of election and provide the clinical rationale for such determinations. The regulations at §476.78 state that providers must inform Medicare beneficiaries at the time of admission, in writing, that the care for which Medicare payment is sought will be subject to Quality Improvement Organization (QIO) review. If a beneficiary disagrees with the hospice determination of what conditions are unrelated to the terminal illness and related conditions (and thus arguably not provided as part of the hospice benefit), we strongly encourage hospices to work to resolve the disagreement with the beneficiary (or representative), taking into consideration his or her wishes, treatment preferences and goals.

**NHPCO Talking Points:**

- There has been a great deal of confusion among hospice providers about the role of the QIO physician and the finality of their decisions about hospice eligibility when a beneficiary or their representative appeals the decision of the hospice. If the QIO physician determines that the patient is still eligible for hospice, does that require that the hospice medical director reconsider their decision and readmit the patient?

- NHPCO recommends that if the QIO determines that a patient continues to be eligible for hospice, the QIO physician should explain to the hospice, in writing, why the patient continues to qualify for the Medicare Hospice Benefit. That explanation may be used by the hospice, and should be accepted by the MAC, as the Certification of Terminal Illness for the next benefit period.

- Hospices spend much effort educating the family as to why a patient is no longer terminally ill, often when the disease process has plateaued, or the patient’s prognosis is longer than 6 months. This plays with the emotions of an entire family (or perhaps individual members) which has/have been gearing up to say goodbye forever. When a member of that family then appeals to the QIO to retain services - and the QIO decrees that the “hospice must stay”, this sends a mixed message to the entire family, who truly gets orphaned by the medical system in the process. This challenges the effort of the hospice to provide a safe, smooth discharge back to acute care or postacute care.

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

**Comments on this Proposal:** In this section, CMS raises the question about what clinical information the hospice medical director (or hospice physician designee) is relying on to support his or her certification that the individual is terminally ill and from where this information was obtained.

CMS also comments that “the inherent challenges in prognostication make it critical for a hospice to obtain, and the certifying hospice medical director or hospice physician designee to comprehensively review, the patient’s clinical information when making the determination that the patient is terminally ill, and thus eligible for the Medicare hospice benefit. By increasing physician
engagement and accountability, patients can be assured they are making the most informed decision possible, without limiting their treatment choices.”

a. CMS is also “soliciting comments for possible future rulemaking, on amending the regulations at §418.25 to specify that the referring physician’s and/or the acute/post-acute care facility’s medical record would serve as the basis for initial hospice eligibility determinations.”

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**Overarching Concern:**
In their descriptive language about this issue, CMS has expressed concerns that there are patients “inappropriately certified as terminally and not actually eligible to elect the Medicare hospice benefit.” There is only anecdotal data to support that admitting patients who are not terminally ill is a widespread issue; in fact with a median length of stay of 18 days, and significant numbers of patients with very short stays in hospice, 7 days or less, the greater concern is that the Medicare beneficiaries who most need symptom management, care and support at the end of life could receive even less hospice care or not receive it if these proposed changes were implemented.

**NHPCO Talking Points:**
- A hospice should make reasonable attempts to obtain records. However, the lack of receipt of records should not delay a hospice admission where an assessment has been completed and eligibility has been reviewed. 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.
- The hospice team, in making an initial visit to a patient referred for hospice services, conducts an assessment of the patient for their possible admission to hospice, reviews current medical information and collects additional, real-time information about the current disease process and prognosis.
- Hospice nurses’ entire caseloads are made up of patients with a limited life expectancy and hospice nurses take the entire patient picture into account – a complete assessment with a focus on terminality yields a more accurate assessment of appropriateness for hospice than notes in routine patient records.
- These clinical records should not be the only source of clinical information as noted above, as other records and a hospice RN assessment for potential admission are also important. The skill of a hospice nurse in gathering clinical information relevant to hospice eligibility cannot be underestimated.
- Receiving records in a timely fashion can be problematic. As opposed to the present process, (with 5 days to complete the cert narrative, sign, and submit the NOE), obtaining records prior to admission to hospice seems restrictive and unnecessary, if other more timely and appropriate clinical assessment information is available.
- It is not unusual for initial records received to be missing information, requiring a second record request or even a “hunt” for other sources for records.
b. CMS requests comments on whether to amend the regulations for certification of terminal illness at §418.25 in future rulemaking to require that the individual be certified as terminally ill prior to receiving hospice services and that the determination fundamentally could not be determined by hospice documentation obtained after admission.

**Overarching Concern:**
The certification process is just that – a process. The requirement that a Medicare beneficiary that must be certified before receiving hospice services adds a layer of regulation that is not necessary for the patients who most need hospice services. There are checks and balances for patients whose length of stay is longer than the median, including continuing review of the patient’s care plan, recertification of terminal illness at the end of each benefit period, and with the face-to-face encounter at the beginning of the third benefit period. In addition, if there are individual provider concerns, they should be addressed by the Medicare Administrative Contractor or the CMS Center for Program Integrity and its contractors.

**NHPCO Talking Points:**
- During the referral process, hospice staff is in communication with the referring physician to gather clinical information and more details on the patient.
- The initial visit to a patient after referral is a discussion of services, a nursing assessment and a confirmation of eligibility. The information gathered in this visit is conveyed back to the hospice physician who is making the final decision on eligibility.
- In determining eligibility, the hospice physician will use medical records, discussions with referral sources and the referring physician, as well as the hospice nurse’s assessment. That combination of information is used in eligibility, the development of the plan of care and in providing ongoing treatment.

c. CMS is soliciting comments on amending the regulations text 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.

**Overarching Concern:**
The hospice medical director or hospice physician now uses their clinical judgment to determine when an in-person visit may be necessary to gather additional clinical information or to supplement the referral source’s medical records. A suggestion that this should be required by regulation negates the hospice physician’s right and responsibility to make this decision on a case-by-case basis.

**NHPCO Talking Points:**
- Many hospices have a process in place for determining which patients may need a physician visit due to questions about eligibility. Often this determination is made after a hospice nurse has conducted the initial assessment and relays findings and uncertainty about eligibility back to the hospice physician.
- An in-person visit from the hospice Medical Director or hospice physician should be a determination made by the hospice physician, and within the physician’s medical judgment, when additional clinical information is needed and should not be a requirement in regulation.
Other details in this section where comments are warranted:

a. Election of hospice is a significant decision and one which patients and their physicians do not take lightly, as it involves a shift in traditional health care philosophy from curative to palliative care.

NHPCO Talking Points:
- The statement in the proposed rule assumes that there is a shift from curative to palliative care, when there is no cure for virtually all of the non-cancer diagnoses served by hospices. These beneficiaries have chronic incurable progressive illnesses.
- It can be difficult for the community physicians who have been practicing disease management for years for these individuals to recognize or determine when the disease trajectory has reached the point of a 6 month or less prognosis. And, often, the physician has not ever told the patient that he/she is likely to die of the disease – and because these conversations are difficult, especially in the context of a long term relationship, the physician may be reluctant to initiate and offer pursue aggressive interventions that prove futile and result in a late hospice referral, if at all. This scenario is even more complicated when there are multiple co-morbidities, any of which might end up being the principle diagnosis for hospice eligibility.

b. 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.

NHPCO Talking Points:
- Data collected by NHPCO in the National Data Set show that the source of the largest number of referrals is the hospital (46%) followed by all physicians (19%). We do not believe that the majority of hospice referrals come from family physicians, but rather hospitals and the hospitalist physicians who are employed there.
- Not all chronic illnesses are terminal or lead to a terminal prognosis (e.g., arthritis, gout, chronic fatigue syndrome, fibromyalgia, hypothyroidism – if treated, schizophrenia). Some ‘events’ or acute illnesses are terminal (stroke, pneumonia, TBI).

c. The admission requirements at §418.22(b)(2) require that this clinical information and other documentation that supports the medical prognosis must accompany the certification and be filed in the medical record with the written certification. Whereas the regulations at §418.25(b) provide the type of clinical information the hospice medical director or hospice physician designee must consider in the certification of terminal illness, the source of this clinical information is not clearly identified. This raises the question as to what clinical information the hospice medical director (or hospice physician designee) is relying on to support his or her certification that the individual is terminally ill and from where this information was obtained.
Multiple clinical tools and guidelines, and more specifically the Medicare Administrative Contractor (MAC) Local Coverage Determinations (LCDs), exist to assist the patient-designated attending physician and hospice medical director/hospice physician designee in determining the patient’s terminal prognosis. These guidelines provide indicators that support a decline in clinical status, including, but not limited to: history of recurrent infections, worsening symptoms that are non-responsive to treatment, increasing emergency department and clinician visits, laboratory results supporting progression of disease, and change in functional status.

However, documentation of these indicators would likely not exist without some degree of long term monitoring and evaluation by a physician separate from the hospice medical director/hospice physician designee. As such, this information would typically be found in the referring physician’s and/or acute/post-acute care facility’s medical records.

NHPCO Talking Points:

- **Clinical information about the referred patient comes from a variety of sources, including the referral source (physician, hospital, SNF, LTAC) or from non-referral sources, such as other physicians, specialists, hospitals, SNFs, LTACs or any other health care provider that may have seen the patient recently.**

- **Clinical information is obtained by the hospice nurse during the assessment for possible hospice admission, where the nurse functions as an extender for the HMD/Hospice Physician. This is often the best or only way to obtain up-to-date and accurate clinical information regarding indicators used for eligibility, such as functional status, cognitive status, nutritional status, palliative performance scores (PPS) or other indicators.**

- **Clinical records from non-hospice/non-palliative care providers do not consistently contain appropriate documentation on indicators necessary for eligibility.**

- **If documentation from a referring physician or health care provider is poor, should it delay or prevent access to hospice services?**

- Clinical records from non-hospice/non-palliative care providers do not consistently contain appropriate documentation on indicators necessary for eligibility. If documentation from a referring physician or health care provider is poor, should it delay or prevent access to hospice services?

- Long term monitoring and evaluation is different than assessing for hospice eligibility. Often the disease process and trajectory, as well as indicators of decline, are not identified by the referring physician, as they are not looking for those indicators in the same way as a trained hospice and palliative care health care professional.

- Would a non-HMP physician have the skill set to continue to follow and document long-term monitoring with the goal of predicting prognosis of 6 months or less life expectancy? Many non-hospice physicians do not understand general decline documentation, and many do not utilize tools such as PPS score. They may not recognize the importance of documenting other general indicators, such as using the FAST scale for following Alzheimer’s patients’ functional status.

- If community physicians are focused on maintaining function, disease management, and “curative” care then documentation of efforts to achieve these goals will likely be present in their patient records with emphasis on acute exacerbations, but evidence of decline is likely to be minimal or missing since decline is not the focus of the care provided.
In response to CMS concerns:

a. A patient may never be seen by a hospice physician who is certifying.

**NHPCO Talking Points:**
- It is possible that the patient may never see the hospice physician. However, it is also true that a patient may never be seen by a non-hospice attending or consulting physician after electing their Medicare Hospice Benefit.
- For the past 35 years, hospice nurses have functioned as case managers and as an extender for the physician. In some states, the hospice nurse initial contact with a patient, where the election statement is signed, suffices to establish the patient-physician relationship.
- Hospice nurses are skilled at recognizing signs and symptoms of terminal illnesses that have progressed to the point of a six month or less prognosis. They are more attuned to what a dying patient “looks like” than clinicians who only occasionally deal with death and dying. Their ongoing responsibility in the care of these patients is to have continuing communication and dialogue with the hospice medical director or physician in responding to symptoms and directing care.

b. Hospice staff information should not be the sole documentation to support initial certification.

**NHPCO Talking Points:**
- In most instances, the hospice staff information supplements any clinical information received by the referring physician or health care providers.
- A hospice physician may look for additional clinical information before making a determination about hospice eligibility or may also visit the patient to review clinical findings, conduct an assessment, and seek clarity on information that may have been missing, unclear or dated.
- There are some circumstances where the hospice staff information is the only recent clinical information available, including those patients where the patient’s last visit to a health care provider did not indicate a terminal illness and the medical information is not relevant for the certification of terminal illness.
- Hospice nurses have particular skills in assessing patients who have been referred and need a review of the patient’s current real-time assessment of clinical indicators and appropriateness for hospice.

**CMS Soliciting Comments from Hospice Providers**

Comments on current processes used by hospices to ensure comprehensive clinical review to support certification and any alternate suggestions for supporting clinical documentation sources are also encouraged.
5. **Proposed Updates to the Hospice Quality Reporting Program (HQRP)**

   a. **Inclusion of Social Risk Factors in Risk Adjustment for Quality Measures**

   We continue to seek public comment on *whether we should account for social risk factors in measures in the HQRP, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors.* Examples of methods include: confidential reporting to providers of measure rates stratified by social risk factors, public reporting of stratified measure rates, and potential risk adjustment of a particular measure as appropriate based on data and evidence.

   **NHPCO Talking Points:**
   
   A key principle in quality measurement is that providers should only be held accountable for what they can control. 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 used to ensure fairness when comparing performance across providers. 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.

   - Hospice providers should be able to perform care processes equably for all patients regardless of social factors. Consequently, social factors cannot be identified as influencing hospice performance on process measures.
   - It is possible that social factors might influence outcomes and subsequent performance on quality outcome measures.
   - If CMS decides to take social risk factors into account in calculating quality measure scores, it would be important to balance disincentivizing hospices to admit patients and families with identified social risk factors and sanctioning provision of less than best possible care for them.

   We are also seeking public comment on *which social risk factors might be most appropriate for reporting stratified measure scores and/or potential risk adjustment of a particular measure.* Examples of social risk factors include, but are not limited to,

   - dual eligibility/low-income subsidy,
   - race and ethnicity,
   - geographic area of residence.

   CMS is seeking comments on *which of these factors, including current data sources where this information would be available, could be used alone or in combination, and whether other data*
should be collected to better capture the effects of social risk. We will take commenters’ input into consideration as we continue to assess the appropriateness and feasibility of accounting for social risk factors in the HQRP.

Of note, implementing any of the above methods would be taken into consideration in the context of how this and other our programs operate (for example, data submission methods, availability of data, statistical considerations relating to reliability of data calculations, among others), so we also welcome comment on operational considerations.

**NHPCO Talking Points:**

- Based on their experience with care delivery and the desired outcomes of care, hospice providers should consider whether, in spite of best care practices, social factors affect outcomes of care.
- If so, social risk factors are relevant to outcomes, hospice providers should share:
  - which social factors CMS should take into consideration;
  - how the effect of the social risk factors should be incorporated into reporting of hospice performance on quality measures; and
  - potential sources for data on the identified social risk factors.
- Also provide suggestions for other means to take social risk factors into account.

**b. Two New Claims-based Measures**

Comments received during this rule (FY2016) were overall supportive of our efforts to develop more robust quality measures that capture hospice performance and show links to patient and family outcomes.

**Priority Area 1: Potentially avoidable hospice care transitions**

Potentially avoidable hospice care transitions at end of life are burdensome to patients, families, and the health care system at large, because they are associated with adverse health outcomes, lower patient and family satisfaction, higher health care costs, and fragmentation of care delivery. By encouraging hospice providers to assess and manage patients’ risk of care transitions, this measure concept has the potential to improve quality care at the end of life by reducing potentially avoidable hospice care transitions.

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

The Medicare Hospice Benefit covers four levels of care to meet patients’ and families’ clinical needs: routine home care (RHC), continuous home care (CHC), general inpatient care (GIP), and inpatient respite care. The goal of this measure concept is to assess the rates at which hospices provide different levels of hospice care. The measure has the potential to improve access to various levels of care for patients and caregivers. Appropriate use of CHC and GIP increases the likelihood of a hospice patient dying in his or her location of choice, decreases health resource utilization resulting in potential cost savings, and increases patient and caregiver satisfaction. Measuring use of levels of care will incentivize hospice providers to continuously assess patient and caregiver needs and provide the appropriate level of care to meet these needs.

These two measure concepts are under development, and details regarding measure definitions, specifications and timeline for implementation will be communicated in future rulemaking.
We are soliciting comments regarding high priority concept areas for future measure development.

**NHPCO Talking Points:**
- While the identified measure areas do focus on important aspects of hospice care, claims do not provide sufficient information to adequately represent hospice practice. Consequently, claims data cannot inform the creation of performance measures that are truly fair and objective.
- 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.
- For example, 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.

**NHPCO Talking Points:**
- 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:
  - 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


This new data collection mechanism would be a hospice patient assessment tool, which would serve two primary objectives concordant with the Affordable Care Act legislation:
1. To provide the quality data necessary for HQRP requirements and the current function of the HIS; and
2. Provide additional clinical data that could inform future payment refinements.
Overall, feedback from the public was supportive of the move towards a standardized patient assessment instrument, and commenters offered some guiding principles for CMS to keep in mind in the development of a patient assessment tool, given the unique nature of hospice care.

We [CMS] envision the hospice patient assessment tool itself as an expanded HIS. The hospice patient assessment tool would include current HIS items, as well as additional clinical items that could also be used for payment refinement purposes or to develop new quality measures. The hospice patient assessment tool would not replace existing requirements set forth in the Medicare Hospice CoPs (such as the initial and comprehensive assessment), but would be designed to complement data that are collected as part of high-quality clinical care.

CMS’s measure development contractor, RTI International, has begun preliminary HEART development activities, including: conducting environmental scans and engaging clinical experts to determine which domains of care are important to capture in a hospice patient assessment; posting a national provider call and forming a Clinical Committee comprised of hospice organizations from across the U.S. to participate in the early development of an assessment; and collaborating within CMS to assess various stakeholder needs and encourage collaboration within CMS and across other HHS agencies.

We will continue to keep the public informed of our progress and solicit input as we establish and finalize domains of care to include in the assessment, and as we move towards specific item wording and development. Once we move past the preliminary phases of development and conceptualization, we will communicate a timeline for the HEART development, testing, and implementation in future rulemaking cycles.

It is important for CMS to develop a hospice patient assessment tool that is scientifically rigorous and clinically appropriate for the hospice population, thus we believe that continued and transparent involvement of stakeholders is critical. We will continue to receive stakeholder input from MedPAC and ongoing input from the provider community, Medicare beneficiaries, and technical experts. Additionally, it is important for CMS to minimize data collection burden on providers in the development of HEART.

**NHPCO Talking Points:**

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.**

CMS wants to ensure that hospice patient assessment data items are not duplicative or overly burdensome to providers, patients, caregivers, or their families. We will also work with the public and other stakeholders to ensure that HEART takes into account the unique aspects of hospice care delivery including symptom burden and psychosocial needs, patient and family
preferences, care of imminently dying patients, and the complexity of providing hospice care in multiple settings and at multiple intensity levels.

**NHPCO Talking Points:**

NHPCO recommends that in the development of a data collection mechanism CMS:

- Systematically and comprehensively gathers 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.
- Employs thorough pilot testing before the patient assessment tool is implemented
- Provides clear data definitions that can be readily understood
- Phases in implementation using a dry run or similar approach
- Provides thorough and ongoing education and support for hospices

**d. Hospice Compare**

We propose to begin public reporting of CAHPS® Hospice Survey measures in 2018. Specifically, we are proposing to publicly report data in winter CY 2018 on all eight CAHPS® Hospice Survey measures. Scores would be displayed based on eight rolling quarters of data and would initially use CAHPS® Hospice Survey data collected from caregivers of patients who died while receiving hospice care between April 1, 2015 and March 31, 2017. We are proposing that the display of these scores be updated quarterly, and that scores be displayed only for those hospices for which there are 30 or more completed questionnaires during the reporting period. Scores will not be displayed for hospices with fewer than 30 completed questionnaires during the reporting period.

Public comments regarding how the rating system would determine a hospice’s star rating and the methods used for calculations, as well as a proposed timeline for implementation will be announced via the CMS HQRP webpage ...

**NHPCO Talking Points:**

- NHPCO recommends that CMS take a criterion approach to constructing the CMS Compare website for hospice agencies and determining the methodology to be used for calculating star ratings.
- 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.

**e. Emergency Extensions/Exemptions**

We are proposing to extend the deadline for submitting an exemption or extension request to 90 calendar days from the qualifying event which is preventing a hospice from submitting their quality data for the HQRP.

Therefore, we are proposing for FY 2019 payment determination and subsequent payment determinations to extend the period of time a hospice may have to submit a request for an
extension or exception for quality reporting purposes from 30 calendar days to 90 calendar days after the date that the extraordinary circumstances occurred, by submitting a request to CMS via email to the HQRP mailbox at HospiceQRPReconsiderations@cms.hhs.gov.

This process does not preclude us from granting extensions/exemptions to hospices that have not requested them when we determine that an extraordinary circumstance, such as an act of nature, affects an entire region or locale. We may grant an extension/exemption to a hospice if we determine that a systemic problem with our data collection systems directly affected the ability of the hospice to submit data. If we make the determination to grant an extension/exemption to hospices in a region or locale, we will communicate this decision through the various means, including the CMS HQRP website, listserv messages via the Post-Acute Care QRP listserv, MLN Connects® National Provider Calls & Events, MLN Connects® Provider eNews and announcements on Open Door Forums and Special Open Door Forums.

We are soliciting comments on these proposals.

**NHPCO Talking Points:**

- We support the extension from 30 to 90 days and concur that this change will be very helpful to hospice providers where acts of nature or a systemic problem with the CMS data collection system prevents compliance with HQRP requirements.

6. **Request for Information on CMS Flexibilities and Efficiencies**

We would like to take this opportunity to invite the public to submit their ideas for regulatory, subregulatory, policy, practice, and procedural changes to better accomplish these goals. Ideas could include payment system redesign, elimination or streamlining of reporting, monitoring and documentation requirements, aligning Medicare requirements and processes with those from Medicaid and other payers, operational flexibility, feedback mechanisms and data sharing that would enhance patient care, support of the physician-patient relationship in care delivery, and facilitation of individual preferences. Responses to this Request for Information could also include recommendations regarding when and how CMS issues regulations and policies and how CMS can simplify rules and policies for beneficiaries, clinicians, physicians, providers, and suppliers. Where practicable, data and specific examples would be helpful.

**NHPCO Talking Points:**

This request for information is an important opportunity to provide CMS with ideas that would reduce regulatory burden. NHPCO is working on a list of issues that should be considered by CMS to reduce regulatory burden and will submit them as a part of the NHPCO Comment Letter on the FY2018 proposed rule. We also encourage hospice providers and other commenters to submit ideas as well.

We are particularly interested in ideas for incentivizing organizations and the full range of relevant professionals and paraprofessionals to provide screening, assessment and evidence-based treatment for individuals with opioid use disorder and other substance use disorders, including reimbursement methodologies, care coordination, systems and services integration, use of paraprofessionals including community paramedics and other strategies. We are requesting commenters to provide clear and concise proposals that include data and specific examples that could be implemented within the law.

**NHPCO Talking Points:**

If there are comments providers and other commenters would make about providing services to those with opioid use disorder and other substance use disorders, here is an opportunity to comment. NHPCO will also be making comments in this section.