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June 23, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health & human Services
ATTENTION: CMS-1675-P
P.O. Box 8010
Baltimore, Maryland 21244-1850

Electronic Submission via regulations.gov

Dear Administrator Verma:

Since 1982, the National Association for Home Care & Hospice (NAHC) has been the leading association representing the interests of hospices, home health, and home care providers across the nation, including home caregiving staff and the patients and families they serve. Our members are providers of all sizes and types -- from small rural agencies to large national companies -- and include government-based providers, nonprofit voluntary hospices, privately-owned companies and public corporations. As such, we welcome the opportunity to comment on **Medicare Program: FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (CMS-1675-P)**.

The proposed FY2018 hospice payment rule contains a number of changes that will impact hospice financial, quality and operational concerns. NAHC has conducted analysis and received input from the stakeholder community. This letter provides comment on the proposals and data CMS has put forth, which we respectfully offer for your consideration.

III. Provisions of the Proposed Rule
A. Monitoring for Potential Impacts – ACA Hospice Reform

As part of this section, CMS describes trends in hospice utilization and provider behavior, as well as data related to CMS' ongoing review of spending outside of hospice during a hospice election. CMS also discusses preliminary information on the costs of hospice care using data from the new hospice cost report (freestanding agencies). We were particularly interested in the sections describing the latest available data on spending outside of hospice, as well as the early analysis of available data from the newly revised hospice cost report.

1. Hospice Payment Reform: Research and Analyses/c. Non-hospice Spending

We see significant value in CMS' continuing efforts to track spending outside of hospice while patients are under a hospice election; we believe that knowledge of these spending metrics has helped to increase sensitivity on the part of hospice organizations and non-hospice care providers as to which items and services are appropriate for inclusion under hospice care and which are not related to the patient's terminal prognosis. We believe the data trends generally reflect that growing sensitivity.

Given the activity over recent years related to Part D spending for patients while on hospice care; the efforts that have been put forth by CMS, the hospice community, and other stakeholders to address concerns; and the considerable upheaval and financial costs that the Notice of Election (NOE) timely filing requirement have had on the hospice community at large, we were troubled to see that overall spending under Part D for hospice patients has increased, rather than decreased. CMS attributes this increase to growth in spending for drugs that CMS has identified as "maintenance" drugs, while spending under Part D for drugs that are currently under a prior authorization (PA) requirement (anti-nauseants, analgesics, laxatives, and anti-anxiety medications) has continued to decrease.

There are a number of questions that the discussion of spending for "maintenance drugs" under this section raise, and we believe that release of additional data connected to the Part D analysis would better inform stakeholders and assist in helping to determine what factors may be contributing to these increased Part D outlays. Following are some of the questions that arose as we reviewed this section:

- It is unclear from CMS' discussion whether the referenced maintenance medications are for the terminal condition or a related condition or are for a condition that accompanies the terminal illness/related conditions but is not part of the terminal prognosis. If the medications are not for a related condition, they are appropriate for coverage under Part D and should be excluded from consideration since current law specifies that beneficiaries retain the right to treatment for non-related diagnoses outside of hospice under Medicare.
- The synopsis of Part D spending for maintenance drugs provides no insight into the extent to which rapid increases in manufacturers' charges (which has been a significant concern in Part D over recent years) are responsible for growing outlays under Part D for hospice patients. This is of particular concerns since some of the drugs identified by CMS as maintenance drugs are

among those that have had significant charge increases associated with them. Additional data would assist in making determinations of the extent to which the increases in spending actually represent a change in hospice patterns of practice or are attributable to increases in manufacturers' charges.

- We also note that while, as part of the initial visit, hospice personnel communicate with the patient and the family about what is covered under hospice care and what is the responsibility of the hospice, as well as what medications are unrelated and either remain the responsibility of Part D or may be the responsibility of the patient, the patient or family member/informal caregiver may not have absorbed the full meaning of those conversations at the start of hospice care. This could result in charges to Part D near and around the start of hospice election. It is unclear from the description of the data if these maintenance drugs are financed by Part D at or near the start of hospice care.
- Additional information would also be helpful in identifying whether this Part D spending is more prevalent in certain areas of the country or specific to certain hospice providers. If so, any aberrant patterns could and should be addressed directly with hospice providers through educational efforts.

An overarching issue connected to spending outside of hospice care is the degree to which beneficiary status information is available to non-hospice providers in CMS systems on a timely basis. The existing process for ensuring timely updates of beneficiary status in the Common Working File (CWF) does not work well, in large part due to the required use of DDE for filing of hospice NOEs. We applaud CMS' efforts to work toward electronic filing of NOEs and urge that this change remains a high priority. We also believe that a cross-systems analysis that identifies the time frames for communication and posting of beneficiary status information among systems used by hospices, Part D plans, pharmacies, and Part A/Part B providers and suppliers with the goal of speeding the transfer of beneficiary status information is essential to minimizing inappropriate spending under other parts of Medicare for hospice patients. Any systems changes that could shorten the time frame for updates to beneficiary status in all systems will be beneficial to the Medicare program as a whole.

We would also note that while the PA process for the four categories of drugs appears to have had a meaningful impact on Part D outlays for hospice patients, it is our belief that additional steps can and should be taken to remind all stakeholders of the appropriate process that should be followed with respect to the PA process and use of the form to alert parties to a patient's status on hospice care and as to which medications are considered "unrelated" to hospice care and therefore are appropriate for payment under Part D. We welcome the opportunity to work with CMS to help to improve stakeholder understanding and use of the PA form.

In summary, there are numerous factors that could play a part in increased Part D spending for maintenance drugs, and additional information related to this utilization must be examined to determine what issues are contributory and how best these can be addressed. We also believe that additional action on the part of CMS and stakeholder groups is necessary in order to maximize use of

existing processes that were designed to help clarify responsibility for hospice patients' prescription medications.

2. Initial Analysis of Revised Hospice Cost Report Data

As part of the preamble to the rule, CMS indicates that it has conducted preliminary analysis using new cost report data for freestanding hospices to ascertain total costs per day by level of care. Based on initial findings that costs for Routine Home Care (RHC) may be less than the base payment rate, whereas costs for other levels of care (Inpatient Respite, General Inpatient Care, and Continuous Home Care) appear to be higher than payment rates, CMS indicates that in the future it may consider recalibration of the payment rates among the various levels of care. CMS acknowledges that these are preliminary analyses and that hospices are only currently getting accustomed to the new cost report; CMS plans to conduct more thorough analyses in the future. Elsewhere in the proposed rule, CMS indicates that it is currently analyzing the new cost report data for possible use in updating the labor/non-labor portions of the hospice payment rates, and that any changes will be proposed in future rulemaking and subject to public comment. CMS encourages hospices to submit the most accurate data possible on Medicare cost reports.

Over the course of the last year, a small group of cost report/hospice finance experts from NAHC's Home Health and Hospice Financial Managers Association (HHFMA) met to discuss the new hospice cost report and specific ongoing structural concerns. The group's comments were summarized in a letter sent to CMS in late September 2016. In mid-June, representatives of the HHFMA group met with cost report and payment policy representatives of CMS' Chronic Care Policy Group to discuss these concerns. We are appreciative of the time and attention that CMS staff invested in that meeting. One overarching concern related to the current hospice cost reporting requirements is that they do not in all aspects take into account existing hospice financial and operational practices. Another major concern is that, due to certain structural aspects of the cost report requirements, a number of costs are not being reported or allocated properly, which will lead to inaccuracies in the data that CMS is collecting and may use to rationalize recalibration of payment rates for different levels of care and for other purposes. Given these important concerns, we recommend that CMS move forward with the changes that we have presented. In the meantime, CMS must take these concerns into consideration when conducting any analysis of data from the cost report in its current form.

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

As part of the rule, CMS indicates that the hospice medical director must consider at least the following information when making a determination of a six-month life expectancy:

1. Diagnosis of the terminal condition of the patient,
2. Other health conditions, whether related or unrelated to the terminal condition, and
3. Current clinically relevant information supporting all diagnoses.

However, the source of the clinical information required to supports a six month life expectancy is not clearly identified, which raises questions as to what clinical information the hospice medical director is relying on to support the certification of terminal illness. CMS believes that without long-term monitoring and evaluation, documentation to support terminal indicators (such as those contained in the LCDs) would not be available to the hospice; CMS notes that such documentation would likely be available in the referring physician's and/or acute/post-acute care facility's medical records. In response to these concerns, CMS has solicited comments for possible future rulemaking on amending the hospice regulations at 418.25 to specify that the referring physician's/facility's medical record should "serve as the basis for the initial hospice eligibility determinations. Clinical information from the referring physician/facility supporting a terminal prognosis would be obtained by the hospice prior to election of the benefit, when determining certification and subsequent eligibility." CMS believes this modification would be in alignment with existing benefit eligibility criteria, and could not be determined by hospice documentation obtained after admission. CMS also is soliciting comment on amending hospice 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. This in-person visit would be required to be made prior to admission onto hospice care.

While NAHC recognizes the need to ensure that patients accepted onto care meet hospice eligibility criteria, we have very serious concerns that the changes being contemplated are inconsistent with the current structure of the hospice program and, most importantly, will delay or deny access to vital hospice services. Following are some of our specific concerns:

Existence of a referring physician/facility: The proposed rule references an article from 2008 indicating that the majority of hospice referrals come from personal physicians. This is a somewhat dated reference, and the particular reference regarding referrals to hospice appears to be drawn from an even earlier study (2003). Regardless, current day hospice experience indicates that the proportion of hospice patients referred by personal physicians who have cared for them over a long period of time varies significantly on a hospice-by-hospice basis. Some hospices report that as many as 63 percent of their patients are referred from hospitals, and that many of these patients have not seen a physician in a number of years, so they may not have a relevant clinical record that would be used to justify admission. Many of these patients have multiple social risk factors, and they will be most adversely affected by the changes under consideration. If the hospital or other referral source determines by clinical evaluation that the patient may be approaching the end of life, and a patient is not inclined to submit to or is fearful of needed testing, the referral source will be unable to conduct the tests that would provide quantitative justification for hospice. Under such circumstances the patient may be denied access to hospice services. In some areas of the country (such as Florida), patients may be part-time residents but may have more extensive medical history with a physician in a different part of the country. These circumstances may present serious challenges to timely communication of medical history.

Under current law there is no existing requirement that a hospice patient be referred by a physician or facility, and many patients/families request an evaluation directly from a hospice provider. CMS has

not indicated what documentation would be permissible for use when a patient is not directly referred by a physician or facility.

Willingness to refer/engagement in hospice care: While a family physician can play an invaluable role in caring for patients at the end of life and their involvement can help to ensure important continuity of care, there is widespread acknowledgement that barriers to physician referral to hospice are prevalent. These barriers include "negative perceptions about hospice, discomfort communicating terminal diagnoses and prognosis, an inability to identify an appropriate diagnosis, a fear of losing control of the patient, and an overestimation of life expectancy" ("The Role of the Family Physician in the Referral and Management of Hospice Patients," *American Family Physician*, March 15, 2008). Additional resistance is found as the result of widespread reports regarding opioid addiction and lack of understanding about the appropriate use of narcotics in hospice care. These factors all have an impact on some physicians' willingness to refer to hospice, and may have an impact on their willingness to assist with the development of documentation that would support eligibility for hospice care.

Availability/quality of referral source records: The quality of records compiled by hospice referral sources is variable, and referral sources frequently do not provide the amount or type of information needed to adequately document eligibility for hospice. Hospices have reported that referral sources express some frustration with hospice as they consider hospice to be "difficult to do business with" given the complexity of the eligibility requirements. The inadequacy of referral source records is due, in large part, to limited knowledge of hospice eligibility requirements, limited exposure to palliative care and hospice education, and variable knowledge related to the dying process. This is not surprising, as most personal physicians focus their efforts on maintaining health and curative services. Establishing as a standard that the referring physician's clinical record must be used as the basis for hospice eligibility signals that establishment of terminal prognosis should be an ability that every physician should have intimate knowledge of, and that they should readily be able to document such as part of routine clinical care. This is not a realistic expectation. The nation's most highly trained palliative care and end-of-life clinicians are employed in hospice and palliative care programs. These physicians and nurses are in the best position to evaluate an individual for eligibility for hospice care, and their skill should not be discounted or disregarded when it comes to determining appropriateness for hospice care.

The proposals under consideration by CMS bear some similarity to regulations currently in place for home health care, which require the use of the referring or ordering physician's documentation to support certification and any required face-to-face encounter. As a result, home health agencies have no control over the quality of the documentation supplied to justify eligibility for home health services, and eligibility determinations could be made based on review of only part of the pertinent clinical record. This has led to widespread denials that are beyond the agency's control. In the case of home health, however, the required documentation must be finalized prior to billing, whereas for hospice the agency would be required to have the documentation in hand prior to taking a patient onto service, a much more challenging task.

Financial risk: Given that the hospice is at full financial and reputational risk if it does not follow proper eligibility requirements, the hospice has the greatest motivation to ensure that documentation meets required standards. This is not always the case with referral sources.

Health system considerations: While an important goal of ongoing changes in the health care system is to achieve coordination among clinicians who care for patients with advanced illness and ultimately

support patient determination of appropriateness of hospice referral at the proper time, our current health care system is not ordered in that way and is still, to a great degree, characterized by care "silos." Until issues of coordination are adequately addressed, imposition of a requirement that hospices rely on documentation developed by clinicians outside of the hospice environment creates undue burdens on hospice providers and will deny eligible patients access to care. Further, systemic issues related to the lack of interoperability of electronic health records between physicians/facilities and hospice make timely sharing of information between referral sources and hospices very challenging, which would further contribute to delays in accessing care.

Currently, more than 25 percent of patients accepted onto hospice service die within seven days of admission, and half of all hospice patients have a length of stay of 18 days or less. Requiring that hospices secure and analyze patient records from the referral source, ensure that the records justify eligibility for service, and then begin the admission process will delay or even deny many patients access to hospice care. One of the biggest challenges in hospice today relates to late admissions onto hospice care, as these patients and their informal caregivers are denied access to the full benefit of hospice care, which was designed to manage the physical symptoms of disease, support patients emotionally and spiritually, and offer bereavement support to loved ones as all prepare for the patient's passing. Imposition of the "sources of clinical information" requirement will impose a significant regulatory burden on all hospice providers and limit access to hospice services. We would suggest that as an alternative CMS might examine claims data for patients on hospice care for longer periods of time where there are limited indications that the patient was treated for serious advanced illness that could lead to imminent death as a better and less burdensome means for identifying potential areas of abuse.

D. Proposed Updates to the Hospice Quality Reporting Program

2. General Considerations Used for Selection of Quality Measures for the HQRP

As part of the rule, CMS indicates that it has been closely examining findings related to the importance of including social risk factors in quality measurement programs. CMS has requested public input on risk factors that are particularly appropriate for use in development of hospice quality measures, as well as input on any means that might be used for collecting such data. This is an important area of exploration but is particularly challenging with respect to hospice, as research in this area for the most part has not focused on end-of-life care. Patients with a high social risk "load" have increased care complexity, and care needs are even more intensified as the patient approaches the final months and weeks of life. Incorporation of social risk factors in hospice quality measures must be approached with great care to ensure that patients at high risk receive quality care but that the challenges these patients pose to hospice providers are also appropriately considered as part of the quality measurement process, and do not unfairly penalize providers. Otherwise, such incorporation could serve as a deterrent to admission.

7. Measure Concepts Under Consideration for Future Years

CMS has under development quality measures in two priority areas:

Priority Area 1 – Potentially Avoidable Hospice Care Transitions

Priority Area 2 – Access to All Levels of Hospice Care

In previous comments, NAHC has expressed some hesitation about use of claims-based measures for public reporting – our concerns center around the need to ensure that any quality measure used for such purposes must provide a clear and direct measurement of quality. Beneficiary self-determination is a governing principle of hospice care. Conveying the role that individual circumstances may play in care decisions and, as a result, quality scores that stem from claims-based measures, can be challenging, and the public can easily misunderstand what these metrics actually measure. These are important considerations as the process of measure development moves forward. This does not mean that claims-based measures are not useful as part of the hospice quality measurement process – only that some measures may require considerable discernment and may not be appropriate for public dissemination.

With respect to **Priority Area 1 – Potentially Avoidable Hospice Care Transitions** – it would be helpful to know what specific transitions CMS contemplates including in this measure. Some policymakers have recommended use of live discharge rates as an appropriate claims-based measure for hospice, but CMS has also referenced specific patterns of care – including live discharge followed by an acute care hospitalization and a readmission to hospice – as "burdensome transitions" of care. As referenced above, additional detail about the ways in which CMS would account for patient/family choice as part of the hospice election/revocation process is a key element in development of and education around such a measure. With respect to rates of live discharge, claim information provides minimal information related to the reason for discharge. For instance, when a patient revokes the hospice benefit, is it because the patient is seeking aggressive treatment, the patient wants to transfer to a different hospice, that hospice was not was the patient expected, or for some other reason? Absent additional information that could rationalize the revocation, the public may misinterpret the meaning of these quality measures/scores. Providing the level of detail such that the public is able to discern meaning from these measures will be challenging, but leaving such detail out will create great potential for misunderstanding.

Priority Area 2 – Access to Levels of Hospice Care –has been identified as a claims-based measure. As such it appears that it will only reflect utilization of non-RHC levels of care, which is based on an individual patient's need. Given that the Medicare hospice benefit was created as a home-based benefit, non-RHC levels of care are expected to be used under very limited circumstances. Only 2-3 percent of billed days at this time are for levels of care other than RHC. While a measure of utilization of such care provides some insight into a hospice's provision of non-RHC levels of care, it does not provide any definitive insight into whether or not the hospice has the capacity to provide all levels of care. We suggest that CMS might explore the potential for including as part of this measure information related to whether or not the hospice has an inpatient unit or a contract with another facility under which inpatient respite and general inpatient care could be provided as this information would help to demonstrate a hospice's ability to provide the inpatient levels of care. Using a strictly claims-based measure in this area could encourage inappropriate use of the higher levels of care in order to secure a positive score on the measure.

8. Form, Manner, and Timing of Quality Data Submission/d. New Data Collection and Submission Mechanisms Under Consideration: Hospice Evaluation & Assessment Reporting Tool (HEART)

As we have indicated previously, NAHC generally supports a comprehensive patient assessment instrument provided that instrument is developed in conjunction with providers and end-of-life care experts and that serious consideration is given to limiting provider burden. We also urge that opportunity for comment from stakeholders and the public is made available at several points throughout the development process. NAHC urges CMS to test any tool(s) in the hospice provider community to allow for necessary revisions prior to full implementation.

It is important for any comprehensive assessment patient instrument in hospice to be comprised of a physical, psychosocial, and spiritual component. All core members of the IDG should be able to document within the tool. Any outcomes generated by the tool must be risk adjustment to reflect the patient's right to refuse or defer services, for short lengths of stay, and to account for situations where attending physicians refuse to give orders aligned with identified patient needs and patient preferences.

We were encouraged by comment in the preamble indicating that CMS intends to use additional time points beyond admission and discharge as part of this instrument; as we have commented previously, it is important to measure care throughout the entire course of care, not just at admission and discharge. We understand patient assessment instruments are utilized by other providers and may be attractive for use in hospice to allow for comparisons across provider types, but strongly recommend that CMS assess the platforms, methodologies, and measures to determine whether they are appropriate for use in the hospice setting. While hospice care shares some similarities with benefits in the post-acute sector it is a distinct service type and must be viewed as such. We note that if measures from the post-acute sector are utilized for hospice, comparing the findings of these measures across provider types would not be appropriate as the unique components of the hospice philosophy may be lost or left unconsidered.

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

Because hospices follow somewhat different processes depending on the patient's site of service, CMS should consider this in development of the instrument, as well as the level of care the patient is receiving, and possibly modify questions based on these factors. Settings include the patient's home, hospice inpatient unit, nursing home, assisted living facility, and hospital. Given that the assessment will be completed by different staff than are currently completing data extraction for the HIS Admission and Discharge records and that the assessment will be more lengthy than the current HIS, CMS must ensure that its estimates of increased costs to hospice programs accurately reflect the higher costs associated with completion of the assessment using skilled disciplines and that completion of the tool itself is not burdensome to the patient/family.

Should the instrument go so far as to prescribe standardized tools (i.e. pain scales, symptom management assessment tools, etc.) it is important that CMS preserve the integrity of the hospice philosophy by allowing hospice IDG members to individualize assessments and care based on their best

clinical judgment and this requires that they be able to use this clinical judgment to determine the best assessment tool to utilize. Again, any comprehensive patient assessment tool must be tested and revised as necessary prior to full implementation.

10. HQRP Submission Exemption and Extension Requirements for the FY2019 Payment Determination and Subsequent Years/a. Extraordinary Circumstances Exemption and Extension

As part of the proposed rule CMS proposes to extend the deadline for submitting an exemption or extension request to 90 calendar days from the qualifying event (currently 30 days) and to extend this policy to the submission of the CAHPS Hospice Survey data, as well. NAHC wholeheartedly supports this change; we commented in relation to previous proposed rules that CMS should either allow hospices to use methods other than email to submit requests for extensions/exemptions or allow more time for submission. We also strongly support extension of the ability to request an exemption/extension on quality data information to the CAHPS survey process. We assume based on information provided in the proposed rule that hospices will still be limited to submission of the request via email, but request clarification on that point.

11. CAHPS Hospice Survey Participation Requirements for the FY2020 APU and Subsequent Years/e. Risk Adjustment

As part of the rule CMS provides information related to its intent to risk adjust hospice CAHPS measures relative to certain caregiver characteristics, patient mix, and mode of survey administration. We believe that respondent characteristics vary substantially, and particularly with respect to length of time on hospice, respondent understanding of hospice care, and the respondent's level of involvement in hospice care. We have recommended informally to CMS staff that consideration be given to determining whether CAHPS question 3 – regarding how often the survey respondent took part in or oversaw care – may be an appropriate factor for inclusion as part of the CAHPS risk adjustment methodology and make that formal recommendation here, as well. If this is a factor that has been examined and rejected as not of measurable impact, information to that effect would be helpful, as well.

14. Public Display of Quality Measures and Other Hospice Data for the HQRP

CAHPS Measure Display. We regret that display of Hospice CAHPS scores will not be part of the initial launch of Hospice Compare as we believe that CAHPS scores may be among the most helpful to the public and referral sources. However, we do understand that CAHPS scores will be available as part of the Winter Compare refresh. We also note that CMS has decided, when displaying CAHPS scores, to include data from eight quarters as opposed to four, and understand that using eight quarters will ensure that data on more providers will be published as a result. We also recognize that use of eight quarters is of concern to some hospice providers as the data represented will include older data that may not be viewed as sufficiently relevant for quality monitoring purposes. At some time CMS may

want to consider whether display of two sets of scores – one representing eight quarters and another representing four quarters – could be of use in addressing concerns related to the age of the data.

STAR Ratings. As we have commented in response to previous regulatory issuances, we recognize that CMS and its quality contractors will look to the star rating methodologies of other providers as potential models when developing and implementing the star ratings. We note that some measures used to determine star ratings on the fee-for-service side utilize a "bell" curve to rank providers' quality performance. We caution that putting hospice star ratings on a bell curve as is used for some measures under home health and other provider types may be misleading to the consumer and may misrepresent the quality of care provided by a particular hospice. Most consumers familiar with star ratings do not expect that the "product" will be rated nationally according to a pre-determined distribution that guarantees some providers will rank very low regardless of how well they have performed in relation to their peers. Further, having some measures ranked according to a bell curve while other rankings are based on a traditional scoring method will create additional confusion for consumers. We also recommend that in developing the star rating system that CMS ensure that all components of the hospice interdisciplinary team are reflected, including bereavement services and volunteer programs. As mentioned previously in these comments risk adjusting for individualized care is a must, i.e. very short lengths of stay, patient right to refuse some IDG services, etc.

VI. Request for Information on Medicare Flexibilities and Efficiencies

We are appreciative of CMS' stated desire to begin a "national conversation" about improvements that can be made to the health care delivery system that reduce unnecessary burdens for clinicians, other providers, and patients and their families, with the goal of increasing quality of care, lowering costs, and making the health care system more effective, simple, and accessible. We have reviewed numerous recommendations for inclusion in our submission but have tried to limit our items to recommendations that would not require legislative changes. It is our hope that CMS' solicitation will be part of an ongoing dialogue.

Timely Filing Requirement/Penalty for Late Notice of Election: Since implementation of the timely filing requirement for hospice Notices of Election (NOE) and imposition of penalties when NOEs are filed untimely, hospices have experienced significant financial losses and considerable operational challenges. These issues are due, in large part, to systems inadequacies. We applaud CMS' ongoing efforts to develop a means by which hospices are able to submit NOEs and Notices of Termination/Revocation electronically, thereby reducing the operational challenges encountered through use of DDE. We urge CMS to continue its efforts to move forward with this change as quickly as possible to benefit hospice providers and the Medicare program, as a whole, as it will help to speed the time frame for making updates to beneficiary hospice status information in Medicare systems. We also believe it advisable for CMS to examine processing issues related to the Notice of Termination/Revocation (NOTR) to make certain that hospice discharges/revocations are processed as quickly as possible so that beneficiaries are

guaranteed access to their regular Medicare benefits as soon as possible following revocation and so as to reduce the time frame it takes for readmissions to post in CMS systems.

We understand that electronic submission of NOEs will be voluntary based on a hospice's ability and interest in utilizing the submission method currently under development. We also understand that CMS is working to modify the manner in which hospice benefit period information is represented in the Common Working File (CWF), and that these changes may help in addressing some of the challenges hospices have faced in utilizing DDE for submission of NOEs. As mentioned previously, we appreciate these efforts. However, given the challenges and financial losses that hospice providers have experienced since the timely filing requirement was put in place, we strongly urge that in conjunction with these systems changes that CMS extend an exception to the timely filing requirement in all cases where any remaining systems issues affect a hospice's ability to timely file a NOE or NOTR and would otherwise result in NOE-related penalties.

While the process for submission and acceptance of NOEs into CMS systems has likely been the single biggest contributor to delays in updates to beneficiary status, we believe that the importance of ensuring timely updates warrants a thorough review of the various systems and processes currently used by Medicare providers and suppliers to determine whether these systems or submission processes can be streamlined to speed the time it takes to post beneficiary status changes across the various systems. Any reduction in time frames will reduce the prevalence of inappropriate spending outside of hospice for patients on hospice care.

Refine Hospice Face-to-Face Requirements. Legislative language governing the hospice face-to-face provision requires that the encounter be conducted prior to the start of the applicable benefit period. During discussion of implementation of the face-to-face, stakeholders expressed concern about patients in need of immediate admission to care but for whom a physician/NP encounter could not be scheduled. In response, CMS crafted the following "exceptional circumstances" exception:

d. Timeframe exceptional circumstances for new hospice admissions in the third or later benefit period: In cases where a hospice newly admits a patient who is in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. For example, if the patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday. Or, if CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period. In such documented cases, a face to face encounter which occurs within 2 days after admission will be considered to be timely. Additionally, for such documented exceptional cases, if the patient dies within 2 days of admission without a face to face encounter, a face to face encounter can be deemed as complete.

Since that time, it has come to our attention that the "exceptional circumstances" allowance may be insufficient to address hospice needs, and may also be interpreted more strictly by CMS and the Medicare Administrative Contractors (MACs) than had originally been understood or intended. Specifically, while the exception provides two days for a hospice to complete the encounter when CMS data systems are unavailable and the hospice is unaware that the patient is entering the third benefit period, in reality it may take considerable time for the hospice to find out that the patient requires a

face-to-face, particularly in cases where a previous hospice provider has not submitted claims. In cases where the admitting hospice does not and cannot know of the need for a face-to-face within two days of admission, a hospice should technically not bill for care days since the patient is not eligible for hospice services because a face-to-face was not been completed timely, and also was not conducted within the two-day exceptional circumstances time frame. Under such circumstances, hospices have experienced significant revenue losses when they have discovered prior to billing but after care has begun that a patient required the face-to-face. Further, it is our understanding that CMS and at least one of the MACs interpret the circumstances for exceptional circumstances provided in the example in the manual language ("For example, if a patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday") as strict criteria that must be met in order to qualify for exceptional circumstances, rather than as illustrative of circumstances under which exceptional circumstances would be permitted. While hospices are required to have physician services available on a round-the-clock basis, they must prioritize use of these resources, and patient needs for medical care would take precedence over performance of the face-to-face. However, under such circumstances, the hospice may lose payment for multiple days of care because the admission did not take place on a weekend. We believe that CMS should reexamine issues related to "exceptional circumstances" and make provision for the circumstances that we have identified.

Definition of Employee for Hospice Purposes. Under existing regulation, *"Employee* means a person who: (1) Works for the hospice and for whom the hospice is required to issue a W–2 form on his or her behalf; (2) if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice; or (3) is a volunteer under the jurisdiction of the hospice." We have received a number of inquiries from hospice providers that are part of hospital systems/organizations that are interested in using system-employed nurse practitioners (NPs) under a strict memorandum of understanding outlining the conditions of assignment of the NP to the hospice to assist with fulfilling requirements related to the hospice face-to-face. CMS' informal guidance to us as to whether such an arrangement is permitted hinges on whether or not the W-2 form for the NP and for hospice employees originate from the same source. In circumstances where the hospice is part of the hospital system but the W-2 is separately issued, CMS has indicated that hospices would not be permitted to use system-employed NPs, regardless of whether the hospice is wholly owned by the system/organization. Under such circumstances, the hospice is required to employ a NP separately, which creates additional costs to the hospice and the system/organization. There are tax and personnel law implications that often prevent the hospice and the hospital/system from employing the same NP. We believe that instead of requiring that the hospice employees and NP receive their W-2 from the same source CMS should permit hospices to utilize system NPs provided that the hospice is wholly owned by the system/organization and that the hospice and the system have established specific terms that govern assignment of the NP to the hospice for specified time frames and circumstances.

Reporting of Visits/Prescription Medications on Claims. Over recent years CMS has significantly increased reporting requirements through expansion of statistics collected as part of the hospice cost reporting process and through additional data collected on hospice claims. These collection

requirements have proven to be particularly burdensome related to reporting of prescription medications while patients are on service in a contracted facility for respite or general inpatient care because the hospice must secure records from the contracted facility and (due to the lack of interoperability of electronic health records) must in many cases manually enter the information. While we recognize that these collections were designed so that CMS could secure more accurate information on hospice costs, we strongly urge CMS to give close consideration to the accuracy of the data that is being collected via claims and whether or not this data is essential for use in the foreseeable future. If there are doubts about the accuracy/usability of the data or if CMS does not anticipate its need in the near future, CMS should eliminate collection of data elements that increase provider costs but have not substantially contributed the quality of patient care.

Data Related to Payment Reform/Accuracy of Utilization Assumptions. We appreciate CMS' willingness to monitor and publish data related to hospice utilization trends, and believe the availability of this data has had a positive impact on hospice self-monitoring. However, we are concerned that CMS has not provided, as part of the FY2018 proposed payment rule, access to data that supplies insights into the degree to which assumptions used by CMS in developing the two-tiered payment system for RHC and the SIA adjustment were accurate and resulted in budget neutrality in the first year of payment reform. Additional information about spending related to RHC and the SIA would also assist in determining whether additional modifications to the new payment system, including expansion of the disciplines for which SIA payments could be made, would be helpful.

Cost Report Changes. As part of our discussion of the Initial Analysis of New Cost Report Data (above) we mention the refinements to the new hospice cost report that we are seeking that would ensure that data secured via the hospice cost report has greater accuracy and utility for making future payment policy decisions. We would underscore as part of this section the importance of moving forward with those changes at the earliest possible opportunity.

We also take this opportunity to urge that CMS modify existing requirements for provider cost report submissions to develop a means by which individuals who prepare Medicare cost reports, even if they are not directly employed by the provider, might submit those reports directly to the MACs.

Establish Time Frames for Approval of Hospice Location Changes. Certification requirements dictate that, in cases where a hospice plans to move from its surveyed, certified location to a new site or open a new location, a hospice must receive approval for the change from CMS before it is permitted to provide Medicare services from the new address. As part of the process, the hospice must:

1. Submit all required documentation and an amended Form CMS-855A to its Medicare Administrative Contractor (MAC).
2. Notify CMS and its state survey agency in writing of the planned change.
3. If under deemed status, notify its national accrediting organization (AO) in writing.
4. Receive formal approval of the change in writing.

The CMS Regional Office (RO) may grant or deny the address change without a survey, or may determine that a survey is needed to establish that the new address complies with all applicable requirements. The opening of a new office (a "multiple location") requires that the new location be surveyed. CMS is expected to advise the provider of its findings. However, CMS has not established specified time frames within which a hospice can count on receipt of a definitive determination on its request for approval of change. A hospice may have invested significant resources to effectuate a move but may receive no official communication for months relative to its request. This can create significant upheaval for an agency, its staff, and the patients and families it serves. To correct this, CMS should establish and enforce reasonable time frames within which state survey agencies, ROs, and MACs must respond to requests for approval of an address change or establishment of a new multiple location. CMS should also consider automatic approval for address changes in cases where a hospice is moving within the same geographical area and has a positive track record relative to its surveys. In cases where surveys are required to facilitate approval of the address change, CMS should establish a clear-cut process that includes access to expedited surveys and is minimally disruptive to the delivery of patient care.

Dietary Counseling. Under the Conditions of Participation, dietary counseling, when identified in the hospice plan of care, must be performed by a qualified individual, which includes dietitians as well as nurses and other individuals who are able to address and assure that the dietary needs of the patient are met. If a RN is capable of meeting the patient's needs, then the dietary counseling may be provided by the RN. If the needs of the patient exceed the expertise of the nurse, then the hospice must have available an appropriately trained and qualified individual such as a registered dietitian or nutritionist to meet the patient's dietary needs. We understand from recent communication with CMS that despite the fact that hospices may use RNs or other trained individuals to routinely provide dietary counseling, a hospice must still have an employment arrangement with a registered dietitian or nutritionist in order to demonstrate that it can meet potential patient needs. This is impractical and expensive. Some hospices report that dietitians/nutritionists who are only going to be working infrequently will not enter into an employment relationship with the hospice. We believe that unless a hospice's patient mix warrants an employment arrangement with a registered dietitian or nutritionist, or the hospice does not have other staff sufficiently trained to supply dietary counseling to the majority of the hospice's patients, this requirement places an unnecessary burden on the hospice.

Waiver for Social Work Supervision Requirement. The 2008 revisions to the Hospice Conditions of Participation (CoPs) require that a hospice social worker either have a master's degree in social work (MSW) or be supervised by an individual with a MSW unless hired prior to December 2, 2008. Many rural hospices struggle to find and retain qualified social workers, as defined in the Medicare CoPs. Specifically, the number of social workers with MSW degrees is extraordinarily limited nationwide and especially in rural areas. We recommend that CMS create a waiver program under which hospices experiencing hardship in employing a MSW-level social worker may obtain an exception to the social work supervisory requirement. Most hospices across the nation serve fewer than 100 patients per day and many of these hospices are located in rural areas where they do not have access to qualified MSW-prepared social workers. As with other professionals, in particular registered nurses, the average age of

the social worker is increasing. While the majority of social workers have an MSW degree, many states do not require this level of education in order to obtain a state social worker license. Therefore, such states tend to have an extremely limited supply of MSWs available to the hospices for contracting for supervision. The extensive distance between the rural hospice provider and its closest urban area is too great for the hospice to find an MSW-level social worker in the urban area who is willing to enter into an arrangement with the rural hospice. In fact, hospices in urban areas are reporting difficulties in hiring and retaining masters-level social workers, as well. The hospice social work supervision requirement in the CoPs exceeds the standard most state licensure laws impose. The Medicare CoPs allow waivers of the requirement that all nursing services be provided directly and waiver of the requirement that physical therapy, occupational therapy, and speech-language pathology be provided by a hospice. The reasons for these waivers are the same reason a waiver of the MSW supervision requirement should be implemented – a shortage of qualified professionals.

Medicare Care Choices Model (MCCM). We have watched with interest developments related to the MCCM and support CMS' efforts to increase participation in this important demonstration. We also urge that CMS initiate development of a demonstration model that fully represents the concept of providing curative services along with the full hospice benefit. Such a model would supply data that is needed to determine with greater accuracy the potential for coordinated, concurrent care to yield better outcomes, more accurately reflect patient choice, and reduce spending for individuals with advanced illness.

Provide Claims Processing Manual Clarification related to Use of Q5003 and Q5004 Codes. Hospices are required to report on claims the level of care provided as well as a HCPCS code that identifies the type of service location where the level of care was provided. CMS expects hospices to use HCPCS Code Q5004 (Hospice Care Provided in Skilled Nursing Facility) under only limited circumstances. However, because some states do not license or identify facilities separately when they provide both nursing care and skilled nursing care within the same entity, hospices believe they should code the location of care as Q5004 even when the patient is not receiving skilled nursing care in the facility. The HCPCS designation of Q5004 may be technically correct, and in keeping with CMS instructions, but does not accurately reflect the level of care the patient is receiving from the facility. This leads to confusion relative to comparisons provided in various data reports, but also has led to special audit focus by at least one of the HHH MACs. We believe that simple clarification on this point would eliminate misunderstanding, ensure greater accuracy in hospice claims data, and eliminate unnecessary audit burdens.

Attending Physician Issues. Since the start of October 2014, hospices have been required to include identifying information for the patient's chosen hospice attending physician on the election statement. CMS goal, which is widely support by the hospice community, is to ensure that choice of the attending physician for hospice purposes rests solely with the patient/responsible individual, rather than being the choice of the hospice or other provider of services. However, there are numerous practical and operational issues that have emerged in conjunction with the requirement, and we receive numerous inquiries from hospices seeking clarification on appropriate action that should be taken under certain

circumstances. We believe that the number and breadth of issues that have been raised by individuals in the field warrants development of additional guidance by CMS for use by hospice organizations.

Use Data Analytics to Target Proper Payment/Program Integrity Efforts. Hospice providers are subject to numerous potential audits that could originate with various audit organizations, including the MACs, RACs, MICs, CERTs, SMRCs, ZPICs, and others. While we support CMS' efforts to ensure that inappropriate payments are not expended from Medicare or Medicaid, we believe that use of sophisticated data analytics to identify providers with the highest potential for abuse would be more effective than some current methods for selecting providers for audit that cast a much broader net, and encourage CMS to pursue program integrity efforts through this means. We also recommend this targeting of reviews in lieu of imposing costly across-the-board policy changes and audits on compliant hospice programs.

Enhance Education Related to Hospice Technical Documentation Requirements. We understand that failure to demonstrate eligibility for hospice services is a key reason for denial of hospice coverage. However, we also know that in many cases hospice coverage is denied because a provider has failed to meet a technical requirement that is unrelated to a patient's eligibility or need for services. While providers, as part of their agreement with Medicare, must ensure that both eligibility and technical requirements are met, we believe that the prevalence of certain technical errors that are detected during medical review may indicate that educational efforts by CMS, the MACs, and provider associations may be insufficient or ineffective. We believe that such errors in the Medicare program could be significantly reduced through efforts that communicate the most frequent types of technical errors that are found and provide education to providers on how to best ensure compliance with such commonly missed technical requirements.

We appreciate the opportunity to comment on the proposed rule, CMS' insights, and proposed changes for the Medicare hospice program. Please feel free to contact us if we can be of assistance in any way.

Sincerely,

Theresa M. Forster
Vice President for Hospice Policy & Programs