June 18, 2019

Seema Verma, MPH

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1718-P

P.O. Box 8016

Baltimore, MD 21244-8016

RE: Comments on Proposed Rule, Medicare Program; FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements; CMS-1714-P

Dear Ms. Verma:

LeadingAge appreciates the opportunity to provide feedback regarding the Fiscal Year (FY) 2020 Hospice Wage Index and Payment Rate Update proposed rule. We offer these comments in the spirit of collaboration and look forward to working with the Centers for Medicare & Medicaid Services (CMS) as it strives to improve payment accuracy for hospice providers as well as consider the future inclusion of hospice into Medicare Advantage (MA) and other alternative payment models.

The mission of LeadingAge is to be the trusted voice for aging. Our over 6,000 members and partners include nonprofit organizations representing the entire field of aging services, 38 state associations, hundreds of businesses, consumer groups, foundations and research centers. LeadingAge is also a part of the Global Ageing Network, whose membership spans 30 countries. LeadingAge is a 501(c)(3) tax-exempt charitable organization focused on education, advocacy and applied research.

Our comments cover several sections of the proposed rule. For ease of interpretation, we have provided the name of the heading or sub-heading most closely related to the specific element on which we wish to comment.

**A. Proposed Rebasing of the Continuous Home Care, Inpatient Respite Care and General Inpatient Care Payment Rates for FY 2020 *– Disproportionate impact on nonprofits and others who rely on contracts for some levels of care; concerns about the underlying assumptions regarding use of all levels of care.***

LeadingAge supports efforts to have payment rates accurately reflect the costs of providing the traditional, robust hospice model. Hospice was the first capitated, interdisciplinary team-based model with psychosocial support for both the patient and family to be integrated into the Medicare program and as such a bellwether of current trends in health care and social services. Hospices must provide all care related to the patient’s terminal condition, including nursing services, case management, medications and medical equipment (DME). This includes having access to each of the four categories of hospice care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIP).

Every hospice patient will not need all four levels of care. However, a hospice providing all four levels is an indicator of quality and hospices must be prepared in terms of staffing, contracts and other resources, to offer each level according to a patient’s needs. In a 2014 report, Abt Associates[[1]](#footnote-1) noted that roughly a quarter of hospices nationwide provided no GIP during the study period, and more than half of hospices provided no CHC care during the same period. Hospices more likely to provide GIP care were older (in operation for 20 or more years), larger, and located in the Northeast.[[2]](#footnote-2) A subsequent OIG report found that hospices that did not provide GIP were more likely to be for-profit. These findings suggest that community-integrated, nonprofit hospices are more likely to meet patient needs with multiple levels of care. We have heard from our members that they lose money on the higher levels of care and often must fundraise and rely on foundations to cover the costs. Given the effort that CMS has applied to rebasing the rates for CHC, IRC, and GIP to make them a more accurate representation of the costs to offer the robust hospice benefit, LeadingAge supports that policy direction.

However, we believe CMS ought to study the redistributive effect of the rebasing proposal. Many hospices do not have their own inpatient facilities and must rely on contracts with other institutions to fulfill the requirements for GIP and IRC. For those providers, the increased rates for the higher levels of care will increase their pass-through payments to their contractual partners and not necessarily benefit the hospice organization. While, some hospices see an opportunity to be in a better position to offer all four levels of care within their own organization due to the rebasing, many are concerned that the shift will not positively impact them. For those organizations who rely on contractual arrangements to fulfill the inpatient care, the budget neutrality component that lowers the RHC rates effectively turns the rebasing proposal into a rate cut even after the proposed 2.7% payment update. LeadingAge is concerned that some hospice providers will see reduced rates because of this proposal, particularly given the slim Medicare margins that MedPAC reports for nonprofit hospice providers (2014: -0.9%, 2015: 0.1%, 2016: 2.7%).[[3]](#footnote-3)

In addition to the proposal to rebase CHC, IRC, and GIP, we have concerns regarding the underlying assumptions for the low utilization of those three levels of care. It seems that CMS assumes that the inaccurate reimbursement rates are the prime factor for the low utilization of those three levels of care. Citing individual past commenters responses to proposed rules relating to contracting challenges the ability to offer all four levels of care seems to be anecdotal evidence at best. We recommend that CMS provide evidence on the difference in levels of service utilization by hospices who own and operate free standing facilities to determine level of care variation and the underlying reason.

**C. Proposed Election Statement Content Modifications and Proposed Addendum to Provide Greater Coverage Transparency and Safeguard Patient Rights *– Timelines related to the addendum are unrealistic; burden underestimated***

LeadingAge agrees with CMS that it is critical issue that beneficiaries and their families understand what is included and excluded when they elect the hospice benefit. Our hospice members take seriously the virtually all-inclusive nature of the benefit for the terminal diagnosis as well as other related health conditions. Due to the importance of waiving one’s rights to Medicare payment for services related to the treatment of the terminal and related conditions, individuals and their families need to be informed about what the hospice provider and Medicare will and will not cover. The process of informing patients that there might be charges for “unrelated” items and services at the time of election is valuable. We support the additions proposed to the hospice election statement as described in the rule.

However, we have concerns and questions about the proposal for the addendum. To begin, the timeline for the addendum with the list and rationale for the conditions, items, services, and drugs determined as unrelated to the terminal illness and related conditions cannot be completed at the time of election. The entire interdisciplinary group must review the plan of care after the original and complete assessment is available. As noted in the proposed rule, the conditions of participation grant the hospice registered nurse 48 hours to finish the initial assessment. It is not possible to generate the list and rationale for the conditions, items, services, and drugs that the hospice has determined as unrelated prior to completion of the assessment and development of the plan of care.

For requirements of sharing the addendum with the beneficiary (or representative), other nonhospice providers that are treating the beneficiary, and Medicare contractors who request the information, we believe that immediately is an unrealistic timeframe. The proposed rule indicates this needs to be shared in writing. We ask CMS for clarification about the intent to have paper versions of the addendum shared or if HIPAA-compliant electronic sharing of the addendum is permissible. With the request for comments on an appropriate timeframe, 48 hours seems like a reasonable expectation given that in most cases generation of the initial and updated addendums will take place not in the beneficiary’s home or inpatient setting but at the hospice offices.

Additionally, we ask for CMS to clarify signature requirements in the final rule. In the proposal, it states that “Name and signature of Medicare hospice beneficiary (or representative) and date signed, along with a statement that signing this addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates)”. Is an original signed version of the addendum in the hospice records the intended condition for payment? Does the timeline relate to the generation of the addendum (or update) or include obtaining a beneficiary (or representative) signature?

The burden associated with the addendum proposal is not an accurate representation of the time and resources to complete and maintain the addendum. While recognizing the requirement to review, determine, and document information on unrelated conditions per the hospice regulations the one-time 30 minute estimate to create a template for the addendum, and 10 minutes of nursing time to “extrapolate this information from the existing documentation in the patient’s hospice medical record and complete this addendum” is insufficient. The 10 minutes for the hospice nurse per patient are only reasonable for patients without items on the “unrelated” list. In cases where a review with the patient and family is required more time is necessary for both the time to generate the list and have the conversation with the patient and family. Additionally, we suggest that this should not be optional based on patient request as described in the proposal. Providing the detailed list of “unrelated” items to the patient is critical to the care process, patient empowerment, quality of care and transparency. Regulation would be improved by making this step a standard part of the process and incorporating appropriate reimbursement for the added time.

Another burden concern is that the addendum will possibly need to be revisited multiple times during a beneficiary’s length of service. Decision making to update the information contained in the addendum often involves the interdisciplinary group, not only data extrapolation on the part of the hospice nurse. There will be administrative burden both as it relates to additional staff time as well as generation of the updated addendum, reviewing it with the beneficiary (or representative), and obtaining signatures. LeadingAge members also note that updates will need to be included by hospice EMR vendors to update records with the new election statement and addendum which has financial and administrative burden components. The operational process for this component of the proposal is not as straightforward as the rule portrays it.

**E. 2. a. Claims-Based and Outcome Quality Measure Development for Future Years – *Support claims-based measures with a transparent connection to outcomes***

LeadingAge is supportive of continued work to develop claims-based and outcome quality measures and appreciates CMS’s recognition of both the shortcomings and benefits of claims-based measures. Additionally, community-integrated, nonprofit hospices welcome new measures provided they align with patient and family goals. In particular, noting the two measures that have been worked on but not endorsed, potentially avoidable transitions and access to all levels of care, have merit but we agree that they need additional specification work. Noting the belief that quality measures should have a transparent connection to outcomes, concerns around claims-based measures have been expressed as more visits do not inherently equate to better outcomes specifically noting the lack of volunteer hours and chaplaincy time on hospice claims.

**D. Request for Information Regarding the Role of Hospice and Coordination of Care at End-of-Life – *Payment models should be designed and evaluated to ensure access to community-integrated hospice services***

To begin, we believe that any alternative payment approaches for hospice should be designed in thoughtful ways and ensure beneficiary and family access to the critical services offered by nonprofit, community-integrated hospice providers. Given experience from other service providers, our members have concern that if hospice migrates out of Medicare fee-for-service into other arrangements that payment will not occur in a timely manner which could directly impact cashflow. Additionally, most alternative payment models have had an explicit focus on reducing lengths of stay and costs per beneficiary. This approach does not inherently align with quality end-of-life care by hospice providers. With over 25% of hospice lengths of service being seven days or less, shorter duration of hospice service and lower costs might not be the quality and payment metrics that should be targets as they often are in other medical settings. We recommend that if alternative arrangements are going to be examined, they ought to be tested and evaluated prior to large scale changes being introduced directly.

LeadingAge is pleased to continue the conversation around hospice services and how federal payment and regulations effect nonprofit providers. Please do not hesitate to contact us (Aaron Tripp, [atripp@leadingage.org](mailto:atripp@leadingage.org)) if you have any questions or would like further discussion. We look forward to our continued work with you on this and related issues.

Sincerely,

Aaron M. Tripp, MSW

Vice President, Reimbursement and Financing Policy

1. Abt Associates. Medicare Hospice Payment Reform: Analyses to Support Payment Reform. (May 2014). https://[www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/May-2014-AnalysesToSupportPaymentReform.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/May-2014-AnalysesToSupportPaymentReform.pdf). [↑](#footnote-ref-1)
2. Department of Health and Human Services, Office of Inspector General. Memorandum Report: Medicare Hospice: Use of General lnpatient Care. OEI-02-1 0-00490. (May 2013). <https://oig.hhs.gov/oei/reports/oei-02-10-00490.pdf> [↑](#footnote-ref-2)
3. MedPAC. (March 2019). Report to the Congress: Medicare Payment Policy. Chapter 12: Hospice Services. <http://www.medpac.gov/docs/default-source/reports/mar19_medpac_ch12_sec.pdf?sfvrsn=0> [↑](#footnote-ref-3)