June 29, 2015

U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1629-P
Post Office Box 8010
Baltimore, MD 21244-8010

Re: File Code CMS-1629-P, Medicare Program; FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

To Whom It May Concern:

The Home Care Association of New York State (HCA), Inc is a statewide not-for-profit organization representing nearly 400 health care providers, allied organizations and individuals committed to the advancement of quality home care and hospice services in New York State.

On behalf of our hospice provider members that serve many of the approximately 42,000 Medicare hospice beneficiaries annually in New York, we appreciate the opportunity to provide comments on the U.S. Centers for Medicare and Medicaid Services (CMS) Medicare Program Fiscal Year (FY) 2016 Hospice Wage Index, Payment Rate Update and Hospice Quality Reporting Requirements proposed rule.

General Overview of CMS’s Data Analysis

CMS’s FY 2016 proposed rule includes a significant amount of data and analyses related to its research on hospice care patterns and spending outside of hospice for hospice-enrolled beneficiaries. HCA believes that the data CMS has provided as part of the FY2016 proposed rule raises concerns about the incidence of unbundling of elements of care that are appropriately part of the hospice benefit. We urge CMS to continue its efforts to review patterns of practice that raise concerns about the potential for unbundling of the benefit.

However, HCA believes a considerable portion of inappropriate billing outside the hospice benefit are due to antiquated CMS systems that do not provide timely access to patient status relative to hospice election. HCA encourages CMS to necessary action to update its systems to allow more timely access to patient status information and allow for better coordination of patient care.

HCA also recommends additional efforts by CMS to educate providers outside of hospice on the interaction of the hospice benefit with other Medicare coverage. We believe that CMS should examine and address potential conflicts or inconsistencies between hospice requirements and policies related to coverage/billing outside of the hospice benefit.
HCA believes CMS should use caution against making any blanket determination that all care provided to hospice patients is the responsibility of the hospice. This is a determination that must be made on a case-by-case basis by individuals trained in end of life care. Any efforts to place the responsibility for all care with the hospice regardless of whether it is related or unrelated to the diagnoses that make up the hospice prognosis is in conflict with existing law that preserves a beneficiary’s right to care outside of hospice for non-related conditions.

Lastly, HCA would like to inquire why CMS has not released the 2015 technical report that was supposed to be developed to accompany the proposed hospice payment changes. Without the technical report, the proposed rule does not provide all of the data to permit a thorough analysis of calculations related to the payment changes. HCA requests that CMS release its technical report at the earliest possible opportunity to permit hospice stakeholders a better understanding of CMS’ calculations and policy decisions, as well as the impact of alternatives that CMS considered.

With regards to the rest of CMS’s FY 2016 proposed rule, we have decided to provide some brief background and then offer our comments, requests and/or occasional recommendations to the following areas in the proposed rule:
- Revisions to the Routine Home Care Rate;
- Proposed Service Intensity Add-On Payment;
- Proposed FY 2016 Hospice Wage Index and Implementation of a New Labor Market Delineation;
- Proposed Inpatient and Aggregate Cap Accounting Year Timeframe;
- Hospice Quality Reporting Program (HQRP) Data Submission and Compliance Thresholds;
- HQRP Quality Measures and Concepts under Consideration for Future Years;
- Proposed Policy for New Hospices to Begin Submitting Quality Data;
- Adoption of the CAHPS Hospice Survey for the FY 2017 Payment Determination; and,
- Reporting of Diagnoses on Hospice Claims.

**Revisions to the Routine Home Care Rate**

CMS is proposing that hospices be reimbursed at a two-tiered rate for routine home care (RHC) level of care, depending on the length of stay for a hospice patient. Under the proposed rule, hospices would receive a higher base payment rate for the first 60 days of care and a lower payment rate for days 61 and beyond of hospice care. These two proposed rates for RHC are based on an extensive body of research concerning resource consumption and visit intensity during a hospice episode, and are likely the first step in addressing CMS’s mandate to implement hospice payment reform.

CMS states the proposal for a two-tiered payment model attempts to better align RHC payment rates with resources used, and is not intended to place an arbitrary limit on hospice services. The proposed base rates for RHC include the following:
- 1-60 Days: $188.20
- 61+ Days: $147.34
To implement the two-tiered RHC rate payment model, CMS has proposed to implement a “count of days”, which will follow the patient to mitigate potential misuse of the payment model resulting from high rates of live discharges and subsequent readmissions to the hospice program. CMS proposes that the hospice day count would follow the patient for an episode of care. Under the proposed rule, hospices would be paid at the higher rate for the first 60 days of hospice care, then the lower rate until discharge. If a hospice patient is discharged after the 60th day and is then re-admitted within 60 days of discharge, the lower rate would continue to apply. If a hospice patient has a gap in service between discharge and a subsequent readmission to hospice of more than 60 days, the episode would be reset and the hospice would again receive the higher rate.

Comments: HCA supports CMS’s approach to defining an episode of hospice care, and recognizes the need to include a hospice care gap that would signal the start of a new episode of care. While HCA appreciates CMS’s efforts to better align RHC payment rates with resources used and understand the rationale for a two-tiered payment model, we have concerns about the adequacy of reimbursement for long length of stay patients who truly maintain eligibility for hospice services. We also believe this new episode gap could have a negative impact on hospices that accept patients onto care as transfers.

HCA requests that CMS conduct ongoing analysis of the adequacy of the payment changes with particular attention to the overall impact on those hospices that provide care predominantly to patients with short lengths of stay as well as the adequacy of reimbursement for longer stay patients.

Lastly, we ask that CMS recognize that from an operational perspective the implementation of the two-tiered payment model will have an impact on operations, especially with discharge/admission procedures, verification of days, and determining the impact on reimbursement for long length of stay patients. Hospice providers will need sufficient time to implement these changes if they are part of CMS’s final rule later this year.

Service Intensity Add-On Payment

In its proposed rule CMS is proposing to implement a Service Intensity Add-On (SIA) payment as one of the first steps in addressing the observed misalignment between resource use and associated Medicare payments and in improving patient care through the promotion of skilled visits at end of life with minimal claims processing systems changes.

To qualify for the SIA payment, CMS proposes that the following criteria must be met:

- The day is billed as a RHC level of care day;
- The day occurs during the last 7 days of life (and the beneficiary is discharged dead);
- Direct patient care is provided by a RN or a social worker that day; and
- The service is not provided in a skilled nursing facility/nursing facility (SNF/NF).

The proposed SIA payment would be equal to the continuous home care (CHC) hourly payment rate (the current FY 2015 CHC rate is $38.75 per hour), multiplied by the amount of direct patient care provided by a RN or social worker for up to 4 hours total, per day, as long as the four criteria listed above are met. The proposed SIA payment would be paid in addition to the current per diem rate for the RHC level of care.
CMS has proposed the creation of separate G-codes for skilled nursing visits to differentiate between RN and licensed practical nurse (LPN) visits to be able to make this adjustment. CMS also notes that social workers also often play a crucial role in providing support for the patient and family when a patient is at end of life. While CMS states that the nature of the role of the social worker does facilitate interaction via the telephone, CMS proposes to only pay an SIA for those social work services provided by means of in-person visits.

**Comments:** HCA appreciates CMS’s recognition of increased service use intensity in the final days of life as demonstrated by the proposed SIA; however, HCA is very concerned that CMS’s proposal excludes the SIA for patients who reside in a SNF or Long Term Care Facility. We believe hospice patients would have the same need for increased support and symptom management in the last days of life regardless of where they reside.

HCA also has concerns about excluding all other disciplines such as LPNs, hospice aides or spiritual counselors since it seems to conflict with the concept that the SIA is intended to mitigate the higher costs incurred by providers for hospice patients who require more intensive services at the end of life. Additionally, we have concerns that hospices in rural areas and in areas with health professional shortages may not have sufficient RNs available to allow them to be reimbursed for the SIA. For these reasons, HCA believes visits by LPNs should be included as reimbursable as an SIA service.

Lastly, HCA has some trepidation with the technical implementation issues associated with the Medicare Administrative Contractor (MAC) processing of these new claims, as well as the timeliness and accuracy of CMS’s Common Working File (CWF). This concern is based on the experience providers have had regarding the implementation of the Notice of Election requirements and the ongoing transition from Individuals Authorized Access to CMS Computer Services (IACS) to Enterprise Identity Management (EIDM), which provides access to the Provider Statistical and Reimbursement system (PS & R). The requirement for sequential billing will also potentially lead to frequent billing and payment adjustments, as a patient’s last seven days of life could overlap two billing periods.

**Wage Index**

CMS is proposing significant changes to the FY 2016 Hospice wage index that includes a one-year transition period beginning October 1, 2015. Specifically, CMS is proposing to apply a wage index adjustment for all geographic areas in FY 2016 that would consist of a 50/50 blend of the wage index values using the Office of Management & Budget’s (OMB’s) current labor area delineation as well as OMB’s new geographic area designations, using the new Core Based Statistical Areas (CBSA).

The reason for the blend is supposedly to provide a smoother transition to the new CBSAs that were approved in 2013 by the OMB. The new wage area designations have already been incorporated into the Calendar Year 2015 home health prospective payment system (PPS) final rule as well as the FY 2015 SNF PPS final rule.

HCA has numerous concerns with CMS’s decision to add new CBSA designation to the Hospice wage index calculation since this same wage index 50/50 blended of new CBSAs has already been
done twice in home health (2008 & 2015) and has had serious negative financial ramifications for New York home health agencies (HHAs) HHAs.

Specifically, we are concerned that hospice providers in the New York City (NYC) Metropolitan area will experience the same kind of negative reimbursement adjustments as HHAs have faced in the NYC areas since CMS moved away from using the Metropolitan Statistical Area (MSA) designation where all of the counties in the NYC designation were from New York State, to the new CBSA designation that include six New Jersey counties (Bergen, Hudson, Passaic, Middlesex, Monmouth and Ocean).

As the provision of hospice and home health care is a local endeavor, CMS's and OMB's decision to view the current CBSA area designation in the “aggregate” for a large geographic region like NYC fails to represent the actual impact of the change. CMS's shift to the CBSA wage index designation has resulted in below trend reimbursement for NYC HHAs since 2007.

HCA has also raised concerns with CMS's decision to maintain the current policy of using the pre-floor, pre-reclassified hospital wage index to adjust hospice and home health services payment rates because this causes continuing volatility of the home health wage index from one year to the next.

In addition, HCA has consistently voiced its concern regarding the lack of parity between different health care sectors, each of which utilizes some form of a hospital wage index yet experiences distinct index values in its specific geographic area. CMS's decision to continue to use the CBSA-based labor market definition serves to exacerbate that instability.

**Comments:** HCA requests that CMS explore wholesale revision and reform of the hospice wage index. This reform should consider the following:

- The impact on care access and financial stability of hospices at the local level;

- The unpredictable year-to-year swings in wage index values that are often based on inaccurate or incomplete hospital cost reports that have negatively impacted New York hospices and HHAs throughout the years and jeopardize access to care;

- The inadequacy of the pre-floor, pre-reclassified hospital wage index for adjusting home health costs; and

- The labor market distortions created by reclassification of hospitals in areas in which hospice and home health labor costs are not reclassified.

Specifically, HCA recommends that CMS should conduct further studies to determine a wage index approach that can be most equitably applied to all Medicare providers. The goal should be to put all providers on a level playing field with their respective wage indexes. If the revised wage index allows for geographic reclassifications for one provider group, it should provide the same allowance for all. Any wage index weight changes in a reformed model should be subject to a transition limitation on increases and decreases from one year to the next.
Inpatient and Aggregate Cap Accounting Year Timeframe

CMS states in the proposed rule that when the Medicare hospice benefit was implemented, Congress included two limits on payments to hospices: an aggregate cap and an inpatient cap. The intent of the hospice aggregate cap was to protect Medicare from spending more for hospice care than it would for conventional care at the end-of-life. If a hospice's total Medicare payments for the cap year exceed such hospice’s aggregate cap amount, then the hospice must repay the excess back to Medicare.

The intent of the inpatient cap was to ensure that hospice remained a home-based benefit. If a hospice’s inpatient days (GIP and respite) exceed 20 percent of all hospice days then, for inpatient care, the hospice is paid: (1) the sum of the total reimbursement for inpatient care multiplied by the ratio of the maximum number of allowable inpatient days to actual number of all inpatient days; and (2) the sum of the actual number of inpatient days in excess of the limitation by the routine home care rate.

However, both the aggregate and inpatient cap accounting year is currently November 1 to October 31. In the past, CMS has considered changing the cap accounting year to coincide with the hospice rate update year, which is the federal fiscal year (FFY) of October 1 through September 30.

Since CMS’s FY 2016 proposed rule represents the first phase of its hospice payment reform, CMS is now proposing to align the cap accounting year for both the inpatient cap and the hospice aggregate cap with the FFY for FYs 2017 and later. Under this proposal, in addition to aligning the cap accounting year with the federal fiscal year, CMS would also align the timeframe for counting the number of beneficiaries with the FFY. This proposal would eliminate timeframe complexities associated with counting payments and beneficiaries differently from the FFY and would help hospices avoid mistakes in calculating their aggregate cap determinations.

Comments: HCA supports CMS’s proposal to align the cap accounting year for both the inpatient cap and the hospice aggregate cap to coincide with the FY 2017 and later hospice rate update of October 1 through September 30. HCA also supports CMS’s proposal to align the timeframe for counting the number of beneficiaries with the FFY. We encourage CMS to direct the MACs to provide timely notice of forthcoming changes so that hospices can adequately track their cap status as well as to minimize confusion when hospice providers calculate and self-report their aggregate cap.

Hospice Quality Reporting Proposals

Data Submission and Compliance Thresholds

Beginning with the FY 2018 payment determination and subsequent FY payment determinations, CMS is proposing that all Hospice Item Set (HIS) records be submitted within 30 days of the event date, which is the patient’s admission date or discharge date.

To coincide with this requirement, CMS is seeking to align hospice providers with other healthcare setting requirements, such as home health (OASIS) and skilled nursing facilities (MDS), by proposing the implementation of compliance goals for timely HIS submission of admissions and
discharges. Specifically, CMS is proposing to establish an incremental threshold for compliance with this timeliness requirement; the proposed threshold would be implemented over a 3 year period.

To be compliant with timeliness requirements, CMS is proposing that hospices would have to submit no less than 70 percent of their total number of HIS-Admission and HIS-Discharge records by no later than 30 days from the event date for the FY 2018 Annual Payment Update (APU) determination. The timeliness threshold would be set at 80 percent for FY 2019 and at 90 percent for FY 2020 and subsequent years. The threshold corresponds with the overall amount of HIS records received from each provider that falls within the established 30 day submission timeframes. CMS’s ultimate goal is to require all hospices to achieve a timeliness requirement compliance rate of 90 percent or more.

CMS Hospices failing to meet these compliance goals will have their reimbursement negatively impacted. Specifically, they will be subject to a 2% reduction in the market basket rate beginning with the 2018 APU.

In the event that a hospice requests an extension/exception for quality reporting purposes, the hospice would submit a written request to CMS. CMS states, that in general, exceptions and extensions will not be granted for hospice vendor issues, fatal error messages preventing record submission, or staff error.

In the event that a hospice seeks to request an exception or extension for quality reporting purposes, the hospice must request an exception or extension within 30 days of the date that the extraordinary circumstances occurred by submitting the request to CMS via email to the HQRP mailbox at HQRPReconsiderations@cms.hhs.gov

**Comments:** HCA appreciates CMS proposing this incremental threshold. We have heard from colleagues that most hospices would not anticipate this being a problem for them.

However, HCA is concerned about instances in which hospices may not be able to email CMS within 30 days (i.e. Hurricane Sandy or other disasters here in the New York). HCA recommends that CMS extend the number of days hospices have to email CMS to 90, in light of these extenuating circumstances that seem to be happening more and more.

**HQRP Quality Measures and Concepts under Consideration for Future Years**

CMS indicates there will no changes to the Hospice Reporting Quality Measures (HRQM) for the FY 2017 reporting cycle; however, CMS is reserving the right to add or delete measures if needed.

Beginning with FY 2018, CMS is proposing that once a quality measure is adopted, it will be retained for use in the subsequent FY payment unless otherwise stated by CMS. CMS has proposed criteria for adding or modifying reporting measures. Based on input from stakeholders, CMS has identified four high priority concept areas for future measure development, and is requesting input from hospices regarding the following four measures:
• Patient-reported pain outcome measure that incorporates patient and/or proxy report regarding pain management;

• Claims-based measures focused on care practice patterns, including skilled visits in the last days of life, burdensome transitions of care for patients in and out of the hospice benefit, and rates of live discharges from hospice;

• Responsiveness of hospice to patient and family care needs; and

• Hospice team communication and care coordination.

Comments: HCA recognizes CMS’s concerns that prompted the focus on these areas as priority areas for future measures.

Relative to CMS’ interest in considering claims-based measures focused on care practice patterns, HCA would like to remind CMS that any claims-based measure utilized in the HQR P should be properly examined to ensure that the measures are directly related to quality of hospice care. Otherwise, the public may derive limited benefit from these measures and could interpret their meaning relative to a particular hospice incorrectly.

HCA reminds CMS that any measures that are part of the HQR P must be: “... endorsed by the consensus-based entity, which holds a contract regarding performance measurement with the Secretary under section 1890(a) of the Act” or, in cases of measures not endorsed by the entity, the Secretary must ensure that due consideration has been given to endorsed measures. Use of claims-based measures that have not been endorsed must meet CMS’ paramount concern that “...successful development of a HQR P that promotes the delivery of high quality healthcare services.”

In considering potential claims-based measures referenced in the proposed rule, we are concerned that as currently proposed they do not meet the above requirements and, in fact, may fall within some of the proposed reasons for elimination from the HQR P, specifically:

• Performance or improvement on a measure does not result in better patient outcomes; or
• Collection or public reporting of a measure leads to negative unintended consequences.

As previously stated, HCA understands CMS’ and others’ interest in claims-based measures but believes they are more appropriately viewed as practice indicators as opposed to quality indicators. A claims-based measure should not be used in the HQR P unless its direct relationship to hospice quality has been proven.

Policy for New Facilities to Begin Submitting Quality Data

Starting with the FY 2018 payment determination and for each subsequent payment determination, CMS proposes that a new hospice be responsible for HQR P quality data reporting beginning on the date it receives its Certification Number (CCN) (also known as the Medicare Provider Number) notification letter from CMS. Under this proposal, hospices would be responsible for reporting quality data on patient admissions beginning on the date they receive their CCN notification.
Comments: HCA supports this proposal and believes this change will be helpful to new hospice providers as generally they do not receive their CCN (Medicare Provider Number) until sometime after they have been formally certified.


Hospice providers have been implementing the requirements for CAHPS Hospice Survey data collection and reporting since January 2015. CMS announced in the proposed rule that CAHPS Hospice Survey data will be publicly reported when at least 12 months of data are available. Currently, there is no date set for implementation of what will likely be referred to as Hospice Compare.

CMS proposes to continue a requirement that vendors and hospice providers participate in CAHPS Hospice Survey oversight activities to ensure compliance with Hospice CAHPS technical specifications and survey requirements. CMS continues efforts to align processes for Hospice Quality Reporting Requirements, proposing that the reconsiderations and appeals process for hospices failing to meet Hospice CAHPS data collection requirements will be part of the process already developed for the HQRP.

CMS proposes options for dissemination regarding the availability of hospice compliance reports in CASPER files using routine communication methods. Of note, CMS proposes to publish a list of hospices who successfully meet the reporting requirements for the applicable payment determination on the HQRP Web site http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting.html. This list will be updated annually after reconsideration requests are processed. Due to upcoming public reporting of these findings, it is imperative that hospices ensure that their staff understand the questions for both the HIS and the Hospice CAHPS Survey and the impact their actions may have on the patient/family experience of care, hospice outcomes, and hospice reimbursement.

To comply with CMS’s quality reporting requirements for the FY 2018 APU, hospices will be required to collect data using the CAHPS Hospice Survey. Hospices would be able to comply by utilizing only CMS-approved third party vendors that are in compliance with the provisions at §418.312(e). Ongoing monthly participation in the survey is required January 1, 2016 through December 31, 2016 for compliance with the FY 2018 APU.

CMS proposes to continue to exempt very small hospices from CAHPS Hospice Survey requirements so that hospices that have fewer than 50 survey-eligible decedents/caregivers in the period from January 1, 2015 through December 31, 2015 are exempt from CAHPS Hospice Survey data collection and reporting requirements for the 2018 APU. To qualify for the survey exemption for the FY 2018 APU, hospices must submit an exemption request form. This form is available on the CAHPS Hospice Survey Web site http://www.hospicecahpssurvey.org. Hospices are required to submit to CMS their total unique patient count for the period of January 1, 2015 through December 31, 2015. The due date for submitting the exemption request form for the FY 2018 APU is August 10, 2016.
**Comments:** While HCA supports the proposal related to the Hospice CAHPS Survey oversight activities, we believe this mandate places yet another unfunded burden on hospices and we request that CMS consider including an administrative reimbursement mechanism in its final rule to help cover these costs.

**Reporting of Diagnoses on Hospice Claims**

In the proposed rule, CMS clarifies that hospices should report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual.

**Comments** – HCA is very concerned that it appears CMS wants hospices to comply with this clarification immediately. We urge CMS to not hold hospices accountable for including all diagnoses on hospice claims unless such clarification is made part of the final rule with a future effective date.

We are also concerned with CMS’s reference in the proposed rule that hospices may not be conducting thorough assessments of hospice patients because all of a patient’s diagnoses are not listed in the patient’s medical record. HCA reminds CMS that there are instances where hospices are not aware of all of a patient’s previous diagnoses because the hospice has not received all of the patient’s medical history. A hospice is limited to the medical history shared by the patient/family and information from other providers to which it has access.

In addition, diagnoses are sometimes historical and don’t impact the patient’s plan of care. Those diagnoses not impacting the plan of care would not be included in the plan of care and, therefore, may not be included on the claim. Requiring hospices to ensure inclusion of non-pertinent diagnoses in the medical record and on the claim is not beneficial to the patient and only distracts the hospice interdisciplinary group from providing the care that is necessary for the relevant diagnoses.

**Conclusion**

HCA thanks CMS for this opportunity to submit comments and respectfully requests CMS’s consideration of our concerns and recommendations.

I would be pleased to answer any questions or assist CMS staff in any way going forward and can be contacted at pconole@hcany.org or (518) 810-0661.

Sincerely,

Patrick Conole, MHA
Vice President, Finance & Management
Home Care Association of New York State, Inc.