June 20, 2016

U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1652-P
Post Office Box 8010
Baltimore, MD 21244-8010

Re: File Code CMS-1652-P, Medicare Program; FY 2017 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 Inc. (HCA) 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) 2017 Hospice Wage Index, Payment Rate Update and Hospice Quality Reporting Requirements proposed rule.

General Overview of CMS's FY 2017 Proposed Rule

CMS’s FY 2017 proposed rule updates the Medicare payment rates, wage index and cap amount for hospices serving Medicare beneficiaries in FY 2017.

In addition, the rule proposes to changes the hospice quality reporting program, including proposing two new quality measures. The proposed rule solicits feedback on an enhanced data collection instrument and describes plans to publicly display quality measures and other hospice data beginning in the middle of 2017. The rule updates hospice monitoring data analysis and provides discussion about ongoing monitoring efforts.

The proposed rule also addresses the costs of pharmaceuticals that CMS believes should be part of the hospice payment that are billed outside of the hospice benefit to Medicare Part D. Finally, the rule proposes a five-year Medicare Care Choices Model (MCCM) for Medicare beneficiaries with certain advanced diseases who meet the model’s other eligibility criteria to receive hospice-like support services from MCCM participating hospices while receiving care from other Medicare providers for their terminal illness.
We offer our comments, requests and/or recommendations on the following areas of CMS’s proposed rule:

- Update to Routine Home Care Rates;
- Service Intensity Add-On Payment Update;
- Proposed FY 2017 Hospice Wage Index;
- Hospice Quality Reporting Program (HQR): Two New Measures and Data Submission and Compliance Thresholds;
- Double Billing of Part D Medication Costs;
- Live Discharge Rates;
- New MCCM Model;
- CAHPS Hospice Survey for the FY 2017 Payment Determination; and
- Use of Health Information Technology (HIT) and the need for Funding;

**Update to Routine Home Care Rates**

1. New York hospices have a low median length of stay (LOS) of 17 days. The updated two tier payment for routine home care (RHC) first implemented as part of last year’s final rule is a very rational approach and more reflective of actual hospice costs. HCA supports CMS decision for developing this very appropriate revision to the reimbursement model.

2. While HCA appreciates CMS’s efforts to better align RHC payment rates with resources used and understands the rationale for a two-tiered payment model, we have concerns about the adequacy of reimbursement for long length of stay patients who 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.

3. CMS should consider adjustments if a patient is transferred from one hospice to another, particularly at or close to the 61 day count. There are adjustments for hospital transfers to assure that one party does not accrue disproportionate benefit from reimbursement and a similar system should be developed for RHC.

4. HCA encourages CMS to monitor the impact of this change on health care reform efforts, in particular the goal of shifting to value-based payment (VBP) models and its impact on cost-savings to the entire health care system. Other providers should have an awareness of the benefit of appropriate hospice referrals for reducing hospital readmissions and emergency department use, as well as increasing patient satisfaction with their health care experience.

5. HCA is also concerned that, without appropriate communication and involvement by CMS, the adoption of the two-tiered payment system could send a contradictory message, one that
discourages hospices from being regarded as vital partners in the integrated health delivery system. Last year, CMS rejected the New York State Department of Health’s recommendation that hospices be considered as Vital Access Providers in the Delivery System Reform Incentive Payment (DSRIP) program. We are very concerned that CMS is undercutting the crucial role hospices can play in health care reform.

**Service Intensity Add-On (SIA) Payment Update**

1. HCA appreciates CMS implementation last year of a SIA covering up to 4 hours of direct care provided by a Registered Nurse (RN) or Social Worker (SW) and reimbursed at the hourly Continuous Home Care rate during a patient’s last 7 days of life. It is critically important to compensate hospices for providing care in the last days of a patient’s life as these can be days of intense service needs for both patients and their loved ones.

2. HCA also has concerns about excluding other disciplines such as Licensed Practice Nurses (LPNs) 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.

   Many hospices in New York State hire LPNs rather than HHAs because of the short lengths of stay and clinical demands of their dying patients. These LPNs work with RNs to observe and report, as clinical partners with the RN to assure appropriate care. To exclude LPNs is to exclude the staff who are likely to be available to care for the patient and family in the final days, and the staff with whom the patient and family have developed trust. Although LPNs’ scope of practice precludes assessment, they can observe and report to the RN so that adjustments in the plan of care can be made in a timely manner.

   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 urges CMS to re-consider including visits by LPNs in the SIA.**

3. Last year, we shared our concerns regarding the technical implementation issues associated with the Medicare Administrative Contractors (MACs) processing these new type of claims. Unfortunately, our concerns on this issue came to fruition where there have been some technical glitches with the claims processing of this add-on.

   One of the glitches that has occurred is when a patient dies within the first seven days of a month, the Medicare system is designed to trigger an automatic adjustment of the prior month’s claim if the prior month’s claim is eligible for the SIA payment. This adjustment will apply the SIA amounts to the previous claim that could not be identified in the initial processing. In some circumstances, these adjustments are not occurring on the prior months claim as designed.

   **Our MAC, National Government Services (NGS), has received information that the issue is expected to be corrected in the July quarterly release.** **HCA asks that CMS and its**
contractors expedite the necessary fixes so hospices can adjust their claims to ensure correct payment.

4. Finally, we have concerns about the impact of the requirement that 60 days elapse prior to the start of a new episode of care in cases where patients either elect to transfer their hospice care due to quality concerns, because they reside for a portion of the year in a different part of the country (e.g. “snow birds”) or due to a move in order to be closer to family toward the end of life. These patients may require what is essentially a new start of care, and the receiving hospice may incur significant costs associated with the transfer or new readmission (including for comprehensive assessments and additional care to ensure the patient is in stable medical condition). We ask that CMS continue its analysis of resource-intensity for patients that transfer or are readmitted late in an episode of care to determine whether an SIA policy should be instituted in such cases to help cover the increased costs.

Proposed FY 2017 Hospice Wage Index

1. HCA is very concerned that CMS’s proposed FY 2017 wage index, beginning October 1, 2016, will be fully based on the new Office of Management and Budget’s (OMB’s) delineations.

   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 many home health agencies (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 Core Based Statistical Area (CBSA) designation that now includes 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 (making it a NY and New Jersey area) fails to account for the costs faced by New York providers.

2. 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 payment rates because this causes continuing volatility of the hospice wage index from one year to the next.

3. 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.

4. HCA requests that CMS explore wholesale revision and reform of the hospice wage index. This reform should consider and take into account the following:
• 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; and

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

Hospice Quality Reporting Program (HQRP): Two New Measures and Data Submission and Compliance Thresholds

1. HCA is generally supportive of the two new quality measures CMS is proposing for FY 2017. We agree that the first, “Hospice Visits When Death is Imminent,” is a measure that will measure hospice staff visits to patients and caregivers in the last week of life. The second, “Hospice and Palliative Care Composite Process Measure,” will account for the percentage of hospice patients who received care processes consistent with guidelines. This measure will be based on select measures from the seven that are currently being submitted under the HQRP (Pain screening, Pain Assessment, Dyspnea Treatment, Patients Treated with an Opioid who are given a Bowel Regimen and Treatment Preferences & Beliefs/Values Addressed if desired by patient).

2. HCA also appreciates that CMS’s measure selection activities for the HQRP take into consideration input from the Measure Applications Partnership (MAP), convened by the National Quality Forum (NQF), as part of the established CMS pre-rulemaking process required under section 1890A of the Act. We look forward to hearing the input from the NQF about these two proposed measures.

3. While we recognize that these two new measures are important areas for hospice, we feel that the focus of CMS’s consideration when considering new measures should be on what measures will help CMS and the industry better analyze performance that reflects actual hospice practice. Performance measures should guide and promote the quality of care received by hospice patients and families; measures must be able to be reported uniformly. As the prior attempt at a hospice outcome measure by CMS evidenced, hospice is a difficult service to standardize.

4. Spiritual counselors/chaplains play an important role in the interdisciplinary team; HCA encourages CMS to establish a code for spiritual counselors/chaplains as it is imperative to have their visits tracked and reviewed for both reimbursement and quality considerations.

5. HCA supports CMS’s decision last year to establish an incremental threshold for compliance over a 3 year period with regards to hospices submitting a certain percentage of their Hospice Item Set (HIS) Admission and HIS-Discharge records no later than 30 days from the event date. The thresholds of 70 percent compliance from January 1, 2016 to December 31, 2016, 80 percent compliance from January 1, 2017 to December 31, 2017 and 90 percent compliance from January 1, 2019 to December 31, 2019 and going forward should be attainable for most hospices including those in New York.
However, HCA is concerned about instances in which hospices may not be able to email CMS within 30 days (i.e. disasters such as Hurricane Sandy or others in New York). HCA recommends that CMS extend the number of days hospices have to email CMS to 90 days or longer when extenuating circumstances like that occur.

**Double Billing of Part D Medication Costs**

HCA appreciates CMS sharing its updated Part D Medicare expenditure data in FY’s 2013 and 2014 for those beneficiaries under a hospice election. We are encouraged that CMS’s analysis shows Medicare payments decreasing for non-hospice Part D drugs received by hospice beneficiaries during a hospice election from $347.1 million in FY 2013 to $291.6 million in FY 2014.

HCA understands CMS’s concern with overlapping hospice claims where Part D drugs are dispensed on a day that a Medicare beneficiary also received hospice care. HCA is against the unbundling of hospice services by third party payors and we agree with CMS’s opinion that unbundling is a detriment to the interdisciplinary care that is critical to hospices. However, we offer the following points regarding these expenditures:

1. Hospices do not have control over other providers. With regards to overlapping claims, some pharmacies simply decide to bill Part D when billing the hospice is appropriate or they intermittently bill Part D by mistake where the hospice has no knowledge of this overlapping claim. The same is true of hospitals, DME companies, etc. The hospice can and should contact each partner provider when the provider’s service should be billed to the hospice as is clearly articulated in the contractual agreement. However, this does not guarantee that that each of the hospices’ provider partners will comply with the terms of the contract.

2. In many cases hospices are unaware when a Medicare Advantage plan pays for a service when a patient is under a hospice election. Part D has taught hospice to instruct patients and families that Medicare should not be paying for anything related to the terminal condition for which the hospice is providing care and to contact hospice if they receive any type of statement saying that Medicare has paid for something. The problem is that many families of hospice patients do not understand that their Medicare Part D provider or Medicare Advantage plan is part of Medicare. Hospices also instruct patients and family members to contact them if they are charged a co-pay for anything that is related to hospice care. Despite this instruction, family members or other caregivers pay the co-pay either as a “favor” to hospice or because it is simply easier.

3. HCA strongly recommends additional efforts by CMS and its MACs 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 and billing outside of the hospice benefit.

4. We also recommend that CMS develop an edit or “stop guard” into the Medicare claims processing system so potential overlapping claim problems can be identified in real time. We also feel it is critical that CMS ensures that other providers are immediately aware of the patient’s hospice election and are instructed to communicate with the hospice provider.
Live Discharge Rates

HCA understand CMS’s interest in hospices with high live discharge rates and its concern that some hospices may be using the Medicare hospice program inappropriately as a long-term care (“custodial”) benefit rather than an end of life benefit for terminal beneficiaries. The Medicare Payment Advisory Commission (MedPAC) has also expressed concern that hospices may be admitting beneficiaries who do not legitimately meet hospice eligibility criteria. However, there are justifiable reasons for live discharges and we ask CMS to consider the following:

1. Some hospices in New York State, and undoubtedly in other states, face an issue with hospitals that are not willing to contract with particular hospices, but are the hospital of choice for a portion of a hospice’s service area. This is particularly problematic where the hospital is outside the hospice’s service area and when the hospital is in another state. This significantly impacts live discharges, but appears unavoidable.

2. HCA believes hospices have become ever more vigilant in review of patients for appropriateness. Clearly, the Conditions of Participation (CoPs) require hospices to discharge patients who no longer have a prognosis of six months or less if the disease runs its normal course. This review is compounded by the increasing demand for hospice services by patients with a diagnosis other than cancer where prognostication is more difficult. It is also not uncommon for hospices to find that with thorough medication review and care provision chronically ill patients with all indications of end stage disease can improve and no longer qualify for hospice. While this rarely occurs in the first few days or weeks of a hospice stay, care over months can certainly result in this type of improvement which impacts the higher percentage of live discharges for longer stays.

3. Lastly, there are many more medicines / treatments available for all diagnoses and more approved daily. Hospices encourage patients to seek appropriate disease modifying treatment when it becomes available. It would be expected that this trend would continue as medical science advances.

Medicare Care Choices Model

HCA is intrigued that through the Medicare Care Choices Model (MCCM), CMS has provided a new option for Medicare beneficiaries and dually eligible beneficiaries to receive hospice-like support services from certain hospice providers while concurrently receiving services provided by their curative care providers. CMS will evaluate whether providing these supportive services can improve the quality of life and care received by beneficiaries, increase patient satisfaction, and reduce Medicare expenditures.

Under current payment rules, Medicare and dually eligible beneficiaries are required to forgo curative care in order to receive services under the Medicare or Medicaid Hospice Benefit.
The MMCM was designed to: (1) Increase access to supportive care services provided by hospice; (2) Improve quality of life and patient/family satisfaction; and, (3) Inform new payment systems for the Medicare and Medicaid programs.

All three hospices in New York participating in the current MCCM demonstration are HCA members and like CMS we look forward to evaluate whether providing these supportive services can improve the quality of life and satisfaction of beneficiaries while reducing Medicare expenditures. We offer the following comments, concerns and requests:

1. According to the details of the demonstration, a patient must meet 14 individual requirements before he or she can be enrolled in the demonstration and we have heard many hospices are struggling to find beneficiaries that meet all 14 criteria. Can or will CMS consider revising the structure of the demonstration by loosening the eligibility criteria so hospices have a less demanding time finding patients that can participate?

2. We also understand that under the MCCM, CMS is paying hospices $400 per beneficiary per month for palliative services while also allowing providers and suppliers of curative services to bill Medicare. $400 per beneficiary per month seems extremely low to even cover the hospice’s costs. Does CMS have any flexibility under the demonstration to increase this monthly payment to hospices?

3. Lastly, we have concerns with the dually eligible population. New York has approximately 700,000 dually eligible beneficiaries most of which are located in the downstate Metropolitan area (where all 3 of New York’s participating hospices are located). Our experience with New York’s dually eligible beneficiaries is that they tend to have multiple co-morbidities, with high needs, while also being very costly to serve. We would like additional information (in the final rule) as to how CMS plans to analyze the possible reduction of Medicare expenditures. Does CMS plan to separate all of the costs incurred from those entities providing curative services from the actual costs incurred by the hospices? Can CMS evaluate how the overall costs compare for the dually eligible population versus the Medicare only beneficiary?

**CAHPS Hospice Survey for the FY 2017 Payment Determination**

1. HCA appreciates the importance of CMS requiring data collection of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) hospice survey and the requirement that vendors and hospice providers participate in CAHPS survey oversight activities to ensure compliance. However, 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.

**Use of Health Information Technology (HIT) and the need for Funding**

1. HCA completely agrees that the use of certified HIT by hospices can help providers improve internal care delivery practices and advance the interoperable exchange of health information across care partners to improve communication and care coordination.
2. While the U.S. Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support adoption of HIT and promote nationwide health information exchange for hospitals and physicians, there has been a lack of grant or capital funding for HIT and other infrastructure enhancements so that hospices and HHAs can network with health partners.

HCA strongly encourages HHS, CMS and our state government partners in New York to begin offering capital HIT funding and/or grants so that more and more hospices and HHAs can begin advancing the interoperable exchange of health information to their critical health care partners.

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@hcanys.org or (518) 810-0661.

Sincerely,

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