June 26, 2018

Seema Verma, Administrator
U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1692-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: File Code CMS-1692-P, Medicare Program; FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

To Administrator Verma:

The Home Care Association of New York State Inc. (HCA) is a statewide not-for-profit organization representing nearly 300 health care providers, allied organizations, managed care providers and individuals committed to the advancement of quality hospice and home care services in New York State.

On behalf of our hospice provider members that serve many of the approximately 47,000 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) 2019 Hospice Wage Index, Payment Rate Update and Hospice Quality Reporting Requirements proposed rule.

General Overview of CMS’s FY 2019 Proposed Rule

CMS’s FY 2019 proposed rule updates the Medicare payment rates, wage index and cap amount for hospices serving Medicare beneficiaries in FY 2019.

In addition, this rule includes regulatory text changes as part of the Bipartisan Budget Act of 2018, so that effective January 1, 2019 physician assistants (PAs) will be recognized as designated attending physicians, in addition to physicians and nurse practitioners. The rule also proposes and/or solicits comments on proposed changes to the Hospice Quality Reporting Program (HQRNP), including: a new factor for HQRNP measure removal; new data review and correction timeframes for data submitted using the Hospice Item Set (HIS); changes to the quality measures displayed on Hospice Compare in FY 2019; and updates to the public display of HIS measures.

We offer our comments, requests and/or recommendations on the following areas of CMS’s proposed rule:

- Routine Home Care Rates;
• Service Intensity Add-On Payment;
• Proposed FY 2019 Hospice Wage Index;
• Non-Hospice Spending;
• Initial Analysis of Revised Hospice Cost Report Data
• Hospice Quality Reporting Program:
  ▪ New Measure Removal Factor;
  ▪ Adding Quality Measures to Publicly Available Websites – Procedures to
    Determine Quality Measure Readiness for Public Reporting;
  ▪ Display of Public Use Data File Data and / or Other Publicly Available CMS Data
    on the Hospice Compare Website; and,
  ▪ CAHPS Hospice Survey for the FY 2019.
• Collection of Information / Regulatory Requirements and;
• CMS’s Goal of Fully Interoperable Health Information Technology and Electronic Health
  Records for Medicare Participating Providers.

Routine Home Care Rates Concerns

HCA believes the two tier payment for routine home care (RHC) first implemented as part of the FY
2016 final rule is a very rational approach and more reflective of actual hospice costs. HCA continues
to support CMS’s decision for developing this very appropriate revision to the reimbursement model.

While HCA appreciates CMS’s efforts to better align RHC payment rates with resources used and
understands the rationale for maintaining 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 two tiered system could potentially have negative impact on hospices that accept patients on to care as transfers.

Since implementing this new payment system for RHC in 2016, CMS has not provided any public
data assessing the actual impact of the payment changes and the degree to which they are on track
with the re-distributional impact that CMS anticipated as part of its modeling (or with first-year budget neutrality requirements). HCA believes that the hospice industry would benefit from seeing the degree to which the actual impact of the payment changes aligns with what CMS originally projected, and the degree to which payments have shifted among various sectors of the hospice community (impact on hospices with a high proportion of long-stay patients, a low proportion of
long-stay patients, and / or a high proportion of short-stay patients, etc.).

We believe that any discussions of redistribution of payment among levels of care (addressed later in
these comments) should be accompanied by consideration of the balance of payments within the RHC
level of care. This is particularly relevant given the shifts in referral patterns that may occur as the
result of the application of the post-acute transfer policy to hospital discharges to hospice beginning
October 1, 2018.

Service Intensity Add-On Payment
HCA still has concerns about excluding other disciplines such as Licensed Practice Nurses (LPNs) from Service Intensity Add-On (SIA) payments since it seems to conflict with the concept that 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.

In the rule, CMS also describes analysis of FY 2017 claims data in which CMS only found marginal improvement in skilled visits during the last 7 days of a hospice election and expressed concern at the limited increase in such visits, particularly given the January 2016 implementation of the SIA payment. HCA is supportive of CMS’s efforts to better calibrate payments to when costs are incurred during an episode of hospice care and to incentivize increased visits at the end of life when they may be of greatest need.

While we believe that CMS’s findings will encourage many hospice providers to consider whether their existing processes are sufficiently sensitive to patients’ changing care needs, hospices currently have no definitive means for assessing how the frequency of visits they provide at the end of life compare with their peers and optimal practice patterns. We believe that receipt of provider quality measure (QM) scores from the Visits at the End of Life Measure Pair will help drive additional agency self-analysis of care processes going forward. In the meantime, as CMS examines the data collected for the Visits Pair Measure, it may want to consider whether some form of direct to provider reports that contain greater detail related to the measure findings might be helpful to individual hospice programs for conducting in-depth self-assessment of visits provided at the end of life.

Proposed FY 2019 Hospice Wage Index

HCA remains very 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 which now includes six New Jersey counties (Bergen, Hudson, Passaic, Middlesex, Monmouth and Ocean) with much lower labor costs.

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 higher costs faced by New York providers.

HCA also continues to be concerned 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.

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.

Non-Hospice Spending

HCA appreciates the need and importance of tracking spending outside of the hospice while patients are under a hospice election and believe that knowledge of these spending metrics will assist hospices in making determinations as to which items and services are appropriate for inclusion under hospice care and which are not related to the patient’s terminal prognosis.

HCA believes that timely posting of beneficiary hospice status is an important part of ensuring that inappropriate spending outside of hospice is kept in check. At times this ability to check the beneficiary’s hospice status may be the only way that a Medicare provider is able to ascertain that a patient has opted for hospice care and respond accordingly relative to the provision and coordination of services. CMS has taken an important step through its development of an interface that allows for electronic submission of hospice Notices of Election (NOEs). While the initial implementation of the NOE process has run into some system related issues, we are hopeful that hospices and vendors will increasingly take advantage of this relatively new option and that it will contribute toward increasing the availability of patient status updates in the CMS systems.

We would also recommend that CMS conduct a detailed review of the length of time it takes across all relevant CMS systems (Common Working File, MARx, other systems) to update patient status information and assess whether there are additional modifications that could be made to make the overall process more efficient. Lastly, we are interested about the recently announced changes to the manner in which the hospice benefit periods are configured in the CWF and would like to obtain additional information from CMS sources as to whether and how these changes might positively affect timing of updates to beneficiary status information.

Initial Analysis of Revised Hospice Cost Report Data

In the proposed rule, CMS also discusses preliminary information on the costs of hospice care using data from the latest version of the hospice cost report (for freestanding agencies). HCA is particularly
interested in CMS’s analysis of costs related to various levels of care and CMS’s modeling of a series of Level I edits to assess overall accuracy in cost reporting.

CMS indicates as part of the proposed rule that, based on its own analysis, approximately 66 percent of free standing hospices would have their cost reports rejected if the Home Health and Hospice Financial Managers Association (HHFMA) recommended Level I edits were put in place. We also understand that CMS is seriously considering imposing those Level I edits at some time in the near future. While we understand that additional Level I edits will require a number of hospice providers (and potentially cost report consultants) to address existing gaps in data collection, to modify their charts of account, and to allocate costs more appropriately, we believe that it is essential that hospices have access to accurate data in order that they may more appropriately manage their financial affairs and that CMS and federal policymakers can use to make future policy decisions. In order to do so, we believe CMS should move to implement additional Level I edits for the Medicare hospice cost report.

However, in doing so, we believe it will be critical that CMS work with all hospice stakeholders (including state and national associations) to make education sessions and webinars on any hospice cost report changes and Level I edits widely available so that all hospices have a better understanding of the rationale behind the latest revisions to cost reporting requirements, are better able to meet those new requirements (and adjust their internal processes), and hopefully benefit from the improved financial data that we expect.

Lastly, as part of the preamble to the rule, CMS indicates it has conducted further analysis of cost report data for freestanding hospices to ascertain total costs per day by level of care. In its analysis, CMS indicates that costs for 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, and the agency plans to conduct additional analyses in the future.

HCA strongly recommends that as part of any future deliberation related to payment recalibration CMS consider a number of factors, including:

- Hospice cost reporting requirements have undergone additional changes recently; CMS should wait until the latest changes (including possible new Level I edits) are reflected in the data to ensure greater accuracy of data inputs.

- Costs for the inpatient levels of care can vary widely depending on whether the hospice provides the care in its own facility or contracts with another entity as this can make a considerable difference in actual costs incurred by the hospice. In order to fairly analyze the appropriateness of payment for inpatient services, CMS must address this variability in cost inputs.

- Many hospices that contract for inpatient care must pay the contracting facility the full payment rate that they would otherwise receive in order to secure a contract. If CMS were to reduce payments for RHC in order to increase payments for inpatient care, it could result in
an overall loss of revenue to the hospice sector as these payments will likely be directly “passed through” to contracted facilities.

Hospice Quality Reporting Program

New Measure Removal Factor

As part of the FY 2019 rule, CMS is proposing to include the following eighth factor for use when considering items for removal from the Hospice Quality Reporting Program (HQRPs): “Whether costs associated with a measure outweigh the benefit of its continued use in the program.”

In general, HCA supports the inclusion of this factor as part of the measure review mechanism but we strongly recommend that in cases where cost concerns are limited to what CMS incurs in collecting and analyzing the measure that CMS request industry stakeholder input before taking final action to ensure that there is agreement on removal of any particular item(s).

Adding Quality Measures to Publicly Available Websites – Procedures to Determine Quality Measure Readiness for Public Reporting

CMS is also proposing that, once a measure is deemed appropriate for public reporting, CMS may notify industry stakeholders and the public through sub-regulatory means of its intent to post the measure on Hospice Compare, rather than through formal rulemaking.

While HCA recognizes CMS’s preference to move promptly in bringing further hospice quality measures to the public, we believe that part of the HQRPs’s success has been the deliberate approach that has been taken by CMS in its implementation and expansion. HCA believes that in the case of measures that have had a thorough professional vetting via the National Quality Forum’s review process and on which the public has had ample opportunity to comment it may be appropriate to move them to Hospice Compare through a sub regulatory announcement of CMS’s intent and the timing for posting. However, under the Affordable Care Act (ACA), CMS is permitted to use measures that have not been NQF approved under certain circumstances. It is HCA’s belief, along with our colleagues at the National Association for Home Care and Hospice (NAHC) that in those instances, it would be most appropriate for CMS to go through formal public notice and comment processes prior to publishing the measures on Hospice Compare. We strongly encourage CMS to continue to submit such measures for public notice and comment prior to displaying publically.

Display of Public Use Data File Data and / or Other Publicly Available CMS Data on the Hospice Compare Website

In the proposed rule, CMS requests comments on its stated plan to post information from the Public Use File (PUF) or other publicly available CMS data on the Hospice Compare website in a user-friendly manner.

HCA has some concerns that metrics from the PUF are similar to the proposed Transitions from Hospice Care measure, and other CMS claims-based measures and do not always have a direct and apparent connection to the quality of care provided.
In many cases PUF and other publicly-available data may raise suspicions or concerns about potential quality lapses, but often it is only by examination of patient files or hospice care processes that a true understanding of the meaning of the metrics can be concluded. For these reasons, we have concerns about CMS seeking a complete endorsement of the posting of PUF or other data on the Hospice Compare website unless such metrics can be directly tied to the quality of care. We believe CMS should develop criteria through the regulatory process and with stakeholder input that will guide CMS’s decisions about the type of public information that is showcased on the Hospice Compare website.

CAHPS Hospice Survey for FY 2019

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.

Collection of Information / Regulatory Requirements

HCA appreciates the opportunity to offer the following recommendations that we believe would help reduce the information collection and regulatory burden for hospice providers:

1. **Revise the Face-to-Face (F2F) Collection / Regulatory Requirement for Hospices:** The intent of the Medicare Face-to-Face (F2F) physician encounter requirement was to ensure adequate and appropriate involvement and accountability of physicians relative to certification of eligibility for hospice care. However, as currently written and interpreted by CMS, it may delay access to care and serve as a deterrent for some hospices to take eligible patients in need of immediate care onto service. This was neither its intent nor an advisable result of the requirement.

   HCA urges CMS to work with the hospice industry to significantly revise the F2F provision to ensure that regulations and guidance governing the hospice F2F provide sufficient flexibility so that hospice programs are able to comply with the requirements without any threat of delayed access to care for beneficiaries in need of hospice services, and without undue financial burden on the hospice.

2. **Amend Sequential Billing Requirements for Hospices that Cause Payment Delays and Increase Regulatory Burdens:** CMS’s sequential billing policy prohibits hospice providers from submitting claims for care to beneficiaries where previously submitted claims are pending. However, claims processing can be delayed for weeks or months for many reasons, including medical review activities, common working file (CWF) problems, CMS or Medicare Administrative Contractor (MAC) claims processing problems and pending claims from other providers, etc.
Hospices have continued to serve patients even though Medicare payments have been delayed. CMS requires that hospices only submit one bill per beneficiary per month. There are situations where the additional data required on hospice claims since April 1, 2014 cause hospices to hit the 450-line claim limit. This causes the hospice to have to submit another bill the following month and, with only one claim allowed per beneficiary per month, this delays the following months’ claims and places a hardship on hospices to be able to continue providing care.

HCA recommends that CMS still require hospices to submit claims in chronological order but process and pay all clean claims as submitted, regardless of whether previous claims have been processed and allow more than one claim per beneficiary per month when the reason for the multiple claims is due to the hospice exceeding the 450-line claim limit. CMS should also pay interest on claims that are not processed timely.

**CMS’s Goal of Fully Interoperable Health Information Technology (HIT) and Electronic Health Records (EHR) for Medicare Participating Providers: Increased Use of HIT and HER and the Need for Funding for Hospices and Home Health Providers**

While, CMS and the U.S. Department of Health and Human Services (HHS) have a number of initiatives designed to encourage and support adoption of HIT and EHR along with promoting a nationwide health information exchange for hospitals, physicians and patients, there has been a lack of grant or capital funding for HIT and other infrastructure enhancements so that hospices and home health agencies (HHAs) can network with all health partners.

**HCA strongly encourages CMS and HHS as well as our state government partners in New York to begin offering capital HIT and HER funding and/or grants so that more and more hospices and HHAs can begin advancing the interoperable exchange of critical 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,

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