

June 9, 2020



Seema Verma, Administrator
U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1733-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: File Code CMS-1733-P, Medicare Program; Fiscal Year 2021 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

To Administrator Verma:

The Home Care Association of New York State (HCA) is a statewide not-for-profit organization representing nearly 400 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) 2021 Hospice Wage Index, Payment Rate Update and Hospice Quality Reporting Requirements proposed rule.

General Overview of CMS's FY 2021 Proposed Rule

CMS's FY 2021 proposed rule updates the Medicare hospice payment rates and aggregate cap amount for hospices serving Medicare beneficiaries in FY 2021.

In addition to the payment and cap updates, as well as an unchanged continuation of the Hospice Quality Reporting Program (HQRP), HCA offers our comments, concerns, requests and/or recommendations on the following areas of CMS's proposed rule:

- Adoption of the most recent Office of Management and Budget (OMB) hospice wage index statistical area delineations, with a 5% cap on wage index decreases.
- Elimination of the Service Intensity Add-on (SIA) budget neutrality factor.
- Continuation of changes to the hospice election statement (which were finalized during the FY 2020 rule cycle and scheduled to become effective October 1, 2020), as well as a review of a model election statement and sample addendum that CMS provided for use in delineating diagnoses and treatments that are unrelated to the hospice terminal diagnosis and related conditions.

Proposed FY 2021 Hospice Wage Index Changes

Background

In its FY 2021 Proposed Hospice Wage Index and Payment Rate Update, CMS reveals its plan to integrate revisions published by the Office of Management and Budget in September 2018. CMS also indicates its intent to potentially incorporate additional revisions that were published in early 2020 into the FY 2021 hospice wage index values. (These revisions are not currently represented in the proposed hospice wage index table for FY 2021.) While these changes are not expected to have a significant impact on a widespread basis, they will impact specific areas of the country; to mitigate any negative impact, CMS is proposing to limit the loss in wage index values between FY 2020 and FY 2021 to a maximum of 5%.

However, CMS will continue to calculate the hospice wage index values using the most up-to-date, pre-floor, pre-reclassified acute-care hospital wage index (with new OMB designations) because CMS believes it is the best Medicare wage index data available.

HCA Comments/Concerns

Although CMS has repeatedly dismissed HCA's longstanding request for wholesale revision and reform of the hospice and home health agency (HHA) wage index, we reiterate our support for more far-reaching reforms to the wage index methodology used under Medicare fee-for-service (FFS) programs.

We believe the pre-floor, pre-reclassified hospital wage index is wholly inadequate for adjusting hospice and home health costs, particularly in states like New York, which has among the nation's highest labor costs. The state's phase-in of a \$15 per-hour minimum wage hike will ultimately cost a stunning \$2.5 billion for New York hospices and HHAs across all payors (Medicaid, Medicare, managed care, commercial insurance and private-pay). These costs will never be adequately addressed due to CMS's ongoing disposition to continue using the pre-floor, pre-reclassified hospital wage index to adjust home health costs.

Yet another concern for hospices and other small HHAs is the need for parity with other health care providers (i.e. hospitals, nursing homes, etc.) that draw from the same labor pool. While the same data are used to establish the basic wage index values applicable to most provider types, hospitals receive special consideration in a number of ways, including that they are permitted to seek geographic reclassification from their assigned geographic area (thereby receiving higher wage adjustments to their payments). Hospice providers and HHAs are not afforded these same options yet must compete for the same types of caregiving professionals.

HCA's Recommendations

The time is long overdue for CMS to develop and implement a wage index model that is consistent across all provider types so that all types of providers have a level playing field from which to compete for personnel. Additionally, the model should incorporate some means by which providers are protected against substantial payment reductions due to dramatic reductions in wage index values from one year to the next. While HCA appreciates CMS's inclusion of a proposed 5% cap on losses in

wage index values for FY 2021, we believe that the cap should be lowered to 3% in order to ease the impact of incorporating the revised OMB revisions as well as to protect hospice providers who are already operating with negative or razor-thin operating margins. Finally, all providers should be guaranteed that their wage index value does not drop below the rural wage index value applicable in the state of operation.

Elimination of the Service-Intensity Add-On (SIA) Budget Neutrality Factor

Background

Beginning in January 2016, CMS implemented a two-tiered payment system for Routine Home Care (RHC) under the hospice benefit, as well as a Service-Intensity Add-on (SIA) payment that is applicable to in-person Registered Nurse (RN) and Social Work visits to patients on RHC during the final seven days of life (limit of four hours per day). In order to ensure that the SIA policy did not increase hospice spending above what would otherwise be the case without the SIA policy, CMS has applied a SIA budget neutrality factor to the calculation of RHC payment rates. In its proposed rule, CMS found that despite the SIA policy, the number of RN and social work visits provided in the final week of life remain relatively constant as compared to the period before this policy was implemented. In the interest of simplifying the payment calculation, CMS is proposing to eliminate the SIA budget neutrality factor beginning with FY 2021.

HCA Comments

While HCA appreciates CMS's efforts to simplify Medicare hospice payment calculations where warranted, and understands CMS's rationale for eliminating the SIA budget neutrality factor, we also understand that there have been recent changes in hospice that provide a justification for additional services in the last seven days of a patient's life, including the incorporation of a "Hospice Visits When Death is Imminent" measure on *Hospice Compare*. Additionally, the FY 2020 payment rule's recalibration of the payment rates has resulted in a considerable increase in the hourly rate for Continuous Home Care (CHC), which is the applicable service area in which SIA visits occur. This change in CHC could, therefore, have an impact on SIA utilization going forward. While HCA does not object to CMS's elimination of the SIA budget neutrality factor, we recommend that CMS continue to monitor visits in the final week of life and utilization of the SIA to ensure a continuation of existing trends that have prompted CMS's decision to consider eliminating the SIA budget neutrality factor.

Hospice Election Statement Modification and Election Statement Addendum

Background

In its FY 2020 hospice rule, CMS finalized modifications to the hospice election statement content and set forth requirements for a hospice election statement addendum. CMS is not proposing any changes to the policies finalized in the FY 2020 hospice final rule regarding the election statement content modifications or the requirements for the election statement. The election statement modifications and the election statement addendum requirements will still be effective for hospice elections beginning on and after October 1, 2020. Also going into effect at that time is the previously

finalized policy that the signed addendum (and any signed updates) would be a new condition for payment.

CMS has also provided a model modified election statement and election statement addendum. However, hospices are free to develop and design their own modified election statement and the addendum. CMS has provided the model documents as an example of one way that the election statement and addendum can be designed. The format of the addendum must be usable for the patient. CMS expects that this would be in a hardcopy format that the individual can keep for his or her own records, similar to how hospices are required by the hospice conditions of participation (CoPs) at §418.52(a)(3) to provide the individual with a copy of the notice of patient rights and responsibilities. CMS is soliciting comments on both of these model examples to see if they are helpful in educating hospices in how to meet the requirements.

HCA's Comments and Concerns with the October 1, 2020 Implementation Date

While it is too early to make a determination as to when risks associated with the COVID-19 virus will subside sufficiently, it is widely believed that health care delivery will be altered for the foreseeable future by COVID-19, and the nation could potentially be facing a second wave of the virus in the fall. In that eventuality, as staff are exposed, possibly with the need to quarantine or self-isolate, hospices could once again be strained in their ability to meet anything other than direct patient care needs. This includes the ability to train staff on new regulations, especially complex changes that rely heavily on staff comprehension in order to ensure patient education.

Also, health experts have warned of this potential second COVID-19 wave coming in the fall, right at the time that the election statement modifications and addendum are slated to be implemented. In such a case, hospices will be constrained in their ability to implement revised electronic medical record (EMR) documentation/paper documentation, new policies and procedures, operational adaptations, and the necessary education of staff. One HCA hospice provider member told HCA that its EMR vendor has not yet had the opportunity to create the needed system enhancements for an October 1, 2020 implementation. The EMR vendor has instead spent the last few months assisting this hospice in creating system enhancements, workflows and procedures for telehealth visits, and other needed tracking mechanisms for the Public Health Emergency (PHE).

We urge CMS to also recognize that its model statement and addendum were released at the height of the current PHE, on April 10, 2020 (as part of its FY 2021 proposed rule). One of HCA's hospice members provided the following comments about reviewing CMS's model statement and addendum during the pandemic:

“Everyday life has ceased as we know it. As a result, the creation, legal review and printing of new election statements/addendums is extremely difficult to accomplish at this time. Hardcopy consents/addendums may not even be possible at print shops who are not considered essential employees in the state of New York. It is unknown as to when they could even start printing these forms considering the backlog of work they will have to deal with. In addition, the model forms have flaws that need to be addressed/clarified, if hospices are to be able to rely on sample documents provided by CMS.”

HCA's Recommendation on the October 1, 2020 Implementation Date

Hospices across the country – and especially in New York – have devoted most of this calendar year to COVID-19 processes, and they continue to do so. CMS has, in turn, recognized the extraordinary needs and services that hospices provide during this PHE by implementing blanket 1135 waivers for all health care providers, including hospices. These waivers were put in place “to put patients over paperwork,” and we ask for a similar policy when it comes to new consent and addendum requirements.

Given these circumstances, **CMS should postpone implementation of the modified election statement and the election statement addendum until October 1 of the year that is at least one full calendar year following the end of the COVID-19 PHE.** For example, if the PHE ends on September 1, 2020, the implementation date for the election statement modifications and addendum would be October 1, 2021. As a precedent, CMS has previously delayed the home health OASIS-E implementation in like fashion beyond the PHE period, and CMS should consider similar actions with new implementation requirements for hospices.

HCA Comments and Concerns with the Election Statement Modification and Election Statement Addendum

HCA supports the overall goal of increased transparency and appreciates CMS's concerns about spending outside of the Medicare Hospice Benefit (MHB) along with the complex nature of unrelated medical care, services and products in hospice. While the purpose of the addendum is to detail non-covered areas, we note the following complications:

- Not all outside spending is within the control of the hospice nor is the timing of it. Hospice providers in New York and around the country have indicated that it can sometimes take upwards of nine days for a hospice notice of election (NOE) to process through the CMS software systems so that non-hospice providers have access to the information. This lag significantly diminishes the addendum's purpose: to control overlapping spending. Also, absent a more immediate exchange of information with the non-hospice provider regarding the coordination of services, a hospice is left without critical information necessary to include in the addendum, and for which a hospice is held accountable.
- Non-hospice providers often bill Medicare using the unrelated condition code without ever speaking to or obtaining any information from the hospice.
- Even though patients sign and acknowledge that they understand the Medicare Hospice Benefit waiver, they and their families often continue to seek services without informing or discussing it with the hospice. And, even though the hospice does not bear the financial responsibility for all of these items, services, and drugs, many hospices still cover them.

HCA's Recommendation

In order to effectively address inappropriate spending outside of the hospice benefit, CMS must take additional steps to identify the extent of issues that are contributing to the problem. These include analysis of spending data to determine what proportion of this spending is occurring within the first

weeks of hospice care when the CMS systems have not been updated with Medicare election information and what proportion of this spending is resulting from the hospice informing the provider that the item/service/drug is unrelated. CMS must look to any additional systems issues (lags in updates to beneficiary status information) as well as to any other delays (including by Medicare Advantage plans) that slow the posting of new beneficiary status information.

HCA Comments and Concerns with the Actual Election Statement and Election Statement Addendum

While CMS's sample modified election statement and election statement addendum are somewhat helpful, they do not provide all of the necessary information for a smooth implementation. In addition to our call for a delay in the implementation date, there are numerous outstanding questions and areas of guidance or answers needed for hospices. Some of the most urgent questions and issues needing clarification/guidance are:

- **How to handle transfers:** When a hospice receives a patient via transfer, would a new election for purposes of the addendum be required and would the timeframe for completing the addendum be five days or three days (72 hours)? Or is the receiving hospice to observe the transferring hospice's determinations regardless of whether it agrees with these determinations? For the hospice receiving a patient case transfer, it is reasonable to allow some time for that hospice to complete its own assessment and make decisions about related and unrelated conditions, items, services, and drugs. Allowing five days for the assessment and decision-making is consistent with the processes hospices follow at the time of election and at the time of receiving a transfer.
- **CMS's expectations around updating the addendum:** When an item, service, or drug that is considered unrelated is included on the addendum but discontinued, does the hospice need to supply an updated addendum and would this update require the hospice to obtain the beneficiary's/legal representative's signature, or is it sufficient to do either of the following: 1) not provide an updated addendum; or 2) provide the addendum but not require the signature? It seems an additional burden to the beneficiary/legal representative to require yet another signature in the case of an item being discontinued as there presumably would be no questions/concerns about coverage. Should the updated items be differentiated in some way (i.e., asterisk/different color text, listed separately, etc.)?
- **How to handle situations where an addendum is requested but there are no unrelated conditions, items, services or drugs.** Should an addendum stating this be provided and does it still require a signature?
- **Can the addendum be provided via a patient portal?** Some EMR vendors are receiving requests for this type of beneficiary access but it is not clear if such access is acceptable or if a hardcopy paper addendum must be provided.
- **What are CMS's expectation when the patient elects hospice with a future effective date?** For instance, the patient elects hospice care on Monday, June 22 but chooses an effective date of Monday, June 29. Does the five-day window begin on June 22 or June 29? It seems that it

would begin on June 29 as the hospice would not be doing the comprehensive assessment until after this date, but clarification is needed.

Finally, we have the following concerns with the sample documents that CMS provided in its proposed rule (and which many hospices and EMR vendors will decide to utilize):

- The beneficiary's financial responsibility as it relates to the drug and respite care copays may be problematic since very few hospices charge these amounts and including them in the election statement is likely to cause great confusion for beneficiaries. These should not be included unless the hospice plans to charge them. Otherwise, it adds to the beneficiary's confusion.
- The term "appeal" is used on the forms to reference the beneficiary's right to immediate advocacy through the Quality Improvement Organization (QIO). Medicare providers already are required to let beneficiaries know that services are subject to QIO review and any complaints or concerns can be directed to the QIO. HCA believes utilizing the term "appeal" may be misleading to some beneficiaries. We urge further CMS education about this process to the hospice community and the QIOs.

Conclusion

Due to the issues and concerns raised in our comments, the guidance that is still needed from CMS and the fact that many providers remain overwhelmed in the midst of this current PHE, we emphasize our recommendation that CMS should not implement the election statement and addendum changes until October 1 of the year that is at least one full calendar year after the end of the COVID-19 PHE.

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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