



Pennsylvania Homecare Association

June 26, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1675-P
P.O. Box 8010
Baltimore, MD 21244-8010

Electronic Submission via regulations.gov

Reference: CMS-1675-P Medicare Program; FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements.

Dear Administrator Verma:

Thank you for the opportunity to comment on “CMS-1675-P Medicare Program; FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements; Proposed Rule.” The Pennsylvania Homecare Association (PHA) represents more than 700 homecare and hospice providers in our state. Our comments and recommendations are listed below:

Discussion and Solicitation of Comments Regarding Sources of Clinical Information for Certifying Terminal Illness

PHA does not support the proposal that would require hospices to obtain data to support certification of terminal illness based solely on the patient’s primary physician. This objection is based on the concern that it does not take into consideration the current industry practice of patients who are referred to hospice from either a hospital, where the patient may be seen by a hospital physician who does not have full knowledge the patient’s history and disease trajectory, or may not have a primary physician.

Of greater concern is the proposal to amend the regulations for certification of terminal illness at §418.25 in future rulemaking to require that the individual be certified as terminally ill prior to receiving hospice services and that the determination fundamentally could not be determined by hospice documentation obtained after admission. This pre-requisite to receive hospice care would be a barrier to delivering timely care to terminally-ill patients.

While we recognize the need to meet hospice eligibility criteria, we have very serious concerns that the proposed changes are inconsistent with the current structure of the hospice program and will

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ultimately delay the start of end-of-life care.

Hospice is a specialized service, with experts in this specialty keenly qualified to assess the patient's need for hospice care. In determining eligibility, the hospice physician will use medical records, discussions with referral sources and the referring physician as well as the hospice nurses' assessment in making determination of eligibility, development of the plan of care and in providing ongoing treatment. Hospice physicians may also make a visit to the patient if needed for further assessment.

In accordance with the current regulations, there are checks and balances for patients whose length of stay is longer than the median, including continuing review of the patient's care plan, recertification of terminal illness at the end of each benefit period, and with the face-to-face encounter at the beginning of the third benefit period.

Our four primary concerns are as follows:

- Requiring documentation solely from the patient's primary physician prior to admission to hospice services will result in patients not able to receive hospice services in a timely manner, and in many cases, not at all. Non-hospice physicians may not understand the documentation required for hospice eligibility and may be unable to recognize when a chronically ill patient has reached the point of a six month or less prognosis. We must do all we can to mitigate late hospice referrals, rather than increase delays of care, which this proposal would surely do.
- This proposed rule will also add more regulatory burden on both the hospice and the referring physician, and lead to denial of services due to documentation issues. We have already seen the results of burdensome and confusing regulations with the physician home health face-to-face rule. With hospice, the consequence of this burdensome requirement would be even worse when non-hospice physicians and hospitalists are required to provide documentation to support eligibility of hospice services. This will require extensive physician education, many of whom have already expressed concern regarding referring to home health and hospice because extensive and confusing rules around documentation requirements.
- Currently, many physicians rely on the skills and resources of hospice physicians and nurses to assist in making this determination and often, in providing support to the family in making the decision to receive hospice services.
- The potential delay in hospice admissions surrounding the proposed requirement to obtain this information to meet CMS requirements for hospice eligibility may result in patients being unfairly denied access to end-of-life care. This is especially troublesome since nearly 35% of patients are only on the hospice benefit for less than 7 days.

CMS' concern that the patient may never see the hospice physician is realistic. However, it is also true that a patient may never be seen by a non-hospice attending or consulting physician after electing their Medicare Hospice Benefit. The Medicare Hospice Benefit requires an interdisciplinary group meeting, including the hospice physician, every 15 days, which provides closer monitoring than most community physicians' oversight. In addition, hospice physicians or nurse practitioners, under the direction of the hospice physician may make visits if needed during care. This practice is already in place for determining ongoing eligibility for long length of stay patients with the current

face to face requirements each certification period for patients receiving hospice care entering the third benefit period or later.

We recommend that CMS makes no changes to the current requirement. This includes allowing the hospice physician to use medical records, discussions with referral sources and the referring physician, as well as the hospice nurse's assessment in determining eligibility for the hospice benefit. That combination of information is used in eligibility, the development of the plan of care and in providing ongoing treatment, and does not delay the hospice admission. An in-person visit from the hospice Medical Director or hospice physician should be a determination made by the hospice physician, and within the physician's medical judgment, when additional clinical information is needed and should not be a requirement in regulation.

Non-Hospice Spending – Part D and Maintenance Medications

PHA is aware of providers across our state who continue to experience system issues with Medicare Part D billing and hospice billing for medications beyond the control of the hospice. Even with the implementation of CR8877 as of October 1, 2014 that requires hospices to file a Notice of Election to provide timely notification to all Medicare Part A, B and D providers that a patient has elected the Medicare Hospice Benefit, there are still issues with non-hospice providers continuing to bill other Medicare programs for services and medications. Most notably there are issues with the following:

- There is a lack of a consistent and accessible contact point at the individual Part D plan that has proficiency in dealing with the process for communicating the hospice election.
- Pharmacies, hospitals and skilled nursing facilities often continue to bill Medicare Part D as the payer of choice, even when the hospice has communicated payment responsibility for drugs for a beneficiary after the hospice election.
- Maintenance medications are often on automatic refills for patients, despite being notified by the hospice provider. Patients and families are not always aware of medications that should be provided by the hospice, even when they are instructed by the hospice provider.
- While hospices have implemented processes for determining what medications are related to the terminal prognosis, there continue to be inconsistencies in the process for notification to the Medicare Part D plan when medications are clearly not related to the terminal prognosis.

We concur with CMS continued review of spending outside of the Medicare Hospice Benefit, however, we recommend that CMS continue to work with industry stakeholders to further refine the process for drugs that are clearly not related to the terminal prognosis, and implementation of a tighter controls on the part of the Medicare Part D plan and providers in other settings to ensure responsiveness to the notice of election.

Proposed Updates to Hospice Quality Reporting Program

Our hospice members support the continued refinement of the Hospice Evaluation and Assessment Reporting Tool (HEART) as a comprehensive assessment tool for hospice patients. We urge CMS to continue to receive stakeholder input from the provider community, Medicare beneficiaries and

technical experts. We recommend extensive opportunities for input from the provider community and implementation of pilot testing before the patient assessment tool is implemented.

Providers are also recommending that the two claims based measures – potentially avoidable hospice care transitions and access to levels of hospice care – be further defined and reviewed especially when it comes to utilizing claims data. While the identified measure areas do focus on important aspects of hospice care, claims do not provide sufficient information to adequately represent hospice practice.

Regarding high priority concept areas for future measure development, we recommend that CMS continue to elicit input from the provider community and expert panels to provide recommendations related to further analysis of these measures. It is imperative that any new measures under consideration be clearly defined and pilot tested over time to determine the validity of any new measures. CMS should continue to utilize the work of the Measure Applications Partnership (e.g., the Performance Measurement Coordination Strategy for Hospice and Palliative Care from 2012) and the National Quality Forum (NQF) in determining priority areas for measure development.

Additional comments related to the Hospice Quality Reporting Program proposed rule include the following:

- Emergency Extensions/Exemptions for Submission of Hospice Quality Reporting Data:
 - We support the proposal to extend the deadline for submitting an exemption or extension request to 90 calendar days from the qualifying event which is preventing a hospice from submitting their quality data for the Hospice Quality Reporting Program.
- We concur with other commenters that social factors cannot be identified as influence in hospice performance on process measures, but that it is possible that social factors might include outcomes and subsequent performance on quality outcome measures.
 - Should CMS decide to take social risk factors into account in calculating quality measure scores, it would be important to balance dis-incentivizing hospices to admit patients and families with identified social risk factors and sanctioning provision of less than best possible care them.

Proposed Updates to the Hospice Quality Reporting Measures Reduce Regulatory Burden

We strongly support the proposal to identify opportunities to reduce regulatory burdens and increase efficiencies. With respect to the CMS proposal noted above related to data collection sources for certification of terminal illness, this would be a significant burden and therefore should not be implemented.

We recommend that CMS convene a panel of hospice industry experts, including, but not limited to state and national associations, providers, CMS, Medicare Administrative Contractor and industry experts to identify and provide recommendations to reduce regulatory burden. The Home Care Alliance of MA and our provider representatives would be interested in participating on a national panel (TEP) to explore and establish these recommendations.

Thank you for consideration of these comments.

Respectfully submitted,

A handwritten signature in black ink that reads "Vicki Hoak". The signature is written in a cursive style with a large, prominent initial "V".

Vicki Hoak, CEO
Pennsylvania Homecare Association