June 16, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: [CMS-1675-P] Medicare Program; FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements proposed rule to update the hospice payment rates for fiscal year 2018.

Dear Ms. Verma:

LeadingAge appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) [CMS-1675-P] Medicare Program; FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements proposed rule posted in the May 3rd Federal Register.

The members of LeadingAge and affiliates touch the lives of 4 million individuals, families, employees and volunteers every day. The LeadingAge community (www.LeadingAge.org) includes 6,000 not-for-profit organizations in the United States, 39 state partners, hundreds of businesses, research partners, consumer organizations, foundations and a broad global network of aging services organizations that reach over 30 countries. The work of LeadingAge is focused on advocacy, education, and applied research. We promote home health, hospice, community-based services, adult day service, PACE, senior housing, assisted living residences, Life Plan communities, nursing homes as well as technology solutions and person-centered practices that

support the overall health and wellbeing of seniors, children, and those with special needs.

We provide comments below on the following sections of the proposed rule:

- Section III.C Discussion and Solicitation of Comments Regarding Sources of Clinical Information for Certifying Terminal Illness
- Section III. D2 General Considerations Used For Selection of Quality Measures for the HQRP
- Section III. D7 Measure Concepts Under Consideration for Future Years
- Section VI. Request for Information on CMS Flexibilities and Efficiencies

ISSUE # 1: Section III.C Discussion and Solicitation of Comments Regarding Sources of Clinical Information for Certifying Terminal Illness

COMMENTS: CMS solicits comments on:

- The appropriate source(s) of the required clinical information for certification of a medical prognosis of a life expectancy of 6 months or less.
- Amending the regulations at § 418.25 to specify that the referring physician's and/or the acute/post-acute care facility's medical record would serve as the basis for initial hospice eligibility determinations for future rulemaking. Clinical information from the referring physician and/or acute/post-acute care facility supporting a terminal prognosis would be obtained by the hospice prior to election of the benefit, when determining certification and subsequent eligibility.
- Amending the regulations text at § 418.25 to specify that documentation of an in-person visit from the hospice Medical Director or the hospice physician member of the interdisciplinary group could be used as documentation to support initial

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hospice eligibility determinations, only if needed to augment the clinical information from the referring physician/facility's medical records.

- Current processes used by hospices to ensure comprehensive clinical review to support certification and any alternate suggestions for supporting clinical documentation sources are also encouraged.

LeadingAge agrees that it is important to have the clinical information necessary for certification, however it is critical that regulatory requirements not delay hospice services because of the inability of the hospice to obtain all the necessary information on the patient to certify that the patient is terminally ill. Hospice providers, most of the time have no control over timely access to patient medical records located at a hospital and physician's office. In 2014, 35.5 percent of hospice patients receive care for just seven days or less; 50.3 percent of patients died or were discharged within 14 days of admission. Any delay in service would drastically diminish hospice services for patients.

The Hospice Conditions of Participation §418.102(b) Standard: Initial certification of terminal illness, in the interpretive guidance states "During the clinical record review, verify that the clinical information necessary for certification is present in the record." LeadingAge hospice members report that medical directors review pathology reports, blood work reports, x-rays, kidney function, heart function, PPS assessment, mental assessment, medications, goals of care, diagnosis, nutritional assessment, weight loss, BMI and any other hospital report available that would indicate the patient has 6 months or less to live. Many times medical directors will conduct a home visit if he or she is not seeing the data to help determine the certification. Many times, the patient's attending physician becomes the hospice physician. The attending physician most likely would have the longest relationship with the patient, and would be familiar with the patient's medical history and personal end of life choices.

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There has been a decline in the overall live-discharge rate because they are no longer terminally ill and a decrease in the rate of beneficiaries revoking the hospice benefit. With the elimination of the Debility and Adult Failure to Thrive as the principle diagnosis for hospice, more time is being spent on the clinical record review to determine eligibility for hospice.

There has been a move by CMS to align regulatory requirements across provider types. Home Health data collection requirements may not be appropriate for Hospice. Home Health is focused on healing the patient through restorative treatment and rehabilitation. Hospice focuses on improving the quality of life for those facing a life limiting illness. Each benefit has different eligibility requirements, quality measures and goals. The home health physician face to face requirement should not be a requirement to initiate hospice services.

The field of hospice is quickly moving to adopt a standardized assessment in order to effectively share medical information among providers. It may be more prudent for CMS to delay regulatory changes to the required clinical information for certification of a medical prognosis of a life expectancy of 6 months or less, until a standardized assessment is implemented, and there is a determination if the standardized assessment improves the quality of the documentation needed to determine certification and subsequent hospice eligibility.

LeadingAge encourages CMS to give the hospice physician the authority to determine if the documentation in the initial hospice eligibility determination is sufficient or if additional clinical information from the referring physician/facility's medical records or if an in-person visit from the hospice Medical Director or the hospice physician member

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of the interdisciplinary group is needed to augment the clinical information in the initial hospice eligibility determinations.

RECOMMENDATION: LeadingAge recommends CMS:

- Delay any major changes in regulations pertaining to the process for data collection until the standard assessment instrument is finalized and implemented.
- Give the hospice physician the authority to determine if the documentation in the initial hospice eligibility determination is sufficient or if additional clinical information from the referring physician/facility's medical records or if an in-person visit from the hospice Medical Director or the hospice physician member of the interdisciplinary group is needed to augment the clinical information in the initial hospice eligibility determinations.

ISSUE # 2: Section III. D2 General Considerations Used For Selection of Quality Measures for the HQRP

COMMENTS: CMS solicits comments on:

- Whether they should account for social risk factors in measures in the HQRP, and if so, what method or combination of methods would be most appropriate for accounting for social risk factors
- Which social risk factors might be most appropriate for reporting stratified measure scores and/ or potential risk adjustment of a particular measure
- Which of these factors, including current data sources where this information would be available, could be used alone or in combination, and whether other data should be collected to better capture the effects of social risk

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- Operational considerations of implementing any of the above methods

LeadingAge agrees with CMS that it is important not to mask potential disparities or minimize incentives to improve the outcomes for disadvantaged populations. The difficulty in improving outcomes for disadvantaged populations that encounter social risk factors is that there are multiple factors that impact outcomes that are beyond the control of the hospice provider.

Social risk factors should be incorporated in the standardized assessment. In FY 2014, 86.73% of individuals receiving hospice where white, non-Hispanic; 8.51% where African American -non Hispanic; 2.06% were Hispanic; and 2.70% other.[1] An examination of end-of-life spending among 37,393 lung cancer decedents found that, even after controlling for confounding factors, use of hospice care was higher among whites than other ethnic populations, and mean total health care costs were significantly higher for blacks and other ethnic minorities when compared to whites, "regardless of length of survival time or hospice care status," suggesting that racial/ethnic disparities exist in end-of-life care for individuals with terminal lung cancer.[2]

Risk adjustment should reflect where the data demonstrates the hospice provider has no control over the outcomes. You shouldn't risk adjust a process measure, but in the Hospice Quality Reporting program, the only outcome measure is in the CAHPS® Hospice Survey, which is risk adjusted. If we don't risk adjust, we will exacerbate the situation where certain hospice providers cherry pick hospice patients that are lower cost in order to increase profits.

Risk adjustment should reflect what the existing data demonstrates as a factor that influences outcomes that is beyond the control of the hospice. For the CAHPS® Hospice

[1] Medicare Hospice Payment Reform: Analysis to Support Payment Reform. Abt Associates Inc. December 3, 2015
[2] Medicare Hospice Payment Reform: A Review of the Literature (2015 Update) Abt Associates Inc. June 9, 2016

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Survey, perhaps risk adjust based on the relationship with the patient. Adult daughters tend to have more involvement with the care of their loved one, than other family members. When measuring response times, the hospice has no control over the rural or frontier location of the patient's home. For measuring re-hospitalization, it is important to look at the patient's past behavior of obtaining treatment at the hospital. We need to collect information that is person-centered.

Social risk factors that have a negative effect on outcomes go beyond racial/ethnic disparities. Hospice serves both the patient and the caregiver. A family dynamic that includes substance abuse, mental illness, or inappropriate behavior by a caregiver can occur in any family, and will pose a challenge for the hospice provider to obtain positive outcomes. Outcomes many times are influenced by economic factors and available resources, such as the available Medicaid covered services in a state or region that are beyond the control of the hospice. The development of measures that reflect person-centered domains are needed to improve our focus on outcomes for disadvantaged populations.

RECOMMENDATION: LeadingAge recommends:

- CMS select measures that reflect person-centered domains that produce outcome data that identifies possible disparities due to race/ethnicity, dual eligibility, location of residence, as well as a dysfunctional family dynamic.
- CMS needs to allocate more resources on the impact of the quality and availability of Medicaid services in each state on Medicare costs and the quality of care provided

ISSUE # 3: Section III. D7 Measure Concepts Under Consideration for Future Years
COMMENTS: CMS solicits public feedback on:

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- Measure concepts under consideration for future years 1) potentially avoidable hospice care transitions,
- Measure concepts under consideration for future years 2) access to levels of hospice care.
- Other high priority concept areas for future measure development

LeadingAge believes that using claims as the only resource to ascertain potentially avoidable hospice care transitions may not be produce accurate data on if the live discharges from hospice, high E.R. utilization and high use of in-patient hospitalization was potentially avoidable. Also, there is a concern that the use of claims data will only measure the continuous care and general inpatient care that is delivered, rather than assessing the actual needs of patients and the quality of care provided by hospices, especially when there are more demanding clinical needs.

More outcome measures are needed to evaluate the psycho-social and spiritual wellbeing of the patient. Too often, there is a focus on only the clinical care provided. The PEACE (Prepare, Embrace, Attend, Communicate, Empower) Instruments for End of Life Care incorporate measures, not only for physical and functional outcomes, but the psychological, social and spiritual outcomes of the care provided. [3]

Not every hospice provider cares for all the levels of hospice care. There is a quality divide between non-profit and for-profit hospices. Non-profit hospices tend to care for individuals with higher acuity levels that require more labor intensive costly services. Many long established hospice providers have made a commitment to credentialing

[3] PEACE quality measures address domains of quality of care included in the National Consensus Project for Quality Palliative Care and endorsed by the National Quality Forum. Materials were developed by a research team from The Carolinas Center for Medical Excellence (CCME) and the University of North Carolina-Chapel Hill, under contract to the Centers for Medicare & Medicaid Services (CMS).

their staff, provide extensive bereavement and volunteer services. CMS should have measures that take all of these factors into consideration.

RECOMMENDATION: LeadingAge recommends:

- CMS should not rely on only claims data to determine potentially avoidable hospice care transitions
- CMS needs to utilize more outcome measures to evaluate the psycho-social and spiritual wellbeing of the patient receiving hospice
- Process Measures that delineate the scope of bereavement and volunteer services
- Process measures that demonstrate the provider's commitment to credentialing their staff

ISSUE #4: Section VI. Request for Information on CMS Flexibilities and Efficiencies

COMMENTS: LeadingAge appreciates that CMS are proposing a "national conversation" on regulatory improvements that reduce unnecessary burdens, lower costs, and/or improve quality. We believe that regulations should be implemented to improve the quality of patient care, not as a means to correct fraudulent behavior by a small number of providers. Many times, regulations such as the submission of Notices of Election and Notices of Termination/Revocation and the hospice face-to-face requirements have led to unintended consequences including delays in the timely initiation of hospice services. A person needing end of life care should not be denied that care because of barriers in obtaining documentation from non-hospice providers.

Due to the strict regulatory requirements for the submission of Notices of Election and Notices of Termination/Revocation, and the limitations of the Medicare system to process the change in the patient's Medicare benefit, hospice providers throughout the country have cumulatively lost millions of dollars.

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We believe that regulations should be implemented to improve the quality of patient care, not as a means to correct fraudulent behavior by a small number of providers.

RECOMMENDATION: LeadingAge recommends:

- CMS discontinue holding hospice accountable for late submission of Notices of Election and Notices of Termination/Revocation until CMS has in place a system that efficiently notifies all Medicare providers when a Medicare beneficiary has elected the hospice benefit
- Simplify the process of submission of Notices of Election and Notices of Termination/Revocation, and create a process that allows hospice providers to correct mistakes in the record that are due to human error or technical problems without receiving a penalty of losing payment for the hospice services.

Please do not hesitate to contact us if you have any questions or would like further discussion. We look forward to our continued work with you on this and related issues.

Sincerely,

Cheryl Phillips, MD

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Senior VP Public Policy and Advocacy

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