



UnityPoint Health

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June 4, 2021

Administrator Chiquita Brooks-LaSure  
Centers for Medicare and Medicaid Services (CMS)  
Department of Health and Human Services  
Attention: CMS–1754–P  
P.O. Box 8010  
Baltimore, MD 21244–1850

RE: CMS–1754–P– Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements; published in Vol. 86, No. 70 Federal Register 19709-19774 on April 14, 2021.

*Submitted electronically via [www.regulations.gov](http://www.regulations.gov)*

Dear Administrator Brooks-LaSure:

UnityPoint Hospice appreciates this opportunity to provide comments on this proposed rule related to hospice rates and quality reporting. Our parent organization, UnityPoint at Home, is the home health agency affiliated with UnityPoint Health, one of the nation's most integrated health care systems. Through more than 33,000 employees and our relationships with more than 480 physician clinics, 40 hospitals in metropolitan and rural communities and 14 home health agencies throughout our 9 regions, UnityPoint Health provides care throughout Iowa, central Illinois and southern Wisconsin. As its home health arm, UnityPoint at Home offers a diverse set of programs: traditional home health, durable medical equipment (DME), pharmacy, palliative care, hospice care, and (in certain locales) public health.

UnityPoint at Home has long recognized the importance of hospice services for our patients. UnityPoint Hospice is affiliated with 5 Medicare certified agencies in Iowa and Illinois and provides high quality care in those service areas. In addition, we are committed to payment reform and are actively engaged in numerous initiatives which support population health and value-based care. Among these initiatives, UnityPoint at Home is an ACO Participant in the CMMI Next Generation ACO Model, is participating in the Home Health Value-Based Purchasing (HHVBP) Model in Iowa, and is a CMMI Medicare Care Choices Model awardee in three Iowa regions.

UnityPoint Hospice appreciates the time and effort of CMS in developing this proposed rule. **As a member of the National Hospice and Palliative Care Organization (NHPCO), we generally support the comments submitted by NHPCO to this rule.** Additionally, we respectfully offer the following input.

### Hospice Utilization and Spending Patterns

*CMS provides a data analysis on the number of beneficiaries using the hospice benefit, live discharges, reported diagnoses on hospice claims, Medicare hospice spending, and Parts A, B and D non-hospice spending during a hospice election. Comment is solicited on the hospice utilization and spending patterns analysis and questions are posed related to non-hospice spending during a hospice election.*

**Comment:** CMS continues to call out live discharge rates as an area of concern, yet CMS has not engaged in targeted enforcement efforts to curb this. Foremost, UnityPoint Hospice has historically had a low live discharge rate of 8%. Despite this, **UnityPoint Hospice urges caution by CMS in its review and characterizations of live discharges from hospice.** While we agree that a high rate of live discharges by hospice organizations may signal fraud and abuse concerns, UnityPoint Hospice has consistently pointed out that terminal illness and individual life expectancies vary and are guided by medical judgment. The mere fact that an individual was the subject of a live discharge does not equate to fraud and abuse; for instance, a beneficiary moving to another service is a live discharge but not fraudulent. **We are concerned that broad enforcement efforts may place further burdens and costs of hospice agencies that are good actors and are operating on thin margins.** CMS has data and enforcement authority to perform targeted investigations of suspected bad actors, but should not subject all hospice agencies to blanket, overly burdensome for-cause removal procedures. An unintended result of additional processes related to for-cause removals (such as a showing that the hospice agency attempted resolution) has been an unnecessary delay in cases where the environment is unsafe for the beneficiary and/or the hospice team. Since the advent of the COVID-19 pandemic, we have witnessed an increasingly dangerous home environment as care has shifted to the community setting and beneficiaries have home situations with drugs, guns and dogs. This is not only troublesome for beneficiary wellbeing but hampers workforce and our ability to recruit and retain hospice team members.

In terms of non-hospice spending, this is an ongoing issue, and we encourage CMS to further analyze data trends by state or by profit versus nonprofit agencies. We believe this will assist CMS in identifying targeted enforcement. Also, an ongoing challenge involves information sharing with other sites of care and does not necessarily indicate that hospices are bad actors. **In many cases, hospice agencies do not know when a Part A or Part B provider bills Medicare after a patient has elected hospice. In terms of Part D billing, we may not even be aware of a claim until Part D auditors review these claims several years after they occur.** Unless CMS mandates the use of a hospice election list to identify participating beneficiaries and then requires all Medicare providers to check that list prior to billing, it is not realistic to expect that hospices should be able to control all non-hospice spending.

As for appropriate hospice utilization, UnityPoint Hospice closely follows our MAC (CGS) LCD's at time of admission and during the course of the hospice length of stay (LOS). For UnityPoint Hospice, our enrollment runs the gambit of primary diagnoses, and the majority are high acuity chronic conditions, like cancer, or entail more complex care. We do not primarily target nursing home residents with Alzheimer's as a terminal diagnosis. **While we have found the use of a data-driven algorithm helpful in**

**identifying potential hospice patients, our median LOS is still lower than the national average with a median LOS of 8 days and an average LOS of 48 days.** Over 50% of our hospice patients are with UnityPoint Hospice less than 7 days in current state. The crisis management required for the admission and death results in a burden for both patient / family and hospice teams. We know that patients and families benefit from at least 15-30 days in hospice so pain and symptoms can be managed and families can be supported. **Ultimately, it is referral patterns of providers that must be changed. We urge CMS to consider incentivizing providers through quality initiatives for proactive pre-acute conversations with patients to determine goals of care and appropriate alignment of services, including hospice.** We are aware that hospice saves Medicare dollars when the LOS exceeds 30 days but is less than six months. **In addition, the continuation of a revised Medicare Care Choice Model or greater collaboration between palliative care and hospice would assure that beneficiaries are provided the greatest access to a potential hospice election.**

#### **Routine FY 2022 Hospice Wage Index**

*CMS proposes a 2.3 percent update to the FY 2022 hospice payment rates as well as a corresponding update to the hospice cap amount.*

**Comment: As a nonprofit hospice provider, UnityPoint Hospice appreciates the proposed rate increase.** As for the proposed cap amount increase, UnityPoint Hospice operates hospice agencies in Iowa and Illinois and our hospice agencies have never hit the cap amount. We attribute this to our focus on the appropriate interpretation and use of hospice program admission and discharge rules. **We believe that the cap amount is an area that CMS could explore under its program integrity authority using available claims and quality data.** Because data is available, this administrative review could be done with little additional burden to hospice agencies and would allow CMS to target enforcement to questionable practices by hospice agencies.

#### **Hospice Election Statement Addendum Clarification**

*CMS provides clarification on, and proposes modifications to, certain signature and timing requirements regarding the election statement addendum.*

**Comment: As has been our position since this was first proposed, UnityPoint Hospice does not believe this addendum provides additional value to the beneficiary.** An important piece of the admission to hospice includes a review with each patient and family that hospice covers virtually all medications and services related to the hospice prognosis. While UnityPoint Hospice is always appreciative of clarifications and guidance from CMS, we are still opposed to these requirements and the additional administrative burdens that have resulted. **We support a continued search for methods to identify patients enrolled in hospice so charges go to the appropriate Medicare provider.**

#### **Hospice Waivers Made Permanent Conditions of Participation**

*CMS proposes to make permanent select regulatory blanket waivers that were issued to Medicare-participating hospice agencies during the COVID-19 PHE. For hospice aide competency evaluations, the use of the pseudo-patient and an addition trigger requiring an evaluation are proposed.*

**Comment:** UnityPoint Hospice is generally supportive of these revisions. **We encourage CMS to reconsider including tele-visits within visit counts on the claim.** This flexibility has been vital during the PHE and has proven particularly efficient in service delivery in rural areas. Should CMS include telehealth visits, it would be reasonable to limit the overall number of tele-visits within the visit count to guard against fraud and abuse concerns and to prohibit the use of telehealth to trigger service intensity reimbursement. **In terms of the hospice aide competencies, we wholeheartedly support these changes** that enable more time-efficient evaluations and promote timely staff onboarding.

### Hospice Quality Reporting Program

*CMS proposes the addition of claims-based Hospice Care Index (HCI) measure and Hospice Visits in the Last Days of Life (HVLDL) measure for public reporting and the removal of the seven Hospice Item Set (HIS) measures to be replaced by the NQF 3235 HIS Comprehensive Assessment Measure. CMS proposed the further development of Hospice Outcome and Patient Evaluation (HOPE) assessment instrument. Due to COVID-19 PHE exemptions, the public reporting refresh cycle will include fewer standard quarters of data. Also, CMS is adding the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey Star ratings.*

**Comment:** UnityPoint Hospice applauds CMS for clarifying measure definitions and including more claims-based measures to reduce reporting burden. That said, terminal illness is unpredictable and it is still challenging to achieve the billable combination of a nurse and social worker to have two visits within the last three days of life. **We would encourage CMS to enable operational flexibility and authorize a visit by any hospice interdisciplinary team member to count as a “billable” or reimbursable visit for purposes of this measure.** Case in point is the irony of a chaplain visit being an ineligible hospice visit. Our hospice interdisciplinary team is already ready and able to offer support 24/7/365. We also respect patient and family choice for when they want and when they do not want visits. Not all hospice families want to have visits during this sacred time and we respect their decision for what level and kind of support is preferred during the last few days of their loved ones life. That patient / family choice should be reflected in the data. While UnityPoint Hospice has been working with analytics and external companies on a last days care pathway, this work is expensive and time-consuming.

### Request for Information

#### A. Fast Healthcare Interoperability Resource

*CMS is seeking feedback on future plans to define digital quality measures for the HQRP. CMS is also seeking feedback on the potential use of Fast Healthcare Interoperable Resources (FHIR) for dQMs within the HQRP aligning where possible with other quality programs. To enable transformation of CMS' quality measurement enterprise to be fully digital, CMS has posed specific questions.*

**Comment:** In the context of an integrated health care system that has historically been early adopters of electronic health records (EHRs) and FHIR, the biggest concerns lie within the variation of FHIR versions, lack of version requirements, and variation in industry timelines. With three different versions of FHIR and no version requirements, this puts limitations on a provider's ability to connect

to certain application interfaces. There is no consistency in who is required to have FHIR, how to submit data, and when to submit data. This becomes a large challenge for providers who attempt to submit data utilizing these vendors and payors. UnityPoint Health (our parent organization) uses a combination of DSTU 2, STU 3 and R4 FHIR Versions to meet requirements for sending data. Since 2017, four main versions have been released in addition to sub-versions released to correct errors or issues in technological builds, meaning vendors and providers have had to sort through up to six version updates to land at v4.1.0, the most recent “Permanent Home” version of FHIR. It should be noted that not all health care organizations are at v4.1.0 yet because vendors and providers are not required to meet ONC CURES Edition CEHRT.

Variation also exists within care settings. For example, hospice, SNFs, and other post-acute care settings are often behind in technology use, largely due to lack of federal support, funding, and program inclusion around the use of EHRs. For UnityPoint Health, post-acute care facilities were not actively participating in Promoting Interoperability (formerly known as Meaningful Use), and therefore many of their software requirements do not contain FHIR components at all. As such, these care settings became delayed in the FHIR timeline as well.

While UnityPoint Health appreciates the attempt to align health care interoperability resources, integrated health systems have competing information technology builds and priorities across care settings, which is true on a smaller scale for providers and smaller organizations. When UnityPoint Health rolled out an EHR through Meaningful Use requirements in the hospital inpatient setting, it was a multiyear process. **Overall, UnityPoint Health recommends slowing down the implementation and updates of new standards in health care interoperability, allowing all parties, including CMS’ technology, to catch up and align as an industry.** Specifically, we urge CMS to consider:

- **A stair step approach to implementation for hospices**, first incentivizing milestones along the way and, at an appropriate point in the timeline, introducing a negative incentive to promote long-term adherence.
- **Biennial updates to FHIR for all providers.** If releases are consistent and across the board, providers can better plan for resourcing, allocations, and cost.
- **Incorporating social determinates of health (SDOH) as part of the standardized CCD documentation applicable to all providers.** This will allow the integration of such information into a patient’s chart and ultimately promote transparency in Health Equity.
- **Standardized reporting requirements across all programs** to enable utilization of software and quality measures across all care settings allowing better continuity of care. This will facilitate vendors and providers to concentrate efforts universally and lessen the chances for some providers and/or care settings to be left behind.
- **Program incentives for stakeholders to partner with vendors in pilot programs and models.** Payment or flexibilities to participating providers would encourage a robust testing environment in which stakeholder input is included.

**B. Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs**

*CMS is committed to closing the equity gap and has a portfolio of programs aimed at transparency of quality. For hospice, CMS is seeking comment on expanding measure development and adding aspects of SPADEs that could apply to hospice and address gaps in health equity in the HQR. To enable continuity of care across different PAC settings, CMS is seeking comment on specific items.*

**Comment:** UnityPoint Health is supportive of diversity, equity and inclusion (DEI) and believes in Health Equity. **Additional recommendations in closing the health equity gap will be included within UnityPoint Health's comment letter to CMS-1752-P, Hospital Inpatient Prospective Payment Systems (IPPS).**

We are pleased to provide input on this proposed rule and its impact on our hospice agencies and our patients, their caregivers and families. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Government & External Affairs at [Cathy.Simmons@unitypoint.org](mailto:Cathy.Simmons@unitypoint.org) or 319-361-2336.

Sincerely,



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