



UnityPoint at Home

Administration
11333 Aurora Avenue
Urbandale, Iowa 50322
unitypoint.org

June 26, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1675-P
P.O. Box 8010
Baltimore, MD 21244-1850

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

Submitted electronically via www.regulations.gov

Dear Ms. Verma:

UnityPoint Hospice appreciates the opportunity to provide comments on the FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements. Our parent organization, UnityPoint at Home, is the Home Health Agency affiliated with UnityPoint Health, one of the nation's most integrated healthcare systems. 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. Among our achievements, we are early HIT adopters (telehealth, video, remote wound care, I-phones) and have been recognized for our progressive programming – our palliative care program started in 2005 and earned the American Hospital Association's Circle of Life Award in 2013.

UnityPoint at Home has long recognized the importance of Hospice services for our patients. UnityPoint Hospice is affiliated with 8 Medicare licenses 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 spent by CMS in developing these proposed regulations. As a member of the National Hospice and Palliative Care Organization NHPCO, we support the formal comments submitted by NHPCO. In addition, we respectfully offer the following detailed comments on a few select issues for your consideration.

SOURCES OF CLINICAL INFORMATION FOR CERTIFYING TERMINAL ILLNESS

CMS is seeking comment for future rulemaking related to the adequacy of supporting documentation for certifying terminal illness. At the root of this request appears to be CMS' concern that some hospice providers lack processes to ensure comprehensive clinical review to support certification and/or lack documentation best practices to support certification. Whereas current regulation sets forth the "type of clinical information the hospice medical director or hospice physician designee must consider in the certification of terminal illness, the source of this clinical information is not clearly identified." CMS has requested input on the adoption of two potential regulatory directives to specify that: (1) the referring physician's and/or the acute/post-acute care facility's medical record would serve as the basis for initial hospice eligibility; and (2) 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 hospice eligibility determinations, only if needed to augment the clinical information from the referring determinations.

Comment: At UnityPoint Hospice, 45% of our beneficiaries die within seven days of Hospice Election. UnityPoint Hospice opposes both proposals as creating unwarranted regulatory barriers to hospice care entry. We urge CMS to keep the regulation as is to allow Medical Directors or the hospice physician designees flexibility to establish best practices in performing a comprehensive assessment. The more CMS regulations require specific documents/processes, the more that the certification becomes about collecting certain documents or performing certain processes as opposed to the substance of the certification.

Referring Physician or Acute/Post-Acute Care Facility Medical Record: Since each beneficiary is unique, we oppose any statement that one source of documentation should be the basis or take precedence in an initial certification of terminal illness. While these sources may in fact be important and significant in this certification, these documents may not target the status of a terminal illness and other clinical documentation including recent home health or post-discharge visits may be more representative of the beneficiaries' current disease state. In establishing a record to demonstrate a comprehensive assessment of terminal illness, Medical Directors should be allowed flexibility.

Also, we take odds with CMS' statement that family physicians constitute the majority of Hospice referrals (footnote 9 within the CMS Proposed Rule) and we suggest that CMS refrain from using this study in support of this concept. First, this source is dated (from 2008) and

the statement appears to be taken out of context.¹ Second and more importantly, CMS does not appear to have examined recent statistics related to referral sources - our own data indicates that at least 60% of UnityPoint Hospice referrals are post-acute and come from hospitalists. Further our referral patterns do not attribute the remaining 40% solely to family physicians, as specialist physicians and/or family members are frequently involved.

Face-To-Face Visit from Hospice Medical Director or Hospice Physician Designee: Again, we oppose reference to specific processes to be used for this certification in lieu of promoting best practice flexibility. Currently this option exists – a Hospice Medical Director or Hospice Physician Designee may conduct a face-to-face visit when warranted. By placing this language in regulation (even as optional), it unduly questions the sufficiency of visits by other hospice team members and disregards processes in place by Hospice Agencies to promote top of practice licensure. For UnityPoint Hospice, which operates in primarily rural areas with distance barriers, this will negatively impact operations and efficiency.

In our opinion, CMS' continual efforts to further regulate this certification process is misguided. The current regulations are sufficient to direct Hospice Agencies to perform comprehensive assessment underlying certifications of terminal illness. Instead, CMS should use existing enforcement mechanisms to correct and penalize Hospice Agencies that continue to engage in fraud and abuse related to hospice eligibility. UnityPoint Hospice cautions CMS against adopting heightened regulatory requirements based on the actions of a relatively few bad actors. We request that CMS refrain from overregulating this area without clear and significant evidence of abuse. The impact of heightened regulations impacts high-performing as well as noncompliant Hospice Agencies and the ability to absorb more infrastructure costs will impact cost margins for all Hospices regardless of the quality provided. More regulations may significantly reduce the number of compliant Hospice Agencies and negatively impact beneficiary and family service options.

NON-HOSPICE SPENDING – QUALITY IMPROVEMENT ORGANIZATION REVIEW

Current regulation requires that providers must inform Medicare beneficiaries at the time of admission, in writing, that the care for which Medicare payment is sought will be subject to Quality Improvement Organization (QIO) review. This provision is intended in part to provide recourse for a beneficiary that disagrees with the Hospice Agency determination of what conditions are unrelated to the terminal illness and related conditions or other changes in circumstances.

¹ Michelle T. Weckmann, MD, MS, University of Iowa Hospitals and Clinics, Iowa *The Role of the Family Physician in the Referral and Management of Hospice Patients*. Am Fam Physician, 2008 Mar 15;77(6):807–812. – page 807-8 reads: “Patients with a non-cancer diagnosis may also benefit greatly from hospice care; noncancer diagnoses (e.g., congestive heart failure, chronic obstructive pulmonary disease, failure to thrive, dementia) currently represent 56 percent of all hospice admissions. The responsibility for hospice referral in a non-cancer diagnosis often falls to the primary care physician, facilitating continuity of care for the patient in his or her final days and months.”

Comment: By definition, hospice care provides patient-centered care, respects patient quality of life goals, and offers emotional, spiritual and physical support for patients with life-limiting prognoses and their families. In some cases, a beneficiary's circumstances change – their disease process has plateaued, their prognosis becomes longer than 6 months, or they desire aggressive/curative treatment disallowed under the Hospice Benefit. Under these changing circumstances, a Hospice Medical Director may choose not to recertify the terminal illness. These recertification decisions are not subject to whimsy and the underlying conversations with beneficiaries and their families can be very emotional when they want to retain hospice services despite need. On the few occasions when these recertification denials have been appealed to the QIO from a UnityPoint Hospice beneficiary, the role of the QIO physician and the finality of their decisions has been confusing and can lead to an increase in non-hospice spending. Recently, a QIO physician overturned the denial of recertification by our Medical Director. In this case, our Medical Director denied recertification because the beneficiary wanted to concurrently seek aggressive treatment for a related condition. The QIO physician ruled that the beneficiary should be recertified. UnityPoint Hospice's Medical Director did not agree with this ruling and, after consulting with the QIO, the beneficiary was ultimately transferred to another Hospice Agency, resulting in a stressful end of life experience for all. Currently, the Medicare Administrative Contractor (MAC) can still deny payment for a hospice beneficiary for not qualifying, even after the QIO rules that beneficiary should remain in hospice.

We urge CMS to clarify the QIO appeals process so that beneficiaries and Hospice Agencies understand the scope and ramifications of these appeals. We believe that QIO appeals should involve the same comprehensive review of clinical information as was used in the most recent certification of terminal illness for that beneficiary, but should give deference to documentation related to change in circumstance, including targeted outreach by the QIO physician during the appeal to the Medical Director. We would also recommend that, in denial cases involving a beneficiary's desire for curative/aggressive treatment, the QIO physician consult with the MAC regarding reimbursement under the Hospice Benefit, as the QIO decision to overrule may impact non-hospice spending.

MEASURE CONCEPTS UNDER CONSIDERATION FOR FUTURE YEARS

CMS is considering two additional claims-based measures – potentially avoidable hospice care transitions and access to levels of hospice care. The intent of the first measure is to encourage hospice providers to assess and manage beneficiaries' risk of care transitions to improve the quality care at the end of life.

Comment - Priority Area 1: Potentially Avoidable Hospice Care Transitions. As CMS determines priority areas for further quality measurement, CMS should continue to implement evidence-based standards and the work efforts 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). While UnityPoint at Home supports the intent of the “Potentially Avoidable Hospice Care Transitions” measure, we encourage CMS to work with stakeholders to carefully define this measure. In particular, CMS with the assistance of stakeholders should identify existing Medicare and other payment rules that presently require transitions in care during a hospice election period so that these situations are excluded from the avoidable transitions definition. Currently, it is close to impossible to qualify a hospice beneficiary at the General Inpatient level for more than 24 hours, requiring a transfer of that beneficiary at a very critical time in their last hours. An example is a beneficiary in an Intensive Care Unit that is being extubated. Although the attending physician knew the beneficiary would likely die during a transfer, the beneficiary’s pain and symptoms were well managed and there was no option to extend General Inpatient services. Ultimately, the beneficiary was required to be transferred from the acute care setting and died in the ambulance in transport during the required transition. Although we would like to see this rule changed, this transition of care was not avoidable under current CMS reimbursement rules. Should this measure progress, we look forward to reviewing and providing comment on measure definitions, specifications, and timeline for implementation.

We appreciate the opportunity to provide comments to the proposed rule and its impact on our Hospice Agencies and beneficiaries. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Executive Director, Government and External Affairs at Cathy.Simmons@unitypoint.org or 319-361-2336.

Sincerely,



Leanne E. Burrack, RN, MSN
Statewide Executive Director
UnityPoint Hospice



Cathy Simmons, JD, MPP
Executive Director, Regulatory Affairs
Government & External Affairs, UnityPoint Health