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June 17, 2019

Administrator Seema Verma
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1714-P
P.O. Box 8010
Baltimore, MD 21244–1850

RE: CMS–1714-P - Medicare Program; FY2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements; published at Vol. 84, No. 80 Federal Register 17570-17618 on April 25, 2019.

Submitted electronically via http://www.regulations.gov

Dear Administrator Verma,

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 healthcare systems. Through more than 32,000 employees and our relationships with more than 310 physician clinics, 39 hospitals in metropolitan and rural communities and 19 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[1] 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 support the formal***

[1] Iowa does not require hospice licensure.

comments submitted by NHPCO. In addition, we respectfully offer the following input.

REBASING OF THE CONTINUOUS HOME CARE (CHC), INPATIENT RESPITE CARE (IRC) AND GENERAL INPATIENT CARE (GIC) PAYMENT RATES FOR FY2020

The proposed rule rebases the payment rates for CHC and GIP and sets these rates equal to their estimated FY2019 average costs per day and also rebases the payment rate for IRC and sets this rate equal to the estimated FY2019 average cost per day, with a 5% reduction to account for coinsurance. For budget neutrality, the proposal applies a 2.71% reduction to the Routine Home Care (RHC) payment rates to offset the proposed increases to the CHC, IRC and GIP payment rates.

Comment: ***We are extremely concerned that the proposed rebasing is misguided and do not believe that CHC, IRC and GIC payments should be increased to the detriment of RHC payments.*** Foremost, we are concerned that CMS does not appreciate level of care distinctions and that level of care should be dictated not by payment rate but by beneficiary need and goals of care. An RHC level of care is, in itself, an intense service and should encompass the vast majority of claims; after all, most goals of care reflect a desire to remain at home. We do not find it inappropriate that RHC claims would represent between 92-98% of claims, and we believe initiatives to reduce RHC would further decrease already low average lengths of stay (ALOS) – the national ALOS is an anemic 17 days and UnityPoint Hospice has a 12-day MLOS.

Further this rebasing would suggest that CMS believes that GIP and IRC levels of care are underutilized and can be incentivized through increased payment, which may not be appropriate for, or preferred by, beneficiaries. Ultimately, it is the hospice care plan, which contains the wishes of the beneficiary and their family, that should take precedence for determining levels of care. ***If CMS believes that GIP or IRC should be utilized more, we would recommend CMS apply substantive and not payment changes to these categories.*** For instance, CMS could alter the length or frequency of the IRC from its current 5-day limitation. As for GIP, we would recommend that CMS reach out to its intermediaries and review their denials in this area to determine how best to incorporate further flexibilities here. While GIP is oftentimes not aligned with beneficiary desires, there are occasions when this is not pursued because intermediaries have refused coverage. We will reiterate our concern detailed in last year's comment letter:

> *For GIP, we have similar concerns. Because every shift must justify this level of care every 8 hours, this requires that physicians make daily visits, which may not be medically required, creates arbitrary caseload constraints and does not encourage top of licensure practices. In our MAC region, we have also experienced denials for GIP that last more than 24 hours, which has changed our practice patterns to avoid greater lengths of stay. If there is a desire by CMS to encourage greater lengths of stay outside RHC, we would recommend that CMS examine underlying staffing and documentation timing requirements in addition to utilization trends. The goal of the regulatory review would be to enable hospices to trigger different levels of care in a more timely manner and without fear of claim denials based on documentation rationale rather than patient need.*[2]

[2] See UnityPoint at Home 2018 comment letter, ID: CMS-2018-0058-0030 at https://www.regulations.gov/document?D=CMS-2018-0058-0030

We would also note our concern that this rebasing will further reduce access to care in rural areas. UnityPoint Hospice operates a rural Hospice that has 100% of its claims categorized appropriately as RHC. Due to its low volume, its current operating margin is barely in the black. This rebasing will disproportionately impact this agency and likely jeopardize its continued operations.

PROPOSED FY 2020 HOSPICE WAGE INDEX AND RATE UPDATE

The proposed hospice payment update percentage for FY2020 would be 2.7 percent. As a result, the proposed FY2020 payments rates are: CHC code 652, $1,378.43; IRC code 655, $441.02; and GIC code 656, $1007.42. The FY2020 hospice cap amount will be $29,993.99. CMS is soliciting comments on (1) the alignment of the hospice wage index with that of the SNF PPS and Home Health PPS, by using the most current pre-floor, pre-reclassified IPPS hospital wage index as the basis for the hospice wage index and (2) suggestions for possible updates and improvements to the geographic adjustment of hospice payments.

Comment: We have two observations:

- The proposed increase in the wage index slightly diminishes the overall payment reductions contained within this rule. We appreciate adjustments in wages that recognize the need to recruit and retain a stable workforce for hospice, but wages are just one component of overall program stability. ***For programs with tight operating margins, the continued compression of rates will result in more limited choices of hospice providers, particularly in rural areas and from non-profit hospice agencies***; and

- The cap amount is again increased. UnityPoint Hospice operates hospice agencies in Iowa and Illinois. Our hospice agencies have rarely hit the cap amount, and we attribute this to our focus on the appropriate interpretation and use of hospice program admission and discharge rules. We recognize that not all hospice agencies operate similarly and 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.

ELECTION STATEMENT CONTENT MODIFICATIONS AND PROPOSED ADDENDUM

This proposal would modify the hospice election statement content requirements to increase coverage transparency for patients under a hospice election. Hospices would be required, upon request, to provide to the beneficiary (or representative) or other non-hospice providers treating such conditions an election statement addendum with a list and rationale for the conditions, items, services and drugs that the hospice has determined as unrelated to the terminal illness and related conditions. During the course of hospice care, hospices are required to issue new addendums if there are changes to the plan of care that result in a determination that a new illness or condition has arisen. Timeframes to provide this information to the requesting party are proposed. Signed addendums would be a new condition for payment.

Comment: While UnityPoint Hospice supports transparency efforts, ***we vehemently oppose the election statement addendum requirement*** for "a written list and a rationale for the conditions, items, drugs or services that the hospice has determined to be unrelated to the terminal illness and related conditions," which has far-reaching implications. Our concerns relate to the following:

- Overreaching scope of the proposal: This proposal is in reaction to anecdotal reports that "**some** hospices are not adequately informing hospice patients at hospice election about the scope of services covered under the hospice benefit." We empathize with the specific instances that were provided in the preamble; however, CMS has not quantified the scope of this issue to justify a "solution" that impacts the entire industry with burdensome paperwork to be completed by a registered nurse "as part of the routine admission paperwork." While we wholeheartedly agree with the CMS expectation that services received outside of the hospice benefit are "rare" and we do not condone care plan decisions "based on cost or convenience rather than the needs, preferences and goals of the patient," the preamble does not state that CMS lacks authority to address this issue under current regulations. That said, ***we oppose a broad-sweeping, non-targeted solution.*** This regulation would impact all hospices with more paperwork, instead of attempting to target bad practices and offending hospice agencies.

- Administrative burden: As proposed, ***this addendum is at odds with CMS' Patients Over Paperwork initiative***, and its administrative burden and rigorous timeframes are extraordinary and would divert interdisciplinary group time away from direct care services to maintain this paperwork. CMS greatly underestimates the time and effort needed for hospice agencies to complete the addendum. We disagree that a registered nurse would be solely responsible for this task and that form completion will take 10 minutes. As an aside, the CMS estimate also does not include any time for addendum completion upon request or in response to *changes during the course of the hospice election*. The addendum as proposed requires beneficiary-specific information, including the beneficiary's terminal illness and related conditions; a list of the beneficiary's current diagnoses/conditions present on hospice admission (or upon plan of care update, as applicable) and the associated items, services, and drugs, not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions; a written clinical explanation as to why the identified conditions, items, services, and drugs are considered unrelated to the terminal illness and related conditions and not needed for pain or symptom management; and references to any relevant clinical practice, policy or coverage guidelines. ***We do not believe that the initial assessment completed by a registered nurse is sufficient foundation to complete this addendum with coverage implications. This addendum appropriately involves input from the larger interdisciplinary group and, more importantly, the physician member to determine medical necessity.*** It will be challenging at best to develop a beneficiary-specific addendum within the timeframes contemplated and to keep this updated and appropriately distributed.

  In addition, CMS has also vastly underestimated the time and effort required to develop the standardized form. Since this is not a standard CMS form but one in which CMS is making suggestions, it is unrealistic to expect this to be developed in 30 minutes – comprised of 15-minute intervals from both a hospice administrative assistant and the hospice administrator. Since this is an outward-facing document to be provided to beneficiaries and their families, UnityPoint Hospice has in place a process that requires more touchpoints prior to launch. The

CMS calculation does not take account any revisions that must occur to our policies and procedures, other materials and website so that this new documentation is referenced and incorporated, review from legal/compliance and health literacy/patient satisfaction teams to assure the new form meets not only regulatory requirements but language and literacy standards, potential incorporation in EHR data reporting and decision support as well as training to the interdisciplinary group and our community partners to assure understanding of this requirement. In some cases, we also conduct focus groups with beneficiaries prior to launching outward-facing materials. ***Incorporating the time and effort of those in the form development process as well as the comprehensive training efforts needed for the interdisciplinary group, we would conservatively estimate time and effort at 40 hours with salary ranges to encompass all positions involved.*** This estimate does not include time and cost related to EHR revisions. It should also be noted that this time estimate would likely need to occur over the course of a couple months for testing and training purposes.

- Operational implications:
    - Timeframe: ***It is unreasonable to require that the addendum be provided within 48 hours at the time of election or immediately during the course of hospice care.*** We are concerned that the 48-hour timeframe does not recognize the time and effort needed for development of a plan of care. From a medications perspective alone, this timeframe does not allow for medication reconciliation and the de-prescribing of medications. For a beneficiary with upwards of 30 prescriptions, it can take a couple weeks to accomplish the de-prescribing process. This process involves updating the medical record and often requires supporting documentation. This documentation burden usually falls to the direct care providers, who have existing caseloads.
    - Distribution of addendum: ***As written, the regulation is inconsistent related to when hospice agencies are required to provide a written copy of the addendum and what triggers such distribution.*** The requirement is "upon request" both at time of hospice election to the individual/representative and during the course of the hospice election to the individual/representative, non-hospice provider or Medicare contractor. If the content of the addendum is changed during the course of the hospice election, the requirement is for the hospice agency to provide the updated addendum to the individual/representative directly, not upon request. From a compliance perspective, UnityPoint Hospice will probably distribute this document to all beneficiaries, regardless of whether a request is made.

As an alternative, we would recommend that the election statement addendum requirement be eliminated and replaced with an advanced beneficiary notice that could be modified or designed to be specific to hospice services, drugs and items. To minimize paperwork but to maintain the spirit of this proposal to assure communication with beneficiaries about the hospice benefit, we would first encourage CMS to vigorous use its current enforcement powers to target bad practices and those hospice agencies that have a history of anecdotal reports. Should CMS decide that more transparency is required, we would suggest that documentation be included as an advanced beneficiary notice outside the election statement and that the documentation be general in nature but detail what is

not covered under the hospice benefit – equipment, supplies and medications that are outside the hospice benefit, not medically necessary and subject to beneficiary financial responsibility. If this notice was general, instead of beneficiary specific, it could be a standardized CMS form and its standardized content would virtually eliminate time and effort for completion or updates and further cement CMS expectations. A standardized notice would also negate our concerns related to the proposed 48-hour timeframe.

THE ROLE OF HOSPICE AND COORDINATION OF CARE AT END-OF-LIFE

CMS is seeking comments on: (1) How hospice under Medicare FFS relates to other treatment options, how it impacts the provision of a spectrum of care for those that need supportive and palliative care before becoming hospice eligible and after, and whether rates of live discharge are a reflection of the current structure of Medicare FFS; (2) Any care coordination differences for hospice patients that received Medicare through traditional FFS prior to hospice election, were enrolled in an MA plan prior to hospice election, or received care from providers that participate in an Accountable Care Organization (ACO) prior to hospice election; and (3) The pros and cons of including hospice services as the part of the benefits provided in value-based or capitated payment arrangements given that some hospices likely have experience with ACOs and experience with Medicaid managed care when providing hospice care through the Medicaid program, as well as experience in providing hospice care to patients enrolled in ''commercial coverage'' (non-Medicare/Medicaid managed care plans).

Comment: ***Regardless of payment model, we believe that any beneficiary should have timely access to hospice services and that hospice should not be consider as an offshoot or siloed service.*** We support efforts to further engage beneficiaries and their families in advanced care planning so that goals of care are patient-driven, understood by healthcare providers and others touching the lives of beneficiaries and aligned with appropriate services. Hospice providers should be embedded in care teams early, when appropriate and reflected in goals of care. Early inclusion allows hospice input and outreach in support of goals of care. ***While there are outliers, the most telling hospice statistic is the relatively short length of stay for this benefit, particularly when coupled with the high patient satisfaction rates. We believe more could be done with physician outreach to better understand this benefit and its use for beneficiaries.***

(1) FFS Medicare. In terms of Medicare FFS, the hospice "election" itself has created a perception of siloed care and its non-coverage of curative services has created a decision cliff that in many instances results in a delay of this benefit election. Under FFS, hospice agencies are continually involved in outreach efforts aimed at both providers and beneficiaries/families to explain the hospice benefit and election. It has been our observation that beneficiaries under the care of palliative care specialists outside hospice tend to delay hospice elections. ***As for live discharge rates, we are hesitant to correlate this to bad actors (either high ALOS or inappropriate non-Hospice spend) or as a flaw inherent to FFS Medicare.*** UnityPoint Hospice has a 10-11% rate of live discharge, yet we have below national averages for MLOS (12 days) and non-Hospice spend. While this measure can identify inappropriate utilization patterns, the reasons underlying live discharges are not solely attributable to questionable referrals or enrollment.

(2) Care Coordination Differences Based on Service Delivery Reimbursement. ***We have found that the care coordination is heightened when beneficiaries have advanced care planning***

in place. UnityPoint Hospice uses the Respecting Choices model, which emphasizes a transformation in healthcare culture to support person-centered care. With a collective focus on care coordination, we believe that ACOs are starting to emphasize advanced care planning. The market penetration of Medicare Advantage in low in our service areas so we cannot speak to its impact on care coordination.

(3) Value-Based Arrangements. UnityPoint at Home is a Participant in the UnityPoint Accountable Care's Next Generation ACO contract. This value-based arrangement has been important in truly representing a continuum of services for beneficiaries, including those which represent care in place. ***Through participation in the Next Generation ACO, UnityPoint Hospice has gained access to heat maps and analytics tools to facilitate shared-decision making conversations and promote hospice election in a timelier fashion.***

In contrast, our experience with being a service provider outside value-based arrangements with Medicaid managed care organizations (MCO) has not been ideal. In Iowa as an example, the state transitioned the bulk of its Medicaid book of business to MCOs in April 2016. While each MCO has its own policies and procedures, enrollees have generally experienced delays in care due to prior authorization or denials for higher levels or care. In addition, since the advent of managed care, Medicaid payment to hospice agencies for the room and board component has been inconsistent at best, which further strain operating margins of hospice agencies.

UPDATES TO THE HOSPICE QUALITY REPORTING PROGRAM (HQRP)

For the ''Hospice Visits When Death is Imminent'' measure pair implemented in April 2017, hospices must continue to collect and submit data on both measures; however, only measure 1 will be posted to and publicly available on the CMS Hospice Compare website in FY2020. Hospices will continue to complete items O5010, O5020 and O5030 from the HIS V2.00.0 for measure 2. CMS is seeking comment of the extension of CAHPS® Hospice Survey participant requirements for FY2023 and subsequent years as well as the institution of an automatic volume-based exemption for data collection and reporting in FY2022. In terms of future quality measure development, CMS is soliciting comment particularly for the ''high priority'' areas in claims-based measures: Potentially avoidable hospice care transitions and access to levels of hospice care.

Comment: ***In terms of posting the Hospice Visits When Death is Imminent measure pair, we support limiting the posting to measure 1 as the validity and reliability testing of measure 2 is ongoing. We are also supportive of measurement development that moves to outcomes measures.*** This is consistent with other CMS programs that transition from claims-based measures to outcomes-based measures. We agree that claims measures do have limitations – they emphasize processes, do not reflect team-based care and disciplines within and, for smaller hospices, often do not contain sufficient data for trending. As such, we support the continuing work by CMS with stakeholder groups towards the development of an assessment tool, which may provide data for future patient/family outcomes measures.

As for the high-priority claims-based measures, we offer the following:

- Potentially Avoidable Hospice Care Transitions. ***We do not support this measure as is***; however, we recognize that avoidable transitions could indicate gaming behavior. We agree that further development in needed. In terms of the exclusion criteria, the treatment of live discharges or transfers needs to accurately reflect service provision and exclude live discharges or transfers when the beneficiary continues to receive hospice care, but from a different provider. Additionally, we support an exclusion for patient choice as suggested by MAP to reflect that hospice transitions may occur for reasons outside the control of the hospice agency. This measure should target misbehavior by hospice agencies but not penalize agencies for beneficiary choice.

- Access to Levels of Hospice Care. ***We also do not support this measure.*** We believe claims data is fundamentally insufficient to support this measure as it lacks patient acuity information.

Lastly, CMS is seeking comment of the extension of CAHPS® Hospice Survey participant requirements for FY2023 and beyond. We have observed that our hospice agencies often obtain feedback targeted to facilities or other providers outside the hospice benefit. Our primary recommendation for this survey would be to better differentiate them so that comments are targeted to hospice providers. Perhaps this could include a hospice logo or formatting to bold/highlight the service. In addition, we would recommend that the survey include less than 20 questions more targeted to hospice; and for caregiver surveys, we would suggest administration through an electronic option as well as a shortened timeframe (from 45 days to 6 weeks).

We are pleased to provide input on this proposed rule and its impact on our hospice agencies and our beneficiaries, 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 or 319-361-2336.

Sincerely,

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