UnityPoint at Home

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May 24, 2024

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1810-P
P.O. Box 8010
Baltimore, MD 21244–1850

RE: CMS–1810-P - Medicare Program; FY 2025 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements; published at Vol. 89, No. 66 Federal Register 23778-23838 on April 4, 2024.

Submitted electronically via 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 29,000 employees and our relationships with 375+ physician clinics, 36 hospitals in urban and rural communities, and 13 home health agencies across our 8 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 CMS Medicare Shared Savings Program Model, is participating in the Home Health Value-Based Purchasing (HHVBP) Model in Iowa and was a former 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) and the National Association of Home Care & Hospice (NAHC), we generally support the comments submitted by NHPCO and NAHC to this rule**. Additionally, we respectfully offer the following input.

PROPOSED FY 2025 HOSPICE WAGE INDEX AND RATE UPDATE

CMS proposed a FY 2025 hospice payment update percentage of 2.6% (an estimated increase of $705 million in payments from FY 2024). This is a result of a 3% market basket increase reduced by a 0.4 percentage point productivity adjustment. The proposed hospice cap amount for FY 2025 is $34,364.85.

Comment: UnityPoint Hospice generally supports increases to the market basket update; however, a 2.6% increase is not sufficient to keep up with inflation and maintain wages to provide sustainable, high-quality services to beneficiaries electing the Hospice Benefit. To put in context, the 2.6% amount will likely not cover the cost to operationalize the new HOPE assessment tool, which entails vendor development and validation expenses as well as staff training. Costs that continue to rise beyond the update are medications, equipment, labor and travel. For our footprint which contains rural geographies, the ability to serve rural beneficiaries is significantly impacted as caseloads for teams serving rural beneficiaries is less than those in urban areas due to distance and travel.

We also encourage CMS to reevaluate the use of the hospital wage data for calculating the Hospice Benefit wage index. We believe that inpatient hospital prospective payment wage index is inappropriate to use as the basis for the hospice wage index as well as the home health wage index and that CMS has other more appropriate wage information for these care settings.

HOSPICE CONDITIONS OF PARTICIPATION (CoP) TECHNICAL UPDATE

CMS proposes clarifying changes to align medical director CoP and hospice payments requirements. CMS also proposes clarifying changes to distinguish the separate requirements for the election statement and the Notice of Election.

Comment: Thank you. **UnityPoint Hospice supports the proposed clarifications**.

PROPOSALS AND UPDATES TO THE HOSPICE QUALITY REPORTING PROGRAM (HQRP)

For FY 2025, CMS proposes to replace the entire Hospice Item Set (HIS) with the Hospice Outcomes and Patient Evaluation (HOPE) collection tool. The HOPE tool includes several domains that are new or expanded. For FY 2028, CMS proposes to add two quality measures: (1) Timely Reassessment of Pain Impact; and (2) Timely Reassessment of Non-Pain Symptom Impact.

Comment: We support the transition to the new HOPE quality reporting tool, but strongly urge CMS to delay implementation until July of 2025. The proposed start of October 1, 2024 (FY 2025) does not allow enough time from final rule issuance to go live for an entirely new tool impacting all hospices. Even if the final rule was released August 1, 2024, this provides only 60 days for vendor solutions and testing as well as EHR changes and staff training. For vendors, they historically have not developed software builds based on technical specifications until those specifications are finalized. For Hospice Agencies, we cannot train staff until EHR changes are developed, incorporated and validated. The magnitude of the change from a new tool is huge, and short-changing the timeframe to operationalize will set up Hospice Agencies for failure.

As for the two proposed measures for FY 2028, these measures miss the mark and do not solve for getting beneficiaries good care. The timely reassessments are process measures, not outcome measures.

Instead CMS should focus on outcome measurement efforts to prevent fraud, waste, and abuse and utilize datapoints that are currently collected. For instance, CMS could be measuring/auditing and enforcing/incentivizing hospices to avoid hospitalizations and/or live discharges. Hospices are charged with symptom management – hospitalization and/or discharge rates are claims based and indicate that symptom management is not occurring.

PROPOSED CAHPS HOSPICE SURVEY UPDATES

CMS proposes to add a web-mail mode, shorten and simplify the survey, modify the administration protocols, add a new Care Preference measure, revise both the Hospice Team Communication and the Getting Hospice Care Training measures, and remove several items, including three related to nursing homes. Additionally CMS intends no impact to the Hospice Special Focus Program from non-substantive changes to the Overall Rating of this Hospice measure.

Comment: UnityPoint Hospice is generally supportive of the CAHPS Hospice survey updates and applauds CMS for revising questions to enhance understanding, expanding modes of delivery beyond mail, and extending data collection periods. These surveys are sent to families who are experiencing a new normal, have survey fatigue, and do not see value in a lengthy "snail mail" survey. We believe these revisions will enhance the survey content and response rate.

UnityPoint Hospice opposes the addition of a prenotification letter, as providing little juice for the squeeze, and urges CMS to remove this requirement. The mailing of a pre-notification letter one week prior to survey administration is stated to be associated with an increase in response rates of 2.4 percentage points. We do not believe that a 2.4% increase is significant or justifies additional vendor time and effort in mailing, tracking and staffing these prenotifications. Additionally CMS fails to account for additional vendor costs for these prenotification letters, which will be passed through to Hospice Agencies. Lastly, CMS does not reference the likely adverse impact on overall beneficiary and caregiver satisfaction with this addition to CMS process emails/notifications. Even if there is a slight bump in response rate, we believe unnecessary notifications will negatively influence the actual responses to survey questions themselves. Given the other proposed changes to enhance survey response, it is premature to insert an additional prenotification into this process.

REQUEST FOR INFORMATION (RFI): PAYMENNT MECHANISMS FOR HIGH INTENSITY PALLIATIVE CARE SERVICES PROPOSAL TO THE HOSPICE QUALITY REPORTING SYSTEM

CMS solicits comments from the public related to potential implementation of a separate payment mechanism to account for high-intensity palliative care services (i.e., palliative dialysis, chemotherapy, radiation, and transfusions) provided under the Hospice Benefit.

Comment: This is the second year that CMS has included an RFI in this annual payment rule that targets services for complex patients. We appreciate that CMS is seeking stakeholder input as these beneficiaries require more resource-intensive care and often the Hospice Benefit reimbursement structure does not fully recognize these differentiated costs. However, we are concerned that this issue is based on anecdotal stories from beneficiaries and families that some Hospice Agencies are not providing palliative relief and symptom control therapies under the Hospice Benefit. This issue is not lack of access, but rather decisions by participating hospices that the costs of these eligible services are prohibitive. **UnityPoint Hospice does**

not support modifying and/or adding to the Hospice Benefit without further CMS analysis to identify gaps in care and potential fraud, waste and abuse (i.e. hospices with a large market share telling beneficiaries they "can't" when really it is they "won't"). At UnityPoint Hospice, our caseload is comprised mainly of oncology, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD) patients, and we provide palliative services within the Hospice Benefit. While UnityPoint Hospice agrees that high-cost palliative services are underfunded under the hospice election, the problem being solved for in this RFI appears to be a fraud, waste, and abuse issue combined with a lack of advanced care planning.

To solve for the fraud, waste, and abuse issue, we suggest that CMS:

- **Incentivize advanced care planning**. This could be accomplished by enhancing reimbursement rates for advanced care planning and/or requiring providers to conduct advanced care planning conversations with beneficiaries at a certain age or upon a certain diagnosis.
- **Monitor and enforce appropriate provision of the Hospice Benefit**. CMS has existing data to identify Hospice Agency behavior that does not align with the intent of the Hospice Benefit, such as high spending outside of the benefit, not admitting patients with high-cost therapies, etc., as well as existing authority to enforce the Hospice Benefit. Specifically, CMS should routinely review claims data to make correlations and identify themes across Hospice Agencies:
    - Specific indicators: Hospitalization rates; rehospitalization rates; percentage of days in long-term care compared to other settings; patient visits in last 3 and 7 days of life; and percentage of live discharges.
    - Beneficiary characteristics: Primary diagnosis; setting of care upon admission.
    - Hospice spending outside the Hospice Benefit.

From this data review, CMS should incentivize good behavior by embedding these within quality measurements or instituting them in corporate integrity measures.

UnityPoint Hospice opposes establishing a fourth per-diem rate structure with different eligibility criteria, heightened documentation requirements, and many unknowns from a payment and operational perspective. Instead, we encourage CMS to adopt the Medicare Care Choices Model (MCCM) for these beneficiaries where there have been proven outcomes with tested pilots. An iteration of this model is also in play in the Concurrent Care Waiver under the REACH ACO model. It is premature to institute blanket provisions impacting the entire hospice industry if the problem relates to select bad actors. Embedding additional requirements to combat fraud, waste and abuse without targeted enforcement will further diminish tight operating margins of high-quality Hospice Agencies with complex beneficiary caseloads. If CMS restructures the Hospice Benefit, It will be unnecessary CMS regulations themselves that will cause access issues and further industry consolidation.

1. *What could eliminate the financial risk commenters previously noted when providing complex palliative treatments and higher intensity levels of hospice care?*

   Higher payment rates or add-on payments would allow Hospice Agencies to provide the additional

treatments and staff to support higher intensity care without having significant financial burdens. **While enhanced payments can address reimbursement, documentation and administrative burden tied to these payments should be minimized to avoid delays in care**.

2. *What specific financial risks or costs are of particular concern to hospices that would prevent the provision of higher-cost palliative treatments when appropriate for some beneficiaries? Are there individual cost barriers which may prevent a hospice from providing higher-cost palliative care services? For example, is there a cost barrier related to obtaining the appropriate equipment (for example, dialysis machine)? Or is there a cost barrier related to the treatment itself (for example, obtaining the necessary drugs or access to specialized staff)?*

The main barrier is the cost of the treatments. In some instances, access and costs are influenced by specialist networks. In the case of dialysis treatments, Hospice Agencies may be required to obtain an agreement and negotiate rates for the dialysis center to provide services. The dialysis sector is highly consolidated with the five largest dialysis organizations accounting for about 85% of facilities and Medicare Fee-for-Service treatments.[1]

3. *Should there be any parameters around when palliative treatments should qualify for a different type of payment? For example, we are interested in understanding from hospices who do provide these types of palliative treatments whether the patient is generally in a higher level of care (CHC, GIP) when the decision is made to furnish a higher-cost palliative treatment? Should an additional payment only be applicable when the patient is in RHC?*

Although specialized treatments should be reimbursed at a higher rate or subject to an add-on payment-based treatment/diagnosis, these treatments should not trigger a higher level of care. In our experience, because the use of these services does not directly correlate to a need for a higher intensity level of hospice care, these beneficiaries typically remain at a Routine Level of Care.

UnityPoint Hospice reiterates from our FY 2024 comment letter the lessons learned from our participation in MCCM. For instance, renal patients generally have a shortened life expectancy. When a hospice election is delayed until dialysis is discontinued, the hospice length of stay is generally short and any palliative effects of dialysis impacting quality of life are foregone, which may address dyspnea, lack of energy, drowsiness, dry mouth, pain, sleep disturbances, restless legs, itchiness, dry skin, and constipation. To increase hospice elections by renal patients, CMS could provide guidance and commensurate reimbursement (i.e. service intensity payment) for palliative dialysis within the Hospice Benefit or alternatively allow renal patients to make a hospice election as presently defined with a palliative dialysis carve-out. Under either it is likely that quality of life will be enhanced, and the hospice length of stay will increase. **We do not anticipate that level of care will increase with most beneficiaries remaining in Routine Hospice Care.** Similarly, UnityPoint Hospice cared for beneficiaries undergoing chemotherapy within the MCCM pilot and found it to be similarly beneficial for their quality of life and family interests.

4. *Under the Hospice Benefit, palliative care is defined as patient and family centered care that*

[1] MedPAC, March 2024 Report to the Congress: Medicare Payment Policy, Chapter 5: Outpatient Dialysis Services, page 135, accessed at https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch5_MedPAC_Report_To_Congress_SEC.pdf

optimizes quality of life by anticipating, preventing, and treating suffering (§ 418.3). In addition to this definition of palliative care, should CMS consider defining palliative services, specifically regarding high-cost treatments? Note, CMS is not seeking a change to the definition of palliative care but rather should CMS consider defining palliative services with regard to high-cost treatments?

UnityPoint Hospice again harkens to our participation in the Medicare Care Choices Model and urges CMS to consider using this tested model. Palliative services were provided and carved out of the Hospice Benefit. This model worked well and allowed earlier interventions by Hospice Agencies without discontinuing palliative treatments. This patient-centered model allowed Hospice Agencies to provide wrap-around, holistic services that improved quality of life, decreased avoidable emergency department visits and hospitalizations, and increased symptom management.

5. *Should there be documentation that all other palliative measures have been exhausted prior to billing for a payment for a higher-cost treatment? If so, would that continue to be a barrier for hospices?*

Documentation to demonstrate that "all other palliative measures have been exhausted" is nebulous and should not be used to trigger enhanced or add-on payments. This standard for additional documentation will undoubtedly create more beneficiary burdens to hospice election and result in delays in hospice admissions and ultimately shorter lengths of hospice stays for these complex beneficiaries.

6. Should there be separate payments for different types of higher-cost palliative treatments or one standard payment for any higher-cost treatment that would exceed the per-diem rate?

A simpler solution would be to carve out the palliative treatments and continue to bill them to Medicare. If provided within the Hospice Benefit, CMS should institute separate payments for different types of palliative treatments, which vary in underlying cost. The rationale for separate payments by treatment is akin to CMS' Innovation Center piloting various value-based models under its specialty strategy (Enhanced Oncology Model; ESRD Treatment Choice (ETC) Model; Guiding an Improved Dementia Experience (GUIDE) Model), instead of one specialty model.

REQUEST FOR INFORMATION (RFI): FUTURE HQRP SOCIAL DETERMINANTS OF HEALTH (SDOH) ITEMS

CMS has identified four SDOH domains that are relevant across the Post Acute Care and hospice care settings: housing instability, food insecurity, utility challenges, and barriers to transportation access. In relation to the HQRP, CMS requests input on data collection items that are suitable for the hospice setting and how they may need to be adapted to be more appropriate for the hospice setting.

Comment: UnityPoint Hospice agrees that capturing meaningful and actionable SDOH items can enhance quality of life. **We support SDOH item collection with the caveat that the process is not administratively burdensome and not duplicative**. For the Hospice industry generally, median average lengths of stay is relatively short at 18 days.[2] With this short length of stay limitation, it is unreasonable and unnecessary

[2] MedPAC, March 2024 Report to the Congress: Medicare Payment Policy, Chapter 9: Hospice Services, page 273, accessed at https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch9_MedPAC_Report_To_Congress_SEC.pdf

to require automatic data collection every 14 days (i.e. triggered at each comprehensive assessment). Instead assessments should be triggered by whether the assessment is actionable – does it impact risk adjustment to per-diem payments, risk adjustment to quality measures, etc. We recommend that CMS start by limiting the assessment triggers to admission, change in place of service, or other significant changes.

1. *For each domain: (a) Are these items relevant for hospice patients?; and (b) are these items relevant for hospice caregivers?*

   The domain of transportation is not as applicable for hospice beneficiaries as they typically are no longer making visits to providers or leaving their home.

2. *For each domain, which of these items are most suitable for hospice?*

   Housing instability, food insecurity, and utility challenges are all suitable for the hospice patient.

3. *For each domain, (a) how might the items need to be adapted to improve relevance for hospice patients and their caregivers?; (b) would you recommend adjusting the listed timeframes for any items?; and (c) would you recommend revising any of the items' response options?*

   Overall, we anticipate that hospice providers will be challenged to collect this data due to short lengths of stay and general difficulty in interviewing patients if a caregiver is not involved.

4. *Are there additional SDOH domains that would also be useful for identifying and addressing health equity issues in Hospice?*

   No.

ADDITIONAL INPUT – HOSPICE CERTIFICATION

Hospice certification related to whether a patient is terminally ill is based on the clinical judgment of the hospice medical director (or physician member of the IDT), and the patient's attending physician, if he/she has one. Nurse practitioners and physician assistants cannot certify that an individual is terminally ill.

Comment: For initial hospice certification, we understand the importance of having the patient's primary provider co-sign the certification. That said, workforce challenges persist across the healthcare industry. In Iowa, 79 of 99 counties are associated with some type of primary care Health Professional Shortage Area (HPSA) designation. To assist with meeting access to primary care, Nurse Practitioners (NPs) and Physician Assistants (PAs) in Iowa have scopes of practice which enable independent practice. **We urge CMS to not only allow NPs and PAs to be a second on an initial hospice certification, but we would encourage CMS to review these requirements to allow NPs and PAs to generally certify an individual's status as terminally ill.**

ADDITIONAL INPUT – TREATMENT OF PASS-THROUGH PAYMENTS IN IOWA

The hospice reimbursement for the Nursing Facility room and board and basic Nursing Facility activities is a pass-through payment. When the Hospice Agency receives Medicaid reimbursement, the hospice provider forwards the payment amount to the Nursing Facility.

Comment: Hospice Agencies are required to collect and pay the room and board component for patients

who rely on the Hospice Benefit through Medicare, but rely on Medicaid payment for their custodial care. As a result, Hospice Agencies are contracted with nursing facilities to pay this room and board pass-through regardless of when or whether Medicaid payment is made. As a result, Medicaid payment to Hospice Agencies for the room and board component has been inconsistent at best. **For UnityPoint Hospice, over 60% of our hospice accounts receivable exceed 120 days due to outstanding room and board payments from Managed Care Organizations (MCOs) and state Medicaid programs in Iowa and Illinois.** As UnityPoint Hospice waits for reimbursement, we continue to pay facilities as their invoices come in. This creates a Hospice Agency cash flow issue in the short term and collection concerns overall. For care delivery, these are dollars we could be putting towards comfort therapy and services for our hospice patients.

This delayed reimbursement is often exacerbated by a lack of understanding by MCOs of hospice coverage requirements. There is an overall failure of coordination between MCOs and state Medicaid agencies on hospice eligibility, facility rates, and client participation, resulting in incorrect payments to Hospice Agencies and increased administrative workload for a process where Hospice Agencies are the intermediaries. The burden is shifted to Hospice Agencies to coordinate with nursing facilities to administer billing and pass-through payments.

CMS should consider allowing room and board payment to be streamlined and managed directly between the state Medicaid program and/or MCOs and the nursing facilities. We urge CMS to eliminate or relax the federal requirement for the hospice room and board pass-through. This would enable each state to determine the best path forward for the coordination and payment of Medicaid nursing facility room and board when a patient is under hospice care. Presently, this federal mandate ties the hands of state policymakers and agencies in evaluating optimal and timely payment options for their state Medicaid program, nursing facilities and Hospice Agencies.

We are pleased to provide input on this proposed rule and its impact on our patients and communities. 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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