UnityPoint at Home

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June 26, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS–1692–P
P.O. Box 8010
Baltimore, MD 21244–1850

RE: CMS–1692–P – Medicare Program; FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements as published in Vol. 83(89) Fed Reg 20934 on May 8, 2018.

Submitted electronically via www.regulations.gov

Dear Ms. Verma:

UnityPoint Hospice appreciates the opportunity to provide comments on the FY 2019 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.

MONITORING FOR POTENTIAL IMPACTS—AFFORDABLE CARE ACT HOSPICE REFORM

CMS describes current trends in hospice utilization and provider behavior, such as lengths of stay, live discharge rates, skilled visits during the last days of life, and non-hospice spending. While no public comment is sought on these topics directly, conclusions drawn from this research and analyses serve as the foundation for current and future revisions to Hospice payment and regulations.

Comment: We appreciate CMS' efforts to continue the collection and tracking of program data to monitor for potential impact. As UnityPoint Hospice strives to employ evidence based practices based on data, we would like to share some of our experiences related to trends and findings called out in this preamble.

- Length of Stays: CMS is reporting that both continuous home care (CHC) and general inpatient care (GIP) continue to have low utilization – CHC comprises 0.28% of all hospice days, while GIP comprises 1.38%. This is very similar to our utilization patterns. While these levels of care comprise a small percentage of overall days, this should not be construed to suggest that different rate settings are not needed for these levels. In fact, we believe that these percentages would climb if the documentation and staffing requirements were not so onerous. For CHC, nursing shortages have impacted our ability to provide CHC, and UnityPoint Hospice continues to experience staffing vacancies particularly in more rural areas. In addition, the hospice regulations have arbitrary time requirements; particularly, the midnight-to-midnight timeframe disqualifies visits that span the overnight hours, and the need for an initial physician order in advance of the visit does not permit hospices to timely bill for changing patient needs when identified hospice staff during what was thought to be routine home care (RHC). Despite decision support tools and outreach, hospices cannot always predict that level of care needs in advance of the visit and that it may require more than one day. 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.

- Skilled Visits in the Last Days of Life: At UnityPoint Hospice, we rank in the 90th percentile for seeing patients within the last week of life. Although this may be attributable in part to our overall 11-day average length of stay, this is also a result of intentional efforts and we have made this a priority within our organization. We have developed decision support tools, performed quality improvement projects, and plan to include this measure within our merit plan for next year. CMS notes that this data has been provided for the last three years. We would request that future utilization trends be broken down by state so that we can make regional comparisons and further develop improvement strategies.
- Non-Hospice Spending: We agree that this continues to be an issue, and would suggest that data be further analyzed and made available for trends by state or by profit versus nonprofit agencies. We also struggle with the fact that this issue 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 the 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. We would be happy to further dialogue with CMS regarding enhanced and timely claims sharing with hospices to minimize these concerns in the future.

  Central to this discussion is the patient and their family/caregiver(s), which is missing from the statistics and data. Despite hospice agency efforts, patients and caregivers still have choice and control over their care. To illustrate, one of our patients fell at home on a Sunday night. The nurse was called immediately and went to the home for examination and consultation. The patient decided to remain at home and the nurse left. Within an hour, the nurse received a call from the patient's son that the ambulance was being called to take the patient to the hospital. By the time the nurse arrived at the hospital, the attending physician had placed the patient in observation status as opposed to GIP. It is unlikely that Hospice Agencies will be able to avert all these situations.

  One additional point in reference to non-hospice spending, CMS again encourages hospices to advise patients and caregivers of the QIO process. We comply with this notice requirement and, although not a common occurrence, our patients have used this

process. Based on our limited exposure, we request that CMS re-examine this process. First, 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. Next, 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.

REQUEST FOR INFORMATION UPDATE—COMMENTS RELATED TO HOSPICE CLAIMS PROCESSING

In review of comments to reduce regulatory burden resulting from the FY 2018 Hospice Wage Index and Rate Update, CMS is proposing to remove the requirement to report detailed drug data on the hospice claim effective October 1, 2018.

Comment: We support this change to allow drug information to be reported in the aggregate on the claim form. While we welcome this change and agree that it reduces regulatory burdens, it should be noted that these changes are not without cost. First, there are costs involved. Any claim changes require retraining of personnel to accurately capture on the claim as well as vendor activities to build software and reports. Second, training and software revisions and testing requires time for implementation. In general, we do not like to proceed with operational changes prior to release of a final rule to insure that we capture new requirements accurately. Given the likelihood that there will be less than 60 days from final rule to implementation, such training and software changes will need to start in advance. We urge CMS not to further change this requirement thereby potentially creating additional implementation and timing challenges. In the alternative, we encourage CMS to relax enforcement efforts during the first quarter of implementation for hospices acting in good faith to implement this new requirement.

PROPOSED REGULATIONS TEXT CHANGES IN RECOGNITION OF PHYSICIAN ASSISTANTS AS DESIGNATED ATTENDING PHYSICIANS

To conform to statutory updates, CMS is expanding the definition of attending physician to include physician assistants (PA) in 42 CFR 418.3. CMS is similarly revising Medicare payment provisions for designated hospice attending physician services provided by physician assistants in 42 CFR 418.304.

Comment: We support this change to allow physician assistants to be included in the definition of attending physicians. This will be of particular help in Iowa, where primary care provider HPSAs

are prevalent. In the future, we urge CMS to consider allowing advanced practice providers to certify or recertify terminal illness and to conduct face-to-face encounters

PUBLIC DISPLAY OF QUALITY MEASURES AND OTHER HOSPICE DATA FOR THE HOSPICE QUALITY REPORTING PROGRAM (HQRP)

CMS is proposing to announce to providers any future intent to publicly report a quality measure on Hospice Compare, including timing, through sub-regulatory means.

Comment: We believe that providers should be given ample opportunity to participate in the measure development process, whether through rule-making or sub-regulatory guidance. We also appreciate that stakeholder involvement needs to be balanced with the timely inclusion or removal of appropriate and accurate measures. We encourage CMS to continue to involve providers as HQRP data collection processes and measurement development are refined.

REQUEST FOR INFORMATION ON POSSIBLE ESTABLISHMENT OF CMS PATIENT HEALTH AND SAFETY REQUIREMENTS FOR HOSPITALS AND OTHER MEDICARE-PARTICIPATING PROVIDERS AND SUPPLIERS FOR ELECTRONIC TRANSFER OF HEALTH INFORMATION

CMS is inviting input on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients.

Comment: Interoperability should be prioritized by CMS and we are pleased to see that CMS is seeking stakeholder input. UnityPoint Hospice utilizes and has invested in EMR software that differs from many area hospitals as well as other providers across the continuum, including skilled nursing facilities. We very much appreciate the need to have interoperability across the entire continuum of care to enable effective communication and care coordination. While CMS has incentivized interoperability through Meaningful Use initiatives, these initiatives were not applicable to all providers. We encourage CMS to include hospice agencies among the organizations eligible for incentive payments.

POTENTIAL STATE PLAN AMENDMENT FOR 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 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 individuals who rely on the hospice benefit through Medicare, but rely on Medicaid payment for their custodial care. As a result, hospices are contracted with nursing facilities to pay this room and board pass through regardless of when or whether Medicaid payment is made. In Iowa, the

state transitioned the bulk of its Medicaid book of business to Managed Care Organizations in April 2016. Since that time, Medicaid payment to hospice agencies for the room and board component has been inconsistent at best. Recently, the Iowa Legislature passed House File 2309 directing the Iowa Department of Human Services (DHS) to submit a report by October 1, 2018, on the options for eliminating the pass-through payments for dually eligible members and instead permitting both the MCOs and DHS' fee-for-service payment system to reimburse nursing facilities directly. Following the submission of this report, DHS intends to submit a State Plan Amendment to CMS for approval. We encourage CMS to approve this State Plan Amendment once it is submitted.

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,

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