AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

*Submitted electronically via www.regulations.gov*

June 26, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements [CMS -1692-P]

Dear Ms. Verma:

On behalf of the more than 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), thank you for the opportunity to comment on CMS's recent proposed rule that would update hospice payment rates and the wage index for fiscal year (FY) 2019 as well as modify the hospice quality reporting program. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes other healthcare and spiritual care providers deeply committed to improving quality of life for patients facing serious illness, as well as their families and caregivers.

AAHPM's members care for our nation's sickest and most vulnerable patients. As such, they are well-positioned to provide feedback on the potential impact of CMS's proposals on beneficiaries with terminal illnesses who have elected the Medicare hospice benefit and not only require, but are entitled to, expert level end-of-life care. Below we offer our feedback on policies included in the proposed rule and how they would impact our Academy members' ability to provide quality care for the hospice patients they serve.

## Trends in Medicare Hospice Utilization

CMS notes that, since the implementation of the hospice benefit in 1983, and especially within the last decade, there has been substantial growth in hospice benefit utilization, coupled with changes in diagnosis patterns among Medicare hospice enrollees. While AAHPM is pleased to see increased use of hospice services – which are shown to reduce patients' pain and suffering, improve quality of life, increase patient and caregiver satisfaction, and promote patient dignity – we are concerned that the number of Medicare decedents who access hospice services in a timely manner remains disproportionately low relative to the population that could benefit from

hospice services. For example, in its *2017 Facts and Figures on Hospice Care in America,* the National Hospice and Palliative Care Organization reports that in 2016 less than half of Medicare decedents received hospice care and, of those, roughly 40 percent received 14 or fewer days of hospice care in total.[1]

***Given the above, we continue to encourage CMS to review and analyze hospice utilization data and changes in diagnosis patterns to determine whether beneficiaries with terminal illness are being appropriately directed to hospice. We also encourage CMS to engage the physician and stakeholder community to increase awareness about the value of hospice and palliative care for Medicare beneficiaries, particularly those in specialty care medicine.*** Conversations about end of life should not be reserved for patients and their families/caregivers and their primary care providers, if they have one. Rather, these conversations should be initiated at the appropriate time in a patient's disease progression, and may begin with a specialty medicine physician.

## Monitoring for Potential Impacts – Live Discharges

AAHPM appreciates CMS's ongoing analysis of data on rates of live discharge from hospice, which we agree can identify the need for remediation in outlier cases, and we continue to be dismayed by the outlier statistics. Specifically, CMS notes hospices at the 95th percentile discharged 47.6 percent of their patients alive in FY 2017. We recognize the challenges of the prognostic markers and the local coverage determination (LCD) criteria for certifying hospice eligibility. However, it appears that some hospices may benefit from additional education, guidance, and technical assistance to improve their standardized processes.

As we noted last year, AAHPM provides such education and training as part of annual educational conferences and through other vehicles, including an online self-assessment study tool focused on hospice regulatory compliance and publication of the *Hospice Medical Director (HMD) Manual* which addresses best practices in organizational standards, clinical care, community relations, clinical research, and administration and management. AAHPM was also the driving force behind the creation of an HMD certification, an effort that reflects our members' desire to improve the quality and consistency of the practice of hospice medicine and the care provided by hospices. Given our resources and expertise, ***we invite CMS to work collaboratively with us to ensure outlier hospices receive the appropriate training on hospice eligibility requirements, which may help reduce their number of live discharges to a threshold more aligned with other hospices with similar demographics.***

***Where hospices then continue to operate outside of widely accepted practices, we urge CMS to directly address those cases, via audit or otherwise, and avoid establishing broad policies in response to the behavior of a minority of hospices.*** AAHPM will also continue to develop and deliver educational content and tools designed to help build the most effective, competent and knowledgeable hospice clinician workforce possible.

[1] National Hospice and Palliative Care Organization (2018). "Facts and Figures: Hospice Care in America, 2017 Edition."

## Part D Spending

CMS explains that non-hospice spending remains a concern, particularly with regard to Part D drugs. While non-hospice Medicare spending for Parts A and B during hospice election declined 23 percent from FY 2011 to FY 2017, spending for Part D drugs increased in FY 2017 compared to FY 2011. Specifically, Medicare payments for non-hospice Part D drugs received by hospice beneficiaries during a hospice election were $325 million in FY 2011 compared to $380 million in FY 2017. CMS's analyses of Part D prescription drug event (PDE) data suggest that the current prior authorization has reduced Part D program payments for drugs in four targeted categories (analgesics, anti-nauseants, anti-anxiety, and laxatives). However, under Medicare Part D there has been an increase in hospice beneficiaries filling prescriptions for a separate category of drugs referred to as maintenance drugs (e.g., beta blockers, calcium channel blockers, corticosteroids, and insulin) that are not subject to the Part D prior authorization process.

We refer CMS to our comments on this topic submitted in response to the FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements, which highlight the following:

- The need to consider patients' use of drugs or other medical treatments on a case-by-case basis to determine "relatedness" to a beneficiary's terminal prognosis;
- The appropriateness of Part D coverage for medications (rather than hospice coverage) in many cases where such medications are not related to the terminal prognosis, including when beneficiaries have been taking such medications on a long-term basis; and
- The limited ability of hospices to control patients' behavior related to ongoing usage of medications, and the role that pharmacy benefit managers (PBMs) play in continuing to fill prescriptions.

As we emphasized last year, hospices are not inappropriately prescribing or filling unnecessary medications for their patients, nor can they prevent patients and their families from having these medications filled. Additionally, we note that hospices rarely receive information about the dispensing and billing of Part D drugs for hospice patients and, when they do, it is usually as a result of auditor reviews years later. Given these circumstances, to the extent that CMS determines that Part D spending on medications is inappropriate – which as noted above is regularly not the case – ***CMS should consider options for addressing this problem through regulatory avenues, such as holding the Part D plan responsible for the cost of the medications that are inappropriately filled when patients have elected hospice or holding the patient responsible for the cost of certain drugs once the recommendation has been made that particular medications will not be covered under the hospice benefit as outlined in the plan of care, rather than pursuing future regulatory action that penalizes hospices that act in good faith and make appropriate clinical decisions about the relatedness of prescribed medications.***

## Initial Analysis of Revised Hospice Cost Report Data

CMS provides information on its initial analysis of revised hospice cost report data for freestanding hospices with cost reporting periods in FY 2016, including information on three "trim methodologies" that CMS applied to evaluate cost report data for implausible cost reports

or cost reports that included unexpected data values. CMS also provides information on overall payments and costs by level of care, based on data included in those reports.

CMS refers to one of the trim methodologies as "Level 1 Edits," referring to edits that were recommended by industry representatives that would cause the hospice cost reports to be revised before being accepted by Medicare Administrative Contractors if certain essential cost centers had no reported costs. In its review of these cost centers, CMS found that almost 66 percent of the cost reports submitted by hospices for 2016 were missing data on one of the reporting lines identified as essential, suggesting that the provided data were not thorough or representative of hospice costs. While CMS notes that these edits are currently for consideration only, CMS also suggests that it might consider them for potential future use.

AAHPM has several concerns about CMS's reported cost data, as well as recommendations for CMS as it continues to review data and engage stakeholders to improve data quality:

- Flawed data as the basis for reported costs. CMS reports total cost per day estimates for the four hospice levels of care. However, CMS's analysis of Level 1 Edits clearly demonstrates the poor quality of cost data reported by hospices and raises significant questions about the validity of the reported cost per day estimates. Indeed, we are concerned that reporting such flawed estimates will paint a misleading picture of hospices' financial well-being, since the data inappropriately suggest that hospice payments far exceed the cost of delivering care. As such, ***we urge CMS to use caution when reporting hospice cost data to prevent the release of inaccurate data, or refrain from such reporting altogether until CMS can assure the accuracy and quality of reported estimates.***
- CMS's approach to remediation. While CMS suggested that it might potentially use Level I Edits to reject cost report data in the future, AAHPM disagrees that CMS should pursue such an approach, particularly given the recent changes to cost reporting requirements and the evident challenges hospices are facing in reporting high-quality data. Reporting the extensive data required on cost reports places significant burden on hospices that may not have sufficient expertise or resources, particularly for small and independent nonprofit hospices. ***Rather than taking a punitive approach to quality assurance, we recommend that CMS provide targeted notice, technical assistance, and training to those hospices whose cost reports contain deficiencies. We are also happy to work with CMS to provide broad-based training and education to our members and the hospice stakeholder community on the complete and accurate cost reporting.***
- Granularity of cost report data. As CMS continues its analysis of hospice cost data, ***AAHPM recommends that CMS consider stratifying data across multiple dimensions to understand how costs may vary across different subsets of hospices.*** For example, CMS should separately review costs based on type of hospice (freestanding or provider based), size, type of ownership (for profit or nonprofit), and urban or rural location, since costs have been shown to vary across these provider characteristics. Reviewing data based on patient characteristics, such as diagnosis and care setting prior to hospice election (e.g. hospital versus nursing facility versus home) would also help to shed light on cost drivers.

## Hospice Reporting of Detailed Drug Data

CMS notes that it is changing requirements for reporting drug data on claims starting October 1, 2018, in order to reduce hospice burden. Rather than requiring the detailed reporting of drug data, CMS will allow hospices two options for reporting hospice drug information. Providers will have the option to continue to report infusion pumps and drugs, with corresponding NDC information, on the hospice claim as separate line items. Alternatively, hospices can submit total, aggregate DME and drug charges on the claim. ***AAHPM thanks CMS for this change, which we recognize alleviates significant burden for certain hospices, particularly around reporting drug data when beneficiaries are receiving General Inpatient Care at a non-hospice facility. However, we'd ask CMS to provide clarification on whether hospices must take a uniform approach in submitting claims with aggregated data or detailed data across all patients, or whether hospices may report differently on a patient-by-patient basis.***

## Physician Assistants as Designated Attending Physicians

CMS implements regulatory changes consistent with Section 51006 of the Bipartisan Budget Act of 2018 (BBA), which allows physician assistants (PAs) to be recognized as designated hospice attending physicians, in addition to physicians and nurse practitioners. ***AAHPM supports the changes enacted in the BBA and proposed by CMS.*** Allowing PAs to serve as hospice attending physicians will increase access to hospice care, particularly for beneficiaries in rural areas. At the same time, we note that state scope of practice requirements may not allow PAs to serve as attending physicians, and therefore this change may not be available in all states.

While AAHPM recognizes that statute still prohibits PAs from conducting the face-to-face visit required to certify terminal illness for ongoing hospice eligibility, we support further consideration of the benefits and risks of allowing PAs to conduct the face-to-face visits, to the extent it would be permitted under their scope of practice. Such a change would further align PA responsibilities with those of nurse practitioners who are already conducting such visits under the Medicare hospice benefit.

## Hospice Quality Reporting Program

### Overview

AAHPM appreciates and supports CMS's effort to identify high-priority areas for quality measurement and improvement through the Meaningful Measures Initiative, in order to improve outcomes for patients, their families/caregivers, and providers, while also reducing burden on clinicians and providers. To that end, we are pleased to see CMS's proposal to add a new measure removal factor for the Hospice Quality Reporting Program (HQRP) that considers the relative costs versus benefits of continuing the use of a given measure.

At the same time, as CMS increases its flexibility to remove low-value measures from the HQRP measure set – as well as works to reduce burden and harmonize duplicative measures – ***we believe that ongoing development of new, meaningful measures should remain a priority.*** This is particularly true for hospice quality measurement, which relies so heavily on the Hospice Item Set (HIS). CMS

has identified palliative care as a measure development priority (as noted in the CMS Measure Development Plan and its gap analysis work); we believe this priority can and should likewise apply to quality measurement for hospice care, and that CMS should pursue opportunities to develop measures that assess those facets of care that are most important for hospice patients at the end of life (for example, person and family engagement, pain and symptom management, effective communication, care coordination, and care concordant with patients' wishes).

We also believe that CMS should be transparent in its planning and development of potential new HQPR measures, in order to ensure stakeholder input into the measure development process. As such, we were disappointed to see little discussion of CMS's current and future plans for further work in this arena in the proposed rule. ***We urge CMS to inform and engage stakeholders about new HQRP measure development as frequently and transparently as possible, and we note that AAHPM stands ready to engage with CMS in setting measure development priorities for the program that are consistent with CMS's goals under the Meaningful Measures Initiative.***

### New Measure Removal Factor

***AAHPM appreciates CMS's proposal to add a new measure removal factor for the HQPR that weighs relative costs versus benefits of continuing the use of a given measure,*** *as noted above, and we thank CMS for its interest in reducing burden for hospice providers*. We note, however, that different stakeholders may have different opinions and perspectives about the relative costs versus benefits of a given measure. ***Accordingly, we request that CMS engage with stakeholders early in the deliberation process when considering measure removal and also emphasize the importance of continuing to use formal notice-and-comment rulemaking for proposing removal of measures under the HQRP.***

### Public Reporting on Hospice Compare and Procedures to Determine Quality Measure Readiness for Public Reporting

CMS describes its process for determining when measures meet readiness standards for public reporting and proposes to announce to providers any future intent to publicly report a quality measure on Hospice Compare, including timing, through sub-regulatory means. ***AAHPM strongly disagrees with the proposal and urges CMS to use formal rulemaking when determining measures to publicly report on Hospice Compare, as well as put in place additional protections for beneficiaries and hospices, as described below.***

Data reported on Hospice Compare are intended to help Medicare beneficiaries and their families and caregivers make informed choices regarding hospice selection. However, many measures that are available or under consideration for hospice assessment are not straightforward or intuitive. For example, measures may not have "optimal" rates (for example if measures are expected to have non-zero or non-100 percent rates), and higher measure percentages may not necessarily align with better quality, which may result in confusion when reviewed by the public. In CMS's description of its process for determining readiness, however, there is no discussion of user testing to ensure that patients clearly understand what a measure may be assessing, what its relationship is to high-quality care, and how a given performance rate may reflect such care or not. Such user testing is conducted for other Medicare reporting sites,

such as Physician Compare, before measures are publicly reported; the apparent absence of such protections to support patients in their hospice selection, when they are at their most vulnerable, is a major oversight that has the potential to result in patient harm. ***As such, we urge CMS to implement a user testing process that enables CMS to identify those measures for which performance can be translated into reliable, meaningful, and actionable information for beneficiaries, prior to reporting any new measures on Hospice Compare.***

In addition to user testing, AAHPM believes stakeholders more broadly should have an opportunity to review and comment on how measures will be displayed and publicly reported on Hospice Compare. Given potential complexity in measure specifications and the potential lack of target performance for new measures, as well the potential consequences of uninformed choice on patients and their caregivers, ***AAHPM believes that measures should be finalized for public reporting on Hospice Compare only after a notice-and-comment rulemaking process. Such a process should not only specify the measure being proposed for public reporting, but also provide information on how the measure will be presented and explained.*** Under such a process, stakeholders would have the opportunity to review CMS's proposed display of performance data in order to increase the likelihood that beneficiaries will be able to understand and use the measure to inform their decision-making, as well as decrease the likelihood of unintended consequences.

Additionally, AAHPM recommends that CMS include formal policies that guarantee that hospices are able to review, analyze, and act on measure performance data before they are publicly reported, such that hospices have the opportunity to receive feedback and improve on the measures before data are publicly posted. ***Specifically, CMS should finalize policies so that measures will not be publicly posted based on the first year of performance and that hospices have the opportunity to review their performance on measures before public reporting.***

### Quality Measures to be Displayed on Hospice Compare in FY 2019

CMS discusses its intent to post data on two new HQRP measures starting in FY 2019:

- Hospice Comprehensive Assessment Measure (NQF #3235; to be reported fall of 2019)
- Hospice Visits when Death is Imminent Measure Pair (to be reported in FY 2019)

***Consistent with our comments above, we disagree that these measures are ready for public display on Hospice Compare – particularly the Hospice Visits when Death is Imminent Measure Pair.***

For both measures, AAHPM is concerned that neither CMS nor hospice stakeholders have information on performance on these measures, given the first year of data collection only ended in March of this year. Such data are needed to ensure the measure is performing as intended. Further, stakeholders should have the opportunity to review and understand their performance on these measures in order to improve their performance prior to public reporting.

***As noted above, we also believe CMS should engage in formal notice-and-comment rulemaking regarding the public posting of measures, and that such rulemaking should include information not only on the measure being reported, but also on how the measure is presented and explained to the public.*** The Hospice Visits when Death is Imminent Measure Pair is a good example of why

such a process is necessary. This measure pair does not have a benchmark and is not expected to have a 100 percent performance rate. Additionally, it fails to provide a complete or accurate picture of hospice care delivery at the end of life, with insufficient measure exclusions (for example related to beneficiary refusal) and limited focus on the subset of hospice team members who are included in the measure calculations. Given this complexity, we believe public input through rulemaking on the measure display is particularly critical for the Hospice Visits when Death is Imminent Measure Pair before it is posted on Hospice Compare.

### Display of Public Use File Data and/or Other Publicly Available CMS Data on the Hospice Compare Web Site

CMS proposes to post information from public use files (PUFs) and other publicly available CMS data in a user-friendly way on a new section of the Hospice Compare Web site. While AAHPM recognizes the value that such data can offer patients as they make informed decisions about their hospice care, for many of the same reasons discussed above, ***we recommend that CMS propose to display specific data elements, including information on how the data would be presented and explained, through notice-and-comment rulemaking before they are posted.*** Rulemaking allows for transparency and public input to help ensure data presented are reliable, meaningful, and actionable for beneficiaries and their families/caregivers who rely on such data in selecting a hospices provider. Further, as CMS considers increasing the use of claims-based quality measures, we are concerned that the line between descriptive data and quality measure data can be easily blurred. Notice-and-comment rulemaking would ensure that claims-based quality measure data that are calculated from data included in the PUFs are reviewed and vetted before they are posted for public display.

As beneficiaries, families, and caregivers review Hospice Compare to learn about their hospice options and inform their decision-making, AAHPM strongly believes they should have meaningful, easy-to-understand, and user-friendly data to facilitate informed choice. We believe that the notice-and-comment rulemaking process for determining data reported on Hospice Compare provides an important protection in support of that goal.

## 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 seeks input from stakeholders on how it could use the CMS health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs (i.e., the Conditions of Participation (CoPs) and Conditions for Coverage (CfCs)) to further advance electronic exchange of information that supports safe, effective transitions of care between hospitals and community providers. Additionally, CMS recognizes the need to address Health Information Technology (HIT) adoption and interoperability among providers that were not eligible for the Medicare and Medicaid Electronic Health Record (EHR) Incentives program, and welcomes specific input on how to encourage adoption of certified EHR technology (CEHRT) and interoperability among these types of providers and suppliers.

AAHPM supports CMS's ongoing interest in strengthening the use of technology to achieve interoperable exchange of health information, and believes that effective, user-friendly HIT that supports the transfer of health data can facilitate seamless care management and care coordination, particularly for the vulnerable patients that our members serve. At the same time, we disagree with an approach that would impose significant new mandates on hospices or other providers and suppliers through CoPs or CfCs that would place such providers' or suppliers' Medicare participation status at risk. We believe such an approach would be particularly challenging for small providers, who would have limited resources to meet new compliance standards. ***Rather, we encourage CMS to offer incentives, resources, and technical assistance to further promote the electronic exchange of health information.*** Such an approach would reflect a less burdensome alternative that would not place undue risk on providers and suppliers or the beneficiaries they serve, while also advancing CMS's goals for greater data exchange.

Additionally, as CMS notes, several providers were not eligible for Medicare and Medicaid EHR incentives to adopt HIT systems. Hospices were among those excluded from participation, and we have seen little effort to accommodate or support hospices' access to these tools. This places hospices at a disadvantage as the cost of upgrading to software that offers interoperability is high and out of reach of many hospice providers, particularly small providers. ***As such, we would have serious concerns with any changes to CoPs for hospice providers that would mandate electronic exchange of information or the use of CEHRT.*** At the same time, AAHPM would be pleased to work with CMS to educate our members and other hospice stakeholders on the adoption and use of HIT. However, hospices need support to undertake the significant costs of HIT adoption and implementation, and ***we continue to urge CMS to work with Congress to facilitate an EHR incentive program for hospices. Further, any CMS efforts to encourage development of EHR technology tailored to the delivery of hospice and palliative care would further facilitate more widespread adoption by Medicare hospices.*** These fundamental barriers must first be addressed to enable hospices to fully participate in effective, interoperable exchange of health information.

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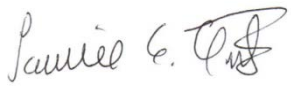
Thank you again for the opportunity to provide feedback on the important issues addressed in this proposed rule. AAHPM stands ready to collaborate with CMS to address the many challenges discussed here and support delivery of high-quality care for Medicare hospice beneficiaries. Please address questions or requests for additional information to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,



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