



## Hospice & Palliative Care Association of NYS

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June 26, 2017

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

Dear Ms. Verma:

The Hospice and Palliative Care Association of New York State (HPCANYS) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS') proposed revisions to the hospice wage index for fiscal year 2018, published in the Federal Register on April 27, 2017. We would like to address the following areas of the Proposed Rule:

### **Trends in hospice utilization**

Some trends are the obvious results of demographics; we would expect utilization to rise with the aging of the Baby Boomers. Also, if people are living longer, we can expect to see more neurological diagnoses. The American Neurological Association finds that, "[t]he huge and sustained capital investments made in cardiovascular and cancer research starting in the 1970s have increased lifespan. Ironically, these gains have increased the number of elderly who are most susceptible to neurological disease, creating a growing epidemic." These patients have substantially different disease trajectories than those patients with a cancer diagnosis, and this cohort will only increase in the coming years.

### **Live Discharge Rates**

A concern raised by the negative focus on live discharge rates is the issue of conflicting State regulatory requirements. For example, New York has a Managed Long Term Care Medicaid product available for dual eligible who are chronically ill or disabled and who wish to stay in their homes and communities. The services available through these plans can help supplement the hospice benefit, allowing the patient to remain in their own home. However, state regulations prohibit patients on the hospice benefit from enrolling in MLTC plans, so to receive both services, patients will often revoke the hospice benefit to enroll in MLTCP, and then reelect hospice. Unfortunately, the fractured health

care delivery system makes these “benefit gymnastics” increasingly common; hospices should not be penalized for this.

### **Skilled Visits in the Last Days of Life**

New York hospices have a low length of stay (17 days median LOS). The SIA is a very rational approach to encouraging a higher frequency of skilled visits during the last days of life, when they are most needed. However, additional compensation for visits within the last 7 days is supposed to be revenue neutral, so by promoting this standard, is CMS setting up the industry for failure?

### **Non-Hospice Spending**

HPCANYS is quite concerned about the issue of maintenance drugs. CMS’s insistence that, “maintenance drug(s)...are appropriate to continue as they may offer symptom relief for the palliation and management of the terminal illness and related conditions, and therefore should be covered under the hospice benefit, not Part D,” is an abdication of CMS’s responsibility for providing prescription drug coverage under the Medicare Modernization Act of 2003. Requiring hospices to absorb more and more costs at end of life – especially when they are not related to the terminal illness – is becoming untenable. Just as a hospice should not be expected to cover the cost of treating a broken arm suffered by a patient with end stage renal disease, so too, should hospice programs not be expected to cover the cost of insulin for a life-long diabetic diagnosed with lung cancer. One of the ways that we “convince” people to come onto Hospice care is by assuring them that they will be kept comfortable, by continuing on any maintenance drugs that contribute to their overall well being and comfort. Implementing a prior authorization process for these drugs imposes an additional burden on patients and families, and will result in increased patient anxiety in an already anxious time. It has been our experience that people with chronic disease, that is not impacting their end of life diagnosis, have very specific routines to acquire and manage their medicine. Quite often, these maintenance drugs are on auto-refill from a mail order pharmacy, which inherently precludes any immediate action, even if the family is diligent about record-keeping. Faced with such roadblocks to what the patient and family have come to regard as essential medications, we fear that patients will be inclined to revoke the hospice benefit.

Healthcare has become increasingly confusing. Hospice patients generally come into care, feeling let down by the “system” and skeptical of healthcare professionals. There will no doubt be times that the pre-authorization process will not be timely or perhaps patients won’t get their meds covered. Forcing patients to pre-authorize their maintenance medicine for conditions not related to their end of life diagnosis will continue the misconception and rumors in our community that hospice and comfort care speed up the end of life by taking away needed maintenance meds, making people increasingly skeptical of the care we provide.

### **Hospice Cap:**

Very few providers are over the cap in the entire region serviced by our Medicare

Administrative Contractor, and New York is a very expensive state – as is California, another state serviced by National Government Services. In fact, although New York State hospice providers spend \$187.50 per day of care (compared to a national mean of \$153.57 per day of care), very few New York State hospices ever exceed the cap. This shows that we have a radically different profile of financial allocation than those in other MAC jurisdictions who spend far less per day of care (Mississippi spends \$128.77 per mean day of care and Alabama spends \$122.32 per mean day of care), yet consistently trigger cap overpayments. Once again, CMS is seeking national solutions for regional problems.

### **Sources of Clinical Information for Certifying Terminal Illness:**

HPCANYS members agree that it is critical that regulatory requirements not delay hospice services because of the inability of the hospice to obtain all the necessary information on the patient to certify that the patient is terminally ill. Hospice providers, have no control over timely access to patient medical records that may be located at a hospital and/or physician's office and interoperability of electronic medical records is not a current reality. 42.1% of hospice patients in New York State die within one week of hospice election. This gives the hospice interdisciplinary team little time in which to establish necessary services for the patient and family. Further administrative delays would only negatively impact the provision of care, prolong care transitions and further fracture our already disjointed health care system. Our current system of allowing five days to complete the certification narrative, sign and submit the Notice of Election is already challenging for many programs; obtaining additional (complete) clinical records prior to admission to hospice is an unnecessary and callous impediment, prolonging transitional distress for patients and families. Additionally, the increased amount of documentation is an unfunded taxation on staff, who will need to devote yet more time implementing duplicative requirements, and less time with patients and families.

We would also like to recognize the important role that the nurse plays in gathering clinical information relative to hospice eligibility. Hospice nurses' sole charge is to care for dying patients, therefore they have a wealth of experience in observing indicators of a terminal prognosis. Their professional assessment of a patient's appropriateness for hospice is extremely comprehensive, taking into account situational as well as clinical factors.

CMS posits the idea of an in-person visit from the hospice Medical Director or the hospice physician member of the interdisciplinary group to be used as documentation to support initial hospice eligibility determinations. HPCANYS rejects any efforts to require a face to face visit for hospice admission; this amounts to an unfunded house call.

### **Updates to Hospice Quality Reporting**

*Claim-based Measure 1: Potentially avoidable hospice care transitions*

In NYS, we have so many regulations that impede stability and even promote transitions of care. One example of this is the dearth of swing beds in hospice residences. State

regulations only allow for 25% of beds in hospice residences to be utilized for a general in-patient level of care. This can result in transferring the patient to a hospital for pain and symptom management, even though state regulations further require that the residence be built and staffed to in-patient standards. Also, New York's labyrinthine Medicaid Managed Care network, with its multiple plans, each with its own set of rules and different contracts negotiated with different providers, often necessitates shuffling the patient between hospital and nursing home. Hospices cannot control these transitions and should not be penalized when they occur.

#### *Claim-based Measure 2: Access to levels of hospice care*

Again, the regulatory environment of New York State provides a skewed picture of hospices providing all levels of care since NYS regulations prohibit CRC in the nursing home, limiting the provision of Continuous Care to a large segment of the hospice population.

We would like to further comment on the cost of implementing any new requirements. In 2016, CMS reported that their budget analysis found that implementing a new reporting requirement will take only .002% of the average agency's budget. In fact, an informal survey of New York State hospice providers found that the median amount spent on completing each new reporting requirement over the past several years (including Face to Face, HIS, NOE/NOTR, and additional staff and training time) is 1% of budget for each measure. Extrapolated nationally, this would total \$165 million per year in new unfunded mandates. Individually, each new requirement might not seem unduly burdensome, but collectively, they make a major fiscal impact.

#### **Public Display of Hospice Data**

HPCANYS supports informing consumers via means such as the proposed Hospice Compare Web site, yet we remain concerned about the quality of data being reported. Hospices do not have the ability to change incorrect data in a timely fashion. We advise that CMS increase the preview and correction period.

#### **Request for information on CMS Flexibilities and Efficiencies**

HPCANYS appreciates the opportunity to provide CMS with ideas that would reduce regulatory burden. It is our suggestion to eliminate the Face to Face requirement for recertification. Our members tell us that the face to face requirement, rather than reducing inappropriate recertifications, actually encourages recertifications for borderline appropriate patients. In fact, a 2013 study by Joan Harrold, Pam Harris, Dena Green, Teresa Craig and David Casarett proved that there was a significant decrease in the decertification rate when the face to face rule was implemented (*Effect of the Medicare Face to Face Visit Requirement on Hospice Utilization*, Journal of Palliative Medicine, February 2013, 16(2): 163–166.). Physicians find it difficult to tell a family – when they are a guest in that family's home – that their loved one no longer qualifies for the services that they have been receiving for months. The face to face requirement takes the most highly compensated hospice employee away from his or her daily work to make an evaluation that could be done more objectively via a records review, and at a lesser cost to the hospice.

HPCANYS, as always, stands ready to serve as a resource to CMS as hospice issues are addressed and looks forward to continuing development of the hospice benefit to provide quality care to both patients and families. We recognize that CMS is responsible for regulating the provision of hospice in all states, but we ask that you bear in mind the circumstances that make each region unique, and not overly regulate the entire industry for the transgressions of a few. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Carla Braveman". The signature is written in a cursive, flowing style with a long horizontal stroke at the end.

Carla Braveman  
President & CEO