June 30, 2014

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1609-P  
P.O. Box 8010  
Baltimore, MD 20124-8010

SUBJECT: Medicare Program: FY2015 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirement and Process for Appeals for Part D Payment for Drugs for Beneficiaries Enrolled in Hospice

Dear Secretary Burwell:

The Visiting Nurse Associations of America (VNAA) respectfully submits for consideration comments in response to the FY2015 Hospice Wage Index and Payment Rate Update Notice of Proposed Rule Making (NPRM). VNAA is a national nonprofit organization that supports, promotes and advocates for community-based, mission-driven, nonprofit providers of home health, palliative care and hospice services. As safety net providers, VNAA members provide care to all patients regardless of ability to pay or to severity of illness and serve a mix of Medicare, Medicaid, privately insured and charity care patients. VNAA members have expertise in managing and delivering high quality care in a patient’s home at a fraction of the cost of institutional settings.

VNAA is also a trusted leader in healthcare policy and a resource for policy makers, providers and healthcare partners. For example, VNAA’s Blueprint for Excellence (www.vnaablueprint.org) is a free quality improvement and staff training tool assisting home health, palliative care and hospice providers to implement best practices for key service components focused on reducing unnecessary hospitalizations, reducing readmissions, improving patient outcomes and health status.

**Background and VNAA Principles for Hospice Benefit Update**

Since its inception in 1983, the Medicare Hospice Benefit has steadily increased the number of Medicare beneficiaries served. Between 2000 and 2012, total hospice enrollment increased from 534,000 to 1.27 million beneficiaries (Abt Associates, 2013). The number of providers has also increased, from 2,255 in 2000 to 3,720 in 2012, as have average length of hospice stays, from 48 days in 2000 to 88 days in 2012, and the types of diagnoses. Specifically, the number of non-cancer diagnoses, the increased prevalence of chronic diseases and other co-morbidities and the increased integration of health information technology to coordinate care among providers including a patient’s primary care physician have each contributed to significant changes and improvements in the delivery of Medicare hospice services. These trends, outlined in Abt Associate’s “Medicare Hospice Payment Reform: A Review of the Literature (2013 Update),” highlight the need to update and reform the Medicare hospice benefit and payment model to better serve and support Medicare beneficiaries at end-of-life.
Despite these statistics, the United States underutilizes hospice care. The NPRM notes that the percentage of Medicare deaths for patients under a hospice election increased from 20 percent in 2000 to 46.7 percent in 2012. Fifty percent of Medicare Advantage dependents compared to 45.6 percent of traditional, fee-for-service Medicare beneficiaries used hospice in 2012 (MedPAC, 2014). The observed rate at which patients elect hospice is well below what would be expected to appropriately care for advanced illness, and significant variation exists in election of hospice by race, age, diagnosis and location (Abt Associates, 2013). Hospice and palliative care providers have the capacity and ability to provide support and care services for many more Americans and to improve quality, care and patient satisfaction at the end of life. Unfortunately, VNAA believes federal regulatory challenges and payment policies currently dramatically restrict the number of patients who receive hospice care and dramatically shorten the period of hospice care provided at the end of life. In many cases, patients are not referred to hospice until the final days of life.

VNAA supports efforts to redesign hospice and palliative care services for terminally ill patients and believes significant opportunity exists to improve patient referrals to, and enrollment in, hospice programs. In part, this may be accomplished through the implementation of provider incentives and new models of care delivery (Munn, et al., 2012). VNAA is also a steering committee member of the Coalition to Transform Advance Care (C-TAC) and actively supports C-TAC’s work to advance a new vision and model for advanced illness care in the final years of life.

Specifically, VNAA advances the following principles for consideration of hospice system redesign:

- Expand and promote advanced care models to support Medicare beneficiaries in the last years of life through improved care coordination in the home and community including earlier entry to palliative care and hospice programs;
- Encourage physicians to discuss advanced care planning and the role of palliative and hospice care with patients and families;
- Strengthen patient choice at the time of hospice election;
- Include concurrent curative treatment for beneficiaries receiving hospice and palliative care services;
- Categorize palliative care within the hospice benefit, rather than under the home health benefit.
- Target program integrity review and enforcement on providers with high numbers of inpatient days, high rates of recertification, and high numbers of live discharges;
- Ensure appropriate reimbursement for hospice and palliative care services to ensure continued accessibility to such services for all eligible patients.

The benefits to encouraging increased utilization of hospice redound to patients, family members and the Medicare Trust Fund have been well documented:

- According to a 2013 study at Mount Sinai, patients who enrolled in hospice received better care at a significantly lower cost to the federal government that those who did not enroll in hospice.
- A 2004 Journal of the American Medical Association (JAMA) survey noted that family members of decedents enrolled in hospice were more likely to report a favorable end-of-life experience.
- Pyenson, et al. (2004) found mean Medicare costs were lower for patients enrolled in hospice care for all diagnoses except for prostate cancer and stroke and the cost differences were significant for patients with chronic heart failure, liver and pancreatic cancer. The study found that the lower cost for patients receiving hospice care was not due to short survival time, since patients with hospice care had longer mean and median time to death than their matched non-hospice controls.
• Taylor, et al. (2007) found that hospice use saved Medicare approximately $2,300 per beneficiary. Average Medicare expenditures were $7,318 for hospice users compared to $9,627 for controls.
• Comparing hospice patients to matched non-hospice controls, Kelley, et al. (2013) found beneficiaries enrolled in hospice were associated with reduced costs and lower rates of hospital utilization and in-hospital death compared to controls.

In light of this evidence, VNAA urges CMS to compare spending at end-of-life, perhaps for the last six months of life, for those beneficiaries who do not elect hospice versus those beneficiaries that do. VNAA urges CMS to include all non-hospice costs in the tally of expenses for patients not electing hospice regardless of whether costs are within a curative care delivery model or any movement toward a palliative care model. VNAA believes that such analysis will help CMS identify opportunities to improve and modernize the Medicare hospice benefit and the patient and family caregiver experience.

Finally, ensuring access to hospice care is a critical component of activities to update the Medicare hospice benefit. VNAA recommends that CMS carefully study access to hospice and palliative care services among Medicare beneficiaries. One measure of access is low percentage utilization areas. A review of these areas, as well as insights from the Hospice Experience of Care Survey from the National Hospice and Palliative Care Organization could help CMS identify challenges to access and propose opportunities to improve and increase utilization. CMS should also study the referral rates to hospice services among hospitals with and without palliative care programs to better understand the impact of such programs on referral rates to hospice at end-of-life.

Payment System Reform

Section 3132(a) of The Patient Protection and Affordable Care Act of 2010 (ACA) requires the Secretary of Health and Human Services (HHS) to revise Medicare’s payment system for hospice care. CMS has not revised the hospice payment system to reflect changes in the provision of hospice care since development of the system in the 1980s. CMS’s hospice contractor, Abt Associates, has begun research and analysis to guide CMS in the development of a new hospice payment methodology. VNAA supports the need for refinements to the current hospice payment model and encourages CMS to prioritize and move to implement models that reduce or eliminate problems that have become evident in the current system and have provided significant opportunities for abuse of the Medicare hospice benefit. These problems have been recognized in CMS-sponsored research conducted by Abt Associations and include long length of stay; late referral resulting in very short stays; high numbers of live discharges; inpatient stay utilization; and a daily payment rate system that does not fully cover costs.

As evidence of abuse in the current hospice payment system, CMS highlights in the NPRM that between 2000 and 2012 the overall rate of live discharges increased from 13.2 to 18.1 percent, and that 71 hospices had live discharges on 100 percent of their patients. Moreover, the average length of stay for these same 71 hospices averaged 193 days. CMS recognized live discharge rates vary significantly by type and size of provider, but raised serious concerns about the patterns of election, revocation and reelection after a hospitalization had occurred. CMS noted that one study of hospice live discharges in cancer patients found that smaller hospices and for-profit hospices had higher rates of hospice live-discharges.

There is ample evidence that the current payment model makes long stays more profitable than short stays and has created adverse incentives and business models designed to capture the increased profit.
MedPAC’s March 2009 report notes very short hospice stays may be a result of financial incentives that may lead acute-care providers to continue treating patients, resulting in a delayed referral to hospice after significant use (and expenditures) of acute healthcare services, or after a patient has used all of his/her Medicare-covered skilled nursing facility days. Therefore, MedPAC stressed the need to create incentives to more appropriately admit patients such that they are able to fully benefit from hospice services.

VNAA Guiding Principles for Payment System Reform
VNAA recognizes that CMS is not proposing a new hospice payment model in the current rulemaking and appreciates the careful approach CMS is undertaking to better understand current hospice cost and utilization data. VNAA’s community-based, nonprofit hospice and palliative care service providers are uniquely positioned to offer guidance to CMS during development of a new payment model. In general, VNAA supports the work of Abt Associates to develop a detailed and tiered-payment model. Upon initial review, VNAA believes that a tiered-payment model offers a solid foundation for further refinement and consideration by all stakeholders but urges careful review of the impact of any potential model on all types and sizes of hospice providers.

VNAA does not intend to propose a payment model for consideration but offers the following principles to guide CMS's work in this area.

• Hospice payment reform must recognize the need to encourage increased election of hospice services, appropriate patient referral time and also recognize policies designed to better integrate care across a continuum of healthcare services. The timing of hospice enrollment also represents an opportunity for improvement. Short hospice lengths of stay raise concerns regarding whether patients and families are able to receive and benefit from the broad range of hospice services available to them prior to death.

• Any new hospice payment methodology must carefully address currently misaligned incentives through reducing the increasingly high rates of recertification and numbers of live discharges. One consideration would be to target CMS auditing practices on hospices with an excessive percentage of live discharge patients (perhaps as low as eight to ten percent).

• Hospice payment reform must consider risk adjustment for patients with higher co-morbidity burdens, case mix add-on payments for hospices with high percentages of complex patients, and possible "premium payment" add-on to reflect the significant and intensive utilization of services in hospices serving patients with very short lengths of stay. For example, Legler, et al. (2011) suggests hospice reimbursement rates may need to be risk adjusted for hospices caring for patients with higher comorbidity burdens. Huskamp, et al. (2008) suggests CMS consider an outlier adjustment to the payment system to account for patients who require excessively expensive hospice care, such as expensive anti-cancer medications.

• A new hospice payment methodology should consider site-of-service payment adjustments to accurately reflect resource use and costs associated with appropriate levels of service. Such adjustments would require careful consideration, however, because of the actual services provided. VNAA cautions that rural hospice providers, who are more likely to support patients in skilled nursing facilities (SNF), should not receive lower payments simply because they are serving SNF-based patients. However, a hospice-based SNF patient receiving service from on-site hospice providers should result in lower costs, lower resource utilization and therefore, a lower overall payment based on a site-of-service adjustment.
VNAA notes with significant interest Abt Associates' consideration of the routine home care (RHC) component of the existing methodology and discussion of changes in the mix of services and associated costs since the 1983 inception of the Medicare hospice benefit. Routine home care accounts for 95 percent all hospice care days. However, the nine RHC components are significantly out of date when compared to the practice of hospice and palliative care today in that the components are not comprehensive and provide inadequate reimbursement compared to costs. VNAA members report, since the 1983 inception of the Medicare hospice benefit, agencies have seen tremendous growth in hospice-associated costs. VNAA notes numerous studies that have demonstrated misalignment between the current per diem system for RHC with the costs incurred by hospices (GAO, 2004; MedPAC, 2006, 2008, 2009, 2010, 2013, 2014; Huskamp, et al., 2008). Further, according to Abt Associates' 2013 report:

"The mix of services used to provide RHC has changed over time: nursing, social services, prescriptions and medical equipment have increased, while home health aide services, supplies and outpatient services decreased."

VNAA believes that rebasing must reflect the significant increase in costs associated with the routine home care component bundle, including the recognition, addition and reimbursement for commonly used and frequently required services, supplies and costs. VNAA does not believe that hospice rebasing should be viewed as an opportunity to simply adjust profit margins and notes that MedPAC’s March 2014 “Report to Congress” cites average 2011 nonprofit provider profit margins of only 2.5 percent.

**VNAA Recommendations for Routine Home Care Rebasing**

- Examine and consider evidence that General Inpatient Care (GIC) reimbursement today outpaces costs while RHC costs have increased and reimbursement levels declined. Numerous studies have found that current hospice payment methodology does not accurately reflect actual care delivery. For example, GAO’s 2004 report compared hospices’ costs to Medicare payment rates to evaluate the appropriateness of the per diem payment methodology. For each payment category (i.e., RHC, CHC, GIC, and IRC,) average per diem costs were more for small hospices than for large hospices (GAO, 2004; Huskamp, et al., 2008).

- Appropriately incorporate interventions currently not in the RHC bundle. For example, pain control is viewed primarily through drug intervention. This perspective ignores and underestimates the positive impact of Master of Social Work (MSW)-provided psychosocial and spiritual care. Further, bereavement care, provided to surviving family members, remains entirely uncompensated, yet bereavement care has dramatically advanced since 1983 and is provided by trained professional staff rather than by uncompensated, community volunteers (National Consensus Project, 2013).

- Adjust reimbursement for current wage costs. CMS reimbursements of nurse expenses have increased on the average of only 4.5 percent per year. However, one hospice in rural New Hampshire, in operation since 1983, documents nursing wage increases from an average of $21,000 per year in 1983 to $68,000 per year in 2014. This increase of 326 percent has certainly not been met by appropriate increases in wages reimbursed through the routine home care bundle.

- Adjust the RHC bundle for new treatments commonly provided in today’s hospice care. Hospices have experienced a growing number of requests over time for very costly symptom management modalities, including blood transfusion and/or radiation to shrink a tumor (and relieve pain or improve breathing). Each of these modalities has significant costs not offset or even recognized by the current RHC bundle.
• Reimburse for costs associated with durable medical equipment, other routine supplies or the use of health information technologies, including telemonitoring.
• Examine and appropriately reimburse for hospice drug costs. VNAA strongly cautions that, despite research and assertions by Abt Associates, hospice-reported drug spend is not accurately reflective of actual hospice drug costs. Specifically, Abt Associates reports a declining trend in drug cost per patient day. VNAA asserts, based on reports from nonprofit hospice providers, that this decline is not aligned with actual practice and reflects incomplete reporting of drugs not reimbursed for hospice services.
• Adjust payment for level of complexity. Perhaps most important to the provision of hospice and palliative care services in 2014, the current RHC components make no distinction between the level of complexity of cases. The NPRM recognizes changes in the diagnosis patterns among Medicare hospice enrollees, including notable increases in neurologically based diagnoses (e.g. various dementia diagnoses). CMS should include adjustments based on different case mixes of hospices. Such adjustment is particularly necessary when considering the cost variation associated with caring for cancer patients versus neurological disorder patients in the RHC component bundle.

**VNAA Recommendations for Timeframe for Routine Home Care Bundle Rebasing**

VNAA is gravely concerned with the cumulative impact of these substantial program changes, including rebasing, a new payment methodology, and other regulatory and administrative program changes. VNAA strongly recommends a focused and detailed review of resource use associated with each of the current components of the RHC bundle as well as input from hospice and palliative care stakeholders on components not currently included but commonly used in routine home care practices. VNAA believes routine home care rebasing should be delayed until the Agency fully examines the data and impact of:

1. implementation and new quality measure reporting requirements;
2. implementation and new Hospice Information Set reporting requirement;
3. full 2014 prescription drug use and cost data for hospices;
4. current wage reimbursement, cost-of-living increases, and expenses for required professionals such as bereavement counselors/coordinators;
5. current and accurate costs of medical supplies including electronic health records and telehealth.

Further, CMS notes in the NPRM the ongoing work to reform hospice costs reports to better collect data on the costs of providing hospice care. The current Medicare hospice cost reporting system does not provide adequate information regarding the segregation of costs by level of care (e.g., routine, continuous, respite or general inpatient care). VNAA supports efforts to modify the Medicare hospice cost report to better capture the full and accurate cost of providing hospice services to Medicare beneficiaries. These reforms should include capturing costs by type of visit and diagnosis as well as by separately tracking costs for pharmacy, bereavement services and overhead costs specific to Medicare beneficiaries. Currently, all costs are simply a per day average. VNAA supports a more accurate cost report reporting system to better illustrate the actual costs of each care level. VNAA believes improved cost reporting would better support rebasing for the routine home care bundle.

**VNAA Recommendations regarding the Hospice Carve out for Managed Care Programs**
Finally, VNAA wishes to express concern with regard to proposals to end the Medicare managed care carve-out. Currently, hospice benefits for beneficiaries enrolled in Medicare Advantage programs are provided outside the managed care provider via the traditional Medicare hospice benefit per diem
payment system. Further, Medicare’s capitated payment to managed Medicare plans does not adjust for end-of-life care, and medical expenses in the last months of life are known to be higher. Medicare managed care plans typically lose money when covering patients who are not in hospice during this period (Riley & Herboldsheimer, 2001). Therefore, the current hospice payment method creates a financial incentive for managed Medicare plans to encourage dying patients to elect the hospice care carve-out provided through traditional, fee-for-service Medicare (Riley & Herboldsheimer, 2001; Abt Associates, 2013). VNAA believes CMS should proceed cautiously and urges the adoption of either an adjusted, increased, payment model for Medicare managed care hospice benefits or the continuation of the traditional hospice carve-out. Regardless, VNAA believes such adjustments to the current delivery and payment system should be piloted in a variety of communities and providers before promulgation of any national policy changes.

Definitions of “Terminal Illness” and “Related Conditions”

VNAA agrees “hospice care is unique in its comprehensive, holistic, and palliative philosophy and practice” and the hospice “bundle” of services should be preserved without dilution to ensure appropriate support of patients and family members at end-of-life. The concept of “terminal illness” has served as the foundation for the Hospice service bundle since the inception of the program and has previously been understood to include conditions related to the terminal diagnosis. Previous definitions of “terminal illness” and “related conditions” have offered the following considerations:

“Terminal illness is defined as a medical prognosis that the patient’s life expectancy is six months or less if the illness runs its normal course.” (Social Security Act Sec. 1861 as per Abt Associates, 2013)

And;

“As generally accepted by the medical community, the term "terminal illness" refers to an advanced and progressively deteriorating illness, and the illness is diagnosed as incurable. When an individual is terminally ill, many health problems are brought on by underlying condition(s), as bodily systems are interdependent. In the June 5, 2008 Hospice Conditions of Participation final rule (73 FR 32088), we stated "the medical director must consider the primary terminal condition, related diagnoses, current subjective and objective medical findings, current medication and treatment orders, and information about unrelated conditions when considering the initial certification of the terminal illness." (78 FR 48236 FY14 Payment Rule/August 13, 2013)

And;

“The condition established after study to be chiefly responsible for admission of the patient to the hospital.” (American Medical Association (AMA) created the following definition of “terminal illness” as included in the current International Classification of Diseases 9th Revision Clinical Modification (ICD-9))

And, with regard to “related conditions”;

"Clinically, related conditions are any physical or mental conditions that are related to or caused by either the terminal illness or the medications used to manage the terminal illness." (FY14
In the current proposed rule, CMS solicits comments for further discussion and consideration for potential future rulemaking expansive new definitions of both “terminal illness” and “related conditions.

**VNAA Recommendations on Proposed new Definitions of Terminal Illness and Related Conditions**

VNAA believes these new definitions are, at best, unnecessary and, at most, damaging, too complex and expansive. VNAA recommends continued use of the existing Social Security Act definition of “terminal illness.” These existing definitions, specifically, the reference to “interdependent bodily systems” found at 78 FR 48236, provide sufficient guidance to hospice providers as to the “bundle” of services required to support patients at end-of-life. VNAA recommends CMS reaffirm and codify the existing definitions of “terminal illness” without attempting to redefine a specific, highly clinical term absent guidance of leading medical and hospice professionals. Absent such reaffirmation, VNAA strongly advises CMS to convene a panel of interdisciplinary clinical experts, including hospice clinicians practicing in the field, to develop a consensus definition of “terminal illness” and “related conditions.”

**Proposed Timeframes for Filing the Notice of Election (NOE) and Notice of Termination/Revocation (NOTR)**

CMS proposes to require the hospice Notice of Election (NOE) to be filed within three calendar days of the effective date. CMS’s survey of the four Medicare hospice Medicare Administrative Contractors (MACs) showed the following:

- NOEs filed within two days: 16.2%
- NOEs filed within five days: 39.2%
- NOEs filed within ten days: 62.1%

**VNAA Recommendation on Timing of NOE Filings**

VNAA submits that hospice providers should not be required to submit Notices of Elections (NOEs) during weekend days and strongly recommends that CMS require NOE filing within five “business” days rather than “calendar” days after beneficiary election. VNAA notes a five "business" day requirement would still result in improvement of filing times for over 90 percent of current NOEs and would not disproportionately burden those hospices with unique challenges in providing benefits (e.g. small, rural providers).

VNAA agrees hospice election and termination must be recorded as soon as possible to protect beneficiaries from financial liability from deductibles and copayments for items or services provided during a hospice election, which are related to the terminal prognosis, to avoid compliance problems with face-to-face documentation requirements, and to alleviate sequential billing problems for hospices. However, VNAA notes that Section 1861(dd)(2)(A)(i) of the Social Security Act requires the following services covered by the Medicare Hospice Benefit to be available, “as needed to beneficiaries 24 hours a day, 7 days a week.”

“These covered services include: Nursing care; physical therapy; occupational therapy; speech-language pathology therapy; medical social services; home health aide services (now called hospice aide services); physician services; homemaker services; medical supplies (including drugs and biologics); medical appliances; counseling services (including dietary counseling); short-term inpatient care (including both respite care and procedures necessary for pain control
and acute or chronic symptom management) in a hospital, nursing facility, or hospice inpatient facility; continuous home care during periods of crisis and only as necessary to maintain the terminally ill individual at home; and any other item or service which is specified in the plan of care and for which payment may be otherwise be made under Medicare, in accordance with Title XVIII of the Act."

VNAA notes that these services are clinical in nature and appropriately designed and designated to support the beneficiary and family members at end-of-life. VNAA members are committed to providing these clinical services in the 24/7, weekends included, concept of true hospice care. However, hospice administrative personnel are not available in these same time periods. The proposed three-calendar day requirement would prove especially burdensome to small, rural hospice providers. Beneficiaries may elect hospice services during any day of the week and hospice providers are able to respond with appropriate support services. However, neither hospices nor Medicare Administrative Contractors (MACs) maintain 24/7 administrative staff, especially during weekend periods.

CMS further outlines concerns that beneficiary transfer from one hospice to another could cause an administrative burden for the second hospice. However, research reviewed by the Abt Associates literature review (2013) indicated that the majority of live discharges (79 percent) are because the patient condition has improved or stabilized with only seven percent leaving hospice to pursue aggressive treatment and 12 percent was the patient or family decision to leave hospice care. Specifically, Kutner, et al. (2004) note: “Transfer between hospices was a rare reason for hospice discharge.” Given these overwhelming statistics, VNAA does not agree that hospice transfer is an adequate reason to implement a three-calendar day filing requirement for NOEs.

Of further concern, VNAA notes that at least one major MAC, serving 33 states, does not allow electronic filing of the NOE and requires hospices to file exclusively via direct data entry (DDE). This approach requires additional administrative staff hours. However, the timeline for DDE is further complicated by delay of up to several days in data available from other vendors, including electronic clinical record vendors that transmit claims electronically.

CMS further proposes to revise the regulations to require hospices to file a Notice of Termination/Revocation (NOTR) within three calendar days after the effective date of a beneficiary's discharge or revocation, if they have not already filed a final claim. VNAA notes that a hospice provider would have difficulty meeting this standard for the reasons noted above and further cautions that short hospice stays would create significant administrative challenges to ensure compliance. Hospice providers note that final bills for short hospice stays are often held back for completion of unsigned orders, including the Certification of Terminal Illness (CTI). Rural providers with large service areas report lengthy delays due to reliance on U.S. Postal Service delivery for receipt of signed physician orders. An additional challenge relates to the inclusion of pharmacy costs on billing documents. Hospice providers report that some pharmacy management contractors maintain response times of up to 48 hours for pharmacy billing information.

For the reasons stated above, VNAA strongly urges CMS to require NOE and NOTR filing within five “business” days.

**Proposed Addition of the Attending Physician to the Hospice Election Form**
CMS notes in the NPRM that the term "attending physician" is defined differently in different health care settings. For the Medicare hospice benefit, "attending physician" means, with respect to an individual, "the physician or nurse practitioner who may be employed by a hospice program, whom the individual identifies as having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice." CMS further notes the requirement that the National Provider Identifier (NPI) of the "attending physician" must be included on the Notice of Election and on each claim and reiterates that the "attending physician" can be a physician or a nurse practitioner (NP).

**VNAA Recommendations on Proposed Definition of “Attending Physician”**

VNAA supports the definition of "attending physician" to include nurse practitioners but strongly urges CMS to remove the language to exclude NPs from signing the initial hospice certification. VNAA believes the role of nurse practitioners in hospice and palliative care services is critical and should be expanded. VNAA remains uncertain why CMS would prohibit nurse practitioners from signing initial certification of hospice orders if, in fact, an individual has indicated that a nurse practitioner has the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice.

VNAA strongly supports an expanded role for NPs in hospice and palliative care and notes that 17 states currently allow NPs to work without a supervising physician. The Health Resources and Services Administration (HRSA) estimates that at least 55 million Americans live in areas with an inadequate supply of primary care doctors (HRSA Justification of Estimates for Appropriations Committees, FY2014). Expanding NP practice can improve patient access to care (HRSA: Projecting the Supply and Demand for Primary Care Practitioners through 2020 In Brief, November 2013). Finally, the Institutes of Medicine cites 50 years of research confirming that primary care provided by nurse practitioners is as safe and effective as care provided by doctors (Health Affairs: Nurse Practitioners and Primary Care, October 2012 and Robert Wood Johnson Foundation: The Future of Nursing: Leading Change, Advancing Health, 2011).

**Coordination of Benefits Process and Appeals for Part D payment for Drugs while Beneficiaries are Under a Hospice Election**

In the NPRM’s discussion of “Hospice Care Today”, CMS outlines non-hospice spending for Hospice beneficiaries during an election period and highlights analysis of hospice drugs paid through Part D sponsors. Specifically, CMS reports Medicare paid $1 billion in CY12 for non-hospice expenses associated with hospice beneficiaries. According to Medicare’s analysis, this breaks down to $710 million in Part A and B spending (including 28.6 percent in inpatient care; 52 percent in Part B services and $268.4 million in ER expenses) and $335 million in Part D expenses.

To be clear, Medicare paid twice as much in non-hospice Part A and B expenses combined than in total hospice enrollee Part D expenses. Further, CMS notes that fewer than 400 hospices (of 3,500 nationwide) were responsible for more than half of these inappropriate expenses. VNAA reiterates long-

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4 [http://www.rwjf.org/content/dam/farm/reports/reports/2011/rwjf67190](http://www.rwjf.org/content/dam/farm/reports/reports/2011/rwjf67190)
standing recommendations for targeted program integrity intervention with hospices and other providers who have demonstrated an inability to appropriately comply with program regulations. A targeted approach by CMS would demonstrate CMS’ commitment to program integrity, respect for honest program participants and good stewardship of the Medicare Trust Fund.

Instead, CMS issued guidance, effective May 1, 2014, requiring Part D plans to put all drugs on prior authorization for members enrolled in hospice in an effort to ensure that the appropriate party is paying for drugs for hospice enrollees. This beneficiary-level of prior authorization, rather than drug-specific level prior authorization, is unprecedented.

At this time, VNAA is primarily concerned that the beneficiary-level prior authorization process established through sub-regulatory guidance without comment opportunity is administratively burdensome on all parties: hospice beneficiaries, caregivers, hospice service providers, Part D sponsors and pharmacists. Specifically, VNAA disagrees with CMS’s consideration that Part D sponsors should have responsibility for determining Part A versus Part D coverage at point-of-sale for any drugs for beneficiaries who have elected the hospice benefit as of the date of the prescription. Simply stated, Part D sponsors do not have access to diagnosis or plan of care information and cannot be expected to reliably and quickly determine Part A versus Part D coverage based on the presence of absence of “related conditions.” VNAA is gravely concerned that hospice beneficiaries are already suffering delays in prescription delivery resulting from Part D determination processes. MedPAC, in a June 25, 2014 letter to Administrator Tavenner, urges CMS to suspend the current Part D authorization process for hospice enrollees and issue a regulatory proposal to establish and improved prior authorization process as soon as possible. VNAA strongly supports MedPAC’s recommendations on this issue.

In the NPRM, CMS solicits comments on processes to determine payment responsibility, recover payment when the wrong party has paid, and resolve disputes regarding payment responsibility. Specifically, CMS contemplates requiring the hospice provider, the beneficiary, the beneficiary’s representative or the prescriber to initiate communication with Part D sponsors to report information concerning a hospice election and/or drug profile. VNAA believes such communication should not be the responsibility of the beneficiary or the beneficiary caregiver. On the issue of payment recovery, VNAA notes that Part D sponsors have already begun to target hospice providers with collection demands for drug costs inadvertently paid on behalf of hospice beneficiaries as long as three years ago. Given that CMS has not issued specific requirements for either MACs or Part D sponsors, VNAA believes these actions by Part D sponsors are egregious. VNAA and our members stand ready to collaborate with CMS and Part D sponsors to develop appropriate and non-adversarial coordination processes and asks that CMS instruct Part D sponsors to permanently cease retroactive collection efforts.

Finally, CMS solicits anecdotes to detail the experiences of Part D sponsors and hospices that “successfully” communicate with each other and how both parties ensured that beneficiaries did not experience any delay in drug coverage. A survey of over 150 hospice professionals among VNAA member agencies did not elicit a single example of “successful” communications between Part D sponsors and hospice providers. To the contrary, VNAA received numerous examples of delayed responses, uninformed Part D call center personnel and uninformed pharmacy personnel contributing to significant delays and, in some cases, denial of medication deemed necessary for hospice beneficiaries.
Two examples presented below for CMS consideration are reflective of the serious, systemic payment coordination problem created by the sub-regulatory guidance on prior authorization process for hospice enrollees:

1. JN is a resident of a nursing home with end stage heart disease. He is a loner and distrustful of medical staff. The physician requests hospice care to help the patient with his declining clinical condition and to support the wife as she remains home in poor physical shape. After months in the hospice program, the wife receives a call from the nursing home stating that Medicare has stopped paying for his medications. She is confused and frustrated that the nursing home does not know why Medicare has discontinued his medications. After researching the issue, it is clear that he is on two medications that are not considered part of his terminal illness; Glipizide and Flomax. The nursing home staff does not have any information from Medicare regarding the Medicare Part D A3 Reject Override. I explain the new guidelines to the wife and promise that I will contact her husband’s part D pharmacy to get these medications filled. His pharmacy, Omnicare, transfers me several times to different people and departments. Each department seems perplexed about how to get the medications covered. I finally speak to a person who is able to give me the patient’s part D plan number. As a hospice, we do not have access to part D plans and through our Ability network I have to rely on pharmacies to access the system and feed me the information. I call his Essence Health/Perform RX at 1-888-765-6383. I am again transferred numerous times and finally speak to someone who takes the information over the phone. She asks me questions about his terminal illness and informs me that they will have a response on coverage within 72 hours. This pharmacy/insurance company was not aware of the Reject Override form. I discuss my progress with the patient’s wife and she informs me that she does not think hospice should be so much trouble and asks to be removed from the program. She also states that the invoices that she receives from Medicare are confusing and the cost of hospice is expensive. It has been 72 hours since I notified the pharmacy and I have not heard a response on his coverage or denial. Discharging him from hospice will only makes this situation worse since his hospice-covered medications will be denied as well and many of them are cardiac medications.

2. JV is a patient that was admitted to the hospice program for dementia. At the time of his admission, he was in poor clinical condition. His wife was overwhelmed by her caregiving responsibilities. With the help and support of the hospice team, his condition improved and his wife became a more equipped caregiver. Her stress level diminished and hospice determined that this patient might plateau for a while and should be removed from hospice. Unfortunately, a few days before his discharge, he suffers an infection and is admitted to the hospital. His wife signs revocation papers. He is admitted for a three-day hospital stay and is discharged back to his home. Mrs. V is not able to get his medications costing $561.00 at the hospital pharmacy. The pharmacy is denied access to Medicare payment because he is still considered a hospice patient. The pharmacy suggests they go to Walgreens. At Walgreens, the story is the same. Mrs. V calls hospice to help her. I am told by Medicare that we have to bill for his hospice services and enter a revocation code into the Medicare system. Unfortunately, this can’t be done until Medicare recognizes the claims we have submitted for March before we can send in May claims. I am forced to choose a different solution. I contact the hospital pharmacy and they are able to give me the Medicare D plan for this patient. I call UHC. After 20 minutes on hold and several transfers to different departments, I am told that his supplemental Medicare plan will not become effective until the first of the next month. No one is able to tell me how to notify them that the patient has revoked the benefit. I am told that “traditional Medicare” will pay for the
medications in the interim. I contact a Care Manager at the hospital to determine if there are charitable funds to assist with the cost of the medication. She regrets that their charitable fund policy states if the patient has insurance, he does not qualify. By this time I have spent 4 hours making phone calls, consoling the patient’s wife and listening to hold music while my other patients must wait for me to return their calls at a later time. Regretfully, I explain to Mrs. V that it is clear she will not get the breathing medications her husband needs tonight and I promise her I will work on it again in the morning. By morning, Mrs. V has decided she will need to pay cash for the much-needed prescriptions or take him back to the hospital. She pays cash out of their meager monthly income. I continue working through the pharmacy system with a slight hope that I can get them reimbursed for their expense, but since they have paid the premium price for the medication, I am not optimistic about the outcome.

Proposed Updates to the Hospice Quality Reporting Program: Future Measure Development

CMS requests in the NPRM suggestions for possible future hospice measures for addition to the Hospice Quality Reporting Program (HQRP). The NPRM specifically requests recommendations for outcome measures for symptom management, particularly for pain; and measures of patient reported outcomes. CMS further requests assistance to better understand the current state of Electronic Health Record (EHR) adoption in the hospice community.

VNAA notes the significant recent activity in the development and implementation of the HQRP. Specifically, in July 2014, hospice organizations will begin to collect data on seven new process measures. Further, in January 2015, hospice organizations will implement a new Hospice Experience Survey to collect and submit surveys. VNAA strongly urges CMS to delay implementation of additional HQRP measures for at least two years given these significant additions to hospice reporting requirements and the lack of reimbursement for additional staffing required. VNAA further notes that such a delay will permit thoughtful development of appropriate new HQRP measures. As a member of the National Quality Forum (NQF) Measures Application Partnership (MAP), VNAA commits to assist and contribute to the development of such measures. Further, VNAA continues to advance quality improvement initiatives for hospice providers with the June 2014 release of best practices for end of life care. VNAA’s Blueprint for Excellence is a free resource for hospice and palliative care providers offering training, clinical guidelines, measurement and improvement opportunities and other resources.

As for recommendations for specific new measures, VNAA directs CMS to NQF’s June 2012 report entitled “Performance Measurement Coordination Strategy for Hospice and Palliative Care” which outlines six areas for further measurement development.

VNAA Recommendations for Future Quality Measure Consideration

- Access and availability is a key area for consideration due to the continued and well-documented problem with short hospice lengths of stay and the resultant quality issues for patients and caregivers. VNAA notes that one possible area for measurement development would be the establishment of a timeframe from initial referral to actual start of care. VNAA believes that such a measure would be valuable for quality improvement efforts but strongly cautions that such a measure would have to take into consideration the hesitancy patients and families sometimes have when deciding to begin hospice care.
- Person and family-centered care is a second area for potential measure development. New process measures for treatment preferences have been developed but future measures could include more specifics such as whether patients and families have completed a Physician’s Order
of Life Sustaining Treatment (POLST) or whether there is clearly stated documentation about hospitalization.

- To expand on the initial measures of pain, VNAA believes that additional, future measures could include a measure of bringing pain to an acceptable level within the 48 hours of initial screening. This acceptable measure is an important indicator of the organization’s response to pain symptoms. VNAA believes, and has previously commented, that the prior pain measure #0209 is flawed and should not be considered. A possible second symptom measure could examine whether dyspnea was brought to a comfortable level within a few hours from initial reporting or at time of admission.

- VNAA believes that ensuring the appropriate competency of the clinical leaders is key to providing high quality hospice care. VNAA supports consideration of a structural measure to ensure the presence of a nurse leader with either an advanced degree or with an appropriate certification such as the Certification in Hospice and Palliative Nurse (CHPN). Structural measures that ensure the presence of nurse leaders with advanced degrees or CHPN certification would ensure quality hospice care by practitioners who are well versed in palliative and hospice philosophy. Herr, et al. (2010) found that hospice nurses with certification in hospice/palliative care or pain management had a positive impact on use of evidence-based practice.

- Appropriateness and affordability are NQF’s fifth area of future measure development. VNAA supports consideration of a risk-adjusted measure of hospitalization (NQF #0171) as well as a measure of Emergency Department use without hospitalization (NQF #0173).

- Care coordination is NQF’s final measurement priority area. VNAA supports consideration of crosscutting measures across the many settings patients move through at end of life. The NQF report specifically targets hand-off tracking as a measurement opportunity. VNAA, however, believes it is most imperative to track preferences, specifically information about patient treatment choice. VNAA believes such measures could include a system for identifying whether a patient has a Physician’s Order for Life Sustaining Treatment (POLST) and whether it is still current. An additional measure could require medication profiles to be part of patient hand-offs across health care settings.

Finally, in response to CMS’s request for information on the current state of EHR adoption, VNAA notes the expense of such systems poses a significant hurdle to adoption, implementation and optimization. Hospice service providers are currently not reimbursed for the use of EHR or other telemedicine technologies, as are hospitals and primary care physicians under the federal “meaningful use” initiative. Further, VNAA notes that hospice providers are not “eligible reimbursement sites” under current Medicare reimbursement policy. One final and critical barrier is the lack of interoperability among EHR systems. Nonprofit hospice providers frequently serve multiple hospitals and physician practices that may utilize two or more EHR platforms that are not interactive. Hospice agencies cannot be expected nor required to integrate EHR platforms until there is appropriate reimbursement and/or incentives for adoption and use as well as federal requirements to ensure interoperability among the existing platforms.

**Conclusion**
VNAA appreciates the opportunity to offer insights and perspective from nonprofit hospice and palliative care providers as CMS considers opportunities to improve access, quality and integrity of the current program. Please do not hesitate to consider us a resource as you work through this and other issues relating to the hospice and palliative care community.

Sincerely,

[Signature]

President and CEO
Visiting Nurse Associations of America