June 26, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: Medicare Program: FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

Dear Administrator Verma,

On behalf of our more than 400 member hospitals and health systems, including more than 10 hospice providers, the New Jersey Hospital Association (NJHA) appreciates the opportunity to comment on the FY 2018 Proposed Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements. This letter addresses the areas of concern we have related to the sources of clinical information for certifying terminal illness as well as concerns related to the priority areas identified by CMS for future hospice quality measures.

Sources of Clinical Information for Certifying Terminal Illness

As part of the proposed rule, CMS indicates that while hospice regulations require that the hospice medical director consider at least diagnosis of the terminal condition of the patient; other health conditions, whether related or unrelated to the terminal condition; and current clinically relevant information supporting all diagnoses when making a determination of a six-month life expectancy, the source of the clinical information that supports the six month life expectancy is not clearly identified. This has raised questions about what clinical information the hospice medical director is relying on to support the certification of terminal illness. CMS believes that without long-term monitoring and evaluation, documentation to support terminal indicators (such as those contained in the LCDs) would not be available to the hospice, but notes that they would likely be available in the referring physician's and/or acute/post-acute care facility's medical records. In response to these concerns, CMS is soliciting comments for possible future

rulemaking on amending the hospice regulations at 42 CFR 418.25 to specify that the referring physician's/facility's medical record should *"serve as the basis for the initial hospice eligibility determinations. Clinical information from the referring physician/facility supporting a terminal prognosis would be obtained by the hospice prior to election of the benefit, when determining certification and subsequent eligibility."* CMS believes this modification would be in alignment with existing benefit eligibility criteria, and could not be determined by hospice documentation obtained after admission. CMS also is soliciting comment on amending hospice regulations at 42 CFR 418.25 to specify that documentation of an in-person visit from the hospice medical director or the hospice physician member of the interdisciplinary group could be used as documentation to support initial hospice eligibility determinations only if needed to augment the clinical information from the referring physician/facility's medical records. This in-person visit would be required to be made prior to admission onto hospice care.

While NJHA recognizes the need to ensure that patients meet hospice eligibility criteria, we have very serious concerns that the changes being contemplated are inconsistent with the current structure of the hospice program and, most importantly, could delay or deny access to vital hospice services. Our specific concerns are:

Existence of a referring physician/facility: The proposed rule references an article from 2008 indicating that the majority of hospice referrals come from personal physicians; this reference draws upon data from a 2003 study. NJHA does not believe that this information reflects today's experience. Current hospice experience indicates that the proportion of hospice patients referred by personal physicians who have cared for them over a long period of time varies significantly. The majority of referrals come from hospitals, skilled nursing facilities and even home health agencies. In many situations, the person has not seen a physician in a number of years so there is no current physician clinical record available. Many of these patients have multiple social risk factors, and they will be most adversely affected by the changes under consideration. If the hospital or other referral source determines by clinical evaluation that the patient may be approaching the end of life, and a patient is not inclined to submit to or is fearful of needed testing, the referral source will be unable to conduct the tests that would provide quantitative justification for hospice. Under such circumstances the patient may be denied access to hospice services. In some cases, patients may be part-time residents but may have more extensive medical history with a physician in a different part of the country. These circumstances may present serious challenges to timely communication of medical history.

There are no existing requirements for a hospice patient to be referred by a physician or facility, and many patients/families request an evaluation directly from a hospice provider. CMS has not indicated what documentation would be permissible for use when a patient is not directly referred by another provider.

Willingness to refer/engagement in hospice care: While a family physician can play an invaluable role in caring for patients at the end of life and their involvement can help to ensure important continuity of care, there is widespread acknowledgement that barriers to physician

referral to hospice are prevalent. These barriers include "negative perceptions about hospice, discomfort communicating terminal diagnoses and prognosis, an inability to identify an appropriate diagnosis, a fear of losing control of the patient, and an overestimation of life expectancy" ("The Role of the family Physician in the referral and Management of Hospice Patients," *American Family Physician*, March 15, 2008). Additional resistance is found as the result of widespread reports regarding opioid addiction and lack of understanding about the appropriate use of narcotics in hospice care. These factors all have an impact on some physicians' willingness to refer, and may have an impact on their willingness to assist with the development of documentation that would support eligibility for hospice care.

Availability/quality of referral source records: The quality of records compiled by hospice referral sources is variable, and referral sources frequently do not provide the amount or type of information needed to adequately document eligibility for hospice. Hospices have reported that referral sources express some frustration with hospice as they consider hospice to be "difficult to do business with" given the complexity of the eligibility requirements. The inadequacy of referral source records is due, in large part, to limited knowledge of hospice eligibility requirements, limited exposure to palliative care and hospice education, and variable knowledge related to the dying process. The nation's most highly trained palliative care and end-of-life clinicians are employed in hospice and palliative care programs. These physicians and nurses are in the best position to evaluate an individual for eligibility for hospice care, and their skill should not be discounted or disregarded when it comes to determining appropriateness for hospice care.

The proposals under consideration by CMS bear some similarity to regulations currently in place for home health care, which require the use of the referring or ordering physician's documentation to support certification and any required face-to-face encounter. As a result, home health agencies have no control over the quality of the documentation supplied to justify eligibility for home health services, and eligibility determinations could be made based on review of only part of the pertinent clinical record. This has led to widespread denials that are beyond the agency's control. In the case of home health, however, the required documentation must be finalized prior to billing, whereas for hospice the agency would be required to have the documentation in hand prior to taking a patient onto service, a much more challenging task.

Financial risk: Given that the hospice is at full financial and reputational risk if it does not follow proper eligibility requirements, the hospice has the greatest motivation to ensure that documentation meets required standards. This is not always the case with referral sources.

Health system considerations: While an important goal of ongoing changes in the health care system is to achieve coordination among clinicians who care for patients with advanced illness and ultimately support patient determination of appropriateness of hospice referral at the proper time, our current health care system is still, to a great degree, characterized by "silos." Until issues of coordination are adequately addressed, imposition of a requirement that hospices rely on documentation developed by clinicians outside of the hospice environment would create undue burdens on hospice providers and could delay and ultimately deny eligible patients access to care. Further, systemic issues related to the lack of interoperability of electronic health

records between physicians/facilities and hospices make timely sharing of information between referral sources and hospices very challenging, which would further contribute to delays in accessing care.

Currently, more than 25 percent of patients accepted onto hospice service die within seven days of admission, and half of all hospice patients have a length of stay of 18 days or less. Requiring that hospices secure and analyze patient records from the referral source, ensure that the records justify eligibility for service, and then begin the admission process will delay or even deny many patients access to hospice care. One of the biggest challenges in hospice today relates to late admissions onto hospice care, even without these additional requirements. Imposition of the "sources of clinical information" requirement will impose a significant regulatory burden on all hospice providers and could limit access to hospice services. We would suggest that as an alternative CMS might examine claims data for patients on hospice care for longer periods of time where there are limited indications that the patient was treated for serious advanced illness that could lead to imminent death to identify potential areas of abuse.

Hospice Quality Reporting Program (QRP) – Future Measures

CMS has identified two priority areas for future QRP measure development: potentially avoidable hospice care transitions and access to levels of hospice care.

Potentially avoidable hospice care transitions at end of life are believed to be burdensome to patients, families, and the health care system at large because they are associated with adverse health outcomes, lower patient and family satisfaction, higher health care costs, and fragmentation of care delivery. CMS believes that by encouraging hospice providers to assess and manage patients' risk of care transitions, this measure concept has the potential to improve quality care at the end of life by reducing potentially avoidable hospice care transitions.

NJHA's concern is that using claims to identify such potentially avoidable transitions is fraught with pitfalls. Claims data is subject to interpretation and cannot be easily linked to issues with quality of care or inappropriate use of different levels of care. We respectfully ask that CMS provide examples of types of avoidable transitions that could be included in this measure.

The goal of the measure concerning access to levels of hospice care is to assess the rates at which hospices provide different levels of hospice care. CMS believes measuring use of levels of care will incentivize hospice providers to continuously assess patient and caregiver needs and provide the appropriate level of care to meet these needs. This is identified as a claims-based measure and therefore will only reflect utilization of other levels of care, which is based on an individual patient's need. Is there any way to connect the claims data with survey data indicating a hospice's ability to provide other levels of care – which could be demonstrated by either ownership of an inpatient facility or documentation of a contract for inpatient respite/GIP? This

could help to balance out the measure given that higher levels of care represent only 2-3 percent of billed hospice days.

NJHA appreciates the opportunity to submit comments on this proposed rule. If you have any questions concerning our comments, please contact me at 609-275-4102 or via email at tedelstein@njha.com.

Sincerely,

Theresa Edelstein, MPH, LNHA
Vice President
Post-Acute Care Policy & Special Initiatives