June 9, 2020

Seema Verma
Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Subject: CMS–1733-P: Medicare Program; FY 2021 Hospice Wage Index and Payment Rule Update

Dear Administrator Verma,

On behalf of our over 6,000 members and partners including nonprofit organizations representing the entire field of aging services, 38 state associations, hundreds of businesses, consumer groups, foundations, and research centers, LeadingAge, ElevatingHOME (EH), and the Visiting Nurse Associations of America (VNAA) are pleased to offer the following comments in response to the FY2021 Hospice Wage Index and Payment Rule published on April 15th, 2020.

A. Proposed Hospice Wage Index Changes

We understand CMS' goals in using the updated Office of Management and Budget (OMB) delineations to try to ensure that the hospice payment system reflects the most up-to-date information regarding population shifts and labor market conditions. We support CMS' proposed transition policy that would cap any decrease in a geographic area's wage index value as compared to the previous fiscal year at 5% but ask that the transition policy be extended beyond one year due to COVID-19 and the financial ramifications of the pandemic.

This transition policy is particularly important because while we understand CMS' goal and practical need to adopt the newest OMB delineations, the delineations do not always match up with the reality of labor market conditions on the ground. For example, hospices in New Jersey that are moving from the New York City Core-Based Statistical Areas (CBSA) to the newly created New Brunswick, NJ CBSA will be taking a large wage index decrease both in actual terms for FY 2021 (about 6% before the adjustment) and even greater when compared to what their wage index would have been had they remained in the New York City CBSA (almost 12%). Hospices in this part of New Jersey will have to continue to compete with the greater New York City area for staff; they will just have fewer economic resources with which to do so. Therefore, the transition policy is critical to offset economic losses for hospices like these throughout the country.

We ask that CMS consider extending the transition policy for multiple years due to the COVID-19 pandemic. LeadingAge is concerned, if CMS proceeds with its current proposal, which only caps the first-year downward adjustment that hospices in regions with significant reductions may not survive, especially when coupled with the extraordinary costs and lost revenues some of them are experiencing during the public health emergency (PHE). Therefore, we request CMS extend the 5% cap to apply each year until the full adjustment is realized. To continue with our earlier example, the hospices in the newly created New Brunswick, NJ CBSA (and others similarly impacted) would be capped at a 5% loss each year for the first three years, and a 2% loss in the final year at which time they would be fully transitioned. By capping the reductions at no more than 5% per year until the transition is complete, it results in a more manageable transition during unprecedented and financially dire times.

We also encourage CMS to continue to examine policies to help assuage these types of issues, including reinstituting the policy that no hospice be paid below the rural floor for their state and considering working with the Congress on policies to reform the wage index such as revisiting MedPAC's 2007 proposal[1] or one that would allow hospices and other post-acute providers to utilize a reclassification board similar to hospitals. Hospice providers are not afforded these same options to adjust their wage indices yet must compete for the same types of caregiving professionals as hospitals.

B. Proposed FY 2021 Hospice Payment Rates

We support and thank CMS for the payment increases for the FY 2021 year. We appreciate the relief offered in March 2020 that suspended reporting for the CAHPS and HIS admission and discharge assessments for the first two quarters of 2020. The public health emergency (PHE) continues and recovery will be a long process even after the PHE is declared over. We ask that hospice quality reporting be suspended for the duration of CY 2020 and that hospices be held harmless from a negative payment adjustment for the remainder of the 2020 performance period. Due to the COVID-19 emergency, we ask that CMS consider working with Congress to delay the reinstatement of sequestration for one year after the end of the PHE to aid in recovery.

C. Proposed Election Statement Content Modifications and Proposed Addendum to Provide Greater Coverage Transparency and Safeguard Patient Rights

As we stated in our comment letter last year, LeadingAge and our partners VNAA/EH agree with CMS that it is a critical issue that beneficiaries and their families understand what is included and excluded when they elect the hospice benefit. Our hospice members take seriously the virtually all-inclusive nature of the benefit for the terminal diagnosis as well as other related health conditions. Due to the importance of waiving one's rights to Medicare payment for services related to the treatment of the terminal and related conditions, individuals and their families need to be informed about what the hospice provider and Medicare will and will not cover. We recommend that the addendum be required

[1]MedPAC, June 2007 Report to the Congress, Chapter 6: An alternative method to compute the wage index. http://www.medpac.gov/docs/default-source/reports/Jun07_Ch06.pdf?sfvrsn=0

for all hospice patients but that the implementation be delayed until one year after the end of current PHE due to the COVID-19 pandemic. We also recommend that CMS utilize the data from the addendum to design a data-driven, targeted, program integrity regime and a reexamination of "related" and "unrelated" in the hospice benefit.

Delay the implementation of the modified election statement due to COVID-19 emergency

The COVID-19 pandemic is an unprecedented crisis for our health care system. We applaud and appreciate all that CMS has done in response to alleviate burdens on hospice and other health care providers so that they can focus on emergency response and continuing to provide the best possible care to patients and families. The pandemic has impacted every facet of hospice care and operations over the past 3 months and the ability to invest time and money into operational initiatives unrelated to COVID-19 will be delayed long after the official end of the current PHE (an end that is not yet in sight). CMS should postpone implementation of the modified election statement and the election statement addendum until October 1st of the year that is at least one full calendar year following after the end of the COVID-19 PHE. For example, if the PHE ends on September 1, 2020, the implementation date for the election statement modifications and addendum would be October 1, 2021.

We detail more background for this recommendation below:

- *Even with the sample statement, there is significant administrative burden to implementing the addendum which needs to be delayed until well after the COVID-19 emergency ends.* As we noted last year, the burden associated with the addendum proposal is not an accurate representation of the time and resources to complete and maintain the addendum. While recognizing the requirement to review, determine, and document information on unrelated conditions per the hospice regulations the one-time 30-minute estimate to create a template for the addendum, and 10 minutes of nursing time to "extrapolate this information from the existing documentation in the patient's hospice medical record and complete this addendum" is insufficient. Not all relevant information is readily available during the initial assessment to have a complete hospice chart. Time is required for information gathering, not merely extrapolation. The 10 minutes for the hospice nurse per patient are only reasonable for patients without items on the "unrelated" list. In cases where a review with the patient and family is required more time is necessary for both the time to generate the list and have the conversation with the patient and family.
- *Operations have shifted due to COVID-19.* As we noted last year, there are a number of administrative burdens associated with the implementation of the addendum ranging from the required time frames, to updating the addendum regularly, to communication with outside medical professionals. All of these administrative barriers are enhanced by the COVID-19 pandemic. Currently, hospices are implementing new workflows related to telehealth and being limited in visitation due to patient and family preference or external rules and regulations. Outside medical professionals are harder to coordinate with because they are not working in their normal places of business. We believe that allowing hospices to have more time before

implementing the modified election statement and addendum will result in a smoother rollout and allow operational focus to remain on COVID-19 response and recovery.

- *Technological Updates:* LeadingAge and VNAA/EH members also note that updates will need to be included by hospice EMR vendors to update records with the new election statement and addendum which has financial and administrative burden components – this work between hospices and EMR vendors is delayed due to the COVID-19 pandemic. Focus on how to integrate new workflows developed due to COVID-19 have been front and center and should continue to be for the foreseeable future.

Other outstanding concerns and recommendations

Documentation of "non-coverage": The amount of space left on the form for description for the "reason for non-coverage" is quite small. While this may simply be a formatting choice on behalf of CMS, our members are still unsure as to how much documentation of "reason for non-coverage" will be required by CMS and its Medicare Administrative Contractors (MACs) in order to receive payment.

Electronic signatures: We appreciate that CMS clarified that hospices can utilize an electronic signature for the addendum if it is utilized for the election statement. However, we ask that CMS issue a uniform policy on electronic signatures. The COVID-19 pandemic underscores the need for electronic signatures and deferring this decision to the MACs has led to confusion and frustration on the part of hospices. At a moment when the utilization of technology is clearly a vital part of our health care delivery system, mandating that all MACs allow for electronic signatures would have a clear and immediate impact on hospice operations.

Make the addendum mandatory: As we noted in our comments last year, we suggest that, when implemented, the addendum not be optional based on patient request as described in the proposal. Providing the detailed list of "unrelated" items to the patient is critical to the care process, patient empowerment, quality of care and transparency. Making the addendum optional will create even more inconsistency in hospice practice than currently exists. We have concerns that many of our members will choose to implement the addendum uniformly in order to reduce confusion for patients and families as well as to properly integrate the addendum into their workflows. There should be uniformity in how this requirement is applied and how CMS and the Medicare Administrative Contractors judge the requirement has been fulfilled and the best way to achieve that is to make it a requirement.

Utilize the addendum to inform future efforts: When this addendum goes forward, we want to emphasize that we hope that CMS utilizes the information provided by the addendum as another data point to inform an overall consideration of "related" and "unrelated." CMS' longstanding position is that "related" and "unrelated" are well-defined but care on the ground tells a different story – the care provided and included under the hospice benefit varies by provider. While this is always true in health care to a certain degree, the stakes in hospice are higher.

LeadingAge and our partners, VNAA/EH supports the intent of the benefit to be holistic and to cover substantially all of the patient and family needs. However, there is reported variation between providers and our members frequently find that they cover more services, drugs, etc. as "related" than most competitors in their markets. While we appreciate CMS's intent around having flexibility to define the care plan, the continued insistence that CMS is clear in its guidance around "related' and "unrelated" is not borne out in practice. The agency's acknowledgement that they receive frequent requests for clarification underscores this reality. Some hospices cover as much as related as possible since that is CMS' intent and is aligned with their organizational mission and values. Others take advantage of the gray space and manipulate the system.

We hope that an upside of the addition of the addendum will be that CMS can see coverage patterns and act upon them to update coverage standards for the Medicare Hospice Benefit. This inconsistency with language contributes to the overall confusion. We hope that the data from the proposed addendum can be utilized in concert with other data, such as data around live discharges, lack of utilization of all four levels of care, and other metrics to develop a more effective program integrity model than exists today. This is not to say that the addendum *alone* should be used for any program integrity efforts; but rather that the data be utilized to continue to drive forward a conversation about a more targeted, data driven program integrity regime.

In short, there are clear differences in what programs offer and as CMS moves toward consideration of the hospice benefit in Medicare Advantage or increasing incentives in other care delivery models (i.e., ACOs) to utilize hospice, this lack of consistency amongst providers as to what hospice is will only continue to grow. We have heard from health plans considering participation in the VBID demonstration who have concerns about inconsistency in coverage standards by hospices across their new networks. In order to address this issue, we recommend first and foremost that CMS gather hospice stakeholders and work to develop more standardized definitions of related and unrelated in order to promote consistency of delivery across the benefit. We would recommend this workgroup to complete this work prior to the development of any new tools or documentation around relatedness.

We thank you for your consideration of the issues highlighted above. My contact information is below if you wish to discuss any of the recommendations.

Sincerely

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