



**National Partnership  
for Hospice Innovation**

IMPROVING THE CARE EXPERIENCE

National Partnership for Hospice Innovation  
1299 Pennsylvania Avenue NW  
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Washington, DC 20004

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1629-P  
200 Independence Avenue SW  
Washington, DC 20201

Dear Administrator Slavitt:

The National Partnership for Hospice Innovation (NPHI) is a collaborative of many of the nation's largest, most innovative, community-integrated not-for-profit hospice and palliative care providers that serves as a critical safety net in communities across the United States. By coming together, we hope to identify, enhance, and spread the best practices our members are engaging in. The members of NPHI have decades of demonstrated experience in providing the highest-quality hospice and palliative care to those facing the final stage of their life. Of the 3,900 hospice providers in the United States, only 34 percent are not-for-profit, but they serve the sickest and most vulnerable patients in our communities and refuse to turn any patient away regardless of their terminal condition or ability to pay, while still providing a comprehensive scope of care to meet patients' goals, values, and wishes during their last stage of life. Many of our programs provide inpatient care, serve patients that have no caregivers themselves and even have programs serving the homeless – playing a critical role at the end-of-life for those who have no alternative supports and who could otherwise go without care during this critical time. This commitment to serve as a much needed and high-quality safety net provider for those in our communities who need hospice care is not only fundamental to our mission, but also distinguishes us as leaders in hospice whose innovative programs reflect the original intent of the Medicare Hospice Benefit (MHB). Our members are longstanding and integrated members of their communities and have been participating in the MHB since its inception - they are foundational and committed to the continued improvement and mission of the benefit.

NPHI members invest heavily at the bedside, refuse to turn patients away, and provide robust bereavement, psychosocial and spiritual support – a comprehensive, patient-centered approach that distinguishes our programs and makes them essential components in the communities we serve. In support of this collective mission, we are pleased to offer the following comments on the *FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements* proposed rule.

### **Wage Index Changes**

NPHI appreciates the positive proposed market basket update of 1.8 percent for FY2016, particularly in the context of broader payment changes for Routine Home Care (RHC) and the new Service Intensity Add-on (SIA) payment; however, the increase is still insufficient to sustainably cover the broad range of services and high-quality care NPHI members already

***A partnership of non-profit, hospice, palliative,  
and advanced illness care providers.***



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provide regardless of diagnosis, location, and payment source. Because we share CMS' goal for high-quality hospice care, NPHI not-for-profit hospice providers offer comprehensive and innovative services consistent with the original intent of the MHB. NPHI members invest in a wide range of services across the continuum of a beneficiary's needs - from the bedside to support for patients and families - and in many cases have incorporated new technologies and methodologies to improve care, such as telehealth services that allow beneficiaries to access care regardless of location and ensure providers are integrated into their communities. As a result of these types of investments in the patient and family experience and commitment to delivering comprehensive, high-value care, not-for-profit hospices often operate at significantly lower margins (3.7% as opposed to 15% with for-profit providers).<sup>1</sup> However, we suspect margins for not-for-profits are even lower than these commonly cited MedPAC numbers, as these are based on 2012 data. With many of our members operating below these margins, the current payment rates undermine their financial viability and sustainability. Our members are operating under growing administrative burdens, which place further financial pressures on their ability to meet the needs in their communities. For instance, one NPHI member has estimated that the regulatory requirements promulgated in the past four years cost the program over \$3.5 million annually - a startling 2 to 3 percent of the overall budget. This underscores the difficult fiscal environment our members are operating under, and the critical need to address unnecessary hurdles so that high-quality hospices can focus on the provision of care.

Most importantly, these variations in margins are a direct reflection of the differences in the care that not-for-profit providers deliver. The core component of not-for-profit hospice care is ensuring that patients receive exceptional care during the last stage of their life that is consistent with their goals, values, and preferences, and considering this mission above the financial bottom line. This translates to an immense effort to leverage care to the bedside with a service intensity that is personalized to meet patients' needs at the end-of life, which often includes more visits per day, per week, per patient and more time spent with patients during each visit. Not-for-profits also tend to provide the full range of levels of care in the MHB to meet patient and family needs. For instance, the percent of General Inpatient Care days are nearly three times greater among not-for-profit providers compared to for-profit counterparts (3.6 percent versus 1.3 percent).

NPHI members operate at these margins because of the value, scope, and quality of services we provide, which fulfill the original intent of the MHB. We strive to invest in patient- and family-centered care and support, resulting in slimmer margins than other programs without such person-centered, comprehensive care. We believe this positively distinguishes us within the hospice community as we reinvest our revenues to better care for and support the patients and families we serve. Our members accept all patients facing the final stage of life regardless of the level of care they require or their diagnoses. We urge CMS to increase the market basket update to support these care goals of the non-for-profit best practices. While payment rates are an immediate issue to maintain our financial viability and beneficiary access to comprehensive care, NPHI is, at the same time, committed to moving to a value-based system that pays for high-quality, appropriate, and efficient care.

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<sup>1</sup> Medicare Payment and Access Commission. 2014. Medicare Payment Advisory Commission: Public Meeting. December 18, 2014. Accessed January 20, 2015. <http://www.medpac.gov/documents/december-2014-meeting-transcript.pdf?sfvrsn=0>



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We also understand the need to revise geographic area delineations, which has resulted in the new Core Based Statistical Areas (CBSAs). While the change will have differential impacts across NPHI's membership, we support the one-year transition in which the payment rate will be a blend between the old geographic area delineations and the new CBSAs. This will allow hospices to adjust to changes in the labor portion of their payment rates.

However, NPHI also urges CMS to put basic safeguards in place to address unintended inequities in the hospice wage index. First, we propose that the area wage index applicable to any hospice that is located in an urban area of a State may not be less than the area wage index applicable to hospices located in rural areas in that State, consistent with the application of budget neutrality. We are making this request because it appears that a growing number of urban designated CBSAs are being assigned a wage index that falls below the wage index for rural areas in the state.

At the same time, several of our members that serve beneficiaries in multiple counties or across state lines are reporting illogical differences in urban and rural designations, and payment rates as a result. In one example, an NPHI member serving beneficiaries residing in both rural and urban designations has found in some cases that areas with greater population density (i.e. persons per square mile) have a rural designation. The inconsistency in the designation is apparent, which then directly impacts payments that may not accurately reflect the underlying cost of providing care in that region. NPHI strongly encourages CMS to evaluate the long-term sources of data that inform wage index calculations as they are critical to determining hospice payment rates.

Demonstrating our commitment to our local communities, NPHI members also serve as safety net providers in rural and frontier areas throughout the country. We believe that payment policy should also take into account the unique distance and other challenges rural and frontier providers face if disparities in hospice utilization are to be addressed – and the financial viability of the hospices willing and able to serve these parts of the country is to be preserved. For instance, we recommend that CMS conduct a pilot allowing telehealth visits for beneficiaries to fulfill face-to-face recertification requirements, as a method of enabling care in a more cost-effective manner. We believe these are the types of innovative ideas that will maintain patient access, improve care, and preserve not-for-profit hospices serving as a safety net in rural communities across the country.

### **Routine Home Care and Service Intensity Add-on**

NPHI members are all not-for-profit providers who are committed to fulfilling the original intent of the MHB. We invest in innovative models of care delivery and are integrated into our communities to ensure that all eligible individuals regardless of diagnosis or other circumstance – especially the medically underserved – receive high-quality, comprehensive care at the end-of-life. Beyond simply a medical or palliative care model, NPHI offers care at all levels of the hospice benefit to match beneficiary needs. Our members provide care to any beneficiary regardless of condition ranging from the bedside all the way to robust psychosocial and spiritual support, including bereavement counseling that they or their friends and loved ones may require. The result of our approach and commitment to beneficiaries is comprehensive, person-centered care that is valued by the communities we



serve. Unfortunately, hospice payment for RHC services has not valued this approach, threatening the financial viability of not-for-profit hospices across the country.

As is widely known, when the MHB was first established in 1983, hospices were solely not-for-profit. Since, there has been explosive growth in the for-profit hospice sector, with nearly two-thirds of the 3,900 hospices in the country being for-profit today.<sup>2</sup> This growth of for-profit hospices and their associated differences in provision of care in comparison to not-for-profit hospices (e.g. longer average length of stay (LOS), greater percentage of live discharges, differences in patient case mix, growth of hospice spending for nursing facility residents and the higher resulting average reimbursements to for-profit hospices), may have contributed to some of the issues related to expenditures, LOS, and overall use of the MHB today.<sup>3,4</sup> For example, comparisons of the diagnosis mix of patients in not-for-profit versus for-profit hospices shows striking differences in the patients served. Not-for-profit hospices accept a substantially higher proportion of cancer patients (31% vs. 21%), who typically have shorter LOS.<sup>5</sup> For-profit hospices serve a greater percentage of patients with heart disease and Alzheimer's or dementia (14% vs. 17% and 12% vs. 18%), with the latter conditions especially prone to long LOS.<sup>6</sup> Further exploration of the differences in patient mix across for- and not-for-profit hospices can demonstrate important differences in the service intensity, cost, and duration of care provided in each of the respective delivery areas.

NPHI appreciates CMS' careful examination and study of the changes in hospice, and the proposed payment changes that are the result of this analysis. We strongly support CMS' two main proposed payment changes to: 1) provide a higher RHC payment rate for the first 60 days of a beneficiary's stay, and a lower RHC payment rate starting at 61 days, and 2) establish a new SIA payment for the last week of an eligible beneficiary's life, when costs of service provision are usually higher. We believe these payment changes will appropriately value the care and safety net role of not-for-profit providers that generally have lower LOS, serve beneficiaries regardless of diagnoses, and provide active care in the patient's final days.

NPHI would also like to offer a recommendation to take the needs of safety net providers into account if the SIA payment is finalized. CMS should consider allowing eligible social worker billable phone calls to home care patients (outside of Skilled Nursing Facilities and Nursing Homes) in the last seven days of life to qualify for any new SIA rate. We believe this will allow not-for-profit providers serving as the safety net in many parts of the country to

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<sup>2</sup>Medicare Payment and Access Commission. 2015. Chapter 12: Hospice Services. Report to the Congress: Medicare Payment Policy. Accessed June 4, 2015. <http://www.medpac.gov/documents/reports/chapter-12-hospice-services-%28march-2015-report%29.pdf?sfvrsn=0>

<sup>3</sup> Medicare Payment and Access Commission. 2014. Medicare Payment Advisory Commission: Public Meeting. December 18, 2014. Accessed January 20, 2015. <http://www.medpac.gov/documents/december-2014-meeting-transcript.pdf?sfvrsn=0>

<sup>4</sup> Department of Health and Human Services. 2011. Medicare Hospices that Focus on Nursing Facility Residents. Office of the Inspector General. <https://oig.hhs.gov/oei/reports/oei-02-10-00070.pdf>

<sup>5</sup> NPHI Member National Benchmarking Data. 2015.

<sup>6</sup> NPHI Member National Benchmarking Data. 2015.



be compensated appropriately for the care they provide beneficiaries and families during the last week of life.

NPHI is also committed to improving and ensuring the integrity of the MHB. NPHI would like to encourage and work with CMS to ensure that a SIA payment accurately reflects the care delivered. For instance, in the Hospice Wage Index Final Rule or in sub-regulatory guidance, NPHI encourages CMS to clarify what documentation is required at point of service for the visit to count towards the SIA and to ensure that the appropriate services are truly qualifying for an SIA payment for care provided in the final stages of life. In addition, we encourage CMS to monitor any unintended consequences related to patient access and continuity of care from the new proposed RHC payment (e.g. programs discharging hospice eligible patients either after 60 or 180 days).

Last, NPHI strongly supports the payment changes CMS has proposed; however, we also urge CMS to prioritize the implementation of the payment changes if finalized to ensure that hospice providers are paid in a timely manner – especially given the profile and limited financial reserves of NPHI members. Payment systems, including coordination with State Medicaid programs, must be updated and ready to process claims on October 1, 2015 to ensure the financial sustainability of hospice providers.

### **Quality Reporting**

NPHI members are committed to ensuring that personal goals, values, and wishes are properly honored at the end of life and that care is tailored to individual needs and preferences. To ensure we are fulfilling our commitment, NPHI members agree to collect data on quality and program performance as part of joining NPHI. While CMS is now requiring hospices to collect data on a series of quality metrics, the information will likely not be released and available until 2017.<sup>7</sup> As part of its data and quality efforts, NPHI is surveying its members to collect data on its programs and performance. For instance, data on patient/family satisfaction, acute service utilization, performance improvement programs, scope of services provided, site of death, and investments in community benefits among other key metrics will be collected. As we move forward in our data collection process, NPHI would like to work with CMS and can offer its diverse experience and expertise as a resource on quality reporting issues and on informing the development of any quality rating system for the MHB, such as a 5-Star Rating system.

Given our commitment to quality and performance improvement, we support the proposed rule's compliance thresholds starting in FY2018. We believe that quality reporting both for internal performance improvement and for beneficiaries and families seeking the best care for their loved ones is essential to our mission. In addition, we also support CMS' efforts to focus on priority areas for measure development, as outlined in the proposed rule. NPHI would like to leverage its extensive experience in the area to be a partner with, and resource to, CMS as it creates more robust performance measures for hospice providers. We are already working with the National Quality Forum (NQF) to advance measure development in

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Medicare Payment and Access Commission. 2015. Chapter 12: Hospice Services. Report to the Congress: Medicare Payment Policy. Accessed June 4, 2015. <http://www.medpac.gov/documents/reports/chapter-12-hospice-services-%28march-2015-report%29.pdf?sfvrsn=0>



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this space and believe that this partnership, bolstered by our members' experiences, and NPHI's focus on collecting quality data and information will prove valuable to CMS throughout the process. NPHI believes that quality measure development and adoption in collaboration with providers is the foundation for transforming hospice payment to one that rewards providers for the value of the care they deliver. In particular, NPHI advocates that measure development focus on outcomes measures and standardized methods for collecting quality data so that performance can be more meaningfully compared across hospice providers.

Last, NPHI asks that CMS consider the potential burden on providers during the measure development, piloting, and adoption process. While the proposed process to allow already adopted measures to continue into the following year (unless CMS takes action) is sensible from a rulemaking process perspective, CMS should ensure that only necessary and meaningful measures are collected from one year to the next to ensure manageable data collection and reporting burdens on providers, and that measures are aligned across payers wherever possible.

### **Diagnosis Reporting**

NPHI members are committed to the original intent of the MHB - to provide holistic, comprehensive care to beneficiaries at the end-of-life. While we understand the need to ensure that hospices are not shifting care (and costs) they should be providing as part of this mission from a program integrity perspective, we are opposed to the blunt approach CMS is proposing to diagnosis reporting. The proposed changes would pose extensive administrative burdens on all hospices regardless of whether or not they are failing to deliver the comprehensive set of services they are required to - and may not improve the quality or scope of care beneficiaries receive. While NPHI members are committed to continuing to provide care to hospice beneficiaries for all their needs related to their terminal condition, the additional proposed requirements in the current rule could be catastrophic for not-for-profit hospices due to the significant administrative and clinical burdens they would create. We urge CMS to adopt a more nuanced and targeted approach to diagnosis reporting by only imposing new documentation requirements on hospice providers that are outliers - and suspected to be stinting or shifting care. Using such a data-driven approach would address and hopefully prevent future program integrity problems, without creating serious unintended consequences for the majority of hospice providers that are not engaging in these behaviors. In this way, hospice providers that are already providing high-quality care can maintain their focus on their primary mission to provide high-quality care and support to beneficiaries and their families.

Specifically, NPHI opposes the proposed requirement to document all of a beneficiaries' needs related and unrelated to their terminal diagnosis. Based on our discussions with physicians, this is not practical or feasible in the context of providing hospice care where patient needs can be complex and numerous - and are often unrelated to the terminal diagnosis or the care a hospice provider is qualified to provide. When beneficiaries present to hospice, they are often at the very end-of-life and placing these expansive documentation requirements could hinder access as well as our ability to provide timely care to beneficiaries, and support to their families at a critical time. Hospice providers also do not often have access to all diagnoses (related and unrelated to the terminal condition) upon



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election into the hospice benefit. Disentangling which diagnoses are related and unrelated is nearly impossible and could ultimately be counterproductive when seeking to provide timely, holistic care to a beneficiary at such a critical stage of their stage in life. The documentation burdens CMS is proposing are significant and would require changes in clinical and administrative procedures, which we believe are unwarranted for those hospice providers that are providing high-quality, comprehensive services to Medicare beneficiaries.

In addition to problems with feasibility, the clinical profiles of hospice beneficiaries have changed significantly since 1983. Often, identifying a single diagnosis for beneficiaries with comorbid conditions, which collectively contribute to their need for hospice and general clinical decline, is very difficult. When the MHB was first established, the majority of beneficiaries had cancer-related diagnoses, which can have a more predictable course when advanced. However, hospice providers are serving a very different beneficiary profile today, with comorbid conditions and more beneficiaries suffering from Alzheimer's and dementia-related diagnoses that can have a much less predictable course. Requiring hospice providers to identify a single diagnosis- regardless of whether or not they have engaged in shifting care and costs - is counterproductive when these providers should be focused on the continued provision of high quality care. NPHI members believe that comprehensive, holistic care should be provided to beneficiaries regardless of diagnosis when the hospice provider is best suited to do so.

Last, NPHI also opposes the requirement that providers must report any mental health conditions that could affect a care plan. This is a broad charge - especially in the context of beneficiaries facing the end-of-life. NPHI members already provide psychosocial and spiritual support when needed; but, assessing how underlying mental health conditions could affect care planning at the end-of-life is outside the scope of our expertise and the original intent of the MHB. We urge CMS to craft a more narrow approach to addressing abuses related to diagnosis reporting - because not all conditions that may "influence" a hospice beneficiary's diagnosis are within the control or expertise of a hospice provider. Beneficiaries should have access to the appropriate level of care and provider regardless of whether they are recipients of the MHB.

NPHI understands the importance of safeguarding the MHB and addressing any and all program integrity issues. However, we oppose the proposed changes to diagnosis reporting as we believe they will have serious unintended consequences in terms of administrative, financial, and clinical burdens on our members who are already trying to operate as efficiently as possible while providing a comprehensive range of services and supports to beneficiaries and their families. In lieu of this blanket requirement on all hospice providers, we urge CMS to adopt a more narrow policy in the final rule that would identify outlier providers who may be stinting on or shifting care, and place new diagnosis reporting documentation requirements on such providers. We believe this will curtail unwanted behavior, while allowing good actors to continue to provide high-quality care to underserved Medicare beneficiaries regardless of diagnosis or location.

### **Other Issues**

Overall, NPHI applauds the payment changes CMS is proposing in the FY2016 rule and urges adoption with the recommendations noted here. As with major changes in any payment



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system, CMS should be prepared to monitor and track unintended consequences. For instance, hospice programs have developed positive partnerships and collaborations with nursing homes and hospitals to promote earlier access to hospice, reduce readmissions, and integrate hospice into patient care upstream. CMS should monitor changes in utilization patterns as a result of any new payment changes to ensure that beneficiaries are not getting discharged from hospice and then be admitted to a hospital setting at end-of-life – resulting in increased spending.

We also urge CMS to target program integrity efforts based on data and evidence on the hospice providers that may be engaging in care delivery or behaviors that are not consistent with the intent of the MHB. Some of the changes proposed in this rule, such as new proposed requirements on diagnosis reporting, would affect all hospices across the country and significantly increase administrative burden – which will only siphon more resources away for the high-quality care NPHI members aim to provide. For instance, one NPHI member that is a national leader in hospice care reported that approximately \$6 million in Medicare payments are currently being withheld due to audits, which accounts for nearly 10% percent of the program’s budget. For many of these providers, the effect of cumulative Additional Document Requests (ADRs) is financial crippling – and limiting multiple unresolved ADRs would offer some relief from the burdens. CMS should consider applying the program integrity-focused policies, such as post-payment audits, in a more targeted way to those providers that are the true drivers of inappropriate behavior – and exempt those programs and providers that are providing high-quality care, consistent with the intent of the MHB.

Last, NPHI applauds CMS for recognizing the correlation between disproportionately high live discharges and inappropriate non-hospice related Medicare spending in this proposed payment rule. In keeping with our support for more targeted program integrity efforts to deter inappropriate behavior, NPHI encourages CMS to identify hospices with high rates of live discharges and place such hospices under greater review scrutiny to ensure appropriateness of hospice care delivery.

In addition to the issues noted in this letter, there are a number of other regulatory issues (and solutions) our members are engaged with to ensure that beneficiaries have access to high-quality hospice care. For instance, a priority for our members is reducing the regulatory burdens our community-integrated hospices provide. As noted earlier, a salient example are recovery audits that individually and collectively cost community-integrated hospices millions of dollars per year (with very little success in eventually recovering any improper withholdings) and our not-for-profit members have no stopgap measures available when funds are withheld for multiple years. Our members are also working on recommendations to reassess the Hospice Aggregate CAP amount, including utilizing a portion of any savings to support the efforts and sustained effectiveness of community-integrated and rural not-for-profit providers. We look forward to partnering with CMS on a range of issues aimed at improving program integrity efforts and increasing access to comprehensive, high-quality hospice care.

Ultimately, NPHI is dedicated to influencing the future of hospice and advanced illness care through innovation and collaboration, and hopes to serve as a partner and resource to CMS as it considers these critical and significant proposed changes that will affect hospices and the communities we serve. NPHI is committed to continuing to serve as a safety net for these



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communities, and hope that the ultimate changes to the Hospice Wage Index and Payment Rate Update will further enable us to do so.

Thank you for your consideration of our comments, and we look forward to continuing to work with you as you refine and improve Medicare hospice payment policies.

Tom Koutsoumpas  
President, CEO  
National Partnership for Hospice Innovations