June 18, 2019

Ms. Seema Verma
Administrator, Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

Dear Ms. Verma,

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule in regard to its effects on those living with advanced illness.

C-TAC is a national non-partisan, not-for-profit organization dedicated to ensuring that all those living with advanced illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC is made up of over 140 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving advanced illness care in the U.S.

C-TAC’s definition of advanced illness is when one or more conditions becomes serious enough that general health and functioning begin to decline, treatment may no longer lead to preferred outcomes, and care oriented toward comfort may take precedence over attempts to cure – a process that extends to the end of life and that for some individuals and their families may lead to transition to hospice.

Overall, we have concerns about some portions of the proposed rule and share the following specific comments:

“Palliative” vs. “Curative”

The introduction of the proposed rule defines these terms as meaning opposing things. While we recognize that this mirrors previous regulatory and statutory language, it is now problematic for two reasons. First, most Medicare beneficiaries suffer from chronic illnesses that cannot be cured but only managed or “palliated.” In this regard the distinction between palliative and curative is both confusing and incorrect. Second, the
emerging field of palliative care, a medical specialty that focuses on improving the health and quality of life of those with serious illness and their families, can be provided in addition to curative care (for an example of CMS’ own recognition of the importance of providing palliative care for a broad category of seriously ill but non-hospice patients, see the recently announced CMMI “Primary Care First” demonstration’s track dedicated to the Serious Illness Population [SIP]). While changing the statutory language that frames “palliative” in opposition to “curative” is beyond the scope of this comment opportunity, we want to reinforce that these types of care outside of hospice are not opposites and, in the case of palliative care, evidence shows that their concurrent delivery can improve outcomes.

**Proposed Rebasing of the Continuous Home Care, Inpatient Respite Care, and General Inpatient Care Payment Rates for FY 2020**

C-TAC has mixed opinions about this change given our broad membership. For the relatively few hospice providers who provide Continuous Home Care, Inpatient Respite Care, and General Inpatient Care through their owned hospice inpatient facilities, this change is helpful as it addresses the known difference in the cost of providing these services and the reimbursement for them. However, for most hospices that predominantly contract with hospitals and nursing homes to provide Inpatient Respite Care and General Inpatient Care, and for whom this is a pass-through cost, this change will have less of an impact. Conversely, the proposed reduced reimbursement for Routine Home Care will impact all hospice providers. As incentivizing more care provided in the home is a goal for policymakers and the broader healthcare system, the proposal to increase General Inpatient Care rates, which could incentivize more of this kind of care, seems contradictory and may, in fact, lead to an increase in Medicare spending. We recommend that CMS keep the routine home care rate flat with FY2019 rates and increase the other levels of care to meet budget neutrality requirements.

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

We would agree that, as it relates to payment, the current process of having individual hospice medical directors accountable to determine whether a service is related or unrelated to the beneficiary’s terminal illness is appropriate. It becomes problematic, however, when CMS does not provide clear guidance on what they consider unrelated services. As it relates to transparency of cost burden to the patient and their family, this often results in an unfortunate situation when there are surprises that an item or service they assumed would be paid for by the hospice is in fact not and they are then faced with an unexpected co-payment.

However, we are not in agreement with the proposed administrative solution of modifying the election statement and adding an addendum. This will only be more burdensome to hospice organizations and confusing for the patients and families they serve. Additionally, the addition of this addendum could have a “chilling effect” on access to hospice as it may dissuade otherwise appropriate hospice candidates from enrollment.
We would instead recommend that CMS work with stakeholders to identify ways to provide clearer direction on what constitutes related and unrelated services. This would provide hospice organizations more consistent direction and greater clarity in this area.

**Request for Information Regarding the Role of Hospice and Coordination of Care at End-of-Life**

Short hospice stays continue to be a problem and CMS should explore all possible ways to address them in cases where a longer length of stay would benefit the patient and family. This is actually not a hospice problem; it needs to be addressed ahead of the decision to enroll in hospice. The wider and easier availability of palliative care for the serious illness population who are “pre-hospice” is one such solution broadly supported by C-TAC’s membership. Palliative care providers can help seriously ill patients and their families discuss their goals of care to inform advance directives and other advance care planning processes. Evidence shows that for those people receiving palliative care later in an illness, transition to hospice tends to be smoother and takes place sooner\(^\text{v}\). This reduces futile medical care and the longer hospice length of stays better support the patient and family at the end of life. Therefore, innovative models that promote the availability and use of palliative care are to be encouraged.

**Updates to the Hospice Quality Reporting Program (HQRP)- Update on Claims-Based Measure Development**

The reliance on claims-based measures misses the richness of the care provided and we therefore urge CMS to focus urgently on the creation of patient-centered outcome measures that would more adequately identify meaningful aspects of care. Ideally, these would capture the patient’s experience during their hospice care and not just post-mortem via the current family caregiver survey alone. We therefore support the development of the hospice assessment tool based on the pilot test results\(^x\) so as to make it available as soon as possible for hospice use. Any public reporting, including public use file data, should offer the opportunity for public comment in advance of such reporting.

Regarding the focus on potentially avoidable hospice care transitions, we have similar concerns as those noted in the proposed rule as reviewed by the NQF-convened CMS MAP process. During that process, the MAP identified many valid reasons why a patient might opt to transition from hospice. While we appreciate CMS wanting to identify those hospices that are possibly “gaming” the system by enrolling patients in hospice too early, we note that Table 1, page 17, on the “Average Length of Stay in Days for Hospice” shows that even for dementia, the median lifetime length of stay of 50 days is well below the theoretical 180 days patients could receive with a timely hospice referral and even the average length of stay, which includes outliers, is only 167.4 days. For all the other categories, the average is significantly shorter than that theoretical 180 days. Therefore, the focus on length of stay and hospice transition may be depriving patients of this appropriate type of care for adequate periods of time.
Thank you for the opportunity to comment on this proposed rules and request for information. If you have any questions, please contact Marian Grant, Senior Regulatory Advisor, C-TAC, at 443-742-8872 or mgrant@thectac.org.

Sincerely,

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i https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3983735/
iii https://ascopubs.org/doi/abs/10.1200/JCO.2016.34.15_suppl.10132