

June 26, 2007
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1539P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Mr. Kuhn

I am writing on behalf of the Visiting Nurse Associations of America (VNAA) to comment on "Medicare Program; Hospice Wage Index for Fiscal Year 2008" (CMS-1539P.) The VNAA represents over 400 non-profit, community based Visiting Nurse Associations (VNAs) across the country, many of whom operate Medicare certified hospices in addition to home health agencies. We appreciate the opportunity to comment on this proposed rule.

At the outset, we would like to express our continued support for the hospice wage index approach reflected in this rule which was developed based on "negotiated rulemaking" with CMS. We would request that any future changes proposed for hospice payment policy follow this precedent rather than "notice and comment" rulemaking. We believe the particularly sensitive nature of the hospice benefit and the good working relationship between CMS and the associations representing Medicare hospices warrant a collaborative approach in hospice rulemaking.

We would also note that the increasing interest reflected in Congress and MedPAC in finding a more reasonable and consistent approach to constructing wage index adjusters for hospitals and post-acute care providers will inevitably have implications for hospice payment. We would urge CMS to be mindful of these implications as it participates in efforts to reform the hospital wage index approach. We believe that any significant change in the hospital wage index approach will require a carefully considered and extended transition period to prevent disruptive payment swings in the affected providers, including hospices.

Rural Areas without Wage Index Data

VNAA supports the provision in the proposed rule to back-fill the wage index for rural hospices in areas without a rural hospital wage index with the average wage index from continuous CBSA areas. While this is far from an ideal approach, this alternative comes closest to an equitable solution to resolve the fundamental flaw in using hospital data to adjust payments to non-hospital providers. Presumably a better alternative will emerge in the course of revising the hospital wage index approach over the next few years.

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Site of Service

VNAA supports the proposal to wage index adjust all hospice payments based on the site of service rather than the location of the hospice office. We believe this is entirely consistent with the purpose of wage index adjustment.

Caregiver Breakdown and General Inpatient Care

At the outset, we would assure you that VNAA shares CMS' concern that General Inpatient Care (GIC) not become a source of potential program abuse in the Medicare program. We and our members have been in contact with CMS and the Office of Inspector General to report specific situations in which we believe inappropriate GIC is being furnished in such a way as to suggest a pattern of abusive conduct between hospice providers and inpatient facilities. We strongly support steps to eliminate any potential collusion or inducements between hospices and inpatient facilities that may generate inappropriate billing. That having been said, we are very concerned that CMS' policy clarification on the coverage of General Inpatient Care is overly prescriptive in totally eliminating coverage for GIC in situations of caregiver breakdown.

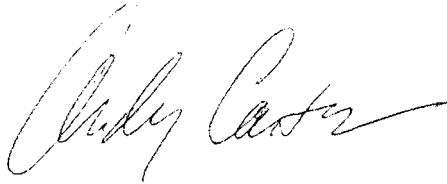
We understand the guidelines for providing inpatient respite care for no more than 5 days at a time and for General Inpatient Care. However, we occasionally encounter patients whose informal care network collapses and is not recoverable after a period of brief respite. Not surprisingly, such breakdowns often occur when the patient's needs are quite heavy. We would prefer to continue to support those individuals in their own homes if they could be cared for at home. But we have concluded in those rare situations when we cannot effectively reconstruct caregiver support in a few days, GIC provides the only option short of discharge to a long-term care facility. However, our understanding of this CMS policy clarification is that GIC would no longer be available to those few patients in this situation. The policy clarification is silent about what a hospice is to do in such a situation. The implication is that hospice care must be terminated since there is no Medicare hospice benefit category available under which the patient can be adequately cared for. As a purely practical matter, even if CMS' preferred solution is discharge to a long-term care facility, the admission process in some states requires multiple levels of approval that can take many days. There needs to be a humane and practical alternative for such patients.

We suggest that this policy be revised to allow the use of GIC in those rare situations in which the hospice has documented that, despite its best efforts and the prudent use of inpatient respite, a sufficient caregiver network cannot be restored in a few days to permit care at home. Alternatively, CMS may wish to propose an alternative payment mechanism under hospice to accommodate this situation. We do not believe CMS' unspoken alternative of discharge from hospice care to a long-term care facility is in the best interest of the patient or good for the Medicare program. We would be happy to

work with CMS to find an alternative policy that meets the needs of patients in these situations while protecting Medicare from abusive billing and referral practices.

Thank you for the opportunity to comment on these proposed regulations. We would welcome the opportunity to clarify or expand upon these comments upon request. You can contact Bob Wardwell, Vice President for Regulatory and Public Affairs or me at our Washington Office at 240-485-1855.

Sincerely,

A handwritten signature in black ink, appearing to read "Andy Carter". The signature is fluid and cursive, with a large initial "A" and a long, sweeping underline.

Andy Carter
President and CEO

CC: Carol Blackford



Hospice
& Palliative
Care Association of New York State

June 29, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1539-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Proposed Rule – FY 2008 Wage Index

To Whom It May Concern:

Thank you for the opportunity to submit comments on the Proposed Rule – FY 2008 Wage Index, published in the Federal Register on May 1, 2007. Please consider our comments concerning site of service and care giver breakdown and general inpatient care.

"Site of Service"

Although we concur with the actual proposed provision, we are greatly concerned that the following statement is misleading and inaccurate: "...hospice providers have been able to inappropriately maximize reimbursement by locating their offices in high-wage areas and delivering services in a lower-wage area. We also believe that hospice providers are also able to inappropriately maximize reimbursement by locating their inpatient services either directly or under contractual arrangements in lower wage areas than their offices." Hospices generally contract with all hospitals in an area and the patient chooses the hospital which he or she prefers. Certainly a hospice might have an inpatient unit in a particular hospital, but it is doubtful that a hospice would do this or arrange contracts based on manipulating inpatient reimbursement rates. Furthermore, since urban areas generally have higher rates, most hospice patients and their families would complain if the patient was forced to receive inpatient services in an area further from home. Is it not possible that any case CMS has seen of inpatient in a lower rate area is actually a reflection of patient choice? This phrasing should be changed unless there is proof that hospice providers have been doing this.

The statement is unnecessarily harsh, given the fact that the following justification seems adequate: "We believe that the application of the wage index values, for rate adjustments on the geographic area, where the hospice care is furnished provides a reimbursement rate that is a more accurate reflection of the wages paid by the hospice for the staff used to furnish care. We also believe that payment should reflect the location of the services provided and not the location of an office."

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“Care Giver and General Inpatient Care”

We strongly disagree that this is a “clarification.” The Medicare policy is stated as it has been interpreted for more than twenty years:

Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting.

(Chapter 9 of the Medicare Benefit Policy Manual 40.1.5 - Short-Term Inpatient Care (Rev. 22, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

This has been the written guidance from CMS and fiscal intermediaries over the twenty plus years that Hospice has been a Medicare covered service. To suddenly state that “...some hospices are billing Medicare for “caregiver breakdown” at the higher “general inpatient level, rather than the lower payment for “inpatient respite” or “routine home care” levels of care...” when this is exactly what the Medicare Benefit Policy Manual states should be done, is incomprehensible.

Further, it is incorrect to state that “To receive payment for “general inpatient care” under the Medicare hospice benefit, beneficiaries must require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting” when the Medicare benefit policy manual states that caregiver breakdown can justify “general inpatient care.” If the justification for short term inpatient care is only pain and symptom management that cannot be provided in another setting, why would the manual and consistent CMS and fiscal intermediary transmittals have referred to “caregiver breakdown” as a justification?

“Caregiver breakdown” should not be billed as “general inpatient care” regardless of where services are provided, unless the intensity-of-care requirement is met.” This is contrary to practice for the past twenty plus years. Caregiver breakdown is and always has been a justification for short term inpatient care. We question the legality of considering this a “clarification” after twenty plus years of precedence.

Perhaps it would be helpful to consider several real life examples of caregiver breakdown. These are situations where the patient was being cared for at home and would not have been considered for inpatient admission, but for the fact that there was caregiver breakdown.

Example A

A young woman is being cared for at home by her husband while receiving hospice services. The patient is routinely receiving break through medication for pain, is bed bound and unable to perform any ADLs without assistance. The hospice volunteer arrives at the home to find the caregiver on the floor unresponsive and the patient screaming. She calls 911 and hospice, and the caregiver is transported to the hospital where he is admitted for an MI. There is neither other family nor friends who can care for the patient so the patient is transferred to the hospital for short term inpatient care. There are no nursing home beds at the time, and the placement process is begun upon admission. What would happen to this patient if she were not admitted for short term

inpatient care? This was not a planned respite and there was no way to guarantee that she could be placed within 5 days. She could have revoked hospice in which case she would have been admitted to the hospital, an IV would be placed and Medicare would pay a hefty reimbursement to the hospital. What would that serve? What did happen to this patient? The hospice staff followed both the patient and her caregiver and the patient returned to the home the day following the caregiver's discharge on the seventh day following the MI. Medicare only paid out the hospice short term inpatient rate for six days, much less than the hospital DRG, the patient did not receive expensive and unnecessary treatment in the hospital, and everyone won.

Example B

An elderly man is being cared for at his home by his daughter. While the care giving is less than ideal at times, the patient and the daughter continue this arrangement with the support of hospice. The caregiver has a fight with two of her siblings who come to the home and complain, but have refused to provide any care. The father supports or appears to support the two non-care giving daughters in the disagreement and the caregiver leaves the home, calling hospice from the bus station to state she is returning to her home out of state. Hospice calls the home and receives no answer. The hospice nurse immediately goes to the home to find the bed bound patient home alone and unsafe. He is soiled and confused. The patient is cleaned up by the case manager and LPN, while the social worker attempts to contact the daughters. No one is willing to care for the father; neighbors and friends are contacted, but are unable to provide care. There is no male bed available in an area nursing home and the patient is placed in GIP given that he is unsafe home alone – unable to toilet himself, provide needed medications himself, etc. He is admitted for short term inpatient and transferred to a nursing home on day 8 when a male nursing home bed becomes available – thanks to extensive work by the social worker.

If the patient is able to care for him or herself at home alone, even though accustomed to having a caregiver and potentially more comfortable with a caregiver, this patient would not be admitted for caregiver breakdown. It is only used when the care giving is essential, there was no way to plan for the circumstance – it is emergent, and there is no other setting. Again, please refer to the exact language from the manual, "Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting." This is the interpretation that hospice and fiscal intermediaries have used consistently. If the patient is unsafe alone, in need of medications that the patient cannot administer alone, and will be alone because of caregiver breakdown, inpatient care is needed. FIs have consistently allowed this on review, generally with the expectation that alternate arrangements are sought immediately and aggressively. However, this is not the same as symptom control for short term inpatient care without caregiver breakdown. In these circumstances, the hospice

patient either develops a new or exacerbated symptom at home that cannot be controlled in the home setting.

It is current and appropriate practice that fiscal intermediaries address inappropriate use of GIP. Hospices who have survived FMR for GIP report that fiscal intermediaries have routinely approved short term inpatient care for caregiver breakdown as described above, as well they should, since this is allowable according to the Medicare manual. It would be inappropriate for CMS to punish patients by removing a long established, needed benefit of the hospice program because CMS perceives some hospices are inappropriately using GIP.

“If the individual is no longer able to remain in his or her home, but the required care does not meet the requirements for “general inpatient care,” hospices should bill this care as “inpatient respite care,” payable for no more than 5 days, until alternative arrangements can be made.” While hospices throughout New York State are fortunate to have hospitals and nursing homes willing to contract for the hospice respite rate, these contracts indicate respite as a planned admission dependent upon bed availability. Caregiver breakdown is not planned and, often, the patient cannot be placed within 5 days since there has not been planning for placement. Nursing home beds are scarce and nursing homes require a Medicaid application, PRI, etc. to be in place before they will consider admitting a patient.

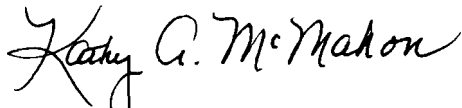
Is CMS seeing more frequent use of caregiver breakdown? This would seem appropriate since most hospices are experiencing difficulty finding adequate care giving as patients outlive family and friends, are more isolated from family and friends, and have family and friends who believe someone else should be responsible for providing custodial care for the patient. More and more frequently, hospice staff are seeing patients who are in unsafe environments, but the patient is making the informed decision to be unsafe, or the family is making the decision and adult protective services determine there is nothing that can legally be done in the situation, particularly in light of the patient’s limited life expectancy with appointment of a legal guardian taking six months or longer. Most hospices would report that patients regularly have caregivers who are only slightly more functional than the patient – the most common example being the elderly hospice patient with an elderly spouse as a caregiver and no other support outside of hospice. Is there a likelihood of caregiver breakdown in these circumstances? Certainly. Are hospices routinely trying to have patients and their family prepare for these circumstances by making applications to skilled nursing facilities, etc.? Of course. However, hospice cannot force patients or families to do this and resistance is often strong.

“As explained, this is a clarification of current Medicare policy and is not anticipated to create new limitations on access to hospice care.” This is not a “clarification” and it will definitely create new limitations on access to hospice care. Hospices will not be able to afford to place a patient in GIP and pay the hospital the inpatient rate while receiving the routine home care rate, nor should a hospice be expected to do so when the need arises from caregiver breakdown. Patients will choose to revoke

hospice and the patient and their physician will seek inpatient admission. Medicare will pay the hospital the DRG, hospice will no longer be involved and often inappropriate and costly consults and services will occur with no benefit to the patient. Who will win in this situation? Clearly, not Medicare, not the patient and not hospice. Isn't a lose, lose, lose situation the very thing that both government and providers should be seeking to avoid? Hospice has witnessed the erosion of the inpatient benefit to the point that many hospices offer very little inpatient care. This "clarification" is completely unacceptable. It is a major reduction in the existing hospice benefit with precedence extending over two decades. Hospice must maintain the ability to admit patients for short term inpatient care when existing caregiving falls apart and the patient will be unsafe or physically uncomfortable (without needed medications, etc.) without caregiving. Hospice will do all it can to avoid these situations and to prepare for caregiving breakdown, particularly if the patient has limited caregiving. However, hospice **MUST** remain able to admit a patient for short term inpatient care in these circumstances.

Thank you for considering our recommendations. If you have any questions or require additional information, please contact me at 518/446-1483 or kmcmahon@hpcanys.org.

Sincerely,

A handwritten signature in black ink that reads "Kathy A. McMahon". The signature is written in a cursive, flowing style.

Kathy A. McMahon
President and CEO



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June 29, 2007

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1539-P,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

Re: Comments on [CMS-1539-P] RIN 0938-AO72 (Medicare Program; Hospice Wage Index for Fiscal Year 2008)

Dear Sir or Madame:

The National Hospice and Palliative Care Organization ("NHPCO") appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") 2008 Hospice Wage Index and proposed Clarification of Selected Existing Medicare Hospice Regulations and Policies. NHPCO is the oldest and largest nonprofit membership organization representing hospice and palliative care programs and professionals in the United States. The organization is committed to improving end of life care and expanding access to hospice care with the goal of profoundly enhancing quality of life for people dying in America and their loved ones. NHPCO represents approximately 80 percent of the hospice providers who care for almost 90 percent of all the hospice patients and families in the country. Our comments on the proposed revisions are set forth below.

Comments regarding "Rural Areas without Wage Data"

We understand the complexities of the calculation for the wage index for rural areas without a hospital. We have no comment or suggestions for a change to the calculation method at this time. More generally, we want you to be aware of the challenges providers face when furnishing hospice care to patients and families residing in rural areas.

Due to the underdevelopment of rural areas, staff in this care setting often travel great distances to reach their patient's homes to provide services. The time involved in travel reduces the number of patients a staff member can visit in a day. There are also staff recruitment challenges. The staffing shortages and subsequent competition for staff (particularly nurses) demands that a hospice offer very competitive wages and benefits and yet receive much less reimbursement than urban counterparts.

Hospices serving rural areas are challenged in securing the best rates on contracts for support services such as durable medical equipment, infusion therapy, ambulance services and inpatient facilities due to the lack of available resources. There are simply fewer companies and hospitals providing those services in the rural setting and the volume for the services is significantly less. We would be happy to discuss this issue with you further to investigate ways that we can encourage hospice care in rural areas.



Comments regarding “Care Giver Breakdown and General Inpatient Care”

When the Medicare Hospice Benefit was first established, the goal of the General Inpatient level of care was not intended to equal the hospital level of care under the acute care benefit provided in hospitals. It was intended to address the patient’s and family’s need for pain control and acute or chronic symptom management that cannot feasibly be provided in other settings. (Sec. 418.302-Payment procedures for hospice care) The intent was also meant to include care for a patient whose home support has broken down and it no longer feasible to furnish needed care in the home setting. We strongly object to having the intensity of care requirement placed into general inpatient requirement as we expect the incidence of patient admission to general inpatient level of care is low due to caregiver breakdown.

A patient is placed into inpatient respite care when the caregiver appears to need a break from daily caregiving duties. However, if a caregiver leaves their caregiving duties without warning or the caregiver suddenly dies or becomes ill themselves, and there is no other able and willing caregiver for the patient, a hospice needs to be able to provide care in an alternative care setting immediately. The patient would not qualify for inpatient respite under these circumstances due to the lack of a dedicated caregiver. Without an able and willing caregiver, the patient’s symptom management could become uncontrolled very quickly which would necessitate the patient’s admission to the general inpatient level of care for symptom management.

In the hospice conditions of participation, (Sec. 418.302-Payment procedures for hospice care (4) General inpatient care day) a general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. If there is breakdown in caregiver support, then the patient would meet the requirements of the regulation in that chronic symptom management could no longer be managed in the home setting.

The original intent of the general inpatient level of care was based on the goal to provide the patient the appropriate level of care to meet their needs. The proposed interpretation of this level of care and change to its implementation shifts the focus from caring for the patient in the appropriate setting to a purely a billing and reimbursement issue. We are most willing to explore other alternatives or discuss this provision further for other possible solutions.

Should you have any questions or need clarification regarding any comments, please do not hesitate to contact me, at (703) 837-3122 or jlundperson@nhpco.org.

Sincerely,

Judi Lund Person
Vice President, Division of Quality End of Life Care,
NHPCO