

June 22, 2009

To: Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

VIA Electronic Submission

Re: NAHA Comments CMS - 1420 - P  
Proposed Hospice Wage Index for Fiscal Year 2010

The National Alliance for Hospice Access (NAHA) is a grassroots coalition of over 500 hospices in 31 states, founded to address the Hospice Cap Crisis, a regulatory inequity that threatens independent hospices' ability to continue to provide quality care to eligible, terminally ill patients.

NAHA members are independent family-owned and community-based hospices that care for tens of thousands of terminally ill patients annually, largely in rural, minority and economically disadvantaged communities.

NAHA respectfully submits this response to CMS' request for comments related to the Proposed Hospice Wage Index for Fiscal Year 2010, especially with regard to possible rulemaking on the calculation of the hospice aggregate cap and hospice payment reform.

#### Summary of NAHA Recommendations

1. CMS should immediately suspend enforcement of the aggregate hospice Cap, before it destroys America's independent hospices, the access these hospices create for rural, minority and non-cancer terminally ill seniors, and the cost savings this access produces for Medicare. The Cap will leave CMS with only two fundamental types of hospices: (a) those urban hospices captive to hospitals, that have no track record of providing timely hospice choice as an alternative to high-cost hospital treatment and (b) those hospices in monopoly positions created by Certificate of Need regulations, where Medicare's total end-of-life care costs are generally the highest in the country, and where timely hospice choice is generally the lowest, especially for minority, non-cancer and rural patients.
2. CMS should immediately promulgate evidence-based National Coverage Determinations for hospice. Current hospice Local Coverage Determinations (LCDs) are not evidence-based and, when honored by hospices, result in very long length of stay for many non-cancer patients. Hospices are increasingly choosing not to honor these flawed LCDs and instead have individually invented a morass of arbitrary and more restrictive hospice eligibility standards that vary by state, by community, by hospice, by diagnosis and possibly by race. This is a root cause of poor timely access to hospice care in America today.

NAHA recently commissioned Avalere, a leading Washington D.C. advisory firm specializing in healthcare research, analysis, insight, and strategy, to compile and model access and length of stay data for 100% of the 3.5 million Medicare beneficiaries who elected the hospice benefit from 2003 through 2007. Avalere's data show there are systemic barriers to timely patient access to

hospice care, especially for the 78% of Medicare decedents who die of non-cancer causes and the 14% of Medicare decedents who are non-white. But, the data showed no evidence of “managing up” of patient length of stay due to incentives in the payment system, as has been hypothesized by MedPAC staff.

- Hospice access was only 41% in 2007; 1 million Medicare beneficiaries died without hospice care. Access varied widely by state, ethnicity and diagnosis. 60% of Arizona Medicare decedents received hospice care but only 24% in New York. 66% of cancer patients received hospice care, but only 34% of non-cancer. 43% of whites received hospice care, but only 33% of minorities, yet Mississippi hospices provide equal access to minorities. Minority non-cancer access was 43% in Mississippi but 8% in New York.
  - And, *timely* access was poor. 2% of hospice patients received only 1 day of hospice care, 25% received less than 5 days, 38% received less than 10 days, 48% received less than 15 days and 72% received less than 60 days. Only 16% of hospice patients – *less than 7% of Medicare decedents* – received between 60 days and 180 days of hospice care, the range in which Duke University’s 2007 landmark research suggests quality and cost-savings converge.
  - There was no evidence of any material increase in the distribution of length of stay for 80% of patients admitted to hospice between 2003 and 2007; this directly contradicts MedPAC staff’s anecdotal suggestion of widespread “managing up” of patient length of stay.
3. CMS should support NAHA’s payment system reform proposal that would replace the flawed and retrospective aggregate Cap with pay-as-you-go reductions in payments for longer stay patients. This proposal would (a) eliminate the harm to patient access currently being inflicted by the aggregate Cap, (b) increase Medicare’s savings from the Cap, (c) ensure there were no unintended financial incentives for long patient stays, (d) fully eliminate CMS’ burden of calculating the cap, and (e) ensure that CMS never pays out dollars that it will later want back.
  4. CMS should view MedPAC staff’s hospice work with caution and skepticism, and should demand full transparency before relying on MedPAC staff’s recommendations for payment reform. We have been disappointed that, despite probing from Commissioners, staff appeared intent on reducing hospice expenditures, rather than on thinking across silos about reforms that would increase hospice access while reducing Medicare’s *total* end-of-life care spending. Staff’s analyses and observations related to hospice access, eligibility, length of stay, hospice margins, the hospice Cap, the behaviors of independent hospices and the “views of an expert panel” are demonstrably flawed and will mislead healthcare policy. These staff analyses have not been subjected to the light of day, and we respectfully submit that they have missed or omitted critical information and that they would greatly benefit from rigorous peer review.

If CMS will not take all of these steps, then NAHA urges CMS at least to:

- Acknowledge that the hospice cap regulation is inconsistent with the Congressional mandate in section 1814(i)(2)(c) to make a proportional allocation of “each patient’s” cap allowance to ensure that cap allowances are accurately matched to CMS reimbursement to hospice.
  - Set aside prior calculations upon request from affected hospices.

- Promulgate an amended regulation that respects the Congressional mandate to allocate cap allowances for each patient proportionally across years of service.
- Promulgate evidence-based National Coverage Determinations for hospice. Medicare’s flawed LCDs currently create a “bait and switch” situation. Terminally ill Medicare beneficiaries are statutorily entitled to hospice care but when they seek such access it is increasingly unavailable; one of two things happens: (i) hospices will not honor the LCDs, or (ii) hospices that do honor the LCDs will subsequently be bankrupted by Cap demands.

NAHA respectfully submits more detailed comments below, organized in two parts:

A. The Aggregate Hospice Cap Calculation

- CMS assumptions about the hospice cap
- The aggregate hospice cap regulation

B. Hospice Payment Reform

- CMS should be skeptical about MedPAC staff’s hospice analyses, and demand full transparency and disclosure, and additional analysis
- Evidence-based eligibility criteria are inseparable from Payment Reform
- Hospice Payment Reform can improve access, reduce Medicare’s total end-of-life care costs and reform the Cap

**A. The Aggregate Hospice Cap and Cap Calculation**

**CMS Assumptions About Hospices and the Hospice Cap**

CMS asserts that hospices with a mix of patients (long and short stay) “rarely exceed the cap.” This is demonstrably false. NAHA members all have a substantial number of short stay patients. And, even though non-cancer admissions have a median length of stay of about 70 days, the problem is that 10-15% of the non-cancer patients live far longer than the anticipated six month average. As CMS knows, these patients may not be ethically discharged if they remain eligible under LCDs. If discharged, such patients have expedited appeal rights where objective LCD criteria determine eligibility. And, if discharged, such patients may well be admitted by another hospice given that there are objective eligibility criteria that they will meet; if they are readmitted, then the discharging hospice incurs more cap liability as the second hospice drains away cap allowances. When these patients live for a year or longer, they place independent hospices inexorably into cap liability.

In Oklahoma alone, the cap has forced closure of 25% of hospices, including more than 60% of the chain hospices. When chain hospices see cap liability coming, they close shop, discharge patients into the community, and leave town. Independent hospices, seeing these objectively eligible patients seeking care, then admit these patients, exacerbating their cap position (because they receive diluted cap allowances). As a result, 20% of independent hospices have closed; and, at least 2/3 of independent hospices in Oklahoma now have cap liability.

CMS' suggestion that cap liability is a signal to change admission practices assumes that the cap is easily measurable, that these hospices' admissions practices are faulty and that cap liability can be avoided in later years. But, once a hospice has cap liability, it almost always recurs year after year, principally because patients who are plainly eligible under Medicare's LCDs live longer than the cap allows.

CMS asserts that the current cap allowance will pay for approximately 166 days of care. NAHA respectfully submits that this assertion is erroneous. CMS has made its 166 day calculation strictly on the basis of the total allowance divided by the daily rate for routine home care reimbursement. But, there are other types of hospice care, such as respite care and inpatient care, where: (a) daily reimbursement is up to four times RHC; (b) where such reimbursement is for many hospices a mere pass-through to non-affiliated hospitals. In addition, CMS well knows that the flawed cap calculation regulation prevents allowances from following patients across years, and this further reduces the number of days of care covered. In practice, the hospice cap allowance seldom covers more than 130 days of care per patient.

CMS also asserts that hospices can easily calculate their own cap position. CMS even suggests that perhaps hospices themselves should be required to self-report cap liability. As CMS knows, the cap calculation is a difficult process given that: (a) any number of patients will have had prior or even subsequent hospice service at another hospice; although CMS may have access to complete records, hospices do not; (b) some patients will revoke the hospice benefit and re-elect later, creating gaps in hospice service – something that the statute freely allows as an option; (c) cap calculation is, under any circumstances, a complex mathematical exercise, one that even in current form takes CMS' intermediaries years to complete and one that is fraught with errors. Given these circumstances, hospices are not in a position to calculate their own cap liability.

The cap is neither an effective guide for admissions decisions nor a replacement for evidence-based eligibility criteria.

### **The Aggregate Hospice Cap Regulation**

In establishing the cap, Congress mandated that CMS allocate cap allowances for “each patient” proportionally across years of service. Section 1814(i)(2)(c).

But, in promulgating a regulation for calculation of the cap, CMS chose what it admitted was an “alternative” way of calculating the cap due to what it considered to be the “difficulty” of making a proportional allocation. 48 F.R. 38,146 at 38,158.

Under this “alternative” approach, CMS did not require a proportional allocation and instead provided that, except where a patient was served by more than one hospice, each patient's entire allocation would be given in a single year. As indicated in the publication, CMS provided that the entire allocation would be made in the first year of service unless the patient was admitted within the last 35 days of a fiscal year (i.e., after September 27). In such case, the entire allocation is given to the next fiscal year.

In making this shift, as admitted in the current publication, CMS assumed an average length of stay of 70 days. But, not every hospice of 3,000 in this country has an average length of stay of 70 days. Some hospices, particularly those controlled by hospitals or those in monopoly positions, have far lower average lengths of stay. Other hospices, particularly independent hospices, necessarily have a higher average length of stay.

For hospices with a higher average length of stay, there can be no doubt that the 35 day shift is insufficient to fairly match cap allowances with actual patient payments. As a result, many NAHA hospices have early year cap surpluses and later year cap liabilities. While the failure to make a proportional allocation does not cause 100% of the later year cap liability, there is no doubt, on a mathematical level, that some of that liability is due to misallocation of allowances.

NAHA hospices have repeatedly raised this issue with CMS and have received a startlingly cold response. That same response continues to be reflected in the defensive current publication where CMS asserts, despite knowing better, that “the regulation complies with the statutory requirements without being unduly burdensome.” This assertion is inconsistent with CMS’ own admission in promulgating the regulation that it was proposing something “different” than, indeed an “alternative” to, the required proportional allocation.

As CMS is aware, several NAHA hospices have appealed cap determinations made under the current regulation. And, in the first such case, Judge Gregory Frizzell in the Northern District of Oklahoma, held the regulation invalid, stating on the record his view that “the number of Medicare beneficiaries is simply not reduced in any way to reflect the proportion of care that each such individual was provided in a previous or subsequent accounting year.” Sojourn Care, Inc. v. HHS, 07 CV 375 GKF (Feb. 13, 2008 Transcript, pp. 54-55).

Other courts that have considered the matter have indicated that they are inclined to agree with Judge Frizzell’s analysis. See Tri-County Hospice, Inc. v. HHS, 08 CV 273 (E.D. Ok. April 20, 2009) (order staying case pending Sojourn Care appeal, but noting that court “might well find [Frizzell’s] analysis persuasive”); and Heart to Heart Hospice, Inc. v. HHS, 07 CV 289 M-P (N.D. Ms. Feb. 5, 2009) (this court “tends to agree with Judge Frizzell’s observations” on the invalidity of the regulation; remanding for injury determination). No District Judge has disagreed with Judge Frizzell’s analysis.

In spite of this impressive track record on the merits of hospices challenging the regulation, CMS continues to assert that the regulation is valid. The only force justifying such a position is the alleged burden of making a proportional allocation.

But, several facts suggest that this burden is indeed not so great.

First, CMS already makes a proportional allocation of allowances for any patient that is served by more than one hospice. While this used to be a small number of patients, that number is growing as hospices discharge otherwise eligible patients in a desperate effort to avoid future cap liability. (NB: Because discharged patients are often objectively eligible under CMS’ intermediaries LCDs, such patients are often readmitted by other hospices.) In short, CMS intermediaries already know how to make a true proportional allocation.

Second, although CMS asserts that a proportional allocation would be subject to revision, it is already the case that CMS intermediaries regularly revise cap repayment demands under the current regulation. It is not at all unusual for NAHA hospices to receive amended cap demands 12-15 months after the initial demand. Invariably, these demands seek more money, not less. So, hospices are already accustomed to this process.

Finally, the fact is that CMS intermediaries issue their initial demands approximately 15 months after the close of a given fiscal year. By this time, even for hospices with some long stay patients, the vast

majority of patients served in the fiscal year in question will have already been discharged from service.

CMS' alternative proposals either to (a) allocate cap across two years of service; or (b) force hospices to calculate their own cap are both unfair. The first still does not respect the Congressional mandate for a proportional allocation and fails to recognize that some patients simply may live longer as a result of flawed eligibility criteria and just the distributive averages. The second proposal is simply not feasible; hospices are not equipped to make the complicated calculations mandated by the statute.

If CMS honestly believes that a proportional allocation is unworkable, then it can and should join NAHA's call for repeal of the cap in favor of pay-as-you-go reductions as patients' length of stay increases. Declining reimbursement would address any allegations of "profit motive" attributed to hospices with longer patient stays. Declining reimbursement schedules though must be accompanied by good faith reform of eligibility criteria using evidence and statistical analysis. (*See Hospice Payment Reform discussion below.*)

If CMS wants to ameliorate the negative impact of the prior flawed regulation, then NAHA suggests that CMS: (a) forgive hospice cap liability to the extent of any prior unused cap surplus (ie, allow full carryforward of unused allowances); and (b) reduce the usurious rate of interest on cap liability from double digit rates to the basic government rate of about 2% at present.

NAHA member hospices are not villains. The fact that they are going out of business in record numbers suggests that they are the honest players in this system, the ones that admit patients deemed objectively eligible by CMS intermediaries, the ones that continue to serve communities where chain hospices have pulled up stakes due to cap trouble, leaving a needy but cap depleted hospice patient population, and the ones that serve non-cancer patients who would not gain access to the hospice benefit through a hospital-captive or certificate of need hospice.

## **B. Hospice Payment Reform**

### **CMS should be skeptical about MedPAC staff's hospice analyses, and demand full transparency and disclosure, and additional analysis.**

We have been disappointed that MedPAC staff appears to have focused on reducing hospice expenditures, rather than on thinking across "silos" to develop reforms that would increase hospice access while reducing Medicare's *total* end-of-life care spending. Despite questions from Commissioners that should have led to better analysis, staff analyses related to hospice access, eligibility, length of stay, hospice margins, the hospice Cap, the behaviors of independent hospices and "hospice experts' views" are demonstrably flawed and will mislead healthcare policy. These analyses underpin MedPAC staff's hospice recommendations but have not been subjected to the light of day, and we respectfully submit that they would benefit from rigorous peer review.

- Access – Staff review of hospice access was at best cursory and as a result is misleading. MedPAC should have known and disclosed what Avalere's analysis of 100% of Medicare hospice users from 2003 through 2007 has shown: that timely access to hospice care remains poor, that there are wide gaps among states, diagnoses and races, and that improving timely access for *all* eligible beneficiaries represents a significant opportunity to improve end-of-life care quality *and reduce Medicare's total end-of-life care costs.*

- Eligibility – Staff did not disclose that current hospice LCDs are widely viewed as non-predictive of patient length of stay in hospice, nor did staff discuss the impact of arbitrary eligibility standards that vary by state, by hospice, by diagnosis and possibly by race. This seems inexplicable in the context of trying to understand hospice access and length of stay.
- Length of stay – Despite probing by Commissioners, it appears that MedPAC staff was unable to calculate length of stay accurately. For example, they apparently could not calculate length of stay for patients whose stays crossed year-ends, which led for example to an incredible assertion that the median length of stay for patients whose stays crossed year ends was 16 times that of patients whose stays did not cross year end. (*MedPAC November 2007 Meeting Transcript, staff exchange with Commissioner DeParle, pages 225 – 227; and, staff testimony: “Beneficiaries who do not die in a given year also have a much longer length of stay, a median of 236 days in 2005”, page 221*) MedPAC staff either did not know or did not disclose that length of stay for approximately 80% to 90% of hospice users has not increased materially in at least 5 years. This directly undercuts their hypothesis that there is widespread “managing up” of length of stay by hospices.
- Hospice profit margins – MedPAC staff’s assertion that they were able to accurately calculate and segment hospice profit margins based on Medicare cost reports, including for example “cap hospices vs non-cap hospices”, is simply not credible. NAHA has reviewed 100% of 2005 and 2006 Medicare hospice cost reports and we have compared our findings with other industry experts. Hospice cost reports are incapable of supporting any useful analysis of hospice industry profit margins, for at least five reasons: (1) hospice cost reports are not financial statements, (2) hospice cost reports often do not report hospice revenues; those that do report revenues may include revenues from many different, non-Medicare hospice sources, (3) costs reported may not be complete and may include non-hospice costs, (4) costs reported, especially from hospital-owned hospices, include unpredictable and inconsistent cost allocations from parent companies, and (5) costs reported do not necessarily disclose what if any accruals were included for Cap liabilities, or for what year the accrual was made.

With regard to the relationship of hospice margins to patient length of stay, we note that staff was unable to accurately calculate either. In addition, we note that the only direct evidence that a hospice consistently reduced services delivered to patients as their length of stay increased came from data from Vitas, the largest publicly owned chain of hospices. Vitas’ numbers suggest margins are not primarily driven by long length of stay. Vitas publicly reports: (a) they operate very large hospices and only in major urban areas; (b) about 33% of their revenues are in Florida, a Certificate of Need state where hospices are effectively awarded monopolies; (c) their hospice margins are about 15% and increasing, which is well above average; (d) they supply about 7% of all hospice patient days of care in the United States, but over 40% of high-cost continuous care days, which offer higher profits per day; and (e) their median length of stay is 13 days, which is below average.

- Hospice Cap – MedPAC staff did not get actual hospice Cap demand numbers from CMS but instead estimated Cap demands, and their model appears flawed. Staff has consistently and significantly understated the number of hospices exceeding the Cap and the dollar amounts of demands. They have issued at least three different estimates of 2005 Cap demands, with the third (\$166 million) being 36% higher than the first and, we estimate, still about 20% below the actual.

We refer you to our comments above regarding the hospice cap and the behavior of independent hospices, but suggest that MedPAC staff analysis of the cap should be viewed

with caution; they are systematically underestimating the harm the hospice Cap is causing to rural, minority and non-cancer patient access.

- Expert panel – MedPAC staff frequently quotes an “expert hospice panel” they convened in 2008. We do not question the credentials or good will of the panel invitees. We do note that MedPAC staff excluded NAHA -- that represents more than 500 hospices and has developed more data on the impact of the Cap than anyone else -- and in fact invited no independent hospice that has received a Cap demand. In addition, staff made no transcript of the meeting available. NAHA has spoken with several panel members who asserted that MedPAC staff had selectively and misleadingly edited the views of the participants. This is disappointing and suggests advocacy rather than analysis.

### **Evidence-based eligibility criteria are inseparable from Payment Reform**

Credible, evidence-based eligibility criteria are the key to improving the distribution of hospice care.

Avalere’s modeling of access and length of stay of 3.5 million hospice patients from 2003 to 2007 suggests there are systemic barriers to timely patient access to hospice care, especially for the 78% of Medicare decedents who die of non-cancer causes and the 14% of Medicare decedents who are non-white. But, the same analysis showed little evidence of “managing up” of patient length of stay due to incentives in the payment system, as has been hypothesized by MedPAC staff. There was no material increase in length of stay for 80% to 90% of patients admitted to hospice between 2003 and 2007; this directly contradicts MedPAC staff’s anecdotal suggestion of widespread “managing up” of patient length of stay.

The evidence suggests that the increasing length of stay of the longest-staying 10% to 20% of hospice patients is being driven by some hospices’ good-faith adherence to Medicare’s flawed LCDs, especially for Alzheimer’s / dementia, heart and lung disease, and adult failure to thrive.

At the same time, we know that an increasing number of hospices have invented their own arbitrary and more restrictive admissions standards that vary widely by state, by hospice, by diagnosis, and possibly by race. This eligibility chaos appears to be a root cause of persistently low access and wide gaps in access among states, diagnoses and ethnicities. 2007 access was: (a) 41% nationally, ranging from 60% in Arizona to 24% in New York; (b) 66% for cancer patients but 34% for non-cancer; (c) 43% for whites but 33% for minorities, even though Mississippi hospices have demonstrated that equal access for minorities is achievable; and (d) 43% for minority non-cancer patients in Mississippi, but 8% in New York.

*Timely access* remained poor. The distribution of hospice length of stay changed little from 2003 through 2007, especially for the shortest-staying 80% of patients.

- 2% of hospice patients received only 1 day of hospice care, 25% received less than 5 days, 38% received less than 10 days, 48% received less than 15 days and 72% received less than 60 days.
- *Less than 7% of Medicare decedents* received between 60 days and 180 days of hospice care, the range in which Duke University’s 2007 landmark research suggests quality and cost-savings converge.

**Hospice Payment Reform can improve access, reduce Medicare's total end-of-life care costs and reform the Cap**

NAHA has identified a four-part solution that would improve access to hospice care, clarify eligibility, reform the hospice cap, improve payment accuracy *and* reduce Medicare's total end-of-life care costs by over \$1 billion annually.

- 1) CMS must introduce evidence-based hospice National Coverage Determinations (NCD's) to clarify hospice eligibility and improve the accuracy of eligibility decisions.
  - End-of-life prognoses will always be somewhat uncertain, but by improving accuracy of admissions and recertification decisions, CMS could reduce hospice spending by \$1 billion annually by reducing the length of stay of the longest-staying 10% of users.
  - Clarifying eligibility could generate another \$1 billion in savings by increasing hospice access from 41% currently to 60% by 2012, and by increasing the length of stay of the shortest-staying 75% of hospice patients. Duke University's 2007 study found that Medicare saves about \$2,300 for every incremental hospice user compared to the costs of traditional care in-and-out of hospitals, and that these savings would increase as hospice length of stay increased, for 70% of hospice patients.
- 2) Congress must reform the aggregate cap by replacing it with pay-as-you-go 10% reductions in per diem payments as patients' length of stay exceeds 180 days and, at the same time, provide targeted relief to law-abiding hospices caught in the LCD / Cap trap in 2006, 2007 and 2008. These reforms would:
  - save Medicare \$600 million over 5 years, compared to expected Cap collections;
  - ensure there were no unintended financial incentives for longer patient stays;
  - eliminate CMS' administrative burden of calculating and enforcing the Cap;
  - ensure that CMS never pays out dollars that it will later want back; and
  - stop the harm the aggregate cap is inflicting on patient access.
- 3) Congress must authorize 20% increased per diem funding for the first five and last five days of patients' stays, funded by a further 2.5% decrease in per diem payments as patient stays exceed 180 days. This would improve payment accuracy and patient access, without creating an undue windfall for hospices with short length of stay, and would be budget neutral.
- 4) CMS and Congress should reconsider and repeal CMS' elimination of the Budget Neutrality Adjustment Factor (BNAF), but linked to offsetting savings from the introduction of evidence-based NCDs. Savings from NCDs will be more than sufficient to fund repeal of this cut.

Sincerely,



Lois C. Armstrong  
President, NAHA



David E. Daucher  
Secretary / Treasurer, NAHA