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General Comment

Although I greatly appreciate and respect that CMS is trying to determine a more appropriate hospice payment structure that better represents the care and services provided to hospice patients, to eliminate Medicare hospice overspending and fraud; however, this proposed rule is blatantly not the answer as written. In essence I support the premise upon which the proposed rule was written - one of them being to help prevent fraud among hospice providers for inappropriate billing. This proposed rule completely missed the mark and only creates an environment by which hospice providers will further manipulate the system and submit inappropriate claims for individuals. Hospices that are more concerned with increasing their bottom line and shareholder dividends, and who completely ignore the philosophy and mission of hospice to provide whatever care and services are needed for hospice patients and families, will foster very quickly and efficiently an internal culture to admit whomever might remotely, and most likely not, qualify for hospice for 60 days and then discharge. The outcome?? Confused patients, angry physicians and families, and last but certainly not least, the patient, at a later date, is now truly eligible and needing hospice care and the hospice provider that provides this now needed care has no option than to only bill for the lower routine home care rate. Two important points - (a) if the goal of this new proposed payment structure is to reduce live discharges, the rule will fail miserably. Hospices that practice this philosophy currently by discharging patients after 180 days will only shorten that time and discharge at 60 days. This proposed rule creates more opportunities for fraud and perpetuates the very essence that the proposed rule is trying to eliminate - live discharges; and (b) the hospice providers that are truly living their mission and more concerned with patient care and family than always the bottom line will see a dramatic decrease in their routine home care revenue stream because a vast majority of their admissions will have previously received hospice service

from another provider for 60 days in the past. Hospices providers already struggle with tight margins in an ever increasing regulatory arena and rising labor costs. These hospice providers cannot afford to bill at lower rates at any level, and will most kick off another ear of ownership changes and bankruptcies of hospice providers.

Further, as if the proposed restructure of the routine home care payment does not invite further fraud and manipulation, certain the Intensity Service payment rate certainly does. The same hospice providers will only increase their bottom line for billing at the higher rates whether the patient needs those services are not - and they will actually market that they will provide a nurse or social worker 4 hours a day - no questions asked. Again, leaving the hospice providers that remain compliant and provide services with integrity will lose market share because they will not adopt the same unethical practices as their neighboring hospices. Again, this proposed Intensity Service payment rate jeopardizes the viability and future operation of hospice providers that follows its mission.

As first mentioned, I applaud CMS for attempting to restructure our hospice payment structure, but the proposed changes in this rule invite further fraud and manipulation by hospice providers leaving CMS to spend more and more dollars to track the data, and by the time CMS has tracked and identified the perpetrators, those fraudulent hospice companies will very politely take their slap on the hand and pay their small fine because they have collected so much money from their overbilling and fraudulent billing opportunities that CMS gave them under this proposed rule.