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Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
P.O. Box 8010
Baltimore, MD 21244-1850

ATTN: CMS-1787-P

Dear Administrator Brooks-LaSure:

Since 1982, the National Association for Home Care & Hospice (NAHC) has been the largest organization representing hospice, home health, and home care providers across the nation. Our members include a wide array of provider types, including nonprofit and proprietary, urban and rural, hospital-affiliated, public and private corporate entities, and government-run agencies. We are writing today to provide our input on [Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements](#) -- **CMS-1787-P**. We welcome the opportunity to comment on the policy changes that the Centers for Medicare & Medicaid Services (CMS) is proposing for hospice for the coming fiscal year, and to respond to your requests for comments on various policy considerations in the hospice arena.

The proposed rule contains a number of items of particular interest to the hospice community, including the following:

- Request for Information (RFI) on Hospice Utilization; Non-Hospice Spending; Ownership Transparency; and Hospice Election Decision-Making
- Proposed FY2024 Hospice Payment Update Percentage
- Proposals and Updates to the Hospice Quality Reporting Program (HQRP) (including Establishing Hospice Program Survey and Enforcement Procedures under the Medicare Program; Provisions Update (CAA 2021, Section 407)
- Request for Information on Health Equity under the Hospice Benefit

- Proposals Regarding Hospice Ordering/Certifying Physician Enrollment

Following are NAHC's comments on these sections of the rule.

REQUEST FOR INFORMATION (RFI) ON HOSPICE UTILIZATION; NON-HOSPICE SPENDING; OWNERSHIP TRANSPARENCY; AND HOSPICE ELECTION DECISION-MAKING

CMS has incorporated a great deal of data in the preamble to the rule and created an RFI containing several questions designed to solicit input on various utilization trends related to hospice care. In response, NAHC has sought input from a wide array of hospices and other stakeholders on questions contained in this RFI during internal committee meetings and several open listening sessions and through a member survey. Following are our comments in response to the RFI based on those inputs.

Are there any enrollment policies for hospices that may be perceived as restrictive to those beneficiaries that may require higher cost end of life palliative care, such as blood transfusions, chemotherapy, radiation, or dialysis?

In recent years certain treatments previously viewed as "curative" in nature have come into use as palliative interventions that, in the right circumstances, can be very effective in managing symptoms associated with various terminal conditions. Among these treatments are blood transfusions, chemotherapy, radiation, and dialysis. Since these treatments that "straddle" the curative/palliative sectors have historically been curative in nature, hospices are at varying levels of understanding about which of these treatments are appropriate palliative interventions versus curative in nature, and under what circumstances. As some hospices have admission policies under which they do not cover treatments that they believe will either hasten or delay death (interference with the dying process); these hospices may not cover some treatments (such as dialysis), which could be viewed as "curative" in nature or life-prolonging. Further, various programs (including the VA and the MA VBID Hospice Component Demonstration) identify many of these disease-directed treatments as "concurrent" care – implying that they are to some degree curative in nature but also appropriate for administering in conjunction with the hospice benefit.

Based on discussions with a wide array of hospice providers and other stakeholders, it is our understanding that most hospices do cover these types of palliative interventions when the interdisciplinary team determines that an intervention can be of benefit to a particular patient and on what terms. Most hospice providers make determinations on a case-by-case basis to ensure that the goals of the treatment are consistent with the goals of hospice and that the treatment will be beneficial to the individual patient. Coverage determinations are made based on the intent of the intervention rather than whether the type of treatment is customarily viewed as "curative" in nature. Hospices make every effort to establish an understanding with the patient and family about the process for use of these treatments and when ceasing these treatments is appropriate. For instance, a common approach to radiation treatments is to assess how many treatments are necessary to achieve palliation of a symptom and to provide only this amount. This may mean that instead of 9 radiation treatments for a tumor there are 5 which will shrink the tumor enough to relieve the pain, immobility, or other symptoms experienced by the patient. Likewise, some hospices continue treatments (such as TPN and blood transfusions) on a time-limited basis to maintain a patient through a specific event – such as sustaining them so that they can attend a wedding or other important function, and then reduce coverage after that.

Hospices have reported that chemotherapy and radiation are relatively straightforward palliative treatments, but transfusions can be more complex because there is a point at which some patients can no longer no longer tolerate the treatment. So great care must be taken in establishing a treatment regimen. Many hospices also report allowing continuation of dialysis on a short-term basis to allow for closure or for treatment as a palliative measure for some patients.

Hospices generally report providing services that they are able to deliver directly or that can be provided in the safety of the home (such as peritoneal drains) is more straightforward. However, when it comes to services that do not fall into these categories it is much more challenging as hospices are beholden to other facilities' policies which often are not accustomed to palliative regimens and may balk at the specifics of the orders. Additionally, in the case of services provided in outpatient or other facilities, scheduling can be a challenge as contracted facilities for such services do not have immediate availability or availability during the time frame that may be needed for timely palliative intervention and relief.

Hospices report numerous challenges related to provision of these types of treatments, including the following:

- The biggest challenge is securing contracts with hospitals or centers as hospices find these entities either won't agree to serve patients according to palliative standards (example: some radiologists insist on providing curative doses while palliative radiation tends to require higher doses at less frequent intervals) and/or the facilities won't negotiate prices. Since hospices cannot provide services without a contract, this creates a challenge.
- As previously referenced, treatments that are offered will likely be offered in a way that varies from a curative approach; families at times are hesitant to agree to reducing and/or ultimately terminating treatment.
- Costs for these types of treatments can be substantial.
 - Some pre-PHE estimates indicate that transfusions can cost \$1500 per treatment, which are usually provided on a weekly basis. Total costs generally exceed this estimate as hospices must also cover the costs of transportation, staff time, and administrative coordination with the facility.
 - Dialysis costs can be significant, with pre-PHE estimates for regular dialysis sessions of \$400 per session (\$120 per session for home peritoneal dialysis). Some hospices report supplying peritoneal dialysis as an alternative to facility treatments. Where regular dialysis is used transportation and staff costs must also be considered.
- While larger hospices (i.e., large independent non-profit, and for-profit and non-profit affiliation/chain multi program organizations) report covering a variety of palliative interventions, small hospices of all types have difficulties providing some of these more expensive treatments to all who might benefit—they do not have the scale such that they can absorb the high costs for numerous patients needing such treatments and the related staffing requirements – so they must limit the number of individuals they can admit with these needs.

Are there any enrollment policies for hospices that may be perceived as restrictive to those beneficiaries that may require higher intensity levels of hospice care?

Based on our discussions, we are not aware of any explicit policies that hospices have in place to refuse patients who require higher levels of care (Continuous Home Care (CHC), General Inpatient Care (GIP)

and Inpatient Respite Care (IRC)). However, we have received reports of hospices continuing to have difficulties obtaining contracts with facilities to provide GIP or IRC. In cases where hospices are able to secure contracts, they still may not be able to access beds in facilities with which they have contracts when they are needed. Given these circumstances, we believe there are instances under which some smaller, single location, independent hospices may not admit patients in need of higher levels of care. These actions represent practices rather than explicit policies for these providers. These circumstances (hospices not being able to secure beds in contracted facilities) at times may lead to revocation of the hospice benefit because the patient has the need for stabilization of symptoms.

In addition to the lack of availability of facility beds for higher care levels, hospices report that patients and families at times do not want the patient to be moved to a facility, either because they are fearful of placement in a group setting and potential harm that may result (exposure to infection) or that placement will be disruptive to the patient and take them away from their loved ones.

- Specific Issues related to IRC – in addition to challenges with contracts and securing beds referenced above (due to staffing issues many facilities are no longer contracting for IRC beds), hospices are finding that the respite benefit in its current form does not lend itself well to the needs of today’s patients and families.
 - Many family members prefer to not move their loved ones out of the home for respite (it is very disruptive and with the PHE still on their minds they do not want to place their loved ones at risk).
 - As recommended previously in comments, we support CMS’ exploration of creating greater flexibilities around the delivery of respite care so that it better serves patient and family needs. While creating a respite model that includes home-based elements would be helpful to patients and families, it should be done with considerable flexibility given continuing staffing and volunteer issues that hospices are experiencing as these will impact various hospices’ ability to provide respite in the home.
- Specific Issues related to CHC – At several points in these comments we have previously referenced challenges hospices are experiencing maintaining a sufficient cadre of staff to address all patients’ needs. This is a particular challenge when it comes to CHC as by its nature CHC is not easy to anticipate. Having sufficient staff employed and on board in order to meet potential CHC needs and keeping them fully productive in times of low CHC need can be financially straining and administratively challenging. Employing staff on an “as needed” basis only has proven even more difficult during the workforce shortage. And we have heard that even hospices in larger markets are finding that they must use multiple agencies to secure sufficient staff to meet patient CHC needs. Further, hospices must meet very specific criteria in order to be eligible to bill at the CHC level. Under current policies, hospices must bill 8 hours of service during the 24-hour billing cycle to meet CHC criteria, and only half of those hours (4 hours) may be aide hours. If the need for CHC develops late in the day and the 8-hour time frame spans two billing periods, hospices are not eligible for CHC. This means that with some frequency hospices cannot bill for CHC even if they have provided intense care that would qualify as that care because the care spans two billing days. Further, provision of more aide hours than nursing hours (even if the combined total exceeds 8 hours) means that hospices cannot be reimbursed for CHC. Further, because CHC is used infrequently, hospices do fear that use of CHC may target them for medical review. Based on these challenges, we believe it is appropriate for CMS to consider modifications to the CHC criteria as follow:

- Reduce the minimum number of hours to qualify for CHC (for example, require 4 or 6 hours of service to qualify).
- Impose an 8-hour requirement over 2 consecutive days (minimum of 4 hours on initial day).
- Cover CHC in cases where aide services are more than 4 hours as long as 4 hours of nursing care are provided.

What continued education efforts do hospices take to understand the distinction between curative treatment and complex palliative treatment for services such as chemotherapy, radiation, dialysis, and blood transfusions as it relates to beneficiary eligibility under the hospice benefit? How is that information shared with patients at the time of election and throughout hospice service?

Hospice organizations with multiple programs (for-profit and non-profit) indicate that they require annual education for physicians with regular updates containing learning from evidenced-based research to ensure they are up to date with the latest practices in palliation and management of symptoms. Hospices also report conducting education related to how to conduct patient/family discussions of how these various treatments might be utilized, for what time frames, and related information, as well as the benefit vs. the burden of such treatments. Enhanced education in this area leads to greater patient satisfaction relative to the choices that patients make.

At admission hospices report that many patients and families are so overwhelmed that it is often necessary to have ongoing discussions about these treatments. It is sometimes the case, though, that patients may enter hospice with the understanding that treatment will, after a certain period of time, be withdrawn. There are times when patients/family members change their minds about withdrawal of treatment, and in those circumstances, it may be necessary for the patient to revoke.

Although the previously referenced analysis did not identify the cause for lower utilization of complex palliative treatments and/or higher intensity levels of hospice care, do the costs incurred with providing these services correlate to financial risks associated with enrolling such hospice patients?

Hospices have reported that they believe costs are a factor for smaller hospices that do not have the scale to support “outlier” high-cost patients. But in addition to costs, as referenced above, securing contracts and ensuring treatment tracks with palliative care standards are also a challenge. We have heard reports of circumstances under which as many as 200 hospices in the same county/city are in competition with one another for contracts with only 5 or 10 facilities in the area. This can create serious problems relative to care access and may contribute to hospices not accepting certain patients onto service based on their special care needs. Also as referenced above, at times there may be conflicts between hospices and treatment facilities relative to the provision of services at palliative doses and frequencies, as well as a lack of willingness on the part of facilities to negotiate prices.

Hospice daily payments are prospectively set, with the assumption that costs for some patients will exceed the daily rate while those for others will be less, allowing for a “balancing” of costs. However, many hospices that cover these high-cost services report that profit from RHC days for longer stay patients does not cover the cost of these services for these patients with specialty needs. This may lead to the difficult decision as to whether to admit patients with higher cost needs and risk financial instability or refuse admission of certain patients. Some agencies find that payments for a small proportion of patients who are longer stay (20 to 30 percent) must cover the cost of care for 70 to 80

percent of their patients (those short-stay patients that frequently have acute exacerbations that require higher cost care or who need high-cost palliative treatments to address their symptoms. Hospices have particularly experienced this during the PHE, when many patients on service for very short periods of time required intensive care.

Finally, many of these treatments were not in use when hospice was first covered by Medicare, and current hospice rates do not take the cost of these treatments into consideration. In essence, the introduction of these treatments represents “scope creep” under the hospice benefit, so actual costs of care are increasing. There is currently no risk-adjustment, outlier, or other mechanism under the hospice benefit to address these costs. As medical care advances, we expect the introduction of more treatment modes like these, which may create further challenges for the hospice community.

What are the overall barriers to providing higher intensity levels of hospice care and/or complex palliative treatments for eligible Medicare beneficiaries (for example, are there issues related to established formal partnerships with general inpatient/inpatient respite care facilities)? What steps, if any, can hospice providers or CMS take to address these barriers?

As indicated in our response to the first question in this RFI, barriers to providing higher acuity levels of care and/or complex palliative treatments include:

- Challenges with securing contracts with hospitals, nursing facilities, and treatment centers (such as dialysis facilities) to provide higher levels of care and palliative interventions;
- Access to beds and treatments in a timely manner and at the dosage/frequency required;
- The financial cost of some interventions; and
- Resistance to some palliative treatment modes (higher doses at less frequent intervals).

Potential interventions could include some type of outlier policy or risk adjustment factor as well as education of facilities regarding use of treatments for palliative purposes.

What are reasons why non-hospice spending is growing for beneficiaries who elect hospice? What are ways to ensure that hospice is appropriately covering services under the benefit?

Spending outside of hospice has been a long-standing concern for CMS, policymakers, and the hospice sector. While this is a great concern, it should be noted that, based on analysis conducted by NORC at the University of Chicago on the [Value of Hospice in Medicare](#) (March 2023), the portion of Medicare spending outside of hospice while patients are on service ranges from 1 percent for patients on service up to 30 days to 3 percent for patients on service between 91 and 180 days. For patients on service for 266 days or more (up to 365 days) 6 percent of total Medicare spending is outside of hospice care. This represents a relatively modest spend in comparison with total spending while patients are on hospice care. Most importantly, NORC found that hospice saves the Medicare program roughly \$3.5 billion annually despite the costs of unrelated care that are factored into the savings conclusion.

Implementation of timely filing for the hospice Notice of Election (NOE) and significant penalties for failure to submit the NOE timely have created a strong incentive for hospices to submit NOEs timely to facilitate updates to beneficiary status information so that other providers are able to determine when a patient is on hospice care. Despite this, CMS systems do not process hospice NOEs on a timely basis, so other provider types do NOT have access to timely information about patient election of hospice care, nor do they have the incentive to coordinate care. Further, non-hospice providers lack sufficient

knowledge about how the services they provide may interact with the hospice benefit, including an understanding of hospice “related” services and the fact that, except in the case of hospice attending physician services, hospices are required to arrange for all services related to the patient’s terminal illness or related conditions. To our knowledge they are also not required to check CMS systems to determine whether patients are enrolled in hospice (it should be noted, though, that even if non-hospice providers check beneficiary election information in CMS systems that hospice election information may not be available due to delays in posting timely). Absent an overhaul of CMS systems and enhanced non-hospice provider education, spending outside of hospice will continue to be a problem. If hospice EMR interoperability were accessible (supported and incentivized) it could help to promote increased knowledge of a beneficiary’s hospice status as well as better coordination of care; unfortunately, hospice and other post-acute providers have not been provided the same benefits that hospitals and physicians have relative to interoperability. The lack of access to interoperability by hospice and post-acute providers has been identified in the Office of the National Coordinator’s recent report¹ to Congress as a “barrier to progress” relative to access, exchange, and use of electronic health information.

Hospices have utilized numerous strategies to limit inappropriate utilization outside of the hospice benefit, including supplying patients with wrist bands and other items that patients are instructed to utilize to contact the hospice when care needs arise. Hospices work to build strong relationships with hospitals or enroll in services that alert the hospice when a patient that has elected hospice presents at the hospital so that the hospice can intervene and directly address the patient’s needs or discuss with them the consequences of entering the hospital for services. Despite these and other efforts, the failure of CMS systems to timely provide information about election of hospice care continues to hinder all providers’ abilities to properly manage and coordinate care for hospice-enrolled patients.

Hospices have limited to no influence on the billing habits of other provider types. Under the hospice benefit, patients are financially responsible for items/services/drugs that are related but are not reasonable and necessary. As part of the election process, hospices inform patients/families of this. However, at times when a hospice will not cover services, the patient may seek them elsewhere, and they may be billed to Medicare by the provider. We understand that with some frequency non-hospice providers utilize the GW modifier as a “workaround” as they have learned that it will allow claims to process, regardless of whether the item/service/drug is related to the hospice prognosis. Use of the GW modifier also allows the provider to avoid burdening the patient with the cost of the services provided.

NAHC and other national associations have been involved with the National Council of Prescription Drug Program’s (NCPDP’s) efforts to create a pilot under which hospice enrollment data is communicated to Part D plans in close to real time. By ensuring that this information is available to the Part D plans on a timely basis, they are able to impose the prior authorization checks for the four classes of drugs that are considered to be hospice-related. This also opens up lines of communication between the hospice and the Part D plan such that they are positioned better to share information about drugs that the hospice will cover as related to the terminal prognosis, thereby avoiding the need for Part D plans to later seek compensation from the hospice for hospice drugs. While we are hopeful this will contribute to a reduction in inappropriate drug spending under Part D, this is only one part of the problem and does not address expenditures under Parts A and B.

¹ 2022 Report to Congress: Update on the Access, Exchange, and Use of Electronic Health Information, United States Department of Health and Human Services, Office of the National Coordinator for Health Information Technology (ONC).

We are familiar with the new PEPPER target areas related to Part B spending outside of the hospice benefit, as well as the recent CBR report for Part B providers who have billed for care while patients are on hospice. These reports are an important step in getting data to providers so that they have a better sense of the volume of services being billed outside of hospice for patients on care with them, and notifying Part B providers that they play a role in ensuring that services are appropriately billed under Medicare. However, hospice providers could benefit from greater detail about what specific services are being billed for their patients and whether the services are linked to patients in specific facilities (nursing homes, SNFs, ALFs).

- 483.30(c)(1) that a resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

These situations raise questions as to whether it may be appropriate for CMS and/or the HHS OIG to issue alerts focusing on schemes that target hospice patients for services that should be included as part of the hospice benefit and should be arranged by the hospice.

What additional information should CMS or the hospice be required to provide the family/patient about what is and is not covered under the hospice benefit and how should that information be communicated?

It is our belief that most of the information that is needed by patients and family members is addressed by the election statement addendum, except that it does not address items/services/drugs that are not “reasonable or necessary” for the palliation and management of the terminal condition and related conditions. Hospices generally explain issues related to those items and services that might no longer be appropriate (items that are determined not reasonable and necessary) at the time a patient enters hospice, and usually allow for some phase-out of its use. At that time hospices also explain to the beneficiary the waiver of traditional hospice services. However, there is so much information that is provided to the patient/family at admission that we suspect this leads to overload, and may add to confusion. We do not believe that requiring disclosure of additional information would be beneficial to them.

Are patients requesting the Patient Notification of Hospice Non-Covered Items, Services, and Drugs? Should this information be provided to all prospective patients at the time of hospice election or as part of the care plan?

It is unclear at this time how many patients actually request the election statement addendum. It is our sense that patients and family members do not request the addendum in large numbers, although it varies from hospice to hospice. It is our understanding that hospices with very short lengths of stay (those with a high proportion of patients admitted close to death and with high care needs) do not find need to receive the Election Statement Addendum. This is also consistent with the view that as patients get closer to death it is more likely that all of their care needs will be related to the terminal prognosis and therefore are the responsibility of the hospice. We do not believe that mandating provision of the Patient Notification of Hospice Non-Covered Items, Services, and Drugs is necessary, and could increase anxiety around potential patient financial liability.

Should information about hospice staffing levels, frequency of hospice staff encounters, or utilization of higher LOC be provided to help patients and their caregivers make informed decisions about hospice selection? Through what mechanisms?

Hospices experience varying staffing needs based on patient referrals and patient mix varies greatly from one hospice to another, even for hospices that have similar patient censuses. For this reason, it would be very difficult to determine what an “appropriate” staffing level might be for hospices.

Relative to utilization of non-RHC levels of care, Care Compare indicates whether a hospice provides care beyond the RHC level; however, the metric used for Care Compare purposes represents a very minimal requirement. There may be a more rigorous metric that could provide deeper insight into the mix of services that a hospice provides, but absent some type of risk adjustment mechanism it could be misleading as each hospice’s patient census has different care needs. Further, the burden of this type of metric – including related to timely updates – could be considerable. This leads us to believe that CMS may need to rely on some type of proxy – such as caregiver satisfaction – as the caregiver response would be expected to reflect that the beneficiary and family have been appropriately informed of what they should expect in terms of services.

In the absence of a good metric relative to various levels of care provided, it may be helpful to include information on Care Compare about when use of the various hospice levels of care is appropriate and questions patients and caregivers could ask the hospice about these levels of care and the hospice’s provision of them. NAHC and the Center for Medicare Advocacy have jointly developed a resource that we believe is of significant value to families (**Questions to Ask When Choosing a Hospice Provider** – is available [HERE](#)). Although this resource does not contain a significant number of questions about various levels of care provided, an approach similar to that used in this resource could be used to craft questions patients and families might ask a prospective hospice about the care they provide.

The analysis included in this proposed rule shows increased overall non-hospice spending for Part D drugs for beneficiaries under a hospice election. What are tools to ensure that hospice is appropriately covering prescription drugs related to terminal illnesses and related conditions, besides prior authorization and the hospice election statement addendum?

As referenced previously, the current NCPDP Part D-Hospice pilot is one tool that holds hope for timely provision of hospice election information and increased communication between hospices and Part D plans. Data related to Part D spending outside of hospice for patients who are part of the pilot will be very instructive relative to whether timely receipt of hospice enrollment information contributes to a reduction in Part D spending for hospice patients. If the pilot is successful in getting information to Part D plans in a more timely manner, it should be built upon to encourage the exchange of additional information that can help to ensure appropriate coverage for drugs for patients on hospice care. In the interim, CMS may want to continue to remind hospices and Part D plans about the “HOSPICE INFORMATION FOR MEDICARE PART D PLANS” form that can be used to convey information about medications that are related and those that are unrelated to the terminal prognosis and assist in making appropriate coverage determinations.

When discussing drug coverage, it should be noted that various hospices may deal somewhat differently with drugs that are unrelated to the terminal diagnosis. Some hospices do not bother to deal with making determinations of unrelatedness and go ahead and cover unrelated drugs (such as thyroid medications, etc.) while others do not.

We understand that the data supplied in the preamble to the rule relative to spending outside of hospice during an episode of care excludes services and drugs that were provided on the day of hospice

admission or the day of live discharge. Relative to drugs it may be appropriate to further trim that data to take into consideration auto-refills and the time it takes for beneficiary hospice enrollment information to filter through to Part D plans, or at a minimum to chart at what point during an episode of care the prescriptions are filled and charged to Part D to see if there is a higher incidence of Part D being charged for medications earlier in a hospice episode and/or very near to a patient's live discharge (which could mean that other practitioners are ordering drugs in anticipation of the patient leaving hospice care).

Given some of the differences between for-profit and not-for-profit utilization and spending patterns highlighted in this proposed rule, how can CMS improve transparency around ownership trends? For example, what and how should CMS publicly provide information around hospice ownership? Would this information be helpful for beneficiaries seeking to select a hospice for end of life care?

For beneficiaries and family members, the quality of care provided is what matters most when it comes to hospice care. Hospice has lagged behind other providers in the development of meaningful quality measures that provide a clear picture of the quality of care that is provided by a hospice. We are deeply supportive of additional actions by CMS to develop a robust set of quality measures for the hospice sector to support informed choice of a hospice provider. Early this year the four national hospice associations submitted a series of program integrity-related recommendations to CMS and other stakeholders that included recommendations for enhancement of hospice information available on Care Compare to better assist the public in making decisions around choice of hospice provider. Those recommendations suggest that the following modifications be made to Care Compare:

- Locate the date of hospice certification and/or change of ownership closer to the top of the Compare listing and have a mechanism for regular and timely updates to this information.
- Indicate whether a hospice participates in the Hospice Quality Reporting Program (HQRP) – both Hospice Item Set [HIS] and Hospice Consumer Assessment of Healthcare Providers and Systems [CAHPS]).
- Indicate whether the hospice was subject to payment penalty for nonparticipation in HQRP and the year of penalty
- Identify which survey entity did the hospice's certification survey (state survey agency or accrediting organization).
- Provide information on contacting Medicare complaint hotline in a prominent location.
- Provide information on contacting a Quality Improvement Organization (QIO) relative to complaints or concerns.
- Make the HCI Score more prominent/easy to find.
- Elevate placement of Quality of Patient Care data to below the Family Caregiver Survey rating on pages comparing multiple providers.
- Prioritize Quality on the menu bar of the individual hospice pages rather than Conditions Treated.
- If a hospice does not receive a star rating for their CAHPS survey, indicate on overview pages whether they have reviewable CAHPS data.

Further, we deeply support inclusion of hospice survey data on Care Compare in a manner that is understandable to the public. This would be a significant addition to the data that is currently available. Given that the hospice survey reforms enacted at the close of 2020 require public posting of hospice survey results, we expect that CMS is in the process of developing a plan to accomplish that task and

hope that that plan will come to fruition in the very near future. In previous comments related to implementation of hospice survey reforms, we have made some of the following recommendations relative to public display of hospice survey findings:

- We anticipate that hospice survey findings will either be directly available or available by a link from Care Compare (in a manner currently used for nursing home surveys). We support posting survey summary information along with a link to full survey report(s) in a single location that is easily accessible by the public.
- Nursing home survey reports do not include the facility's plan of correction or information indicating that the provider has come into compliance, leaving a viewer with questions about the facility's compliance status. We strongly recommend that any posting related to survey findings in which a provider was cited for failure to meet the hospice Conditions of Participation (CoPs) includes a notation that the provider has corrected any deficiencies and is in full compliance with the hospice CoPs, and the date that the hospice achieved full compliance. If a hospice is deemed by an accrediting organization, the notation should include notice that once compliance was achieved the hospice was once again accredited by the Accrediting Organization (AO).
- Hospices with inpatient units have more CoPs for which they are surveyed, including a substantial number of Life Safety Code (LSC) requirements. We recommend that as part of any metric representing survey performance that CMS distinguish between hospices that provide inpatient care directly and those that do not to ensure appropriate comparison. Further, we recommend that such a display provides information related to the difference between LSC violations and other CoPs, including that LSC violations are not always directly related to patient care but may be failure to meet a technical requirement.
- Given the complexity of the survey process, we strongly recommend that any posting of survey findings be accompanied by guidance about the hospice CoPs, how to read and interpret a Form CMS-2567 report, and the survey process that are geared toward a population that may not be familiar with the process. We also strongly recommend that CMS include an explanation that a single citation is not an indication that a hospice has systemic quality of care concerns.
- We note with some concern that there appears to be a lag in posting time for nursing home survey finding reports. It would be helpful if CMS could establish an explicit policy with respect to the time frames for posting of hospice survey reports and that CMS consider enforcement provisions for survey entities to submit reports.

In terms of provision of hospice tax status information to the public, CMS currently provides hospice tax status (Ownership) on Care Compare. We suspect that Compare is likely the best location to display any specific characteristics that CMS may want to highlight about individual hospice programs. Beyond ownership information, it is unclear what additional detail CMS might want to highlight relative to tax status that would be meaningful to beneficiaries and families. As referenced above, it is our belief that the single most important issue relative to choice of a hospice is the quality of care and the ability of the hospice to meet the patient's care needs in a timely and compassionate manner. We would also note that as the proportion of for-profit hospices grows, analyzing quality, care patterns, or utilization based strictly on profit status may be too simplistic an approach to yield meaningful or actionable results.

While much has been made of the differences in care provided by for-profit and non-profit hospices, recent research² indicates that the quality of care in hospice varies widely across both for-profit and non-profit hospice types. For this reason, “choice of a hospice should not assume that profit status is a proxy for quality, but should be guided by the reported care experiences and other quality indicators for a particular hospice [emphasis added].” Further, “Just as with non-profit hospices, there are numerous for-profit hospices that perform substantially better than the national average.”

During hospice payment reform discussions some analysis was conducted that looked at utilization and care patterns based on a hospice’s length of time in the Medicare program, hospice size, geographic location, etc. Given the dramatic growth in hospices over recent years and the significant variability among providers (whether for-profit or non-profit) we believe deeper analysis that looks at additional hospice attributes is needed to get a better sense of where problematic utilization and spending patterns are occurring and to formulate corrective action.

PROPOSED FY2024 HOSPICE PAYMENT UPDATE PERCENTAGE

The proposed FY 2024 hospice payment update percentage is based on the proposed inpatient hospital market basket update of 3.0 percent reduced by a productivity adjustment as mandated by the Affordable Care Act. CMS currently projects the productivity adjustment to be 0.2 percentage point, which results in a net payment update percentage of 2.8 percent. While base payments will be adjusted by the update percentage, payments to hospices will be further reduced by 2 percent upon payment due to the reinstatement of the across-the-board sequester. Based on the proposed update of 2.8 percent, this essentially eliminates more than 2/3 of the update. While it is anticipated that CMS will revise the payment update percentage in the final FY 2024 hospice payment rule later this year to reflect more recent data if such is available, the current projected update of essentially less than 1 percent at a time of continuing increases in costs raises serious concerns that many hospice entities will struggle to maintain operations and deliver high quality care to patients and their families. Hospices have struggled over recent years with the following price inputs:

Workforce Costs: By far the most significant financial stressor for hospices at this time is maintenance of a sufficient workforce to provide direct care at the appropriate levels to terminally ill patients and support to their family members. While the hospice payment update and wage index values are based on the base values utilized for inpatient hospitals, hospices do not have the benefit of provisions that allow for reclassification or other considerations that could provide financial benefit. Additionally, wages and wage-related costs are the most significant cost factors for hospice operations. In the FY2022 hospice payment rule, CMS rebased and revised the labor share for all hospice levels of care based on hospice cost report data. By those recent CMS determinations, 66 percent of the payment rate for hospice Routine Home Care (RHC), which is the predominant level of care provided to hospice patients (nearly 99 percent of hospice care days were billed at the RHC level in FY 2022), is attributed to labor costs.

In addition to the fact that a high proportion of hospice costs are driven by wages and wage-related costs, these costs have dramatically increased in recent years due to the significant staffing shortages across the health care spectrum. These shortages pre-date the COVID-19 PHE and have only worsened since its onset. Hospices are hard-pressed to compete with wages and benefits that hospitals and some

² “Association of Hospice Profit Status with Family Caregivers’ Reported Care Experiences,” JAMA Internal Medicine, February 27, 2023, Rebecca Anhang Price, PhD; Marc N. Elliott, PHD; Anagha A. Tolpadi, MS; Melissa A. Bradley, BA; Danielle Schlang, MS; Joan M. Teno, MD, MSc

nursing facilities are able to offer the same personnel. These workforce shortages have been accompanied by rapid turnover, escalating recruiting costs, and reduced productivity as newly hired staff become acclimated to hospice policies and practice, creating additional financial challenges for hospice providers. Additionally, as a result of the PHE and the fact that a high proportion of hospice volunteers have been advanced in years and have existing conditions that place them at-risk if exposed to communicable diseases, many hospices have lost a great deal of their volunteers upon which they have historically depended to provide a portion of patient services. While hospices are working diligently to rebuild their volunteer forces, we have concerns that a return to pre-PHE capacity will be a long-term challenge.

In addition to general reports of rapid rises in hospice labor costs over recent years, some hospices have provided detailed statistics that underscore the failure of the market basket update to capture increased costs. Following are some examples:

- One large agency indicates that over 2021 and 2022, RN salary costs have increased by 19.4% and Aide salary costs have increased by 27.9%. During the same time period, non-labor costs rose 26.2%.
- Another multi-state provider indicated that over 2021 and 2022, salaries and wages rose 13.1% (with all labor-related costs rising 18.9% during the same time period). For this same provider, over five years salaries and wages rose 29.1% (with all labor-related costs rising 35.2%).
- Another multi-state provider reports that over 2021 and 2022, RN salaries rose 11% and Aide salaries rose 17%. For this same provider, over five years (2018-2023) RN salaries rose 21.2% and Aide salaries rose 24.6%.
- Another multi-state provider found that RN salaries rose 1.8% in 2021 and 5.25% in 2022, while Aide salaries rose 2.8% in 2021 and 7.8% in 2022.

These data clearly illustrate the significant financial challenges that hospices are facing as the result of the health care workforce crisis, which impacts every aspect of hospice operations.

The COVID-19 Public Health Emergency: While the COVID-19 Public Health Emergency (PHE) has officially ended, hospice providers continue to deal with its aftermath. Hospices continue to experience changes that emerged during the pandemic, including reductions in referrals (particularly from nursing homes), higher numbers of short-stay patients, increased severity of patients admitted to service, and reduced access to contract bed in hospitals and facilities to supply higher levels of care (as hospitals are cutting costs, they are less interested in contracting with hospices to provide GIP and IRC). We are hearing reports from hospices that they are continuing to experience declining lengths of stay. This may be due in part to the substitution of other care (such as SNF care) but also is occurring because patients are waiting to access the system as they are waiting longer and longer periods to see specialists, resulting in later stage referrals. Late referrals lead to higher overall costs per patient. Hospices are also experiencing significant costs related to the unwinding of the PHE-related flexibilities and reinstatement of various regulatory requirements.

Resumption of the 2% Sequester: Hospices deeply appreciated the financial relief provided during the worst days of the PHE, including the waiver of the 2% Medicare sequester on a temporary basis to relieve financial pressures for all Medicare provider types. However, the sequester was phased back in over the course of 2022, and as noted above, its reinstatement will nullify a substantial portion of the payment update for FY2024.

Increased Regulatory Oversight: In addition to resumption of pre-PHE regulatory requirements (referenced above) that are leading to increased operating costs, CMS is implementing further changes that will increase the costs of doing business. In early 2023, CMS released revised surveyor guidance ([Revisions to Hospice-Appendix M of the State Operations Manual and the Hospice Basic Surveyor Training](#)). These revisions have the potential to improve the quality of care provided by Medicare hospice programs. However, we are already hearing that the revisions are leading to longer survey time frames, which increases administrative costs related to the survey process. Further, CMS is in the process of implementing significant hospice survey reforms as mandated by the [Consolidated Appropriations Act of 2021](#) that will lead to further increases in administrative costs. Finally, with support from the national hospice associations CMS is taking action to increase oversight of hospice to address program integrity concerns that have come to light over recent years. All of these have the potential to increase routine operating costs going forward to ensure appropriate compliance.

Financial Uncertainty/Inflationary Pressures: While inflation pressures have abated somewhat from where they were one year ago, hospices continue to experience significant financial pressures resulting from higher prices, financial uncertainties, and growing interest rates. Hospice providers particularly continue to struggle with rising costs of supplies, drugs, wages, and other items essential to the delivery of high-quality hospice care. Further, unlike many other Medicare provider types (such as hospitals), most hospice care is financed by federal health care programs (predominantly Medicare and Medicaid). As a result, hospice providers are unable to shift costs to other payers to help offset losses under Medicare. Even hospices that have significant commercial contracts have very limited pricing power and are forced to accept rates set by the payer. Most of the increased cost factors attributable to inflation will not recede and will represent a new base for hospice spending. This is particularly the case relative to wages -- across the board wages for hospice staff continue to increase at rapid rates, as referenced above.

Market Basket Forecast Update: We are deeply concerned that the projected payment update for hospice providers will be insufficient to address the accelerating financial demands that hospices have faced over the course of the recent three years. These increased financial demands have become “baked” into hospice operating costs, but hospice payment updates have lagged significantly behind as the result of both the failure of the forecast update to keep up with cost inflation and as the result of annual productivity cuts and other reductions (such as the limiting of the hospice payment update to 1 percent for FY2018). While historically CMS’ forecasts for the hospital market basket (upon which hospice payment updates are based) have been relatively accurate, in more recent years those forecasts have fallen far short of actual cost inflation. Following is a table reflecting the CMS forecasted payment update for hospice payments during 2021 and 2022 as compared with actual cost inflation for the same time period. It should also be noted that the forecast/update for FY2023 for hospice providers, as compared with the current estimates (which are not final) indicate that the update for the current year may also reflect a lower update than actual costs being experienced in the health sector:

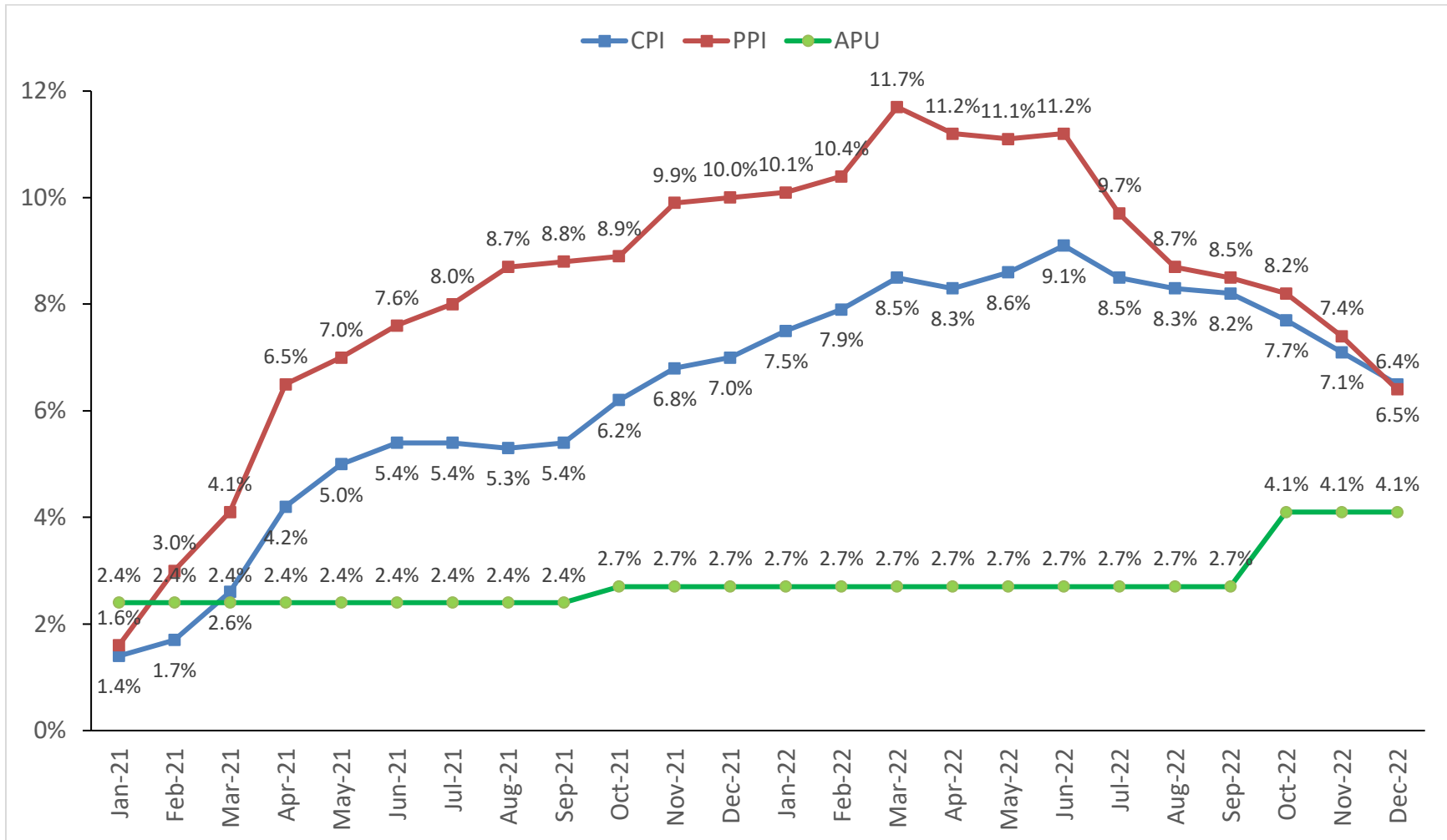
Hospice Market Basket for FYs 2021 & 2022 – Forecast v. Actual

| Year | Forecast/Update | Final/Actual | Shortfall |
|-------------|-----------------|--------------|-----------|
| 2021 | 2.4% | 3.0% | 0.6% |
| 2022 | 2.7% | 5.7% | 3.0% |
| Cumulative* | | | 3.7% |

*3.7 percent is the cumulative compounded forecast error over the two-year period.

We also note that other metrics indicate rapid growth over recent years that dwarfs the annual percentage update for hospice providers. The table below compares 2021 and 2022 growth in the Consumer Price Index/Urban Consumers (CPI-U) and the Producer Price Index (PPI) as compared with hospice payment updates for the same time period. The variance represents a significant loss in purchasing power that is permanently factored into hospice rates.

Rapid Rise in Consumer and Producer Inflation Not Captured in Hospice Annual Payment Update



NAHC Recommendation: We believe that the significant workforce challenges and other cost inputs being experienced by hospices warrant additional action, and are requesting that CMS consider a one-time, “catch-up” adjustment to address the significant forecast error relative to payments updates for FY2021 and FY2022 to avoid significant underfunding of hospice services. The adjustment would be applied to FY2024 payment rates based on the best data available at the time the change is promulgated. CMS has applied a forecast error correction policy for Skilled Nursing Facilities (SNF) beginning in FY2004 with the rationale that then-recent prior updates failed to reflect high labor expenses. At the time, the cumulative shortfall for SNF updates was 3.26 percent. If CMS believes that implementation of a one-time forecast error adjustment for hospices may be outside the scope of the current rule, we understand that the forthcoming CY2024 Home Health Payment Rule is expected to contain regulations related to hospice (specifically regulations proposing a Special Focus Program for Hospice), so that rule could appropriately include a proposed one-time forecasting error adjustment for hospice.

PROPOSALS AND UPDATES TO THE HOSPICE QUALITY REPORTING PROGRAM (HQRP) (including Establishing Hospice Program Survey and Enforcement Procedures under the Medicare Program; Provisions Update (CAA 2021, Section 407))

CMS intends to develop several quality measures based on information collected by the Hospice Outcome & Patient Evaluation (HOPE) instrument when it is implemented. Currently, CMS intends to develop at least two HOPE-based process and outcome quality measures focusing on the following two process measures first:

- (1) Timely Reassessment of Pain Impact; and**
- (2) Timely Reassessment of Non-Pain Symptom Impact.**

NAHC encourages CMS to continue to offer stakeholder engagement opportunities for these measures and future measure development. Specific to the HOPE, NAHC requests more information sharing before CMS proposes implementation of the HOPE, including progress reports along the way. We look forward to continued engagement with CMS, including the opportunity to receive updates about HOPE and ask clarifying questions and would be pleased to host or co-sponsor an educational webinar serving to educate hospice providers, staff, and patient advocacy groups before HOPE is implemented.

We understand that when HOPE is implemented hospice-wide there will be more data from which measures can be developed. In the interim, we read with interest the [2021 Technical Expert Panel \(TEP\) Hospice Quality Reporting Program Summary Report](#). Consistent with feedback shared from the TEP on the two process measures CMS is considering for the HQRP, NAHC believes that reassessment of pain and non-pain symptom impact is an important process supporting the delivery of quality hospice care. Overall, NAHC supports future HQRP process measures that build the framework for future outcome measures as we strongly believe that outcome measures are necessary in the HQRP. In both process and outcome measures it is imperative that patient preferences be incorporated.

Hospices work with patients to develop goals and interventions for the plan of care based on the assessment of the patient’s needs and desires. It is not uncommon for patients to have a goal to maintain pain at a moderate or severe level for reasons related to their cultural and/or religious beliefs. They may also wish to maintain a moderate to severe impact level for pain/non-pain symptoms due to not wanting to experience some of the trade-offs (increased hours of sleep/drowsiness; inability to carry on a conversation with family, etc.) that come with the treatments necessary to reduce the impact level. Therefore, conducting a follow-up reassessment with these individuals may not be necessary and could

be an annoyance and burden. The process measure calculation should exclude those situations where the patient's pain/non-pain symptoms are at or below their self-determined desired level.

For purposes of the measures, must reassessment be an in-person visit? Most hospices conduct follow-up for symptoms (pain and non-pain) within hours of identifying symptom impact above a patient's preference/goal. This follow-up is completed via phone, in-person visit or telehealth (two-way audio and video). If not required to be an in-person visit, CMS should consider reducing the timeframe for reassessment to one day instead of two. As a matter of practice, hospices follow-up well within the first 24 hours after symptoms are identified as above a patient's preference/goal. Depending on the symptom, initial follow-up often does not require an in-person visit.

Patients experience pain and symptoms on the physical, emotional, social, and spiritual levels. CMS requires hospices to utilize an interdisciplinary team (IDT) in order to adequately address these levels. In situations where a patient's pain/non-pain symptoms are above their desired level, CMS should recognize reassessment by any of the appropriate IDT members.

CAHPS Hospice Survey

NAHC was pleased when CMS shared that it was conducting a CAHPS Hospice Survey Mode Experiment. We were encouraged when results of the 2021 experiment resulted in a response rate of 39.1 percent for the web-based surveys, which is 13 percentage points more than the mail-only mode. An increase in the response rate to the survey could result in an increase in the number of hospices having a CAHPS Hospice Survey star rating publicly reported on Care Compare. As stated in comments NAHC has submitted in response to previous proposed rules, we encourage CMS to move with all deliberate speed on the implementation of a web-based survey.

As NAHC looked at the CAHPS hospice survey through an equity lens, we are increasingly concerned that the survey might be asking the wrong questions for some ethnically diverse families. Many hospice providers note a difference in response rates between English speaking families and families that speak other languages. English-speaking families respond to the survey much more frequently than those that do not speak English, even when the survey is translated into their language. NAHC requests that CMS review relative responses of English and non-English speaking individuals in other CAHPS surveys. If the same differences are present as in the hospice CAHPS survey, we request that CMS meet with stakeholders to examine methods that would encourage higher response rates for non-English speaking families in hospice. NAHC recommends that great care be given to having ethnically and culturally sensitive and competent questions as the survey is translated into other languages.

Chaplain and Telehealth Visits

Three new Healthcare Common Procedure Coding System (HCPCS) codes for chaplain services were approved by CMS in late 2022. This is a positive first step toward meeting the requests of hospices and stakeholders for CMS to begin collecting data on chaplain services delivered to hospice beneficiaries. Currently, CMS collects data on all core disciplines in hospice – physician, registered nurse, medical social worker – except chaplains (pastoral counselors) via hospice claims. This data from these other core disciplines is used in quality measures in the Hospice Quality Reporting Program (HQRP). With the approval of the HCPCS codes, delineated below, CMS would have data on all the core services of hospice care and could expand the HQRP to include chaplain services.

- HCPCS Level II code Q9001 "Assessment by chaplain services"
- HCPCS Level II code Q9002 "Counseling, individual, by chaplain services"

- HCPCS Level II code Q9003 “Counseling, group, by chaplain services”

However, it is not clear if or when CMS will utilize these codes on hospice claims or as part of the HQR. Further guidance from CMS may be needed, i.e., defining what is considered chaplain services, and it may be necessary for CMS to identify or create a corresponding revenue code for the HCPCS codes to be utilized on hospice claims. **NAHC urges CMS to take all necessary action and begin collection of data related to chaplain/pastoral counselor visits on claims.**

In its March 2022 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) urged Health and Human Services Secretary Becerra to “require that hospices report telehealth services on Medicare claims.” Throughout the COVID-19 Public Health Emergency, the *CARES Act* has granted hospice patients and providers telehealth flexibilities which have expanded access to essential post-acute care and protected the health and wellbeing of the most medically vulnerable populations. These flexibilities allow patients to take part in telehealth visits from wherever they call home and allow for the use of telehealth for low-touch, administrative face-to-face visits prior to recertification for the hospice benefit.

Through the Consolidated Appropriations Act, 2023, these flexibilities were extended beyond the end of the COVID-19 Public Health Emergency until December 31, 2024. However, because CMS does not require the collection of data on the use of telehealth through the hospice claim form, no consistent information on the use of telehealth and its impact on patient access and quality is being gathered. Hospice providers need the opportunity to reflect the full scope of care provided to patients experiencing serious illness. Right now, care delivered through telehealth is not measured, and therefore, many visits are not noted in any official record. This means that patients’ records fail to reflect the full scope of care they receive, and hospice organizations are left without a way to fully capture the quantity of their patient visits and quality of their work. An unforeseen benefit of the COVID-19 pandemic has been the rapid development of telehealth technologies and practices which help patients access care more easily, without sacrificing quality. We believe that this will be borne out by the data; and believe that collecting accurate information is critical to drafting long term policy, and effective guardrails, around the use of telehealth in the future. **NAHC urges CMS to develop and implement any necessary revenue or other codes or modifiers for hospice telehealth visits and add them to the hospice claim.**

HEALTH EQUITY RFI

NAHC applauds CMS for the continued focus on health equity in this proposed rule and strongly supports embedding the principles of health equity in the design, implementation, and operationalizing of policies and programs to improve health and reduce disparities for all people served by the Medicare program and stand ready to assist and partner in this endeavor.

In general, hospice readiness to develop and implement health equity initiatives still varies greatly. Some hospices report that health equity concepts are new to their organization while others report collecting and analyzing data related to health equity for some time and using it as part of their performance improvement program. Consistent feedback from members indicates that there are hospices operating all along this spectrum. Primary factors impacting readiness level include workforce shortages, financial constraints, and lack of standardized definitions and approaches to health equity. Many hospices report that the COVID-19 pandemic required a shift in priorities prohibiting them from focusing on any priorities other than urgent ones. It has only been recently that some hospices have

been able to dive deeper into health equity concepts and plan for adoption or expansion in their organizations. Those hospices that are hospital-based or part of hospital-based systems have had earlier and greater exposure to health equity concepts primarily due to CMS' introduction of these concepts to hospital providers over the course of years. These hospices also have access to more resources to learn about and address health equity and disparities. Somewhat unique to hospices are end-of-life cultural values and beliefs of underserved and minority populations that are barriers to these individuals accessing hospice care and seeking employment and volunteer opportunities in this area. CMS should consider this as it looks to incorporate health equity measures into the HQRP. Further, CMS should allow for adoption of health equity initiatives with hospices in a manner like that utilized with hospitals – slowly and over the course of years.

What efforts do hospices employ to measure impact on health equity?

As part of hospice practice, social determinants of health and their impact are part of the psychosocial assessment, and the interdisciplinary group (IDG) uses the results of this and the entire comprehensive assessment to create care plans to address unmet needs. See comments below to the question on what sociodemographic and SDOH data should be collected and used to effectively evaluate health equity in hospice settings for additional information on assessments incorporating social determinants of health (SDOH) and their impact.

Some hospices have hired staff or are contracting/consulting with Diversity, Equity, and Inclusion (DEI) experts to assist with expanding the collection of data on the impact of health equity.

What factors do hospices observe that influence beneficiaries in electing and accessing hospice care?

Primary factors observed are cultural and ethnic beliefs and practices as well as pragmatic issues such as timely admission, reputation of the hospice, and insurance coverage. Another significant factor is the barrier, mentioned elsewhere in these comments, of having to make the decision not to utilize any curative treatments. On the other hand, some beneficiaries are not given the option of choosing hospice care or made aware of choice of hospice agencies. Hospices continue to report lower utilization of hospice services by minorities and those who have limited resources for seeking healthcare (e.g. uninsured/underinsured).

What geographical area indices, beyond urban/rural, can CMS use to assess disparities in hospice?

There are many ways in which CMS could assess the disparities as morbidity and mortality profiles are impacted by numerous factors. Below are some of the most frequently mentioned indices when discussing this specific question with hospices.

- Population size by county
- Income
- Social mobility
- Number of healthcare providers
- Areas with the highest proportion of individuals aged 65 and above.

What information can CMS collect and share to help hospices serve vulnerable and underserved populations and address barriers to access?

Hospices indicated that they would appreciate CMS sharing the most significant barriers to hospice care it has found based on its research of available data and suggestions for actions hospices can take to help break down these barriers. Also, sharing information to help hospices understand *why* these barriers

exist will help them develop targeted actions at the local level. It would also be helpful to know what CMS is doing globally to address the reasons for the disparities.

Hospices also suggested that CMS work closely with the CDC on the collection of data as the CDC collects data on community populations that could help with access, cultural influence, and mortality/morbidity data. State economic development plans could help determine the financial health of the community.

What sociodemographic and SDOH data should be collected and used to effectively evaluate health equity in hospice settings?

- Age, financial income, living environment, number in the household, support system
- Gender identity (not just male/female). Charity spend (underfunded).
- Capture more detailed information (e.g., Asian Americans broken down by region of national origin (East, Southeast, South, and other Asians) and Pacific Islanders broken down to four groups (Melanesians, Micronesians, Polynesians, and other Pacific Islanders)) would be helpful as would including measures of socio-economic status – income and education and insurance status.
- Specific programs that may be in use (homeless care, LGBTQ care).
- CMS is reminded that hospices have long gathered information on social determinants of health such as socioeconomic status, housing, food security, access to interpreter services, caregiving status, and marital status as part of the psychosocial component of the hospice comprehensive assessment. It is best practice to collect this information when caring for individuals in the home environment. There are some hospices that have been able to progress to the stage of utilizing health equity data and information in performance improvement activities, but still few reported using qualitative data collection and analysis methods to measure the impact of its health equity initiatives.

What are feasible and best practice approaches for the capture and analysis of data related to health equity?

- Require all EMR vendors to embrace specific needs identified per the comments to this proposed rule such that it is easy to capture patient data without an inordinate use of categorizing data in 'other' categories.
- The ability of EHR systems to capture this type of data is inconsistent due, in part, to not having standardized determinants of health and agreement in the industry on what data should be captured related to disparities and equity. Furthermore, there is no central repository for the data, so its value is minimal currently. It can only be used internally, preventing true comparisons and benchmarks and subsequent performance improvement.

What barriers do hospices face in collecting information on SDOH and race and ethnicity? What is needed to overcome those barriers?

- Patient/family reluctance to share data. This often seems related to both distrust and shame.
- Language, literacy, and embarrassment
- EMR limitations. Require standardization and fuller descriptions.
- The cost of collecting data, especially if there is a change in software required, is often a barrier. EMR systems may not be well suited to collect accurate information on gender, sexual orientation, race/ethnicity identities. For example, most ask participants to choose “one” option out of several races and ethnicities, which overlooks those of mixed races and ethnicities. Gender is also still binary, disregarding patients who may identify as non-binary.

- Race does not seem to be a problem for patients to self-identify. Ethnicity is a problem for patients to identify due to lack of knowledge or willingness to share.

PROPOSALS REGARDING HOSPICE ORDERING/CERTIFYING PHYSICIAN ENROLLMENT

CMS proposes that physicians who order or certify hospice services for Medicare beneficiaries be enrolled in or validly opted-out of Medicare as a prerequisite for the payment of the hospice service in question. Enrollment would be accomplished through the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) process. This requirement would apply for all hospice certifications, meaning that the patient's designated attending physician, if any, and the hospice medical director or physician member of the interdisciplinary group (IDG) completing the initial hospice certification, as well as the hospice medical director or physician member of the IDG completing any recertifications, would need to be enrolled or be validly opted-out.

The purpose of the enrollment process is to help confirm that a physician meets all applicable Federal and state requirements and is, to an extent, a "gatekeeper" that prevents unqualified and potentially fraudulent individuals and entities from entering and inappropriately billing Medicare. NAHC supports program integrity efforts to identify and terminate hospices and/or the physicians connected to them that are engaging in fraudulent behavior. NAHC further supports a requirement that all hospice medical directors and hospice physicians are Medicare enrolled or have a valid opt-out on file.

However, a unique aspect of the Medicare hospice benefit is the patient's right to designate an attending physician. This right may be compromised under this proposal if the designated attending physician is not enrolled/validly opted out. In situations where the patient's designated attending physician is not enrolled/validly opted out, the hospice would not know this until after the hospice staff member admitting the patient is able to verify the physician against the PECOS file. The hospice staff would then have to go back to the patient to allow the patient an opportunity to designate a different attending physician. It will take time for the hospice to do this, which delays care, and the patient will be burdened with having to complete a change in designated attending physician form. Also, the hospice may have obtained orders from the designated attending physician to address immediate patient needs and would have to go through the process of obtaining these orders again from a different physician. With 25 percent of hospice stays being less than 5 days³ and the median length of stay for a hospice patient being 17 days⁴ this could negatively impact the final days of life for a significant number of beneficiaries. Most importantly, patients should not have to sever their relationship with the physician who has been most involved in their care in order to elect hospice care.

In addition to the extra time and unnecessary patient burden associated with the situation of a designated attending physician not being enrolled or validly opted out, hospices have administrative and payment concerns. The hospice has two days after the effective date of the Medicare hospice election in which to obtain a verbal or written certification. The hospice most likely will not be able to accomplish this if a different attending physician needs to be designated and located to secure a verbal certification. The hospice may not even be able to address the situation with the patient or their representative, due to clinical and logistical conditions beyond their control. For example, many patients are not able to make their own decisions, or their condition may have changed, and they are no longer able to do so. Patients also may have died, and their representatives often are not reachable (do not live in the area or

³ [MedPAC 2023 Report to the Congress, Chapter 10.](#)

⁴ [MedPAC 2023 Report to the Congress, Chapter 10.](#)

otherwise are not available or engaged in the patient's care) after the election of hospice care. In these situations, the designated attending physician will be listed on the election statement. Would the hospice have to include this physician in the attending physician locator on the claim? If so, this would unreasonably result in payment denial if the attending physician were not enrolled in or validly opted-out of Medicare. Under a medical review, the reviewer will be looking for a certification from the designated attending physician and there will not be one. Would this result in payment denial? Another scenario that may occur when the designated attending physician is not enrolled or validly opted out is that the hospice could obtain a verbal certification from a different designated attending physician within the required timeframe of two days but is not able to obtain the change in designated attending physician form from the patient or representative (patient death or condition change or representative not available/not responding). Without the patient or representative completing the designated change in attending physician form the hospice would not be able to receive payment.

We understand that CMS is concerned about false certifications of terminal illness. The physician narrative on the written certification of terminal illness is reviewed in CMS' or its contractor's determination of whether the certification of terminal illness is appropriate. Both the hospice medical director (or hospice physician) and the designated attending physician must certify the terminal illness initially and most narratives for the initial certification are completed by the hospice medical director/hospice physician. CMS' concerns about false certification and ensuring that the physicians ordering or certifying hospice care for Medicare beneficiaries are doing so appropriately would still be addressed in the absence of requiring the attending physician to be enrolled or validly opted out of PECOS. In cases where the designated attending physician is employed, contracted, or volunteering for the hospice, he/she will also likely be listed as the certifying physician on the claim, thereby processing through the claim edit. Furthermore, most of the non-hospice physicians designated as the attending physician by patients are enrolled or validly opted-out as part of the requirements applicable to their daily work. Most of these physicians are working in a community practice or CMS-certified facility.

Some hospices currently require that their employed or contracted physicians be enrolled/validly opted-out. Other hospices (mostly smaller ones) employ or contract with physicians who are not enrolled/validly opted out. These physicians are not practicing outside their role with the hospice and, for whatever reason, the hospice and/or the physician do not desire to bill Medicare for their hospice services. Feedback from hospice providers is that most of these physicians would complete the enrollment or opt-out process. However, some physicians have told the hospice that they would not do so and would resign from the hospice. This would be a burden for some hospices as these physicians, if not fulfilling the role of medical director, are the medical director's designee and/or help to cover 24/7 physician services. This raises the question as to whether hospices would be able to employ or contract with a physician or have a physician volunteer if that physician is not enrolled or validly opted out even in cases where the physician does not certify hospice services for Medicare beneficiaries and does not fulfill the role of attending physician for Medicare beneficiaries.

CMS makes clear in the proposed rule that the enrollment requirement would apply only to certifying physicians.

§ 424.507(b)(1) states: "The ordering/ certifying physician, or the ordering/ certifying physician assistant, nurse practitioner, or clinical nurse specialist working in accordance with State law . . .". Under 42 CFR 418.22(b), and as alluded to previously, only a physician (which can include the hospice's medical director) can certify that the beneficiary is terminally ill. We propose to revise

the beginning of § 424.507(b)(1) to state: “The ordering/certifying physician for hospice or home health services, or, for home health services, the ordering/certifying physician assistant, nurse practitioner, or clinical nurse specialist working in accordance with State law . . .”. This would help clarify that § 424.507(b)(1) should not be read to imply that the eligible professionals listed therein can certify the beneficiary’s terminal status.

What is not clear is how CMS would identify when the attending physician is a physician assistant or nurse practitioner and waive the claim from enrollment edits. **NAHC asks CMS to address this in the final rule as well as to identify which resource files/datasets CMS intends to use.**

If this proposal is finalized, hospices will automate the PECOS verification process as other providers have done. For example, CMS provides an Ordering and Referring Physician dataset for providers and their vendors to access to determine if physicians are legally eligible to order and refer in the Medicare program and who have current enrollment records in Medicare that is sourced from the PECOS file. This dataset is updated by CMS twice per week and exists at this location: <https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/order-and-referring> . There are currently columns for Part B, DME, HHA and PMD physicians in this dataset but no column exists for Hospice. Does CMS plan to update this dataset and accompanying documentation (i.e., [Fact Sheet](#)) to include a column for hospice? If yes, there would need to be advance communication on how and when this dataset would be updated to indicate PECOS enrollment with opt-in or out status for hospice physicians and additional time for providers/vendors to implement as of a specified implementation date.

NAHC reminds CMS that electronic medical record (EMR) vendors need time to revise and update their programs to incorporate this process for hospices. This may take several months. Should CMS finalize the proposal as written, there would need to be communication to not just hospices and the physicians they employ, contract with, or who volunteer, but also to all physicians in their community, as they may be designated attending physicians for Medicare hospice patients. It is impossible for hospices to communicate with and educate all non-hospice physicians about new requirements. CMS would need to communicate with these physicians and provide education either directly and/or through the Medicare Administrative Contractors (MACs) for physicians. This will take a significant amount of time, as will recruiting and hiring new physicians, which some hospices will have to do. Likewise, there is time associated with some hospice physicians having to go through the PECOS enrollment or opt-out process, and for all hospices to develop a potential list of alternative physicians and prepare communications to patients explaining the cause for a rejected admission.

In summary, including the attending physician in the proposed enrollment or valid opt-out requirement compromises patient rights, could result in delayed pain and symptom management, unnecessarily burdens the patient/representative, and could have medical review/audit consequences resulting in unreasonable payment denials for hospices and increased resource burden in filing appeals. Hospices employing or contracting with physicians who are not enrolled or validly opted out or have such physicians volunteering may have to recruit and hire new physicians. For all these reasons **NAHC urges CMS to exclude the Medicare hospice patient’s designated attending physician from the PECOS enrollment/valid opt-out requirement and to delay implementation by at least one year until October 1, 2024.**

NAHC reminds CMS that the PECOS files are not always updated timely and are not always accurate. This is a common complaint from providers that must deal with orders and certifications from only enrolled

or validly opted out physicians. NAHC strongly encourages CMS to find a technical fix for this to reduce burden on providers and MACs.

NAHC asks that CMS answer the following questions if the proposal is finalized:

- Must the physician be enrolled/validly opted out for the entire benefit period attached to the certification/recertification?
- How would hospices handle situations where they learn the physician is no longer enrolled? Would they be required to obtain a new certification and, if so, how would this impact the benefit period days and any associated face-to-face encounter timing?

As indicated above, we appreciate the opportunity to comment on the proposed rule and to provide comment on the two important RFIs that CMS incorporated into the rule. If you have questions about our comments, or if we can be of assistance in any way, please feel free to contact us.

Sincerely,



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Vice President, Hospice Policy & Programs



Katie Wehri
Director of Home Health & Hospice Regulatory Affairs



Davis Baird
Director of Government Affairs, Hospice

These comments are also submitted on behalf of the following organizations:

California Association for Health Services at Home

California Hospice and Palliative Care Association (CHAPCA)

Home Care and Hospice Association of Colorado

Healthcare Association of Hawaii

Indiana Association for Home and Hospice Care
Kentucky Home Care Association
Home Care & Hospice Alliance of Maine
Minnesota Home Care Association
Missouri Alliance for Home Care
Nebraska Association for Home Healthcare and Hospice
Home Care & Hospice Association of NJ
Association for Home & Hospice Care of North Carolina
Oklahoma Association for Home Care & Hospice
Oregon Association for Home Care
South Carolina Home Care & Hospice Association
Homecare and Hospice Association of Utah
VNAs of Vermont
Virginia Association for Home Care and Hospice
Wisconsin Hospice and Palliative Care Association