



May 30, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

RE: Comments on the Proposed 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]

Dear Administrator Brooks-LaSure,

The National Partnership for Healthcare and Hospice Innovation (NPHI) is pleased to submit the following comments on the U.S. Department of Health and Human Services (HHS) Proposed Fiscal Year (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].

NPHI is a collaborative of 100+ not-for-profit, community-integrated hospice and palliative care providers dedicated to ensuring patients and their families have access to care that reflects their individual goals, values, and preferences. Representing providers from 38 states and the District of Columbia, NPHI and its members help design innovative and effective models of care, advocate for comprehensive and community-integrated care customized to meet each person's unique needs and build collaboration between national thought leaders and policy makers.

The proposed rule, issued by the Centers for Medicare and Medicaid Services (CMS) on March 31, would provide routine updates to the hospice base payment rates, wage index, and aggregate cap amount for FY 2024. The rule discusses the inclusion of the new Hospice Outcomes and Patient Evaluation (HOPE) tool in the Hospice Quality Reporting Program (HQRP), among other HQRP updates. Additionally, the rule proposes to require hospice certifying physicians to be Medicare-enrolled or to have validly opted-out. Lastly, the rule also contains two Requests for Information (RFIs) related to hospice utilization and spending patterns and health equity.

NPHI recognizes the important and timely changes made in the proposed rule and values the opportunity to offer the unique perspective of not-for-profit providers with respect to these specific proposed changes. We offer additional details and comments on specific policies below.

1. Requests for Information

a. Hospice Utilization; Non-Hospice Spending; Ownership Transparency; and Hospice Election Decision-Making

NPHI appreciates CMS's interest regarding level of care utilization, lengths of stay, live discharge rates, and services rendered outside the hospice benefit for individuals under a hospice election. A few specific comments from the proposed rule stand out to NPHI upon review. CMS indicates

that despite previously rebasing payment rates for the three higher levels of care, there remains a high percentage of hospices that provide little to no continuous home care (CHC), inpatient respite care (IRC), or general inpatient care (GIP). Looking at GIP specifically, CMS data illustrates that more than 56% of hospices provided zero GIP days and of those providers, nearly 83% were for-profit. Additionally, while unrelated to higher levels of care and occasionally justified, CMS finds that for-profit hospices have approximately 22% live discharge rates per year compared to approximately 12% for not-for-profit providers. These two data points strongly suggest a worrisome inclination on the part of many for-profit hospice providers to avoid providing higher level acute and expensive care. This is fundamentally at odds with the intent of the Medicare hospice model which is to provide all four levels of care necessary to palliate a patient's symptoms. The increased cost and acuity of patients more likely to require higher levels of care in hospice, particularly GIP or CHC, have led a subset of providers to artificially manipulate their census mix to suit their desire to maximize profit margin.

NPHI is similarly concerned with these trends, as well as with the rapid increase in unrelated hospice spending. We provide additional information in response to each of the questions posed by CMS below.

- *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?*
 - While NPHI appreciates the intent behind CMS's question, we suggest that the broader issue at hand is related to the requirement that patients revoke all curative treatment related to their terminal illness to elect hospice. This is a well-known barrier to earlier hospice election and inadvertently restricts patients with treatment needs such as those listed in the question from accessing the benefits of hospice while still receiving clinically appropriate palliative treatments. A more holistic recognition and discussion around the possible role hospice could play in expanding access to transitional concurrent care treatments would alleviate limitations on access more than any change to current enrollment policies.
 - Some hospices are unable to accept patients receiving these expensive therapies for financial reasons because the reimbursement is substantially below the costs of providing that care. Also, admissions can be delayed for patients receiving these expensive therapies (which are usually, though not always, curative in nature) while hospice investigates coverage under the hospice benefit.
 - In some cases, providers may avoid admitting these complex patients entirely to avoid covering the costs associated with more acute conditions.
 - Lastly, in some cases it may be difficult for a hospice to gain access to complex therapies or services provided in a facility as opposed to a residential setting (for instance, a hospital or dialysis provider may not be willing to contract with a hospice provider depending on the particular circumstances of the provider's market) thus impacting the patient's ability to access that care when enrolling in a particular hospice.
- *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?*

- Generally, the primary issue is not with enrollment policies but with the structure of the hospice benefit and opportunities to game its reimbursement model as detailed below. However, some NPHI members report that finding continuous care staffing and locations for GIP placement do impact their ability to provide the higher intensity levels of hospice care.
- We are not aware of specific written enrollment policies that would decline to enroll patients that may require high intensity levels of hospice care. However, providers that aim to select low-cost patients to maximize profits have been known to influence their patient mix in several ways, including:
 - Focusing their marketing on settings (e.g., assisted living facilities) that have a high percentage of low-intensity patients.
 - Avoiding marketing in settings with a high percentage of high-intensity patients (e.g., hospitals).
 - For a patient with multiple chronic conditions along with dementia, encouraging practitioners to establish a terminal diagnosis of dementia for hospice and allowing concurrent treatment for other conditions to be deemed as unrelated to the terminal illness and related conditions and thus billed to Parts A and B as unrelated care to avoid hospice liability for the expensive care.
 - Not providing GIP, CHC, IRC levels of care and forcing patients to revoke their hospice election when they need a higher level of care followed by a transfer to a safety-net hospice, hospital ICU, or non-contracted nursing home.
- *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?*
 - NPHI members report that education is provided at admission and on an ongoing basis to patients and families using information from research and conversations with the patient's treating providers. Hospices provide verbal, and when appropriate, written education on the benefits of complex treatments. Hospices discuss that in some cases the burden may outweigh the benefit of certain therapies such as with chemotherapy which causes numerous side effects. As questions arise throughout the course of care, additional education is provided specific to the treatment being considered.
 - CMS has an opportunity to provide additional clarity on the types of curative care that have some legitimate crossover into a palliative treatment regimen to help better inform providers of the nuances between how services should be offered in the hospice context versus for a patient that has yet to elect hospice. That training should extend to its hospice MACs and other contractors (e.g., Supplemental Medical Review Contractor) that at times view such complex palliative therapy as an indicator that the patient is seeking curative care and is not hospice eligible.
- *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?

- Not-for-profit, community-based, safety-net hospices on average serve a higher intensity, shorter length-of-stay patient, and accept these patients without regard to intensity and serve them at all levels of care. These hospices often operate a hospice inpatient unit (IPU) where they can provide GIP level care directly.
- The median length-of-stay for not-for-profits hospices is 17 days. This large proportion of short-stay patients results from a much higher proportion of patients (e.g., cancer patients) who are referred very close to the end-of-life and with a very high intensity of care needs. Many of these patients start hospice care at the GIP level in an IPU. The costs of serving these patients can exceed the payment for the short period of time they are in hospice. As a result, not-for-profit hospices overall have high costs and low profit margins relative to for-profit hospices.
 - If not properly managed, a patient mix made up of too many short-stay, high-cost patients can cause tremendous financial difficulty for smaller, not-for-profit providers. This burden has been exacerbated by the many GIP audits CMS contractors have initiated that have the net effect of discouraging GIP care, even when that care is appropriate, for fear of audits and payment denials that then require costly appeals.
 - It stands to reason that the current targeting of audit and compliance activity focused on GIP eligibility has created an atmosphere in direct contradiction to CMS's stated goal of aiming to increase the utilization of higher levels of hospice care.
- *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?*
 - The rebasing of rates that led to an increase in GIP reimbursement was not sufficiently large enough to motivate hospitals to coordinate with hospices to ensure smooth transitions of patients from the community into the hospital and onto the GIP level of care when appropriate.
 - Additionally, many NPHI members have found that most skilled nursing facilities (SNFs) are unable to provide the level of support necessary for appropriate GIP care because they do not staff with a registered nurse that can provide direct patient care every shift. In states where there is no certificate of need and for-profit hospices are allowed to open many new locations, hospitals find there are too many hospices vying for a contract, and they may decide not to contract with any hospice at all. In those situations, the hospice may have to discharge the hospice patient for being in a non-contract facility.
 - Other barriers to serving these patients include:
 - Hospices that don't provide GIP level of care and transfer patients in need of this care to hospices with an IPU.
 - Inadequate number of hospice IPU beds to account for community need.

- Occupied IPU beds for patients with no safe discharge plan who won't be accepted by a facility and are not eligible for the GIP level of care but continue to reside in the IPU.
 - Aggressive auditing of GIP billing with an arbitrary cutoff at 5 days (a time period first arbitrarily selected by OIG in a prior GIP audit that OIG believed accorded to a "short" stay) or 7 days (a cutoff used by a MAC) that adds to GIP cost and discourages use of GIP with no basis in regulation or statute.
 - SMRC audits that review GIP care provided up to three years prior that result in denials due to the patient not showing enough symptoms or medication changes per the reviewer's opinion. This phenomenon gives no credence to CMS guidance that GIP may be appropriate for monitoring and observation of a patient requiring skilled intervention and care.
- *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?*
 - General feedback:
 - For patients with multiple conditions, some hospices employ the practice of selecting one diagnosis that does not have curative treatment available as the terminal condition (e.g., dementia) resulting in other providers billing Medicare for continued curative treatment for other "unrelated" conditions.
 - Despite repeated education from hospice staff, some patients choose to seek care without obtaining approval from the hospice provider and the hospice is unaware the care was provided.
 - Other provider and supplier types, like DME suppliers, are not required to check a patient's Medicare account to ascertain if a patient has hospice services before billing for services or items provided or are poorly educated on the use of the GW billing modifier. CMS should require other providers to verify benefits and should better educate those providers on their obligations to validate hospice coverage for the item or service instead of placing the onus solely on the hospice provider.
 - Furthermore, hospices would benefit from being able to access Medicare claims data in real time to determine what other provider types are billing Medicare Parts A, B, and D for their patients.
 - Medicare Part B:
 - NPHI members have observed growth in specialized Part B services provided in the community setting. (Example: podiatrist that routinely visits a residential community to provide nail care).
 - Beneficiaries may seek to continue these specialized services and should not be denied this specialized care because they have elected hospice when such routine nail care is unrelated to the terminal illness and related conditions.
 - Facilities may have financial incentives to maximize Part B therapy use that hospices may not be aware of.
 - Providers have seen activity by unscrupulous vendors and consultants attempting to educate hospice billing personnel on how to get specific items

- included in the hospice benefit (e.g., DME and wound supplies) billed to Part B.
- Patients in SNFs often receive services, such as psychotherapy, unknown to the hospice provider until the personal representative calls to ask about copays. We are aware of a situation where a psychotherapy provider refused to cancel claims to Medicare Part B and bill the hospice provider even after the hospice supplied information from CMS that those services should be billed to hospice.
 - The volume of medical equipment vendors preying on unsuspecting Medicare beneficiaries is increasing. They convince a patient that it is acceptable for them to provide services such as continuous glucose monitoring, portable oxygen, a motorized wheelchair, etc. Those services are billed to Part B and the hospice is not aware of this until they see the equipment or devices in the hospice patient's home.
- Medicare Part D:
 - Hospices continue to see situations where the SNF pharmacy provider ignores communication from the hospice and submits claims to Part D. With repeated education, some hospices have seen improvement as evidenced by PEPPER data, but pharmacy providers need to do more from their end to validate if certain drugs are appropriate and billable to Medicare Part D sponsors.
 - Real time adjudication in the Part D pharmacy benefit would enable Part D sponsors to expand its payment edits for prescription drugs furnished to hospice enrollees. This may take additional investment by Part D Plans and their pharmacy benefit managers and may require indirect funding by CMS for those enhancements.
 - Hospice may deem a medication not part of the plan of care (e.g., statins for end-stage heart disease patients) and inform the patient they will have to pay for the medication. Instead, the patient has the medication filled at the pharmacy as they always have and seek Part D coverage for the drug. Some patients do not disclose this when the nurse performs medication reconciliation.
 - *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?*
 - Hospices could be required to provide education about their pharmacy formulary offerings, if applicable, and costs for non-formulary drugs and supplies.
 - CMS can provide more information to beneficiaries about the palliative nature of hospice care, what services may be aggressive, and the importance of coordinating all care with the hospice provider to ensure they are informed of all ongoing treatments, therapies, or services.

- *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?*
 - NPHI members report that approximately 5-10 percent of hospice patients are requesting the notification. NPHI recommends that CMS not require expanding access to the hospice non-covered information to all patients automatically. Even utilizing the CMS-provided addendum and election statement, as it stands now, patients do not seem to perceive the information as important or helpful.
- *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?*
 - Yes, this information should be displayed on Care Compare and be accompanied by detailed explanations of what each measure means in practice for the patient. CMS should take careful consideration to ensure consumers are informed of the rationale behind the legitimate differences that might exist between the staffing levels of one hospice and another (particularly with regard to non-profit providers).
 - Additionally, we would suggest that CMS consider adopting the recommendations (item #17) first shared with CMS in January and developed by a group of leading national hospice advocacy organizations that deal with Care Compare and informed decision-making.
- *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?*
 - NPHI members report that an avenue for communication between the hospice and the pharmacy or Part D sponsor would be beneficial. The letters that some pharmacies send with lists of covered medications for hospice patients provide an opportunity for providers to correct any discrepancies but should be timelier and more consistently comprehensive. It may be three years before the Part D sponsor's vendor contacts the hospice about refunds, notwithstanding the real time adjudication and information available to the Part D sponsors.
 - CMS can continue to support the efforts of the Hospice Workgroup of the National Council for Prescription Drug Programs (NCPDP)/RelayHealth to facilitate a process for electronic communication of hospice election to the Part D plan sponsors. This will automate the process and avoid unnecessary edits or prior authorizations processes.
- *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?*
 - This information is now available following the April 4, 2023, HHS announcement regarding hospice ownership data. NPHI applauds this important step and recommends that CMS take additional steps to curtail fraud, waste, and abuse in

the hospice industry by implementing the **recommendations** first shared with CMS in January and developed by a group of leading national hospice advocacy organizations.

- Note that NPHI members have found many errors in CMS's recently released ownership data and information. Not-for-profit hospices are frequently listed as for-profit and efforts between hospices and various agencies including QIES and the MACs have not resulted in data errors being corrected in a timely manner.

b. Health Equity Under the Hospice Benefit

- *What efforts do hospices employ to measure impact on health equity?*
 - Many hospices track demographics closely and compare patient populations to the demographics of their community by reviewing enrollment data to ensure it's congruent with the census demographic data of their service area.
 - Assessing CAHPS satisfaction scores based on language and other factors.
 - Many hospices screen new referrals for SDOH needs (food insecurity, lack of transportation, etc.). They then try to connect patients with community-based organizations to alleviate those concerns. Some hospices may track the connections made to follow up on their impact to patients and families.

- *What factors do hospices observe that influence beneficiaries in electing and accessing hospice care?*
 - The role of faith-based communities in the patient's life and the reality that trust and safety in medical settings needs to be built through different spheres of influence in the community, including:
 - Ethnic community organizations.
 - LGBTQ+ advocacy and engagement organizations.
 - Other community touch points.
 - Additional factors include:
 - Lack of easily accessible and culturally competent information about what hospice is and the value it provides.
 - In communities where hospice has not been widely utilized there are residual downstream impacts in the form of decreased opportunities to learn about the service through friends and family who have experienced it with their loved ones.
 - The availability of services such as on-call nursing and hospice aides which make up the majority of quantitative demands by the average patient and their family.
 - Lack of access to lifelong medical care and payment for that care.
 - Lack of healthcare providers who are informed and understand the benefit of hospice care and can recognize a terminal condition.

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

- Concentration of hospice organizations within a certain mile radius, or by county or state, keeping in mind the inherent differences in the number of hospices needed to effectively serve diverse geographic areas.
- *What information can CMS collect and share to help hospices serve vulnerable and underserved populations and address barriers to access?*
 - CMS should consider disseminating information on the breakdown of total Medicare beneficiaries compared with those electing the hospice benefit by race, poverty rates/average income (using zip codes), and education level within individual service areas.
- *What sociodemographic and SDOH data should be collected and used to effectively evaluate health equity in hospice settings?*
 - Utilize community needs health assessment data publicly available from county and/or regional health systems.
 - Hospices can track their enrollment data against this baseline and then compare themselves against it over time.
 - Poverty rates/average income of patients should be analyzed due to possible impact on the cost of caring for these patients. Low-income patients may utilize more resources because they may have less informal/family support or privately paid support. These discrepancies may also impact CAHPS scores.
- *What barriers do hospices face in collecting information on SDOH and race and ethnicity? What is needed to overcome those barriers?*
 - Standardized tools and agreed upon best practices for what data to collect and how to do so is needed. Electronic health record vendors need to have standardized data elements.
 - National CLAS standards could be utilized as a framework – the lack of a national consensus limits providers from pursuing innovative collection efforts.
 - Short length of stay can impact ability to collect data. There is already too much information that needs to be collected at the start of care, and this can be exhausting and overwhelming for patients and families at a time of immense difficulty. Also, some patients and families may be hesitant to disclose information related to their SDOH.
 - Providers also often lack comfort in discussing these issues with patients and families for fear of making a wrong step or alienating individuals during early meetings when this data is most likely to be gathered.

2. Proposed FY 2024 Hospice Payment Update Percentage

CMS is proposing a 2.8% proposed rate increase for hospice providers for FY24. However, a 2.8% increase does not constitute a sufficient increase to adequately support the care and additional costs that not-for-profit hospices provide to their patients and communities. Among a multitude of challenges, not-for-profit providers are facing elevated overhead and personnel costs due to

inflation and record-high workforce shortages, particularly among nurses. Given the immense community benefit that not-for-profit providers offer and their demonstrated history of providing the highest quality of care to those facing end-of-life, a more substantial payment increase is warranted. CMS could consider a one-time forecast error adjustment, annual adjustment, or utilize any other authority it possesses to modify payment rate methodology to better account for the impacts of heightened inflation and ongoing workforce challenges that materially impact NPHI member hospices that provide high quality end of life care.

As Medicare beneficiaries increasingly choose hospice at the end-of-life, the CMS should take all reasonable steps within their power to fund high quality providers at a rate that will support their long-term financial and operational sustainability.

3. Establishing Hospice Program Survey and Enforcement Procedures Under the Medicare Program; Provisions Update (CAA 2021, Section 407)

NPHI has been and continues to be strongly supportive of the hospice special focus program (SFP) technical expert panel (TEP) that has been tasked with providing input and guidance to CMS on the development of this new program integrity tool. NPHI provided staff that participated on the TEP and we look forward to thoughtfully reviewing the SFP when it is proposed in future rulemaking.

4. Proposals Regarding Hospice Ordering/Certifying Physician Enrollment

Given clear instances of program integrity concerns in the hospice benefit and the role that the hospice certifying physician plays in both the initial and ongoing certifications of hospice eligibility, NPHI is supportive of the change to require the hospice certifying physician to be enrolled with Medicare or properly opted out. However, NPHI is concerned about the inclusion of the patient's attending physician as part of this proposal. Concern arises primarily from the fact that hospice patients are given the right to choose their attending physician who must also certify the patient's initial eligibility for the hospice benefit. Requiring that attending physician, who may have no contractual connection to hospice, to be enrolled or validly opted-out may compromise the patient's rights and complicate the hospice enrollment process by forcing patients to choose a different attending physician at a time of transitions between care. As such, NPHI would suggest that CMS remove the patient's attending physician from this requirement.

Additionally, NPHI suggests that if this proposal is finalized, it is done so in a manner that clarifies that both the hospice and attending physicians do not need to be hospice and palliative medicine specialists (as it relates to their PECOS enrollment application) to enroll or validly opt out and certify a patient for initial hospice eligibility. If the rule is finalized and enrollment is set to verify that hospice is a type of service the physician provides (based on how they filled out their PECOS application) it could result in unnecessary delays in patient care as hospices scramble to go back to the patient to explain that their designated attending is not able to fulfill this role and obtain certification/orders from a different attending.

Lastly, we would also highlight that while this constitutes a commonsense step forward by providing CMS with the ability to aggressively target physicians involved in fraudulent behaviors, this action alone is not sufficient to address the ongoing fraud, waste, and abuse issues impacting

the Medicare hospice benefit. We refer CMS to the comprehensive list of program integrity reform recommendations linked above.

Conclusion

Thank you again for the opportunity to provide comments on CMS's proposed regulation regarding the FY 2024 Hospice Wage Index and Payment Rate Update. As always, NPHI appreciates the opportunity to provide insight and commentary into how various proposed regulatory, compliance, and quality reporting changes may impact the not-for-profit hospice and palliative care provider community. If you have any questions concerning these comments or would like to discuss these issues further, please contact NPHI's Policy Director, Ethan McChesney, at emcchesney@hospiceinnovations.org.

Sincerely,

A handwritten signature in black ink that reads "Tom Koutsoumpas". The signature is written in a cursive style with a large, sweeping initial "T" and "K".

Tom Koutsoumpas
Founder and CEO
NPHI