August 29, 2023

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

RE: Comments on the Proposed Calendar Year 2024 Home Health Prospective Payment System Rate Update [CMS-1780-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 Calendar Year (CY) 2024 Home Health Prospective Payment System Rate Update.

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 37 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 June 30th, primarily focuses on routine updates for home health providers. However, it also includes information relevant to hospice providers, specifically the implementation of the hospice special focus program (SFP) and various proposals related to hospice provider enrollment and program integrity.

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. Hospice Informal Dispute Resolution

NPHI supports the proposed process to allow a hospice with a Condition-Level Survey finding to resolve disputes related to the findings informally and allow for continued participation in the Medicare program. This will save time and financial resources for all parties involved as noted by CMS.

However, NPHI requests that there be a defined timeframe implemented for CMS, the Survey Agency (SA), or the Accrediting Organization (AO) to review the IDR and render a decision. CMS states, “Additionally, we propose that failure of CMS, or the State or the AO, as appropriate, to complete IDR must not delay the effective date of any enforcement action.” The IDR should be reviewed in a reasonable timeframe, perhaps 14 days, so that enforcement action can be halted

if the Condition Level Deficiency (CLD) is removed. Of course, any type of immediate jeopardy circumstances should not be delayed by this timeframe.

2. Hospice Special Focus Program

NPHI appreciates CMS sharing details of the proposed implementation of the hospice SFP. We thank CMS for listening to stakeholder feedback and convening a technical expert panel (TEP) to inform the development of the SFP where non-profit, mission-driven provider voices were heard. NPHI was joined by other leading hospice organizations in sending a ***letter*** to CMS on July 16th which outlined various concerns related to the SFP and the elements included in the proposed algorithm. Below are questions and points of clarification intended to echo and build upon the comments included in that letter; however, despite these concerns, we remain broadly supportive of the SFP concept and hope that it will have a meaningful impact on improving the performance of poor-preforming hospices providing care under the Medicare hospice benefit.

Our primary apprehension with the proposed hospice SFP concerns the factors included in the algorithm used to identify and select hospices for eligibility. CMS proposes to use survey data, both standard and complaint, along with CAHPS and Hospice Care Index (HCI) data to determine eligible hospices for the SFP. We have concerns that many hospices will not be included in the calculation and that hospices that have large average daily censuses (ADC) will be disproportionately and unfairly categorized as poor performers merely due to their size. Given the ongoing program integrity and quality challenges facing the hospice community and the preponderance of those concerns among hospices that disproportionately do not report CAHPS data, it is especially alarming that the algorithm weights said data so heavily. Why did CMS choose to have hospices not reporting CAHPS data be excluded from the algorithm despite these providers being more likely to have substantiated complaints and would CMS consider utilizing the same algorithm that identified over 300 poor performers to see if survey data alone would yield the low performers the OIG identified[1]?

The success of the SFP is crucial to ensuring the Medicare hospice benefit remains a trusted option for patients and families as they experience advanced illness. As currently constructed, we worry the proposed SFP algorithm would not only miss the opportunity to improve truly poor-performing hospices, but also could further burden those already undergoing rigorous audit scrutiny. Broadly speaking, while supportive of the program, **we ask that CMS work with the existing SFP TEP to improve the SFP algorithm, pilot the new algorithm prior to its application to hospices, and implement an interim performance report where all providers are given reports of their performance ranking under the algorithm metrics. This may require a delay in implementation and that CMS issue a new proposed rule with the modified algorithm to give stakeholders the opportunity to comment**. Below are specific concerns and associated questions for each element of the algorithm:

- **Quality of Care Condition Level Deficiencies (CLDs) Surveys**: CMS calculated that 88.3% of hospices had no quality-of-care CLDs cited over the 3 years considered, CY 2019-2021. CMS stated that those hospices had either not received their survey, not received results, or there were no findings. We ask that CMS look at those hospices and use their

[1] https://oig.hhs.gov/oei/reports/oei-02-17-00020.asp?utm_source=mmpage&utm_medium=web&utm_campaign=OEI-02-17-00020

last survey on file. Some SAs and AOs are not surveying every 36 months despite current requirements to do so, meaning that it has been 4+ years since some providers were surveyed. This creates the potential for an unequal distribution of survey reviews nationwide. Additionally, we ask that CMS provide additional information regarding:
    - Are there any trends in the states where these hospices are located?
    - Are the hospices that have not experienced surveys consistent with statute located in states where the SA is understaffed? If so, has CMS considered any corrective or supplemental action to address these issues?
    - Would CMS consider scaling the size of the program to the number of complaints received? Common sense dictates, and the TEP suggested, that a provider with an ADC of 250 is more likely to receive a CLD than one with an ADC of 50.
- **HCI Overall Score:** Approximately 22% of hospices did not have a publicly reported HCI score according to CMS.
    - How many of those hospices are also not captured by the CAHPS data?
    - How many of those hospices also did not have survey data during the timeframe proposed?
- **CAHPS Data:** More than 50% of hospices did not report CAHPS data. Given the importance of CAHPS data in the proposed algorithm and the number of hospices not reporting it, we request that CMS determine a methodology for capturing providers not reporting CAHPS data for their inclusion into the algorithm or consider providing additional credit to those hospices that do have a publicly reported CAHPS score. Additionally, the decision to double weight the CAHPS score for purposes of the algorithm may have the inadvertent impact of biasing the algorithm to those that do report this data and could incentivize hospices to not participate in the CAHPS Hospice Survey and simply accept the four percent payment cut as an acceptable cost of doing business.
    - How many of those hospices were not represented by the survey (CLDs or substantiated complaints) data or HCI scores?
- **Complaints with Substantiated Allegations:** Some patients and families do not know they are receiving poor quality care and may find it acceptable for a provider to take 2+ hours to return a call or to go weeks without a visit. Without regular surveys every 36 months, poorly performing hospices can fly under the radar. Additionally, some State Survey Agencies automatically log a Discharge for Cause as a complaint which can trigger additional surveys in some states.

CMS states they propose to report information on hospice programs on "at least an annual basis" on a special website. We ask that CMS provide updates regularly, more than just annually, so that hospices do not stay on the SFP list once they are cleared. Ideally, the list needs to be updated monthly. Additionally, some hospices have found that their data, especially the results of their surveys, are incorrectly being publicly reported. We ask that providers be given an opportunity to validate the accuracy of their data prior to its inclusion in the algorithm and have the chance to correct it as appropriate. This could take the form of a preview period that allows hospices to learn they are at risk of being selected so they can take corrective action or CMS could provide individualized reports similar to how they provide PEPPER enabling hospices to benchmark themselves against others.

We share the concerns of stakeholders that have expressed frustration about inter-surveyor reliability and state-to-state variability in surveys. Some focus heavily on the plan of care, which may lead to a CLD, while others are more lenient and focus on other areas. A hospice using the same electronic medical record and workflow processes can have two very different survey experiences and outcomes in two different states. Some SAs or AOs are not adding additional disciplines and will have only RNs doing surveys. Others will have pharmacists, social workers, and other disciplines which will shift the areas of focus for surveyors. These discrepancies can lead to variances in survey findings. We request that CMS require more uniformity in the surveyor disciplines and monitor survey findings across SAs and AOs to identify trends with higher or lower numbers of CLDs by SA, AO, and/or surveyor disciplines involved.

Lastly, the lack of consistent staffing across SAs and AOs could have the inadvertent effect of delaying the timely surveying of providers as is prescribed in the proposed rule thereby making it more difficult for a provider to graduate from the SFP. We worry about the possibility of providers getting "stuck" in the SFP through no fault of their own because of these challenges. CMS should take action to ensure providers who graduate from the program are removed from the program in a manner consistent with the proposed timeframe.

3. Health Equity

NPHI and our members strongly supported the creation of a TEP to examine the possibility of a potential future health equity structural composite measure as part of the hospice quality reporting program (HQRP). We look forward to working with CMS to support the development of such a measure in a manner that effectively identifies gaps in care, differences in outcomes, and accessibility concerns. Additionally, the measure should appropriately incentivize providers to implement initiatives to expand access to care to underserved populations.

4. Provider Enrollment Changes

a. Categorical Risk Designation – Hospice

We support the decision of CMS to elevate the risk screening of new hospices and those submitting applications to add new owners from moderate to high given the growing number of program integrity concerns shared by the hospice community and summarized by CMS. However, we are concerned with the resource burden placed on the SAs to complete the assigned tasks associated with the elevated screening level as some states are already dealing with staffing shortages that are delaying standard survey activity. Given that the effectiveness of the elevated screening is in large part dependent on timely screening and intervention, we ask that CMS consider what, if any, supplemental support is necessary for SAs to conduct this oversight successfully.

b. Hospice 36-Month Rule

Likewise, having seen the result of the 36-month rule on the proliferation of home health providers in past years, we support the application of the 36-month rule in hospice. Specifically, this rule will carry more weight if the new hospice is concurrently required to maintain an active census during that time period allowing for the ongoing monitoring of hospice care provided. We also support the inclusion of hospice in the existing exceptions allowed for home health providers.

c. Definition of "Managing Employee"

We believe the clarification that both the facility administrator and medical director must be disclosed as managing employees on an enrollment application is worthwhile as we frequently hear that these individuals are making the daily operational decisions until the hospice has achieved its initial certification. We believe the inclusion of those who are also indirectly managing the organization should begin to help identify those "consultants" who are simply seeking to exploit the system on behalf of an owner.

Conclusion

Thank you again for the opportunity to provide comments on CMS's proposed regulation regarding the CY 2024 Home Health Prospective Payment System 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,

Tom Koutsoumpas
Founder and CEO
NPHI