



May 28, 2024

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 FY 2025 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements Proposed Rule [CMS-1810-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) FY 2025 (FY25) Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements proposed rule.

NPHI is a collaborative of over 100 non-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 28, would provide routine updates to the hospice base payment rates, wage index, and aggregate cap amount for FY25. NPHI understands the rule proposes to adopt the most recent Office of Management and Budget (OMB) statistical area delineations and proposes to clarify current policy related to the hospice "election statement" and the "notice of election" (NOE), as well as adding clarifying language regarding hospice certification. Additionally, the rule proposes the new Hospice Outcomes and Patient Evaluation (HOPE) collection instrument, two HOPE-based process measures, and specifies other updates to future quality measures (QMs). Lastly, the proposed rule includes two Requests for Information (RFIs) regarding implementing a separate payment mechanism to account for high-intensity palliative care services and the potential development of future social determinants of health (SDOH) focused QMs.

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. Proposed Routine FY 2025 Hospice Wage Index and Rate Update**

NPHI appreciates the proposed 2.6 percent increase for providers included in the proposed rule. However, for NPHI's non-profit member programs, whose average profit margin according to the

most recent Medicare Payment Advisory Commission (MedPAC) Report to Congress is 5.2%<sup>1</sup>, this increase woefully underfunds the providers more likely to care for the most acute patients who often have shorter stays on hospice. According to MedPAC, hospice profitability is closely related to length of stay and hospices with longer stays have higher margins. Specifically, MedPAC has stated that “for-profit hospices have substantially longer average lengths of stay than non-profit hospices (113 days compared with 70 days, respectively, in 2022). For-profit hospices have more patients with diagnoses that tend to have longer stays, but they also have patients with longer stays than non-profit hospices for all types of diagnoses.” Medicare claims and HQRP data illustrate that non-profit providers on average have significantly higher costs compared to for-profit providers while delivering higher quality care due in part to the fact that they care for more acute patients<sup>2</sup>. All the while the average for-profit provider is reaping a near 20% profit margin out of the current benefit. This is an unsustainable fiscal trajectory for the benefit and the Medicare program. Moving forward, CMS should consider how to better adjust reimbursement rates to match patient needs and associated costs to providers while disincentivizing the ability to self-select lower cost patients.

NPHI is generally supportive of CMS’s effort to implement new OMB labor market delineations. We also appreciate prior rulemaking by CMS that established a floor on negative year-over-year changes in the current wage index at 5%. However, problems still persist with the hospice wage index writ large. Medicare per diem payment amounts to hospices are adjusted annually using a wage index to reflect changes in the cost of labor. CMS bases the wage index for each geographic area on the change in the cost of labor for area hospitals relative to the change for all hospitals nationally, as described in the proposed rule. For several reasons, the resulting annual payment adjustments for hospices often do not reflect the reality of the labor cost increases that hospice providers experience. NPHI members are non-profit hospices with little or no margin, they are especially vulnerable to reimbursement updates that do not reflect their own costs. Yet, too often, non-profit hospices -- small or large, urban or rural -- receive anomalous payment adjustments that are driven by conditions at area hospitals unrelated to the cost of their own labor. Moreover, they are forced to compete with much better resourced segments of the healthcare industry for the same pool of skilled providers.

Medicare’s hospital-based wage index has been an acute problem for many hospices for several years. One such example is that of HopeWest, an NPHI member located on the Western Slope of Colorado. HopeWest has cumulatively received \$8.5 million less in revenue from 2013-2023 for hospice patients residing in Mesa County, considered urban by OMB delineations, compared to what they have received if they cared for the same patient but in adjacent rural counties such as Montrose and Delta. Mesa County is the only county on the Western Slope considered urban for purposes of the hospice wage index. Mesa County has four hospitals each with different reimbursement mechanisms (hospital-specific exclusions, exemptions, designations, etc.) which contributes to the difficulties in utilizing hospital cost reports to determine the wage index value for hospices in Western Colorado. Conversely, in many parts of the country, rural rates end up being calculated significantly lower than urban rates. That leads to significant financial impacts on

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<sup>1</sup> [https://www.medpac.gov/wp-content/uploads/2024/03/Mar24\\_Ch9\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch9_MedPAC_Report_To_Congress_SEC.pdf)

<sup>2</sup> [https://www.hospiceinnovations.org/wp-content/uploads/2020/05/Hospice\\_Medicare\\_Margins\\_NPHI\\_7-2019-1.pdf](https://www.hospiceinnovations.org/wp-content/uploads/2020/05/Hospice_Medicare_Margins_NPHI_7-2019-1.pdf)

hospices with broad geographic service areas due to the inherent need for additional drive time and corresponding travel costs. This also contributes to staffing challenges since it can be harder for a hospice to budget for higher salaries when travel expenses are greater. These are just two of the many examples of anomalous wage index calculations shared with NPHI by member programs in recent years.

In 2007, MedPAC recommended an alternative wage index method that Congress failed to adopt which would have more-accurately reflected labor costs among distinct types of providers. Since then, the anomalies and inequities have only grown worse. In June 2023, MedPAC again recommended an alternative hospital wage index methodology that would more adequately reflect geographic differences in labor costs and provide more equitable results across provider types by unbundling the wage index for different provider types from the hospital wage index.

**Since the goal of this recommendation is to separate payment to hospices and other non-hospital providers from the hospital wage index, NPHI recommends that separation and reform proceed now – on a separate schedule from the reform for the hospital wage index overall given the complexities associated with the MedPAC proposal.** We understand statutory change is required to actualize this proposal; however, we nevertheless welcome CMS's perspective and appreciate the opportunity to offer commentary on an issue of critical importance to NPHI's non-profit membership.

## **2. Proposed Clarifying Regulation Text Changes**

### **a. Medical Director Condition of Participation**

**NPHI broadly supports this clarification in the regulatory text. In addition to this proposed modification, we suggest that any other place in which there is misalignment between the CoPs and the payment requirements regarding the distinction between medical director and physician designee be modified as well.** For instance, 418.26 (b) Discharge order states that “prior to discharging a patient for any reason listed in paragraph (a) of this section, the hospice must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.” Additionally, to ensure clarity, we recommend a small change (the inclusion of the word “designee”) in the beginning paragraph of § 418.102. We believe that the addition of this word will reference the definition of physician designee in § 418.3 and avoid confusion.

CMS has defined a Physician designee to mean a “doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available.” There is no logical reason that the physician designee should not also be able to provide a discharge order as detailed above. Moreover, as with the proposed clarification below, we believe any hospice physician should be allowed to provide a discharge order assuming they have consulted with the interdisciplinary team as appropriate.

### **b. Certification of Terminal Illness and Admission to Hospice Care**

**NPHI supports this proposed clarification.** However, we note that the language in both (a) and (b) does not include the “physician member of the interdisciplinary group” and we question why this

language does not mirror other changes in regulatory text in this proposed rule. The language in question does appear in § 418.102. We also recommend that “or the physician member of the IDG” be added to § 418.25 (a) and (b) to avoid ongoing confusion about the hospice admission process.

Generally, we wish to note that the hospice medical director may be unavailable due to their wide range of operational, clinical, and administrative oversight responsibilities. These responsibilities could include operational planning, staff education, budgeting, policy development, and quality improvement. The medical director may also manage other lines of service such as community-based palliative care which can divert their attention from being solely focused on new hospice admissions. Medicare beneficiaries considering the election of hospice are entitled to and often in need of an immediate assessment to determine eligibility and interventions to alleviate uncontrolled symptoms. Therefore, it stands to reason that any hospice physician member of the interdisciplinary team should be able to certify terminal illness and admission to hospice care, not just the physician designee. This is in line with the CoPs at 418.64(a) that outlines Physician Services as being provided by the “hospice medical director, physician employees, and contracted physician(s) of the hospice.” We ask that CMS allow this same set of physicians to provide all patient care services and orders, including, but not limited to admission, certification, medical care, and discharge. The medical director would continue to have responsibility for supervision of all hospice physicians.

### c. Election of Hospice Care

**NPHI supports the clarification of the terminology as one term is used to reference billing and the other is to assure patient and family understanding of what a hospice election means.** We do however wish to address CMS’s comments related to the hospice election statement model example. NPHI members are overwhelmed by “technical” audits and payment denials based off trivial differences in the model form and the form a provider may choose to implement in practice. For instance, our members have experienced denials centered on nuances related to the inclusion of specific BFCC-QIO language, not having specific wording around aspects such as “exceptional and unusual” or cost savings, and election statements signed but missing a date such as that of the hospice admission nurse. **We implore CMS to rectify this misallocation of resources by reaffirming to the MACs that the model election statement is just that – a model – and that there is flexibility in how providers organize their statement.**

## 3. RFI on Payment Mechanism for High Intensity Palliative Care Services

### Summary

NPHI appreciates the solicitation of feedback regarding this topic and the questions posed by CMS. The current status quo in which patients are often discharged upon their provider incurring increasing costs and complexity of care only to be transferred to an NPHI member provider with an open access policy or readmitted into a hospital is not how the hospice benefit is intended to be applied. Likewise, we recognize and appreciate that even some of the most well-meaning providers do not always have the financial and operational wherewithal to provide these high intensity services due to a lack of staffing capacity, clinical expertise, or insufficient reimbursement to cover the costs associated with the care. Nevertheless, it has long been the case that non-profit hospices disproportionately tend to care for the sickest patients who often require the types of

high-intensity services referenced in the proposed rule. **To reflect this reality, CMS should consider the following overarching comments:**

- The nature of who receives care from hospice and what care they require has evolved significantly over recent decades. Meanwhile, the Medicare hospice benefit has remained largely the same. Providers need enhanced and targeted reimbursement to deliver treatments that are not adequately reimbursed under the current per-diem structure.
- Certain hospices, for instance, those operating in rural areas with limited census size, will face increased difficulty in attracting qualified staff, partnering with other providers to deliver certain services (such as dialysis), and achieving the scale necessary to facilitate a financially viable delivery of the high-intensity services envisioned by CMS in the proposed rule.
- Speaking globally in regard to the Medicare program, there are likely savings to be found in enhancing reimbursement to hospices for these high-intensity services due in part to the fact that under the status quo many patients continue to receive these services but delay electing hospice due to the misunderstanding that hospice won't cover them or the hospice simply being unable to afford them. Thus, the Medicare program does not benefit from the patient electing hospice earlier in their disease progression and transitioning from intensive treatments earlier than they otherwise would have if they had a better understanding of what was covered under the hospice benefit or Medicare more appropriately reimbursed providers for the services.
  - Such reimbursement would allow hospices to transition patients earlier, allowing them to receive assistance with their end-of-life goals of care and providing them with the ability to make an informed decision about continuing curative care.
- CMS would need to revise the aggregate cap calculation process so that the additional reimbursement for higher-intensity services is not included in the calculation.

**RFI Responses:**

- a. What could eliminate the financial risk commenters previously noted when providing complex palliative treatments and higher intensity levels of hospice care?

**NPHI believes that more robust reimbursement to support the costs associated with delivering high-intensity services will reduce some of the financial risks that hospices would experience.** We discuss several aspects of this in the comments below.

- b. What specific financial risks or costs are of particular concern to hospices that would prevent the provision of higher-cost palliative treatments when appropriate for some beneficiaries? Are there individual cost barriers that may prevent a hospice from providing higher-cost palliative care services? For example, is there a cost barrier related to obtaining the appropriate equipment (for example, dialysis machine)? Or is there a cost barrier related to the treatment itself (for example, obtaining the necessary drugs or access to specialized staff)?

The most common higher-cost palliative treatments that place financial burdens on hospice providers include but are not limited to the following: blood transfusions, palliative radiation, palliative chemotherapy, paracentesis, kidney dialysis, parenteral nutrition, negative pressure

wound vacuum, pleural catheter drain, celiac plexus block, intrathecal pump refills, Trilogy non-invasive ventilator, inotrope infusions, and expensive drugs and biologics.

- Often these treatments are contracted out to hospitals or specialty care providers. This can lead to cumbersome contracting and billing practices that may be unavoidable for some providers based on their own internal capabilities to provide these services and the availability of them from other providers in their service area. Or in some situations, the hospitals or specialty care providers will not contract with hospices because they cannot accept the low reimbursement that hospice can afford to pay. Hospices will need additional reimbursement to offset the expense of training staff on the technology, treatments, and interventions. Ongoing education will be needed to ensure staff understand the potential side effects and adverse reactions that various treatments can cause and to maintain skillsets as technology changes.

Additionally, medications covered by Medicare Part D prior to hospice election continue to prove challenging for hospices to manage. Many of the new treatments for conditions such as ALS, Parkinson's, cancer, Alzheimer's Disease, and others are extremely expensive. For instance, Nuplazid is a new atypical antipsychotic that can treat hallucinations. At \$3400 per month, a hospice in a Rural CBSA would spend 70-75% of its monthly reimbursement on this one medication. Other drugs can end up costing more than a hospice's entire monthly per diem. For example, some immunotherapy treatments may have a legitimate palliative use case, but the cost for one drug could be upwards of \$8000 making it cost-prohibitive to provide to patients when reimbursement does not match the cost. Palliative chemotherapy tends to be astronomically expensive, sometimes tens of thousands of dollars a month, so this is a treatment that even large hospices cannot afford to cover. Hospices receive requests for intravenous antibiotic therapy that may need to be administered for 3-6 weeks to treat infections such as endocarditis. The costs of the drugs, supplies, and frequent nursing visits is cost prohibitive.

- c. Should there be any parameters around when palliative treatments should qualify for a different type of payment? For example, CMS is interested in understanding from hospices who do provide these types of palliative treatments whether the patient is generally in a higher level of care (CHC, GIP) when the decision is made to furnish a higher-cost palliative treatment? Should an additional payment only be applicable when the patient is in RHC?

Most of these services are provided in the patient's home or the place of residence at the RHC level. However, there are cases in which a patient could be receiving the GIP level of care over a short period of time to receive care that can only be provided in an inpatient setting. Delivery of these services would necessitate additional staff time, equipment, supplies, etc. Similarly, the reimbursement for CHC would be inadequate to cover the cost of high-tech equipment, blood transfusion-related expenses, etc. As such, payment for these services should not be adjusted by level of care unless CMS identifies inappropriate patterns of increasing GIP utilization for patients who could be managed at home even with the provision of the more intensive services.

- d. Under the hospice benefit, palliative care is defined as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering (§ 418.3). In addition to this definition of palliative care, should CMS consider defining palliative services, specifically regarding high-cost treatments? Note, CMS is not seeking a change to the definition of palliative care, but rather should CMS consider defining palliative services with regard to high-cost treatments?

NPHI acknowledges that there needs to be a definition of an area of therapy that would normally be considered part of ongoing curative or life-extending treatment, is intensive and/or high cost and that hospices would not normally be expected to provide within the per diem and might otherwise necessitate a hospitalization, and that would be determined by the hospice or attending physician to be necessary to provide in certain cases for palliation (to ameliorate pain or discomfort). The definition should not specify particular drugs, DME, or other therapies, but provide for the circumstances that would allow for separate billing for these items based on the clinical judgment of the clinicians on the IDG.

- e. Should there be documentation that all other palliative measures have been exhausted prior to billing for a payment for a higher-cost treatment? If so, would that continue to be a barrier for hospices?

NPHI believes that the rationale for billing for a higher-cost treatment should be documented in the record but that the provider should not be required to exhaust other palliative measures. These claims should be subject to audit oversight to determine any inappropriate patterns of treatment. However, subjecting them to retrospective audits questioning the clinical appropriateness of providing one treatment instead of another furthers a chilling effect on providing the services at all. We recommend that the services and drugs that will be eligible for enhanced payment be reported separately instead of being lumped together as one item on the claim (as is currently standard practice for medications). Moreover, given the time sensitivity with which care is often provided for patients at the end of life, it is not always appropriate to exhaust all “other palliative measures.”

- f. Should there be separate payments for different types of higher-cost palliative treatments or one standard payment for any higher-cost treatment that would exceed the per-diem rate?

For almost every service referenced above or conceived of under this RFI there is an existing CPT or HCPCS code tied to it and payment differences should reflect the reimbursement differences currently existing for those services. In general, any reimbursement modifications should consider the cost of delivering one service compared to another. Unless CMS intends to create a case-mix adjustment, then separate payments would be necessary to adequately account for cost variation among higher intensity services.

#### **4. Proposals to the Hospice Quality Reporting Program (HQRP)**

NPHI appreciates the ongoing commitment of CMS to improve the quality of hospice care and agrees that the Hospice Outcomes and Patient Evaluation (HOPE) Assessment Instrument can yield patient-level data to gain insight into care provision and to inform future quality measure development. **We would like to see continued initiatives to develop outcome measures and**

suggest discontinuing collection of some of the Hospice Item Set (HIS) measures instead of rolling them into the HOPE tool because they are a snapshot of a single point in time and are not indicative of patient outcomes.

**a. Proposal to implement two process quality measures based on proposed HOPE data collection**

NPHI prefers the development of outcome measures but understands that current collection tools do not lend themselves to this type of measure. The addition of *Timely Reassessment of Pain Impact* and *Timely Reassessment of Non-Pain Impact* will determine how many patients assessed with moderate or severe pain impact at one of three data points were reassessed by the hospice within two calendar days. Ensuring ongoing assessment of the impact of a patient's symptoms is an important component of effective care planning and quality care. The Partnership for Quality Measurement (PQM) used the Pre-Rule Making Measure Review (PRMR) process to formally evaluate all aspects of the measures. The final recommendation from the Measures Under Consideration process was "Recommend with conditions" for both measures. The final 2023 Recommendations Report<sup>3</sup> listed that those conditions included "further testing of the HOPE tool as well as endorsement of the measure by a consensus-based entity." No consensus-based entity (CBE) has endorsed these measures; therefore, the committee's recommendations have not been addressed. As noted in the Report, it is not a requirement currently that measures under consideration have the CBE endorsement approval before being considered for a CMS program; however, CMS does support the PRMR process and needs to consider if additional development of these measures is warranted before including them in the required reported measures.

**b. Proposal to Implement the HOPE Assessment Instrument**

**Based on input from our member hospices that participated in pilot testing, as well as our broader membership, we do have concerns about the significant burden that implementation of the HOPE tool will add to hospices in terms of training, resource development, and additional staffing in multiple areas.** Many of our members have limited information technology, education, quality, and administrative staff. Another significant concern is that the electronic medical record (EMR) vendors will incur significant expense and resource utilization to develop and deploy the tool. We have concerns that some EMR vendors will decide not to implement the new tool because of plans to sunset certain versions of their product. This will mean that a hospice must choose a new EMR and implement that before being able to begin completion of HOPE assessments. This may take more than a year to occur. Or it will mean that hospices must determine a manual process for implementation of the HOPE tool.

NPHI believes the two new HOPE-based process measure Symptom Reassessment (SRA) visits should allow for the utilization of telehealth or a phone call as a satisfactory reassessment approach instead of requiring an in-person visit. We understand from our members that nurses do follow up on unmanaged symptoms, but it is not always necessary for that follow-up to be an in-person visit. The patient does not need to be assessed visually or physically to ascertain the impact of symptoms. Given the existing workforce shortages facing NPHI members, we do not believe it is feasible or appropriate to require an additional in-person visit at this time if telehealth

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<sup>3</sup> <https://p4qm.org/sites/default/files/2024-02/PRMR-2023-MUC-Recommendations-Report-Final-.pdf>



or phone call follow-up is deemed appropriate given the patient's condition as determined by the interdisciplinary team. Previous NQF endorsed measures such as #0209 Pain Brought to a Comfortable Level<sup>4</sup> allowed for visits to be conducted over the phone (note this was proposed in 2009 before the pandemic fueled growth in telehealth utilization). However, we would also request that CMS capture whether the follow-up visits were provided in-person or virtually to inform future quality measure development and rulemaking.

**Additionally, we request that CMS allow any hospice team member, clinical or administrative, to complete the SRA because it is not a reassessment of symptoms but of the impact of symptoms.** In rural hospices or those with a nursing shortage, in-person visits or nursing telehealth visits can be a burden. Based on the CMS guidance, there could be a need for three (3) SRA visits in the first month if symptom impact is moderate to severe at admission and the two HUVs. This could mean a total of six (6) nursing visits must be completed in a short time. Allowing other disciplines to complete SRAs and/or allowing telehealth visits would alleviate some of the additional burden on the nursing staff.

Given the challenges associated with implementing a new patient assessment tool, we request that CMS expand the learning period from 1 to 2 quarters. CMS notes in the proposed rule, "Typically, the first two quarters of data reflect the learning curve of the providers as they adopt a standardized data collection; these data are not used to establish reliability and validity." Yet CMS proposes that only first quarter data will not be used to establish reliability and validity. For any patient living 30 days, there will be a minimum of six submission points (admission, two HUVs, and discharge) and potentially nine if three SRAs are needed. It will take quite some time for hospices to determine the processes for collection, aggregation, and submission of the data. It is likely that there will be technical issues with some EMR processes as some aspects of the overall process cannot be tested prior to implementation. A 90% compliance threshold is unrealistic with such a significant change in the amount and frequency of data collection and processes. We request that CMS extend the timeliness thresholds to allow a longer runway for all processes to ramp up to the desired level.

**Regarding the time burden estimates CMS included, we do not see an accounting of time for completion of the SRA, either by clinical or administrative staff. Please consider the time needed for completion and submission of those documents.** Also, CMS calculated the total time estimates based on one HUV per patient. Data shows that in 2023, 43.3% of hospice patients had a lifetime length of stay greater than 30 days<sup>5</sup>. That time needs to be included in the calculations. There will be an additional time burden for the nurse (or other discipline) conducting the assessment and for the administrative person collecting and submitting the data to CMS. In addition, we believe that the estimates of time and costs for the "clerical" aspect is too low. The Proposed Rule quotes that "clerical staff are assumed to take 5 minutes per timepoint to upload data" which we see as highly inaccurate. CMS must consider the time spent to validate that the tool was completed correctly and then the time that may be needed to follow up with the nurse to address any necessary corrections. It will take more than 5 minutes for this process even if no follow-up with the nurse is needed. We ask that CMS reconsider the time burden on hospices both clinically and

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<sup>4</sup> [https://www.qualityforum.org/projects/n-r/palliative\\_care\\_and\\_end-of-life\\_care/0209.aspx](https://www.qualityforum.org/projects/n-r/palliative_care_and_end-of-life_care/0209.aspx)

<sup>5</sup> <https://www.cms.gov/files/document/hospice-monitoring-report-2024.pdf>

administratively. The financial and operational demands for the entire HOPE Tool implementation and ongoing administration must be considered more carefully.

## 5. Health Equity Updates related to HQRP

### a. RFI Regarding Future HQRP SDOH Items

**NPHI supports the exploration of new SDOH-related elements that could be added to the HQRP.** We support the inclusion of item A.1910 Availability of Assistance in the HOPE tool because the level of support a patient receives can have a substantial effect on their physical well-being. Lack of support with activities of daily living (ADLs) may lead to negative outcomes such as falls, poor nutrition, medication mismanagement, and other issues. Additionally, studies show that loneliness was perceived by professionals as highly prevalent for people with a terminal illness<sup>6</sup>. The lack of adequate caregiver support contributes to loneliness and depression. Data from this item will be the first step in better understanding the gaps in caregiver support for hospice patients.

On the four included domains, we offer the following comments:

*Housing instability:* This is a critical domain for hospice care because the patient's home, wherever that may be, is the central location for the delivery of effective, compassionate hospice care. The two proposed questions address distinct aspects of housing instability and could both be useful in identifying housing instability issues. The question about problems in the home is much more relevant to the situations our members see in their patient populations.

*Food insecurity:* This is an important domain, particularly for a hospice patient's caregiver. The proposed "Hunger Vital Sign" questions that focus on food insecurity "within the past 12 months" may be too broad a time window for most hospice patients and caregivers, as the median length of stay for Medicare hospice patients was 18 days in 2022<sup>7</sup>. Instead, the timeframe could be modified to within the past 6 months." Another question to consider is whether the patient has the ability to prepare meals for themselves. Many patients have food but are physically unable to prepare it.

*Utility challenges:* Similar to housing instability, the availability and access to reliable utilities is an essential aspect of hospice care at home. As with the food insecurity questions that focus on "the last 12 months," that timeframe may be too broad to be applicable to many hospice patients' circumstances.

*Transportation challenges:* For some hospice patients, the lack of transportation keeps them from attending church or participating in community social activities. Many other patients are not physically able to leave their home, so transportation may not be as critical to them. Also, hospice may arrange transportation to medically necessary appointments. But there can be periods during a hospice stay where access to transportation is important for the hospice patient

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<sup>6</sup> Hanna JR, McConnell T, Harrison C, Patynowska KA, Finucane AM, Hudson B, Paradine S, McCullagh A, Reid J. 'There's something about admitting that you are lonely' - prevalence, impact and solutions to loneliness in terminal illness: An explanatory sequential multi-methods study. *Palliat Med.* 2022 Dec;36(10):1483-1492. doi: 10.1177/02692163221122269. Epub 2022 Sep 8. PMID: 36081273; PMCID: PMC9749015.

<sup>7</sup> [https://www.medpac.gov/wp-content/uploads/2024/03/Mar24\\_Ch9\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch9_MedPAC_Report_To_Congress_SEC.pdf)

such as when the patient needs transportation to a medical appointment or facility for treatment of a condition unrelated to the hospice diagnosis. Another important consideration is the transportation needs of the caregivers because they need to leave the home to conduct household business, run errands, and attend their own appointments, as well as to meet the needs of the patient.

## 6. Proposed CAHPS Hospice Survey and Measure Changes


**NPHI welcomes the proposed changes to the hospice CAHPS survey and believes they will increase response rates over time.** The addition of a web-based survey option is well received among our members. We suggest including a QR code in the follow-up mailing to non-responders. This would increase ease of access for those who prefer that technology, which is becoming more widely used for survey access in the business community. We do ask that CMS keep in mind the fact that some hospices do not currently collect email addresses of caregivers and would need to add this into their intake process. While not particularly difficult in practice, we ask that CMS carefully consider the fact that EMR vendors will need time to implement this change to their respective systems. Moreover, we are concerned that the proposed implementation timeline of January 1, 2025, for the new mode does not leave sufficient time between the publishing of the final rule and implementation for survey vendors to make the changes specified in the proposed rule.

**We support reducing the number of questions in the survey and encourage CMS to consider further reductions as additional research and data analysis is completed.** The inclusion of the new Care Preference measures will help hospices know if they are addressing what is most important to the patients and caregivers. We ask that CMS continue to consider alternative wording on survey questions. For instance, the question *“How often did the hospice team let you know when they would arrive to care for your family member?”* can be interpreted as if the hospice is supposed to provide a specific time. Hospices try to give an overall window of time to allow for delays due to traffic or other unforeseen circumstances. Another way to phrase the question could be: *“How often did the hospice team let you know the visit schedule for your family member?”* Other revisions in wording could include uniformity of phrasing such as changing *“Did your family member get as much help...?”* to match other questions phrased as *“How often did your family member get the help they needed...?”* We support ongoing attention to the CAHPS survey tool questions and verbiage.

## Conclusion

Thank you again for the opportunity to provide comments on CMS’s proposed regulation regarding the FY25 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](mailto:emcchesney@hospiceinnovations.org).

Sincerely,

A handwritten signature in black ink that reads "Tom Koutsoumpas". The signature is fluid and cursive, with a long horizontal stroke at the top that curves over the first few letters.

Tom Koutsoumpas  
Founder and CEO  
NPHI