



July 12, 2024

The Honorable Earl Blumenauer
United States House of Representatives
1111 Longworth House Office Building
Washington, DC 20515

RE: Request for Comment on the Hospice Care Accountability, Reform, and Enforcement Discussion Draft

Dear Representative Blumenauer:

The National Association for Home Care & Hospice (NAHC) and the National Hospice and Palliative Care Organization (NHPCO) (collectively, the NAHC-NHPCO Alliance – “the Alliance”) appreciate the opportunity to submit comments on the Hospice Care Accountability, Reform, and Enforcement (Hospice CARE) Act discussion draft. We commend Representative Blumenauer’s commitment to addressing hospice program integrity issues, and his efforts to ensure continued and appropriate access to the highest quality hospice care for our nation’s terminally ill beneficiaries and their families.

Since 1982, NAHC has been the leading association representing the interests of hospice, home health and home care providers across the nation, including the home caregiving staff and the patients and families they serve. Our members are providers of all sizes and types—from small rural agencies to large national companies—and including government-based providers, nonprofit organizations, systems-based entities, and public corporations. NHPCO is the nation’s largest membership organization for hospice providers and professionals who care for people affected by serious and life-limiting illness. NHPCO members provide care in more than 4,000 hospice and palliative care locations and care for over two-thirds of the Medicare beneficiaries served by hospice. Together, the Alliance is the largest organization representing, advocating for, educating, and connecting providers of care in the home for millions of Americans who depend on this care.

We have always been a strong advocate for safeguarding the integrity of the hospice benefit to ensure continued availability of hospice services for generations to come. Illustrative of this effort, in November of 2022, NAHC and NHPCO proactively alerted the Centers for Medicare & Medicaid Services (CMS) to our concerns regarding reports of rapid proliferation of certified hospice agencies in certain States.¹ Further, in January of 2023, we jointly submitted 34 program

¹ https://www.nhpc.org/wp-content/uploads/National_Hospice_Stakeholders_to_CMS_regarding_Certification_Activity_November_2022.pdf

integrity recommendations to CMS, many of which the agency has subsequently implemented.² Similarly, we have long emphasized a need to improve the benefit to meet the evolving needs of beneficiaries and their families, ensuring they receive compassionate, person-centered end-of-life care. Both NAHC and NHPCO worked with bipartisan members of Congress on, and supported, the important hospice survey and quality reforms in 2020's HOSPICE Act legislation. We have also been proud to engage with Congressman Blumenauer over the last two years on a series of roundtables focused on the future of the Medicare hospice benefit (MHB).

While we are proud of our work to date, we acknowledge that additional efforts are necessary to ensure the Medicare hospice benefit is working as effectively and appropriately as possible to meet the needs of the millions who depend on it to facilitate a dignified dying process. With regards to program integrity and fraud concerns, there are still too many exploitative entities and individuals making their way into the Medicare program. Despite over a year of media and policymaker focus on and awareness of problematic hospice fraud in certain parts of the country, recent reporting³ and data analysis highlights the continued Medicare certification of new hospices in the four states at highest risk for fraud and abuse: Arizona, California, Nevada, and Texas. Additional targeted integrity and anti-fraud measures could help shore up the remaining oversight gaps. However, we stress that these tools need to be as tailored as possible so as not to impair appropriate access and unfairly burden the vast majority of high-quality, compliant hospices, many of whom feel the overall reputation of hospice as a concept is sadly being tarnished by a much smaller segment of providers who are not committed to providing quality and compliant care.

Policy makers should also consider the number of new authorities given to CMS in the HOSPICE Act which can be deployed to target fraudulent actors and whether additional new authorities would be leveraged in an effective way. It is critical CMS prioritize cleaning up their data to effectively identify and remove fraudulent actors. Consideration should also be given to CMS capacity to correctly implement new authorities in a manner consistent with Congressional and stakeholder intent. Given past experiences with the implementation of the Special Focus Program and new physician enrollment requirements, both critical to get right, we worry about unintended consequences.

We also know much more focus must be paid to increasing timely and appropriate access to hospice for those who do not utilize the benefit at all or are otherwise on service for very short periods of time, a challenge especially pronounced for those from traditionally underserved communities. Slightly under half of all Medicare beneficiaries that die each year use *any* hospice at all, and the median length of stay is still only 18 days,⁴ which is too short to benefit fully from the holistic care model hospice provides. A full quarter of all beneficiary stays in 2022 were for five days or less. Policies to support eligible beneficiaries' earlier enrollment in hospice would likely improve patient and family outcomes while reducing Medicare spending even more than in the current environment.

² Press Release, NHPCO, Concerned by Growth of Unscrupulous Operators, Organizations Outline Areas of Focus, Key Steps (Jan. 19, 2023), <https://www.nhpc.org/national-hospice-leaders-urge-cms-and-congress-to-advance-program-integrity-in-hospice-care-through-effective-oversight/> .

³ <https://www.propublica.org/article/medicare-california-hospice-care-fraud-southwest>

⁴ https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch9_MedPAC_Report_To_Congress_SEC.pdf

Amidst the conversation about how the hospice benefit needs to evolve to best meet the needs of patients and families, it is important to bear in mind that the current program *is* one of the overall health system’s greatest success stories. The Medicare hospice benefit is an authentically person- and-family-centered bundled payment and care model that produces significant savings by avoiding costly, unwanted, and burdensome treatments during the last phase of a person’s life. For years, research has shown hospice improves quality of life for dying individuals and their caregivers. As an example, earlier this year, a study that analyzed interviews with thousands of family and friends of people who died under many different types of care and in different settings (e.g., hospital, nursing home, ICU) found “*Dying at home with hospice received the highest rating of quality of care.*”⁵ Likewise, while the hospice benefit was originally created to serve patients with cancer, it is now supporting people with a wide variety of terminal illnesses, and research shows it improves quality of life for people and families facing dementia,⁶ cancer,⁷ heart failure,⁸ and other many other conditions.

From a cost-savings perspective, a 2023 seminal research analysis from NORC at the University of Chicago found Medicare spending for those who received hospice care in the last year of their life was 3.1% lower than spending for non-hospice users, which translates to \$3.5 billion less than similar individuals who did not use hospice care.⁹ The study also found that even for patients who are on hospice for longer than six months in their last year of life, Medicare spending is lower than people who do not use hospice.

Once again, we applaud Congressman Blumenauer for his dedication to improving the quality of life for people and families facing terminal and serious illness. The draft Hospice CARE Act of 2024 represents an opportunity for hospice stakeholders to engage with a number of important questions facing our community. While some of our provisional positions on a handful of the proposals are listed as “oppose”, we want to stress that we are intent on, and eager to, engage in further productive discussions about how best to address the issues or challenges that such proposals are intended to respond to. We strive to serve as partners to Congress and other stakeholders in dialogue about the future of the Medicare hospice benefit and commit to doing the hard work to analyze and consider different potential approaches to the issues facing our community. We affirm that we are not reflexively resistant to significant changes, but rather must have sufficient time to evaluate their potential impacts in order to avoid potential future negative unintended consequences on patients, families and hospices. We are also proud that hospice policy has consistently been bipartisan, and encourage prioritization of efforts on policies

⁵ Zhu et al. *Bereaved Respondent Perceptions of Quality of Care by Inpatient Palliative Care Utilization in the Last Month of Life*. *J Gen Intern Med*. 2024 May;39(6):893-901. doi: 10.1007/s11606-023-08588-4.

⁶ Harrison et al. *Hospice Improves Care Quality For Older Adults With Dementia In Their Last Month Of Life*. *Health Aff (Millwood)*. 2022 Jun;41(6):821-830. doi: 10.1377/hlthaff.2021.01985.

⁷ Kumar et al. *Family Perspectives on Hospice Care Experiences of Patients with Cancer*. *J Clin Oncol*. 2017 Feb;35(4):432-439. doi: 10.1200/JCO.2016.68.9257

⁸ Cross et al. *Hospice Use Among Patients with Heart Failure*. *Cardiac Failure Review*. *Card Fail Rev*. 2019 May 24;5(2):93-98. doi: 10.15420/cfr.2019.2.2

⁹ NORC at the University of Chicago. *Value of Hospice in Medicare*. 2023.

https://www.norc.org/content/dam/norc-org/pdf2023/Value%20of%20Hospice%20in%20Medicare_Final%20Report.pdf

which can garner a wide range of support, effectively target fraudulent actors without burdening high quality mission-driven hospices, and expand access to this valuable benefit.

We appreciate your consideration of our comments and welcome the opportunity to meet to discuss our recommendations. If you have questions or would like to schedule a meeting, your staff should feel free to contact Davis Baird, NAHC vice president of hospice policy and advocacy, at dbaird@nahc.org or Logan Hoover, NHPCO vice president of policy and government relations, at lhoover@nhpc.org. Our detailed comments are provided below.

Sincerely,



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Section 2. Ensuring the Integrity of Hospice Care Furnished Under the Medicare Program

Subsection (a). Mandatory Temporary Moratorium on Enrollment

(1) Moratoria: Nationwide Medicare hospice enrollment moratorium for 5 years (with process for exceptions based on need/access) – [SUPPORT WITH MODIFICATION](#)

Concerns/Considerations:

While we emphatically endorse temporary and targeted moratoria, as included in our 34 program integrity recommendations, in areas where the data would warrant such action, we have concerns the untargeted nature of a five-year nationwide moratorium will negatively impact hospice access and innovation in many states and areas of the country that do not have hospice enrollment or utilization data that would indicate they are experiencing, or are at high-risk of experiencing, high levels of fraud, waste and abuse (FWA). We understand the concern that truly fraudulent providers may simply move to non-moratoria states, but current data does not indicate this is occurring to such a degree that would warrant blanket moratoria beyond those areas where there is such data (namely certain counties in CA, TX, AZ, and NV). Additionally, many of the new non-moratoria program integrity changes CMS has implemented in the last few years, such as subjecting new hospices to the “high” risk screening category; imposing a “36-month” change of ownership rule for the hospice program; moving up the deactivation timeline from 12-months of non-billing to 6 months of non-billing, as well as some of the proposals in this draft legislation, will prevent unscrupulous entities from entering the Medicare hospice program.

When similar FWA issues as those impacting the hospice community now were present in the home health program years ago, CMS began addressing this concern by imposing a temporary moratoria targeted at first to a small number of counties for six-month increments.¹⁰ CMS expanded the home health moratoria periodically, which eventually covered four entire states, for a total of five years. However, this moratoria was never imposed nationwide. Despite this limited scope, the data suggest this targeted moratoria was still effective at curbing the proliferation of new home health agencies. Illustratively, the Medicare Payment Advisory Commission (MedPAC) found the number of home health agencies overall has declined in every year the moratoria was in place, and “was concentrated in areas that experienced sharp increases in supply in prior years.”¹¹ Unlike starting with a blanket nationwide moratorium, these expansions and extensions were based on CMS’ evaluations of the underlying data indicating FWA activity.

To reiterate, our prevailing concerns/considerations are:

¹⁰ https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/CMS_PEWD_Fact_Sheet-081518.pdf

¹¹ https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_medpac_ch9_sec.pdf

- Five years is too long when access to care issues still exist and we have yet to see data to justify making it nationwide.
- Congress should use the precedent of prior Medicare home health moratoria being targeted to certain geographic locations (counties) and extended in six-month increments.

Outstanding Questions:

1. How would CHOW rule interact with moratoria? Would a hospice buying an existing program be subject to moratoria?
2. How would expansion of service area, addition of multiple location and hospice inpatient unit be managed under the moratorium?
3. Does CMS have the ability/resources to design, implement, and run an exceptions process based on “need?”

Recommendations:

1. Require CMS to develop targeting criterion for a moratorium, including metrics developed by Congress, Require CMS to provide accountability for withholding a moratoria extension and justification for any extension to Congress.
2. Provide an exception for states with certificate of need programs.
3. Provide clear exceptions to the moratorium to ensure continued access.

(2) Prepayment medical review during moratoria: While moratoria is in place, CMS would conduct prepayment medical review of routine home care claims submitted after the first 90-day benefit period by hospices with aberrant billing patterns (e.g., high rates of live discharges). CMS can remove the prepayment medical review requirement if a hospice has low rate of denial - **SUPPORT WITH MODIFICATION**

Concerns/Considerations:

While we understand hospices with very unusual billing or utilization patterns indicative of FWA may need additional scrutiny, we have concerns about the lack of consensus on what “aberrant billing patterns” means operationally, as well as the focus on moving medical reviews to after the first 90 days on service, as opposed to after 180 days. The MHB is a six-month benefit, and we fear that by shifting review focus to the stays over 90 days would create an expectation from CMS and its review contractors that lengths of stay between 90 and 180 days are considered “long lengths of stay” and, therefore, appropriate targets for medical review and audits. This will have an even greater chilling effect on hospices, many of whom may be even more cautious about serving patients with diagnoses with more unpredictable clinical trajectories. Recent research indicates CMS’ prior focus on patients with long stays has had a chilling impact on access for patients with Alzheimer’s Disease and Related Dementias (ADRD).¹²

¹² Gianattasio et al. *Evaluation of Federal Policy Changes to the Hospice Benefit and Use of Hospice for Persons with ADRD*. *Jama Health Forum*. 2022 May 6;3(5):e220900. doi: 10.1001/jamahealthforum.2022.0900

Additionally, a recent Supplemental Medical Review Contractor (SMRC) audit project that entailed medical review of claims after the first 90-day period found a relatively modest 16% error rate, one of the smallest rates amongst the SMRC’s portfolio of review projects.¹³ Similarly, CMS’ most recent Improper Payment report to Congress indicates the overall improper payment rate for hospice in 2023 was only 5.4%, which was well lower than the rate for skilled nursing facilities (13.8%), inpatient rehabilitation facilities (27.3%), and the overall Medicare Part B program (10%).¹⁴

Our prevailing concern is:

- The prepayment medical review of patients after the first 90 days may have a chilling effect and encourage shorter lengths of stays, thereby limiting access for terminally ill beneficiaries.

Outstanding Questions:

1. How will “aberrant billing patterns” be defined? What are the threshold levels of live discharges or long lengths of stay that would qualify as “aberrant” such that it would trigger the reviews?
2. How will the Secretary define and operationalize “low rate of denial?”

Recommendations:

1. Modify the prepayment review to 180 days which is aligned with the six-month terminal prognosis under the hospice benefit.
2. CMS should define and publish the aberrant billing pattern data and make it available to hospices via the PEPPER report.
3. Pair this provision to areas with a federal moratorium to increase effectiveness and limit unintended consequences.

(3) Revalidation: Within the first six months of enactment, CMS would have to revalidate the enrollment information of each hospice – **SUPPORT WITH MODIFICATION**

Concerns/Considerations:

We understand the desire to perform validation surveys on every hospice to ensure they are operational and that their organizational information is accurate and up to date. However, we have concerns that if this is approached in an untargeted manner, it could constrain already limited CMS resources, many of which would be further stressed by the many other new CMS oversight obligations proposed in the draft legislation. Revalidations should focus first on those hospices raising the most concerns, consistent with recommendations of the Government Accountability Office urging CMS to “prioritize completion of standard surveys for those

¹³ <https://noridiansmrc.com/completed-projects/01-099/>

¹⁴ <https://www.cms.gov/files/document/2023medicarefee-servicesupplementalimproperpaymentdatapdf.pdf#page=12>

hospices that are overdue based on potential risk factors.”¹⁵ Further, CMS recently conducted a nationwide hospice site visit that failed to capture many fraudulent actors, including the hospice featured in a ProPublica story.¹⁶ Targeted and focused efforts, informed by data, should be preferred over nationwide resource-intensive projects.

It is also unclear how this new revalidation process would interact with the existing revalidation timelines for hospices. Efforts need to be made to streamline and harmonize these so as not to increase burdens on both hospices and CMS.

Outstanding Questions:

1. In what year would CMS have the ownership and managing control information under the existing hospice revalidation schedule? Is moving up this timeframe worth the additional burden to CMS?
2. How would this impact the revalidation timeframe going forward? For example, would all hospices be on a cycle of every five years or would hospices resume following the existing schedule?

Recommendations:

1. Limit and/or prioritize accelerated validation activity to hospices that may need this most urgently, including those who are non-compliant with the hospice quality reporting program (HQRP) and those located in high-risk counties that would be appropriate for a temporary targeted moratoria.

(4) Publication of ownership and managing control information: CMS would publish the ownership interest and managing control information of each hospice not later than one year after enactment. This information would be collected via the revalidation process described in the previous provision - [SUPPORT WITH MODIFICATION](#)

Concerns/Considerations:

We are supportive of transparency in the hospice community. The hospice ownership data CMS recently published contains many errors, is not user-friendly, and there was no clear or simple process for hospices to reach out to CMS to fix inaccuracies. CMS needs to address these concerns before any additional ownership/managing control information is published with straightforward tools for hospices to correct CMS data, when inaccurate.

Outstanding Questions:

1. Is the intent for CMS to publish only the *type* of organization that has ownership/managing control and not information on *individuals* with ownership/managing control?

¹⁵ <https://www.gao.gov/assets/gao-24-106442.pdf>

¹⁶ <https://www.propublica.org/article/medicare-california-hospice-care-fraud-southwest>

Recommendations:

1. CMS should create a mechanism or process that makes it easier for hospices to correct any inaccurate ownership or managing control data that is published as a result of these efforts.

(5) Report to Congress on hospice ownership: No later than Jan 1, 2027, the Office of the Assistant Secretary for Planning and Evaluation (ASPE), in conjunction with the Federal Trade Commission (FTC) and Department of Justice (DOJ), would submit a report to Congress on hospice ownership and control trends and the role of private equity in ownership and control of hospice programs - [SUPPORT WITH MODIFICATION](#)

Concerns/Considerations:

This report must include analysis or discussion of *all* impacts, not merely the negative ones, of different kinds of ownership and control types and trends (e.g., for-profit, non-profit, government-backed).

Outstanding Questions:

1. What specific questions about ownership control/trends would be required to be answered?

Recommendations:

1. Reframe the directive to include an analysis of all impacts of all ownership and control types and trends, including in comparison to other provider types.

Subsection (b). Authority to Extend Oversight of Newly-Enrolled Hospice Programs

(6) Authority to extend oversight period for newly-enrolled hospices: Extending the ability of CMS to establish provisional periods of enhanced oversight (PPEO) to two years (currently PPEO is only allowed to be in place for one year – PPEO is in place now for new hospices and those undergoing majority changes in ownership in CA, TX, AZ, NV) – [MORE INFORMATION NEEDED BEFORE DEVELOPING POSITION](#)

Concerns/Considerations:

- There has not been a public update or data released on the impact of the current PPEO in CA, TX, NV, and AZ. Having information on the impact of the current process (e.g., on hospices, patients) is critical in order to determine if the program is having the intended effect of curbing FWA activity in the four states, and whether there have been any unforeseen unintended consequences.

Outstanding Questions:

1. Has the current PPEO accomplished what was intended?
2. Will CMS be sharing public information on its effects?
3. What happens to existing PPEO in place for hospices in CA, TX, AZ, and NV on July 13, 2024? Can it be extended without statutory change?

Recommendations:

1. Require the Secretary to submit a report to Congress on the current PPEO's implementation and impact on the hospice community in the four states where it is active.

Subsection (c). Increase Survey Frequency for Certain Hospice Programs

(7) Increased surveys for new hospices and those five years or “younger”: New hospices (i.e., first submit claims to Medicare on or after the date of enactment) and those five years and “younger” (i.e., first submitted claims to Medicare within five years prior to the date of enactment) would be surveyed more frequently, every 15-18 months, rather than every 36 months. Hospices would be removed from the more-frequent survey list (reverting back to being surveyed every 36 months) if they have been on the list for a continuous five-year period and during such period were not subject to an enforcement action for being non-compliant with the hospice Conditions of Participation related to providing substandard quality of care - [MORE INFORMATION NEEDED BEFORE DEVELOPING POSITION](#)

Concerns/Considerations:

We have in the past recommended an increased survey frequency for newer hospices, as FWA may be potentially more prevalent in this subset of providers and there are fewer means for overseeing the quality of care for these hospices. Newer hospices are not immediately submitting quality data to CMS and may not serve the number of beneficiaries necessary to have publicly reported quality data for some years after their initial certification.

In January 2023, CMS implemented reforms to the hospice survey process. It took some time for accrediting organizations and state survey agencies to adopt the revised process, with most having done so in the summer of 2023. Based on anecdotal information, the new process has resulted in more accurate identification of quality-of-care deficiencies. However, it has been slightly over a year since full implementation by survey agencies without a study of the effectiveness of these changes.

Concerns include:

- Major existing hospice survey backlogs and limited surveyor workforce capacity at many state survey agencies (SAs). Recent GAO report highlighted a significant number of hospices being behind on the required 36-month surveys.

- CMS must ensure surveyors are properly trained to perform these new and increased surveys, including training on recent changes to the hospice survey process and priorities, as reflected in January 2023 and May 2024 CMS guidance to surveyors.

Outstanding Questions:

1. Does CMS have the capacity to stay up to date on these increased surveys?
2. Will surveyors be required to have up-to-date training on the most recent survey changes/guidance from CMS?
3. How exactly would CMS define “*not subject to an enforcement action for being non-compliant with the hospice Conditions of Participation related to providing substandard quality of care*”?
 - Would the only way to get off the more-frequent survey list be to have zero quality-of-care condition-level deficiencies (CLDs) or standard-level deficiencies for five consecutive years?
4. Would SAs, AOs, or some other kind of survey entity (or some combination of all three) be responsible for these more frequent surveys?

Recommendations:

1. Congress should consider directing CMS to explore/pilot a Risk-Based Survey (RBS) approach in hospice to better target survey resources to hospices that demonstrate patterns/histories of performance warranting more frequent surveys. CMS is currently piloting an RBS approach for SNFs, given that the backlog and workforce challenges existing for hospice surveys are also present in the SNF sector. RBS could better prioritize limited surveyor resources.
2. If utilizing the existing survey structure instead of an RBS approach, hospices should be removed from the more frequent surveys if they do not have any condition-level deficiencies (CLDs) for the quality-of-care conditions of participation.

Subsection (d). Prohibition on Payment for Failure to Meet Quality Data Reporting Requirements

(8) Prohibiting all payment to hospice programs that fail to meet quality data reporting requirements: Starting in fiscal year 2027, CMS would cut off payment to hospices that do not submit required Hospice Quality Reporting Program (HQRP) quality data to CMS. The current exemptions and extensions policies would continue to apply (there are exemptions from HQRP reporting requirements for hospices that are new and sufficiently small) – [SUPPORT WITH MODIFICATION](#)

Concerns/Considerations:

There is a difference between providers fully non-compliant with HQRP (i.e., not submitting any HIS records and not participating in the CAHPS Hospice Survey) and those that fall short of the HIS and/or CAHPS Hospice Survey thresholds. We strongly support a severe penalty for hospices that choose to be fully non-compliant.

Key considerations include:

- Given the outsize impact total non-payment would have on hospices, there must be adequate guardrails in place to ensure hospices that are non-compliant with HQRP for less egregious reasons than voluntarily refusing to submit any quality data to CMS are not unduly impacted, such that they would be unable to operate at all.
- Exemptions currently exist for size for the CAHPS® Hospice Survey, but not for the submission of Hospice Item Set (HIS) data. The “newness” exception is very limited.
- Providers who make a good faith effort to submit data but nevertheless make errors or miss deadlines should not be penalized with total non-payment for an entire year. Accordingly, some flexibility should be provided.
- Consider how the Hospice Outcomes & Patient Evaluation (HOPE) data collection instrument implementation may impact HQRP compliance. Since HOPE will not be tested prior to implementation, we anticipate significant technology and submission issues affecting some or all hospice providers. Hospices experiencing these types of issues when submitting HOPE data should not be punished with non-payment.

Recommendations:

1. Clarify language that total non-payment should only be applied to those hospices non-compliant with HQRP because they voluntarily choose not to submit *any* data to CMS at all.
2. Include “good faith” provision to protect providers who demonstrate they are working to comply, while removing payment for those that are flagrantly non-compliant. For example:
 - Modify the prohibition on payments for providers to only those who have shown a pattern of flagrant non-compliance (e.g., not submitting data for six months).
 - For providers that are non-compliant with HQRP because they missed the HIS threshold – which is the vast majority of those who are non-compliant – consider a tiered penalty approach. For example, apply an increased APU penalty greater than the current 4% (e.g., 10%) and increase this penalty in step with the length of time the provider remains non-compliant or some other intermediate penalty that is less severe than total non-payment.
 - Allow for an appeals process that considers administrative/technical errors (e.g., changeover to new EMR causes a technical glitch for a batch of submissions but otherwise the agency can evidence their compliant submissions).
3. Notification of non-compliance should be provided more frequently than annually to alert providers to administrative/technical errors contributing to non-compliance.
4. As an alternative to total non-payment, Congress could consider non-compliance to be a reason for deactivation. Deactivation may allow for more information from and greater oversight of these non-compliant providers. Under a total non-payment approach, nefarious providers willfully not participating in the HQRP could simply accept non-payment for a year, possibly even reducing their census to alleviate some of their non-reimbursed expenses. Deactivation requires providers to go through the revalidation process, which is another opportunity for CMS provider enrollment to review the provider. It could also implement a site survey to ensure the hospice is truly operational,

with possible addition of a full Medicare survey (as is done for home health agencies). For deactivated providers in areas where PPEO is being applied, the claims of any deactivated providers would go through the enhanced oversight reviews.

Subsection (e). Independence of Attending Physician

(9) Prohibiting a physician that is employed by or has an ownership, financial, or contractual relationship with a hospice program from certifying terminal illness for a patient at that hospice for the initial 90-day election period through the role of the patient's attending physician - OPPOSE

Concerns/Considerations:

We understand this provision is intended to go after the problem of doctors being inappropriately incentivized to fraudulently enroll patients at hospices. We acknowledge this problem exists; however, this provision would cause exponentially more harm to hospice and palliative care physicians and high-quality hospices than it would to fraudulent actors. It would further reduce access to the benefit when access issues continue to exist in many areas. Policies that would make it more difficult to establish hospices by fraudulent actors would be more impactful and would not harm good providers.

Key concerns include:

- By limiting who can serve as a patient's attending physician, this provision would limit a beneficiary's right to choose their preferred clinician. The Medicare statute emphasizes the attending physician must be chosen by the patient (or their representative).¹⁷
- Prognostication is not an exact science, and many physicians and non-physician practitioners not specializing in hospice and palliative medicine do not have the expertise or are not comfortable with making a certification of terminal illness.
- Unlike other Medicare benefit sectors, the hospice benefit requires a physician be incorporated within the operational structure of the hospice as a medical director and member of the interdisciplinary team (IDT). This proposal blocks the inclusion of a physician who is an expert on hospice care from participating in the prognosis of the patient.
- This provision does not solve the problem of a physician inappropriately certifying an ineligible patient as terminally ill.
- There are many cases where a patient does not have a pre-existing primary care physician or community physician who is interested in serving as the patient's attending physician when electing hospice services. In these situations, the hospice physician is responsible for meeting the medical needs of the patient. Patients may select the hospice physician to

¹⁷ See 42 U.S.C. § 1395x(dd)(3)(B) ("The term "attending physician" means, with respect to an individual, the physician (as defined in subsection (r)(1)), the nurse practitioner (as defined in subsection (aa)(5)) or the physician assistant (as defined in such subsection), who may be employed by a hospice program, whom the individual identifies as having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care.") (emphasis added).

serve as their attending often because these physicians specialize in hospice and palliative medicine. Prohibiting a specialist, required to be part of the hospice IDT, from being chosen by the patient is akin to prohibiting a patient from choosing a cardiac surgeon to perform heart surgery. This provision would seemingly prohibit this, which could have serious access impacts for patients.

- We have major concerns related to physician shortages. It is well documented there are not enough physicians available in many communities, and this provision would limit access even further. This is especially true in rural areas with the most severe shortages. Even in urban areas there are shortages of primary care physicians and physicians willing to accept new patients.
- Recent experience with CMS' fraught implementation of the certifying physician enrollment requirement gives us major concerns about the unintended consequences of this provision.

Outstanding Questions:

1. How would CMS define “significant ownership, financial or contractual relationship”?
2. Is there data on the current and historical percentage of certifications that are performed by attending physicians with a “significant ownership, financial or contractual relationship” with the hospice?

Recommendations:

1. Remove this provision

Subsection (f). Allowing Nurse Practitioners to Certify Terminal Illness

(10) Allowing nurse practitioners (NPs) to certify terminal illness: Would allow NPs acting as the patient's designated attending physician to certify terminal illness – **SUPPORT WITH MODIFICATION**

Outstanding Questions:

1. Would NPs under this provision also be subject to the previous provision requiring an independent attending physician (i.e., one not employed by or does not have an ownership, financial, or contractual relationship with the hospice program)?

Recommendations:

1. Should Congress decide to extend the allowance to certify terminal illness to NPs, Physician Associates (PAs) should also be included to the extent permitted in accordance with scope of practice under state laws.

Subsection (g). Allowable Use of Supporting Materials in Medicare Review of Hospice

(11) Requirement for medical reviewers to use medical documentation from the hospice patient's attending physician: Would require CMS and its medical review contractors to utilize documentation from the patient's designated attending physician when reviewing medical records for hospice care. Would also allow (but not require) CMS and its medical review contractors to use documentation from the hospice program itself as supporting material -
OPPOSE

Concerns/Considerations:

It is currently best practice for hospice providers to use documentation and information from the beneficiary's medical history in their determination of eligibility. This medical history may come from a recent acute care stay, the patient's primary care physician/provider (NP/PA), or specialist. This may or may not be the patient's designated attending physician. If this provision becomes a requirement, it will create a burden for beneficiaries who have not received consistent and timely care from a primary care physician or provider in the preceding months and years. This could lead to delayed admission and access issues and may result in audit challenges for hospices, which could further result in a chilling effect on beneficiary access.

By requiring the medical record of a patient's attending physician be used in medical review, there is an implicit presumption a patient *must* designate an attending physician, which is not required under the Medicare hospice benefit. Under current regulation, the patient may choose to designate an attending physician or may choose to have none at all.

By placing greater emphasis on the ability of non-hospice trained physicians, nurse practitioners, and physician assistants to document the clinical indicators of a terminal prognosis, this provision devalues the expertise hospice-trained clinicians (many of whom have specialty certifications in hospice and palliative medicine) have on prognostication and places greater reliance and trust in those lacking commensurate training.

We are also concerned about unintended interpretations by the MACs or auditors which might view this as a requirement to have this information in every case and weigh the information in the medical history more heavily than documentation from trained clinicians.

Outstanding Questions:

1. How exactly is this requirement different than what is already required under current law/regulation?

Recommendations:

1. Remove this provision

Subsection (h). Inclusion of Hospice Care as a Designated Health Service

(12) Requiring hospices be subject to the requirements of physician self-referral law (the so-called “Stark” law): Adds hospice care as a designated health service for purposes of the physician self-referral (“Stark”) law. The physician self-referral law prohibits a referral by a physician of a Medicare or Medicaid patient to an entity for the provision of designated health services if the physician or immediate family member has a financial relationship with that entity – [MORE INFORMATION NEEDED BEFORE DEVELOPING POSITION](#)

Concerns/Considerations:

- Appropriate exemptions need to be in place in order to reduce unintended access impacts (e.g., exemption for a hospice part of a broader organization with a physician practice)
- Without appropriate safeguards, beneficiaries might be denied their right under the Medicare hospice benefit to choose their attending physician. Under Section 1861(dd)(3)(B)) of the Social Security Act, this physician is identified by the individual *“as having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care.”* Including hospice as a designated service under the Stark law could result in beneficiaries having fewer choices for physicians, thereby limiting their right to make this choice at a time when they are most vulnerable at end-of-life.
- In rural and regions traditionally underserved where access is limited and staffing is strained, restricting physicians in their ability to refer terminally ill beneficiaries for medically appropriate hospice services could result in increased access challenges.
- Similarly, hospices serving these beneficiary populations might face additional hurdles in timely providing care for beneficiaries to navigate through Stark law-related hurdles. This could result in delays, at a time when beneficiaries are electing hospice too late in their dying process. Illustratively, in 2021, the median length of stay for all Medicare hospice admissions was only 17 days.¹⁸

Outstanding Questions:

1. What specific restrictions would be newly applicable to hospices if the benefit is included as a “designated health service” under the Stark law?

Recommendations:

1. Include hospice under the physician recruitment exception at 1877(e)(5), such that in the case of remuneration which is provided by a hospice to a physician to induce the physician to relocate to the geographic area served by the hospice in order to serve as a physician of the hospice, provided the physician is not required to refer patients to the hospice, the amount of remuneration is not determined in a manner that takes into

¹⁸ https://www.medpac.gov/wp-content/uploads/2023/03/Ch10_Mar23_MedPAC_Report_To_Congress_SEC.pdf

account the volume or value of referrals, and the arrangement meets other requirements as the Secretary may impose.

2. The policy must address what is to happen to *existing* hospices under physician ownership.

Subsection (i). Prohibition on Certain Changes in Majority Ownership

(13) Extending the 36-month change of majority ownership (CHOW) rule to 60 months:

CHOW rules prohibit the hospice provider agreement and billing privileges from conveying to a new owner within a certain time period. This provision would extend that period from the current 36 months to within 60 months of initial certification (or the last majority change in ownership) – [OPPOSE](#)

Concerns/Considerations:

- As CMS only recently (January 1, 2024) implemented the 36-month rule for hospices, there has not been sufficient time to evaluate its impact on access or fraud, waste, and abuse.
- The 60 month-period, in tandem with the proposed five-year nationwide moratorium, could result in impaired access in certain areas where existing hospice services are disrupted.

Recommendations:

1. Evaluate the impact of the 36-month rule change on hospices before expanding to 60 months.
2. Provide CMS with the authority to expand this provision to 60 months only after the current 36-month CHOW requirement has been active for at least 36 months.
3. Require CMS to submit a report to Congress with the rationale for why moving to a 60-month CHOW rule is necessary.
4. Require exceptions in the cases of demonstrated community harm if a CHOW is not allowed.

Subsection (j). Medical Review of Hospice Outliers and Care Unrelated to Terminal Condition

(14) Medical review of claims from hospices with outlier utilization patterns: CMS would be required to conduct prepayment medical review for patients with stays longer than 90 days in instances where a hospice has a certain percentage of patients with long stays (180 days or longer) or has a certain percentage of patients that were discharged alive (e.g., the hospice discharged the patient or the patient revoked their election), as determined by the Secretary - [OPPOSE](#)

Concerns/Considerations:

Similar to the concerns expressed in relation to provision 2(a) above (“prepayment medical review for certain hospices while moratoria is in place”), we are worried that moving the review focus timeline to right after the first benefit period further erodes the recognition that the MHB is a six-month benefit to which eligible beneficiaries are entitled. Continuing to shift the review lens further upstream will, regardless of intent, signal to hospices that stays beyond 90 days are considered “long,” an interpretation that may result in hospices being even more cautious than they are now when considering what types of patients they can take onto service for fear of being audited or having their claims denied.

Additional concerns and considerations include:

- It is unclear if CMS ever implemented a provision from the Affordable Care Act (ACA) requiring medical review for patients with stays longer than 180-days in instances where a hospice has a certain percentage of patients with long stays (180 days or longer).
- Moving medical review to stays of 90 days or longer in a six-month benefit could have a chilling effect on beneficiary access to care. Indeed, there is a growing body of research indicating CMS’ current intense focus on auditing longer lengths of stay has resulted in access challenges for patients with diagnoses with more unpredictable trajectories, especially those with Alzheimer’s Disease and Related Dementias (ADRD) and other neurological conditions.
- Utilizing other criteria in conjunction with a high proportion of long length of stay patients (e.g., high live discharge rates) may be most effective in targeting hospices with fraudulent behaviors.
- A recent Supplemental Review Contractor (SMRC) audit project that performed post-payment review on hospice claims at 90 days found only a 16% error rate, one of the lowest error rates of any of the SMRC’s recently completed projects.

Outstanding Questions:

1. What percentages would CMS set as thresholds for long stays and live discharges that would trigger the prepayment medical review?

Recommendations:

1. CMS should work with hospice stakeholders and other outside experts to determine what would constitute “outlier” utilization in terms of percentages of long stays and percentages of live discharges.
2. The 90-day medical review provision should not be implemented; rather, CMS, if it has not already, should be allowed to pursue implementation of the existing requirement for review of stays longer than 180-days in situations where a hospice has a certain proportion of patients with these longer stays. This could provide insightful information about how best to identify and target hospices that inappropriately enroll and recertify beneficiaries.
 - a. If CMS has implemented the ACA requirement, the agency should provide a report to Congress on their findings.

(15) Medical review of claims from non-hospice providers for “unrelated” care: Would require CMS to perform prepayment reviews for claims submitted by non-hospice providers and suppliers for items or services unrelated to the patient’s terminal condition for which a terminal illness diagnosis has been made - [MORE INFORMATION NEEDED BEFORE DEVELOPING POSITION](#)

Concerns/Considerations:

Hospices’ hard work to educate and partner with other providers to ensure proper billing and support pre-payment review for non-hospice spending notwithstanding, hospices have little control over much of the spending that occurs outside of the hospice benefit.

Since hospices were mostly excluded from federal interoperability initiatives, many still operate with systems that cannot connect with those of non-hospice providers. This has resulted in broad unawareness across the non-hospice electronic health data ecosystem of when a beneficiary has elected hospice. In recent discussions about unrelated care for hospice beneficiaries, MedPAC commissioners strongly advised against financially punishing hospices for this spending.¹⁹

Additional concerns include:

- This provision would seemingly allow a non-hospice-trained medical reviewer to assume the role of a hospice physician or the patient’s attending physician in determining if an item or service is related.
- This provision would presumably require information and data under both Medicare Part A and Medicare Part B records. CMS has not been able to implement such reviews to date.
- It is unclear if medical reviewers will have the necessary training or access to patient medical record information to determine relatedness, whether the service is reasonable or necessary, or if the hospice was asked to provide the service or supply.
- Guardrails and clear guidance must be in place to ensure these “unrelated” medical reviews will not cause harm or reduce access to necessary and appropriate care for hospice patients.

Outstanding Questions:

1. Would the medical reviewers performing review on “unrelated” claims be required to have any specialized training in hospice, end-of-life care, or how to determine “relatedness”?
2. What data and information would CMS use to make a determination of “unrelatedness”?

Recommendations:

¹⁹ See MedPAC December 7, 2023 Public Meeting; MedPAC November 2, 2023 Public Meeting

1. Should prepayment review for non-hospice spending determine a service was “related,” there should be clear protocols and guidance that allow for the recouping of funds from the non-hospice provider that delivered the service. Hospices should be held harmless under these reviews
2. Alternatively, require the pre-claim review determination to be shared with the hospice and allow the hospice an opportunity to determine if the service is indeed related.
3. Require CMS to provide more patient-level “unrelated spending” detail to hospices.
4. Add funding for hospice interoperability measures and initiatives. This should include a system for non-hospice providers and suppliers to confirm a beneficiary’s enrollment in hospice.

Subsection (k). Required Provision of Addendum of Non-Covered Services

(16) Required provision of the addendum of non-covered services to all patients: Would require hospices to automatically provide to all patients the election statement addendum that explains whether the hospice has determined that any necessary items or services are unrelated to the patient’s terminal condition and thus not the responsibility of the hospice. Currently, hospices only provide the addendum upon request - [MORE INFORMATION NEEDED BEFORE DEVELOPING POSITION](#)

Concerns/Considerations:

- Although it is best practice to ensure beneficiaries understand non-covered services, the current timing requirements associated with provision of the addendum make this hard to operationalize and limit its usefulness to patients and families.
- Additional research is needed to further understand the impacts of the provision of the addendum, including how often it is currently provided, to what types of patients is it commonly provided to, and whether or not it has had any impact on patient and caregiver decision-making, including an analysis on if it has contributed to beneficiaries/families choosing not to proceed with hospice services.

Recommendations:

1. Before making hospices provide the addendum to all patients/caregivers:
 - a. The timeframe for the current addendum furnishing requirement must be extended through the comprehensive assessment update.
 - b. The signature requirements for the addendum must be simplified.
 - c. The addendum should be reformed to ensure it is both understandable and accessible to beneficiaries.

Subsection (l). Provision of Explanation of Benefits Upon Hospice Election

(17) Provision of explanation of benefits (EOB) upon hospice election: Within 15 days of an individual’s hospice election, CMS would have to provide notice of such election to the beneficiary or their representative, so they can identify any mistakes or fraud in such an election and report such instances to the hospice, CMS, or the OIG – [SUPPORT WITH MODIFICATION](#)

Concerns/Considerations:

- Where a beneficiary is inappropriately enrolled by a fraudulent actor, the beneficiary should not be put in a position where they are encouraged to contact that “provider.” Rather, CMS should provide a new Medicare Beneficiary Identifier (MBI) to the beneficiary.
- The provision states this EOB must include a statement which “*indicates that, because errors do occur and because Medicare waste, fraud, and abuse is a significant problem, such individual should carefully check the individual’s hospice election information for accuracy and report any errors...*” We worry this language unfairly casts suspicion upon all hospices. We are unaware of any other provider type where this kind of language would be included in an EOB. Sending this message to the 1.7 million Medicare beneficiaries that use the benefit each year would add unnecessary and misplaced concern for the beneficiary and their family, and could result in hasty and panicked un-enrollments, which may only serve to decrease their quality-of-life if indeed they could benefit from the person-and-family centered holistic care that hospice provides.

Outstanding Questions:

1. Roughly a quarter of beneficiaries use the hospice benefit for less than 5 days.²⁰ Would their families be sent an EOB weeks after their loved one’s death?

Recommendations:

1. Rather than requiring a beneficiary to contact a fraudulent actor, there should be an expedited process for CMS to issue a new MBI .
2. Remove the requirement these EOBs include language that states that Medicare waste, fraud, and abuse is a significant problem in hospice.

Subsection (m). Medical Review of Hospice Care Contractor Requirements

(18) Required training for hospice medical review contractors: Requires contractor staff performing medical reviews of hospice care to receive specialized instruction on the philosophy behind hospice care and specialized training in medical prognostication for reviews conducted on or after Jan 1, 2027 - [SUPPORT](#)

Concerns/Considerations:

²⁰ MedPAC July 2023 Data Book, Chart 11-13

Outstanding Questions:

1. Does this provision only apply to physicians performing medical review on behalf of the contractor? Or would it apply to additional kinds of contractor staff?

Recommendations:

1. Implement this provision

(19) Report to Congress on hospice medical review activities: Requires the Secretary to submit a Report to Congress no later than January 1, 2027 on all hospice medical review activities performed between January 1, 2019 and December 31, 2024 and provide information on the total number of claims reviewed, the percentage of claims denied that were appealed, the percentage of appealed claims overturned on appeal by level of appeal, a list of hospice medical review projects undertaken by contractors, and steps the Secretary will take to reduce the audit burden on hospices and to minimize the number of denials of claims for hospice services that are overturned on appeal - [SUPPORT](#)

Recommendations:

1. CMS should be required to annually publicly post data in a consolidated and user-friendly way on the hospice medical review activities highlighted in this provision, including the total number of claims reviewed, the percentage of claims denied that were appealed, the percentage of appealed claims overturned on appeal by level of appeal, and a list of hospice medical review projects undertaken by contractors.
2. CMS should operationalize the “limitation on liability” provision, 42 U.S.C. § 1395pp, which protects hospices that rely, in good faith, on the physician’s certification of terminal illness from retroactive claim denials, The current approach has the equivalent of applying a presumption that the hospice knew or should have known the patient was not terminal.

Subsection (n). Requiring Face-to-Face Encounters Before Recertification of Terminal Illness

(20) Requiring a face-to-face (F2F) recertification visit before all recertification periods, only allowing these F2F visits to be performed no more than 10 days before such recertification periods and prohibiting F2F visits from being performed via telehealth:

Current law only requires a F2F to be performed before the second and later recertifications. This provision would require a F2F also be performed before the first recertification period at 90 days. It would also compress the timeframe during which a F2F can be performed, from the current limit of no more than 30 days before the recertification date to no more than 10 days before the recertification date. It would also require all F2F visits to be performed in-person (as opposed to via telehealth, a flexibility put in place during the COVID pandemic and is currently set to expire at the end of 2024) - [OPPOSE](#)

Concerns/Considerations:

Following a 2009 MedPAC recommendation to “ensure an adequate level of accountability for the hospice benefit”²¹ and deter inappropriate long stays, the Affordable Care Act (Pub. L. 111-148) required a hospice physician or nurse practitioner (NP) to have a F2F encounter with every Medicare hospice patient to determine the continued eligibility of that patient prior to the start of the third benefit period, approximately 180 days (about 6 months), and every 60 days thereafter for recertification.

Since this time, there has been no data or evidence indicating the F2F requirement has served to prevent inappropriate recertifications. An NIH-funded study found the opposite, reporting that the “F2F visit requirement may decrease hospice discharges, contrary to intention.”²²

F2F encounters are more administrative in nature than truly clinical. By adding yet another administrative requirement before the start of the second benefit period, physicians and NPs will be further time-constrained and burdened in ways that will continue to limit their availability to deliver necessary clinical and supportive services that are higher-value than the F2F visit.

In March 2020, Congress included a provision in Section 3706 of the CARES Act (Pub. L. 116-136) to allow hospices to perform the F2F via telehealth for the PHE. Research on the telehealth flexibility concluded no “statistical significant differences in reauthorization recommendations were found between telehealth and in-person visits.”²³

The allowance to perform the F2F via telehealth has allowed hospices to free up the time of their physicians and NPs to focus on more important clinical and support activities. This is especially true in rural and frontier areas, where those performing the F2F can spend many hours merely driving to a patient’s home. Additionally, many hospices report the virtual allowance has supported more robust and meaningful F2F visits in which the RN case manager is at the home of the patient, while the physician or NP is performing the F2F virtually. This dynamic allows for a collaborative dialogue between members of the IDT in real-time.

Requiring an additional F2F will not stop bad actors intent on exploiting the hospice benefit from fraudulently certifying patients. Removing the option for the F2F encounter to be conducted virtually will likely reduce access to hospice.

Lastly, this provision also runs counter to the Ways and Means Committee unanimously passing H.R. 8261, the *Preserving Telehealth, Hospital, and Ambulance Act*, which extended the ability for hospices to use a virtual option for the F2F encounter with guardrails.

Outstanding Questions:

²¹ https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Mar09_Ch06.pdf

²² Harrold J et al. *Effect of the Medicare Face-to-Face Visit Requirement on Hospice Utilization*. J Palliative Med. 2013;16(2):163-166. doi:10.1089/jpm.2012.0349

²³ Moore SL et al. *Using Telehealth for Hospice Reauthorization Visits: Results of a Quality Improvement Analysis*. J Pain Symptom Mgmt. 2020 Sep;60(3):e22-e27. doi: 10.1016/j.jpainsymman.2020.06.002

1. How would moving the timeframe for the F2F up to no more than 10 days before the recertification date intersect with the existing rule that allows the recertifications themselves to be completed up to 15 days before the start of the next benefit period?

Recommendations:

1. Remove this provision.
2. CMS should pay for F2F visits, especially if they would increase in frequency as a result of this change.

Subsection (o). Ensuring Medical Director and Physician Availability

(21) Requirement for immediate availability of the hospice medical director or physician:

The medical director or physician member of the interdisciplinary group would be required to be available for immediate consultation (which may be through telehealth) when hospice care is provided in an individual's home - [MORE INFORMATION NEEDED BEFORE DEVELOPING POSITION](#)

Concerns/Considerations:

- 42 CFR 418.100(c)(2) already requires that physician services (along with nursing services and drugs and biologicals) be made routinely available on a 24-hour basis seven days a week.

Outstanding Questions:

1. How would CMS define/operationalize and audit around "immediate consultation"?
2. How is this provision different than what is required by the existing regulation at 42 CFR 418.100(c)(2)?

Recommendations:

(22) Prohibition on physicians serving as the medical director for more than two hospices:

There is currently no limit on the number of hospices a physician can simultaneously serve as medical director for – [SUPPORT WITH MODIFICATION](#)

Concerns/Considerations:

There are legitimate reasons why a physician might serve as the medical director at more than two hospices. For example, it would not be unreasonable to expect a single physician serving a very rural region to act as the medical director for a number of hospices in the area, given each hospice is likely to have a small census or coverage area.

There may also be situations where a hospice would contract with a physician to provide short-term physician services, such as in an emergency. Given many hospice physicians are specialists in their fields, it would not be unreasonable to expect contracting would occur with a physician working with another hospice. However, a restriction here prohibiting service of more than two hospices might restrict this capacity on the basis another physician could already be working with more than one hospice, which could result in impaired beneficiary access and quality of care.

Recommendations:

1. Congress should require CMS to work with the hospice community and outside stakeholders to analyze data to identify a more reasonable or workable limit on the number of hospices a physician could serve as medical director at simultaneously, as well as identify commonsense exceptions or a possible waiver process to allow for exceeding the limit based on the needs of the community.
2. Allow short-term contracting for core services.

Section 3. Payment Reforms for Hospice Care Furnished Under the Medicare Program

Subsection (a). Adjusted Payment for Hospice Care

(23) Align hospice payment rates to the costs of providing care: CMS would be required to calculate the percentage difference between the hospice payment rates and the average costs of providing hospice care, which may vary based on the setting in which the care is furnished and taking into account any additional factors as determined appropriate by the Secretary. Based on this rates-to-costs calculation, the payment rates for hospices would be adjusted by percentages specified by the Secretary for specified fiscal years. The specified fiscal years are 2027 and every fifth year thereafter for non-routine home care (RHC) levels of care. In the case of RHC, such payment adjustments would begin in fiscal year 2032 and occur every fifth year thereafter – [OPPOSE](#)

Concerns/Considerations:

A fundamental overhaul of the entire hospice payment rate setting process would be a transformative change for the hospice community, and as such, much more data, modeling, and analysis needs to be available and completed before transitioning away from the current system. There is no way to ascertain what impact this change would have on hospices or patients and families. Process-wise, when similarly large payment system changes have been implemented in other Medicare sectors, such as home health, they came only after the kinds of aforementioned data and analysis were performed, and such information was available for the provider community to review, comment upon, and suggest recommendations around. Prior payment reform efforts driven by Congress have often included steps like the creation of Technical Expert Panels (TEPs) and/or the publication of detailed analytic reports that modeled and provided commentary on proposed payment reform ideas. Similar steps should be taken with the hospice community before any large-scale payment system changes are pursued.

With regards this specific proposed change, some of our primary concerns are:

- The payment adjustments in this provision are a major deviation from the current process by which hospice payment rates are established. As it is currently presented, given no analysis has been conducted to support the proposal, the hospice community has no way to fully understand how this change would impact its ability to provide care to patients and families.
- CMS would presumably use hospice cost reports as the source for hospice cost data. Current cost reports are often inaccurate and do not account for the true costs of delivering hospice care. As an example, there is no reimbursement for certain required services, such as bereavement care and volunteer management.
- There are no guardrails enumerated to prevent CMS from continually reducing rates over time based on reduced costs, a dynamic that could result in a “death spiral” of payment rates that could paradoxically reduce patient access and attract even more poor-performing hospices with no qualms providing substandard care in exchange for the lowered rates.

Outstanding Questions:

1. How will services currently not included in cost reports be reimbursed?
2. How will services like bereavement, provided after the death of a beneficiary, be paid for?
3. Would this require CMS to set rates specific to individual hospices’ costs or rely upon averages?

Recommendations:

1. Remove this provision

(24) Creation of new blended per-diem + “per-visit” payment structure for RHC: In fiscal year 2027, CMS would establish a new per-diem payment amount for routine home care that reflects the components of such rates attributable to hospice care not consisting of direct patient care costs (e.g., drugs, DME), and establish new per-visit payment amounts for visits, amounts that can vary based on the type, duration, and setting of the visit. The Secretary would have the authority to set frequency limits on visits for hospice patients. Visits would have to be in-person (no telehealth or telecommunications allowed to count as visits) - **OPPOSE**

Concerns/Considerations:

We understand there is a desire to address issues related to hospices that exploit the per diem payment system by skimping on needed visits. However, these hospices are a small minority of overall providers, and most hospices utilize the per diem structure appropriately and ethically, leveraging the flexibility it provides to tailor the care plan, including the type, volume, and cadence of visits, to the unique needs and preferences of each patient and family they serve.

A pay-per-visit model would represent a “step backward” in terms of where the broader Medicare (and overall health care system) is going in terms of shifting to more value-based and capitated payment structures that do not incentivize volume of services. In this way, the current basic shape of the hospice payment model can actually serve as a model for other sectors that still have not transitioned to any kind of risk-based payment mechanism.

Finally, we reiterate the arguments and data cited in the introduction to our comments that highlights the cost-savings and quality-of-life benefits the current model drives to Medicare and patients and families. We should be extremely cautious about making major changes to a system that works extremely well for the vast majority of patients and take small, targeted approaches to improve the system in cases where it is not working.

Specific concerns include:

1. The payment changes in this provision are a major deviation from the current per diem payment model. As it is currently presented, given no analysis has been conducted to support the proposal, the hospice community has no way to fully understand how this change would impact its ability to provide care to patients and families.
2. As a concept, paying providers for individual visits seems to run counter to the nature of hospice as a capitated model with built-in flexibility to customize visits to meet unique patient and family needs. It also runs counter to the broader shift across the entire Medicare landscape towards value-based care that moves away from paying per unit.
3. Setting limits on the number, type, or cadence of visits for dying hospice patients is antithetical to the philosophy of patient-and-family centeredness core to the hospice benefit. It could severely reduce access to high-quality care for vulnerable beneficiaries and their loved ones.
4. A per-visit structure might incentivize inappropriate visits where care is not wanted or needed in order to maximize revenue by bad actors, creating new problems.

Recommendations:

1. Remove this provision

(25) Additional payment for high-cost complex palliative care treatments: Starting on October 1, 2026, and ending in September 30, 2031, in lieu of the routine home care rate, hospice programs would get paid 200% of the fiscal year 2026 routine home care rate for each day during which palliative chemotherapy, radiation, blood transfusions, or dialysis are provided to a patient under their care (or such other amount determined appropriate by the HHS Secretary, which may vary based on the type of item or service). In the case of palliative dialysis, payment is only made at 200% of the routine home care rate if the individual was receiving dialysis before electing hospice, and payment is limited to 10 sessions of dialysis, unless any sessions over 10 are prior authorized – [SUPPORT WITH MODIFICATION](#)

Concerns/Considerations:

We are appreciative of the recognition that current payment mechanisms make it hard for many hospices to afford provision of these kinds of interventions, a reality that has resulted in access challenges for some patients that may benefit from their palliative effects. We have been pleased to work with Congressman Blumenauer in the past on specific ideas for how best to modify the system to ensure more timely access for some of these types of patients. An example includes efforts to propose a novel way to pay, via Medicare Part B, for palliative dialysis for ESRD patients who are hospice eligible. We understand the importance of increasing access to these types of services and are committed to exploring the best path forward for doing so in a way that provides resources and policy guidance sufficient and specific enough to support hospices' capacity to broaden their coverage of these treatments.

Priority considerations include:

- Given the very high and variable costs of some forms of the four specified palliative interventions, 200% of the prevailing RHC rate would likely be far too little in order for this provision to have its intended effect of meaningfully improving access to hospice care for patients that could benefit from provision of these complex palliative services. Additionally, a single uniform rate for all of these kinds of services does not account for the large discrepancies in their unique costs.
- The provision only covers four interventions, when there are in fact many others that would qualify as high-cost complex services that can address hospice patients' pain and symptoms. Additional examples include inotropic medications for heart failure patients and ventilator-assisted breathing apparatuses for patients with pulmonary conditions. Limiting the additional payment to the four services specified in the provision would unfairly reduce access for other similarly situated patients that would need and benefit from additional interventions to reduce their pain and symptom burden.
- The language "under the supervision" of an oncologist or nephrologist seems to further pull care coordination and delivery away from the hospice IDT and to physicians without hospice and palliative care training.

Outstanding Questions:

1. The legislative language states these services must be furnished "under the supervision" of an oncologist (for palliative chemotherapy, radiation, and transfusions) or nephrologist (for palliative dialysis) – how would CMS define "under the supervision of" in this instance?

Recommendations:

1. In order to ensure an adequate and appropriate payment level, CMS should be required to analyze the real and common costs associated with provision of the types of palliative treatments listed in the legislative language, as well as work with the hospice community and other expert stakeholders to determine what other services should be eligible for the additional payment.

2. Alternatively, CMS could establish a nationwide demonstration project aimed at evaluating the effectiveness and impact of complex palliative treatments with increased payments under the Medicare hospice benefit over a period of five years.

(26) Requirement that the plan of care for high-cost palliative treatments be reviewed by an independent oncologist or nephrologist: If the patient’s plan of care includes palliative chemotherapy, radiation therapy, blood transfusions, or dialysis, the plan of care must be reviewed by an oncologist (in the case of chemotherapy, radiation therapy, and blood transfusions) or nephrologist (in the case of dialysis) that does not have a significant ownership interest in or significant financial relationship with the hospice program - [MORE INFORMATION NEEDED BEFORE DEVELOPING POSITION](#)

Concerns/Considerations:

- There is no definition provided for “significant financial relationship.” An overly stringent definition could make contracting for these services nearly impossible given physician shortages.
- While oncologists and nephrologists bring invaluable expertise in their respective fields, hospice and palliative care physicians possess the specialized knowledge and experience critical to the development and review of a patient’s hospice plan of care. Relying upon the review of oncologists and nephrologists could undermine the central role hospice physicians play in these decisions to ensure the appropriate palliation and management of the patient’s terminal condition under the hospice benefit.

Outstanding Questions:

1. How would CMS define “significant financial relationship” under this provision?
2. Would there be exceptions to this requirement for areas with shortages of the specified specialists?
3. What specifically would a specialist’s review of the hospice patient’s care plan entail? Would they be solely responsible for determining if the high-cost palliative service were related, reasonable, necessary?
4. Would these reviews be paid for under Medicare?

Recommendations:

(27) Removing payment coverage of home health aide and homemaker services from the hospice benefit for hospice patients residing in a skilled nursing facility or nursing facility - [OPPOSE](#)

Concerns/Considerations:

We have extreme concerns about a proposal that would seemingly remove coverage for services of a critical IDT member for a patient population that may be especially vulnerable. While we acknowledge there might be unscrupulous actors that see the contractual relationship between a hospice and a SNF or NF as an opportunity to game the system, punishing patients by taking

services away from them is not the appropriate response. We understand the proposal does not flatly disallow hospices from providing aide services to facility patients, but the lack of payment for those services will effectively force most providers to refrain from using them, which could have very negative impacts on patient satisfaction, safety, and well-being.

The assumption that hospice patients that reside in these facilities receive all the aide services they need directly from the facility's staff presumes these entities are sufficiently staffed, both in quantity and skill, to provide such a level of care. Data and CMS' own regulations would suggest otherwise, however.²⁴

Our priority concerns include:

- This provision would limit or prevent access to necessary aide services for hospice patients in SNFs/NFs.
- Lack of data or analysis on the aide visits provided to facility patients vs. those in traditional homes, and whether or not there is truly less need for hospice aide services in SNFs/NFs
- Hospice patients often have unique and more intense care and support needs than other residents of SNFs/NFs, needs that justify the services provided by hospice aides above and beyond those delivered as part of the facility's Medicare room-and-board payment to the SNF/NF.
- Many SNFs/NFs are understaffed and do not have adequate numbers of aides (or aides trained in/familiar with care for dying patients) to meet the care needs of hospice patients in the facilities.
- This provision seemingly contradicts 42 CFR 418.122(b), which states, "*the hospice is responsible for providing all hospice services including... Provision of hospice aide services, if these services are determined necessary by the IDG to supplement the nurse aide services provided by the facility.*"

Outstanding Questions:

1. If this provision were to become law, and hospices chose to provide aide services even without getting paid for them (because it was the right thing to do for the patient), would that represent a violation of rules prohibiting "inducement"?

Recommendations:

1. Remove this provision.
2. Alternatively, consider requiring CMS to audit hospices with high percentages of SNF and NF patients combined with high rates of home aide visits to ensure duplication of services is not occurring.

(28) Outlier payments for RHC: Starting on October 1, 2031, CMS may provide an additional payment for unusual variations in the type or amount of routine home care provided under the

²⁴ <https://www.cms.gov/files/document/nursing-home-staffing-study-final-report-appendix-june-2023.pdf>

hospice benefit (i.e., outlier payments). Total outlier payments estimated to be made in a given fiscal year may not exceed 5% of total Medicare hospice payments, and total outlier payments to an individual hospice program in a given fiscal year may not exceed 10% of total payments to that hospice. Per-diem payments for routine home care would be reduced by 5% for all hospices if an outlier policy is implemented in a given year. Note that we understand these outlier payments would be intended to help cover the cost of the high-cost palliative care treatments referenced in provision #26 above (the 200% of RHC rate method of payment for those services would end Sept 30, 2031, right as this outlier payment policy would go into effect) - **OPPOSE**

Concerns/Considerations:

- Combined with the other payment reform provisions, the creation of outlier payments represents a major deviation from the current per diem payment model. As it is currently presented, given no analysis has been conducted to support the proposal or model its effects, the hospice community has no way to fully understand how this change would impact its ability to provide care to patients and families.

Outstanding Questions:

1. Is the assumption articulated in the description of this provision above accurate, i.e., is the intent that the broader outlier payment structure would eventually be the sole mechanism by which hospices would be paid for provision of the high-cost palliative treatments referenced in a previous provision?

Recommendations:

1. Remove this provision

(29) Update the aggregate cap calculation to account for the other payment changes in the draft legislation: Would adjust the hospice cap amount in specified fiscal years to reflect the estimated change in percentage in the total payment amount made for hospice pursuant to the changes in that result as a function of aligning hospice rates to costs (highlighted in provision #23 above). This paragraph would also update the cap amount from the previous fiscal year by the market basket percentage increased, reduced by a productivity adjustment - **OPPOSE**

Concerns/Considerations:

- This provision is not needed under the current payment structure.

Recommendations:

- Remove this provision

Subsection (b). Wage Adjusting Caps

(30) Wage-adjustment of the aggregate cap: Would require the hospice cap amount to be multiplied for a given year by a wage index ratio so that a hospice's aggregate cap reflects differences in area wage levels - [MORE INFORMATION NEEDED BEFORE DEVELOPING POSITION](#)

Concerns/Considerations:

- Given wage-adjusting the cap would have major re-distributional impacts on the hospice community, it should not be pursued until more analysis is performed to model its impact and ensure its implementation would not cause such serious access challenges for certain kinds of hospice patients. As drafted, this provision does not protect hospices or patients in low-wage areas from being unduly burdened by wage-adjustment
- Reductions in the hospice cap have been associated with reductions in access to care for certain patient populations, especially those with ADRD diagnoses.
- In 2014, the IMPACT Act changed how the cap was calculated in such a way it has effectively shrunk every year since implementation, compared to how it would have been calculated without the IMPACT Act change. Research, previously cited in these comments, has shown the IMPACT Act changes are correlated with reduced access to hospice care for ADRD patients.
- While the concept of subjecting the aggregate cap to a geographic adjuster can make sense within the context of the current payment system, recent research would justify Congress exploring whether the cap itself is an appropriate and effective tool to support access and efficiency.²⁵

Recommendations:

1. Congress gave CMS authority to modify the wage indices applying throughout Medicare and no serious action has occurred. Hospice continues to be subject to the pre-rural floor, pre-reclassified hospital wage index. Improvement in the applicable wage index for hospice would be a necessary concurrent action if wage-adjustment were pursued.

(31) Reducing the aggregate cap by the sequestration amount: Would require the cap amount to be reduced by sequestration if it is applied to hospice payments in any given year - [OPPOSE](#)

Concerns/Considerations:

- Reductions in the hospice cap have been associated with reductions in care access for certain patient populations, especially those with ADRD diagnoses.
- In 2014, the IMPACT Act changed how the cap was calculated in such a way it has effectively shrunk every year since implementation, compared to how it would have been calculated without the IMPACT Act change. In this way, the cap is already being lowered relative to where it would have been absent this change. This change has cumulatively

²⁵ [Dying or Lying? For-Profit Hospices and End of Life Care](#). NBER Working Paper No. 31035, Nat'l. Bur. Economic Research. 2023 Mar. doi: 10.3386/w31035

produced nearly \$1 billion of savings in the years since its implementation,²⁶ the vast majority of which has not been reinvested by Congress into improving the hospice program, but rather has been used to fund other non-hospice priorities.

Outstanding Questions:

1. Since the current cap is applied in a manner where the revenue side of the equation is at pre-sequestration level, does that fact have the same or comparable mathematical result as this proposal?

Recommendations:

- Remove this provision

Subsection (c). Modification of Requirements Relating to Short-Term Inpatient Care

(32) Changes Inpatient Respite Care (IRC) level of care to only allow five IRC days in a given benefit period: Would change the current statutory language that limits inpatient respite care to no more than five consecutive days to no more than five days during an election period (i.e., five days in the first 90-day election period, another five days in the second 90-day period, and 5 days for each 60-day election period thereafter) - **OPPOSE**

Concerns/Considerations:

The provision represents a limitation not previously imposed on hospice patients. Although beneficiaries may currently only use five days of respite at a time, they may use these five consecutive day periods multiple times in a benefit period. A beneficiary and their caregivers' needs rarely line up neatly with benefit periods, and this imposed limitation could create a new burden for some caregivers. Further, when taking into account the newly developed 15-day transitional respite allowance highlighted later in this document, a beneficiary who availed themselves of the transitional option for the full 15 days would only be able to get five days of IRC during the remaining 75 days of their first benefit period.

Recommendations:

- Remove this provision

(33) Adding coverage of a transitional inpatient respite care period of an additional 15 days: Today, some patients who would otherwise elect to receive hospice care instead opt to receive care at a skilled nursing facility so that room and board is covered for a period of transition. Other beneficiaries in the hospital who are hospice-eligible and families need time to

²⁶ CBO Estimate for H.R. 2471, the Consolidated Appropriations Act, 2022, as Cleared by the Congress on March 10, 2022: https://www.cbo.gov/system/files/2022-03/HR2471_As_Cleared_by_the_Congress.pdf#page=4

figure out how to ensure the patient has sufficient caregiver support to be safely cared for at home. This provision would create a transitional inpatient respite period of 15 days to be used to help eligible patients transition into hospice care sooner from a hospital stay rather than choosing to first go to a skilled nursing facility. Would only be applicable for a beneficiary's first ever election to hospice. – [SUPPORT WITH MODIFICATION](#)

Concerns/Considerations:

We appreciate the innovative concept proposed here that would, if designed appropriately, help address the current access challenges that arise from existing limitations of the IRC level of care's structure. We have heard many stories from our members of cases where appropriate access has been delayed or interrupted for very sick and vulnerable patients coming from the hospital that lack timely caregiver support or are otherwise unable to quickly set up the infrastructure necessary to be cared for in a traditional home.

Overall, IRC is underutilized, and changes may be needed to make it more flexible and responsive to the modern needs of families and caregivers, as well as hospices. Given that, we do have concerns about the limitation proposed here that would restrict this option to only the very first time an individual comes on to hospice. For a beneficiary who revokes or is discharged and wants to come back to hospice, they would seemingly not have access to this transitional respite care. That seems overly restrictive, if the goal is to increase access to this important level of care for more patients and families.

Outstanding Questions:

1. The legislative language states the transitional respite care days would be available to a patient "*only if such individual does not have sufficient caregiver support to be safely discharged to the individual's home.*" – how would CMS define and confirm whether or not an individual has such support?

Recommendations:

1. Allow this level of care flexibility to be available to patients who are not solely electing hospice for the first time.

(34) Reduces the current inpatient day cap from 20% of a hospice's total Medicare patient care days to 10%: The Secretary would be able to increase the cap from 10% up to 20% if the Secretary determines such an increase is necessary to ensure sufficient access to care. [MORE INFORMATION NEEDED BEFORE DEVELOPING POSITION](#)

Concerns/Considerations:

- The reduction of the inpatient cap from 20% to 10% seems to run counter to the fact the other proposed changes in this section impacting inpatient care (e.g., transitional respite, at home respite, counting days a patient gets high-cost palliative treatments) will result in more inpatient days included in the calculations.

- The reduction of the cap also runs counter to CMS concern some hospices rarely if ever provide inpatient care (in FY2023, IRC represented only 0.3% of all Medicare hospice days, while GIP represented only 0.8%²⁷).

Recommendations:

1. The Secretary should study the impact of including more days in the cap calculation and have flexibility in establishing the new percentage to ensure it does not limit access to needed care.

(35) Requiring that days that a patient receives palliative chemotherapy, radiation, transfusions, or dialysis would count towards the overall cap on inpatient days: Currently, only general inpatient care (GIP) and inpatient respite care (IRC) days count towards the overall inpatient cap. This provision would add the days that a patient receives the high-cost palliative services to those that count towards the overall inpatient cap - [MORE INFORMATION NEEDED BEFORE DEVELOPING POSITION](#)

Concerns/Considerations:

- Without comprehensive data or analysis on the amount/volume of days hospice patients currently receive these specific services, it is not possible to determine what impact counting them towards the inpatient cap would have on hospice operations or patient access.

Recommendations:

1. CMS should study and publish data on the volume, timing, and other relevant information related to the provision of these high-cost palliative services delivered to hospice patients

Subsection (d). Hospital Discharge Planning Requirements

(36) Requiring hospitals to include more information and education about hospice in a patient’s discharge planning evaluation: Beginning on January 1, 2028, hospital discharge planners would be required to include in a patient’s discharge planning evaluation the availability of hospice respite care, including the new transitional respite period, in addition to assessing a patient’s likely need for hospice and the availability of hospice care – [SUPPORT WITH MODIFICATION](#)

Concerns/Considerations:

- Although proper discharge planning and execution is essential for patient transitions to hospice, there are outstanding questions about how the execution of this would play out.

²⁷ <https://www.cms.gov/files/document/hospice-monitoring-report-2024.pdf>

- The requirement for discussion around the new transitional respite care presumes ability for all hospices providers to provide this at all times and might improperly induce referrals to certain providers.

Outstanding Questions:

1. What criteria will discharge planners use to determine patients likely eligible for hospice?

Recommendations:

1. Include a requirement for patients likely eligible for hospice be offered a palliative care consult or hospice referral.

Subsection (e). Payment for Respite Care Furnished in the Home

(37) Creation of a short-term in-home respite level of care: Beginning no sooner than October 1, 2026, a new in-home respite level of care would be implemented for use when respite care is provided to individuals in their homes (other than a skilled nursing facility, nursing facility, assisted living facility, or other facility as defined by the HHS Secretary) for at least eight hours during a 24-hour period. In-home respite would not be allowed for more than five days during an election period – [SUPPORT WITH MODIFICATION](#)

Concerns/Considerations:

As defined in statute²⁸ IRC is currently only allowed to be delivered in inpatient settings. Medicare policy does not permit IRC to be provided in a patient's own home. This means in order to qualify for this valuable level of care, very sick and vulnerable individuals must be physically transferred to an inpatient setting, a logistical process that can be burdensome for patients, families, and clinicians, and one that results in very few families availing themselves of IRC, despite research showing that taking care of a loved one on hospice can be demanding and stressful.²⁹

Adding an in-home respite option under the MHB could help alleviate caregiver stress and burden. However, thoughtful consideration of its potential scope, structure, and real-world implications needs to be considered before advancing any policy that would create a dedicated in-home respite benefit in hospice. One particularly impactful factor in such a benefit's potential value and success relates to staffing it appropriately and with properly trained care providers. Given the workforce shortages hospices are experiencing currently, it would be important to design an in-home respite option as voluntary, and not something all hospices are required to deliver. This would give hospices the flexibility to provide the service as it is needed and as their resources allow. Additional consideration would need to be given to the duration of the benefit, as well as its reimbursement level.

²⁸ 42 U.S.C. § 1395x(dd)

²⁹ Pottie CG et al. *Informal Caregiving of Hospice Patients*. *J Palliative Med*. 2014;17(2):845-856. doi: <https://doi.org/10.1089/jpm.2013.0196>

Some key concerns include:

- Beneficiaries and caregivers have requested respite care in the home to minimize transitions; however, with the current workforce challenges facing hospice providers and the healthcare industry in general, being able to provide this level of care would be hard to operationalize for many providers.
- The current requirements and structure for continuous home care (CHC) have highlighted the struggles of providing and documenting eight hours of care, and serve as a cautionary tale for this proposal's requirement for in-home respite be delivered for at least eight hours in a day. In CHC, this has resulted in underutilization of this level of care, even when it may be beneficial, and many instances of hospices not being reimbursed for the services they have provided because it did not meet the complicated rules related to the allowable timing of care provision.
- Creation of this level of care option will encourage use that will contribute to the inpatient cap amount, which a previous proposal would reduce from 20% to 10% - this sends mixed signals to the hospice community about the importance of providing this level of care (and all other kinds of inpatient care, including GIP).

Outstanding Questions:

1. Would this provision require eight hours of care from midnight to midnight (this would require a beneficiary to start this respite care before 4:00 pm to count for the day, which is not how care generally works)?

Recommendations:

1. Do not make this a required level of care but an optional benefit hospices may choose to provide.
2. Allow hospices to contract for this service.
3. Remove the eight hours per 24 hours requirement or allow the eight hours to roll into a second day.

Topics not addressed in the draft bill that should be considered

In addition to the issues and topics addressed in the draft legislation, we believe there are additional proposals worth including in the package.

1. Special Focus Program (SFP) Fixes:

- a. We remain extremely concerned CMS' Hospice SFP will fail to properly identify poor-performing hospices and cause reputational harm to those incorrectly identified as poor-performing. Congress should have CMS refocus the algorithm to focus on hospices that fail to submit quality data, require CMS to provide

additional transparency in the data they use, allow for preview report of a hospices score, and allow a hospice to contest their score based on faulty data.

2. Eliminate the Medicaid room-and-board pass through requirement and have Medicaid NF payment made directly to the NF.

- a. Typically, when a dual eligible individual resides in a nursing home, the nursing home would bill the state Medicaid program for nursing home residential care. However, when such residents are admitted to a hospice program, federal law requires the nursing home “room and board” payments instead be remitted by Medicaid directly to the hospice, which in turn pays the nursing home for providing room and board, as well as, in some circumstances, additional services, under an agreement. The Medicare program pays the hospice for hospice care to the patient. Under federal law, these nursing home room and board payments to the hospice must be at least 95% of what the Medicaid program would have paid directly to the nursing facility if hospice had not been involved.³⁰ Therefore, the vast majority of Medicaid funds paid to hospices are actually for the nursing home room and board care that the state otherwise would have been paying directly to the nursing home. This “pass-through” feature is administratively complex and burdensome to most hospices. Paying the nursing home directly for the room-and-board is a cleaner and more appropriate way to structure these arrangements.

3. Provide funding for hospice interoperability initiatives

- a. Hospices operate in increasingly complex regulatory environments that demand the use of sophisticated technological solutions to manage patient care, report claims data, track quality metrics, and coordinate care with other providers. With a more recent focus on the collection and measurement of the quality of care, and a broader shift towards value-based care models that require seamless data sharing across provider types, advancements in technology coupled with the challenges of collecting data and maintaining up-to-date systems will increase the responsibilities of hospices to respond to data management trends.
- b. Despite the significance of interoperability, post-acute care providers, including hospices, have been left out of previous federal health information technology (HIT) investment programs. Congress should provide financial assistance to hospices to encourage the adoption of certified and interoperable electronic health records (EHRs), especially for providers with limited capital for investments in technology solutions. This monetary support could include incentives such as small business loans, tax incentives, and grants from the Medicare and Medicaid programs. Additional funding should include directing the Office of the National Coordinator (ONC) to develop standards and guidance to support hospice EHR systems’ interoperability with other non-hospice providers’ systems. This more robust and seamless connection across hospice and non-hospice systems is a foundational element that will more easily facilitate future innovation within the hospice benefit itself.

4. Tracking of and reimbursement for chaplain services

- a. In October 2022, [CMS approved](#) three Healthcare Common Procedure Coding System (HCPCS) for chaplain services in the Medicare program. These codes

³⁰ 42 U.S.C. § 1396a (a)(13)(B)

track assessment and counseling (individual and group) by spiritual care givers. However, CMS, through communication with NAHC-NHPCO Alliance, stated these codes cannot be used on hospice claims. Spiritual care givers are core members of the hospice IDT and an essential service for many beneficiaries who have elected hospice. Tracking and reimbursing for chaplain services is necessary to understand the impact and utilization of this service.

5. Late Referral/Admissions to Hospice Study

- a. Require CMS to undertake a study and create a technical expert panel (TEP) focused on the drivers and potential solutions for late referrals/admissions and very short stays on hospice. MedPAC has noted more than one-quarter of hospice decedents enroll in hospice only in the last week of life, a length of stay commonly thought to benefit patients less than enrolling somewhat earlier. They note late hospice referrals stem from broader issues in the health care delivery system that precede the hospice referral including physicians reluctance to have conversations about hospice, patients and families having difficulty accepting a terminal prognosis, and financial incentives.

6. Upstream incentives to support more awareness of and timely access to hospice and palliative care incentives

- a. These incentives could include the development of quality measures for non-hospice providers to support more education on hospice and palliative care and more timely referral to hospice when appropriate. Example metrics applicable to [PPS-Exempt Cancer Hospital Quality Reporting \(PCHQR\) Program](#) include: Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (PCH-32); Proportion of Patients Who Died from Cancer Admitted to the ICU in the last 30 Days of Life (PCH-33); Proportion of Patients Who Died from Cancer Not Admitted to Hospice (PCH-34); Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (PCH-35)
- b. An education and awareness campaign for primary care providers, hospital discharge planners, specialty physicians and non-physician practitioners, and other provider types upstream of hospice who often serve as referral sources for the benefit. A similar type of [campaign](#) was mandated in recent years by Congress for a newly created cognitive assessment and care planning code.
- c. Test a Medicare Care Choices Model (MCCM)-type palliative care demonstration that serves as a transition to the Medicare Hospice Benefit. Eligibility should center around disease constellations or trajectories that place patients at risk for use of high-cost, low value care. Qualified hospice and home health providers should be eligible to provide services under the model. The MCCM evaluation report found the model holds great promise – beneficiaries enrolled in the model were 20% more likely to enroll in hospice and entered hospice one week earlier than their peers in a comparison group, the model reaped substantial reductions in total Medicare expenditures for model participants who transitioned to hospice care, and caregivers of beneficiaries who participated in the model and transitioned to hospice care reported highly positive experiences. The findings from the MCCM model are sufficiently promising that further exploration of a MCCM or similar home-and-community based palliative care model is warranted.