

May 30, 2023

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



Subject: CMS-1787-P: Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements

Dear Administrator Brooks-LaSure,

On behalf of our over 5,000 members and partners including mission-driven organizations representing the entire field of aging services, 38 state associations, hundreds of businesses, consumer groups, foundations, and research centers, LeadingAge is pleased to offer the following comments in response to the FY2024 Hospice Wage Index and Payment Rule.

### **Proposed FY2024 Hospice Payment Rates**

We support the increase in the wage index and rate update but want to emphasize that the proposed 2.8 percent increase is not sufficient to cover the current needs of hospice providers. In the FY2022 Final Rule, CMS staff reviewed the cost pressures for hospice and raised the final rate to 3.8 percent. We do not believe the cost pressures have changed in the time between the finalizing of the FY2022 rule and the release of the FY2023 proposed rule. With the Public Health Emergency (PHE) coming to an end this month, hospice providers took on renewed burdens while still working to support patients, families, and staff impacted by COVID-19. The resources and flexibilities from the government over the past three years have been immensely helpful. However, the ongoing expenses for personal protective equipment (PPE), which will still be required to meet guidance from the Centers for Disease Control and Prevention as part of infection control processes, as well as increased costs for gas, and other increased expenses will remain in hospices' budgets. Many of our members' margins were already thin so increased payment this year and into the future will continue to be essential.

As we shared in our comments on the FY2022 Hospice Wage Index, current workforce shortages have significant impacts on hospice providers and those they serve. Many LeadingAge hospice members are still struggling to hire and retain nursing, social work, and hospice aide staff and even physicians due to rising wages and scarcity of professionals. Burnout and stress continue to add significant strains on existing nurses with more than one-third of nurses in a recent survey saying it is very likely they will leave their role by the end of 2022.<sup>1</sup> Evidence is mounting around this crisis, with surveys showing by 2027 nearly 900,000 RNs are expected to leave the workforce.<sup>2</sup> And it is not just RNs, licensed practical/vocational nurses, who generally work in long-term care settings including hospice, have lost 33,811 of their peers since the beginning of the pandemic.

Regardless of the factors driving the current shortage, the United States is on track to have a shortage of 3.6 million nurses for 82 million aging adults due to demographics by 2030.<sup>3</sup> Hospices are experiencing

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<sup>1</sup> Incredible Health. *STUDY: 34% of Nurses Plan to Leave their Current Role by the End of 2022.*

<https://www.incrediblehealth.com/blog/nursing-report-covid-19-2022/>

<sup>2</sup> National Council of State Boards of Nursing.

<sup>3</sup> American Association of Colleges of Nursing. *Fact Sheet: Nursing Shortage.* <https://www.aacnnursing.org/news-information/fact-sheets/nursing-shortage>, U.S. Department of Health and Human Services, *Supply and Demand*

similar issues with other critical components of the interdisciplinary team like social work and aides. Due to these factors, it is likely that this average wage has increased since the staffing shortages continue to get worse.<sup>4</sup>

Unfortunately, we have also heard from members that many professionals are leaving the field of hospice due to the actions of for-profit entities which have diluted the critical work of supporting the dying into a profit driven venture. We strongly encourage CMS to consider the [34 recommendations](#) we submitted earlier this year in collaboration with other hospice associations to ensure program integrity remains the top priority of the industry.

We have repeatedly shared concerns with the quality of cost report data especially with regards to capturing actual labor costs. Cost reports should be improved and optimized before they are used for payment purposes. Specifically:

- We recommend that the cost reports be amended to allow for a greater breakdown of costs for contracted vs. hospice-administered inpatient services to apportion the labor share appropriately.
- We request that CMS clarify how frequently they intend to update the labor shares component moving forward and clarify the development and methodology around the “standardization factor.” This includes clarification as to how CMS will adjust the labor share if certain types of hospices are found to provide more services and thus, likely have a larger labor share, but contribute fewer cost reports.
- If the labor shares are going to have a greater weight on CHC, let hospices utilize it effectively. We recommend that the definition of a day be any 24-hour period or that CMS create a modifier to allow hospices to bill into a second day up to a 24 hour limit.

### *Wage Index*

We encourage CMS to continue to examine policies to help assuage ongoing wage index inequities. The current workforce crisis has created access issues across the country for individuals seeking hospice services but rural communities, which have larger portions of the aging population, have been hit hardest.<sup>5</sup> **We ask that CMS reinstitute the policy that no hospice be paid below the rural floor for their state and consider working with the Congress on policies to reform the wage index such as looking at how MedPAC’s new proposal<sup>6</sup> would impact hospice and work with the stakeholders, including Congress, on how to implement a fairer system that also takes into account the increased labor costs.**

### **Conforming Regulations Text Revisions for Telehealth Services**

The public health emergency provided flexibilities to hospices in a multitude of areas, but the flexibility to allow expansion of telehealth is one of the most impactful. This is an unprecedented opportunity for hospices to capture data to evaluate the use of telehealth to serve beneficiaries more effectively. CMS

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*Projections of the Nursing Workforce: 2014-2030.* <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nchwa-hrsa-nursing-report.pdf>

<sup>4</sup> Kaiser Health News. “Pandemic Fueled Home Health Care Shortages Strand Patients.”

<https://khn.org/news/article/pandemic-fueled-home-health-care-shortages-strand-patients/>

<sup>5</sup> Hospice News. “Obstacles Persist for Rural Patients to Access Hospice.” Sept. 2021. Available from:

<https://hospicenews.com/2021/09/28/obstacles-persist-for-rural-patients-to-access-hospice/>

<sup>6</sup><https://www.medpac.gov/wp-content/uploads/2022/07/Wage-index-March-2023-SEC.pdf>

proposes in this rule to retroactively remove interim regulations regarding patients receiving routine home care via telecommunications (retroactive to May 12, 2023).

For years before the COVID-19 PHE, hospice providers have used phone and video calls, as well as communication between a hospice nurse in the home consulting with a physician at a remote location, to supplement the high-touch in-person care which is a hallmark of high-quality hospice care. These virtual connections allow hospice providers to maintain constant contact with hospice patients and caregivers when needed, bring far-away loved ones in to end of life care decision making, and provide on-the-spot guidance for caretakers in the home.

During the PHE, CMS affirmed that hospices could continue to use telehealth for these purposes, in the Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency Interim Final Rule with Comment (85 FR 19230), the regulations at 42 CFR 418.204 were amended to allow hospice providers to provide services to a Medicare patient receiving routine home care through telecommunications. Included in this interim change were details of how hospices were to document the use of these telecommunication services (e.g., they had to be included in the plan of care, tied to patient-specific needs, etc.) This reassured hospice providers who were facing the challenges of continuing to see patients and communicate with families while protecting their safety during the height of the COVID-19 pandemic and provided relief from the corresponding unprecedented workforce shortage. As such, hospices used telehealth to supplement in-person care and were able to provide high quality care to patients who were able to receive it through audiovisual technologies.

#### *Adequately Capturing Telehealth in Claims and Cost Data*

The Consolidated Appropriations Act of 2023 extended the authority for hospices to conduct the face-to-face recertification via telehealth through December 31, 2024. The CARES Act enabled hospices to do the required face to face recertification at 180 days (and every subsequent recertification) via telehealth. This recertification must be done via video-audio technology; it cannot be done using audio-only technology. Additionally, MedPAC called on the Department of Health and Human Services to require that hospices report telehealth services on Medicare claims.<sup>7</sup> While some kinds of technology have been used to supplement in-person patient care for years, data on these visits has not been collected on the hospice claims form. Data measuring these visits should be included on the form for the sake of transparency, and to better understand the patient population being served by these in person visits.

In the CY2023 Home Health Final Rule, CMS implemented MedPAC’s recommendation and starting on January 1, 2023, home health agencies began voluntarily reporting G-Codes associated with telehealth use on their claims. This will be mandatory for all home health agencies July 1, 2023. **We ask that CMS implement a modifier or G-code and create a field on the hospice claim for telehealth visits from any discipline, to more accurately represent the full range of visits that hospices provide.**

Furthermore, while hospices can report the total cost of telehealth services on cost reports, the expenses are covered in the non-reimbursable cost centers. In the CY2021 Home Health final rule, CMS gave home health agencies the ability to capture the costs of these services as allowable on cost reports. **We urge CMS to allow that these costs be considered an allowable administrative cost on the hospice agency cost report.**

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<sup>7</sup> Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2022 Mar. Chapter 11, Hospice services; p. 299 – 320. Available from: [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_Ch11\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch11_SEC.pdf)

## Request for Information on Hospice Utilization; Non-Hospice Spending; Ownership Transparency; and Hospice Election Decision-Making

LeadingAge is incredibly appreciative of the opportunity to provide feedback on the utilization of higher levels of care, Part B spending, ownership transparency, and election decisions. In January of this year, LeadingAge, in partnership with other national hospice associations, provided CMS and key Congressional stakeholders with [34 recommendations](#) grouped into 11 core issue areas to improve hospice program integrity. Additionally, LeadingAge responded to a request from a member of Congress, with a [memo around reforms and improvements](#) to the hospice benefit. Many of the questions answered in this RFI are echoed in these two thought pieces which we have linked above. We support CMS' call to action to address issues related to the quality of care and access to hospice care to improve health equity for all Medicare beneficiaries.

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

One often mentioned barrier to hospice care is the lack of the availability of concurrent care. First, we believe that there needs to be a consistent definition of what concurrent care is. Is it treatments that have a palliative effect but are financially prohibitive to hospices? Or is it seeking concurrent curative treatment with hospice? We appreciate CMS using the phrase "end of life palliative care," in an attempt to distinguish these two concepts but believe a consistent definition of each would be helpful.

Second, in addition to consistent terminology, CMS needs to be consistent in expectations. Many of our members have policies on coverage of blood transfusions, chemotherapy, radiation, or even dialysis. These hospices often refer to themselves as "open access" hospices and, according to CMS' own language, that concept should not have to exist since all hospices should be open access. Despite CMS' continued insistence that it is policy that these treatments be covered under the hospice benefit, there is huge variation, no enforcement, and insufficient funding for coverage to be universal.

Realistically, many hospices cannot afford to cover every palliative therapy that may be consistent with a patient's plan of care – which is why we have advocated to Congress for a payment mechanism that would allow for universal coverage of appropriate palliative therapies. But even if Congress were to make sure the funding exists, we would need oversight from CMS to make sure all hospices were actually offering access.

There is also not consistency in how every hospice looks at certain therapies and their intent. Some examples given to us by members include:

- Non-invasive ventilation machines such as the Trilogy machine, are expensive to supply patients despite their ability to provide palliative support.
- Patients with end state renal disease who still are on dialysis almost never receive hospice care. Dialysis is seen by some hospices to be life prolonging to a degree that it is outside the scope of what even an open access hospice should pay for; others do occasionally pay for it or would if it were not cost prohibitive.
- A medication like a heart inotropic medication increases a patient's comfort and is somewhat life prolonging but does not change the underlying diagnosis nor, usually, the prognosis timeline beyond the scope of hospice care. Many members will admit patients in need of a treatment that has a palliative purpose like an inotropic heart medication but others cannot afford to.

The bottom line is that there is not consistency across hospices, patients, or disease states. There are examples like this one across conditions – including treatments that we often think of as “curative” like chemotherapy (which can be used to shrink a tumor to make a patient more comfortable).

If CMS were to eliminate barriers for the coverage of treatments that have a palliative effect while on hospice, the change would extend the length of stay in hospice care and enable more people to access the benefit in a timely manner. For those who are electing truly curative treatments (such as a third line chemotherapy with the intent to cure the disease), we recommend that the billing remain the same.

We ask that CMS:

- Bring together experts (through a TEP or other mechanism) to review common therapies that are barrier to hospice and provided some consensus recommendations around when a therapy is “palliative” in intent vs. “life prolonging” vs “curative.”
- Through this process, it will likely make sense to update local coverage determinations (LCDs) accordingly; LCDs need updating regardless.
- Update, as appropriate, regulatory guidance and work with Congress on corresponding changes to payment policy.

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

We appreciated it when CMS rebased the rates in FY2020 to encourage the utilization of the higher levels of care. The ability to receive GIP or CHC to deal with intense crises throughout a hospice enrollment is a critical component of hospice care. However, CMS enforcement policy is not aligned with its payment policy. According to the data presented in the analysis in this rule, GIP and CHC are still only marginally utilized. If CMS really wants to encourage utilization of the higher levels of care (and LeadingAge believe that they should), they need to match payment and enforcement.

The oversight of GIP is a key example of the mismatch between payment and enforcement. There are significant barriers on the regulatory implementation of the level of care that prevent many individuals from accessing this higher level of care. Regulators and hospices do not have a mutual understanding of GIP eligibility. Often, a hospice provider will admit someone to GIP that they view as meeting medical necessity eligibility criteria – in an acute pain crisis, for example. The goal of GIP is to stabilize that crisis. Hospice providers today are caught in a Catch-22 – if they do this job well, the patient will be stabilized (e.g. pain controlled) but if the hospice keeps them for even a short period of time after some level of stabilization has been documented, their claims may be rejected for not meeting medical necessity. This problem has reached a point where a hospice may get paid for days 1 and 3 of a GIP stay but not for days 2 and 4—this never happens with ICU care. GIP is woefully underutilized and that is because, in the current environment, hospices that take GIP patients are asking to be constantly audited – so while higher payment may seem like an incentive, the regulatory burden of taking this patient far outweighs any payment changes. Contractors are also inconsistent – hospice providers could approve two identical patients for GIP and have one set of claims approved and one set rejected. **We ask that CMS undertake a stakeholder engagement process to identify where the gaps in understanding regarding GIP eligibility lie – both with providers and with contractors. After this review, CMS should issue new clarifying guidance and offer education to all stakeholders.**

The issue with CHC is different than GIP, but also there are regulatory barriers to enrollment. The definition of CHC is that the beneficiary receives at least 8 and up to 24 hours of care during a day that is defined as midnight to midnight. If someone’s need for CHC begins at 4:30pm on Friday and the “day”

ends at midnight Saturday, the hospice cannot count those Friday hours towards the CHC calculation therefore decreasing access to this level of care. **We ask that CMS develop either a modifier that would allow a hospice to bill CHC on a second “day” or allow a “day” to be any 24-hour period.** This change would increase utilization.

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

LeadingAge hospice members follow the published literature on palliative treatments as it becomes available. However, the issue of cost and how to provide uniform access still remains. For example, much of the literature states that 2-3 palliative radiation treatments are effective for hospice patients to remain comfortable, however the cost of purchasing just a few treatments is far more expensive than purchasing 20 or more.

We heard repeatedly from our members that the use of these palliative measures is based first and foremost on the individual goals of each patient. These discussions can slow the hospice enrollment process and since the median length of stay is 17 days, any delays in admission cut down on the time the hospice has to do its work.

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

As mentioned above, many palliative treatments are beyond the reach of hospice patients due to costs. Many members shared with LeadingAge that they do not enroll certain patients because of treatments and even medications the patients and families wish to continue. Because of the barrier of not wanting to forgo certain treatments, patients who are ready for hospice often do not elect. Programs exist to support patients at home, like outpatient or home-based palliative care, but they are not as comprehensive as hospice and not consistently offered or defined.

LeadingAge also represents many smaller hospice programs. Several shared they are simply too small to cover certain therapies and do have to turn away beneficiaries at times. They have done some short-term IVs/transfusions for a specific reason, like goal of attending a granddaughter’s wedding or to be around for a birth. Once again, we ask that CMS clarify what types of treatment fall into what categories – and make recommendations around coverage guidelines with the help of stakeholders. Payment would also have to be adjusted to reflect the more consistent cost of offering certain therapies, but an important step would be all hospices have a mutual understanding of what they should be considering with regards to coverage.

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

We reiterate here our comments above about GIP and CHC. On the GIP side, one main barrier is the regulatory enforcement. Hospices that offer robust GIP services are, in essence, raising their hands and asking to be audited. Since it is such a small percentage of the hospice community that offers GIP, the same providers are getting audited repeatedly, often by different entities who have seemingly different standards. We recommend that CMS work with stakeholders on what the gaps in understanding are.

They should use this assessment to clarify minimum standards and the intent around the general inpatient level of care and issue clarifying guidance accordingly for all its contractors and surveyors on the goals of GIP, creating a cohesive approach to this level of care. Education is also going to be critical. We cannot put enough emphasis on the amount of administrative burden it takes to offer consistent GIP care in the current environment and implore CMS to take a holistic approach to matching payment and oversight. If the current trend keeps up, no hospice is going to offer GIP.

For hospices that do not have their own inpatient units, it can be challenging to secure contracts for GIP and/or respite care. It depends on the geography. There would need to be requirements on our partners with whom we must contract to accept our Medicare rates – right now, contracting for beds is often a money loser for a hospice.

We strongly believe that GIP is critical and more inpatient hospice care should be available. LeadingAge advocates for the creation of a residential room and board level of care, similar to what exists in some states, because we hear from members about patients and families that do not want to die at home for a whole slew of reasons from cultural to caregiver support.

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

Unfortunately, hospices do not see billing outside the benefit as a new issue with their services though there has been growth in recent years as CMS' analysis identifies. While LeadingAge understands CMS' concerns with billing outside the hospice benefit, we strongly do not agree that this is strictly a hospice issue. Our members shared that they are seeing significant growth in outside the benefit billing in facility-based settings with podiatry billing for hospice enrollees and wound care physician visits with supplies not pre-approved by hospice. Sometimes these services are eligible for support under the hospice benefit, but other times hospice is not even consulted. Many nursing facilities have struggled to hire and retain staff in the current workforce crisis, often resorting to staffing agencies where staff are not consistent making education about the hospice benefit and services more difficult. In these situations, CMS needs to more clearly identify each individual provider's responsibility to support the patient.

It is incredibly difficult and onerous to put the full responsibility of managing other professionals on to an individual hospice especially as they have no ability to track billing by other providers. These professionals should have access to patient charts and see clearly the election of hospice. There should be a "red flag" option similar to what DME providers have when they go to bill in support of home health visits. If someone is on hospice, DME providers will be notified prior to billing that the individual is on service with another agency and they should not be billing Medicare directly. Additional training of all health care providers would go a long way to help them understand that billing outside the hospice benefit when a beneficiary is enrolled could be considered fraudulent or may be rejected if not part of the plan of care. Nearly every provider can run a check on insurance and an individual's Medicare eligibility, just like hospice, and there could be a flag that the individual is on the hospice benefit. We have yet to see CMS take action against other provider types for inappropriate billing of services when an individual is on hospice.

In order to better share information between providers, LeadingAge believes that federal financial support is necessary to ensure nationwide interoperability of health IT and data exchange and sharing across the care continuum, including technological functionality to improve quality of care, patient safety, and infection control during this pandemic and beyond. Interoperable health IT technology is

foundational and a key enabler of data collection and reporting and other models to come. Unfortunately, post-acute care providers including hospices were not included in interoperability incentives which has caused a significant lag in the transfer of information and the coordination of patient care. CMS must work with the Office of National Coordinator of Health Information Technology to advance hospices ability to proactively participate in interoperability.

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

LeadingAge's nonprofit, mission driven members are incredibly focused on communicating clearly with families and patients about what is and is not covered by the hospice benefit. Our members work diligently to create individual, goal-oriented care plans for each patient so they understand what services they can and cannot receive on the hospice benefit. Sometimes that does include items that would be traditionally considered curative but are being utilized for palliation to achieve a specific patient goal. Additionally, our members work closely with care networks to connect patients who may not be ready to give up mor aggressive curative treatment to make sure they have access to additional palliative care support.

Going along with our recommendation that CMS further differentiate certain types of therapies and treatments to aim for a more uniform coverage policy, that information should also be communicated to patients and families – and a hospice can then build on how their own policies might differ from the standard.

A note on enforcement here – inherent in the question is the assumption that there might be more information beneficiaries need to know. While that is likely true, we also need more oversight around what IS being told to beneficiaries. Contained within our 34 program integrity recommendations is one around marketing practices which is relevant here. We hear terrible stories about patients and families being told that they can get aide services or durable medical equipment – which are indeed part of hospice care for appropriate patients – but these services are being used as an inducement onto the benefit. We have also heard about hospices who buy cars or luxury goods for high referral sources. Whether it is a new condition of participation or part of a survey or some sort of “secret shopper program” – these are practices that should be the source of CMS oversight.

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

Our hospice members explain the Patient Notification of Hospice Non-Covered Items, Services and Drugs on admission. However, understandably, the decision to elect hospice can be difficult and emotional for many Medicare beneficiaries and their loved ones and the admission process includes a lot of information critical to the benefit. Some information will remain intact, and some will not. While many individuals understand the benefit at a high level many are also very used to driving their own health care usage and seeking out services independently. Hospice is a unique benefit in that patients must give up much of their autonomy to make health care decisions especially about their primary diagnosis that made them eligible for hospice services. Hospices often find beneficiaries continue to seek out services outside the hospice benefit regardless of the information shared with them when they elect the benefit, simply out of preference or habit with no ill intention. When a hospice is notified of beneficiary spending outside of hospice, it is often too late for the hospice to cover that service.



Hospices share this information with individuals when they elect the benefit, but again, given the gravity of the decisions individuals are often overwhelmed at this time and do not fully understand the limits of the benefit. There is also often miscommunication from the community based primary care clinician on the benefit and what is allowed or not allowed. There should be a stronger requirement for the attending physician to communicate with the hospice initially and identify items and services that are related to the terminal diagnosis that the hospice should be paying for.

While beneficiary education should always be a priority of every Medicare provider, it is critical that non hospice providers take responsibility for not billing services inconsistent with the hospice plan of care.] That burden should not fall to terminally ill individuals and their families to figure out.

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

While LeadingAge absolutely understands and supports CMS' interest in making information available to patients and families to make informed decisions about hospice selection, we find the current structure of consumer facing information on hospices lacking. Many of our members feel that as healthcare professionals, the Hospice Care Compare is navigable, but as a lay person, the public has no idea how to interpret the data presented. Levels of care specifically may not be a helpful tool as the authorization and eligibility for each is very complex and individuals may not know if they or their loved ones could qualify. We also believe the current method to make comparisons on Care Compare would be easier if comparable hospices, up to four at a time, were automatically pulled for consumers to compare. In our joint recommendations for program integrity reforms, we specifically outlined an item to improve the readability of Hospice Care Compare for Consumers; those recommendations are:

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

There is not clear evidence to state that the quality of the visits and care provided is held in the number of visits or the total minutes. More visits are not always better. Caseloads also vary greatly based on agency structure and their technology use.

With regards to staffing levels, the nursing shortage will factor into this as well. If hospices were compensated more appropriately for current labor costs, they would be competitive with hospitals to offer greater intensity of service. However, for hospices in rural areas, staffing continues to be a challenge on two fronts. First, even with the Public Health Emergency (PHE) ending, having skilled beds available for respite care remains low and reengaging partners to contract for these beds remains slow in the post COVID19 era. Second, in rural areas it is difficult to have enough staff to dedicate to one patient based at home, potentially miles from other patients, instead of bringing them to one in patient location.

This could also be an opportunity for publicly reviewing the holistic nature of a hospice's care. Not only does a hospice provide nursing care, but it also provides spiritual care. Sharing how often and what types of support are available could help families make more informed decisions. Looking at volunteer use and what types of support families can receive from volunteers could help. Auxiliary services outside the core of the benefit like music or massage therapy could also help make decisions. A critically important piece of the hospice's conditions of participation which are not shared currently is the availability of after-hours care or looking at how often the hospice can accommodate weekend admissions. All this provides a more robust view of a hospice's commitment to the philosophy of hospice.

With regards to higher levels of care, yes it would be helpful if this were more prominently displayed on Care Compare. CMS should provide context as to what those levels of care are, why it is important a hospice offer them, and some information about where a certain hospice is in comparison to others with regards to offering higher levels of care. For example, it would be important to know if a hospice offers no levels of care besides routine home care; but also if one hospice offers 1 day of a higher level of care in a year and another hospice offers it more regularly, that is also important to know

Building on this last point, we have looked at the HCI index and the elements that make up the measure that CMS offers publicly. **We found it was impossible to receive a deduction for not offering CHC or GIP.** This is supposedly a component of the HCI yet it is not possible to actually lose a point on the index for not offering the higher levels of care rendering this portion of the metric meaningless. CMS should fix this by changing the measure to account for the tremendous variance in the sizes of hospices. The denominator (total service days) ranges from 113 patient days to 7,205,651 patient days, and yet the criterion to meet the measure (at least 1 day CHC/GIP) is the same for all hospices. Many of the higher patient day totals likely comprise multiple hospice locations under one CCN, yet providing a single day of CHC or GIP is enough to earn a point for this measure. CMS should consider providing the numerator for transparency and if percentile is to be used in a re-described measure, then rounding should not be employed.

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

Arguably patient care is becoming more complicated. Medicare beneficiaries may have a long-term illness that is not associated with their terminal illness such as A-Fib on Eliquis but their terminal diagnosis is Stage IV Cancer. Discontinuing long term drugs could have a detrimental impact on their quality of life, which continuing the sometimes very expensive medications could help with palliation even if they will not cure the primary diagnosis.

This issue is similar to billing outside the hospice benefit. Often hospices lack access to all clinical records and other providers are not well versed in the hospice election and coverage process. Often beneficiaries who have a Part D plan have opted for automatic refilling and do not know how to turn that option off. With all the options for Part D plans it is overwhelming for a hospice to track down each plan to inform them that the beneficiary has elected hospice. Hospice should be identified when a Part D plan is billing for a service that a hospice has not approved, and it should be denied. If the services is truly critical to the care of a patient, hospices would have identified it in their comprehensive assessment and person-centered planning process. Hospices have no authority or control over other provider billing, and as such Part D items are billed outside the control of hospices. Hospice should not be subject to penalties due to the inappropriate actions of other providers.

Additionally, for many beneficiaries they have been taking maintenance medications for many years, possibly decades and there is a psychological comfort in continuing the medication. Even drugs deemed related can be expensive to offer, as discussed in the earlier portions of this comment. Admissions teams review what medications are in the current plans of care and the costs of those drugs to provide. The clinician overseeing the hospice plan of care may not think a medication is necessary now that the patient is on hospice, but it would take time with the patient and family to form that trusting relationship. All of these situations lead to access barriers for individuals who qualify for hospice.

We strongly encourage CMS to pursue additional program integrity measures as well as clear education to other providers who bill for services outside the hospice benefit when a patient has elected hospice services. We also encourage CMS to more clearly identify the types of drugs that would fall under the hospices responsibility vs those that could remain on a Part D plan benefit to avoid barriers to hospice access.

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

LeadingAge has advocated for over a year to make ownership information public and transparent. We were incredibly grateful to the administration for releasing this data in April so the industry can better understand the composition of ownership. This sets hospice and home health on a level playing field with hospitals and nursing homes to understand the impact of ownership types on the quality of care.

While we appreciate this information, we would encourage CMS to look at Hospice Care Compare and work to integrate this new information effectively.

- CMS should identify which hospices are part of larger national or regional chains. This could be helpful information for consumers who may want to be with a larger organization if they are planning any transitions during their election (if they wish to see family across the country as part of the goals a chain could help with continuity of care), still others may wish to work with a local independent hospice that knows and understands their community.
- CMS should either eliminate the “other” category of hospice ownership from Hospice Care Compare or further explain to consumer what entities fall under that category. We fear that many hospices are miscategorized based on the broad definition of “other”. Types of ownership should be consistent across all Care Compare platforms.
- CMS should include the “Doing Business As” names in the care compare data as many agencies may be part of larger hospice ownership groups but have a local name that is more commonly

used in a community they serve. This will make it easier for individuals to search for local agencies.

- CMS should include information on “Provider Changed Ownership in Last 12 Months” as they do for nursing homes. This will help understand the current conditions of the hospice and if there are any transitional issues that often arise in a change of ownership, including changes in previous hospice policies around payment for palliative treatments like chemotherapy.

### **Request for More Information on Health Equity**

LeadingAge made a commitment in to increase focus on governance, diversity, equity, and inclusion within LeadingAge member organizations.<sup>8</sup> To achieve this work we have launched a series of initiatives including member networking opportunities, education on equity, diversity, and inclusion for member organizations, and supporting public policy to make aging services responsive to underserved populations.

The LeadingAge LTSS Center @UMass Boston published a research brief in late 2021 with insights about diversity, equity, and inclusion from leaders of LeadingAge member organizations.<sup>9</sup> While many of our hospice members have worked carefully to identify barriers within their own communities, the efforts are made more difficult without a nationally recognized and required assessment tool like all other post-acute settings have.

We look forward to partnering with CMS on this important work and hope there will be more opportunities to comment on health equity. This is a critical learning opportunity for providers across the continuum of aging services but unfortunately the playing field is not yet level for all providers including hospices.

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

Many hospices work hard to understand the makeup of the communities they serve to provide culturally appropriate and representative care. They also work to build relationships with those communities through events and activities at respective community centers and churches. Many track the hospice enrollment for underserved communities. This effort is often one of the core missions of mission driven, non-profit hospices, to understand and serve their entire community.

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

Many of our members report upstream influences on decisions to elect hospice. Having a supportive primary care clinician is essential to creating hospice referrals and accessing the benefit. Additionally, most beneficiaries will utilize the routine home care level of hospice almost exclusively. While this is a tremendous benefit and prioritizes many individuals’ wish to die at home and not in an institutional setting, it requires an immense commitment from families to support the dying individual. One barrier to accessing hospice is the lack of consistent family caregivers to support someone at the end of life. While many hospices provide aide support, volunteers, and nurses, this is not a 24-hour benefit and often families find themselves alone during crisis situations. Education and training are critical for family

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<sup>8</sup> LeadingAge. LeadingAge 2021-2023 Strategic Plan. Dec. 2020. Available from: <https://leadingage.org/sites/default/files/2021%20LeadingAge%20Strategic%20Plan.pdf>

<sup>9</sup> LeadingAge LTSS Center @UMass Boston. Creating a Diverse, Equitable, and Inclusive Workforce Culture: Perspectives of LeadingAge Members. Nov. 2021. <https://www.ltsscenter.org/research-how-are-leadingage-members-advancing-dei-values/>

members, but even more, easier access to the higher levels of care, could ease family stress and create greater access to the benefit.

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

Going deeper into the divide between urban and rural, LeadingAge would encourage CMS to look at a rural deprivation index. These indices have been developed in the United Kingdom not to look just at the rural nature of an area based on population but also opportunities for housing, work, and services among other indicators. This gives a much better picture of the type of community an individual beneficiary lives in vs. simply assessing how many people may be in a given area.

Similarly, looking at urban centers through the lens of built environmental factors could help hospices adjust to understanding they type of individual needing services in a given urban center. For example, food deserts could compound care for terminally ill individuals and their family caregivers. Presence individuals in heat islands, which are urbanized areas that experience higher temperatures than outlying areas, can affect the symptoms and necessary interventions of a hospice to serve individuals in those areas.

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

With the development of the new assessment instrument, CMS will have access to comprehensive data on the patient population served by hospices. Stratifying the data and identifying individuals served by hospices in vulnerable and underserved populations could give insight into the struggles those communities have in accessing services. For example, certain communities of underserved individuals lack access to hospice due to not having enough family caregiver support. Having this understanding of the patient population could help hospices in similar communities identify innovative ways to support those experiencing access issues due to a lack of family caregivers by supplementing with more volunteers. A more holistic approach to data collection and analysis from CMS' global view could help prompt innovative interventions and even possible changes in the benefit to support vulnerable and underserved populations.

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

Collecting information on other health-based program enrollment (i.e. other programs that support or supplement Medicare services) would be beneficial to better understand the sociodemographic and SDOH. Due to the siloed nature of the health and human services system across the country, and the variability between states, it is often difficult to understand the true nature of a patient's environment and access to services and supports. While many hospice beneficiaries may qualify for support outside of the Medicare system, like supplemental food benefits or rental support, hospices do not necessarily know about these benefits or how to support individuals in accessing them. Even at the end of life, access to additional support can ease anxiety and make hospice access more feasible especially in the case of identifying housing. If CMS would be willing coordinate with other federal agencies and identify ways to tag Medicare beneficiaries eligible for other supporting benefits, hospices could help individuals access those benefits to ease the burdens of transition at the end of life.

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

Our hope is that the forthcoming Hospice Outcomes and Patient Evaluation (HOPE) tool will offer some immediate support to hospices around capture of data for health equity. Much like the other settings of post-acute care, including home health and skilled nursing, the consistent collection of SDOH data across settings that often transition patients to hospice will be critical.

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

Consistency between care providers is critical. As of right now, there is not a consistent assessment tool which all hospices use to collect data on patients. Hospice has historically been behind all other settings in the Medicare program on quality measurement. Abt Associates is currently conducting research and development for CMS on the HOPE tool which is long overdue. However, it will not be completed and formally implemented in the program for several more years. CMS and Abt Associates should ensure the HOPE tool contains the means to measure impact on social determinants of health and that it is consistent with efforts in other settings, creating standardization across post-acute care providers. Given this ongoing tool development, collecting SDOH and race and ethnicity information has been a barrier generally. Some providers will find barriers in training staff to differentiate social determinants of health from race and ethnicity and understanding the root causes of health inequality including racial bias and racism. We also hope that it will be consistent, to the extent practicable, with tools used in other sectors and that data sharing is supported and promoted. Any and all information that can be provided to a hospice upon admission of a patient that helps them to implement that most patient centered care quickly would be helpful.

#### **Codifying Hospice Data Submission**

LeadingAge supports CMS' proposal to codify requirement that hospices must meet or exceed a data submission threshold set at 90 percent of all required Hospice Item Set (HIS) records within 30 days of the event (that is, patient's admission or discharge) and submit the data through the CMS designated data submission systems. We also support codifying that hospices must meet or exceed this threshold to avoid a 4-percentage point reduction to its annual payment.

LeadingAge represents the continuum of aging services and appreciates CMS' commitment to aligning requirements across provider setting including home health which currently has a 30-day submission requirement for the OASIS, and skilled nursing which has a similar proposal in their FY2024 proposed rule for completion and submission thresholds for the Minimum Data Set. Not only will this additional requirement align with other settings, but we believe it has the potential to help prevent fraud and abuse of the benefit by agencies that purposefully enroll fewer patients than the reporting threshold for the Hospice Quality Reporting Program.

CMS also proposes that this threshold would apply to all HIS or successor instrument records adopted into HQRP. We question if it is premature to codify all instrument-based measures and data elements of successor instruments without allowing providers to review what those measures and elements are and provide feedback to CMS. The report on the Hospice Outcomes and Patient Evaluation (HOPE) tool, as of the publication of the FY2024 Hospice Wage Index proposed rule, has not been released, meaning the majority of providers not engaged in the beta testing process have no indication of what elements and measures are in the new tool or the time required to complete and submit this assessment.

**We encourage CMS to focus first on the submission threshold and timeline for HIS and amend the requirements in future rulemaking once HOPE is officially proposed for data collection and providers have had the opportunity to comment on the elements and collection process.**

### Proposals Regarding Hospice Ordering/Certifying Physician

We understand and strongly support CMS' efforts to improve hospice program integrity oversight including monitoring the role of physicians in fraud and abuse. We do question what impact this may have on access to the hospice benefit if physicians find this enrollment process, or the process to opt-out, which is not clearly defined in this rule, too burdensome.

LeadingAge would like to share some concerns regarding the process CMS took to initiate this effort. Last year, CMS issued [CR 12889](#) which instructs Medicare Administrative Contractors (MACs) to edit for validating the attending physician's NPI includes hospice claims. This was prior to the stakeholder community having any opportunity to comment on the inclusion of provided NPI numbers from the FY2024 proposed rule. In the rule CMS included a proposal that physicians ordering and certifying hospice care be enrolled in PECOS or validly opt-out, as of right now hospice attending physicians are not required to be PECOS enrolled. The edit for MACs, which went into effect April 3, caused hospice claims to be rejected when the physician's NPI was not found in the PECOS file. While CMS has made efforts to correct this initial issue, it leaves the provider community concerned that CMS will not take into consideration concerns voiced in the comment period for this year's proposed rule.

Additionally, we are concerned that there will be an additional burden placed on hospice agencies to track down provider numbers or ensure their referral sources are properly opt-ed out of enrollment. While this requirement has been implemented in the home health space for years, there has been very clear burden placed on home health agencies to follow up with referring physicians if they neglect to include their information. This leads to home health agencies hiring couriers and expeditors to run between agencies and certifying physicians' offices adding unnecessary administrative burden.

Finally, we recognize that both the Office of Inspector General (OIG) and the Government Accountability Office (GAO) have identified instances of significant physician involvement in fraud. However, it is not clear from the information presented in the proposed rule how many physicians who have referred patients to Medicare hospice services were not enrolled in Medicare themselves or how many of the physicians identified in the OIG and GAO reports as conducting fraud were not enrolled in Medicare. The OIG report did not specifically identify the examples of fraudulent certifications as being conducted by non-Medicare enrolled providers. This type of information would be critical to understanding the breadth and depth of the issues and weighing those integrity concerns against the potential for more administrative burden on physicians and hospices.

**LeadingAge asks CMS to review existing data on hospice referrals from non-Medicare enrolled physicians and present those findings in future rulemaking. We also ask that CMS review the administrative burden on hospices, not just physicians, and include this information in future rulemaking. Allowing the stakeholder community to see this information and provide feedback is essential to making informed policy decisions that improve program integrity without creating unnecessary barriers to services.**

We thank you for your consideration of the issues highlighted above. My contact information is below if you wish to discuss any of the recommendations.

Sincerely,



Katy Barnett

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