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May 30, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator, The Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20101

RE: 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:

The National Hospice and Palliative Care Organization (NHPCO) appreciates the opportunity to submit comments on the provisions in the **FY 2024 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements** proposed rule (CMS-1787-P), published in the Federal Register on April 4, 2023. We look forward to our strong, continued collaboration with CMS regarding the full range of issues impacting the hospice and palliative care provider community and the patients and families we serve.

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. In addition, hospice and palliative care members employ thousands of professionals and volunteers.

We have focused our comments on the potential impact of these proposals on hospice providers serving patients with serious and life-limiting illness and their families, including comments directly from providers, in italics below. Comments from providers are from large and small hospices, for profit and not for profit providers, as well as from hospices throughout the country. NHPCO wants CMS to hear directly from hospice providers, particularly in the responses to the questions in the two Requests for Information (RFIs).

## A. FY 2024 Hospice Wage Index and Rate Updates

NHPCO heard from hospice providers throughout the country with concerns about the 2.8% hospice payment update, which is failing to keep pace with the rising costs hospice providers have experienced in recent years. The Consumer Price Index for All Urban Consumers (CPI-U) increased 4.9% year-over-year in April 2023.<sup>1</sup> Hospice providers have also reported significant wage increases required to address competition for healthcare workers.

Hospice providers are uniquely impacted by insufficient payment rates for several reasons.

- The hospice per-diem payment covers all services related to the beneficiaries' terminal illness. This means hospice providers are at financial risk for rising costs and reimbursement that does not match the cost of care. This has been magnified during the public health emergency and an inflationary period. MedPAC reports 25% of hospice patients had a length of stay of five days or less, and 50% of patients had a length of stay of 17 days, a decrease from the previous year.<sup>2</sup> Since hospices incur significantly higher costs during the intake and admission of patients and at the start of care, for the increasing numbers of hospices with rising numbers of short stay patients, patient care costs significantly exceed payments.
- Given the demographics of hospice patients, Medicare reimbursement represents nearly 90% of a hospice provider's patient care revenue,<sup>3</sup> in comparison to other Medicare provider types whose payment mix includes a higher proportion of Medicaid and private insurance carriers, as well as various other streams of payment. This reliance on Medicare, along with a set per-diem payment makes hospice providers uniquely dependent on Medicare for almost all of their reimbursement and leaves no room for negotiation on price.

NHPCO has gathered specific concerns from hospice providers around the country about the cost of delivering hospice care in these challenging times and shares them below:

**Workforce issues:** Hospice providers are now seeing critical staffing shortages among nurses, social workers, aides, and other members of the interdisciplinary team (IDT). Hospices generally need staff who have experience furnishing end-of-life care, further limiting the pool of candidates who are qualified to serve in hospice care roles. Additional concerns include burnout and an aging workforce which is plaguing all of healthcare.<sup>4</sup>

Providers report for 2022, nursing wages increased by as much as 23%, aide wages increased by as much as 12% and wages of other members of the interdisciplinary team increased by 5-6%. Due

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<sup>1</sup> U.S. Bureau of Labor Statistics. *Consumer Price Index – April 2023*, (May 10, 2023), <https://www.bls.gov/news.release/pdf/cpi.pdf>.

<sup>2</sup> Medicare Payment Advisory Commission (MedPAC), MARCH 2023 REPORT TO CONGRESS, fig. 10-2, 297, <https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/>.

<sup>3</sup> *Id.* at 289.

<sup>4</sup> Kamal AH, Wolf SP, Troy J, et al. *Policy Changes Key to Promoting Sustainability and Growth of the Specialty Palliative Care Workforce*. 38 *Health Affairs* 6 (2019), <https://doi.org/10.1377/hlthaff.2019.00018>.

to the highly competitive marketplace, hospice providers also needed to provide retention bonuses and incentives to minimize staff vacancies. Hospices are not well positioned to compete with hospitals, staffing agencies, and other post-acute healthcare providers to recruit qualified care team members without significantly increasing their compensation costs. This is particularly troubling as the need for a robust and skilled hospice workforce will grow given the nation's aging population and the increasing demand for hospice services.<sup>5</sup>

**Inflation:** The rate of inflation continues to increase and creates pressure on hospice providers through increased costs of gas and mileage reimbursement, medical supplies, drugs, and purchases for operations.

**Increases in other hospice costs:** In addition to the substantial increases in staffing costs, providers report other hospice costs also increased, such as medical supplies increasing by 18% and the cost of some medications increasing by as much as 73%. These cost increases are not sustainable without an increase in Medicare payments. The financial pressures on hospices are real and significant. The FY 2024 proposed market basket adjustment of 2.8% is not nearly enough to provide adequate reimbursement more closely matching the cost of providing quality care.

**Special exceptions and adjustments authority:** In FY 2021 and FY 2022, the final hospice market basket payment updates published by CMS were 2.4% and 2.7%, respectively. However, the data used to set this update did not take into account the record high inflation or the substantial increases in staffing costs, the cost of medical supplies, and the cost of drugs over the previous two years. Our analysis of the actual market basket update for 2021 is 3.0% and for 2022 is 5.7%, using the IHS Global Inc. (IGI) 2022Q4 forecast.<sup>6</sup> This represents a 3.7% variance from the combined FY 2021 and FY 2022 actual market basket updates.

The FY 2024 proposed market basket adjustment of 2.8% does not take into account the inflationary pressures hospices are facing, the continued challenge with the cost of staffing in a highly competitive market, or the extreme financial pressures on hospices today.

### **NHPCO Recommendation:**

- NHPCO requests a one-time retrospective adjustment, using CMS' special exception and adjustment authority to revise the Hospice Wage Index and Quality Reporting final rule. We request a 3.7% adjustment for the combined FY 2021 and FY 2022 market baskets to ensure Medicare payments more accurately reflect the cost of providing hospice care. We request

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<sup>5</sup> Holly Vossel. *Hospice Market to Nearly Double by 2030; Palliative Care to See Large Gains*, Hospice News (Sept. 29, 2022), <https://hospicenews.com/2022/09/29/hospice-market-to-nearly-double-by-2030-palliative-care-to-see-large-gains/>; *Nation's median age jumps to almost 39, while fewer babies born: census*, the Associated Press (May 25, 2023 10:03 am ET), <https://thehill.com/homenews/4020409-nations-median-age-jumps-to-almost-39-while-fewer-babies-born-census/>.

<sup>6</sup> CMS, *Market Basket Data* (Apr. 14, 2023 12:07 AM), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData>.

consideration for this FY 2024 Hospice Wage Index rule, but if it is not possible, we further recommend this special exception and adjustment request be included in the upcoming CY 2024 Home Health proposed rule, where we also expect the hospice regulations related to the Hospice Special Focus Program to be published.

**B. Request for Information (RFI) on Hospice Utilization; Non-Hospice Spending; Ownership Transparency; and Hospice Election Decision-Making**

**1. 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?**

We are concerned the question posed above seems to make the assumption these are treatments the hospice should provide, and hospices who have not provided these higher cost treatments are somehow not providing the full range of services available in the hospice benefit. NHPCO urges CMS to review our comments and the comments from providers to fully understand the challenges of providing these treatments without some change in payment policy.

NHPCO has discussed the provision of these higher cost end of life treatments with many providers as we prepared these comments. The provision of hospice in 2023 is vastly different than the original Medicare Hospice Benefit designed in the 1980s. Today, there are many treatment options that allow some hospice patients to have reduced symptom burden and improved quality of life; however, many of these treatments are so expensive they cannot be used without a separate payment. For some smaller and rural hospices, the cost alone of such treatments would be such a financial burden that to include one of these treatments on the patient's plan of care could seriously compromise the financial viability of the hospice; offering these treatments to a number of patients could bankrupt the hospice with the current per diem payment structure.

Other considerations include the lack of knowledge among some specialists about palliative treatments, the unwillingness of some specialists to communicate the benefits of hospice earlier in the disease process or the decision to continue to treat, even when it was very clear the patient was eligible for hospice and could no longer tolerate aggressive treatment.

**Limited use of these treatments for end of life hospice care:** As published in the FY 2024 proposed rule, the median length of stay in hospice is 19 days and data show 25% of patients have a length of stay in hospice of five days or less. Providers report it is highly unlikely these higher cost treatments would be appropriate for most patients with such a short length of stay in hospice, and even for hospice patients with longer lengths of stay, the burdens of these interventions often outweigh potential benefits. Some patients delay hospice admission to continue receiving these costly interventions, which further contributes to the short length of stay when they do elect hospice.

**Transportation:** Sometimes, the patient can travel to the treatment appointment to receive these interventions by personal car, but often additional transportation assistance is necessary. The ambulance or non-urgent transport costs are also the responsibility of the hospice, adding to the cost of the treatment and creating an additional impediment.

**Providers' experiences:**

***For all treatments:***

- *It depends on whether the intervention or treatment is intended to meet a goal. Delaying admission due to these reasons often contributes to a short length of stay.*
- *The costs to provide palliative chemotherapy or radiation, airway support for those with ALS (such as cough assist or CPAP type devices), and blood transfusions makes it cost-prohibitive for hospices to admit these patients until so late in the disease process that they do not receive the full benefit of hospice care. Our hospice tends to approve a few of these procedures but can only do in limited circumstances because of the high cost. We lose admissions sometimes.*

***Radiation:***

- *We approached an interventional radiology practice to ask about single fraction radiation to target pain in bone metastasis. The response was that “we don’t do that anymore.” We expected that the payment for one treatment was not enough to be of interest to the practice.*
- *Cost is a huge factor – one radiation treatment at \$8,000 will put us out of business so we cannot absorb those costs and wait until the treatment is complete before admitting.*

***Blood Transfusions:***

- *In our area, blood transfusions can only be done in the inpatient setting, so if the hospice does not have a contract with the hospital, blood transfusions could be difficult to arrange.*
- *For patients who want to elect their hospice benefit and have been receiving regular blood transfusions, our hospice physicians often offer the pt the opportunity for one more blood transfusion after signing on, but if the patient is not willing to stop this support we do not admit.*

***Dialysis:***

- ***Transitions in care:*** *What the Medicare Hospice Benefit does not allow for is a transition of care across a broader period of time. A patient on dialysis is a perfect example. A patient does not simply decide today that they are going to stop dialysis - it is a transition of understanding and expectations. If hospice could provide care to patients with End State Renal Disease (ESRD) concurrently with dialysis, where the cost of a set number of dialysis treatments is not paid by the hospice daily rate, the hospice could help the patient transition to stopping dialysis with greater support and compassion. Curative and non-curative treatment modalities are worlds apart and leave an ocean between that our patients and families must navigate often on their own, with limited information and understanding.*

- ***CMMI model on dialysis and concurrent care:*** *The concurrent care option for beneficiaries that elect the Medicare hospice benefit would allow Kidney Care First (KCF) Practices and Kidney Contracting Entities (KCE) to waive the requirement that beneficiaries elect to forego curative care as a condition of Medicare coverage of hospice care.*<sup>7</sup>
- ***Testing concurrent care for dialysis patients:*** *The option for concurrent care with dialysis and hospice together has been tested with philanthropic support in Pittsburgh and Seattle [Details on the models are shared below] where hospices have offered a small number of dialysis treatments while the patient is transitioning to discontinuing dialysis while being enrolled in hospice.*
  - **Dialysis Clinic, Inc. (DCI) partnered with the University of Pittsburgh Medical Center (UPMC) and UPMC’s Family Hospice**<sup>8</sup> to design and implement a concurrent care program. This program allows beneficiaries with end-stage renal disease (ESRD) to receive as many as ten hemodialysis sessions after beginning hospice. By removing the dilemma of having to choose between starting hospice and stopping dialysis, DCI and UPMC aimed to improve their patients’ experience with end-of-life care.

Between January 2018 and December 2021, DCI and UPMC enrolled 43 beneficiaries in the concurrent care program in Pittsburgh. Program enrollment has been stable. After piloting the program with four people in 2018, DCI and UPMC have enrolled 13 people per calendar year on average. The race and ethnicity of program enrollees generally reflected the demographics of Pittsburgh according to 2020 Census data. Interestingly, 53 percent (n = 23) of those who enrolled in the program ultimately declined to pursue further dialysis. Of the 20 people who sought dialysis, 15 people received hemodialysis and five received peritoneal dialysis. People on hemodialysis received 3.5 dialysis treatments, on average. No one used all 10 of the available hemodialysis sessions (range one to nine sessions). People on peritoneal dialysis received 19.2 sessions on average (range 3–65). As expected, beneficiaries who received dialysis had a longer length of hospice stay than beneficiaries who received no dialysis (19 days compared with seven days). Beneficiaries who enrolled in the concurrent care program but ultimately declined dialysis spent seven days on hospice, which is slightly higher than the national average of hospice length of stay for beneficiaries with ESRD (seven days compared with five days).

- Another novel effort exists in Washington state at **Northwest Kidney Centers, based in Seattle.**<sup>9</sup> This program embeds palliative care within a kidney center whose clinics treat

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<sup>7</sup> CMS, *Kidney Care Choices (KCC) Model* (Dec. 4, 2019), <https://www.cms.gov/newsroom/fact-sheets/kidney-care-choices-kcc-model>.

<sup>8</sup> CMS, *Case Study: Dialysis Clinic, Inc.’s Concurrent Care Program* (Nov. 2022), [https://www.nhpc.org/wp-content/uploads/DCI\\_and\\_UPMC\\_Concurrent\\_Hospice\\_on\\_CMS\\_Value\\_Based\\_Care\\_Learning\\_System\\_Case\\_Study.pdf](https://www.nhpc.org/wp-content/uploads/DCI_and_UPMC_Concurrent_Hospice_on_CMS_Value_Based_Care_Learning_System_Case_Study.pdf).

<sup>9</sup> Northwest Kidney Centers, *Kidney Palliative Care: Improving Quality of Life* (Accessed May 25, 2023), <https://www.nwkidney.org/palliative-care/>.

patients living with kidney disease; and then later pair dying patients with hospice care without forcing them to forgo the comfort dialysis may still provide. Traditional hospice services require kidney patients to abandon dialysis, a decision which hastens death, and almost inevitably comes with acute symptoms, including muscle spasms and nausea. While the goal of both hospice and palliative care is pain and symptom relief, hospice has traditionally been regarded as care without the intent to treat or cure the primary disease. The nuance with dialysis is it is central to keeping a kidney patient's body functioning; discontinuing it abruptly results in death within days. In the Washington state program, there is no limit on the number of sessions a patient can receive. This helps ease the patient into the new arrangement, instead of abruptly halting the treatment they have been receiving, often for years.

- Accountable care organizations (ACOs) and value-based care organizations interested in integrating palliative and hospice care to better support terminally ill patients might wish to consider either Northwest Kidney Centers and DCI and UPMC's approach.
- *Another hospice's comments: Our hospice policy is to not admit patients who want to continue dialysis due to cost being too high to support this, although we know these [patients] would usually meet criteria. Asking those patients to stop dialysis to admit to hospice is very burdensome for the patient. However, hospice can offer so much to them from a symptom management and psychosocial/spiritual support perspective.*

### **NHPCO Recommendations**

- NHPCO recommends CMS consider a separate payment for expensive treatments and medications so they could be provided as appropriate palliative care for hospice patients who would benefit from them.
- NHPCO recommends CMS explore allowing transitional concurrent care. Transitional concurrent care would allow hospice patients to continue disease-modifying treatments for some period of time while also receiving hospice services. These patients could transition to hospice care while tapering other treatments to increase their length of stay in hospice and the benefit they would receive from end-of-life care and lower the number of patients who receive care for five days or less.
- Given the flat per diem reimbursement rate for hospice care, there is a cost threshold for these higher cost treatments which makes them unaffordable for a hospice to provide to many patients, even when they may provide a palliative benefit. We recommend CMS explore what the cost threshold options could be through an outlier or add-on payment to allow additional reimbursement when these treatments are provided.

## 2. 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?

In discussions with hospice providers, the many challenges with providing the higher intensity and higher cost levels of care would not be considered restrictive enrollment policies, but rather barriers or challenges with providing those types of care. NHPCO has provided comments and feedback from providers by specific level of care below.

**Use of continuous home care (CHC):** Hospice providers report CHC has significant challenges, including the requirement to provide eight hours of CHC beginning and ending at midnight. Many patients develop symptom management issues requiring CHC in the evening and the eight hour minimum per calendar day cannot be met if the hospice had provided some hours of CHC earlier in the day, when CHC is often not indicated. Some providers say they provided 7.75 hours before midnight or had one hour more of aide services than allowed and are unable to bill the CHC rate. With the severe shortage of nurses and aides, and the prohibition on using contracted staff, staffing for CHC is also problematic.

NHPCO asked providers to provide feedback on providing higher levels of care. The comments below represent challenges impacting enrollment in higher levels of care, but these are not enrollment restrictions per se.

### Providers' experiences:

- **Rarely meet the 8 hour minimum:** *Our hospice takes pride in being proactive and getting on top of symptoms as fast as possible and although we do consider CHC, we rarely meet the 8 hour timeframe. The most common reason staff must remain in a patient's home setting to manage complex symptoms is due to terminal restlessness. This often arises in evening hours and though we may end up spending 8 or more hours providing care over 24 hours, when the crisis goes past midnight, we usually don't end up having enough hours [in any one calendar day]. I can recall at least two examples where our time adds up to 7hr, 45 min of time. If CHC could be counted over a continuous 24 hour window or if there was consideration for shorter timeframes to count as CHC, we would utilize this level of care more frequently.*
- **Staffing:** *The staffing structure of CHC, with the combination of nursing and aide services, has become much more difficult because of the shortages of nurses and aides. Our hospice cannot keep nursing and aide staff on standby for CHC needs, so current staff must be assigned when the need for CHC arises. The hourly rate does not cover the costs of an hour of CHC since the salaries of nurses and aides have risen dramatically over the last couple of years.*

### NHPCO Recommendations:

- Allow CHC to be provided over two calendar days with some hours provided on the first day and the remaining hours to be provided on the second. With this change in the hour count,

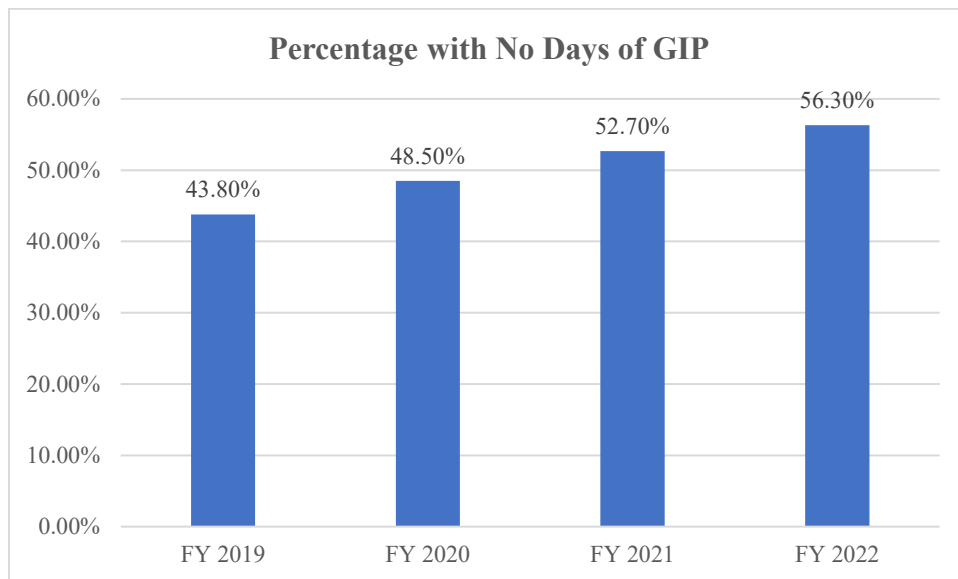


many patients with symptom management issues in the evening would meet the hours requirement overnight.

- Change the 24 hour period to a rolling 24 hour period, eliminating the midnight to midnight requirement.
- Reduce the number of hours required to qualify for CHC. Four hours, for example, could accommodate those patients whose symptoms worsen in the evening.
- Consider adding social workers and chaplains to the list of disciplines considered for CHC. One provider shared a social worker and a chaplain both spent extensive time with a patient who intended to commit suicide. Yet the time they spent was not able to be counted for CHC as they were not the allowed disciplines for the level of care.

**Use of General Inpatient Care (GIP):** Hospice providers report there are mixed messages from CMS when it references hospice general inpatient care (GIP). The messages are both contradictory and confusing to providers, who often feel as though they cannot win – not enough GIP, too much GIP, GIP for too long, documentation not good enough, no proof of medical necessity, and a goal of reducing hospitalizations. The data in the chart below showing a drop in the use of GIP and an increase in no GIP at all is directly related to the messages and the amount of scrutiny for GIP care. Providers are anxious about the messages, whether they will do something wrong and not get paid, and whether the various reviews and audits of GIP care and length of stay at GIP will apply to them.

NHPCO has worked with the MACs to promote their education and resources about GIP and has also developed NHPCO resources for members, *A Compliance Guide for Hospice General Inpatient Care*.<sup>10</sup>



<sup>10</sup> NHPCO, *A Compliance Guide to Hospice General Inpatient Care* (Feb. 2022), [https://www.nhpc.org/wp-content/uploads/NHPCO\\_GIP\\_Compliance\\_Guide.pdf](https://www.nhpc.org/wp-content/uploads/NHPCO_GIP_Compliance_Guide.pdf).

Here are examples of the GIP targeted measures and audits, with mixed GIP messaging:

- The Hospice Care Index (HCI) score takes into account whether any GIP or CHC has been provided.
- The Hospice PEPPER provides target measures for no GIP or CHC as well as long length of stay in GIP.
- The Medicare Administrative Contractor (MAC) Targeted Probe and Educate reviews claims with a GIP inpatient stay of seven days or longer. Medical necessity for each day of the inpatient stay must be documented.
- The Supplemental Medical Review Contractor (SMRC) providing post-payment review of claims for Medicare Hospice General Inpatient (GIP) Level of Care, based on an OIG report that cited overpayments for higher levels of care.
- Recovery Audit Contractor approved topic: *Hospice General Inpatient Care: Medical Necessity and Documentation Requirements (4/1/23)*.
- In the FY 2024 Hospice Wage Index and Quality Reporting proposed rule, the CMS statement on the uses for the information gathered under the Request for Information (RFI) on Hospice Utilization; Non-Hospice Spending; Ownership Transparency; and Hospice Election Decision-Making specifically state “lower rates of hospitalization,” bolded below:
  - [CMS] believe the information gathered under this RFI would help to improve the continuum of care under the hospice benefit by:
    - (1) heightened patient and family satisfaction;
    - (2) improvement in quality indicators;
    - (3) **lower rates of hospitalization** (to include decreased intensive care unit admission and invasive procedures at the end of life); and
    - (4) significantly lower health care expenditures at the end of life.

### **Providers’ experiences:**

- *A hospice attempts to obtain a hospital contract for general inpatient care (GIP) with a hospital in their community but is told that the hospital only contracts with the hospice that is a part of their health system. The hospice seeks another contract with a skilled nursing facility (SNF) provider only to find that the required 24-hour nursing coverage is not consistently available at that facility. Bed availability has also been reported as a problem. The hospice then obtains a contract with a hospital that is 50 miles away, meets the requirement to have a contract to provide GIP care, but is totally unacceptable to most patients and their families. The patient whose family believes needs inpatient care will go to the nearest hospital and the hospice will have to discharge for “moving out of the service area” because there is no contract.*
- *We have problems meeting the need of GIP and inpatient respite. Not because we're not willing or have the staff, but our contracted facilities (Nursing Home and Hospital) don't have enough staff and are not able to accept our patients. We're often on the bottom of the priority list. We're not able to provide these services (particularly inpatient respite) in other facilities like assisted living or group homes.*

- *Our hospice contracts with a neighboring hospice with an inpatient unit for GIP care. The hospice with whom we contract requires us to transfer our patients to their hospice for GIP care, and then transfer back to us when GIP is concluded. The patient receives GIP but there is no evidence in our claims that GIP was provided by our hospice.*

**NHPCO Recommendations:**

- NHPCO recommends CMS review the various messages, reviews, and audits hospices receive from CMS and auditing entities about GIP to ensure messages are clear and not contradictory. Work with MACs and audit contractors to ensure reasons for TPE and audits are clear and understandable to providers and the messaging does not deter providers from providing GIP care when appropriate.
- NHPCO recommends CMS consider requiring all hospitals be required to contract with their community hospice providers so when a patient does need an inpatient level of care they do not have to be discharged from hospice with the 'out of service area' reason so the hospital can admit them and bill acute hospital regular rates.
- Review audit goals and auditor education and knowledge about hospice to ensure GIP audits are accurate and reviews are based on a knowledge of the GIP level of care and its requirements.

**3. 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?**

The distinction between curative and palliative treatments can be based both on prognosis as well as the goals of a particular treatment. Using hospice as an example, when an enrolled patient has an illness considered to be terminal (i.e., where life expectancy is less than six months should an illness run its normal course) any treatment received under this philosophy and related to the terminal illness or related conditions, including chemotherapy/radiation, dialysis, blood transfusions, surgery, is going to be aimed at mitigating symptoms (i.e., not attempting to cure the illness) and improving quality of life consistent with patient goals. Even when related to the terminal illness, hospices must consider their financial ability to provide these treatments within the daily rate. In contrast, for those patients whose goals are life-prolongation, whether having a terminal prognosis or if their illness has not yet reached this phase, they could choose to receive (outside of hospice) the types of treatments just listed to achieve their desired goal of either life-extension or even cure. The nature of the treatment is irrelevant – the distinction between curative and palliative then, is determined by the patient’s prognosis and the goal of treatment.

NHPCO has developed process maps many providers use for determining relatedness for a symptom<sup>11</sup> and relatedness for medications.<sup>12</sup> Developed after many months of debate and discussion by a workgroup of hospice medical directors and other clinicians, these tools help the IDT to determine whether a symptom or treatment is related to the terminal illness and related conditions. Its companion process helps a provider determine whether a medication is related to the terminal illness and should be covered by the hospice. NHPCO has also developed a toolkit on deprescribing,<sup>13</sup> which many providers use to talk with families about the discontinuation of medications after hospice enrollment and near the end of life. Clinicians also receive extensive training each year on clinical best practices and learn about new palliative treatments by attending conferences, grand rounds, and webinars.

### **Providers' experiences:**

- *The admitting nurse will collaborate with our Medical Director to determine if a treatment would impact hospice eligibility. This is then discussed either during the admission process or if we are aware of treatments before admission; then the discussion with the family occurs prior to an in person assessment visit.*
- *Our hospice physicians collaborate with training teams to keep abreast of treatment changes and intentions. We use the May 2017 paper in *The Oncologist*, “Curative, Life-Extending, and Palliative Chemotherapy: New Outcomes Need New Names”<sup>14</sup> as a way to differentiate between curative, palliative, and life extending chemotherapy regimens. We find the categories very helpful and use this information as a part of decision making throughout hospice care. Each case is presented holistically at the time of election and families and patients are afforded the opportunity to determine their desired course of action and review potential future needs in relation to the disease, prognosis, and anticipated course of decline.*
- *Our hospice reviews the patient’s goals for care and treatment with the patient and their family. We are constantly educating community partners and specialists.*
- *There is a lot to cover at admission. Our handbook reviews how all services are incorporated into a care plan which is reviewed by the interdisciplinary team as well as the patient and their family. The care team continues to monitor the care plan, reassessing and changing the care plan to meet changing patient needs.*
- *Hospices collaborate with primary care providers during the admission process to learn more about the needs of the patient for complex palliative treatment.*

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<sup>11</sup> NHPCO, *Determining Relatedness to the Terminal Prognosis Process Flow* (Apr. 2020), [https://www.nhpc.org/wp-content/uploads/NHPCO-Relatedness-Process-Flow\\_Revised-Version-2.0-2020vFINAL.pdf](https://www.nhpc.org/wp-content/uploads/NHPCO-Relatedness-Process-Flow_Revised-Version-2.0-2020vFINAL.pdf).

<sup>12</sup> NHPCO, *Determination of Hospice Medication Coverage* (June 2022), <https://www.nhpc.org/wp-content/uploads/NHPCO-Medication-Flow-Chart.pdf>.

<sup>13</sup> NHPCO, *Hospice Medication Deprescribing Toolkit* (Nov. 2020), [https://www.nhpc.org/wp-content/uploads/NHPCO\\_Deprescribing\\_Toolkit.pdf](https://www.nhpc.org/wp-content/uploads/NHPCO_Deprescribing_Toolkit.pdf).

<sup>14</sup> Alfred I. Neugut, Holly G. Prigerson, *Curative, Life-Extending, and Palliative Chemotherapy: New Outcomes Need New Names*, 22 *THE ONCOLOGIST* 8, (May 2017), <https://doi.org/10.1634/theoncologist.2017-0041>.

**4. 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?**

Costs are a huge factor in determining the use of complex palliative care treatments, as they must be covered by the hospice's daily rate without an add-on payment. In addition to complex palliative treatments, NHPCO recommends including the use of costly medications. Even for a large hospice, a hospice cannot cover many patients with several courses of radiation, coupled with medications costing \$7,000 to \$11,000 per month. Some patients may benefit from a single fraction radiation, but many radiation providers respond they can no longer do this type of radiation therapy. Education of providers is key, but consideration should be given to some type of add-on payment or payment outside the daily rate to cover the extraordinary cost of some medications or treatments when they are clinically appropriate for hospice patients and consistent with their goals of care.

**Providers' experiences:**

- *The amount reimbursed for hospice services at routine level of care is not enough for our hospice to be able to provide many of these complex treatments, such as dialysis, palliative radiation, and chemotherapy. In addition, we also encounter patients who are taking very expensive medications for certain conditions and the only way these medications are affordable for the patient is if they are enrolled in a special program through a drug company or some other organization that offers grants to offset costs. In our experience, these special programs are not available to hospice-enrolled beneficiaries. Patients often revoke or don't elect hospice because losing these medications can cause such significant symptom burden and patients choose to continue the medications. In one example, the monthly cost is \$4,400 for the medication and our hospice cannot assume those costs without a special program that covers at least some of the cost.*
- *The cost of providing hospice care is outpacing the reimbursement provided. The cost of labor due to staffing shortages, the cost of having to discharge patients because they went into a hospital with whom the hospice cannot get a contract, the cost to patients due to a fundamental lack of knowledge of their primary care provider is squeezing everyone hard. We have to determine how many of these higher cost treatments our hospice can take, and it is not limited by these few examples given.*
- *Could hospices receive a higher level of payment for complex cases? Definitely some of these treatments are very expensive and challenging for a hospice to consider the costs and enroll a patient. If there was a better mechanism for contracting or billing outside the daily rate that would help support the provision of these more expensive treatments, that would be helpful.*
- *The cost certainly correlates to financial risk but also these "types" of patients are at higher risk of revoking, deciding to seek more treatment, or requesting a hospital stay which can hurt the hospice in terms of the Hospice Care Index (HCI). No matter how much education is provided, these patients are at high risk for readmission which could eventually be a financial*

*risk. In these cases, we continue to offer palliative care services, but those are not as all-encompassing and supportive as hospice services.*

- *I think people who enroll in hospice are relieved to discontinue these sorts of treatments due to their significant side effects.*

**NHPCO Recommendations:**

- Please see our recommendations above under question one.

**5. 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?**

**Partnerships and contracts:** NHPCO heard from providers all over the country about the challenges with partnerships and contracts with hospitals and skilled nursing facilities in order to meet the requirements for providing inpatient respite (IRC) and general inpatient care (GIP). For IRC, which is most often provided in the skilled nursing facility (SNF), the issues hospices frequently face are bed availability, 24/7 nursing coverage providing direct care, and confusion about whether the Minimum Data Set (MDS) must be completed.

**Relatedness:** Clinicians in hospice deliberate every single day on whether a particular treatment or medication is related or not related to the terminal illness and related conditions, as well as what treatments or medications would best meet the patient’s goals of care. IDT team meetings include discussions about treatment modalities and next steps in the disease progression. As hospices embrace and implement diversity, equity, and inclusion initiatives, there is an increasing awareness of the role of cultural humility and cultural awareness for the needs of patients and families. That includes sensitivities and considerations for death in an inpatient setting rather than at home to honor the cultural beliefs of some patients and families. The patient may or may not qualify for GIP in these situations.

**Difficulty with hospital contracts:** For GIP, hospices often find nearby hospitals are unwilling to contract with the hospice, either because it only contract with the hospice in their own health system or it already contracts with several community hospices and cannot or will not consider contracting with others. A hospice may attempt to establish a one-time contract to ensure a specific patient can get GIP care in a specific hospital, with very limited success. Hospices may resort to contracting with more distant hospitals, but patients and families may be unwilling to accept care in a location that requires significant travel time.

**Hospital mortality statistics:** Hospices are getting increasing pressure to admit the hospital’s patients who are very near death in order to avoid the death being included in the hospital’s mortality statistics. If the hospice does not agree to admit these patients, many of whom may have

only hours to live, at the GIP level of care, they risk not receiving referrals from the hospital in the future. Information about the hospital mortality rates and the calculation are deeply buried in the CMS QualityNet<sup>15</sup> website for hospitals, making it difficult for hospice providers to understand the metric and correct the misconception, or “urban legend,” about how the metric works and hospice’s role. Specific guidance about this metric should be available from CMS or its contractor specifically for hospitals and hospices.

**Bed availability:** Providers report there are a limited number of beds available for GIP, particularly when other patients wait in the emergency department or in the hallway for bed availability. There is also confusion about the two midnight rule and how hospice GIP should be counted.

**Cultural considerations:** Providers have begun implementing diversity, equity, and inclusion policies which consider the wishes and beliefs of their diverse patient populations. For some families, their belief system includes special considerations for the location of death and ensuring the patient does not die at home is central to the dying and grieving process. These cultural beliefs are documented and considered as the hospice IDT develops and updates the plan of care. Hospice clinicians focus on goals of care and informed decision-making and help patients and families make informed decisions about the care they want at the end of life, including the use of GIP and CHC, which are cultural issues for some families.

**Providers’ experiences:**

- *Facilities being so under-staffed has been a barrier, but we have a hospice house where we can provide inpatient respite (IRC) and GIP to help offset that. In addition, many facilities want greater reimbursement than the daily GIP rate, which is a financial limitation for us.*
- *GIP - we have agreements with several areas hospitals to provide GIP care, but during the PHE hospitals were very reluctant to open beds for GIP due to high census. Even with bed space more readily available, the hospitals prefer that we get patients out of hospital beds as soon as possible as the reimbursement rate for GIP does not cover their costs.*
- *The hospitals with whom we contract pressure hospices to admit patients to the GIP level of care in the last hours of life so that the death is not counted in the hospital’s mortality statistics. If a hospice declines GIP admission for these patients, the hospice risks getting referrals for future patients. A clear understanding of how hospice admission does/does not apply to the hospital mortality statistics is needed for hospitals and for hospices to share with hospitals.*

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<sup>15</sup> CMS, *QualityNet Frequently Asked Questions* (Accessed May 26, 2023), [https://qualitynet.cms.gov/files/6425914b9920e9001651ebef?filename=2023\\_CBMFAQs\\_032823.pdf](https://qualitynet.cms.gov/files/6425914b9920e9001651ebef?filename=2023_CBMFAQs_032823.pdf).

### **NHPCO Recommendations:**

- Provide hospitals and nursing facilities with information on hospice requirements for contracting, including eligibility for the level of care, staffing requirements, MDS involvement, and mortality statistics.
- CMS, or its contractors, should publish specific and accessible guidance about the hospital mortality metric specifically for hospitals and hospices.

### **6. 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?**

In discussions with many hospice providers, hospices continue to state they cannot prevent spending when they have no knowledge a patient has made a non-hospice visit, non-hospice billing has occurred, or they get this information so late an intervention is impossible.

**Medicare claims processing system problem:** The challenges in addressing non-hospice spending start with a Medicare claims processing systems problem.

- No flags are available in the system to prohibit a provider or physician office from filing *and getting paid* for an office visit or treatment when the patient has elected hospice or notify the hospice provider. NHPCO has recommended some type of flags for hospice enrollment in the claims processing system since meeting with CMS senior staff on May 20, 2015, where flags in the system were suggested, as well as education for physicians and other non-hospice providers. Little action has occurred since this time.
- The hospice has no way of knowing, in real time or close to real time, the spending has occurred. Because hospice and other post-acute care providers are not included in the agency's interoperability focus, other providers have no way of knowing the patient's hospice election and the hospice has no way of knowing a visit, treatment, admission, or service has been provided. The inclusion of hospice and other post-acute care provider EMR software considered for interoperability may help with both billing provider knowledge and hospice tracking in the future.

**Checking hospice enrollment:** It is clear that information about the hospice election is not being checked during a hospital admission process, before a non-hospice office visit, or treatment by a physician is provided. The information may or may not be available in the HIPAA Eligibility Transaction System (HETS), or an admissions department or physician may not be aware of a difference in billing is required for patients receiving hospice care.

**Billers knowledge of hospice billing requirements:** The vast majority of providers and medical practices are not aware of any difference in how claims are submitted when they are treating a hospice patient or the use of the GV or GW modifiers or condition codes. When hospices have attempted to provide additional information and education to physician offices, they have been told "we know how to bill Medicare and don't need any help from hospice."



**Conflicting regulations:** Providers report nursing home regulations require the nursing home physician, nurse practitioner, or medical director to provide a regular visit every 30-60 days after admission. NHPCO encourages CMS to check the HCPCS codes for physician (and NPP) visits to determine which visits are provided in the nursing home setting. Because the visits are required under nursing home regulations, typically the hospice provides additional visits by various disciplines and services under the daily rate for patients in nursing homes.

**Ambulance codes (A0425 and A0428):** The non-urgent ambulance transport is included in the top 20 HCPCS codes. NHPCO recommends continuing education for both hospice and ground ambulance providers on the financial responsibility for ambulance services after the hospice election. If there is a way to flag hospice patients in an ambulance claim so the claim is not paid before the hospice is consulted, it would be helpful.

**Codes related to the terminal illness and related conditions:** Hospice clinicians review HCPCS codes for every patient individually, as it is not possible to determine whether a certain procedure is related to the terminal illness for the patient. It is impossible to determine unilaterally whether a code is related or not related.

**Inclusion of Part B Claims on Hospice PEPPER:** NHPCO is pleased to see the addition of the count of Part B claims measure on the Hospice PEPPER, based on location of care. While this brings some additional awareness of Part B claims submissions, there is no way for the hospice to take any action on the data received. While the statewide reports on Part B claims give some additional information, it is still too broad to be helpful. For instance, a hospice sees in their PEPPER they have a large number of Part B claims from the ALF, SNF, and NF locations of care. The hospice has contracts with five assisted living facilities, 35 SNFs, and 10 NFs, and determining the source of these Part B claims is difficult or impossible

There is no way to address the Part B claims submissions without more specific data. In discussions with providers and with the PEPPER contractor, NHPCO has requested more detail on the Part B claims, particularly if there is a way to identify the specific nursing home or physician practice where volume is high. NHPCO calls this issue to the attention of CMS and would welcome a dialogue as all parties are trying to address this issue.

**New research on hospice cost savings to Medicare:** NHPCO is pleased to share new national research showing hospice provides significant cost savings to the Medicare system, including when the length of stay is greater than 266 days.<sup>16</sup> Specifically, the research found the total costs of care for Medicare beneficiaries who used hospice in 2019 was 3.1% lower than those who did

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<sup>16</sup> NORC at the University of Chicago, *Value of Hospice in Medicine*, (March 2023), [https://www.nhpc.org/wp-content/uploads/Value\\_Hospice\\_in\\_Medicare.pdf](https://www.nhpc.org/wp-content/uploads/Value_Hospice_in_Medicare.pdf).

not use hospice, and earlier enrollment in hospice and longer lengths of stay likely reduce overall Medicare spending. The report calculates this reduction in spending translates to an estimated \$3.5 billion less in Medicare outlays for beneficiaries in their last year of life.

**Providers' experiences:**

- *To get additional information on spending outside the benefit, our new protocol is for the nurse to ask at each visit whether the patient has been to the doctor, gotten a lab test, or received any other treatment. The nurse gathers as much information as possible so that the billing office at the hospice can follow up, determine whether the service was related to the terminal illness or related conditions, and redirect claims so that hospice receives the bill, rather than being filed with Medicare. We have had some success with this approach.*
- *We tell patients and families to send us any bills they receive that may be related to their care. We know we are responsible for them. We are not sure how we can control other parties from billing Medicare when they should bill us as we have no knowledge of the bill.*
- *Our regulations have become convoluted, making it difficult for staff to understand what is and is not related. The vast majority of hospice providers try very hard to cover hospice appropriately per the benefit's guidelines. It is difficult to do that when various survey/accreditation organizations cannot even be consistent in their own understanding of what is and is not a related item and how it should be documented.*
- *Every diagnosis and treatment should be included in the plan of care, and determination at the time of the item addition regarding the relatedness of the item accurately documented. Families, caregivers, and patients must be active participants in the plan of care development and maintenance to eliminate 'surprise treatments' or misalignment.*

**NHPCO Recommendations:**

- NHPCO requests CMS seriously consider some type of claims processing flag for non-hospice providers to alert them about the patient's hospice enrollment and encourage communication between the Part A or B provider and the hospice. To be effective, the flag should include the name and contact information for the hospice where the patient is enrolled.
- NHPCO requests CMS review the HCPCS codes and consider which Part B claims have been submitted by the nursing home physician or NPP for a visit required by nursing home regulations. NHPCO further requests CMS consider removing them from the "spending outside the benefit category" because of the regulatory requirement for nursing homes.
- NHPCO requests CMS work with the MACs to continue providing billing and claims submission information to Part A and Part B providers, including resources available on the Part A and B websites.
- NHPCO requests CMS work with the Hospice PEPPER contractor to include more detailed information on the source of Part B billing outside the hospice benefit, preferably by physician group or providers, to allow hospices to correct and educate for correct billing processes.

**7. 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?**

Additional resources about what is covered under the Medicare Hospice Benefit and how the information is shared with patients and families can be improved. The admission process is a time of great confusion and a heavy volume of information. To improve this process, a set of simple resources could be shared with patients and families throughout the first few visits might be welcomed by providers.

**NHPCO Recommendations:**

- NHPCO recommends CMS work with the hospice community to develop simple patient and caregiver friendly resources about hospice care, relatedness, and hospice benefits for the patient and family.

**8. 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?**

Yes, some patients and families are requesting the “Patient Notification of Hospice Non-Covered Items, Services and Drugs” (addendum) at the start of care. NHPCO has received anecdotal reports this is requested infrequently but is a helpful part of the conversation for care planning.

**Providers’ experience:**

- *Since the initiation of the Patient Notification form, we have heard other hospices report that between 5 and 30% of patients request the addendum at the time of admission. We have found only rare instances where this needs to be provided after admission as our teams are effective at educating patients and families on the need to reduce medications and provide rationale for why certain DME is not covered. Anecdotally, we have observed that once the patient and family develop trust in the IDT, it is often common for them to decline the need to get a second addendum if something else changes with covered meds, services, or items.*

**NHPCO Recommendations:**

- NHPCO does not recommend that the “Patient Notification of Hospice Non-Covered Items, Services, and Drugs” form (addendum) be required to be provided to all prospective patients.

**9. 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?**

Sharing information about staffing levels and the frequency of hospice staff encounters with patients and families at the start of care dramatically adds to the stress and overwhelming feelings of the patient and caregivers. In addition, these metrics are subject to relatively frequent changes, and it would be a challenge to maintain accurate and consistent measures. Information about levels of care and when and how those decisions would be made would be helpful, both included in the admission handbook and through ongoing discussions and updates to the plan of care with the patient and family. NHPCO does not recommend information about staffing levels, or the frequency of staff encounters be shared online or at the start of care.

**Providers' experience:**

- *I don't think this information should be shared. Hospice staffing levels should not be shared with patients and their caregivers. This information would not be useful and in some cases could cause undue stress for them if they thought their care could be impacted by short staffing. Patients and their caregivers should however be informed at admission of the higher levels of care as part of the hospice benefit. Mechanisms should be verbal, supported by admission booklets or other documentation.*

**NHPCO Recommendation:**

- CMS should recommend hospices share information on all four levels of care in their admission handbook or paperwork, including reasons a hospice may recommend a change in the level of care for a patient during the course of care.
- NHPCO does not recommend information about staffing levels, or the frequency of staff encounters be shared online or at the start of care.

**10. 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?**

For the past ten years, NHPCO and other national hospice organizations have been integrally involved in the National Council of Prescription Drug Programs' Hospice Task Group. Under a special CMS contract, RelayHealth is serving as a transaction facilitator to match the hospice Notice of Election to the Part D enrollment information, with the goal of alerting the Part D plan to the hospice election more promptly. NHPCO has shared the information about the pilot project with the hospice PEPPER contractor, so it is aware of this option for alerting the Part D plan about the hospice election. NHPCO is encouraging our members to join the pilot to address the Part D

spending outside the benefit, is working with other hospice software vendors to participate, and bring awareness to the hospice about where the spending is occurring.

Providers are also using the hospice PEPPER to review the location of care for Part D spending. While the specific location cannot be identified, hospices can conduct reviews of medication spending by location of care and educate billers, particularly in long term care facilities, about how to bill when the patient is enrolled in hospice. It should be noted that even when the contract the hospice has with the nursing home specifies bills for medications should be sent to the hospice, the nursing home billing office continues to send to Part D.

### **Providers' experiences:**

- *For Part D, the biggest challenge is working with facilities (ALF, SNF) and facility pharmacies who continue to fill prescriptions for medications without getting authorization from hospice. Part D providers have improved their processes in the last few years and more often seek recoupment for medications that are not billable to Part D. Because the recoupment often occurs well after the patient is already discharged, we do not have the opportunity in real time to determine if the medication is necessary and related or not. If Part D providers could easily see in the CMS Part D system that their enrollee is a hospice patient (in real time) and can easily identify the hospice and confirm medication coverage with the hospice before filling these medications, it would help hospice to better coordinate care and reduce costs.*
- *We have had constant engagement with the hospice [Pharmacy Benefit Manager] we use. This also goes back to the fundamental issue of the continuum of care - there is none because hospice is an after thought. It is difficult to plan, there is no migration of medications, or education about the efficacy of those medications. We cannot simply stop people's medications and we must evaluate the medications that are related and include those in the plan of care. We cannot simply pay for everything. Dying is a process and we often get the patient too late, they are confused and frightened and the media has created a perception that all hospices are fraudulent. So, when we start talking to patients about stopping X medication, they assume we are just trying increase our profit margins – it is hard to communicate that X medication is providing them with zero benefit and that they will feel much better when they reduce the volume of medications down.*
- *We admit the patient in the place where they will be receiving care. If a patient is coming home from the hospital, a family member may stop to fill a pain medication prescription even when we tell the hospital not to send home a prescription. Our hospice does not know that the family member got the prescription filled until 2-3 years later.*
- *We have detailed agreements with the pharmacy and monthly review of pharmacy bills.*

### **NHPCO Recommendations:**

- NHPCO recommends continued support for the RelayHealth/CMS Part D pilot with publicity and ways the project can be expanded to more hospice software vendors, clearinghouses, and hospice providers.

- NHPCO recommends CMS work with the Hospice PEPPER contractor to ensure more detailed information is available about the location where Part D issues exist.

**11. 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, 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?**

The first improvement in ownership trends CMS should address is the inaccuracies in the ownership data available on Care Compare. Hospice providers report it has taken *years* to get the ownership information changed, most often corrections for a for-profit designation to not-for-profit, even when the agency has never been for-profit in its existence and the classification was erroneous from the start.

Hospice providers report a variety of challenges with requesting demographic and ownership corrections in Care Compare. In many instances, providers are following the CMS Provider Demographic Update process but find demographic and ownership data are correct in PECOS, with their MAC, and even in iQIES, yet incorrect on Care Compare. One provider reports being directed to their state survey agency to request an out-of-survey cycle correction to the iQIES database using form CMS-417. NHPCO has heard from providers their demographic and ownership information which was previously correct on Care Compare changed without warning, and without any corresponding ownership or other changes on the part of the provider.

A consumer seeking hospice information would more likely be interested in the length of time the hospice has been in business, star ratings, and performance on quality metrics as ways to select a hospice provider, rather than knowing their tax status. Profit status is not at the top of a consumer's list of information as they choose a hospice. NHPCO joined three other national hospice stakeholder organizations to submit recommendations to CMS concerning hospice program integrity.<sup>17</sup>

**Providers' experiences:**

- *While transparency is an important concept, used in this context it risks clouding patient/beneficiary's ability to choose a local hospice due to the nature of national statistics.*
- *This information might not apply to the hospices local to the patient and might seem overwhelming. I am not sure this information would be beneficial to those seeking hospice care.*

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<sup>17</sup> 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/>.

- *Hospice is already overwhelming for patients and their families. They are usually focused on the anticipatory grief process and not on what each agency has to offer.*
- *We believe there should be transparency around who owns the hospice and for-profit/non-profit status. Including this on the Care Compare website appears to be the most effective means of communicating this status currently. However, the accuracy of profit status has proven to be wrong so often that until there is a system to correct misinformation in a timely way, this data should NOT be included on the Care Compare website.*

**NHPCO Recommendations:**

- CMS should develop a comprehensive list of resources for providers to reference when requesting demographic and ownership changes in Care Compare, including a list of all of the potential avenues providers may need to pursue in order to request the corrections (e.g., PECOS, MAC, iQIES, state survey agencies, etc.)
- Providers should document the attempts made to change demographic and ownership changes and have a CMS-identified process to appeal their changes if the requests have not resulted in changes that have been requested.
- Until CMS can ensure hospice provider demographic and ownership data is accurately presented on Care Compare and providers have a streamlined, effective method for requesting and promptly receiving confirmation of corrections to inaccurate data, NHPCO recommends Care Compare focus on presenting quality measure performance and **limit** the extent of demographic and ownership information that is publicly available.

**C. Request for Information on Health Equity Under the Hospice Benefit**

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

Hospices note they have not yet implemented initiatives to measure the impact of their health equity initiatives through qualitative data collection and analysis methods, exemplifying the need for better data collection, analysis, and subsequent action.

**NHPCO Recommendations:**

- NHPCO recommends any policy or program addressing health equity considers current support, infrastructure, and funding, which varies greatly by provider.
- NHPCO also recommends the development of a universal database accessible across government and will enable programs to accurately assess the extent of the disparities and barriers existing today and to measure progress made by the government in promoting health equity over time.

## 2. What factors do hospices observe that influence beneficiaries in electing and accessing hospice care?

NHPCO recently published *Hospice with a DEI Lens*<sup>18</sup> which finds multiple factors influence when and how patients elect and access hospice care. There is a reported lack of general knowledge, specifically by those from underserved communities, of what hospice care and palliative care includes. The diversity of hospice staff is another factor. Hospice staff who are culturally representative of the communities they serve leads to an increase in trust between hospice staff and their patients. The level of trust beneficiaries have for their overall healthcare experience can have either a negative or positive influence on beneficiaries' decisions to elect hospice care.

### **Providers' experiences:**

- *Patients and families are often not given a choice or made aware of the choice of hospice agencies. Physicians/hospitals often just tell them that the hospice will be contacting them. They are not aware of having the right to choose an agency.*
- *We do see less utilization of hospice services by certain populations, such as racial and ethnic minorities, and those who have limited resources to seek healthcare (such as those who are uninsured).*
- *There are cultures that are more willing to accept hospice than others. Most people, regardless of cultural background, are willing to accept palliative care but hesitate to commit to hospice.*
- *By this question I am reading it as either a positive or a negative influence. Reimbursement models; meaning who is getting paid and when are they ready to release the revenue stream. Knowledge base, White, higher socioeconomic status more open. Level of education by the staff at the agency level (those admitting) as we continue to dispel the myths of what hospice is and is not. Bad actors - ongoing media coverage of misaligned views -yes there are bad actors out there; however, the vast majority of hospice providers come to work every day to provide quality care. Racial and ethnic diversity and a misaligned benefit.*

### **NHPCO Recommendations:**

- NHPCO requests CMS collect more data on the cultural and ethnic reasons a patient and their family may choose or not choose hospice. We believe having more data will also increase awareness of the possible increased use of higher levels of care, such as GIP, or the possible decrease in CHC, due to concerns about the healthcare team in the home.

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<sup>18</sup> NHPCO, *Hospice with a DEI Lens* (Dec. 2022), <https://www.nhpco.org/education/tools-and-resources/diversity/>.



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

CMS can assess areas based on population by race and ethnicity, where health disparities may take on many forms, including higher rates of chronic disease, housing insecurity, and premature death rates. Furthermore, communities not diverse in population tend to reflect the same within healthcare facilities and providers.

Income levels and access to transportation should be used to assess disparities in hospice. Low-income areas, when combined with lack of transportation access, are more likely to experience food deserts. Food deserts are communities, usually in low-income areas lacking grocery stores, farmers markets, and healthy food providers.<sup>19</sup> Disparities in options for healthy food choices and transportation within an area are often indicators of larger disparities, including those related to hospice.

#### **Providers' experiences:**

- *The use of ethnicity data and migration of beneficiaries [from the 2022 census can help [provider address disparities].*
- *Both sides of that dichotomy contain many different groups that can be described in many ways. For example, areas with heavy industry have different morbidity and mortality profiles than areas that do not.*

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

Providers want to better support vulnerable populations and underserved populations but are still struggling with the general logistics in identifying these communities and the specific barriers they are facing. In addition, identifying and addressing these barriers require support through staff time, the identification of data for specific communities, and funding not all providers are able to access.

#### **Providers' experiences:**

- *State health plans can help. CDC collects data on community populations that could help with access, cultural influence, and mortality/morbidity data. State economic development plans could help determine the financial health of the community.*
- *The only barrier we have is location. We have one island in our county that we cannot provide service for. It is due to the lack of ferry availability to get onto the island.*

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<sup>19</sup> Michele Ver Pleog, *Access to Affordable, Nutritious Food is Limited in "Food Deserts,"* USDA ERS, March 1, 2010, <https://www.ers.usda.gov/amber-waves/2010/march/access-to-affordable-nutritious-food-is-limited-in-food-deserts/>.

- *I am not sure this is the right question. For any of us to provide care to vulnerable populations would require program development (money) and a champion who was passionate about the population. Most days we are simply focused on taking care of the patients we have today.*
- *CMS needs to tell us what they consider the biggest barriers to hospice care (language? logistics? lack of education?) and how can we overcome them? I think most hospices want to service as many people as possible, but we need to know how to help underserved communities.*

**NHPCO Recommendations:**

- NHPCO recommends CMS collect and share information on professional development opportunities focused on increasing cultural competency and best practice approaches to how hospice staff can work to strengthen community partnerships with organizations working with underserved populations. By doing so CMS will bring awareness and education about hospice care into those communities.
- CMS should collect and share data on social determinants of health (SDOH) to help decrease risk factors leading to negative health outcomes and address barriers to access of hospice care.

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

SDOH are influential drivers of health disparities particularly for people of color, and the LGBTQ+ community. High rates of unemployment or underemployment, limited access to appropriate healthcare, and discrimination can have a negative impact on the behaviors and engagement of patients from underserved communities with hospice staff. In addition to other SDOH discussed in question four, education levels, preferred language, religion, gender identity (inclusive list), and location of residence could all be used to effectively evaluate health equity in hospice settings.

**Providers' list of SDOH and sociodemographic data include:**

- Gender identity (not just male/female)
- Additional breakdown of race and ethnicity (e.g., Hispanic - Mexican, Cuban, etc.).
- Charity spending to raise additional funding needed for programs in specific communities
- Specific programs that may be in use (e.g., homeless care, LGBTQ+ care)
- Safe housing, language and literacy skills, race/ethnicity, and religion

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

Many NHPCO providers have noted difficulty in data collection and analysis related to health equity outcomes. Providers shared potential ways to improve these difficulties.

**Use of CAHPS® hospice survey:** Providers have mentioned the utilization of the CAHPS® hospice survey as a way to identify the details of health equity in care delivery. There is a need for

more data to be gathered so hospices can identify service trends and better understand methods garnering the largest positive effects on health equity. In considering CAHPS® survey for this use, the survey must include enough detail and nuance to ensure inclusivity of different identities (e.g., gender identity, multiracial and ethnicity options, socioeconomic status, etc.) and strategies to address SDOH.

Currently, the CAHPS® hospice survey does not include any information to directly assess health equity. While assessment of the current domains (e.g., communication skills of providers, ease of access to healthcare services and patient experience) are very important for delivery of quality care, these measures need to be able to be compared across relevant demographic information. As recommended by the Institute for Healthcare Improvement, each hospice should collect, at a minimum, race/ethnicity, socioeconomic status, gender, and a measure of geography such as zip code or US Census tract.

**Development of universal database:** NHPCO recommends the development of a universal database accessible across the government to enable programs to accurately assess the extent of the disparities and barriers existing today and to measure progress made by hospice in promoting health equity over time. This database should be informed by stakeholder feedback to ensure the identification of the right key metrics, encourage data standardization, and incentivize investment in data collection and submission, e.g., investment by electronic medical record (EMR) and electronic health record (EHR) vendors to require interoperability when collecting these important data points. This would also require substantial investment in home and community-based providers' access to the technology necessary to assure interoperability.

**Community assessment:** Hospices should be able to compare the demographics of the hospice's patient population to local population data to determine the hospice's reach in the community, identify areas for improvement and assessment of quality care measures as they are rated by diverse racial and ethnic groups, diverse socioeconomic status (SES) groups and diverse sexual orientation identities.

**Providers' experiences:**

- *The population of the area being analyzed should be considered.*
- *Require all EMR vendors to embrace specific needs identified (via whatever comes out of this) such that it is easy to capture patient data without putting people into 'other' categories. Develop connection with organizations like NHPCO to expand on their offerings that may help hospice organizations have a program that they do not have to develop and engage in.*
- *Include race/ethnicity questions in the Hospice Item Set (HIS).*

### **NHPCO Recommendations:**

- NHPCO recommends more health equity data be collected so hospices can identify service trends and better understand methods garnering the largest positive effects on health equity. In order to evaluate progress in health equity in hospice, the CAHPS® survey could be used, but must include enough detail and nuance to ensure inclusivity of different identities (e.g., gender identity, multiracial and ethnicity options, socioeconomic status, etc.) and strategies to address SDOH.
- NHPCO recommends the development of a universal database accessible across the government to enable programs to accurately assess the extent of the disparities and barriers existing today and to measure progress made by hospice in promoting health equity over time.
- NHPCO recommends CMS pay special attention to needed health equity data and how it could be collected by the hospice EMR software, providing a list of possible data points needed to EMR vendors.

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

As previously stated, the lack of cultural competency and cultural humility among hospice staff can lead to barriers in collecting information on SDOH, race, and ethnicity. This specific barrier can lead to the unwillingness of hospice staff to learn about diverse cultures, ethnic, or identity groups and less trust from patients and their caregivers potentially leading to patients' hesitation in sharing information vital to provide quality hospice care they desire.

**Limited resources and consistent and sustained organizational efforts:** Providers have noted data collection may not be a priority due to limited staff members available to administer data collection.

**Poorly suited Electronic Medical Record (EMR) systems:** EMR systems may not be well suited to collect accurate information on gender, sexual orientation, SES, race, or ethnicity identities. For example, it only asks participants to choose “one” option out of several races and ethnicities, which overlooks those of mixed races and ethnicities. Gender is also still a binary question, disregarding patients who may identify as non-binary.

**Limitations and lack of DEI specificity in the CAHPS® survey:** Further, while providers have indicated the utilization of CAHPS® report, they also noted a need to develop more data collection methods to analyze and qualify impacts on health equity. Having the CAHPS® survey only as a mail or phone survey is a larger barrier to collecting data. CAHPS® email availability would increase responsiveness for some, but at the same time may be a barrier to others. Utilizing email, phone, and mail options may increase participation.

To address barriers to high-quality and equitable hospice care, NHPCO has an active Diversity Advisory Council, made up of hospice providers with expertise in diversity, equity, and inclusion. With their help, NHPCO has created a number of toolkits and resource guides for providers to promote more inclusive practices, internally and externally. Resources developed by NHPCO include:

- *Inclusion and Access Toolkit* in Spanish and English (2020)<sup>20</sup> designed to provide information on basic strategies to promote access to care for communities underserved by hospice and community-based palliative care and provide resources to help promote a culture of inclusion, both for staff as well as patients and families. The framework of the toolkit is centered around eight topic areas:
  1. the business case for inclusion
  2. vision and values
  3. community presence
  4. marketing and public relations
  5. board development
  6. administration
  7. quality assessment and performance improvement
  8. workforce development
  9. patient and family care services
- A series of outreach and resource guides can be found on the NHPCO Diversity webpage,<sup>21</sup> including guides for Black and African Americans, Chinese American, Latino, and LGBTQ+ patients and families. NHPCO aims to provide resources and educational content so hospice organizations can provide high-quality care to diverse populations.

NHPCO hospice providers themselves have also begun working on ways to address barriers identified in their communities. Reports from hospice providers include:

- *Hospice providers have noted the importance of staff training and raising awareness to address barriers.*
- *Providers have partnered with EMR vendors for data collection to add more survey fields related to diversity, equity, and inclusion and prepare reports on health equity after data is collected.*
- *Hospices employ community liaisons to connect with patients informally right after admission.*
- *Include SDOH measures (consider z codes, particularly Z-55 to Z-65) on social work assessment.*
- *Identify additional social determinants that may be specific to hospice care.*

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<sup>20</sup> NHPCO, *Inclusion and Access Toolkit in Spanish and English* (Oct. 2020), <https://www.nhpc.org/education/tools-and-resources/diversity/>.

<sup>21</sup> NHPCO, *NHPCO seeks to increase access to hospice and palliative care services within diverse communities* (Accessed May 25, 2023), <https://www.nhpc.org/education/tools-and-resources/diversity/>.

- *Increase involvement of social work staff to engage in QI projects by social work staff to address identified SDOH barriers to care. Social workers are trained in research and evaluation in their training programs and should be encouraged to engage in SDOH QI projects either individually or in consultation with other members of interdisciplinary team.*

**Providers’ experiences:**

- *Our biggest barrier to collecting this information is the ability to easily extract that data from our EMR. This makes it difficult to evaluate where and performance improvement efforts should be focused when the data is not readily accessible for tracking and analysis.*
- *Patient/family reluctance to share data. This often seems related to both distrust and shame.*
- *Race does not seem to be a problem for patients to self-identify. Ethnicity is a problem for patients to identify due to lack of knowledge or willingness to share.*

**NHPCO Recommendations:**

- NHPCO recommends CMS provide additional resources and funding opportunities for providers to increase professional development opportunities for hospice staff to improve their cultural competency, increase their knowledge best practices collecting culturally inclusive data, recognizing biases, and expanding their skills for working with diverse communities.

**D. Conforming Regulations Text Revisions for Telehealth Services**

Revise § 418.204, to remove paragraph (d) to eliminate the use of technology in furnishing services during a PHE.

**Clarification on the use of technology:** NHPCO appreciates recent clarification about the use of technology as a follow-up to, or to supplement, in-person visits. We have used the transcript from the CMS Office Hours on the End of the Public Health Emergency, held on April 25, 2023<sup>22</sup>, as our source for the information on the use of technology after the PHE has concluded. If there is additional guidance CMS can provide for clarity, it will be most appreciated by hospice providers.

**Tracking telehealth visits:** NHPCO supports the regulatory adjustments proposed at 418.22(a)(4)(ii) and 418.204(d) to align with post-PHE telehealth requirements and requests consideration for codes or modifiers that would track telehealth visits on the claim form.

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<sup>22</sup> Centers for Medicare & Medicaid Services Office Hours on the Ending of the Public Health Emergency (Apr. 25, 2023), <https://www.cms.gov/files/document/transcriptofficehoursendingphe04252023.pdf>,

**Tracking chaplain visits:** NHPCO again requests CMS consider adding HCPCS codes for hospice chaplains as approved by the CMS HCPCS committee in June 2022.<sup>23</sup> Chaplains are the only discipline on the IDT whose visits are not tracked, and hospices are interested in being able to see the visit information for all disciplines.

### **NHPCO Recommendations:**

- Since the PHE has concluded, providers are adjusting their use of technology as a follow up to in-person visits. NHPCO requests CMS issue additional guidance for clarity on the use of technology in routine home care provided after the end of the COVID-19 PHE. Hospice providers would be very appreciative.
- NHPCO strongly recommends CMS adopt codes to better track the usage of telehealth technologies in providing hospice care. CMS should develop and implement Healthcare Common Procedure Coding System (HCPCS) codes or modifiers for visits using telehealth technologies and add them to the hospice claim form as recommended by the Medicare Payment Advisory Commission (MedPAC) in March 2022.<sup>24</sup> Without the ability to measure the use of telehealth technologies through the claims form, we are not able to understand the full breadth of impacts or the volume of such visits compared to in-person visits. Tracking visits provided through telehealth technology is critical in ensuring effective guardrails are in place for quality care.
- NHPCO again requests CMS add HCPCS codes for hospice chaplains. These codes, approved by CMS' Healthcare Common Procedure Coding System (HCPCS) Level II Final Coding, Benefit Category and Payment Determinations First Biannual (B1), 2022 HCPCS Coding Cycle,<sup>25</sup> (Chaplain Services - HCP2201034JRL4) include:
  - HCPCS Level II code Q9001 "Assessment by chaplain services"
  - HCPCS Level II code Q9002 "Counseling, individual, by chaplain services"
  - HCPCS Level II code Q9003 "Counseling, group, by chaplain services"

## **E. Proposals and Updates to the Hospice Quality Reporting Program (HQRP)**

### **1. Proposed Hospice Outcomes & Patient Evaluation (HOPE) Update**

NHPCO is appreciative of the ongoing updates from CMS on the HOPE instrument. Feedback from hospice providers includes the request ample lead time is provided to transition to the HOPE tool, for both EMR vendors and hospice providers, and to allow for sufficient resources to be allocated for modifications to EMR systems and staff training. This could take many months to fully implement. It would be very helpful to give access to the HOPE tool for a year prior to

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<sup>23</sup> CMS, *Centers for Medicare & Medicaid Services' (CMS') Healthcare Common Procedure Coding System (HCPCS) Level II Final Coding, Benefit Category and Payment Determinations* (Oct. 2022) at 168-73, <https://www.cms.gov/files/document/2022-hcpcs-application-summary-biannual-1-2022-non-drug-and-non-biological-items-and-services.pdf>.

<sup>24</sup> MedPAC, MARCH 2022 REPORT TO CONGRESS, 360, (March 2022), [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).

<sup>25</sup> CMS' HCPCS, *supra* at 169, 171, 173.

enforcing the rules around how it will be used so they can test and revise processes prior to any enforcement.

In addition, providers have indicated they will need extensive time to implement changes to internal policy and procedures for visit frequency, assessment and reassessment of the patient assessments included in the HOPE tool. Providers are concerned the HOPE tool will include specific requirements for in-person visits that may be different than providers' current practices.

**Providers' experiences:**

- *When this tool is implemented, please allow for extensive time for hospices to adopt the tool. Implementing the tool will require significant changes to EMRs, as well as changes to internal policy/procedure for visit frequency, assessment, and reassessment. This would take many months to fully implement. It would be very helpful to give hospices and EMR vendors access to the HOPE tool for a year prior to enforcing the rules around how it will be used so they can test and revise processes prior to any enforcement.*

**NHPCO Recommendation:**

- NHPCO recommends CMS provide at least one year of lead time prior to the implementation of the HOPE instrument.

## **2. Proposed Update on Future Quality Measure (QM) Development**

NHPCO and hospice provider members agree the proposed future quality measures *Timely Reassessment of Pain Impact* and *Timely Reassessment of Non-Pain Symptom Impact* address critical aspects of the hospice patient experience. Many hospice providers already have existing clinical processes in place to address pain and non-pain symptoms within a specific timeframe, typically between 24 and 48 hours, which involve requirements for telephonic or in-person reassessments of identified symptoms.

Hospice provider feedback on these measures includes the request that provisions be included to allow for initial telephonic reassessment as well as the patient's right to refuse reassessment.

**Providers' experiences:**

- *We use a combination of reassessment visits and telephone follow-up depending on patient/family preference and severity of initial symptoms. Requiring an in-person visit would eliminate the patient and family's choice.*
- *Usually we do in-person visits, however some families will request just a phone call.*
- *We strive to do in-person reassessments as much as possible.*
- *Symptoms that are new or worsened are reassessed the following day to ensure that interventions are effective. This is completed via an in-person visit.*



**NHPCO Recommendation:**

- NHPCO recommends implementation of future quality measures related to timely symptom assessment take into account hospice provider capability to perform reassessments both in-person and telephonically, and patient and family preferences for reassessment modality be considered.

**3. Proposed Health Equity Updates Related to HQRP**

As discussed throughout the Health Equity RFI, NHPCO strongly supports the utilization of SDOH to better support patients and caregivers as well as inclusion into HQRP. By utilizing measure stratification, CMS and providers will be able to better understand the communities they are serving. NHPCO looks forward to continuing to partner with CMS to address health inequities and better support all communities who desire hospice care.

**4. Proposed CAHPS Hospice Survey Updates**

Hospice providers congratulate the CAHPS® Hospice team for testing the possibility of a web-based mode for the CAHPS® Hospice Survey. Having a web-based option for survey completion will increase survey response rates and allow hospices to target their areas for improvement. NHPCO encourages CMS to move as soon as possible to implement a web-based survey, as many providers are anxiously awaiting the revised survey and web-based alternative tested in 2021. Hospices are also pleased to see the CAHPS® Hospice team is considering a shortened survey, as many respondents have commented about the length of the survey as a reason for not completing it.

Many hospices have expressed concern return rates for CAHPS® Hospice Surveys remain low, and the volume requirement has prevented them from having star ratings reported on Care Compare. These providers are hopeful a shortened, web-based survey will make the survey more accessible to hospice caregivers and increase survey response rates.

In addition, providers have reported caregivers of hospice patients who were cared for in a facility, such as a nursing home or assisted living, or who receive multiple CAHPS® surveys due to recent hospitalizations, are frequently confused about which survey applies to each care setting. NHPCO welcomes any opportunities for the CAHPS® Hospice team to clarify survey questions for patients who resided in facilities or had recent hospitalizations.

**Providers' experiences:**

- *We have received feedback that the survey is not filled out by some patient caregivers due to the length of the survey. The section on caregiver training is confusing for those patient caregivers who are not providing direct care when the hospice patient resided in a facility while on hospice services.*
- *An online platform would be most welcome.*

- *Any opportunity to simplify the survey and increase the ability to send it in mixed modes will be effective to capture additional feedback and make it easier for caregivers to respond.*

**NHPCO Recommendation:**

- NHPCO recommends implementation of the web based CAHPS® survey as soon as possible, as providers are anticipating this very necessary improvement.

**F. Proposals Regarding Hospice Ordering/Certifying Physician Enrollment**

**Medicare enrollment for the certifying hospice physician:** NHPCO supports the proposal to require the enrollment, or valid opt-out, of the certifying hospice physician in Medicare through the internet-based Provider Enrollment, Chain, and Ownership System (PECOS) process or through a paper process. As we have discussed with CMS previously, Medicare enrollment, or a valid opt-out, is a program integrity initiative to prevent “unqualified and potentially fraudulent individuals from entering [hospice] and inappropriately billing Medicare.” NHPCO recognizes this proposed enrollment, by itself, is not enough to target fraud and abuse in hospice but is a step in the right direction.

**Hospice attending physician:** The hospice physician who certifies and recertifies terminal illness is in the best position to understand initial and continuing eligibility for hospice patients. However, NHPCO has concerns about the inclusion of language indicating the “attending physician” meets the definition of “ordering/certifying physician” and would also be required to be enrolled. NHPCO does not support the proposed enrollment for hospice attending physicians for the one time review and signature on the certification of terminal illness.

**Concerns about the list of services on the application:** If this proposal is finalized, most hospices will automate the PECOS verification process as other providers have done. During the application process, the physician must identify the types of services they are delivering, and hospice will be added to the list on the application. NHPCO urges CMS to only require the hospice certifying physician be enrolled with a broad list of services, without regard to the types of services provided or the taxonomy code of the physician.

**NHPCO Recommendations:**

- NHPCO strongly supports **ALL CMS** efforts to address fraudulent behavior by all providers as highlighted in the 34 recommendations submitted to CMS Administrator Chiquita Brooks-LaSure in January 2023.<sup>26</sup>

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<sup>26</sup> 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/>.

- NHPCO supports the proposal to require hospice physicians who certify hospice services for Medicare beneficiaries to be enrolled in or validly opted-out of Medicare as a prerequisite for payment of hospice services.
- NHPCO does not support the inclusion of attending physicians in the PECOS hospice enrollment requirement.
- If this proposal is included in the final rule, NHPCO requests CMS and the Part A and B Medicare Administrative Contractors provide education to physicians and hospices about the enrollment requirements, process, list of services, and taxonomy codes.
- NHPCO recommends a one year delay in the implementation of this proposal, if finalized, so hospice physicians who are not currently enrolled have the time necessary to complete the process.

Thank you for your consideration of NHPCO's comments on this proposed rule. We welcome continued engagement with you and your staff and the opportunity to meet to discuss our recommendations. If you have questions or to schedule a meeting, your staff should feel free to contact Judi Lund Person, Vice President, Regulatory and Compliance at [jlundperson@nhpco.org](mailto:jlundperson@nhpco.org) or Aparna Gupta, Vice President, Quality at [agupta@nhpco.org](mailto:agupta@nhpco.org)

Sincerely,



Ben Marcantonio  
Interim Chief Executive Officer