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Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1714-P  
P.O. Box 8010  
Baltimore, MD 21244-1850

***RE: CMS-1714-P: Medicare Program; FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements***

***Submitted Electronically via [www.regulations.gov](http://www.regulations.gov)***

Dear Administrator Verma,

The National Hospice and Palliative Care Organization (NHPCO) appreciates the opportunity to provide comment to the Centers for Medicare and Medicaid Services (CMS) on *CMS 1714-P, FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements*, posted for public inspection as a Notice of Proposed Rulemaking (NPRM) in the April 19, 2019 issue of the Federal Register.

NHPCO is the largest membership organization representing the entire spectrum of not-for-profit and for-profit hospice and palliative care programs and professionals in the United States. Comprised of almost 4,000 hospice locations with more than 57,000 hospice staff and volunteers, as well as 46 state organizations, NHPCO members served 71% of Medicare beneficiaries who elected hospice in 2016, the last year for which data is available. NHPCO is committed to improving end-of-life care and expanding access to hospice care with the goal of creating an environment in which individuals and families facing serious illness, death, and grief will experience the best that humankind can offer.

In preparing our comments on this proposed rule, NHPCO prepared a detailed Regulatory Alert and wage index rate charts for our members and reviewed the various proposals with NHPCO committees and councils. Given the magnitude of the proposals, we organized workgroups to focus on specific

proposals in the rule to discuss possible responses. In addition, NHPCO held two listening sessions to gather additional input from providers across the country. We have both concerns and recommendations based on our own analysis and experience, as well as those of our providers. Our comments focus on the payment rates, the election statement and addendum, the request for information on care coordination, and changes to the hospice quality reporting program. Detailed comments and recommendations follow.

## **I. Trends in Medicare utilization**

Thank you for the information on top diagnoses and average and lifetime length of stay. We appreciate the updates each year and use the information in hospice provider education. We are encouraged to see that CMS is using information collected from the revised hospice cost report to estimate hospices' average costs per day by level of care. This is a step in the right direction.

However, using cost reports is not sufficient because they are not consistently accurate across the provider community due to a lack of training. We urge CMS to assure that providers are correctly preparing and submitting cost reports and that Medicare contractors are applying edits consistently. These are complex documents that can be burdensome to navigate and comprehend, particularly for new providers. Putting patients over paperwork demands simplification of documents and investments in training providers. In our ongoing discussions with the Medicare Administrative Contractors (MACs), MAC leadership has clearly communicated that there are no plans in place to provide needed education to hospice providers on cost report preparation. As such we are working with cost report preparation consultants to provide detailed education on the cost report changes and Level 1 edits to the extent possible, but we strongly suggest that cost report training be offered by the MACs to ensure that providers have access to the right information that will lead to improved accuracy in the cost reports across all providers.

Understanding the total non-hospice expenditures for beneficiaries after their hospice election is critical for purposes of provider education. CMS has made this information available in previous hospice proposed rules. The total payments outside the benefit, for Parts A, B and D has also been provided. These important data are missing from the FY 2020 proposed rule, which only includes the non-hospice expenditure beneficiary cost-sharing amounts. NHPCO has tried to fill the gap by tracking the total expenditures outside the benefit for the past five years to use in provider education. We request that the total spending for our beneficiaries be included in the preamble to the FY2020 final rule and included in future rulemaking in proposed rules.

In the discussion of Part D expenditures after the hospice enrollment, we note that there is no mention of the *Hospice Information for Medicare Part D Plans form, commonly known as the A3 reject form*. The form was developed by the National Council of Prescription Drug Programs (NCPDP) Hospice Work Group and designed to be used by hospice providers to document drugs that are unrelated to the terminal prognosis, communicate changes in the beneficiary's hospice status, and to communicate medications listed on the plan of care. We have been an active member of the work group for several

years and we suggest working collaboratively with NCPDP as the issue of Part D expenditures after the hospice election is further analyzed.

## II. Rate Rebasing for GIP, CHC and IRC and Rate Adjustment for RHC

NHPCO appreciate the analysis on the cost of care as it compares to reimbursement rates. However, we are very concerned about the data used in the analysis—specifically how few hospices were considered after applying the Level 1 edits and the 1% trim. The resulting sample size is very small and only includes cost reports from a small subset of providers—RHC (1,098), GIP (809), CHC (437) and IRC (906) as referenced in the proposed rule. It is also important to acknowledge that the exclusion methodology included Level 1 edits that were not yet in place for hospice providers when their cost reports were submitted. For these reasons, we strongly believe that the cost data on which CMS relied were not sufficient for calculating the proposed reimbursement amounts.

NHPCO recommends that **the routine home care rate (RHC) be maintained at the FY2019 level in FY2020**, that **payment increase recommendation for GIP, CHC and IRC be increased and adjusted to meet budget neutrality requirements**, that **provider-based cost reports should be included**, and **rate adjustments should be based on two more years of hospice cost report data**. Justification for and details on the recommendations follow.

With these concerns in mind, we offer the following detailed comments on each of the four levels of care.

### A. General Inpatient Care (GIP)

NHPCO agrees that the rate for general inpatient care (GIP) is too low and has caused challenges for hospice providers in contracting with hospitals and in successfully operating hospice inpatient facilities. However, there are other factors affecting GIP use as well, including patients' desire to die at home, increased GIP scrutiny, and impact on both freestanding hospice facilities and on GIP contracts in hospitals. NHPCO shares comments below from hospice providers, with which we agree, about the use of GIP and the impact of the proposed rates on their programs.

- **Patients want to die at home:** While GIP is an important level of care, the vast majority of patients prefer to die at home and specify that desire during the hospice admission process. Hospices work to honor that patient's wishes and provide the care at home as much as possible.
- **GIP scrutiny:** For some time, there has been intense scrutiny from the Medicare Administrative Contractors about the use of GIP. Hospice providers have changed their practices to avoid denials and admission practices have tightened. More recently, the Supplemental Medical Review Contractors (SMRCs) had been conducting audits on hospice GIP with high denial rates and this has had a further chilling effect on the use of GIP.
- **Freestanding hospice facilities:** For hospices providing GIP directly, this rebasing would

have a positive impact. Hospice providers report that this change would allow their freestanding inpatient facility to operate in the black for the first time.

- **GIP contracts in hospitals:** For hospices who offer GIP through a scattered bed or hospital-based inpatient units, the results are different. The rate increase will flow from the hospice directly to the hospital and the hospice will not see any benefit to the increase. Providers report that under their contractual arrangements with hospitals they're typically required to pay 100% of the GIP rate to the contracted hospital, so the proposed additional payment will not stay with the hospice.
- **Challenges with GIP contracting with hospitals:** The higher rates for GIP may be enough of an incentive for hospitals and critical access hospitals to consider contracting with a hospice. For some, the reason for not contracting was the low reimbursement rate. In some markets, the hospitals will only contract with specific hospices to do GIP. In some areas, the area hospital refuses to contract with any hospice for GIP. The low reimbursement rate for GIP is sometimes the reason for the hospital's decision, but not always. The hospices who cannot obtain a hospital contract must contract with a skilled nursing facility to provide GIP – much less desirable for the patient and family.

## B. Continuous Home Care

NHPCO believes that there are both financial and structural reasons for the low utilization of the CHC rate and agrees that the CHC rate should be increased.

Our members have discussed the provision of continuous home care (CHC) and have identified several issues, with which we concur:

- **Hourly CHC rate:** The current low rate means that the cost of having CHC staff to provide care exceeds the reimbursement rate.
- **Staffing for CHC:** Staffing for CHC is challenging, particularly in areas with nursing shortages. The requirement that the nurse be a direct hospice employee also presents a challenge. Employed nurses have a case load or are "as needed" staff covering visits. It is difficult to have employed nurses readily available to meet the unpredictable but urgent need for continuous care. Allowing the hospice to utilize contracted nursing staff would increase timely access to continuous care. Hospices understand the contracted staff will need to have education and competence in the provision of hospice care.
- **Alternatives to increase CHC utilization:** For many patients, the greatest need for CHC is in the evening and through the night. Current regulations require continuous care be provided for at least 8 hours in a 24-hour period, beginning and ending at midnight. That means that the patient who has a continuous care need after 4:00 pm may get a nurse and aide continuously until midnight without qualifying for the minimum CHC hours. Options discussed by our members to increase utilization of CHC:
  - Change the midnight to midnight rule to a 24-hour period, which could span 2 calendar days. We understand that the calendar day issue may make this option

challenging, but we request CMS's consideration.

- Consider shortening the minimum number of hours required for CHC. We recommend that CMS consider shortening the number of hours required to trigger CHC from 8 hours to 4 hours in a 24-hour period, with a majority being nursing care.

### C. Inpatient Respite Care

NHPCO supports the increase in the respite care rate but notes that the size of the increase is substantially higher than the other levels of care. A second look at the data is warranted before this rate is finalized. We make two comments below about inpatient respite – both its use and the increased ability to contract.

- **Family choice:** Inpatient respite is always a family's choice and its utilization is not under the hospice's control. This is an important level of care to provide as a safety net for families, and its use is sporadic.
- **Increased rates will increase contract options:** Many hospices report that the increase in the IRC rate will enable them to find nursing facilities willing to contract with them for respite stays, since the current rates makes that challenging in many areas.

### D. Routine Home Care

As CMS notes, 98.2% of hospice care days are provided at the Routine Home Care (RHC) level of care. The number of beneficiaries receiving hospice care has increased and hospice providers provide care wherever the beneficiary calls home – at home, in assisted living and in nursing homes. The original intent of the Medicare hospice benefit was to keep patients at home – where they want to be and where the costs are significantly less than for inpatient care.

RHC is the core of hospice care. The proposed cut in this level of care, impacting 98% of the days of care, is threatening the ability of many of our members to continue to provide high-quality hospice care to any patient who needs it. Providers also report that the cost of providing care to patients in hospice for a very short time is higher than the reimbursement rate. In 2017, NHPCO's data analysis showed that 27.8% of patients had a length of stay of 7 days or less. When we include patients with a length of stay of 14 days or less, the number of patients served rises to 40.5% of total patients served. Data presented by Abt Associates at the 2019 NHPCO Leadership and Advocacy Conference indicates that in the first and last weeks of hospice care, costs exceed the reimbursement rate.

As we review the proposed rule, we are gravely concerned about the impact the proposed reduction in the RHC care will have on care, as well as the message the increased reimbursement for the other levels of care sends to providers. NHPCO is concerned that the substantially increased rates for the other levels of care could drive provider behavior away from RHC and toward the higher levels of care. This is not in keeping with the wishes of

patients and families or the original intent of the Medicare hospice benefit. The reduction in the RHC rate will be especially difficult for smaller hospices and those in rural areas, which do not have economies of scale and where the cost of personnel and drugs are increasing.

Concerns from our providers include:

- **Short stay patients:** We find an increase in costs for the first 60 days of care. The majority of our patients expire during that time frame, so our agency will see an overall decrease in funds to care for our patients. RHC is by far the level of care we utilize at 97% of total days, and with clients being referred so near the end of life, we also have the majority of clients in the first tier of payment rates, which will be cut. This will definitely have a negative impact on our organization.
- **Costs continue to rise:** The cost of personnel, drugs, DME and supplies continue to rise. A reduction in the RHC rate will be very difficult for hospice providers to handle.
- **Impact on hospice care in rural areas:** Since 98% of hospice care is routine care, I fear this will mean providing rural hospice care will be even more difficult than it already is. The adjustment accounts for the inadequate reimbursement for hospice inpatient level of care; however, the decrease in reimbursement for routine level of care places increased burden for hospices providing care in more rural areas. The decrease may further diminish the ability of rural Medicare beneficiaries to receive hospice care, as rural providers are forced to reduce their service area or cease to operate.
- **Wage index adjustments impact rates:** While the national rate projects a \$0.42 increase in the RHC 61+ day rate, in our CBSAs, representing over 90% of our business, both levels of RHC have a rate reduction. In other words, we will NOT see an increase in 61+ days RHC rate.

#### **NHPCO Recommendations:**

- **Routine home care rate should be maintained at the FY2019 level in FY2020:** We respectfully request that the RHC rates be kept level with the FY2019 rates for FY2020, and until providers have corrected Level 1 edits and CMS has access to a larger sample size for evaluating the RHC rate. We note that calculation of the cost of a day of care is based on the hospice cost report, with data available for the last three years. Although Level 1 edits to the hospice cost report were not applied until 2018, in the CMS analysis these edits were applied to the 2017 cost reports already accepted by the Medicare Administrative Contractors (MACs) as complete. This left only 34% of cost reports available for the RHC calculations.
- **Payment increase recommendation for GIP, CHC and IRC:** NHPCO believes that

some upward adjustment in these three levels of care is warranted and we recommend a stepwise approach to that adjustment. This is important, as we want to make sure that CMS contractors are in synch with CMS policy, and that patients and families receive access to the right care at the right time. Making this change too abruptly, and at the cost of RHC, might lead to negative unintended consequences. We recommend that after the RHC rate adjustment to maintain FY2019 rates is calculated, then the GIP, CHC and IRC levels of care be increased in amounts that meet budget neutrality requirements.

- **Include provider-based cost reports:** NHPCO recommends that all hospice cost reports be considered when calculating new payment rates, including provider-based cost reports, representing 22% of the total. These were excluded from CMS' analysis.
- **Two more years of cost report data needed:** NHPCO believes that it is too soon to make the significant changes in payment rates for GIP, CHC and IRC based on the cost report data used by CMS. The number of cost reports in the sample is too small and not sufficiently representative for use in rate setting. Two more years of data are needed to have the volume of cost reports on which to base recommendations on payment increases. The proposed payment increases are too much too soon with the limited data available.

### **III. Removing One Year Lag by Using Current Year Hospital Wage Data to Establish Hospice Wage Index**

NHPCO is supportive of removing the one-year lag in the hospital wage data to establish the hospice wage index and believes that the impact will not be significant for providers. However, providers experience swings in wage index values from year to year, and they are often surprised by the variation in their rates. We support the ongoing CMS work to determine new options for wage index values for all Medicare provider types.

### **IV. Proposed Election Statement Content Modifications and Proposed Addendum to Provide Greater Coverage Transparency and Safeguard Patient Rights**

#### **A. Proposed Election Statement Content Modification**

CMS has proposed certain modifications to the content of the hospice election statement, and has also proposed imposing, as a new condition of payment, that hospices provide patients with a written addendum, upon request, cataloguing all conditions, items, services or drugs determined to be unrelated to the patient's terminal illness and related conditions, and to provide an updated version of this addendum whenever there are changes. As noted below, **NHPCO strongly objects to the proposed election statement addendum**, and we are

particularly concerned that CMS proposes to make it a condition of payment. In addition, we do not believe it will address the concerns cited by CMS.

NHPCO appreciates CMS' continued support of quality hospice care for patients and their families. We agree that hospice patients should be adequately informed about the scope of services covered, and not covered, under the Medicare hospice benefit, and that patient rights should be fully protected. We also agree with the importance of care coordination between all providers involved in the care of hospice patients, and we share CMS's concern with ensuring that neither the Medicare program nor beneficiaries are billed separately for services that should be provided under the hospice benefit. We are committed to continuing to work with CMS and other stakeholders to address the concerns CMS cites in the proposed rule, and below we offer a number of recommendations.

### **Changes to the Election Statement and Requirement to Provide an Addendum**

We certainly agree that patients have a right to understand what services will, and will not, be provided by the hospice, and that in electing the hospice benefit they are waiving the right to payment for certain items and services that would otherwise be covered by Medicare. NHPCO believes this information is already present on the election statement and additional information is provided to the patient and their family during the admission process. Hospices already are required under the Conditions of Participation at 42 CFR §418.52 to inform patients about the services covered under the hospice benefit, and the scope of services the hospice will provide as well as any specific limitations on those services.

**Election statement additions:** CMS proposes that the Statement also include language informing patients that services unrelated to the terminal illness and related conditions are exceptional and unusual and that hospice should be providing virtually all care needed by the patient. NHPCO believes that there are circumstances in which a patient or representative may misunderstand or refuse to understand why a drug or treatment should no longer be provided, whether related or unrelated to the terminal illness and related conditions. Hospices provide information on this issue in the patient and family handbook, review the information with patients and families during the admission process and review coverage with patients and families during the course of care. NHPCO suggests that the survey process, either by the state survey agency or by the accrediting organization, could be used to review the information provided to patients and families. NHPCO pledges to continue to provide guidance to hospices about their responsibility for services covered by the hospice, and the importance of communication and documentation regarding services determined to be unrelated.

**Cost sharing:** CMS also proposes to require that the election statement include information on individual cost sharing for hospice services. Hospices are permitted, but not required, to impose small coinsurance payments for hospice drugs and for inpatient respite care. However, most

hospices do not charge patients for any coinsurance. While we believe hospices that do require cost sharing for drugs and/or inpatient respite care must inform beneficiaries of this, if applicable. This should not be required on the election statement used by all hospices. When it's not relevant to their care, this would be confusing for patients and burdensome for hospices to have to explain.

**BFCC-QIO Immediate Advocacy:** NHPCO fully supports informing beneficiaries of their option to seek immediate advocacy from the BFCC-QIO if they disagree with the hospice's determination regarding services that are unrelated. Hospices already provide information on how to contact the QIO as a part of the admission packet, in compliance with the regulations at §476.78. We note that CMS referenced this issue in the FY2018 Hospice Wage Index proposed rule and NHPCO continues to provide education and guidance on the issue. NHPCO requests that CMS provide additional clarity about the findings of the BFCC-QIO and how the hospice is to implement them, so there is no confusion about the authority of the BFCC-QIO, the hospice medical director and the Medicare Administrative Contractor when determining relatedness, eligibility and continued hospice coverage.

**Consideration for changes to the Election Statement:** To the extent CMS believes hospices should provide additional information to patients, changes could be made to the Patient Rights Condition at §418.52. This would give hospices flexibility in how it is operationalized rather than imposing specific requirements in the election statement that must be used by every hospice. Requiring hospices to make any changes in their election statement will also require changes to the printed patient guide to hospice care and to the paper forms signed by the patient or their representative, as well as the election statement language in the electronic medical record (EMR).

Consideration should be given to the amount of time, effort and cost needed for software vendors to make changes in the EMR, along with the time and expense of updating the hospice's patient guide to hospice and any print version of the hospice election statement. These are not insignificant burdens.

#### **NHPCO Recommendations**

- NHPCO recommends no changes to the election statement, but rather an adjustment in language at §418.52.
  - (7) Receive information about the services covered under the hospice benefit;
  - (8) Receive information about the scope of services that the hospice will provide and specific limitations on those services, including information about care that is unrelated or unnecessary for the palliation of the terminal illness and related conditions and will not be covered in the

patient's plan of care.

- Language could also be added to the Interpretive Guidelines to provide additional guidance to providers and surveyors. Additional guidance could include documentation requirements by the hospice physician when drugs and treatments or treatments are deemed unnecessary as well as documentation of the patient/family discussion by the hospice nurse.
- We also believe that if any changes are made, CMS should allow sufficient time for the EMR vendors to make adjustments in processes. NHPCO recommends that implementation of any changes be delayed until FY2021.

## **B. Proposed Election Addendum**

CMS proposes to require that the election statement includes an addendum notification of the individual's right to receive an addendum if there are conditions, items, services, and drugs the hospice has determined to be unrelated to the individual's terminal illness and related conditions and would not be covered by the hospice. CMS proposes to make the provision of this addendum a new condition of payment for the hospice. As addressed in detail below, **NHPCO strongly objects to this requirement** and believes it would be extremely burdensome for hospices, potentially confusing for patients and families, and would not address the concerns cited by CMS in the proposed rule.

While CMS has expressed its commitment to reducing regulatory burden and prioritizing patient care over paperwork, this requirement would impose a substantial regulatory burden on hospice providers and we do not believe it would enhance patient care, or effectively address the concerns cited by CMS.

### **1. Timing**

**Unrealistic timeframes:** Expecting hospices to develop and provide such an addendum statement, in writing, within 48 hours of election is completely unrealistic. The whole certification, election and admission process is extremely stressful and emotional for families, and very hectic for hospices. During the first couple of days, the hospice is just getting to know the patient and their needs and goals. If CMS required the proposed addendum to be issued within 48 hours of election, the only information the hospice has at that point is the information on the initial assessment, conducted by the hospice nurse, identifying their immediate care and support needs. This is the beginning of the process for developing the patient's plan of care.

**Nurse scope of practice:** Decisions about relatedness are outside the scope of practice for the nurse. Those decisions must be made by the hospice medical director or hospice physician in consultation with the interdisciplinary team and the patient’s attending physician. The timing might be 7 to 10 days after admission, depending on the schedule for the IDT team meeting.

**Logistics of delivery:** Providers have also expressed the difficult logistics of delivering the addendum to the patient and family within 48 hours. Who will be responsible for delivering it to the patient? Does that require scheduling an additional patient visit? Can hospice staff provide it at the next scheduled visit?

**Addendum during the course of hospice care:** If the addendum is requested after the election, during the course of the hospice election, the hospice must provide it, in writing, “immediately.” This is unrealistic given that the hospice would have had no advance notice that an addendum needed to be prepared.

## **2. Updating the Addendum**

CMS is proposing that “if there are changes to the plan of care that result in a determination that a new illness or condition has arisen, we are proposing that hospices would be required to issue an updated addendum to the patient (or representative) reflecting whether or not items, services and supplies related to the new illness or condition will be provided by the hospice.”

**Changes to plan of care:** NHPCO members share that there are changes in patients’ plan of care often, sometimes daily, to adjust medications, discontinue medications, and update the type and schedule of visits. Over time, as the patient’s condition changes, items and services included on the addendum may be discontinued. A change to the addendum is required each time that change occurs? This would be burdensome to providers, but more importantly confusing to a family that is already dealing with so much.

## **3. Providing the Addendum to Non-Hospice Providers and Contractors**

In addition to patients and representatives, CMS is proposing that hospices would be required to provide the election statement addendum, upon request, to other non-hospice providers who are treating the patient, and to Medicare contractors who request such information.

NHPCO has received comments from hospice providers about this requirement. We agree with the importance of care coordination between all providers who are providing items or services to hospice patients, and it is already a condition of participation for hospices to have a communication system in place for communicating with non-hospice providers who are furnishing care unrelated to the terminal condition. We believe there more effective ways to communicate with non-hospice providers than to send them an election statement addendum.

Some of these care coordination issues could be solved if more hospice provider EMR solutions were interoperable with EMR solutions of other providers, although incentive funding will be necessary for hospices and other post-acute care providers to move toward interoperability.

The language in the proposed rule also presupposes that it is only the hospice's responsibility to communicate with other providers. The reverse should be true as well, as noted in our recommendations below. Is the hospital provider required to check the Common Working File (CWF) to check hospice status before billing? Is the DME provider checking on hospice enrollment before billing DME outside the benefit? Does the claims process system block other providers from billing Medicare with a flag in the system indicating the beneficiary is a hospice patient? A few years ago, NHPCO prepared a report on relatedness and the issues and challenges for hospices and others providing services to patients and families. It was sent to CMS in February 2015, followed by a meeting with senior CMS officials in May 2015. We share excerpts of that work below, and our recommendations to CMS, to illustrate that the issues are not new, and to reiterate our commitment to work with CMS to find solutions for all provider types, and to better serve hospice patients.

Hospice providers can identify communication strategies to provide information to other providers, when those providers are identified. In addition, many hospice providers have proactively worked with referral sources and other Medicare providers to establish communication methods that work to coordinate and enhance patient care. However, there are frequent instances when care is provided to a patient without the hospice's knowledge and the hospice discovers that the service or medication has been provided after the fact.

#### **Excerpts from NHPCO Suggestions to CMS and Proposals for Change – February 2015**

##### **Other Provider Issues**

NHPCO has worked to educate hospice providers about the importance of care coordination and ensuring that any expenditures outside the hospice benefit have been appropriately determined to be unrelated to the terminal prognosis, and we welcome the opportunity to work with CMS to discuss ways to further enhance these efforts. But, NHPCO has also identified that other providers billing Medicare for services provided to hospice patients do not have sufficient knowledge about hospice, may not have an accurate understanding about billing rules and modifiers, or may not have "flags" in their billing systems that would indicate that the patient has elected or revoked/terminated their hospice election, or to prevent them from billing.

These other providers may be unaware that the patient has elected the hospice benefit, be unaware that they need to coordinate with the patient's hospice to determine whether the services are unrelated to the terminal prognosis, and unaware that claims

for hospice patients must be treated differently. Some provider types may also have financial incentives to bill separately, and there is nothing in the Medicare billing system to preclude it. Hospices can make additional efforts to educate other providers and coordinate with them, but they cannot control whether, how, and when other providers bill Medicare, or even know when another provider has billed for items or services provided to a hospice patient.

The list below offers suggestions related to other Medicare provider types who are providing services to beneficiaries who have elected their Medicare hospice benefit.

### **1. Provider Knowledge of Hospice Election**

There is an ongoing system challenge, due to limitations in the FISS/CWF, with the timely notification of other Medicare provider types about a Medicare beneficiary's hospice election, revocation or discharge. Hospices are now required to file the NOE within 5 days of election, but the hospice election will not be indicated to other Medicare providers in the Common Working File for another 5-8 days. There have been instances of the CWF not showing a hospice election for 21 days or longer after the NOE was filed. Similar concerns exist regarding delays in notification when patients revoke their hospice election or if the hospice discharges the patient. In these circumstances, the patient's access to their full Medicare benefits should not be delayed.

CMS should develop ways for the hospice election, revocation, or discharge information to be made available in the system faster, which would help prevent inappropriate expenditures outside the hospice benefit and would ensure that a patient discharged from hospice has immediate access to their regular full Medicare benefits. CMS should:

- a. Develop a shortened process that will expedite the notification of election in the CWF so that other provider types will be aware of essential information more quickly.
- b. Implement flags that can be placed in the system to notify other Medicare provider types of the hospice election, and should require these other providers to communicate and coordinate with the hospice regarding whether the item or service is related or unrelated to the patient's terminal prognosis prior to submitting any claim.
- c. At the outset of providing care, all provider types should be required to check the Common Working File to determine whether a beneficiary has elected the hospice benefit. All provider types should at least be required to ask the beneficiary and/or their representative if they are a hospice patient.

## 2. Physician Billing Requirements

- a. CMS and the Medicare Administrative Contractors should provide clear guidance to physicians on billing requirements for using the GV and GW modifiers. CMS should circulate the guidance widely and in a variety of publications. NHPCO is pleased to be working with all three HHH MACs to encourage the development of job aids and training for Part B providers on hospice billing issues.
- b. The claims processing system for Medicare Part B should develop a flag to reject physician claims for services provided to hospice patients if the claim does not have a GV or GW modifier.
- c. To address the problems created when billers don't know the code to put on bills to designate that a service to a hospice patient was unrelated to that patient's hospice prognosis:
  - i. CMS should develop tools and resources, such as an MLN article, among others, that will provide details on coding for services for hospice patients.
  - ii. NHPCO could work with CMS and HHH MACs to expand the education to Part A and Part B providers regarding the need to coordinate with hospices, and the appropriate codes to bill when conditions are determined by the hospice to be unrelated to the terminal prognosis.

## 3. Hospital Admission/Discharge

- a. CMS should place a flag in hospital billing systems via the Common Working File so that hospitals will know, in a timely fashion, when a beneficiary has elected hospice.
- b. CMS should require hospitals to ask patients or their representatives whether they have elected their hospice benefit.
- c. CMS should revise the language of condition code 07, which hospitals use to bill for a hospital stay that is unrelated to the terminal diagnosis, to reflect that by using the condition code, the hospital is indicating that it has notified the hospice of a patient's hospitalization, and that the hospice concurs that the reason for the hospitalization is unrelated to the terminal prognosis.

### **NHPCO Recommendations**

- NHPCO is opposed to the requirement to develop a hospice election statement addendum. While we believe in and support the patient's and representative's rights to information and transparency, the process proposed is cumbersome and increases regulatory burden for hospice providers without achieving the intended goal.

- NHPCO is opposed to the presence of an election statement addendum as a condition of payment. It is proposed to be provided only upon request, and to be recorded in the patient’s medical record. The process to determine whether and when it was requested, whether it is present, and whether the condition of payment requirement has been met, is fraught with issues.
- NHPCO proposes that a hospice-specific “Hospice Change of Care Notice” be developed and provided to patients and representatives upon request to meet the requirements for communication about items and services determined to be unrelated to the terminal prognosis. NHPCO would envision such a form to be similar to the Home Health Change of Care Notice and could be provided, on patient or representative request, after the initial and comprehensive assessment is complete, the plan of care has been established and the hospice physician and the interdisciplinary team have agreed about items and medications that may be unrelated or no longer necessary. NHPCO would be pleased to discuss with CMS the development of such a form and when and how it would be used.

If CMS were to develop such a form, software vendors would need sufficient time to develop and test changes to hospice EMR software. NHPCO would recommend an implementation date of FY2021.

## **V. Request for Information Regarding the Role of Hospice and Coordination of Care at End-of-Life**

In looking ahead, to help inform development of future CMS payment models and consider how to incorporate hospice care into other kinds of care delivery models, CMS has requested information regarding hospices’ experiences to date. CMS seeks feedback on the following, in bold. NHPCO feedback and responses based on our members’ experiences follows.

- A. Alternative network approaches might be considered, incorporating hospice into MA could result in MA plans only contracting with a subset of local hospices, thereby potentially limiting patient access and choice, and network adequacy standards would need to be developed by CMS.**

**Contracting with a subset of providers:** Hospice providers are very concerned about ensuring that all Medicare beneficiaries have access to quality hospice care, and to choose a hospice provider that best meets their needs. Providers are concerned that if hospice becomes part of the MA benefit package, smaller hospices, or hospices that serve more rural areas, will not be considered for MA contracting, particularly when some providers claim to cover a plan’s whole geographic area. Patients will have limited access and choice as a result. NHPCO strongly urges CMS to develop network adequacy standards for hospice.

**Inequities:** Providers report concern that if hospice is carved into Medicare Advantage, there will be inequities in services and care between those in FFS Hospice and MA hospice, and also differences between MA plans, and in how hospice services are offered. Care should be taken to ensure that the full range of hospice services included in the hospice benefit are available to patients and families regardless of the Medicare payer type, and that MA plans don't impose administrative impediments to timely access to appropriate hospice care. Hospices are concerned about MA plan implementation of prior authorization requirements for hospice care, or for particular levels of hospice care, and about maintaining the authority and autonomy of the hospice physician and interdisciplinary group, which are at the core of the hospice benefit.

- B. One way managed care or value-based arrangements could address concerns about MA plans contracting for lower rates, resulting in changes in the quantity and types of services provided by hospices may be to construct payments for hospice care such that they align closely with how hospices are paid under traditional FFS Medicare.**

**MA contracting experience:** Providers report that discussions with MA plans about hospice services and rates vary widely. Plans are seeking to pay less than the current Medicare rates, and may seek to contract for only a subset of the hospice benefit, stating that their enrollees do not need all hospice services. Specific targets for elimination by plans include social work and chaplain visits, and reduction in the frequency of services. The plans also want to use their own pharmacies and DME suppliers. Hospices are often pressured to unbundle their services in order to obtain or maintain the MA contract. NHPCO strongly believes that the integrity of the hospice benefit, and the role of the hospice physician and interdisciplinary group must be protected as hospice is considered for incorporation into MA.

**MA plan accountability:** Hospice providers are concerned that MA plans may contract with a hospice for hospice services but not be accountable for any hospice quality standard or any requirement for beneficiary/enrollee access. NHPCO believes that there should be accountability requirements that ensure timely hospice referrals, access to the full range of hospice services and hospice quality.

- C. CMS seeks information on the interaction of the hospice benefit and various alternative care delivery models, including MA, Accountable Care Organizations (ACOs), and other future models designed to change the incentives in providing care under traditional FFS Medicare.**

**ACO Experiences:** Our providers with ACO experience report that ACOs are particularly sensitive to cost concerns, but they understand that hospice is beneficial because it will increase quality scores. Hospices report that they have designed opportunities for ACOs to learn about hospice, sharing the value proposition and also identifying how a timely hospice referral may avoid hospital readmissions and ER visits, and increase quality of life and patient satisfaction.

That said, interaction between ACOs and Hospice has not yet been robust and has much room for expansion.

**D. Lessons learned that we should consider for the future design of the Medicare hospice benefit.**

**Medicare Care Choices Model (MCCM) Experience:** Among the hospice providers who have participated in the MCCM model, we have learned about seriously ill beneficiaries' need for support before hospice, and among beneficiaries participating in MCCM, CMMI reported, in the First Annual Evaluation Report in September 2018, a 83% conversion rate from MCCM to hospice. They state that "when a MCCM program connected to the seriously ill hospice-eligible beneficiary earlier in their disease process, they were able to learn about, and get comfortable with, the hospice model of care." MCCM providers reported an average length of stay in MCCM of two months. Those who enrolled in hospice had a one month stay in hospice, significantly longer than the 18 day median length of stay found among Medicare beneficiaries today.<sup>1</sup> The model of concurrent care offered under MCCM gives the beneficiary much needed time to transition and get accustomed to the hospice referral, representing a great palliative care model to meet patients and families where they are and to provide the right care to the right beneficiaries at the right time.

**Future design of the Medicare hospice benefit – Six-month prognosis:**

- The determination of whether a person would benefit from hospice care should be based on their medical and nonmedical needs – not an arbitrary six-month barrier.
- Hospices should have more flexibility to provide the care an individual needs at the appropriate time, based on a doctor's recommendation, not their predicted life expectancy.
- Eliminating the six-month prognosis requirement would mean that the hospice eligibility is based on a physician's assessment of need, rather than an arbitrary time frame. NHPCO would like to work with CMS to develop new criteria for determining hospice eligibility based on patient needs.

**Allow for concurrent care access:**

- Earlier access to hospice care is good for patients and payers.
- Under current regulations, beneficiaries must opt to forego curative care to receive hospice, even though the beneficiary would benefit from the services hospice provides, and introduction of a palliative care model would help terminally ill patients transition to hospice care earlier, when they would most benefit from it. To be clear, despite our hope that Medicare will have a unique person-centered, interdisciplinary "palliative care" benefit in the home, such a benefit does not yet exist in fee for service Medicare. A good start would be to allow hospice to provide services to individuals who are eligible for hospice but

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<sup>1</sup> Evaluation of the Medicare Care Choices Model Annual Report #1 (September 2018)) <https://innovation.cms.gov/Files/reports/mccm-firstannrpt.pdf>

not yet ready to admit it. The MCCM demonstration should show us that once these individuals are connected to hospice services and supports, they embrace the model.

- Providers should be allowed to provide the right support to the right people at the right time and avoid difficult transitions and confusion.
- A design element for a future Medicare hospice benefit will allow patients to pursue curative therapy concurrently with as they transition to hospice care if they so choose.

**E. How hospice under Medicare FFS relates to other treatment options, how it impacts the provision of a spectrum of care for those that need supportive and palliative care before becoming hospice eligible and after.**

The number of Medicare enrollees is expected to rise significantly through 2050 while the number of workers per beneficiaries is expected to decline at a similar pace. According to a Kaiser Family Foundation report (2019) 32% of Medicare beneficiaries have functional impairment in 1 or more activities of daily living; 25% self-report their health as fair/poor; 22% have 5 or more chronic conditions; and 12% are age 85 or older<sup>2</sup>. Studies show that individuals receiving hospice care lived longer with significantly reduced hospitalizations and lower total cost of care than those that did not receive hospice care<sup>34</sup>. Furthermore, access to palliative care services upstream from hospice care also significantly impact utilization and total cost of care<sup>5</sup>. Palliative care and hospice also demonstrate high patient and family satisfaction and increased quality of life. Given the burgeoning Medicare population and the reduction in workforce, hospice programs should be a key strategy in the provision of palliative care services to improve quality of life, align care with the wishes of seriously ill individuals, and minimize avoidable hospitalizations. Allowing hospice programs to serve the seriously ill patient population and their families supports timely access to the right care at the right time.

**F. Are rates of live discharge a reflection of the current structure of Medicare FFS?**

**Live Discharges:** Patients are discharged alive from hospice for many reasons. Much of the data on live discharge includes both patient revocations and hospice-initiated discharges. To really understand the core issues for live discharges, revocations and hospice-initiated discharges

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<sup>2</sup> Henry J Kaiser Family Foundation. (2019). Issue Brief: An overview of Medicare. Retrieved from <https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/>

<sup>3</sup> Unroe, K. T., Sachs, G. A., Dennis, M. E., Hickman, S. E., Stump, T. E., Tu, W., & Callahan, C. M. (2016). Effect of Hospice Use on Costs of Care for Long-Stay Nursing Home Decedents. *Journal of the American Geriatrics Society*, 64(4), 723–730. doi:10.1111/jgs.14070

<sup>4</sup> Chiang, J. K., Kao, Y. H., & Lai, N. S. (2015). The Impact of Hospice Care on Survival and Healthcare Costs for Patients with Lung Cancer: A National Longitudinal Population-Based Study in Taiwan. *PLoS one*, 10(9), e0138773. doi:10.1371/journal.pone.0138773

<sup>5</sup> Isenberg, S.R., Lu, Chunhua, et al. (2017). Impact of a New Palliative Care Program on Health System Finances: An Analysis of the Palliative Care Program Inpatient Unit and Consultations at Johns Hopkins Medical Institutions. *Journal of Oncology Practice*, 13(5), e421-e430. retrieved from: <https://ascopubs.org/doi/abs/10.1200/JOP.2016.014860>

should be separately tracked. Reasons for hospice-initiated discharges may include a patient moving out of the hospice's service area to move in with a family member, or they may have gone to a non-contracted hospital. Revocation could occur because the patient has decided to seek curative treatment or doesn't like the particular hospice's services.

**NHPCO Recommendation:**

- NHPCO recommends that CMS consider expanding the reasons for a live discharge to better understand why hospices discharge patients and why patients revoke the hospice benefit. Additional information would help identify ways to address live discharge issues. Adding more discrete live discharge codes to expand the "moved out of the service area" live discharge code to include:
  - Hospital refuses contract with hospital where patient seeks care
  - Patient is assigned to observation status in the hospital and GIP is not an option
  - Patient moved out of the service area to be with loved ones

**G. Comments on any care coordination differences for hospice patients that received Medicare through traditional FFS prior to hospice election, were enrolled in an MA plan prior to hospice election, or received care from providers that participate in an Accountable Care Organization (ACO) prior to hospice election.**

Care coordination is essential, and hospice providers report that there is confusion between the ACO and the hospice about who is responsible for care coordination when beneficiaries participating in ACO have elected the hospice benefit, each believing that they are in charge. Providers ask how differences in care coordination approaches and plans will be resolved, as one entity or the other will have to have primary responsibility for care coordination

Providers also report that ACOs are not likely to approve a level of care change for a hospice patient who might need continuous home care or general inpatient care. There is no consistency on what documentation the ACOs request for a level of care change, and even if approved, the higher level of care may not be paid.

Under the current hospice benefit, once a beneficiary elects the hospice benefit the hospice is responsible for providing, or managing, all aspects of the patient's care. When other entities are involved, whether it's an ACO, a managed care plan, or some other entity in an alternative care delivery model, there is confusion regarding lines of authority and management responsibility. For terminally ill patients receiving hospice care, maintaining the integrity of the full hospice benefit is essential, and this includes insuring that patients have access to all benefits and levels of care without requirements to jump through various administrative hoops and get multiple levels of approval.

## **H. Pros and cons of including hospice services as the part of the benefits provided in value-based or capitated payment arrangements and experience with Medicaid managed care when providing hospice care through the Medicaid program and commercial coverage.**

### **Hospice experience with Medicaid managed care:**

NHPCO's members who have experience with Medicaid managed care organizations (MMCOs) report numerous challenges. Managed care plans typically have little experience with hospice and do not understand the scope of the benefit or how it works. Since hospice itself is a type of all-inclusive "managed care", there is often conflict between the hospice's established system of care and the way the managed care plan is accustomed to interacting with its contracted providers. The plan's standard managed care provider contracts typically don't mesh with the structure and operation of the hospice benefit, and since hospice is a small part of the health care system, getting plans to adapt their contracts and/or operational policies is very difficult.

**Prior Authorization and Levels of Care:** Managed care plan requirements for prior authorization for hospice care can be a significant impediment to patients getting timely access to hospice services. Providers report significant time lags in getting prior authorization for hospice services, and given the short length of stay for most hospice patients, many patients die before any services are approved. Tracking prior authorization requests is a constant resource issue for staff. Our members also report that MMCO's rarely approve authorization for general inpatient care or continuous care, even when patients clearly meet the criteria for these levels of care.

**Claims Payments:** Providers report that two scenarios frequently exist for MMCO claims for hospice – the claim is denied the first and second time it is submitted. Often a claim must be submitted four or more times before it is approved for payment. Once the claim is approved for payment, payment is very slow, reported by some providers to be over one year from services provided to claim paid. The accounting staff are constantly "working the claim" and there are challenges with cash flow, especially with smaller providers.

**Nursing Home Room and Board:** While not an issue for Medicare Advantage, confusion is constant about the MMCO's responsibility for nursing home room and board payments when a dually eligible patient residing in a nursing home receives hospice services from Medicare and room and board services from Medicaid. Although the statutory requirement for payment currently is a pass through from Medicaid to the hospice, which then pays the nursing home, there is no clarity or guidance from CMS to address this issue.

## **VI. Hospice Quality Reporting**

### **A. Claims-based measures**

NHPCO believes that claims data cannot appropriately be used to inform the creation of performance measures that improve quality of care, and that performance measures should guide and promote the quality of care received by hospice patients and families. Measuring hospice care by quantity of services provided does not necessarily provide evidence of the quality of hospice care provided to the patient/ family. The individualized plan of care developed by the hospice is designed to meet the specific patient's/family's needs and preferences. Volume does not indicate the quality of care provided to the patient and their family.

Claims-based data also does not reflect the full scope of the beneficiary's hospice experience because not all disciplines of the hospice team are captured on the claim. NHPCO recommends that spiritual care services be added as a discipline on the claim form to gather additional information on the services provided.

#### **NHPCO Recommendations:**

- NHPCO believes that claims data cannot appropriately be used to for the creation of performance measures. Claims data can support process measures only, which are not solely indicative of the quality of care.
- NHPCO recommends that if CMS intends to create any additional process claims-based quality measures for hospice care, all disciplines in the interdisciplinary team that are not currently captured on the claim form should be added.
- NHPCO strongly recommends that a HCPCS code be developed for hospice chaplains. They are members of the interdisciplinary team and their visits and work is not captured on the claim form.
- NHPCO supports the development and implementation of the hospice assessment tool which will provide data to drive the development of patient/family focused outcome measures.

#### **B. Update on Claims-Based Measure Development**

##### *1. Transitions from Hospice Care, Followed by Death or Acute Care Measure*

NHPCO submitted comments to CMS on April 20, 2018 related to the call for comments - *Development of the Draft Transitions from Hospice Care, Followed by Death or Acute Care Measure for the Hospice Quality Reporting Program*. We expressed then that there may be several reasons for a patient transition, including a live discharge, initiated by the hospice, and revocation or transfer, initiated by the beneficiary for various reasons.

**Revocation:** A patient who chooses to revoke their benefit or transfer to another hospice provider is a live discharge from hospice care, but the decision is made by the patient rather than initiated by the hospice. NHPCO is concerned that these patient decisions are included in the draft measure, although they are out of the control of the hospice.

**Hospice-initiated discharge:** We note that there is no distinction made in the measure for the various reasons for a live discharge. Hospices may have to discharge a patient if the family panics during a patient symptom crisis and they go to a hospital with whom the hospice does not have a contract. The live discharge reason is “moved out of the service area.” This live discharge may not be avoided. The disease process for the patient who is discharged for “no longer terminally ill” may have plateaued and the hospice medical director and interdisciplinary team may determine that they no longer meet the six- month eligibility criteria.

We want to ensure that hospices are not penalized for live discharge issues beyond their control.

**Measure Applications Partnership Feedback:** The Measure Applications Partnership (MAP) reviewed the *Transitions from Hospice Care, Followed by Death or Acute Care* measure in December 2018 and did not support this measure for rulemaking as currently specified. MAP recognized the need to address a potentially serious quality problem for patients if they are inappropriately discharged from hospice. MAP noted that transitions of care at the end of a person’s life can be associated with adverse health outcomes, lower patient and family satisfaction, and higher costs, but they raised concerns that the measure under consideration is not garnering this information from claims data in a way that is fair to hospice care providers.

MAP also notes concerns that conceptually, “there is too much noise in the measure” and suggests that there should be criteria for exclusions from the denominator. They commented that as the measure is currently written, the unequal distribution of patients with the identified exclusions across hospice providers leads to a measure that would not be suitable for accountability purposes. They commented that due to the variability implied in the data, it is not possible to say clearly that one provider has done better than another, nor that an individual provider has improved over time.

MAP identified the following methods in which the measure developer could potentially alleviate the concerns raised, and NHPCO agrees:

- MAP recommended the developer reassess the exclusion criteria for the measure particularly the exclusion for Medicare Advantage patients, as this may be excluding too many patients.
- The developer should consider adding an exclusion to allow for patient choice, as a patient may choose to transition from hospice for many reasons. For example, a patient may choose to revoke their hospice benefit to pursue additional curative treatment, even if it is medically futile treatment.
- The developer should also clarify how patients transferred to palliative care or another hospice affects the measure, as this is also a patient choice.
- MAP recommended that the developer examine the use of a predicted to expected ratio to score this measure and provide guidance on how the measure will address hospices with a small volume of patients.
- MAP noted that the developer split out the concepts addressed in the measure, as the measure may be trying to address different concepts by including both death within 30 days and acute care use within seven days.
- Finally, MAP recommended the developer examine the impact of shortening the timeframes for capturing the post-discharge events, including death or admission to an acute care facility.
- MAP also proposed that CMS consider a trial run of the measure before publicly reporting results and explore the need for a survey of patients with a live discharge from hospice to better understand their reason for discharge and the potential scope of the problem.

The MAP also questioned whether a claims-based measure is the best means to capture whether patients' and their families' wishes were respected upon the transfer from hospice. MAP suggested that a patient-reported outcome could be a more effective form of measurement.

**NHPCO Recommendation:**

NHPCO concurs with the MAP recommendations listed above. While the measure focuses on an important aspect of care, claims alone do not provide enough information to accurately represent the complexity of hospice practice and the overlap between quality and compliance.

2. *Access to levels of hospice care measure concept*

As with live discharges, claims data do not sufficiently reflect the factors that determine appropriate provision of the various levels of hospice care. Patient needs vary greatly, even for patients with similar principle diagnoses and disease trajectories. It is necessary to know patient acuity to evaluate appropriate GIP and CHC utilization, but acuity

information is not available in claims data. Or, a low rate of GIP might indicate excellence in care management, and a hospice with high degree of proficiency in handling symptoms in the home setting and good anticipation of needs before symptoms get out of control. Such hospices could be penalized for not meeting the threshold set for GIP utilization.

**NHPCO Recommendation:**

If CMS decides to move forward with development of this measure concept, despite the deficiencies in the use of claims data for hospice quality measures, an attempt should be made to base the measures on interdependent patterns of care. Paired measures focused on related patterns of utilization would be both fairer to hospices that are employing appropriate practices and would promote appropriate access to care for hospice patients.

**C. High priority concept areas for future measure development**

It is important that quality measures reflect the holistic and comprehensive care provided by hospice and recognize the patient and family as the unit of care. NHPCO is pleased to be a MAP participant and encourages CMS to continue utilizing the work of the Measure Applications Partnership, specifically the 2012 Performance Measurement Coordination Strategy for Hospice and Palliative Care, to determine priority areas for measure development in hospice.

**NHPCO Recommendations**

- NHPCO believes that claims data alone cannot appropriately be used to inform the creation of performance measures that improve quality of care, and that hospice performance measures should guide and promote the quality of direct care received by hospice patients and families. Therefore, CMS should not pursue development of quality measures based on claims data.
- NHPCO supports use of the Comfortable Dying/NQF #0209 (pain brought to a comfortable level within 48 hours of initial assessment) measure. This outcome measure is endorsed by NQF and is currently in use as a MACRA/MIPS measure.
- Some important areas of practice with potential for quality measurement are:

- Access to the healthcare team on a 24-hour basis with a goal of providing timely and appropriate interventions
  - Psychological and psychiatric aspects of care—managing anxiety, depression, delirium, behavioral disturbances, and other common psychological symptoms
  - Care planning—establishing and periodically reviewing patient/family/caregiver goals
  - Timely communication of patients’ goals across all providers
  - Impact on total cost of care
- NHPCO is willing to help CMS explore these areas of practice for possible outcome measure development.

#### **D. Update on the Hospice Assessment Tool**

NHPCO thanks CMS for the opportunity to provide feedback on the design and details of the hospice assessment tool. NHPCO has offered opportunities for hospice providers to participate in focus groups and feedback sessions to discuss the details of a hospice assessment tool and appreciates the opportunity to be involved in its creation and development. NHPCO suggests that the hospice assessment tool will be a source of data for the future development of symptom-based outcome measures, important to expand the measures available to hospice providers.

#### **NHPCO Recommendation**

- We recommend that CMS keep the name of the assessment tool simple such as the ‘Hospice Care Assessment Tool.’ We look forward to continuing dialogue about the development and testing of the tool.

#### **E. Hospice CAHPS® Survey Questionnaire**

NHPCO is grateful to CMS for this opportunity to provide feedback about changes to the current Hospice CAHPS® survey tool. We recognize the value of a post-death caregiver survey as an extremely valuable tool to evaluate quality of care, as it is currently the only means for evaluation of the entire episode of hospice care. However, one of the exclusion requirements - caregivers of patients who died within 48 hours of admission to hospice care – is of concern. Over one third of hospice patients die within 7 days of admission to hospice, and subsequently, the 48-hour exclusion will likely mean that the care provided to a significant segment of the hospice population will not be evaluated by the survey. We also offer CMS the following feedback related to the current CAHPS survey tool:

- **Survey length:** The survey currently contains 47 questions which is very long for a caregiver to complete. Hospice providers are concerned that the length is overwhelming and could be a barrier to caregiver completion.
- **Method of survey:** The survey is only available via mail or telephone interview and many of today’s hospice caregivers are digital natives and prefer, or will only respond to, electronic communication.
- **Timeframe after death:** The survey is currently initiated two months following the month of patient death. Hospice providers expressed to NHPCO that the survey should be initiated sooner to capture the caregiver’s experience while it is still fresh in their mind.
- **Health literacy of caregiver:** The vocabulary used in certain CAHPS questions is not user friendly and doesn’t consider the health literacy of the caregiver. For example, the word ‘training’ is repeatedly used in questions asking the caregiver if they were taught a specific task. Hospice providers tailor their communication with patients/families to accommodate education and health literacy levels. Using vocabulary in questions such as ‘trained’ is not common language or user friendly and may be confusing to caregivers who were ‘given’ information or ‘shown’ a task by the hospice team v. ‘trained’. Caregivers may interpret “trained” as requiring some formal training and certification or assessment.
- **Top box answers:** Hospice providers expressed their concern to NHPCO about the top box scoring methodology for CAHPS survey measures. The “top-box” score for each response is calculated as a “100” if the most positive response category(ies) for that question is selected or a “0” otherwise. The “bottom-box” score for each response is calculated as a “100” if the least positive response category(ies) for that question is selected or a “0” otherwise. The scoring needs to give credit for “usually” answers as there may be individuals who are uncomfortable with absolutes such as “always”.
- **Answer sequence:** The CAHPS answer choices alternate, beginning with a negative choice of answer to beginning with a positive choice of answer. NHPCO recommends consistency in answer choice format, to increase reliability and to reduce caregiver confusion. Below are two examples:

27. How often did your family member get the help he or she needed from the hospice team for feelings of anxiety or sadness?

- 1  Never
- 2  Sometimes
- 3  Usually
- 4  Always

30. Moving your family member includes things like helping him or her turn over in bed or get in and out of bed or a wheelchair. Did the hospice team give you the training you needed about how to safely move your family member?

- 1  Yes, definitely
- 2  Yes, somewhat
- 3  No
- 4  I did not need to move my family member

- **Addition of hospice logo to survey:** Hospice providers expressed concern to NHPCO that there may be confusion for the caregiver about who is initiating the survey. Inclusion of the hospice provider's logo could help a caregiver more readily identify the survey as coming from the hospice that provided care for their loved one.
- **Care provided in a contracted facility:** Hospice providers reported to NHPCO they perceive caregiver confusion related to patients who received hospice care in a contracted facility (i.e. routine home care in a nursing facility). Caregivers seem to be providing feedback to survey questions related to facility staff care v. hospice staff care. Providers state that if survey questions were targeted for specific environments of care, better assessment of hospice care could be provided by the caregiver.
- **Care provided in a variety of settings:** Hospice providers also reported to NHPCO they perceive caregiver confusion related to patients who received hospice care in a variety of settings of care during their hospice experience. Caregivers seem to be providing feedback related to the environment of the patient's death v. the entire hospice experience. Providers state that if survey questions were targeted for specific environments of care, better assessment of hospice care could be provided by the caregiver.

#### **NHPCO Recommendations**

- We recommend that the hospice CAHPS® survey:
  - Be reduced to 20-25 questions.
  - Be made electronically available.
  - Be initiated at the 45-day mark to capture the caregiver's experience while it is still fresh in their mind.
- We recommend that CMS review:
  - The vocabulary in all Hospice CAHPS® questions and revise the language to ensure it is user friendly and considers the health literacy of the caregiver.
  - We recommend that CMS review the top box methodology for the answer choices throughout the survey and consider integrating additional choices to allow a caregiver to provide an accurate perspective of their care experience. We also recommend that for reliability and to reduce caregiver confusion, CMS consider consistently realigning the sequence of answers in all questions to ensure the order of positive to negative, or vice versa, is consistent.

- We recommend that the hospice CAHPS survey include the hospice provider’s logo, if it is mailed or sent electronically, as it could help a caregiver more readily identify the survey as related to the hospice who provided care for their loved one.
- We recommend that CMS group survey questions:
  - For specific environments of care to ensure better assessment of the hospice care provided. For example, “if your loved one received hospice care while residing in a nursing facility, answer questions 3-7.” A skip pattern could be incorporated into the survey if a patient did not reside in a nursing facility. We also recommend adding an explanation that differentiates between care provided by the facility staff and the hospice staff.
  - About care they received in different hospice settings, as applicable, to ensure a better assessment of hospice care by the caregiver. For example, the caregiver would answer questions about care received in the home separately from questions for care provided in an inpatient setting.

NHPCO is pleased to offer to meet with CMS staff to further discuss our recommendations and suggestions for changes to the current hospice CAHPS® survey tool.

**F. Display of Publicly Available Government Data on the Hospice Compare Website - Proposal to Post Information from Government Data Sources to the Hospice Compare Website**

NHPCO is not clear how publicly available government data would make the Hospice Compare website more meaningful and informative to our beneficiaries, their caregivers, and families. We would like clarification and an example of how information from the Centers for Disease Control and Prevention or the National Institutes for Health would assist a patient/family in choosing a hospice provider. We also would like clarification related to how this additional information would be related to the quality of care a hospice organization provides to patient/family.

**NHPCO Recommendation**

- Please provide more detail and clarification on the reasons for using other publicly available data for the Hospice Compare website, including how it would help a consumer choose a hospice.

NHPCO looks forward to working with CMS on the various proposals in this comment letter and stand ready to assist in any way.

Sincerely,

A handwritten signature in black ink, appearing to read "Edo Banach". The signature is stylized with a large, sweeping initial "E" and "B".

Edo Banach, JD  
President and CEO