NAHC Defends Hospice Providers in Comments to CMS

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On Tuesday, May 28, 2024, NAHC **submitted comments** in response to the Centers for Medicare & Medicaid Services' (CMS) FY2025 hospice proposed rule (*Fiscal Year (FY) 2025 Hospice Payment Rate Update Proposed Rule (CMS-1810-P*) (Proposed rule text HERE; CMS Fact Sheet HERE; NAHC Report article on proposed rule HERE).

The proposals included updates to the hospice payment rates and wage index, hospice quality reporting program and two Requests for Information (RFI) – one related to a payment mechanism for high intensity palliative care services and the other related to the use of Social Determinants of Health (SDOH) in the Hospice Quality Reporting Program (HQRP).

NAHC's high-level feedback on the rule's various provisions follow below.

INADEQUATE PAYMENT RATE UPDATE & WAGE INDEX CONCERNS

The 2.6 percent base payment rate update CMS proposed is extremely inadequate. The rate update is based on the hospital market basket, and while, historically CMS' forecasts for the hospital market basket have been relatively accurate, in more recent years those forecasts have fallen short of actual cost inflation. NAHC commented that this, combined with the significant workforce challenges and other difficult cost inputs being experienced by hospices, warrant a higher rate increase that reflects the true costs hospices are facing and the value the program drives to patients, families, and taxpayers. NAHC requested that CMS once again consider a one-time, "catch-up" adjustment to address the significant forecast error relative to payment updates for FY2021- FY2023.

Another factor impacting hospice payment is the wage index. While NAHC and our hospice members appreciate CMS' policy to adopt a permanent 5 percent cap on wage index decreases beginning in FY 2023 and each subsequent year, we maintain that there are longstanding, structural issues with how hospices' wage indexes are developed. We outline these issues in the comments and state we strongly believe that wage-index creation policies should reflect the goal of moving more care to home and community-based settings, where a vast majority of Medicare beneficiaries prefer to receive many kinds of supports and services. NAHC stands ready to work with CMS to identify opportunities to better address

the limitations and challenges of the current hospice wage index development process.

An important component of wage index development is the labor market designation process. CMS proposes to apply the most recent labor market areas to the wage index beginning in FY 2025. The most recent delineations were issued by the Office of Management and Budget (OMB) on July 21, 2023, and include an updated list of Core-Based Statistical Areas (CBSAs) that reflect 2020 Census data. In some instances, these updated labor market designations will have major impacts on hospices' wage-index values. While CMS' policy is to adopt a permanent 5% cap on wage index decreases beginning in FY 2023 and each subsequent year, we worry that some the impact of a 5% wage index decrease on some hospices will make it difficult for them to meet the demands for high-quality hospice care in their communities. We encourage CMS to conduct a thorough review of CBSA wage index changes to ensure they accurately reflect the true cost of providing hospice care in different regions and do not result in extreme access challenges for patients served by hospices in CBSAs that are experiencing major wage-index decreases.

REQUEST FOR INFORMATION ON HIGH-INTENSITY PALLIATIVE CARE

Relative to the RFI on high intensity palliative care, NAHC commented that over recent years, advances in treatments have expanded the types of services that can be utilized to control pain and other symptoms for terminally ill patients. These services include renal dialysis, blood transfusions, chemotherapy and radiation. The costs of these treatments can be significant, and some hospices may struggle to admit otherwise eligible patients receiving these services or may exclude payment for these services because they are not widely accepted as part of a hospice's palliative care regimen. We believe that the hospice community and other stakeholders would benefit from a thorough examination of the full array of treatment approaches currently in use in palliative care, study of the extent to which these treatments are being used in hospice, and consideration of payment mechanisms in the Medicare payment system to ensure that these treatments can be more broadly utilized by hospice-eligible patients. Specifically, NAHC recommends that CMS research and publish data on the historic and current utilization of these high-cost palliative interventions for hospice and hospice-eligible patients. The hospice community and other stakeholders need this data in order to be as informed as possible to weigh the detailed benefits and unintended consequences of any potential payment modifications related to these services, and as such, CMS should share this data and allow for stakeholder feedback before it proposes any new policy changes. Our comments go into detail on each of the questions posed in the RFI.

HOPE QUALITY MEASURE PROVISIONS

NAHC commented extensively on the proposed changes to the HQRP, primarily the implementation of HOPE and revisions to the CAHPS Hospice Survey and its administrative protocols. CMS proposes to begin collecting the HOPE standardized patient level data collection tool on or after October 1, 2025.NAHC supports the expansion of the HQRP to include the HOPE, a standardized patient-level data collection tool. The primary objectives CMS has for the HOPE are to (1) provide data for the HQRP quality measures and its requirements through standardized data collection; and (2) provide additional clinical data that could inform future payment refinements. HOPE would be a component of implementing high-quality and safe hospice care for patients. It would also contribute to the patient's plan of care through providing patient data throughout the hospice stay.

NAHC urges CMS to permit some of the visits at HOPE timepoints to be conducted via telehealth as well as in person. NAHC further urges CMS to collect data on telehealth and in person visits from all members of the IDG in the HQRP as these visits represent care and services provided by the hospice. Without both the telehealth visits and visits from all IDG members, CMS is not able to assess the full scope of patient and family services delivered by hospice and identify the full value of hospice care. As NAHC has recommended previously (see NAHC Regulatory Blueprint for Action), a code or modifier to identify telehealth visits on hospice claims would be valuable in expanding the amount and type of data CMS has on hospice care and expanding the HQRP. We urge CMS to implement such a code(s)/modifier.

NAHC strongly recommends that CMS allow ample time, 12 months after the technical specifications are available, for the EMR companies to make the necessary software changes to incorporate the HOPE into their programs and that CMS incorporate a testing period for submission of the electronic version of the HOPE to minimize technical glitches which may adversely impact the amount and quality of HOPE data to be used in the HQRP.

NAHC further commented that CMS should continue to refine the HOPE to expand the data collected and to support meaningful outcome-based measures. The two HOPE-based quality measures CMS proposes are process-based and NAHC looks forward to the evolution of more robust quality measures. NAHC also recommends that CMS not utilize data from the HOPE for quality measures until the data has been appropriately tested and validated.

CAHPS CHANGES

CMS also proposes to implement a revised CAHPS Hospice Survey beginning with January 2025 decedents. Revisions would be made to the survey instrument, a web-based completion mode added, and administrative protocols changed. CMS

tested these changes in a mode experiment in 2021 and found slightly higher response rates for the survey. NAHC enthusiastically supports the proposed revisions to the survey instrument, however, we have concerns about the timeline for implementation, a dropping response rate, and demographic factors missing from the risk adjustments. There are significant changes to be made and the technical specifications to do so will not be available until approximately four months before the implementation date. This is not enough time for the data warehousing firms to make the changes and, therefore, we recommend implementation not occur prior to January 1, 2026.

NAHC would also like to see the CAHPS Hospice Survey response rates improved. The hospice community has shared concerns with CMS about the CAHPS Hospice Survey response rates being low and falling further over recent years, and NAHC recommends that CMS research the reasons for the low overall response rate and dropping state response rates to identify possible changes that could help in reversing this trend. If the rates continue to decrease it could negatively impact the validity of the HQRP measure related to the CAHPS Hospice Survey.

Again, NAHC supports the proposed revisions to the Survey but has concerns that the CAHPS survey does not adjust for certain demographic factors, specifically race and ethnicity. Hospices serving a larger proportion of the traditionally underserved community members may experience significantly different responses and response rates than other hospices. We recommend that CMS use race and ethnicity data in adjusting the Hospice CAHPS case-mix to accurately compare service experience and quality across diverse patient groups.

Relative to the RFI on the SDOH, NAHC supports the addition of the four specific SDOH to the HQRP. It is expected that this new data will assist providers in improving the delivery of high-quality individualized hospice care and will also help to advance health equity within care in the home. The unique vulnerability of the hospice population and challenges associated with delivering care in the home and the very short lengths of stay in hospice should be considered by CMS in developing any expectations it may have for hospices in addressing these SDOH. CMS should also strongly consider how the SDOH information would be collected by hospices, allowing for observation in addition to interviewing. NAHC also encouraged CMS to provide education and resources to providers for development of health initiatives.

NAHC staff are grateful to our members for sharing their input and experiences as the throughout the comment-development process. We look forward to continuing to work collaboratively with CMS and other policy stakeholders to improve the hospice program and support access to high-quality care at the end-of-life.