May 30, 2023

Administrator Chiquita Brooks-LaSure  
Centers for Medicare and Medicaid Services (CMS)  
Department of Health and Human Services  
Attention: CMS–1787-P  
P.O. Box 8010  
Baltimore, MD 21244–1850

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; published at Vol. 88, No. 64 Federal Register 20022-20057 on April 4, 2023.

Submitted electronically via http://www.regulations.gov

Dear Administrator Brooks-LaSure,

UnityPoint Hospice appreciates this opportunity to provide comments on this proposed rule related to hospice rates and quality reporting. Our parent organization, UnityPoint at Home, is the home health agency affiliated with UnityPoint Health, one of the nation’s most integrated health care systems. Through more than 32,000 employees and our relationships with more than 400 physician clinics, 36 hospitals in metropolitan and rural communities and 13 home health agencies, UnityPoint Health provides care throughout Iowa, central Illinois and southern Wisconsin. As its home health arm, UnityPoint at Home offers a diverse set of programs: traditional home health, durable medical equipment (DME), pharmacy, palliative care, hospice care, and (in certain locales) public health.

UnityPoint at Home has long recognized the importance of hospice services for our patients. UnityPoint Hospice is affiliated with 5 Medicare certified agencies in Iowa and Illinois and provides high quality care in those service areas. In addition, we are committed to payment reform and are actively engaged in numerous initiatives which support population health and value-based care. Among these initiatives, UnityPoint at Home is an ACO Participant in the CMS Medicare Shared Savings Program Model, is participating in the Home Health Value-Based Purchasing (HHVBP) Model in Iowa and was a former CMMI Medicare Care Choices Model awardee in three Iowa regions.

UnityPoint Hospice appreciates the time and effort of CMS in developing this proposed rule. As a member of the National Hospice and Palliative Care Organization (NHPCO) and the National Association for Home Care & Hospice (HAHC), we generally support the comments submitted by NHPCO and NAHC to this rule. Additionally, we respectfully offer the following input.
PROPOSED ROUTINE FY 2024 HOSPICE WAGE INDEX AND RATE UPDATE

CMS is proposing FY 2024 hospice payment update percentage of 2.8 percent (an estimated increase of $720 million in payment from FY 2023). This is a result of the 3% market basket percentage increased reduced by a 0.2 percentage point productivity adjustment. The proposed hospice cap amount for the FY 2024 cap year is $33,396.55, which is equal to the FY 2023 cap amount ($32,486.92) updated by the proposed FY 2024 hospice payment update percentage.

Comment: UnityPoint Hospice supports the market basket update.

PROPOSED CAHPS HOSPICE SURVEY UPDATES

CMS is proposing no changes.

Comment: UnityPoint Hospice encourages CMS to revisit the number of questions and time/effort needed to respond to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey. Survey timing, length, and mode negatively impact return rates. These surveys are sent to families who are experiencing a new normal, have survey fatigue, and do not see value in a lengthy “snail mail” survey. From March through August 2021, our largest hospice agency (located in Des Moines, Iowa) volunteered with 55 other hospice agencies to participate in a RAND pilot, which distributed surveys via various delivery modes – mail, telephone, mail-telephone, and web-mail. The response rate for electronic–mail survey was a higher percentage compared to mail only. While mail delivery was higher overall, the option for an electronic mode for response boosted the overall response rate. UnityPoint Hospice notes electronic modes are becoming increasingly used in all areas of care. At UnityPoint Clinic (UnityPoint Health’s ambulatory care setting arm), we have drastically reduced survey length and switched to electronic-only distribution. As a result, the response rate in multiple regions doubled, if not tripled. This underscores not just the impact of the modality but the use of short, tailored survey questions. As the population ages, individuals will be more connected electronically and expect to use email and text to receive and respond to surveys.

PROPOSALS REGARDING HOSPICE ORDERING / CERTIFYING PHYSICIAN ENROLLMENT

To strengthen the hospice program integrity aspect of physician certifications, CMS proposes changes to the physician screening process to help CMS determine whether the physician meets all federal and state requirements (such as licensure) or presents any program integrity risks, such as past final adverse actions.

Comment: Embedded in a hospice election statement is the patient’s right to choose an attending physician. UnityPoint Hospice opposes this proposed physician screening process and would respectfully suggest that CMS has ample enforcement authority to address potential fraud, waste and abuse that does not infringe upon patient choice.
REQUEST FOR INFORMATION (RFI) ON HOSPICE UTILIZATION; NON-HOSPICE SPENDING; OWNERSHIP TRANSPARENCY; AND HOSPICE ELECTION DECISION-MAKING

CMS noted persistent decreases in the use of higher level of care (even after increased payments) and limited higher cost palliative treatments under the hospice benefit suggest that there may be some barriers for those beneficiary populations with complex palliative needs to access higher level of care. To focus on improved access and value within the hospice benefit, CMS is soliciting public comment.

Comment: UnityPoint Hospice appreciates CMS’ efforts to seek stakeholder input prior to developing proposed rules for reaction in these areas. As a nonprofit hospice provider in urban and rural geographies, we have experienced an uptick in complex patients. While complex patients arguably would benefit most from hospice, they require more resource-intensive care and often the hospice benefit reimbursement structure does not fully recognize these differentiated costs.

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?

Many of the referenced interventions may be perceived as “life extending” or “aggressive interventions,” which contradicts the intent of hospice in that hospice care is to provide comfort at the end of life without utilizing aggressive or ineffective therapies. When hospice agencies become financially responsible for the terminal illness and related conditions, any and all conditions, medications, treatments, interventions and supplies related to the patient’s comfort became the financial responsibility of the hospice agency. For complex patients with cancer or renal failure, transition costs can be costly. These interventions do not qualify the patient for a higher intensity level of hospice care (e.g. higher daily reimbursement rate) nor are there any add-on payments available to the hospice agency. As a result, the financial burden can be too great for the hospice agency to assume, which leads to a delayed admission to hospice until the patient is no longer seeking or able to seek these interventions.

We urge CMS to revisit the Medicare Concurrent Care Model (MCCM) for lessons learned in terms of what end-of-like palliative care interventions should be included or carved out from the hospice benefit with an emphasis on quality of life. For instance, renal patients generally have a shortened life expectancy. When a hospice election is delayed until dialysis is discontinued, the hospice length of stay is generally short and any palliative effects of dialysis impacting quality of life are foregone, which may address dyspnea, lack of energy, drowsiness, dry mouth, pain, sleep disturbances, restless legs, itchiness, dry skin, and constipation. To increase hospice elections by renal patients, CMS could provide guidance and commensurate reimbursement (i.e. service intensity payment) for palliative dialysis within the hospice benefit or alternatively allow renal patients to make a hospice election as presently defined with a palliative dialysis carve-out. Under either it is likely that quality of life will be enhanced, and the hospice length of stay will increase. We do not anticipate that level of care will increase with most remaining in Routine Hospice Care. Similarly, UnityPoint Hospice cared for patients undergoing chemotherapy within the MCCM pilot and found it to be beneficial for the patient’s quality of life and family interests.
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?

Patients that require General Inpatient Care (GIP) level of care typically are being referred from an acute hospital setting. **The structure of this level of care is administratively burdensome and its criteria are not conducive to transitioning among levels of care.** First, meeting and documenting daily criteria is frustrating. Second, it is difficult to transition patients to another level of care, especially for patients who cannot be discharge to home. Often, these patients do not yet have Medicaid in place for room and board, required for a discharge to Skilled Nursing Facilities once they are made comfortable and no longer meet the GIP eligibility requirements. Skilled Nursing Facilities are reticent to accept patients with Medicaid pending and families are not willing to take the patients home, which leaves the hospice agency in the unfortunate position to have to discharge the patient from GIP level of care making the family responsible for hospital room and board costs (assuming there is a Routine Hospice Care level of care option in the contract with the hospital). This proves to be a financial burden for the family, a financial burden for the hospital if the family revokes hospice services, and counterintuitive to a hospice election as it does not provide the end-of-life comfort to patients and their families, the hallmark of hospice care.

To address the above, we encourage CMS to consider a local coverage determination process to extend the GIP benefit for several days to keep the patient comfortable when passing is imminent (see language in #5). It would be incumbent on the hospice agency to document the quantitative assessment supporting imminence. In exploring this option, CMS should examine practices of commercial plans. UnityPoint Hospice has served patients with private insurance where the insurer has approved GIP level of care and the “approval” includes this level of care for end-of-life care.

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?

This distinction between curative treatment and complex palliative treatment is blurry and often there are differing opinions. **Having a strong partnership between Palliative Care and Hospice is key to maneuvering through these cases and would be more effective if these two service lines were managed together** – often Palliative Care is managed under the hospital and Hospice is managed under home health agencies. The shift from curative interventions to palliative interventions MUST include both the patient’s physician and the hospice physician so the patient and family have a good understanding as to the changes being made with these interventions. These discussions occur at the time of referral, at admission, and on an on-going basis as the patient continues to decline. **In our experience, discussion of the parameters as to when to cease curative interventions is most effective when presented on hospice admission.**

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
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?

The overall barriers relate to the benefit structure itself.

- **GIF duration**: The challenge with the higher intensity levels of hospice care provided in the acute care setting is the need to move the patient out of the facility when they no longer meet the GIP level of care criteria. Often these patients are now comfortable but are fragile and will likely expire within a couple of days. Moving patients in this state is not only challenging for staff to locate both a facility and payor to receive the patients but is challenging for families and the care team given the potential that patients may expire in transit which is not a comfortable nor peaceful passing. **We encourage CMS to restructure the GIP level of care to enable the GIP patient to remain at GIP level of care for a finite amount of time once they have achieved comfort AND the patient is too fragile to move (i.e. is actively dying).** LCDs could be developed in collaboration with stakeholder interests to guide these determination and alleviate any fraud, waste and abuse.

- **Capacity for GIF in Skilled Nursing Facilities (SNFs)**: The number of SNFs that provide GIP level of care are few. The more complex the patient, the less likely the facility staff will be able to manage their care. **With the ongoing workforce shortage, it is unlikely that CMS will be able to move the needle in encouraging SNFs to be able to accept and manage GIP patients for short durations.**

- **Inpatient Respite Care duration**: This level of care is limited to 5 days. For Inpatient Respite Care needs, the challenge is the amount of work the Skilled Nursing Facility must do to admit a patient for only 5 days – it is an ongoing challenge in all communities to find accepting facilities. **We urge CMS to consider increasing the duration of this level of care.**

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?

As a non-profit hospice agency with thin margins, we are concerned that trends in this area are being correlated to the hospice industry generally. **We would encourage CMS to delve into the**
data to distinguish caseloads and operational practices of nonprofit versus for-profit hospice agencies. As the industry ownership becomes increasingly for-profit, these agencies tend to heavily market facilities/physicians’ groups with the intention of admitting the longer term, low-cost patient. These agencies do not manage the highly complex (and costlier) patient, provide minimal after hours/weekend support, and are fast to re-admit the hospice patient to the hospital which results in a discharge from hospice care. In examining cost and utilization trends, CMS should correlate:

- GIP level of care with hospice ownership. As this level of care often results in a fiscal loss, its use by for-profit agencies likely trails nonprofit agencies.
- CHC level of care frequency of encounters / interventions with hospice ownership. Again it is likely that for-profit agencies provide minimal interventions to realize a fiscal benefit.

We would also recommend that CMS explore the use of Advanced Beneficiary Notices (ABN). CMS should examine utilization of ABNs to absolve hospice agencies from covering the cost of a procedure. We believe that if procedures related to the primary diagnosis ONLY were expected to be covered by the hospice benefit, it would make it much more difficult for hospice agencies to deny coverage for a procedure. This clarity would reinforce that hospice agencies guide and cover services/procedures related to the primary diagnosis only, and for other procedures, the hospice agencies will deny coverage requiring the patient to revoke the hospice election or forgo the desired procedure.

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?**

Patients do not request this notification in the majority of cases. As CMS reevaluates this process, we urge consideration of timing and associated administrative burden. If CMS elects to mandate this notice for every patient, it should be incorporated as a subsequent communication to enable relevant Interdisciplinary Team (IDT) review and decisions. In addition, if the hospice agency must ensure a signed acknowledgement is on file for every patient, this will cause a significant amount of agency time and effort and potential frustration on behalf of the responsible party. In practice, it is common to not see the responsible party after patient admission (as they may live out of town) so the signature requirement requires implementing a secure way to electronically provide the document AND to enable them to sign and return it.

For notifications related to Part D drugs, see our response to RFI #10 below.

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?**

UnityPoint Hospice supports being transparent and accountable for the services provided under the hospice benefit. Hospice Visits in the Last Days of Life (HVLDL) and Level of Care usage are presently being reported and the public can access these measures via Hospice Compare. In terms
of staffing levels and approaches, UnityPoint Hospice would not support the reporting of staffing levels without more information. Staffing level measures are very fluid, reflect a point in time, and dependent upon patient condition / needs, level of care, and geographic factors. Staffing is also influenced by workforce availability that has been exacerbated across the health care continuum stemming before the COVID-19 pandemic and must take into account the use of technology as a staffing extender. Because staffing is influenced by multiple factors, we urge CMS to carefully consider any measure in this arena with stakeholders and lengthy periods of testing and validation.

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?

CMS could consider identifying particular classes of drugs that are “never” related to curative treatment (i.e. vitamins, supplements, over-the-counter medications), with a caveat that any exception would need to be approved by the hospice IDT. These “never” drug classes could be listed on the hospice consent. Upon removing / excluding these “never” classes of drugs, virtually all remaining medications would be related to either the terminal diagnosis, contributing diagnosis, or the patient’s comfort.

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, what and how should CMS publicly provide information around hospice ownership? Would this information be helpful for beneficiaries seeking to select a hospice for end-of-life care?

Private equity ownership has seen an uptick in health care interests and hospice is not immune. JAMA reported that “between 2011 and 2019, there were 409 private equity transactions in hospice, with 58% of those transactions involving the purchase of a nonprofit agency.” In 2020 and 2021, these transactions continued with private equity accounting for 78% of hospice transactions in the fourth quarter of 2021. By design, a private equity ownership structure targets grow, profit, and sales of assets and does not focus on care delivery or patient / service quality. UnityPoint Hospice supports the collection of ownership interests and encourages CMS to examine trends in hospice care, quality measures and Part D spend pre- and post-acquisition by private equity interests. Ownership should also be more easily seen on the CMS hospice site, including hospice status as non-profit versus for-profit.

REQUEST FOR INFORMATION (RFI) ON HEALTH EQUITY UNDER THE HOSPICE BENEFIT

To address health disparities, CMS is interested in receiving input regarding the potential collection of additional indices and data elements that can provide insight regarding underlying health status and non-

medical factors, access to care, and experience in medical care.

**Comment:** As part of an integrated health system, our parent UnityPoint Health is committed to diversity, equity, and inclusion (DEI) at all levels of the organization. UnityPoint Health’s Chief Diversity Officer (CDO) is a Senior Vice President with a direct reporting relationship to the UnityPoint Health Chief Executive Officer and Chief Human Resources Officer. The CDO leads a dedicated team charged with elevating and embedding DEI efforts and deploying resources across our system. Initiatives target internal education and development for team members including hospice as well as strategies to address health equity and health care disparities within the communities we serve.

Like our parent organization, **UnityPoint Hospice is committed to ensuring that disparities are proactively identified and addressed in the workforce and our communities.** This is intentional, embedded, and ongoing work but we are still refining goals and objectives. As many hospice agencies are likely at different stages of their health equity journey, we respectfully suggest that CMS deploy a phased approach to measuring and implementing health equity strategies, to carefully evaluate underlying data collection burden and accuracy, and to begin with a rewards or incentive program instead of a punitive system for performance. Below are responses to select questions.

1. **What efforts do hospices employ to measure impact on health equity?**
   UnityPoint Health and UnityPoint Hospice have Epic as our EHR solution. Some health equity indicators are captured in our EHR and, for those patients that have other UnityPoint Health providers, this enables a wider data capture. As is a limitation of an EHR, data capture only encompasses our patient population and does not capture comparison or reference populations representative of the larger community. In addition, UnityPoint Hospice serves areas with lesser population density and rural classifications. As health equity is considered, outreach and services associated with a patient’s geography significantly impacts service availability and expense.

2. **What factors do hospices observe that influence beneficiaries in electing and accessing hospice care?**
   This is an area of continued data collection without definitive trends at this point.

3. **What geographical area indices, beyond urban/rural, can CMS use to assess disparities in hospice?**
   CMS could review sites of service for trends in disparities. For nursing facility sites of service, CMS could examine the availability of hospice services and encounter types in conjunction with health equity data. In particular, claims data may indicate encounter types and provide insight into whether aide care versus nursing care are more prevalent in certain locations. In an era post-COVID-19 public health emergency, some nursing facilities appear to be using a hospice benefit as a staffing extender (e.g., using hospice aids to provider daily personal care to residents). The scope of this issue and whether it has disproportionate health equity impacts is uncertain.

4. **What information can CMS collect and share to help hospices serve vulnerable and underserved populations and address barriers to access?**
   Hospice agencies typically collect data on their patients but not generally on the community. It would be helpful if CMS could provide data / information or artificial intelligence (AI) to enhance our understanding of the “rising risk” population that died without a hospice election. In this arena, CMS could use the MCCM criteria and apply it to individuals who died within the past six months.
without a hospice election. The results could be captured in a heat map or other tool and overlaid with health equity indicators.

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

We would suggest starting with Race, Ethnicity and Language (REAL) data, Sexual Orientation and Gender Identify (SOGI) data, and readily available socio-economic data related to zip code or census tract. This can be compared to the hospice patient population to examine the breadth that services are reaching underrepresented populations and areas.

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

UnityPoint Hospice would recommend capturing data from pre-existing data sources to minimize underlying data collection burden.

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

In general, the hospice program already requires extensive data collection and reporting on numerous indicators. Additional information collection and reporting demands extra time and effort, which often diverts time from assessments and direct care duties. If additional information is required, we request that CMS target data indicators to particular desired outcomes upfront and utilize pre-existing data sources as available.

**ADDITIONAL INPUT – HOSPICE CERTIFICATION**

_Hospice certification related to whether a patient is terminally ill is based on the clinical judgment of the hospice medical director (or physician member of the IDT), and the patient's attending physician, if he/she has one. Nurse practitioners and physician assistants cannot certify that an individual is terminally ill._

**Comment:** For initial certification, we believe it is important to have the patient’s primary provider co-sign. In the State of Iowa for example, Nurse Practitioners (NPs) and Physician Assistants (PAs) have scopes of practice which enables independent practice. **We urge CMS to not only allow NPs and PAs to be a second on an initial hospice certification, but we would encourage CMS to review these requirements to allow NPs and PAs to generally certify an individual’s status as terminally ill.**

**ADDITIONAL INPUT – TREATMENT OF PASS-THROUGH PAYMENTS IN IOWA**

_The hospice reimbursement for the Nursing Facility room and board and basic Nursing Facility activities is a pass-through payment. When the hospice agency receives Medicaid reimbursement, the hospice provider forwards the payment amount to the Nursing Facility._

**Comment:** Hospice agencies are required to collect and pay the room and board component for patients who rely on the hospice benefit through Medicare, but rely on Medicaid payment for their custodial care. As a result, hospice agencies are contracted with nursing facilities to pay this room and board pass-
through regardless of when or whether Medicaid payment is made. As a result, Medicaid payment to hospice agencies for the room and board component has been inconsistent at best. For UnityPoint Hospice, over 60% of our hospice accounts receivable exceed 120 days due to outstanding room and board payments from Managed Care Organizations (MCOs) and state Medicaid programs in Iowa and Illinois. As UnityPoint Hospice waits for reimbursement, we continue to pay facilities as their invoices come in. This creates a hospice agency cash flow issue in the short term and collection concerns in the long run. For care delivery, these are dollars we could be putting towards comfort therapy and services for our hospice patients.

This delayed reimbursement is often exacerbated by a lack of understanding by MCOs of hospice coverage requirements. There is an overall failure of coordination between MCOs and state Medicaid agencies on hospice eligibility, facility rates, and client participation, resulting in incorrect payments to hospice agencies and increased administrative workload for a process where hospice agencies are the middlemen. The burden is shifted to hospice agencies to coordinate with nursing facilities to administer billing and pass-through payments.

CMS should consider allowing room and board payment to be streamlined and handled directly between the state Medicaid program and/or MCOs and the nursing facilities. We urge CMS to eliminate or relax the federal requirement for the hospice room and board pass-through. This would enable each state to determine the best path forward for the coordination and payment of Medicaid nursing facility room and board when a patient is under hospice care. Presently, this federal mandate ties the hands of state policymakers and agencies in evaluating optimal and timely payment options for their state Medicaid program, nursing facilities and hospice agencies.

We are pleased to provide input on this proposed rule and its impact on our patients, families and communities. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Government & External Affairs at Cathy.Simmons@unitypoint.org or 319-361-2336.

Sincerely,

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