

August 27, 2021

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

RE: CMS-1747-P: Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; Inpatient Rehabilitation Facility Quality Reporting Program Requirements; and Long-Term Care Hospital Quality Reporting Program Requirements

Dear Administrator Brooks-LaSure:

The National Hospice and Palliative Care Organization (NHPCO) appreciates the opportunity to provide comments on the hospice provisions included in the Calendar Year (CY) 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; Inpatient Rehabilitation Facility Quality Reporting Program Requirements; and Long-Term Care Hospital Quality Reporting Program Requirements proposed rule (CMS-1747-P) (or “the CY 2022 Home Health PPS Proposed Rule”).¹

NHPCO is the nation’s largest membership organization for hospice and palliative care providers and professionals who care for people affected by serious and life-limiting illness. NHPCO members provide care in more than 4,000 hospice and palliative care locations and care for over two-thirds of the Medicare beneficiaries served by hospice. In addition, hospice and palliative care members employ more than 60,000 professionals and hundreds of thousands of volunteers.

Our comments focus on the potential impact of these proposals on hospice providers serving patients with serious and life-limiting illness and their families. Specifically, our comments pertain to the

¹ 86 *Fed. Reg.* 35874 (July 7, 2021).

following sections:

- I. **Requirements of Accrediting Organizations (AOs) (Section I; p. 3)** – NHPCO appreciates CMS’ proposals that aim to standardize and streamline the survey process. Paramount to improving this process is the design of a “user-friendly, understandable” Form CMS-2567 for public or consumer consumption and comparison. NHPCO welcomes the opportunity to work with CMS on the modernization of this form. Incorporated in our comments are a set of proposed data elements for CMS’ consideration in updating the form.

- II. **Provisions Pertaining to Surveyors, Consistency of Survey Results, and the Special Focus Program (SFP) (Section II; p. 11)** – NHPCO strongly supports reforms to the survey process that will increase surveyor training and competency and ultimately improve the survey process. At the same time, our members are concerned that focusing on intermediate remedies, without having fine-tuned the underpinning survey process, belies the purpose of this important quality improvement tool, and has the potential to jeopardize patient access. We urge CMS to focus on improved surveyor competency and consistency – between states, as well as between states and AOs. NHPCO furthermore calls on CMS to convene a Technical Expert Panel (TEP) to gather stakeholder feedback on the SFP prior to design and implementation of such program.

- III. **Enforcement Remedies for Hospice Programs with Deficiencies (Section III; p. 33)** – Clear, consistent, and transparent guidelines for the imposition of the intermediate remedies outlined in CMS’ proposal are absolutely crucial. NHPCO recommends a “step-wise” or graduated application of the enforcement remedies – beginning with front-end, targeted technical assistance (e.g., directed plan of care (POC) and directed in-service education) to more advanced remedies levied for more severe deficiencies (e.g., Civil Monetary Penalties (CMPs) and suspension of payments). NHPCO is very concerned about CMS’ proposed language regarding the potential suspension of all payments. We strongly urge CMS to clarify the application of this remedy and to specify its limited, or targeted, imposition to “all new admissions” and only for deficiencies posing immediate jeopardy (IJ). Doing so would be consistent with regulations applied to other post-acute care providers and would ensure parity in their application.

Our detailed comments follow.

Background

In the proposed rule’s background description of hospice eligibility, the proposed rule describes the certification process, which includes both the patient’s attending physician (if any) and the medical director of the hospice.

As referenced in hospice program regulations at § 418.22(b)(1), to be eligible for Medicare hospice program services, the patient’s attending physician (if any) and the hospice program medical director must certify that the individual is “terminally ill,” as defined in section 1861(dd)(3)(A) of the Act

and our regulations at § 418.3.

NHPCO urges CMS to also include the regulatory reference at § 418.22(c)(1)(i), which provides clarification that the “medical director of the hospice or physician member of the interdisciplinary group” may provide the oral or written certification. Including this additional regulatory reference will provide clarity to hospice providers about the certification process and the role of the physician member of the interdisciplinary group.

I. Requirements of Accrediting Organizations (§ 488.5)

As detailed more fully below, NHPCO strongly supports the Centers for Medicare and Medicaid Services (CMS’) proposed requirement that Accrediting Organizations (AOs), as part of the application and reapplication process, submit a statement of deficiencies via Form CMS-2567. Doing so would help to make the survey process more consistent and centralized.

Further, NHPCO appreciates CMS’ thoughtful consideration of revisions to Form CMS-2567. NHPCO provider members welcome the opportunity to provide further input to CMS on these proposed revisions, proposing a set of data elements for CMS and a TEP to consider for its “user friendly” consumer or public-facing version on Care Compare, as seen on page 9.

A. AOs to Submit Statement of Deficiencies Using Form CMS-2567

CMS proposes to add a subsection at § 488.5(a)(4)(x) requiring AOs to include the Form CMS-2567 or a successor form to document findings of the hospice Medicare conditions of participation (CoPs).

NHPCO Comments:

- NHPCO appreciates CMS’ efforts to standardize the AO and State Agency (SA) survey processes to enhance the consistency and reliability between the currently divergent processes. We strongly support CMS’ recommendation that AOs use Form CMS-2567 or its successor to document a hospice program’s compliance with Medicare CoPs. However, our members seek clarification on the scope of this proposal and have the following question:

Are the findings regarding a hospice program’s compliance with CoPs related only to what is typically published in Form CMS-2567, or does it reflect a broader set of information (e.g., what may be found through AO-specific standards or state licensure)? NHPCO requests that clarification be made in the final rule.

B. AOs to Develop a Process to Submit Form CMS-2567

The proposed requirements at § 488.5(a)(4)(x) stipulate that AOs submit the Form CMS-2567 to CMS. As such, AOs must be able to incorporate the form into their proprietary data systems.

NHPCO Comments:

- NHPCO is concerned that the incorporation of the Form CMS-2567 into AO data systems will result in the duplication of data. Furthermore, several questions remain to be answered:
- Will there be an opportunity for hospice programs to preview the forms before they are submitted to CMS? NHPCO provider members believe it will be beneficial for hospices to view identified deficiencies to clarify accuracy of the reported information and to use internally to take action to correct the issues.
- What happens if a deficiency is corrected during the survey process? Responding to this situation has often been at the discretion of the surveyor. Will CMS outline clear procedures for how surveyors should address deficiencies corrected during the survey? Would the deficiency still be reflected on the Form CMS-2567?

C. Release and Use of Accreditation Survey Results (§ 488.7)

The proposed requirements at § 488.7(c) stipulate that CMS post the Form CMS-2567 in a manner that is prominent, accessible, understandable, and searchable.

NHPCO Comments:

- NHPCO appreciates and supports CMS' intent to provide greater transparency to consumers on hospice quality. NHPCO has several comments related to the accessibility of the information and other aspects of the proposal, as reflected below.

1. Consumer Understanding of Survey Results

The proposed regulation would require CMS to post the Form CMS-2567 in a manner so that the general public is readily able to understand and search for relevant information. The public's understanding of this crucial information is predicated on how the results are presented.

NHPCO Comments:

- It is unclear if CMS has a method to easily separate and highlight factors of the findings that would be considered as contributing to risk, such as condition level deficiencies (CLDs), which are instances of noncompliance that substantially limit the provider's

capacity to furnish care or that negatively affect patient health or safety. It is also unclear if CMS intends to help consumers identify the key sections of the findings, such as the four core CoPs identified by CMS as impacting quality of care, relevant to informing consumers' decisions.

- NHPCO encourages CMS to develop a user-friendly version of the CMS-2567, reflecting survey findings in a way that is broadly accessible to the public. We are concerned that the current version of the form contains too much detail and is difficult for consumers to read and understand, considering the low levels of health literacy among US adults.² Rather than publishing the current version of the form, CMS should develop and publish a consumer-facing version of the form.
- We believe CMS should look at creative options to display the information to make survey findings as user-friendly as possible. Some AOs, including the Joint Commission, provide the option for AOs to view dashboards on the hospice program's data and trends.³ This method eases users' ability to sift through data to find and compare relevant information.

NHPCO Recommendations:

- NHPCO recommends that CMS create a TEP to discuss considerations for creating a version of the CMS-2567 form that is accessible to consumers. It is crucial to ensure that consumers are able to understand survey results and we strongly believe that more careful consideration is needed from provider and consumer representatives to better ascertain the best manner to portray the information.
- NHPCO recommends CMS post only information relevant to patient rights and safety and program certification, rather than all the voluminous domains of the surveys. Posting all survey findings, including information that is not directly relevant to consumer decisions, may present added burden for consumers.
- We recommend that CMS develop, with input from the TEP and from stakeholders, a public-facing dashboard to which survey findings may be published. This will allow consumers to navigate the information more easily.

² *Forbes*. *Low Literacy Levels Among U.S. Adults Could Be Costing the Economy \$2.2 Trillion*. September 9, 2020. <https://www.forbes.com/sites/michaelnietzel/2020/09/09/low-literacy-levels-among-us-adults-could-be-costing-the-economy-22-trillion-a-year/?sh=3e1bf5de4c90>

³ The Joint Commission. *SAFER Dashboard*. <https://www.jointcommission.org/performance-improvement/joint-commission/dash/safer-dashboard/>

2. Complaint Surveys

CMS may post SA complaint survey results. However, guidelines are unclear on several aspects of complaint surveys. NHPCO requests clarification on the following areas of concern.

NHPCO Comments:

- NHPCO is concerned regarding the lack of clear guidelines on who conducts the complaint survey. If deemed organizations conduct complaint surveys, the AO, rather than the SA, would be responsible for follow-up. How would the complaint survey findings be posted in that instance? Furthermore, the distinction between jurisdictions for responding to and resolving complaints is unclear. When does a SA handle a complaint versus an AO?
- There is no indication if CMS publishes complaints without substantiation or if the agency evaluates complaints to publish only substantiated complaints.

3. Removing Prohibition for AO Hospice Program Survey Reports to be Considered Confidential and Proprietary

CMS proposes to require AOs to release deficiency reports for deemed surveys. NHPCO supports this proposal. We appreciate CMS' efforts to increase transparency for hospice consumers.

4. Proposed Revisions to Form CMS-2567

CMS proposes to make updates to the Form CMS-2567 to include AO information, such as the name of the AO. NHPCO supports this proposal to modify the form and add a place for the name of the AO performing the survey.

5. Standard Framework to Convey Salient Survey Findings

CMS comments on the need to develop a standard framework to identify relevant data regarding hospice performance.

NHPCO Comments:

- NHPCO supports developing a standardized framework to assess hospice performance. We suggest developing a standardized and defined decision matrix. NHPCO provider members agree such an algorithm would be helpful for hospice organizations, especially to develop strategies to prevent situations leading to deficiencies. For instance, hospices

could be provided with a decision matrix detailing the amount and degree of standard level deficiencies that would ultimately lead to a CLD. However, before focusing on how to identify and present survey results, we strongly urge CMS to first address persistent shortcomings with the underlying survey process.

6. “See One Cite One” and Other Survey Processes

Under the “See One Cite One” guidance for survey process, surveyors must record a citation even if the issue was cited in only one medical record, regardless of the total records sampled.

NHPCO Comments:

- NHPCO is concerned about the underlying principles of this process. “See One Cite One” has the potential to unfairly penalize hospice organizations that have employed quality improvement principles and effective QAPI programs. For instance, a hospice may identify a problem and implement a performance improvement project (PIP) in their QAPI program to successfully address the issue, but a surveyor using the See One Cite One principle would record a citation or deficiency based on records preceding the PIP’s implementation. This stands in direct opposition to prevailing quality improvement principles predicated on evaluating trended data to identify issues. The practice does not accurately reflect the hospice’s current standards and demotivates organizational change.
- Additionally, NHPCO is concerned about the variability and inconsistency of surveys. It is unclear if there is guidance for surveyors on how to handle issues that are corrected during the survey. The decision to cite the issue in such situations is typically at the discretion of the surveyor, leading to inconsistencies between surveys, between SA surveyors and AO surveyors, and between states.
- A surveyor may decide to record a citation twice for an issue that can apply to two headings. For instance, an issue may fall under a subheading for a standard number. The surveyor may decide to record the citation under only the subheading or the subheading and the standard number. The latter decision creates the appearance of more than one citation for the same issue and may create unwarranted consequences for the hospice organization. This practice varies between states and creates more inconsistency in surveys. We support the development and ongoing updating of the Surveyor Training Modules as a foundational step in the direction towards standardization and consistency.

NHPCO Recommendations:

NHPCO requests written information on the rationale for “See One Cite One”, including how the process is applied to both SAs and AOs, as well as how it follows quality improvement principles.

- We suggest that CMS consider employing a method of assessing whether an issue is seen in a certain percentage of medical records rather than a single medical record and setting a percentage threshold to determine if the issue should be cited.
- To minimize variability and inconsistency among surveys and surveyors, we strongly support the consistent and centralized training using the CMS Surveyor Training Modules. We strongly encourage CMS to use the pre- and post-test process in the training modules to develop a scoring system that would indicate proficiency and competency with the hospice survey process. It may also be helpful to develop survey case studies and add them to surveyor training.

7. Public Feedback

NHPCO appreciates CMS’ solicitation of stakeholder feedback and offers specific commentary on the following provisions:

AO Customization of Proprietary Systems to Incorporate a Version of the Form CMS-2567 and Submit to CMS via Electronic Data Exchange

CMS seeks comment on how AOs can customize their systems to allow for incorporation and submission of the form.

NHPCO Comments:

- NHPCO is pleased to compile and provide feedback from hospice providers on the incorporation of the Form CMS-2567 into AO systems. NHPCO provider members report that several states have yet to adopt the electronic standard for the Form CMS-2567. Thus, we recommend that CMS create and offer an electronic version of the form to all states to ensure consistency between states and strongly encourage AOs to also use an electronic format.
- Further, as previously stated, NHPCO is concerned that the incorporation of the Form CMS-2567 into AO data systems will result in the duplication of data. We recommend CMS to consider data duplication carefully in assisting AOs for the incorporation of the form.

Utilization and Display of Data Elements from the Form CMS-2567

CMS seeks recommendations on how data elements from the form and other relevant information may be utilized and displayed.

NHPCO Comments:

- In its current form, CMS-2567 is unnecessarily difficult for consumers to read and understand. The form contains an abundance of information, often irrelevant to consumers' needs. We encourage CMS to work with a TEP to identify and display select, relevant information and examine creative options for display, such as a dashboard like those employed by some AOs, including the Joint Commission.

NHPCO Recommendations:

- We recommend CMS work with the TEP to fully develop a list of data elements needed for a public-facing CMS-2567. A group of NHPCO providers met to discuss the data elements important to a public-facing document, based on their experiences with consumers and with patients and families. NHPCO suggests the following data elements as a starting point for this discussion:
 1. Type/Purpose of the survey – complaint, infection control, initial certification, recertification, or validation. Only substantiated and “unique/unduplicated” complaints should require posting.
 2. Date of the most recent survey.
 3. Name of hospice agency and contact phone number – we do not recommend including the name of the ED, Clinical Director, etc. as this information changes and quickly becomes outdated. Do not recommend including signature of agency be included when posting the 2567 form.
 4. Recommend posting only findings that result in Standard level deficiencies that roll up to a condition level deficiency, Condition Level deficiency or Immediate Jeopardy. Posting of standard level deficiencies alone are not meaningful and can be overwhelming to a consumer and not understood.
 5. Ensure that 2567 does not present survey tag in such a way that provides so much detailed information that the identification of the patient is possible, even without the patient's name. This is particularly important in smaller, more rural communities and in locations where there is only one hospice provider.
 6. Citations should be categorized in the 5 areas of focus:
 - a. Patient Rights
 - b. Assessment
 - c. Plan of Care
 - d. QAPI
 - e. For Inpatient Units – include Life Safety condition-level findings.

- f. Other
7. Total number of condition level findings and comparison to state and national averages for that element as well as an indication of whether lower score or higher score is preferable.
 8. Include only findings with a completed POC be published.
 9. We recommend that that each accrediting agency use the CMS-2567 developed to comply with the Consolidated Appropriations Act (CAA of 2021), including survey findings and the agency's plan of correction. The current 2567 form is not in electronic format for SAs, AOs or hospice organizations to use and does not present the findings in a manner that would be meaningful to the consumer. The 2567 should be the version that includes the POC.
 10. We recommend CMS develop a method for electronic, web-based submission of the 2567 for all SAs and AOs in order to promote consistency, including the submission of the POC. Providers, SAs and AOs have struggled with the current 2567 form which is not editable or easy to use.
 11. We recommend the ability to have a dashboard view that incorporates graphs. For example, a comparison bar graph could be developed showing the # of deficiencies by provider, by State, by region, and nationally. Graphs are typically a more meaningful way to represent this type of information to the consumer. Graphs could then be followed below with an asterisk or link that takes them to the survey document or detailed report.

Hospices already have a challenge with educating Medicare beneficiaries and their families and helping them reach the decision to elect to use their hospice benefit. This public reporting of survey results, if not presented in a useful and meaningful way, could potentially be an additional barrier to a decision that is already hard for patients/loved ones to make.

II. Provisions Pertaining to Surveyors, Consistency of Survey Results, and the Special Focus Program (SFP) (§ 488.1100; § 488.1105; § 488.1110; § 488.1115; § 488.1120; § 488.1125)

As we discuss below, NHPCO strongly supports applying uniform training standards across both SAs and AOs and holding surveying entities accountable to performance standards. We also support using the CMS Surveyor Training Modules as a basis for surveyor education and appreciate that CMS is taking steps to include AO surveyors under the conflict-of-interest policy, though we encourage CMS to broaden its proposed exclusion criteria. Implementing these reforms will help to ensure the competency and consistency of surveyors which is critically important to establish if enforcement remedies are to be levied against hospices based on their findings. However, we note that there is no mention of updating the surveyor training modules when new regulations are promulgated and urge CMS to provide updates to the surveyor modules and add requirements for continuing education for surveyors.

NHPCO is pleased that the frequency of surveys was confirmed by the Congress as every 36 months and that this requirement has been made permanent. We also enthusiastically support the use of multidisciplinary teams but encourage CMS to place guardrails around the assignment of roles within surveyor teams to ensure each surveyor operates within their knowledge base and scope of practice.

A. Surveys (§ 488.1100; § 488.1105; § 488.1110)

1. Surveys

NHPCO Comments: We commend CMS on its efforts to improve surveyor training and increase consistency across surveyors. Our experience has been that the hospice survey process is flawed and needs to be corrected. Division CC, section 407 of the CAA of 2021 included the “HOSPICE Act,” which incorporates programs that may improve the survey process by increasing surveyor training and competency.⁴ We strongly believe these reforms should be a top priority and urge CMS to put them into place *before* implementing enforcement remedies or activating the Special Focus Program (SFP). CMS’ use of enforcement remedies could be applied inappropriately if surveyors are not properly trained and do not identify deficiencies among hospice providers in a consistent manner. Instead of appropriately applying penalties to hospices that need to improve, we are concerned that poorly trained surveyors may unjustifiably flag hospices who are providing quality care or inconsistently apply standards in such a way that unfairly penalizes some hospices relative to others.

Further, our conversations with hospice providers have brought several issues to our attention that we urge CMS to consider as it works to improve the survey process. Our provider members report that the length of time it takes to administer the survey can vary depending on the surveyor (SA or AO) and the surveyor team. The efficiency with which surveys are completed is of great importance to hospice providers since hospices pay AOs by the day for the survey and because hosting surveyors requires an investment of time and administrative resources. For example, hospices must provide access to the electronic medical record (EMR) platform – sometimes even after hours or after the on-site survey is completed.

Feedback on the Survey Process by NHPCO Members: NHPCO also collected feedback on the Medicare survey process from NHPCO members through a survey. 240 responses were received. The states with the highest percentages of respondents across the country included Iowa (8.78%); Minnesota (7.43%); Pennsylvania (6.08%); California (5.41%); and New York (4.73%). Most members received the Medicare survey in 2021 (32.9%), followed by 2020 (30.32%) and 2019 (27.10%). Sixty-three percent of surveys were conducted by state survey agencies, with 30% of surveys conducted by

⁴ <https://www.congress.gov/bill/116th-congress/house-bill/133/text>

accrediting organizations Typically, two or more surveyors conducted the Medicare surveys (58%), while 42% of respondents say that only one surveyor was present.

For the majority of NHPCO members (78.06%), the survey lasted between 3-4 days, while 12.90% were surveyed over the span of five days or more. In total, 86.54% of those surveyed were receiving recertification, 4.49% were in response to a complaint, and 4.49% were for initial certification purposes. Of those who answered that the survey was given for other reasons (4.49%), licensure, recertification/dual complaints due to COVID backlogs, and infection control focus were listed as the explanation.

When respondents were given the opportunity to freely respond as to whether or not the citations they received were in conflict with hospice regulations, those who responded 'yes' listed a variety of reasons for their answers, including:

- **Conflicting interpretations of regulations**
 - Reason for citation not clearly specified in regulations;
 - Multiple conflicting interpretations of certain regulations;
 - Surveyors kept citing home health regulations, asking why 485s weren't in the hospice charts;
 - Surveyor had many questions regarding Hospice CoPs as she was used to surveying LTC;
 - Confusion about difference between initial and comprehensive assessment; and
 - The interpretation of the regulations seems to change each year. We get sign off one year; the next year they say we didn't complete the requirement in its entirety.

- **Overly prescriptive expectations/excessive documentation requirements**
 - Cited for medication instructions that had never been corrected or called out previously;
 - Surveyor's intense care plan scrutiny (e.g., noting areas that weren't indicative of patient concerns);
 - Wound care deficiency (extensive treatment to heal wound beyond what would be typically needed for a hospice patient); and
 - Cited for not having physician orders for every frequency change. Hospice appealed and won .

- **Review of employee records**
 - Staff licensure not obtained from primary licensure source; and
 - Request to produce all employee files.

Of those who received citations, 79.7% felt that they were held to regulations that applied to hospice. If the respondent replied that they were held to another Medicare regulation, 7% were held to home health regulations, 3% were held to nursing home regulations, and 10.5%

were held to other regulations, including COVID screening. Respondents reported that the specific COVID screening requirements applied to patient care areas, but did not apply to administrative buildings, but were cited anyway.

NHPCO Recommendations:

- NHPCO recommends that CMS provide additional, standardized, computerized programs for training, education, and competency evaluations for hospice surveyors to ensure knowledge of hospice regulations and consistency of surveys, including both SAs and AOs. Proper training will not only benefit the surveyors in their work but has the potential to improve the survey process as well – particularly in the interpretation of regulations, expectations around documentation, and accessing employee records. Given the obvious inconsistencies among surveyors, we strongly believe that CMS should not put the cart before the horse in creating remedies/sanctions for noncompliance when the survey process has not yet been fixed.
- Additionally, to encourage consistency in the survey process, we suggest CMS establish parameters around the number of charts a surveyor team is expected to review per day. We also recommend CMS issue guidance to AOs that encourages surveyors to spend a full day on site if they are paid for the full day.

2. Hospice Program Surveys Every 36 Months

CMS proposes at §488.1110(a), a standard survey would have to be conducted not later than 36 months after the date of the previous standard survey.

NHPCO Comments:

- NHPCO supports the requirement to conduct standard surveys at 36-month intervals.

3. More Frequent Surveys

CMS proposes a survey could be conducted more frequently than every 36 months to assure that the delivery of quality hospice services complies with the CoPs and confirm that the hospice program corrected deficiencies that were previously cited.

NHPCO Comments:

- NHPCO encourages CMS to implement oversight approaches that do not hinder access to high-quality care for patients and their families. Hospice providers that are following the rules should not be subjected to excessive administrative burden and forced to divert resources from patient care.

- NHPCO also has serious concerns about the ability of SAs and AOs to increase staffing to support more frequent surveys, given the existing delays for standard surveys and the long delays for complaint surveys. The Department of Health and Human Services (HHS) Office of the Inspector General (OIG) has documented a substantial backlog of standard surveys, with roughly 71 percent of nursing homes having gone at least 16 months without a standard survey as of May 31, 2021.⁵ This is a critical issue, as an insufficient number of SA and AO survey staff will unnecessarily result in survey reforms and enforcement remedies being ineffective or implementation delayed.

4. Complaint Surveys

At proposed §488.1110(b)(1), a standard or abbreviated standard survey would have to be conducted when complaint allegations against the hospice program were reported to CMS, the State, or local agency.

NHPCO Comments:

- NHPCO supports mandating complaint surveys but encourages CMS to establish a reasonable timeline by which complaint surveys must be completed that takes into consideration when the complaint is received.

NHPCO Recommendations:

- We suggest CMS establish a 6-month timeframe in which surveyors must conduct complaint surveys once an allegation is reported.
- Further, NHPCO encourages CMS to consider innovative ways it can move away from punitive oversight measures and focus on increasing knowledge among hospice providers to improve the quality of care. For example, require surveyors to offer technical assistance to hospices when survey results identify deficiencies.
- We also ask CMS to clarify what happens when a deficiency is resolved during the survey. If such a policy does not already exist, we urge CMS to create a policy that surveyors do not include a deficiency on the CMS-2567 if it is resolved during the survey.

5. Toll-free Hotline for Hospice Programs

As specified in the CAA of 2021, CMS proposes to add at § 488.1110(b)(2) a requirement that the State or local agency must establish and maintain a toll-free hotline to receive

⁵ Office of the Inspector General. *Addendum to OEI-01-20-00431: States' Backlogs of Standard Surveys of Nursing Homes Grew Substantially During the COVID-19 Pandemic*. July 2021. <https://oig.hhs.gov/oei/reports/OEI-01-20-00431.pdf>

complaints (and answer questions) with respect to hospice programs in the State or locality and to maintain a unit to investigate such complaints. CMS explains that the requirement for the hotline will be described in the annual CMS Quality, Safety and Oversight Group's Mission and Priority Document (MPD) which provides the scope of work contractually for SAs.⁶

NHPCO Comments:

NHPCO supports this requirement for State or local agencies to maintain a toll-free hotline for hospice programs and complaints. We request that CMS clarify that there will be a single hotline in each State and that questions or complaints will be followed up by the State as appropriate.

B. Surveyor Qualifications and Prohibition of Conflicts of interest (§ 488.1115)

1. Disparities in Overall Survey Performance

Currently, AOs are required by § 488.5(a)(8) to provide training to their surveyors. As the AO requirements outlined in § 488.5 also allow for standards and processes that exceed those of CMS, the AO's training may differ from what CMS provides to SA surveyors, thereby creating a potential disparity in overall survey performance. CMS is proposing that all SA and AO hospice program surveyors would be required to take CMS-provided surveyor basic training currently available, and additional training as specified by CMS.

Training modules are available free of charge through the Quality, Safety & Education Portal (QSEP), which contains the CMS training. QSEP training is accessible on an individual, self-paced basis.⁷

NHPCO Comments:

- We strongly support requiring all SA and AO hospice program surveyors take CMS-provided basic training. Our provider members report that consistency between surveyors and surveyor types is severely lacking and has led to undue administrative burden and strife for hospice providers. After closely reviewing the CMS surveyor training modules, we believe both surveyors and hospice providers would benefit from this training being mandatory for both SAs and AOs.
- For example, one of our members reported being surveyed by an AO that failed to comply with several CMS State Operating Manual procedures, including: promoting

⁶ <https://www.cms.gov/files/document/fy-2021-mpd-admin-info-20-03-all.pdf>

⁷ <https://qsep.cms.gov>

consistency; seeking to ensure surveyors have sufficient information to make compliance decisions; fully investigating issues of concern through further observation, interviews, and document reviews before making compliance decisions; and not making an evaluation of deficiency until necessary information is collected. This AO issued 16 citations to the hospice facility after its tri-annual survey, of which, 5 were ultimately overturned.

The hospice also shared its divergent experiences with unannounced complaint surveys by the AO and the SA. The AO was at the facility for 4 hours, did not interview or observe any staff, and returned an “immediate jeopardy” finding. In contrast, the hospice reported that the SA remained at the facility for 2 days and interviewed all clinical staff involved in the patient’s care as well as the chief medical officer, pharmacists, and quality department staff. The SA also reviewed policies, procedures, and patient charts, as well as documentation of an internal investigation into the complaint. This more thorough review resulted in a single citation related to a lack of individualized care plans.

Clearly, more needs to be done to ensure AO surveyors are adequately trained, surveys are conducted in a consistent manner across surveyor types, and hospices are fairly evaluated. Hospice staff are required to have documented competency assessments, supervisory visits, and performance evaluations, while clinical staff are expected to thoroughly document the care they deliver and their interactions with patients. The AO in this case did not abide by similar quality assurance processes, skills verification, or competency assessments, putting access to hospice care at risk for Medicare beneficiaries.

2. Comments Sought

CMS invites commenters to review the trainings by signing up for a free account on the homepage of the CMS website, or by choosing the “Public Access” button on the upper right-hand corner of the website homepage. CMS seek comments on the requirement for continued SA and AO surveyor training as CMS releases additional basic course updates.

- **Review of Training Modules**

NHPCO is pleased to provide in-depth feedback from hospice providers on the CMS Surveyor Training modules. Our detailed comments and recommendations for edits and additions to the CMS Surveyor Training modules are included in a separate appendix for your consideration. Please see Appendix A.

- **Requirement for Continued SA and AO Surveyor Training**

NHPCO Recommendation:

NHPCO fully endorses a requirement for continued SA and AO surveyor training. We also ask that CMS update its training when new regulations are promulgated and require surveyors to complete refresher trainings annually to ensure competency on any regulatory changes.

3. Focus of Surveys and Emphasis on Assessment of Quality of Care

CMS is updating the hospice program basic training and including enhanced guidance for surveyors. The updated training will emphasize assessment of quality of care. CMS is emphasizing four “core” hospice program CoPs to emphasize the assessment of quality of care:

- §418.52 Condition of Participation: Patient’s rights
- §418.54 Condition of Participation: Initial and comprehensive assessment of the patient
- §418.56 Condition of Participation: Interdisciplinary group, care planning and coordination of care
- §418.58 Condition of Participation: Quality assessment and performance improvement.

NHPCO Comments:

- We support the development of a comprehensive surveyor training program and support requiring surveyors to complete training and pass competency testing prior to participating on a hospice surveying team.

NHPCO Recommendation:

- NHPCO urges CMS to specifically address the hospice emergency preparedness provisions in the training. It is possible that emergency preparedness is available for all surveyors, but it is not referenced in the CMS Hospice Surveyor Training modules. We also suggest that the patient safety assessment be integrated into the comprehensive assessment, perhaps with an expanded standard for patient safety.

4. Conflict of Interest

In section 4008 of the SOM, scenarios are described that constitute conflicts of interest for SA surveyors, including surveyors who have an outside relationship with a facility surveyed by the SA. CMS is proposing to codify that the conflict-of-interest provision

applies to both SA and AO surveyors to “ensure that there is no conflict of interest between the organization and the surveyor.”

NHPCO Comments:

- We strongly agree that the conflict-of-interest provision should apply to both SA and AO surveyors and appreciate CMS taking steps to include AO surveyors.

5. Criteria for Exclusion as a Surveyor

CMS proposes that a “surveyor [be] prohibited from surveying a hospice program if the surveyor currently serves, or within the previous 2 years has served, on the staff of or as a consultant to the hospice program undergoing the survey. Specifically, the surveyor could not have been a direct employee, employment agency staff at the hospice program, or an officer, consultant, or agent for the surveyed hospice program regarding compliance with the CoPs.”

CMS also proposes that a “surveyor would be prohibited from surveying a hospice program if he or she has a financial interest or an ownership interest in that hospice. The surveyor would also be disqualified if he or she has an immediate family member who has a financial interest or ownership interest with the hospice program to be surveyed or has an immediate family member who is a patient of the hospice program to be surveyed.”

NHPCO Comments:

- We commend CMS for putting safeguards in place to guard against surveyor bias in the assessment of hospice providers. However, providers are concerned that the exclusion criteria CMS proposes may not identify all circumstances where a survey lacks objectivity, such as surveyors who have worked for a competitor hospice in the service area within the last two years or if an immediate family member or friend was served by the hospice being surveyed. A more global solution is required, where there is a process in place for a surveyor to declare a conflict of interest, there is guidance for SAs and AOs on addressing conflicts of interest, and training on conflict of interest is added to the CMS Surveyor Training Modules.
- While the surveyor exclusion criteria CMS proposes is a good start towards meeting the goal of avoiding potential conflicts of interest, we believe additional processes are necessary to protect hospices more fully from surveyor bias.

NHPCO Recommendations:

- In addition to the criteria proposed by CMS, we suggest the following:

- CMS should develop materials to guide a surveyor in identifying situations in which he/she may have a conflict of interest and add conflict of interest to the CMS Hospice Surveyor Training Modules to ensure that the topic is covered.
- CMS should develop guidance for SAs and AOs that addresses the process for identifying conflicts of interest and disqualifying a surveyor from a specific survey.
- CMS should develop a surveyor “Code of Ethics” or “Attestation” with the goal of the surveyor maintaining objectivity throughout the survey process. An attestation or agreement to a Code of Ethics should be addressed in the CMS Surveyor Hospice Training Modules and could be signed by the surveyor during the training process.
- Add language to the State Operations Manual that would address procedures for conflict of interest among SA and AO surveyors in hospice.

C. Survey Teams (§ 488.1120)

1. Multidisciplinary Survey Teams

CMS proposes that the survey team must include at least one registered nurse (RN) and, if the team is more than one surveyor, the additional surveyors should include “other disciplines with the expertise to assess hospice program compliance with the conditions of participation.” This proposal would require all survey entities (SAs or AOs) to include “diverse professional backgrounds among their surveyors to reflect the professional disciplines responsible for providing care to persons who have elected hospice care.” The disciplines in the multidisciplinary team may include physicians, nurses, medical social workers, pastors, or other counselors – bereavement, nutritional, and spiritual.

NHPCO Comments:

- We note the use of the word “should” in the proposed rule, which states that “additional surveyors should include “other disciplines with the expertise to assess hospice program compliance...” We want to ensure that SAs and AOs interpret that language in the same way and begin to make efforts to broaden the disciplines on the survey team.
- It is critical that all surveyors on the hospice survey team be knowledgeable about end-of-life care and the goals for this type of care. NHPCO recommends that language be added to the multidisciplinary team section of the final rule to reflect this expectation.
- Our members are extremely supportive of having other disciplines outside of nursing represented on the survey team and are encouraged by CMS’ interest in improving the standard of care holistically. However, NHPCO does have concerns about the time it

takes surveyors to complete the survey and the impact changes to the makeup of the survey team may have on efficiency. Hospices pay for AO surveys by the day so additional days would increase survey costs for hospices.

- Further, we want to make sure that members of the survey team are operating within the scope of their practice and not assessing areas with which they are unfamiliar or lack a knowledge base. We believe all areas of the survey are important for assessing and maintaining quality care and support efforts by CMS to ensure surveyors give each piece the attention it deserves. One of our members noticed during a recent home visit and record review by a social worker that the surveyor was focused more on psycho-social considerations and was not paying as much attention to medication, the nursing plan, or patient safety. For example, in that case, we would want to be sure that a surveyor with the requisite experience assessed those more clinical aspects thoroughly as well.

NHPCO Recommendations:

To ensure the expertise of these surveyors is effectively leveraged, we recommend CMS:

- Identify areas of the survey that certain disciplines may be more skilled at assessing (e.g., psycho-social needs – social workers) and provide guidance about assigning roles accordingly to ensure surveyors operate within their scope of practice
 - Adapt survey process language to reflect multiple disciplines, not just nursing
 - Provide clarity to SAs and AOs about CMS’ intent to include surveyors from other disciplines.
- 2. Baseline Knowledge of Survey Teams** – CMS proposes to establish baseline knowledge about the teams conducting surveys by asking all survey entities:
- the extent to which their surveys are conducted by one professional, who by regulation must be a registered nurse.
 - the professional makeup of their current workforce; and
 - estimate a timeframe in which they could effectuate multidisciplinary teams if not already in place.

NHPCO Comments:

NHPCO has no comments.

- 3. Specialty Surveyors** – CMS suggests that they may use as a model, current guidance for long-term care facilities (LTCFs) which uses specialty surveyors with expertise not typically included in a survey team (pharmacist, physician, registered dietitian, for example) which may not be needed for the entire survey but may be onsite during the survey.

NHPCO Comments:

- Although we are generally supportive of CMS using the current LTC guidance for hospice facilities, we have reservations about specialty surveyors without end-of-life-care experience.

NHPCO Recommendation:

- We urge CMS to require specialty surveyors be familiar with and knowledgeable about end-of-life-care, preferably hospice.

D. Consistency of Survey Results (§ 488.1125)

1. Measuring and Reducing Survey Inconsistencies

The CAA of 2021 requires that each state and the Secretary implement programs to measure and reduce inconsistencies in hospice survey results. CMS also believes that this applies to “reducing discrepancies between SA and AO surveys of hospice providers.” CMS proposes to enhance the requirements of the State Performance Standards System (SPSS) to direct states to implement processes to measure the degree or extent to which surveyors’ findings and determinations are aligned with federal regulatory compliance and with an SA supervisor’s determinations.

NHPCO Comments:

- We commend CMS on its efforts to increase consistency across surveyors. We strongly believe this reform should be a top priority and urge CMS to consider putting measures to reduce survey inconsistencies in place before implementing enforcement remedies or activating the SFP. CMS’ use of enforcement remedies could be undermined if surveyors are unable to identify deficiencies among hospice providers in a consistent manner.
- NHPCO also fully endorses enhancing requirements of the SPSS to instruct states to monitor surveyors’ alignment with federal regulatory compliance and with an SA supervisor’s determinations. However, we believe CMS should go farther and take steps to address surveyor differences between SAs as well as between SA and AOs.

2. Disparity Ratings between AO and SA Surveys

CMS proposes to analyze trends in the disparity rate among States, as well as among AOs and states that they “believe that the disparate deficiency citations between AO surveyors and SA surveyors may, in part, be attributed to differences in surveyor training and education.”

NHPCO Comments:

- As we note elsewhere, we believe discrepancies in ratings between AO and SA surveys is a serious issue that unfairly burdens hospices and does not necessarily improve patient care and quality. We support additional steps by CMS to further standardize and improve training, measure inconsistencies, and explore ways to improve reliability.

NHPCO Recommendations:

- We recommend CMS review survey consistency between SAs and AOs at least quarterly to ensure individual surveyor judgement is tempered with objective measurement.
- We also strongly encourage CMS to convene a TEP to study survey consistency and develop strategies for achieving greater reliability.

3. Uniform Surveyor Training Provided by CMS

The variations in deficiency citations could be due to inconsistencies in AO training with the CMS-provided SA basic surveyor training. CMS believes that “uniform surveyor training would increase the consistency between the results of the surveys performed by SAs and AOs.” If surveying entities do not meet performance standards, they must develop and implement a corrective action plan.

NHPCO Comments:

- We strongly support requiring uniform surveyor training and holding both SA and AO surveying entities accountable to performance standards.
- Division CC, section 407 of the CAA of 2021 requires that the Secretary provide surveyor training, no later than October 1, 2021. Can CMS confirm this timing is both feasible and accurate? What steps will CMS take to enhance surveyor training, competency, and consistency after the October 1, 2021 date to ensure that there is continuing improvement on this issue?

E. Special Focus Program (SFP) (§ 488.1130)

In response to highly concerning OIG reports in 2019 that recommended CMS to develop a hospice program based on the Special Focus Facility (SFF) program for nursing facilities, CMS proposes § 488.1130 to establish a SFP for poorly performing hospices.⁸

⁸ Office of Inspector General (OIG). *Hospice Deficiencies Pose Risks to Medicare Beneficiaries*. July 3, 2019. https://oig.hhs.gov/oei/reports/oei-02-17-00020.asp?utm_source=mmpage&utm_medium=web&utm_campaign=OEI-02-17-00020.

1. **Criteria for SFP** – Under the proposed § 488.1130(b)(1), a hospice program could be included in an SFP if it is found to have condition-level deficiencies during two consecutive standard or complaint surveys or if it is found to have two or more condition-level findings during a validation survey.

NHPCO Comments:

- In its first 2019 report on hospice care, OIG identified over 300 poorly performing hospices, characterized by having at least one serious deficiency or one substantiated severe complaint in the survey period.⁹ NHPCO supports efforts to address systemic issues leading to serious and substantiated deficiencies in hospices and is dedicated to improving quality of care for hospice beneficiaries.

However, we are concerned that the criteria as proposed do not accurately capture poorly performing hospices. There is no language about the status of CLDs at the time of consideration for SFP inclusion. CLDs are typically anomalies and will be corrected immediately; in fact, many may be corrected while the survey is in progress. Thus, these criteria may be outdated as it is based on past deficiencies that may already be corrected by the time that the hospice is considered for participation in the program. Additionally, the proposed rule does not consider a hospice’s quality trending, which is a core principle of quality improvement.

- We are also concerned that the criteria may unfairly penalize hospices through the “see one cite one” practice that surveyors employ. Under this practice, surveyors are required to cite an individual incorrect medical record regardless of its significance in context of the volume of total records, penalizing hospices that otherwise provide high quality care. Thus, we encourage CMS to consider a matrix approach that will avoid placing undue weight on any one citation.
- Furthermore, we encourage CMS to provide additional guidance on how complaint and validation surveys will be used to make a determination for entry into the SFP. We understand that multiple CLDs may indicate a hospice in need of assistance to bring the program back into compliance. However, we believe focusing solely on CLDs has the potential to inadvertently exclude truly poorly performing hospices that would benefit from special attention. For instance, a hospice may not meet the criteria for a CLD but may have multiple standard-level deficiencies (SLDs) that would otherwise raise concern that the hospice needs additional guidance. Another area of surveys that may raise alarm but would not be included by focusing on CLDs is the frequency of re-visits needed to ensure a hospice is compliant.

⁹ Ibid.

- Finally, although one of the proposed criteria focuses on CLDs on complaint surveys, a hospice may have several serious and substantiated complaints that do not rise to the level of a CLD but still raise due concern.

NHPCO Recommendations:

- To more accurately identify poorly performing hospices, NHPCO suggests that CMS screen out hospices that have resolved their condition-level deficiencies and consider:
 - A hospice’s trends in performance over time;
 - Number, scope, and severity of a hospice’s deficiencies;
 - Frequency of re-visits necessary to ensure a hospice’s compliance; and
 - Number and severity of substantiated complaints.
- We recommend CMS employ a matrix of criteria using a weighted scale of several metrics of performance beyond condition-level deficiencies. Such a process will help hospices understand how to prioritize their actions to maintain a high-quality level of care.

2. **Selection for SFP** – Under the proposed rule, CMS will provide SAs a list of possible candidates for the SFP based on the specified criteria and a subset of the hospices would be selected to participate “based on State priorities.”

NHPCO Comments:

- NHPCO has concerns about the subjectivity and validity of selection. Given that selection depends on surveys that are often variable and inconsistent, we are concerned that the results of the SFP will be similarly drastically different between states. Thus, we urge CMS to focus first on standardizing the survey process prior to designing and implementing the SFP. Moving ahead with the SFP with the current survey process will only create greater inconsistency and misalignment.

NHPCO Recommendations:

- NHPCO strongly urges CMS to delay implementing the SFP until the survey process is standardized across all stakeholders. We urge CMS to carefully consider and evaluate the survey process.
- Once CMS has successfully standardized the survey process, we recommend employing a gradual implementation schedule to allow hospices time to adjust to the changes and allow for CMS to thoughtfully and effectively implement the SFP.

3. **State Priorities** – CMS proposes a subset of the hospices would be selected to participate in the SFP “based on State priorities”.

NHPCO Comments:

- NHPCO is concerned about the language stating that “State priorities” will inform selection decisions. This language is unclear and lends to a higher probability of great variability and inconsistency between states for the SFP.
- In addition, according to sub-regulatory guidance, CMS has instituted a quota system in the SFF Program that has existed in the nursing home space with each SA selecting new SFFs from a list of candidates that CMS supplies.¹⁰ The number of nursing homes on the candidate list is based on five candidates for each SFF slot, with a minimum candidate pool of five nursing homes and a maximum of 30 per State.
- NHPCO and our provider members strongly object to a quota system. The quota system for the SFF program has resulted in inconsistencies among states about which providers are selected for the special focus program and why. Quotas also unfairly penalize smaller or rural states with limited providers by requiring them to build a candidate list with providers who are furnishing high quality care. On the other hand, the quota system creates the potential for states to be unable to add low performing providers to the list, inadvertently increasing health inequities. Because the quota system requires that a State may only include a maximum of 30 providers on the candidate list, states with many low performing providers are put at a disadvantage by being unable to include all providers who meet inclusion criteria. For example, a state with under 30 hospices and a state with over 500 hospices would be held to the same arbitrary quota standards.
- It is crucial to be thoughtful about the creation of the SFP candidate list because inclusion on the candidate list has proved to create irreparable damage for nursing homes, as the list is made publicly available on Nursing Home Compare. This lends even greater importance to the need to make careful and accurate decisions about the selection of facilities to include either on the candidate list or in the program itself.
- We fervently urge CMS to avoid placing similar unnecessary burdens on states and providers with the SFP. All hospice providers should be given the opportunity to provide exemplary care to their patients, without threat of being part of an arbitrary quota for an SFP. In addition, because the surveyor education and consistency has not yet been corrected, a quota system is also ill timed. Thus, we believe that a quota is detrimental to the purpose for the SFP and encourage CMS to take a centralized approach to SFP participant selection.

¹⁰ Centers for Medicare & Medicaid Services (CMS). *Fiscal Year (FY) 2017 Special Focus Facility (SFF) Program Update*. March 2, 2017. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-20.pdf>.

NHPCO Recommendation:

- We strongly urge CMS to eliminate inequitable and unfair state-level quotas and apply a standard formula or algorithm to look broadly across all states to select low performing hospices for the SFP in a centralized manner. We strongly support a standardized and centralized approach using objective criteria with no state-level quota system. This will address inconsistencies between states and place hospice providers in the SFP using the same criteria and standards throughout the country.

4. **Surveys During SFP** – The proposed § 488.1130(c) states that SAs would conduct onsite surveys of SFP hospices at least once every 6 months and may include progressively stronger enforcement actions if the hospice continues to fail to meet the conditions for participation with Medicare and Medicaid.

NHPCO Comments:

- The general purpose of the SFP is unclear. NHPCO asks the following clarifying question:
 - Is CMS' intent to (1) penalize low performing hospices and thus serve as a deterrent to prevent hospices from meeting the criteria for the program; or (2) to help low performing hospices improve by offering additional technical assistance, resources, and support before imposing penalties?
- We strongly encourage CMS to offer technical assistance first, which should not be punitive in nature but rather should provide additional support for providers to learn hospice best practices and consistent compliance with Medicare regulations.
- We support the proposal to conduct surveys at an increased frequency as we believe it would be necessary to assess the hospice's progress in this program.
- We also support the proposal to seek additional enforcement actions or remedies if improvement is not seen by reviewers in the SFP.

NHPCO Recommendations:

- NHPCO recommends CMS offer a technical assistance approach to the SFP and explore how to better support hospices to improve quality of care for the duration of their participation in the SFP. If no progress is made with technical assistance resources offered, additional enforcement actions may be required.
- We support the proposal to conduct surveys at increased frequencies and seek additional enforcement actions if no improvement is seen for SFP participants.

- 5. Graduation from SFP** – Under the proposed rule, a hospice remains on the SFP until it graduates from the SFP or is terminated from Medicare, Medicaid, or both programs. If a hospice completes two consecutive 6-month surveys with no condition-level deficiencies, CMS proposes to move the hospice to graduation, while a hospice with continuing condition-level deficiencies would be moved to a track towards termination from Medicare, Medicaid, or both programs.

NHPCO Comments:

- The rule as proposed leaves much unclear regarding the graduation process and what it means for providers in the SFP. NHPCO asks CMS to expand on the details for the path to graduation including the following points:
 - Please describe the procedures for determining compliance with and time in compliance with hospice regulations.
 - What are the procedures for exiting the program?
 - What information would remain on Care Compare or any other federal website regarding the hospice’s time and experience in the SFP? What is the timeframe for removing the SFP reference when the hospice provider has graduated?
- We also have concerns about how staff shortages at SAs and AOs will affect the statutory requirement for 6-month surveys and, by proxy, a hospice’s ability to exit the SFP through graduation or termination.

6. Comments Sought

i. Similar Criteria/Process/Framework for the SFP as in the Current Long-Term Care Program

CMS seeks comment on considerations for similarities and differences, if any, between the SFP and the current SFF program.

NHPCO Comments:

- Throughout our comments on the SFP, NHPCO has referred to the current SFF program for nursing home care to point to lessons learned. We are pleased to compile and provide extensive feedback regarding the effective processes of the SFF program that should be applied to the SFP and, conversely, what time has taught us to be ineffective and harmful in the SFF program and should thus be avoided in the SFP.

ii. Criteria

The SFF program employs a scoring methodology calculating a composite SFF score signaling greater seriousness at higher scores. The score includes a deficiency score, in

which deficiencies are weighted based on the scope and severity, and a revisit score, which grants increasing noncompliance points for providers that require increasing numbers of revisits to demonstrate compliance. The deficiency and revisits scores are then summed to create total scores by period, and weights are added to the sums to weigh recent periods more heavily. Candidate lists are created by considering the nursing homes with the highest SFF scores.¹¹

On the other hand, the proposed SFP would employ much simpler criteria. A hospice could be considered for the SFP candidate list if it is found to have condition-level deficiencies during two consecutive standard or complaint surveys or if it is found to have two or more condition-level findings during a validation survey.

NHPCO Recommendations:

- NHPCO supports a matrix approach to scoring criteria for the SFP, similar to the SFF program.
- We also support using weighted criteria to focus more heavily on recent deficiencies and deficiencies greater in scope and severity. We urge CMS to consider the nuances of a weighted matrix approach for several reasons. A matrix approach would allow CMS to consider several criteria, assisting CMS to identify low performing hospices more accurately. It would also help hospices identify their priorities and create plans of action to maintain a high quality of care.

iii. Quota

In the SFF program, SAs must create a candidate list with a minimum of five nursing homes and a maximum of 30.

NHPCO Recommendation:

- NHPCO emphasizes our strong opposition to implementing state-level quotas of any kind in the SFP for hospice providers. The SFF program has shown us that state-level quotas create confusion, promote inconsistency, unfairly penalize providers, and inherently act against national efforts to increase health equity. Thus, to enhance the positive impacts of the SFP, we urge CMS apply a standard formula to look broadly across states and select low performing hospices for the SFP in a centralized manner, instead of instituting arbitrary state-level quotas.

¹¹ Hamilton, Thomas E. *Special Focus Facility (SFF) Program Survey Scoring Methodology*. October 10, 2008. <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SCLetter09-05.pdf>.

iv. SFP Designation

NHPCO asks CMS: What designation on Care Compare or any other federal website, if any, will CMS use if a hospice provider is on the SFP?

For the SFF program, nursing home participants are marked with a yellow triangle symbol on Care Compare, with the following language associated with the symbol:

“This facility is not rated due to a history of serious quality issues. This nursing home is subject to more frequent inspections, escalating penalties, and potential termination from Medicare and Medicaid as part of the Special Focus Facility (SFF) program.”

Care Compare’s symbol wields a significant impact on the labelled providers. The symbol is heavily stigmatized, rendering it extremely difficult for providers to serve new patients and residents. By deterring potential consumers from considering facilities in the SFF program, these often under resourced nursing homes are left to flounder.

NHPCO Recommendation:

- NHPCO strongly urges CMS to consider the ramifications of using a symbol that will do more harm than good as shown through the SFF program to inform consumers about the SFP. It is even more important to consider how hospices participating in the SFP are presented because of the unreliable and inconsistent nature of the survey process that is used to select participants. CMS needs to also commit to keeping this information as current as possible so that if a hospice is no longer in the SFP, the information is updated accordingly in a timely fashion.

v. Additional Selection Criteria

CMS seeks comment on any additional criteria not proposed that should be included for consideration when selecting hospices for the SFP candidate list.

NHPCO Comments:

- NHPCO is pleased to compile and provide extensive feedback regarding SFP selection criteria for CMS’ consideration. The proposed SFP program relies solely on surveys that are inconsistent and subjective. The results of surveys often rely on the surveyor’s opinion, rendering this approach ineffective at achieving CMS’ aim to improve hospice care. Additionally, surveying is only one tool to assessing quality care. CMS would be remiss to limit criteria to depend only on surveys. Furthermore, hospices can calculate objective measures themselves for internal monitoring efforts. This will help hospices understand how to improve and circumvent the need for possible participation in the SFP.

NHPCO Recommendations:

NHPCO proposes the following selection criteria and processes to help standardize results in a more balanced manner:

- **Matrix Approach with Weighted Criteria:** As previously described, NHPCO broadly recommends a matrix approach to scoring hospices with weighted point scales for criteria.
- **Trends:** The trend of a hospice's quality is important to consider. CMS should examine a hospice's overall trends as well as more heavily weighting recent performance over past performance data.
- **Number, Scope, and Severity:** NHPCO encourages CMS to consider the number, scope, and severity of a hospice's deficiencies, reminiscent of the SFF program for nursing homes.
- **Revisits:** Similarly, NHPCO encourages CMS to consider the frequency of revisits necessary to ensure a hospice's compliance, which is also used as a criterion in the SFF program.
- **Relative Size:** We recommend CMS normalize certain criteria such as the number of substantiated complaints by the relative size of hospices to avoid unfairly penalizing smaller hospices.
- **Hospice Care Index (HCI):** We support using claims-based measure information to objectively assess a hospice's performance. The HCI measure is claims-based, based on multiple indicators, and is already used in the Hospice Quality Reporting Program

vi. Utilization of a TEP

According to the proposed regulation, the purpose of a TEP is to enhance the SFP in terms of selection, enforcement, and technical assistance criteria while in the program and to assist in identifying contextual data and relevant information to assist public understanding of overall performance of a hospice provider.

NHPCO Comments:

- NHPCO commends CMS' commitment to stakeholder engagement, as more input is needed from stakeholders about the design, criteria, decisions for entry, and implementation of the SFP before it is finalized. We strongly support the creation of a TEP charged with, among other tasks, the creation, and details of the SFP. Detailed below are considerations for TEP content crucial to the development of the SFP.
 - **Selection Criteria:** A TEP should provide input on what characteristics define a poorly performing hospice and how those characteristics should be measured.

Experts should also aid in designing the selection process.

- **Emphasis During SFP Enrollment:** The TEP should consider the role of surveyors while the hospice is enrolled in the SFP, including a technical assistance focus prior to imposing enforcement remedies. Surveyors should be aware of the goals for enrollment and the approach that should be used before and during the survey process.
- **Exit from SFP:** Stakeholders should provide input on the processes and criteria for graduation or termination, including identifying the appropriate amount of time hospices should be expected to improve to be eligible for graduation.
- **Care Compare:** For a hospice that has entered the SFP, consideration should be given to the information listed on Care Compare about the hospice. Graphics and details about the SFP should be carefully developed and discussed with stakeholders for concurrence to convey information accurately and without undue alarm.
- We also urge CMS to convene a TEP that includes trade association and provider representation. CMS and the SFP would benefit immensely from consistent input from hospice workers who are on the frontlines of care. Additionally, the TEP should include representatives from both large and small hospices, as well as hospices representing different parts of the country, to be inclusive of different viewpoints and consider how policies may affect hospices of different sizes.

NHPCO Recommendations:

- NHPCO strongly supports the use of a TEP to focus on enhancing the SFP while providing assistance in other ways to increase transparency and consumer understanding of hospice performance.
- We recommend the following topics for a TEP's consideration: SFP selection criteria, emphasis during SFP enrollment, exit processes and criteria, and reflection of the SFP on Care Compare (see above comments).
- We urge CMS to include representation national stakeholder organizations as well as hospices and frontline workers (see above comments).

III. Enforcement Remedies for Hospice Programs with Deficiencies

NHPCO has been and continues to be a champion for accountability and transparency within the hospice community. We have long supported additional oversight of the hospice program, including via appropriate compliance and quality resources, as well as through the availability of education and professional development.

While an array of enforcement remedies – ranging in scope and severity – are a key part of the hospice compliance and quality assurance process, they are largely ineffective without underlying reforms to the survey process, as outlined in the preceding section of our comments. Absent increased surveyor training and competency, enforcement will continue to vary from state to state or between SAs and AOs. This includes variation in the imposition of sanctions – including CMPs and suspension of payments – remedies that carry significant implications, including potentially on patients’ access to care, if haphazardly or inconsistently applied.

For these reasons, NHPCO firmly believes that clear and consistent guidelines for the imposition of these remedies is crucial. As detailed more fully below, NHPCO recommends a “step-wise” or graduated application of the enforcement remedies, beginning with front-end, targeted education remedies (e.g., directed POC and directed in-service education) to more stringent remedies levied for more severe deficiencies (e.g., CMPs and suspension of payments). Regarding suspension of all or part of payments, NHPCO urges CMS to clarify the application of this remedy and to specify its limited, or targeted, imposition to new admissions only, consistent with other post-acute care providers, and only for deficiencies posing immediate jeopardy (IJ).

Finally, we note that the survey process, in general, is only one tool to identifying poor-performing or deficient hospices. We encourage CMS to consider a broader set of data and supplementary information (e.g., Program for Evaluating Payment Patterns Electronic Report (PEPPER)) to foster greater hospice accountability and performance.

A. General Provisions (§ 488.1210)

NHPCO’s comments on specific enforcement provisions are encapsulated in the respective sections that follow.

B. Factors to be Considered in Selecting Remedies (§ 488.1215)

CMS delineates the proposed criteria by which it intends to consider imposing one or more remedies on deficient or non-compliant hospices, including:

- The extent to which the deficiencies pose immediate jeopardy to patient health and safety.
- The nature, incidence, manner, degree, and duration of the deficiencies or noncompliance.

- The presence of repeat deficiencies, the hospice program’s overall compliance history and any history of repeat deficiencies at either the parent hospice program or any of its multiple locations.
- The extent to which the deficiencies are directly related to a failure to provide quality patient care.
- The extent to which the hospice program is part of a larger organization with performance problems.
- An indication of any system-wide failure to provide quality care.

NHPCO Comments:

- NHPCO appreciates the broad criteria by which CMS proposes to impose one or more specified enforcement remedies. We continue to believe that oversight, when done correctly, has the potential to enhance accountability and compliance among hospices.
- However, program integrity ought not to be applied in such a way that it imposes excessive administrative burden on hospices, especially for those hospice providers following the rules. Further – and more importantly – new federal program integrity requirements must in no way inhibit access to high quality care for patients nearing the end of life and their families, even if an unintended outcome of their application.
- Further, the intent of these remedies should be more clearly considered and conveyed to make the connection between remedies and improved quality of care; how patients benefit from the proposed approach; and how patient access will be maintained especially amid a growing workforce shortage.
- Consistent surveyor training and competency is foundational to ensuring that beneficiaries ultimately have access to high-quality hospice care. NHPCO continues to maintain that reduced variability in enforcement will ultimately help to ensure an even playing field for hospices, and more consistent quality of care for the patients and families they serve. Thus, enhanced surveyor training and competency testing are **crucial prerequisites** to the application of these remedies and should be prioritized accordingly.
- NHPCO welcomes the opportunity to work with CMS to provide further clarity regarding this framework to ensure that enforcement is conducted in a transparent, uniform manner.

NHPCO Recommendations:

- NHPCO recommends that CMS thoughtfully outline a standardized, stepwise, or graduated approach or framework to the imposition of specified enforcement remedies based on the scope and severity of the deficiencies. Doing so would be consistent with the incremental

imposition of remedies based on the degree of severity of the deficiency (i.e., “incrementally more severe fines for repeated or uncorrected deficiencies”) codified in statute.¹²

Our proposed recommendation for hospice is also consistent with the decision matrix or graduated selection criteria codified in SNF regulations at (§488.408) that stipulate the explicit criteria CMS and the state must follow in the selection of available remedies. For SNFs, this includes imposing escalated remedies “according to how serious the noncompliance is” – i.e., Category 1 (directed POC, state monitoring, and directed in-service training); Category 2 (denial of payment for new admissions; denial of payment for all individuals imposed only by CMS; and CMPs); and Category 3 (temporary management; immediate termination; and CMPs).¹³ A similar framework exists for home health whereby sanctions are applied based on the “seriousness of the deficiencies,” including whether the deficiencies pose IJ to patient safety.¹⁴

Following CMS’ promulgation of final rulemaking, further CMS guidance to states and hospice providers elucidating and operationalizing these criteria, analogous to the front-end educational measures CMS undertook for SNF and home health providers, is critical to ensure complete understanding and compliance by states and hospice providers.

- Specifically, NHPCO recommends that intermediate remedies be applied in the following order, based on the scope and severity of the deficiencies. The following framework emphasizes front-end education and correction *prior* to the imposition of sanctions and significant penalties.
 1. Directed POC
 2. Directed in-service education
 3. Temporary management
 4. CMPs
 5. Suspension of all or part of payments
- With this framework in mind, NHPCO supports the suspension of payments only in cases involving deficiencies posing IJ. However, for the reasons detailed more fully below, suspension of payments ought to be applied as a “last resort.”

¹² Sec. 1822(c)(5)(A)(ii)

¹³ See also corresponding SOM updates at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07pdf.pdf>

¹⁴ See section 10010.6, Chapter 7 of SOM, available at: <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107c10.pdf>

C. Action when Deficiencies Pose Immediate Jeopardy (§ 488.1225) and Termination (§ 489.53)

To address hospice deficiencies that pose an IJ, CMS outlines a process that generally aligns with home health requirements.

NHPCO Comments:

- NHPCO provider members report inconsistencies in surveyor notification of deficiencies, noting for example that while some hospices may be afforded an opportunity to correct a deficiency during the survey or as part of the exit conference at the end of the survey, others are not.

NHPCO Recommendations:

- As noted above, NHPCO supports the suspension of payments only for new admissions and only in cases involving deficiencies posing IJ. However, suspension of payments ought to be applied as a “last resort” – i.e., not without having first implemented front-end remedies, such as a directed POC, directed in-service education or other program integrity compliance tools.
- To ensure consistency in enforcement, NHPCO recommends that CMS refer to underlying sub-regulatory guidance regarding the definition of IJ and the core guidelines by which to determine IJ as specified in Appendix Q of the SOM.¹⁵

D. Action when Deficiencies are at the Condition-level but Do Not Pose Immediate Jeopardy (§ 488.1230)

CMS outlines a process by which it proposes to impose remedies over a 6-month period in lieu of terminating a hospice program’s participation in the Medicare program.

NHPCO Recommendations:

- It is precisely in these instances where front-end instructive remedies could be helpful to “course correct” or improve a hospice program’s performance, such as a directed POC and directed in-service education. NHPCO advocates for the application of these targeted front-end educational and corrective remedies, as opposed to sanctions (rightfully) applied to more egregious or repeated deficiencies compromising patient safety.
- Further, NHPCO recommends that CMS continue Medicare payments to hospices with CLDs meeting criteria set forth at § 488.1260. This would include the continuation of Medicare

¹⁵ CMS, *State Operations Manual Appendix Q – Core Guidelines for Determining Immediate Jeopardy* (Rev. 187, Issued: 03-06-19), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf

payments in cases when a resurvey has yet to be conducted at no fault of the hospice program's (e.g., surveyor fails to present at resurvey during 6-month window or survey backlog prevents surveyor from meeting 6-month window deadline).

E. Temporary Management (§ 488.1235)

CMS proposes the circumstances under which it would utilize its authority to place a hospice program under temporary management. As such, CMS delineates proposed application requirements and procedures regarding the imposition of this remedy.

NHPCO Comments:

- NHPCO appreciates that the proposed temporary management requirements generally align with those of other providers, such as home health providers (§ 488.835), including that the substitute manager be under the direction of the hospice program's governing body.
- Some of our provider members have requested that the qualifications of a temporary manager, outlined in the broader rule – i.e., “be appointed based on qualifications described in § 418.100 and § 418.114” – be specifically referenced in the proposed regulatory language § 488.1235 or further clarified in forthcoming sub-regulatory guidance. It is also unclear in the proposed rule how a temporary manager would be chosen, and which entity (federal or state) would be responsible for their selection.
- Further, our members recommend that the temporary manager be qualified to “oversee correction of deficiencies on the basis of experience and education, as determined by the State,” consistent with SNF regulations (§ 488.415(b)(1)). Inclusion of this language would ensure that the temporary manager has an appropriate background and expertise in hospice compliance to fulfill their duties, whether the individual is selected from within or outside the organization.

F. Suspension of Payment for All or Part of the Payments (§ 488.1240)

CMS proposes provisions describing when and how it would apply a suspension of payment of all or part of the payments. If a hospice program has a CLD(s) – regardless of whether an IJ exists – CMS may suspend all or part of the payments to which a hospice program would otherwise be entitled for items and services furnished by a hospice program on or after the effective date of the enforcement remedy.

NHPCO Comments:

NHPCO is deeply concerned about the imposition of this remedy, including the process and frequency by which it could be employed. While NHPCO wholeheartedly endorses measures

that will enhance beneficiaries access to high-quality hospice care, we remain strongly opposed to measures – including this remedy if implemented without critical checks – that will undoubtedly inhibit access to care.

Absent clearer guidance, this remedy could have immediate, deleterious effects on hospice programs and patients nearing the end of life and their families. This is especially true for many of our smaller, rural, not-for-profit hospice provider members that lack the financial resources to sustain the gravitas of this remedy, especially if it is levied to its fullest (i.e., suspension of *all* Medicare payments). As such, a remedy intended to foster hospice compliance essentially becomes ineffective and, arguably, a detrimental barrier to patient access. With suspension of Medicare payments, many hospices would be forced to close within days or weeks, with nothing left to “correct.” Patients and their families would be forced to forego critical end-of-life care absent seamless transfer to a nearby qualifying provider – an “option” that is not always available (e.g., in geographic areas where there is a sole community provider).

In comparison to other post-acute care providers, the proposed hospice regulations differ in important ways. While the proposed hospice regulations align with those for home health in many respects (§ 488.840), there are clear differences in that suspension of payment for home health applies only to “all new admissions”, whereas the proposed hospice payment suspension could apply to “all or part of the payments to which a hospice program would otherwise be entitled.” Compared to SNF regulations (§ 488.417), denial of payment for new admissions is optional for a period, but following 3 months, denial of payment is mandatory. The SNF regulations also distinguish between cases where there are or are not repeated instances of substandard quality of care. In addition, there is an option to deny all payments (not just for new admissions).

The difference in the proposed hospice regulations, when compared to other post-acute care providers, is striking, especially considering the unique benefit provided by hospice providers along with differences in their overall composition. Hospice provides patients and their loved ones with comfort, peace, and dignity during life’s most intimate and vulnerable experiences. Since over half of all Medicare decedents receive their care via the Medicare hospice benefit (hence, Medicare is the predominant payer of hospice), hospice providers are highly sensitive to fluctuations in Medicare reimbursement. This stands in contrast to SNFs, for example, the vast majority of which are part of a nursing facility where Medicare is a minority payer.¹⁶ Further, hospice providers tend to be smaller and have a much lower average daily census (ADC) when compared to SNF providers,¹⁷ compounding the potential financial impact of this remedy.

¹⁶ http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_ch7_sec.pdf

¹⁷ https://www.nhpco.org/hospice-facts-figures/http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_ch7_sec.pdf

- If CMS were to broadly impose suspension of “all or part of the payments to which a hospice program would otherwise be entitled,” it would be overly punitive and inconsistent with Congressional intent, which calls on CMS to “implement these statutory changes in a manner consistent with the programs that already exist in other Medicare settings of care” such as home health and SNFs.
- Specifically, pursuant to H. Rept. 116-660, 18 Congress calls on CMS to promulgate oversight and enforcement tools in a manner that “ensure[s] greater parity across Medicare’s post-acute and end-of-life settings of care.” From p. 8 of the report:

Given the OIG’s reports of patient safety concerns across many hospices in the Medicare hospice program and the lack of intermediary oversight and enforcement tools at the Secretary’s disposal, the Committee believes it is necessary to improve hospice quality and ensure greater parity across Medicare’s post-acute and end-of-life settings of care. More specifically, the provisions in H.R. 5821 require the Secretary to implement a number of changes to the hospice program to align it with both the SNF and home health settings and improve the quality of care delivered to Medicare beneficiaries receiving hospice services. Thus, the Committee anticipates CMS will implement these statutory changes in a manner consistent with the programs that already exist in other Medicare settings of care.¹⁹

- NHPCO provider members seek clarification on the following relative to the implementation of this provision:
 - Does the imposition of the payment suspension, all or in part, impact hospice aggregate cap limits? If so, how, and will there be a cap credit applied?
 - Is it possible for a hospice provider to retroactively recover payment under specified circumstances (e.g., correcting deficiencies by a specified date or following a successful appeal)?
 - As discussed above, what remedies would be employed *prior* to the imposition of the suspension of payments? Will this be outlined in regulation or sub-regulatory guidance?

NHPCO Recommendations: For the reasons outlined above, NHPCO respectfully requests that CMS:

¹⁸ <https://www.congress.gov/116/crpt/hrpt660/CRPT-116hrpt660.pdf>

¹⁹ Ibid.

- Codify in regulation that the suspension of payments applies only to new admissions, consistent with home health requirements.
- Impose this remedy only in response to significant deficiencies posing IJ, and only after consideration of the impact on access to care. Codify in regulations that this enforcement remedy is to be used only in the case of immediate jeopardy. Otherwise, this remedy could be unilaterally applied and significantly impede patient access.
- Work with NHPCO and other stakeholders to clarify, via sub-regulatory or other guidance, the frequency and application of this remedy. Specifically, NHPCO recommends that this remedy be imposed in the “step-wise” or tiered application as outlined above.
- Stipulate an accelerated timeframe by which the State or other entity must render a decision regarding the hospice program’s compliance with the conditions of participation (CoPs) to resume prospective payments to the hospice program.
- Institute patient guardrails to protect against unintended consequences of this enforcement remedy, particularly in the event of a hospice closure resulting from this provision. For example, CMS could stipulate that, to the extent a hospice patient is displaced due to a hospice provider closure, the admitting hospice provider refers the patient to another Medicare-certified hospice provider within a specified proximity or service area. However, there are some parts of the country where this isn’t feasible, ranging from states with a Certificate of Need law that limits the number of hospices in one geographic area, to rural areas where a hospice may be the sole community hospice provider for many hundreds of square miles. These safety-net guardrails are crucial, but may be difficult to implement, especially considering the ongoing COVID-19 Public Health Emergency (PHE) period and persistent health workforce shortages.

G. CMPs (§ 488.1245)

CMS proposes to impose a CMP against a hospice program deemed noncompliant with one or more CoPs, regardless of whether the hospice program’s deficiencies pose IJ to patient health and safety. CMS proposes both “per day” and “per instance” CMPs. Penalties range from \$1,000 to \$10,000 per instance (not to exceed \$10,000 for each day of noncompliance). CMS uses a three-tiered framework for the application of CMPs based on the level of seriousness – “upper range,” “middle range,” and “lower range.”

In determining the amount of the CMP, CMS has discretion to consider certain factors, including the size of the hospice program and its resources; and whether the hospice program has a built-in, self-regulating quality assessment and performance improvement (QAPI) system.

NHPCO Comments:

There is no informal dispute resolution (IDR) process identified for hospices in the proposed rule, as there is available to home health providers (§488.745) and SNFs (§488.331). NHPCO believes that there are significant benefits to hospice providers and to the appeals process in general if an IDR process were outlined specifically for hospice providers.

NHPCO Recommendations:

NHPCO appreciates the general consistency of the proposed hospice CMP regulations with CMP requirements under the home health program at § 488.845. However, when compared to the SNF setting in which the imposition of CMPs are also authorized, SNFs are afforded far greater opportunities for an IDR process (see § 488.431). NHPCO recommends that hospices be provided with an analogous opportunity to participate in an IDR process – one that, like the SNF IDR process – is bifurcated from the formal appeals process to which hospices should also have access.

- NHPCO supports CMS’ proposed criteria by which to determine the amount of the CMP, including factors that account for the size of the hospice program and its resources. We encourage CMS to finalize a proposal that differentiates the CMP based on the hospice size and resources, providing some relief for small hospices. Toward that end, NHPCO furthermore recommends that CMS provide a standardized, transparency process regarding the calculation of CMPs.
- Regarding the proposed CMPs for hospices, it is notable that the range of CMPs for SNFs (at § 488.38) differs significantly for those of hospice and home health providers. Several members inquired as to CMS’ rationale for that discrepancy (i.e., considerably lesser CMP amounts for SNFs v. hospice or home health), especially considering that the average hospice is roughly half the size of a SNF (in terms of ADC)²⁰ and has a much higher proportion of Medicare patients, with over half of all hospice descendants covered by Medicare.²¹ NHPCO recommends that the CMPs be graduated to reflect the unique services and resources of hospices compared to SNFs.
- Further, the CMP regulations at § 488.33 for SNFs are much more extensive than the proposed hospice regulations with respect to the uses and approval of CMPs imposed by CMS, including stipulations regarding the collection of CMPs to be held in escrow. Feedback

²⁰ Hospice ADC: <https://www.nhpc.org/factsfigures/>; SNF ADC: http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_ch7_sec.pdf

²¹ Hospice: Over 51% Medicare hospice descendants (see: <http://medpac.gov/docs/default-source/meeting-materials/asc-esrd-hospice-update-medpac-jan-2021.pdf?sfvrsn=0>); and SNF: 4% Medicare FFS beneficiaries (Medicare only comprises 16% of a SNF’s revenue) (see: <http://medpac.gov/docs/default-source/meeting-materials/snf-hh-irf-ltch-update-medpac-jan-2021.pdf?sfvrsn=0>; and http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_ch7_sec.pdf)

from our members suggests that any hospice CMP funds retained in escrow go back in the form of services or supports to hospice patients and their families or to hospices directly.

- The statute at new section 1822(c)(5)(C) of the CAA of 2021 regarding CMPs authorizes “retention of amounts for hospice program improvements” but we see no reference to this statutory provision in the proposed rule. Consistent with the aforementioned SNF regulations, NHPCO calls on CMS to leverage its administrative authority, pursuant to the statute, to retain these funds “to support activities that benefit individuals receiving hospice care, including education and training programs to ensure hospice program compliance with the requirements of section 1861(dd).”

H. Directed Plan of Correction (§ 488.1250)

CMS proposes to include a directed POC as an available remedy to encourage hospice programs’ correction of deficient practices. As proposed, a directed POC can be developed by CMS or by the temporary manager, with CMS approval. Should the hospice program fail to achieve compliance within the timeframes specified in the directed POC, CMS could impose one or more additional enforcement remedies prior to the hospice program achieving compliance or being terminated from the Medicare program.

NHPCO Comments:

NHPCO hospice provider members questioned whether there would be any transparency into the directed POC process (e.g., will these reports ultimately be publicly reported?).

NHPCO Recommendations:

- NHPCO agrees with CMS that a directed POC has the potential to be an effective tool in the hospice setting and is pleased to see the inclusion of this front-end corrective remedy included in the array of options available to CMS. NHPCO encourages CMS to finalize its proposal to include a directed POC as an available remedy developed by CMS or by the temporary manager, with CMS approval.
- NHPCO recommends that the directed POC process include follow-up reports to CMS or another designated authoritative entity (e.g., State, Regional Office/Location) and/or a re-survey to ensure continued progress and compliance with the directed POC. Continuation of payments to the hospice program could then follow consistent with § 488.1260.
- NHPCO members recommend that directed POCs delineate between and among deficiencies, especially regarding the scope and severity of such deficiencies. For example, if directed POCs are made public, NHPCO calls on CMS to convey this information in such a way that distinguishes or differentiates minor or inadvertent deficiencies committed by the vast

majority of lawfully abiding hospices from those deficiencies (e.g., those posing IJ) that are indisputably egregious and rightfully cited.

I. Directed In-Service Training (§ 488.1255)

CMS proposes requirements for conducting directed in-service training for hospice programs with CLDs. Hospice programs would be required to participate in programs developed by well-established education and training services, including, but not limited to, schools of medicine or nursing, area health education centers, and centers for aging. CMS notes that it will recommend but not require a hospice program to utilize a specific program.

NHPCO Recommendations:

- NHPCO supports the provision of this remedy and its general alignment with the home health and SNF regulations on directed in-service training. We support finalization of this proposal.
- As previously indicated, directed in-service training, along with a directed POC, are valuable front-end education and improvement tools for hospices – tools that ultimately enhance the provision of care to patients and their families. NHPCO encourages these tools be leveraged at the outset of the enforcement process *prior* to the imposition of more onerous penalties and suspension of payments.

J. Continuation of Payments to a Hospice Program with Deficiencies (§ 488.1260)

CMS proposes to continue Medicare payments to hospice programs not in compliance with specified requirements over a 6-month period provided certain criteria are met.

NHPCO Recommendation:

- NHPCO recommends CMS modify the proposed regulatory text at § 488.1260(a) by replacing “may” with “will.” Doing so ensures the continuity of these payments to hospices with CLDs meeting specified criteria and appears to be consistent with the intent conveyed by CMS in the supplementary regulatory text (on p. 35979).

K. Termination of a Provider Agreement (§ 488.1265)

CMS outlines the proposed parameters by which it would address the termination of a hospice program’s Medicare provider agreement, as well as the effect of such termination.

NHPCO has no comments.

In closing, thank you for your consideration of NHPCO's comments on this proposed rule. We welcome continued engagement with you and your staff and the opportunity to meet to discuss our recommendations. If you have questions or to schedule a meeting, your staff should feel free to contact Judi Lund Person, Vice President, Regulatory and Compliance at jlundperson@nhpco.org.

Sincerely,

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

Edo Banach, JD
President and CEO