

FY 2024 Hospice Wage Index and Quality Reporting Proposed Rule NHPCO Recommendations at a Glance

1. 2.8% Proposed Hospice Payment Update

- a.** NHPCO requests a one-time retrospective adjustment, using CMS' special exception and adjustment authority to revise the Hospice Wage Index and Quality Reporting final rule.
- b.** We request a 3.7% adjustment for the combined FY 2021 and FY 2022 market baskets to ensure Medicare payments more accurately reflect the cost of providing hospice care.
- c.** We request consideration for this FY 2024 Hospice Wage Index rule, but if it is not possible, we further recommend this special exception and adjustment request be included in the upcoming CY 2024 Home Health proposed rule, where we also expect the hospice regulations related to the Hospice Special Focus Program to be published.

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

a. Blood transfusions, chemotherapy, radiation, and dialysis

- Separate payment for expensive treatments and medications.
- Allow transitional concurrent care, allowing hospice patients to continue disease-modifying treatments for some period of time while also receiving hospice services.
- Consider cost threshold options and allow outlier or add-on payments for these treatments.

b. Barriers to higher intensity levels of hospice care

• Continuous Home Care:

- Allow CHC to be provided over two calendar days with some hours provided on the first day and the remaining hours to be provided on the second.
- Change the 24 hour period to a rolling 24 hour period, eliminating the midnight to midnight requirement.
- Reduce the number of hours required to qualify for CHC. Four hours, for example, could accommodate those patients whose symptoms worsen in the evening.
- Consider adding social workers and chaplains to the list of disciplines considered for CHC.

• General Inpatient Care:

- NHPCO recommends CMS review the various messages, reviews, and audits hospices receive from CMS and auditing entities about GIP to ensure messages are clear and not contradictory.
- NHPCO recommends CMS consider requiring all hospitals be required to contract with their community hospice providers so when a patient does need an inpatient level of care they do not have to be discharged from hospice with the 'out of service area' reason so the hospital can admit them and bill acute hospital regular rates.

- Review audit goals and auditor education and knowledge about hospice to ensure GIP audits are accurate and reviews are based on a knowledge of the GIP level of care and its requirements.
- Provide hospitals and nursing facilities with information on hospice requirements for contracting, including eligibility for the level of care, staffing requirements, MDS involvement, and mortality statistics.
- CMS, or its contractors, should publish specific and accessible guidance about the hospital mortality metric specifically for hospitals and hospices.

c. Growth in non-hospice spending

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

d. Use of the addendum

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

e. Information provided to the patient and family

- NHPCO recommends CMS work with the hospice community to develop simple patient and caregiver friendly resources about hospice care, relatedness, and hospice benefits for the patient and family.
- CMS should recommend hospices share information on all four levels of care in their admission handbook or paperwork, including reasons a hospice may recommend a change in the level of care for a patient during the course of care.
- NHPCO does **not** recommend information about staffing levels, or the frequency of staff encounters be shared online or at the start of care.

f. Ownership information

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

3. Health Equity Under the Hospice Benefit

a. Resources and programs

- NHPCO recommends any policy or program addressing health equity considers current support, infrastructure, and funding, which varies greatly by provider.
- NHPCO recommends CMS collect and share information as well as provide additional resources and funding opportunities for providers to increase professional development opportunities for hospice staff to improve their cultural competency, increase their knowledge best practices collecting culturally inclusive data, recognizing biases, and expanding their skills for working with diverse communities.

b. Data collection

- NHPCO recommends the development of a universal database accessible across government and will enable programs to accurately assess the extent of the disparities and barriers existing today and to measure progress made by the government in promoting health equity over time.
- NHPCO requests CMS collect more data on the cultural and ethnic reasons a patient and their family may choose or not choose hospice.
- CMS should collect and share data on social determinants of health (SDOH) to help decrease risk factors leading to negative health outcomes and address barriers to access of hospice care.
- NHPCO recommends more health equity data be collected so hospices can identify service trends and better understand methods garnering the largest positive effects on health equity. In order to evaluate progress in health equity in hospice, the CAHPS® survey could be used, but must include enough detail and nuance to ensure inclusivity of different identities (e.g., gender identity, multiracial and ethnicity options, socioeconomic status, etc.) and strategies to address SDOH.
- NHPCO recommends CMS pay special attention to needed health equity data and how it could be collected by the hospice EMR software, providing a list of possible data points needed to EMR vendors.

4. **Telehealth Services**

- a. NHPCO requests CMS issue additional guidance for clarity on the use of technology in routine home care provided after the end of the COVID-19 PHE.
- b. NHPCO strongly recommends CMS adopt codes to better track the usage of telehealth technologies in providing hospice care. CMS should develop and implement Healthcare Common Procedure Coding System (HCPCS) codes or modifiers for visits using telehealth technologies and add them to the hospice claim form.
- c. NHPCO again requests CMS add HCPCS codes for hospice chaplains.

5. **Hospice Quality Reporting Program**

- a. NHPCO recommends CMS provide at least one year of lead time prior to the implementation of the HOPE instrument.
- b. NHPCO recommends implementation of future quality measures related to timely symptom assessment take into account hospice provider capability to perform reassessments both in-person and telephonically, and patient and family preferences for reassessment modality be considered.
- c. NHPCO recommends implementation of the web based CAHPS® survey as soon as possible, as providers are anticipating this very necessary improvement.

6. **Hospice Physician Medicare Enrollment**

- a. NHPCO strongly supports **ALL CMS** efforts to address fraudulent behavior by all providers as highlighted in the 34 recommendations submitted to CMS Administrator Chiquita Brooks-LaSure in January 2023.
- b. NHPCO supports the proposal to require hospice physicians who certify hospice services for Medicare beneficiaries to be enrolled in or validly opted-out of Medicare as a prerequisite for payment of hospice services.
- c. NHPCO does **not** support the inclusion of attending physicians in the PECOS hospice enrollment requirement.
- d. If this proposal is included in the final rule, NHPCO requests CMS and the Part A and B Medicare Administrative Contractors provide education to physicians and hospices about the enrollment requirements, process, list of services, and taxonomy codes.
- e. NHPCO recommends a one year delay in the implementation of this proposal, if finalized, so hospice physicians who are not currently enrolled have the time necessary to complete the process.

The FY 2024 Hospice Wage Index and Quality Reporting proposed rule is published in the [Federal Register](#). Comments were due on May 30, 2023, and the final rule will be published by August 1, 2023 for implementation on October 1, 2023. For additional information on these recommendations, review the [FY2024 comment letter](#).