



May 24, 2023

Chiquita Brooks-LaSure  
Administrator  
Center for Medicare and Medicaid Services  
Department of Health and Human Services  
200 Independence Ave, SW  
Washington, DC 20201

Subject: (CMS-1787-P) Fiscal Year (FY) 2024 Hospice Payment Rate Update Proposed Rule

Submitted Electronically via: <http://www.regulations.gov>

Dear Administrator Brooks-LaSure,

Trinity Health at Home (THAH), a National Health Ministry of Trinity Health, is a faith-based organization that provides Hospice Care to patients in six states; our average daily census exceeds four hundred patients. We appreciate the opportunity to comment on CMS-1787-P, the FY 2024, Hospice Payment Rate Update Proposed Rule. Our comments and recommendations reflect a strong interest in public policies that support better health, better care, and lower costs to ensure affordable, high quality, and people-centered care for all.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 123,000 colleagues and more than 26,000 physicians and clinicians caring for diverse communities across 26 states. Nationally recognized for care and experience, the Trinity Health system includes 88 hospitals, 135 continuing care locations, **including 7 hospices in 6 states**, the second largest PACE provider in the country, 136 urgent care locations and many other health and well-being services. Trinity Health has 15 medical groups with 1,324 primary care providers and 4,193 specialty care providers. Based in Livonia, Michigan, its annual operating revenue is \$21.5 billion with \$1.4 billion returned to its communities in the form of charity care and other community benefit programs.

**Payment Update – 2.8%:** THAH supports an increase to the Medicare Hospice payment rate. However, the proposed 2.8% is woefully inadequate. Hospice providers across the country, including THAH, have experienced insufficient reimbursement to cover the increasing costs related to staffing and mileage. The proposed increase does not come close to adequately meeting the inflationary increases experienced by hospice agencies. Inflationary increase includes a projected 4.2% surge in staffing costs for salaries and benefits, and 12.9% in mileage costs. Our Fiscal Year to Date numbers show an alarming statistic: our expenses have increased 5.3%, while our revenue has increased *less than 2%*.

This inadequate payment update will likely disproportionately impact areas with less dense population or rural areas as it will take a much higher hospice census to reach a margin. Providers such as THAH who remain in low-density, low-volume territories to serve underserved populations, will suffer greater losses.

**THAH is requesting that CMS adjust the percentage update to account for real-time expenses experienced by Hospice providers.**

**Physician Enrollment/Valid Opt-Out in Provider Enrollment, Chain, and Ownership System (PECOS):** THAH supports the proposed rule requiring Hospice Physicians either be enrolled in, or validly opted out of, Medicare through PECOS. THAH already requires this. A unique aspect of the Medicare hospice benefit is the patient's right to designate an attending physician. This right may be compromised if the designated attending physician is not enrolled/validly opted out. Patients should not have to sever relationships with physicians who have been actively involved in their care in order to elect hospice care.



Therefore, **THAH recommends that CMS exclude hospice patient attending physicians from this requirement.**

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

**Are there any enrollment policies for hospices that may be perceived as restrictive to those beneficiaries that may require higher cost end of life palliative care, such as blood transfusions, chemotherapy, radiation, or dialysis?**

THAH believes that any clinical decision, whether viewed as curative or palliative in nature, should always be made on a case-by-case basis. Defining a one-size fits all clinical guardrail that would require the Hospice agency to provide very specific services should be highly scrutinized. Part of the election process is education of patients and families on the difference between treatments used for curative or life-sustaining purposes and Palliative care. Once a decision is made in conjunction with the patient, family, physician and IDT, treatment is ordered based on those wishes. The hospice provider also provides information about the process and when ceasing treatment would be appropriate. Blurring the lines between curative, palliative, and hospice care would make the election process more difficult and the agency's ability to fully educate the patient and family on the treatment options complicated.

**Are there any enrollment policies for hospices that may be perceived as restrictive to those beneficiaries that may require higher intensity levels of hospice care?**

While higher intensity levels of hospice care are needed at times, family, caregivers, and the patient themselves usually prefer not to be taken from the home and placed in either a hospital or skilled nursing setting. The process can be disruptive and the fear of the patient not dying at home is a concern. Continuous Home Care (CHC), although a more desirable option, has become increasingly difficult to accommodate due to staffing challenges. The need for CHC is difficult to anticipate. Having sufficient staff employed and fully productive during times of low need for CHC is financially straining and administratively challenging. Employing staff on an "as needed" basis only is proving more difficult in this workforce shortage.

General Inpatient Care (GIP) requires contracting with a skilled nursing facility (SNF) and issues do often arise in admitting patients when bed capacity is limited. In circumstances where hospices have contracts but are unable to place patients, it often results in patients needing to revoke the benefit and enter the hospital in order to secure care to stabilize their conditions.

Inpatient Respite Care (IRC) depends on a contract with a skilled nursing facility. As staffing challenges have wreaked havoc on all areas of health care especially nursing homes, nursing homes often cannot accommodate a request for IRC. That, along with patients' desire to not enter a facility, makes IRC a level of care not often utilized. THAH believes that CMS should review the IRC benefit and consider creating greater flexibilities around the delivery of respite so that it better serves the needs and desires of both the patient and the family. CMS should be increasingly mindful of staffing challenges, including the hospice agency's ability to recruit volunteers post pandemic and the impact that will have on respite care in the home.

THAH believes that any recommendations or regulatory changes proposed by CMS must recognize that the United States has a severe nursing shortage that is unlikely to improve anytime soon. This shortage will continue to contribute to the hospice agency's ability to deliver care, whether in the home or in a higher-level setting.

**What continued education efforts do hospices take to understand the distinction between curative treatment and complex palliative treatment for services such as chemotherapy, radiation, dialysis, and blood transfusions as it relates to beneficiary eligibility under the hospice benefit? How is that information shared with patients at the time of election and throughout hospice service?**

THAH provides ongoing education to our staff. We employ Education Leaders who design and deliver educational opportunities that maintain hospice competencies for all staff.

As patients are admitted under the hospice benefit, they and their family/caregiver are given information that explains eligibility of certain treatments under hospice. However, this is a time of great stress, so quite often, repeating this information is necessary.

**Although the previously referenced analysis did not identify the cause for lower utilization of complex palliative treatments and/or higher intensity levels of hospice care, do the costs incurred with providing these services correlate to financial risks associated with enrolling such hospice patients?**

High-cost, outlier patients often require securing difficult contracts and ensuring that clinical treatment tracks are consistent with palliative care standards. This is often a challenge. Inpatient facilities may not be comfortable approving less than curative treatments to maintain the palliative dosage and often prices for these services are not negotiable. This puts the hospice in a financially risky situation.

THAH has found that the reimbursement we receive for patients on service with longer lengths of stay (20%), subsidizes the financial losses we experience with patients who have short stays, with acute exacerbation of symptoms that do require higher levels of care or who need palliative treatments to address symptom management (80%).

Many of the treatments now in use were not available when hospice was first covered by Medicare, and current rates simply do not take the cost of those treatments into consideration. In essence, the introduction of these treatments represents “scope creep” under the hospice benefit, so actual costs of care are increasing and there is currently no risk-adjustment, outlier, or other mechanism to address these costs. As medical care advances, we expect the introduction of more treatment options and therefore, higher costs associated with end-of-life care.

**What are the overall barriers to providing higher intensity levels of hospice care and/or complex palliative treatments for eligible Medicare beneficiaries (for example, are there issues related to established formal partnerships with general inpatient/inpatient respite care facilities)? What steps, if any, can hospice providers or CMS take to address these barriers?**

All the barriers discussed above apply here. Difficulty with securing contracts, admitting patients when the need arises, staffing challenges at inpatient facilities, and palliative care treatment models versus curative.

CMS should address these barriers by providing hospice providers with risk adjusted payment models that address the cost of higher-level care. CMS should also engage stakeholders to address an outlier policy for hospice care that would address the disparity in reimbursement and the ability to care for the population that requires treatment for exacerbation of symptoms in a higher-level of care.

**What are reasons why non-hospice spending is growing for beneficiaries who elect hospice? What are ways to ensure that hospice is appropriately covering services under the benefit?**

Non-hospice spending is historically a problem. The solution will involve not just the hospice provider, but a strong effort by CMS, and other provider types, to provide education on and recognize the role of the hospice provider. Other provider types need sufficient knowledge about the hospice benefit and how



services they provide may interact or conflict with the intended outcome. Yet, providers are not required to seek information about the patient election of hospice care, and even if they did, CMS systems to determine enrollment in hospice is not timely. Absent an overhaul of CMS systems and enhanced non-hospice provider education, this will continue to be a problem.

**What additional information should CMS or the hospice be required to provide the family/patient about what is and is not covered under the hospice benefit and how should that information be communicated?**

Enrollment into hospice is often a highly emotional and challenging time. Patients and families are often on information overload and more information would not alleviate the difficulty of this choice. We do not believe that requiring disclosure of additional information would be beneficial.

However, as stated previously, THAH does believe that CMS needs to better educate other providers on the hospice benefit, eligibility requirements, and the role and responsibility they have.

**Are patients requesting the Patient Notification of Hospice Non-Covered Items, Services, and Drugs? Should this information be provided to all prospective patients at the time of hospice election or as part of the care plan?**

For THAH, this request varies broadly across our footprint. But as stated previously, we do not believe a mandatory provision for this should be necessary.

**Should information about hospice staffing levels, frequency of hospice staff encounters, or utilization of higher LOC be provided to help patients and their caregivers make informed decisions about hospice selection? Through what mechanisms?**

THAH does not use a one-size-fits-all modality when determining frequency of staff encounters. This determination is and should always be made on a case-by-case basis to ensure that each patients' individual needs are met. Our Interdisciplinary Teams (IDT) across our footprint are comprised of diligent professionals who make decisions of this nature daily. Therefore, hospice staffing levels vary depending on the census make-up and the needs of individual patients.

Designation of levels of care on the Care Compare website is very minimal and can be misleading information for patients and their family. One way to alleviate some confusion would be to include a section on, "Good Questions to Ask the Hospice Provider." Most patients and family members do not know what to ask and something like this would give them a good place to start the conversation.

**The analysis included in this proposed rule shows increased overall non-hospice spending for Part D drugs for beneficiaries under a hospice election. What are tools to ensure that hospice is appropriately covering prescription drugs related to terminal illnesses and related conditions, besides prior authorization, and the hospice election statement addendum?**

Hospices tend to cover drugs differently. At THAH, our Part D invoices are minimal because we cover medications that some other agencies do not. THAH recommends that when CMS is analyzing drug spending, it should factor out medications that are ordered at the very beginning or the end of a hospice election as it is probable those medications were not ordered by the hospice but by a non-hospice physician prior to election of enrollment or even in preparation for discharge from hospice.



**Given some of the differences between for-profit and not-for-profit utilization and spending patterns highlighted in this proposed rule, how can CMS improve transparency around ownership trends? For example, what and how should CMS publicly provide information around hospice ownership? Would this information be helpful for beneficiaries seeking to select a hospice for end-of-life care?**

As a not-for-profit, faith-based hospice provider, we support the CMS provision to improve transparency around ownership, including publicly providing that information. THAH believes this is part of making an informed decision regarding hospice enrollment.

## **QUALITY**

**CMS intends to develop several quality measures based on information collected by HOPE when it is implemented. Currently, CMS intends to develop at least two HOPE-based process and outcome quality measures: (1) Timely Reassessment of Pain Impact; and (2) Timely Reassessment of Non-Pain Symptom Impact.**

THAH passionately believes that CMS should continue to seek provider input prior to implementing additional quality measures.

THAH encourages CMS to consider Remote Patient Monitoring (RPM) as one way to provide timely reassessment of Pain Impact and Non-Pain Symptom Impact. RPM is a best practice and allows for timely, two-way communication for patients in the home. However, RPM is not reimbursed by Medicare as an add-on. CMS should reimburse hospice providers who use RPM for quality, safety, and satisfaction as an add-on to the Medicare hospice benefit.

### **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey:**

THAH encourages CMS to implement a web-based version of the CAHPS Hospice survey. Our experience with mail-only surveys is a 4 to 5% return rate. The CAHPS Hospice Survey Mode Experiment in 2021 resulted in a response rate of 39.1 percent for the web-based surveys, this is thirteen percentage points more than the mail-only mode. An increase in response rate could result in an increase in the number of hospices having a CAHPS Hospice Survey star rating publicly reported on Care Compare. CMS should make this a priority.

### **Health Equity RFI:**

THAH, as a faith-based organization, is committed to diversity, equity, and inclusion within our Ministries. Advancing health equity is a shared goal and we recognize policy change to improve data collection, create new access points, and innovate payment models are needed. The Trinity Health Mission and Core Values compel us to advocate for change to the systemic policies that limit and shape opportunities for minority and underserved populations. We have undertaken systemwide efforts led by our senior leadership to examine our role as a health system in advancing equity in every community we serve. As part of this effort, we have developed a set of principles to guide our journey to health equity. The Core Values of reverence, commitment to those who are poor, safety, justice, stewardship, and integrity guide this work to improve the health of all communities and dismantle barriers to inequities in health care. We support CMS and the efforts to reach all communities needing Hospice Care. THAH is committed to care for all members of the communities we serve. We ask that CMS provide flexibility, adequate reimbursement, and support to the Hospice community as it expands efforts to address gaps in care. Additionally, CMS must consider challenges created by the workforce shortage crisis when establishing standards for diverse hiring practices.

### **What efforts do hospices employ to measure impact on health equity?**

As part of hospice practice, social determinants of health (SDoH) and their impact are part of the psychosocial assessment. This is part of the entire comprehensive assessment to create care plans to address unmet needs. THAH recognizes the importance of this effort and as part of Trinity Health, has designated colleagues to assist us in expanding our practice of Diversity, Equity, and Inclusion (DEI) and how it impacts health equity.

### **What factors do hospices observe that influence beneficiaries in electing and accessing hospice care?**

Primary factors observed are cultural and ethnic beliefs and practices as well as pragmatic issues such as timely admission, reputation of the hospice, and insurance coverage. Another significant factor is the barrier of having to make the decision not to utilize any curative treatments. This is often viewed as surrendering to the illness or giving up. Some beneficiaries are not given the option of choosing hospice care or made aware of choice of hospice agencies. Hospice care continues to have lower utilization of services by minorities and those who have limited resources for seeking healthcare.

### **What geographical area indices, beyond urban/rural, can CMS use to assess disparities in hospice?**

There are many ways in which CMS could assess the disparities as morbidity and mortality profiles are impacted by numerous factors. Below are some of the most frequently mentioned indices when discussing this specific question with hospices.

- Population size by county
- Income
- Social mobility
- Number of healthcare providers
- Areas with the highest proportion of individuals aged 65 and above.

### **What information can CMS collect and share to help hospices serve vulnerable and underserved populations and address barriers to access?**

CMS should share the most significant barriers to hospice care it has found based on its research of available data and suggestions for actions hospices can take to help break down these barriers. Also, sharing information to help hospices understand why these barriers exist will help them develop targeted actions at the local level. It would also be helpful to know what CMS is doing nationally to address the reasons for the disparities.

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

- Age, financial status, living environment, number in the household, support system
- Gender identity (not just male/female)
- Capture more detailed information such as region of national origin
- Socio-economic status – income and education and insurance availability
- Specific programs that may be in use (homeless care, LGBTQ care)
- CMS is reminded that hospices have long gathered information on social determinants of health such as socioeconomic status, housing, food security, access to interpreter services, caregiving



status, and marital status as part of the psychosocial component of the hospice comprehensive assessment. THAH believes it is best practice to collect this information when caring for individuals in the home environment.

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

- Patient/family reluctance to share data. This often seems related to both distrust and shame.
- Language, literacy, and embarrassment
- EMR limitations. Require standardization and fuller descriptions.
- The cost of collecting data, especially if there is a change in software required, is often a barrier. EMR systems may not be well suited to collect accurate information on gender, sexual orientation, race/ethnicity identities. For example, most ask participants to choose “one” option out of several races and ethnicities, which overlooks those of mixed races and ethnicities. Gender is also still binary, disregarding patients who may identify as non-binary.
- Race does not seem to be a problem for patients to self-identify. Ethnicity is a problem for patients to identify due to lack of knowledge or willingness to share.

**Telehealth:**

THAH urges CMS to collect data on technology-based visits on claims. As stated above, we implore CMS to consider Remote Patient Monitoring as a best practice and reimburse hospice providers as an add-on to the Medicare claim.

**Conclusion**

Trinity Health at Home appreciates the opportunity to submit our comments on the proposed Hospice rule. If you have any questions, please feel free to contact me at [donnaw@trinity-health.org](mailto:donnaw@trinity-health.org) or 251-504-7353.

Sincerely,

/s/

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