C+TAC
COALITION TO TRANSFORM ADVANCED CARE

May 28, 2024

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

Re: FY 2025 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements

Submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure,

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule regarding its effect on those living with serious illness.

C-TAC is a national non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC comprises more than 200 national and regional organizations, including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

C-TAC defines serious illness as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life, or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF).

Serious illness is also a health equity issue. A history of disenfranchisement has led to healthcare gaps across the country. Per a 2021 Commonwealth report on racial and ethnic health equity, communities of color live fewer years, on average, than white people do, are more

likely to die from treatable conditions, and are also at higher risk for many chronic health conditions. For serious illness, the lack of access to health insurance and primary care mean many are diagnosed only at a late or end stage of illness, when disease-modifying treatment is typically no longer effective. Those from historically under-resourced communities who also have serious illness experience poorer care and access, making improving their care a health equity opportunity.

Here are our comments on the pertinent parts of this proposed rule:

Proposed Clarifying Regulation Text Changes
We support the proposed text changes with the following recommendations:

- Medical Director Condition of Participation- That the word "designee" be added after physician in this section. Thus, the revised text would read: The hospice must designate a physician to serve as medical director. The medical director must be a Doctor of Medicine or osteopathy who is an employee or is under contract with the hospice. When the medical director is not available, a physician *designee,* designated by the hospice, assumes the same responsibilities and obligations as the medical director.

- Certification of Terminal Illness **–** Our concern here is that the hospice medical director may be unavailable due to other responsibilities. People considering hospice often need immediate assessment to determine eligibility and treatments for uncontrolled symptoms. Therefore, any hospice physician member of the interdisciplinary team should be able to certify terminal illness, not just the physician designee.

- Admission to hospice care- Related to the above, we recommend similar changes be made to this section:
    - The hospice admits a patient only on the recommendation of the medical director (or the physician designee, as defined in § 418.3) *or the physician member of the IDG*, in consultation with, or with input from, the patient's attending physician (if any).
    - In reaching a decision to certify that the patient is terminally ill, the hospice medical director (or the physician designee, as defined in § 418.3) *or the physician member of the IDG* must consider at least the following information:

Request for Information (RFI) on Payment Mechanism for High Intensity Palliative Care Services
We appreciate the opportunity to provide input on this important issue.

First, we must point out the misleading alignment of the terms "comfort care" and "palliative care" on page 48:

Hospice care changes the focus of a patient's illness to comfort care (palliative care) for pain relief and symptom management from a curative type of care.

While it is true that hospice incorporates palliative care principles and practices it is first and best described as 'end-of-life' care in that it is solely directed at optimizing the comfort and quality of an individual's daily experiences during the last period of life. Palliative care as a medical specialty now encompasses care well before that end-of-life period and is focused on symptom management, communication, education, and support associated with a serious illness and concurrent with other treatment. So, using the umbrella term "palliative care" in this context is inaccurate as not all palliative care is hospice or comfort care. Further, CMCS' recent approval of Hawaii's Medicaid State Plan Amendment describes palliative care as a "preventive" service which would allow people to get it throughout a serious illness to prevent crises and suffering. Additionally, the term comfort care is a vague one used in a range of situations and not a confirmed medical term. Its alignment with palliative care here suggests that palliative care is only for comfort/end of life. This contributes to patient and clinician misconceptions about palliative care and keeps people from accessing these important services. Therefore, please revise the text in the final rule to avoid the use of "comfort care" and not align it with "palliative care."

Continuing this discussion, the use of the term "palliative "for treatments in this RFI is also problematic. The historic language about curative vs palliative has always been erroneous as chronic conditions, such as heart failure or diabetes, were never curable. And so, any treatment for them is technically palliative in that it helps optimize function and quality of life but doesn't cure the underlying illness. This increasingly also applies to some cancers where treatments such as hormone therapy or immunotherapy can add meaningful months or even years to peoples' lives, making caner a chronic illness for some as well. Therefore, perhaps calling palliative treatments "disease-modifying" treatments instead would be more accurate. And given that many hospice patients could benefit from such disease-modifying treatments, whether related to their terminal illness or not, hospice policy needs to help pay for those that help symptom management and quality of life. The Medicare Care Choices Model showed that allowing such concurrent treatment improved hospice enrollment and length of stay and heath equity while saving money via reduced utilization.

In that light, here are our responses to this RFI's questions:

• *What could eliminate the financial risk commenters previously noted when providing complex palliative treatments and higher intensity levels of hospice care?*

At present, hospices are hesitant to offer such disease-modifying treatments for fear of audits or the financial resources needed to provide them, even though those treatments may meet the goal of improving the patient's comfort or their health.

Options to allow hospices to feel more comfortable offering such disease-modifying treatments include:

1. Clarifying with new hospice enrollees upfront what such treatments will be covered and included in the hospice plan of care and expanding those options. Although there is a process in place to do so already, we hear that patients and hospices are still confused.
2. Having the Hospice Medical Director or nurse case manager coordinate any such additional disease-modifying treatment with the outside specialist(s) involved.
3. Providing payments to the clinician or entity delivering these disease-modifying treatments in collaboration with the hospice. This is a more complex change that requires CMS to better identify data that is available to model such additional payment to the hospice provider.
4. Acknowledging that the coordination between hospice teams and specialists is challenging, which argues for better EMR coordination and interoperability so all parties know what additional treatment is being provided.
5. Recognizing that additional payment for high-cost disease-modifying treatments could allow bad actors to take advantage of them. This would require tight monitoring to flag and reduce that.

Should there be any parameters around when palliative treatments should qualify for a different type of payment? For example, CMS is interested in understanding from hospices who do provide these types of palliative treatments whether the patient is generally in a higher level of care (CHC, GIP) when the decision is made to furnish a higher-cost palliative treatment? Should an additional payment only be applicable when the patient is in RHC?

The paraments for such disease-modifying treatments should be determined based on their ability to improve the person's quality of life. That should be done via care plans made with the patient, their family, and the hospice team. Payment for these services should not be adjusted by hospice setting as they could legitimately occur in both home and inpatient hospice care.

Under the hospice benefit, palliative care is defined as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering (§ 418.3). In addition to this definition of palliative care, should CMS consider defining palliative services, specifically regarding high-cost treatments?

We do not recommend that CMS define disease-modifying services as this is a dynamic area and treatments need to be determined on an individual patient basis. We instead suggest that it be the judgment of the hospice team to determine when a particular disease-modifying treatment is appropriate with approval of the Hospice Medical Director and confirmed in the hospice plan of care.

Should there be separate payments for different types of higher-cost palliative treatments or one standard payment for any higher-cost treatment that would exceed the per-diem rate?

We agree that payment is the key issue here. There needs to be additional payment for the high-cost disease-modifying treatments. However, with such disease-modifying treatments as part of the hospice care plan, hospices could use existing CPT or HCPCS codes for them. Any

payment differences between a care plan with such treatments and the more usual hospice per diem payment should reflect the reimbursement differences currently existing for those services. Separate payments would be necessary to adequately account for cost variation among higher intensity services unless CMS intends to create a case-mix adjustment.

Proposals to the Hospice Quality Reporting Program (HQRP)
We support the addition of the two process measures to the HQRP calculated from data collected from HOPE: *Timely Reassessment of Pain Impact* and *Timely Reassessment of Non-Pain Symptom Impact*. Pain and other challenging symptoms are key factors in quality of life for hospice patients and families and timely reassessment will help ensure those issues are addressed promptly. However, we do feel that allowing such reassessment to be done, when appropriate, by telehealth would allow hospice staff to best manage their limited clinical time. A phone call as follow up may be adequate to ensure the patient's pain or other symptom are being managed.

Request for Information (RFI) Social Determinants of Health (SDOH) Items
We support the proposed four domains of housing instability, food insecurity, utility challenges, and transportation challenges as these are all important areas that affect health and quality of life. We agree that these items are relevant for hospice patients and for hospice caregivers and that all are suitable for hospice. We have suggested adding assessing for family caregiver burden on previous regulatory comments and, while this is technically already the case with hospice care, it would be helpful to consider adding this as an additional SDOH domain here.

Our other suggestion is that it may perhaps make more sense to assess for overall financial challenges and include an economic stability domain rather these individual ones, since that underlies all of these domains. People have housing, food, utility and transportation issues because they lack adequate financial resources. Assessing financial insecurity must be sensitively done and the hospice team is the right group to figure who and how to do that assessment. Once assessed, any needs also need to be addressed with referrals to appropriate and available services and a mechanism in place to confirm that these services were actually delivered. Referring people to service waiting lists is not the goal but instead to refer them to the actual services themselves.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact Marian Grant, Senior Regulatory Advisor, C-TAC, at mgrant@thectac.org.

Sincerely,

Marian Grant

Marian Grant, DNP, ACNP-BC, ACHPN, FPCN, FAAN, RN
Senior Regulatory Advisor
Coalition to Transform Advanced Care (C-TAC)