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The Honorable Michael C. Burgess, M.D.
U.S. Committee on the Budget
U.S. House of Representatives
204 Cannon House Office Building
Washington, D.C. 20515

RE: Request for Information: Solutions to Improve Outcomes and Reduce Federal Health Care Spending in the Budget

Dear Chairman Michael C. Burgess and Members of the Committee:

The National Hospice and Palliative Care Organization (NHPCO) appreciates the opportunity to submit comments on the *RFI: Solutions to Improve Outcomes and Reduce Federal Health Care Spending in the Budget*.

NHPCO is the nation's largest membership organization for hospice 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 thousands of professionals and volunteers.

Palliative and hospice care are models of care which both describe and deliver person-centered care planning. Hospice and palliative care are philosophies of care addressing the whole person, not just physical aspects of health or illness. Both types of care employ an interdisciplinary approach to care with assessments of multiple domains of the human experience (physical, psychological, spiritual, cultural, practical).

Hospice and palliative care engage the patient and their loved ones in the care planning process to address pain and symptoms negatively impact a person's quality of life. In creating care plans, providers lead thoughtful goals of care conversations to ensure the care delivered matches patient's stated goals, wishes, and values. Through robust care coordination with all members of a patient and family's care team, both models of care strive to minimize burdensome transitions across and between settings of care. Hospice and palliative care respect a patient as being in charge of their care as well as the significant role families and caregivers play in supporting and maintaining health. Too often the burden of serious illness results in patients falling into dependent roles, but, with support, patients can maintain as much independence as they wish. In addition, those around the patient receive support to help offset the strain of having a loved one with a serious illness.

Regulatory, statutory, or implementation barriers that could be addressed to reduce health care spending

1. Audit and Survey Burdens on Hospices

We appreciate CMS' efforts to address hospice program integrity concerns (which we expand upon later in our comments) and reduce improper spending under the Medicare program. However, repeated audits of hospice providers, often many different types at the same time, have imposed extraordinary burdens on hospice operations, finances, and staff. These audits are conducted by many different entities, such as Medicare Administrative Contractors (MACs), Recovery Audit Contractors, Comprehensive Error Rate Testing Contractors, Unified Program Integrity Contractors, Supplemental Medical Review Contractors, and the Office of Inspector General.

Many of these audits require a considerable amount of time and resources to respond to additional documentation requests (ADRs) – resources many hospices, particularly in rural and underserved communities, can ill afford to spare. Responding to ADR requests requires, for many organizations, devoted full-time staff, who otherwise could have been utilized for patient care. Our nation is experiencing an unprecedented workforce crisis in our health system, and in the midst of efforts to both attract and retain a skilled and robust workforce, hospices struggle to manage onerous audits and appeals.

Further, we understand many hospice claim denials are overturned on appeal, which calls into question the efficacy of auditor medical reviews, actual savings for the Medicare program, and an overzealous focus on certain areas of the hospice benefit, such as General Inpatient (GIP) level of care and long lengths of stay. We are concerned an overwhelming focus in these two areas will result in a [chilling effect on beneficiary access](#) to medically appropriate hospice services due to fears of payment denials. We have united with other national associations to provide [recommendations](#) to CMS to ensure audit review activities are conducted appropriately and effectively to reduce improper spending and Medicare fraud, while protecting beneficiary access to hospice care.

2. Support Hospices Implement Interoperability for Electronic Medical Records (EMR)

To begin hospice care, a beneficiary must sign [an election statement](#), agreeing to “waive (give up) the right to Medicare payments for items, services, and drugs related to my terminal illness and related conditions. This means that while this election is in force, Medicare will make payments for care related to [their] terminal illness and related conditions only to the designated hospice and attending physician that [the beneficiary has] elected.” However, hospices and MACs do not have the technology or ability to notify other providers a beneficiary has elected hospice and, therefore, should not be accessing other items, services, or drugs. This non-hospice spending should be covered under the current hospice daily payment. Hospices have not been included in the movement for interoperability in the

healthcare system which has created a situation where there is duplicative or unnecessary Medicare billing.

The challenges in addressing non-hospice spending start with a Medicare claims processing systems problem.

- No flags are available in the system to prohibit a provider or physician office from filing *and getting paid* for an office visit or treatment when the patient has elected hospice or notify the hospice provider. NHPCO has recommended some type of flags for hospice enrollment in the claims processing system since meeting with Centers for Medicare & Medicaid Services (CMS) senior staff on May 20, 2015, where flags in the system were suggested, as well as education for physicians and other non-hospice providers. Little action has occurred since this time.
- The hospice has no way of knowing, in real time or close to real time, the spending has occurred. Because hospice and other post-acute care providers are not included in the agency's interoperability focus, other providers have no way of knowing the patient's hospice election and the hospice has no way of knowing a visit, treatment, admission, or service has been provided. The inclusion of hospice and other post-acute care provider EMR software considered for interoperability may help with both billing provider knowledge and hospice tracking in the future.

In the [FY 2024 Hospice Wage Index and Payment Rate proposed rule](#), CMS shared that \$882,965,833 worth of non-hospice payments were made during days of hospice stays between FY 2019 and 2022. In FY 2022, most of these claims come from physician billing (\$471,598,388), outpatient services (\$150,063,938), and inpatient services (\$144,970,909). Hospice is expected to cover virtually all services related to the terminal illness and hospice work extensively to educate beneficiaries, caregivers, and other providers on this expectation. However, hospices are only made aware of this non-hospice spending after the fact. When hospices attempt to educate other providers on the requirement to work with the hospice for these services, they are dismissed or ignored. One provider has shared when they were attempting to educate and partner with a non-hospice facility on spending outside the benefit, the facility told them they knew how to bill Medicare and ignored the hospice's guidance. Hospice providers are committed to reigning in these payments that should be included in the daily hospice rate; however, hospices are being held accountable for this spending when hospices have no control over other providers and do not have all the tools from CMS to hold those providers accountable for the excessive spending.

Checking hospice enrollment: It is clear that information about the hospice election is not being checked during a hospital admission process, before a non-hospice office visit, or treatment by a physician is provided. The information may or may not be available in the HIPAA Eligibility Transaction System (HETS), or an admissions department or physician may not be aware of a difference in billing is required for patients receiving hospice care.

Billers knowledge of hospice billing requirements: The vast majority of providers and medical practices are not aware of any difference in how claims are submitted when they are treating a hospice patient or the use of the GV or GW modifiers or condition codes. When hospices have attempted to provide additional information and education to physician offices, they have been told “we know how to bill Medicare and don’t need any help from hospice.”

Conflicting regulations: Providers report nursing home regulations require the nursing home physician, nurse practitioner, or medical director to provide a regular visit every 30-60 days after admission. NHPCO encourages CMS to check the HCPCS codes for physician (and NPP) visits to determine which visits are provided in the nursing home setting. Because the visits are required under nursing home regulations, typically the hospice provides additional visits by various disciplines and services under the daily rate for patients in nursing homes.

Ambulance codes (A0425 and A0428): The non-urgent ambulance transport is included in the top 20 HCPCS codes. NHPCO recommends continuing education for both hospice and ground ambulance providers on the financial responsibility for ambulance services after the hospice election. If there is a way to flag hospice patients in an ambulance claim so the claim is not paid before the hospice is consulted, it would be helpful.

Codes related to the terminal illness and related conditions: Hospice clinicians review HCPCS codes for every patient individually, as it is not possible to determine whether a certain procedure is related to the terminal illness for the patient. It is impossible to determine unilaterally whether a code is related or not related.

NHPCO strongly recommends additional financial support to hospice providers to implement interoperability as well as improvement to the Medicare claims process to allow flags in the systems for non-hospice providers to be notified a beneficiary has elected hospice.

Efforts to promote and incorporate innovation into programs like Medicare to reduce health care spending and improve patient outcomes

1. Telehealth

Throughout the COVID-19 Public Health Emergency (PHE), hospice and palliative care providers had access to telehealth for the routine home care (RHC) level of care. Telehealth can be beneficial in accessing patients and communities who have limited access to transportation and allow check in with patients. Through telehealth, providers can share appointment links with long distances family members so they can, with the patient’s consent, be included in care planning and decision making. This simple and tested innovation can provide additional flexibility for hospices and ensure providers are able to access more patients, more consistently at lower cost.

Temporary flexibility allowed for the use of telehealth for face-to-face visits prior to recertification for the hospice benefit was also allowed through the CARES Act. This

flexibility has since been extended, including through the Consolidated Appropriations Act, 2023, through CY 2024. Telehealth is appropriate for these low-touch, administrative visits, and increases provider efficiency by reducing drive time for overworked physicians and nurse practitioners. We encourage this flexibility to be made permanent.

2. *Increase Use of Nurse Practitioners and Physician Assistants*

Nurse practitioners (NP) and physician assistants (PA) are essential providers; however as the Medicare Hospice Benefit currently stands, these providers are unable to work at the top of their license. For example, NPs and PAs are unable to complete the certification of terminal illness (CTI) and PAs are unable to complete the face-to-face visit. By allowing these providers to fully utilize their clinical knowledge and skill to support hospice medical directors, hospice organizations will be able to relieve some of the workforce issues they face while also improving patient access.

Comments on CBO’s modeling capabilities on health care policies, including limitations or improvements to such analyses and processes

1. *Calculating Overpayment for Long Lengths of Stay*

Currently, when calculating the impact of hospice overpayments at the national levels, analysts, such as CBO and MedPAC, will review long lengths of stay and deem the entire stay as improper. This results in the payment for every day of the election period to be calculated as an overpayment which incorrectly over estimates improper hospice payments. The clinical assessment for a six month prognosis is not exact and many factors can impact a beneficiaries actual length of stay, such as impeccable care from their loved ones or an unexplained turn to better health. For these patients, the care they received when they were initially certified for hospice care was not improper and, therefore, these calculations should not use the entire length of stay to calculate improper payment.

Hospice payments are unique as the hospice receives a daily rate based on the level of care provided on any given day. This payment model allows to account for the pain and symptom management and coordination of services required of the hospice interdisciplinary team (IDT). This payment model is different than other Medicare payments which can identify a specific day or incident of improper payment. This is additionally concerning since [studies have shown](#) hospice care is beneficial to both beneficiaries and taxpayers, saving Medicare \$3.5 billion in 2019 alone.

NHPCO recommends CBO and others adjust their modeling of hospice over of improper payments to conduct a more exact analysis of only when specific payments become improper rather than deeming the entire hospice election period to be improper.

Examples of evidence-based, cost-effective preventive health measures or interventions that can reduce long term health costs

1. Hospice Benefit

[New national research](#) shows hospice provides significant cost savings to the Medicare system, including when the length of stay is greater than 266 days. Specifically, the research found the total costs of care for Medicare beneficiaries who used hospice in 2019 was 3.1% lower than those who did not use hospice, and earlier enrollment in hospice and longer lengths of stay likely reduce overall Medicare spending. The report calculates this reduction in spending translates to an estimated \$3.5 billion less in Medicare outlays for beneficiaries in their last year of life. Hospice continues to not only be a patient-centered Medicare benefit but a benefit to the Medicare trust fund. Increased support for hospice is a benefit to Medicare beneficiaries and their families.

In addition, legislation such as the *Palliative Care and Hospice Education and Training Act* (PCHETA) ([S. 2243](#)) are crucial to provide much needed funds to expand the pipeline of doctors, nurses, social workers, and chaplains into the hospice and palliative care fields. PCHETA will give providers the support needed to serve an ever growing patient population.

2. Community-Based Palliative Care

Palliative care is the premier strategy to provide comprehensive, longitudinal, person-centered care planning to improve the care of people living with serious illness. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitates patient autonomy, access to information, and choice. Although there are growing numbers of providers and organizations providing palliative care in the hospital and in community-based settings, it is still not accessible or understood by enough patients and providers. There continues to be pervasive misconceptions of what palliative care is and does. Confusion continues to exist regarding what palliative care is – and is not – at many levels. In particular, palliative care continues to be mistakenly associated with hospice care only and considered a benefit only for persons who are terminally ill. Palliative care is both a medical specialty as well as an approach to care. Palliative care should be a benefit available to any patient living with a serious illness, or with a terminal illness, with supportive care available to the patient and their caregivers. The benefits of palliative care help the patient, families, and the medical system by helping to reduce unwanted or unnecessary expenditures when care is delivered based on patients’ and families’ established goals.

Congress should support palliative care by building upon the CMS Innovation Center’s [Medicare Care Choices Model \(MCCM\)](#) which improved quality and produced cost savings when testing concurrent care in hospice by developing a [Community-Based Palliative Care \(CBPC\) demonstration](#). A [CMS review of the original MCCM](#) found a 25% decrease in Medicare expenditures while 96% of caregivers would recommend the program. This program would provide essential interdisciplinary care to people with serious illness in their home. There is significant evidence to support the need for a CMS supported CBPC effort to

improved quality and cost outcomes for beneficiaries experiencing serious illness. A [2021 NORC study](#) found a next generation MCCM model would result in \$472 Million net Medicare savings. This is especially important for patients with higher risk comorbidities, such as heart disease or diabetes. We urge support for [S. 1845, *Expanding Access to Palliative Care Act*](#).

Recommendations to reduce improper payments in federal health care programs

1. Program Integrity

NHPCO is a committed partner in addressing improper payments and program integrity concerns in the Medicare Hospice Benefit to ensure the longevity of the Medicare fund. We have united with other national associations to [recommend steps to address](#) these concerns and continue to work with CMS to support the delivery of the highest quality, highest value care and ensuring hospice providers deliver person-centered, interdisciplinary care. We are glad to see CMS take steps to implement 17 of our 34 recommendations. Lawmakers, regulators, and hospice organizations must be intolerant of deceptive hospice care not living up to the standards of high-quality care patients and families deserve. Comprehensive hospice compliance is essential to the future of the Medicare Hospice Benefit and we urge this committee to support CMS in their efforts to address fraudulent providers to ensure bad actors are not taking advantage of federal healthcare programs.

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 comments. If you have questions or want to schedule a meeting, your staff should feel free to contact me at lhoover@nhpco.org.

Sincerely,

/s/

Logan Hoover
Vice President, Policy and Government Relations