



COALITION MEMBERS

March 2, 2021

American Academy of Hospice
and Palliative Medicine
(AAHPM)

Association of
Professional Chaplains
(APC)

The Catholic Health Association
of the United States
(CHA)

Center to Advance
Palliative Care
(CAPC)

HealthCare
Chaplaincy Network™
(HCCN)

Hospice and Palliative
Nurses Association
(HPNA)

National Association for Home
Care & Hospice
(NAHC)

National Hospice and
Palliative Care Organization
(NHPCO)

National Palliative
Care Research Center
(NPCRC)

Palliative Care Quality
Collaborative
(PCQC)

Physician Assistants in Hospice
and Palliative Medicine
(PAHPM)

Social Work Hospice &
Palliative Care Network
(SWHPN)

Society of Pain & Palliative
Care Pharmacists
(SPPCP)

Captain Thomas Pryor, MS, BSN, RN
Nurse Consultant & Hospice Lead
Quality Safety & Oversight Group
Division of Continuing and Acute Care Provider
Centers for Medicare & Medicaid Services (CMS)
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Baltimore, Maryland 21244

Dear Captain Pryor,

On behalf of the National Coalition for Hospice and Palliative Care, we welcome the opportunity to provide comments and recommendations from our Coalition [Members](#) to the Centers for Medicare & Medicaid Services (CMS) on the approach to the implementation of the hospice provisions in the recently enacted [Consolidated Appropriations Act \(CAA\)](#). To inform our comments, we drew on the hospice expertise represented within the 13 professional organizations that comprise our Coalition. We are pleased to offer the feedback below on behalf of our Coalition.

Our Coalition is dedicated to advancing the equitable access, delivery and quality of hospice and palliative care to all those who need it. The national organizations that form the Coalition represent more than 5,500 hospice programs and their related personnel, 5,200 physicians, 1,000 physician assistants, 11,000 nurses, 5,000 chaplains, 8,000 social workers, researchers, and pharmacists, along with over 1,800 palliative care programs caring for millions of patients and families each year across the United States. As such, we bring a broad, multidisciplinary perspective on hospice care and the changes this legislation will have on the vulnerable population we serve – patients and families nearing the end of life. These changes have the potential to dramatically impact the delivery of vital hospice services across the nation and ensure an improved understanding of CMS' expectations for hospice compliance with important health and safety standards for patients, family members, hospice agencies and surveyors. With these goals in mind, we strongly recommend that CMS initiate a Technical Expert Panel (TEP) to address the wide variety of changes that may be needed to maximize the benefits that accrue through implementation of the legislation.

I. Public Reporting, Transparency, and Meaningful Use

The CAA requires that CMS publish, no later than October 1, 2022, the information from the CMS Form-2567 in a way that is readily understandable

and provide for the timely update of such information, among other stipulations. The current QCor website has some of the survey information available, but its accuracy is wholly dependent upon the timeframe in which it is uploaded by the survey entity. We have found that there are significant lapses in times from the date of survey until the results are posted in QCor and some instances where they are not ever posted. It is also not clear from QCor that the only information from accrediting organization surveys of hospices is for complaint surveys. Further, QCor requires the user to request data and reports using variables that are not commonly known to consumers, i.e., what an accrediting organization is, the tag numbers for deficiencies, etc. Therefore, we presume that the QCor site would not be utilized for the display of survey information required in the Consolidated Appropriations Act. It is imperative that information displayed be *meaningful* to consumers to be of value. The recommendations below reflect that focus and are based on the assumption that there will be a link from the Care Compare site to hospice survey results, similar to what is used for nursing homes currently in the “Health Inspections” section.

- **Public Reporting:** To be meaningful, survey information reported on Care Compare should include contextual data and information to assist viewers. Such information should include:
 - A basic summary of the framework of the survey process and Conditions of Participation against which hospices are surveyed. This could include information on the frequency of surveys, types of surveys, the survey entity, as well as the total number of conditions and standards against which a hospice is surveyed.
 - Designation/identification of a condition level deficiency with an Immediate Jeopardy citation, possibly identified with a simple “IJ”. The date the “IJ” was abated should also be posted.
 - Provide a link to the “Top 10 Survey Deficiencies” cited nationally from the most recent year available/the year of the most recent hospice survey.

- **Consumer Friendly Language:** Survey information reported on Care Compare should indicate the type of survey being reported; initial certification, recertification, or complaint survey. In addition, the statement that the hospice is required to submit a plan of correction for each deficiency should also be provided on Care Compare. If CMS would like to identify whether a deficiency is standard level or condition level, it is important that all these terms be explained in “plain English language” that patients, families and caregivers understand. The average American is considered to have a readability level equivalent to a 7th/8th grader (12 to 14 years old).¹ This level has been recommended by experts for use in all public health communications. Most patients, families and caregivers searching for hospice information are most interested in whether the deficiency was related to patient care or was a “paperwork” violation. The terminology used now is meaningless to the average consumer. Therefore, we believe it is most helpful to identify the condition of participation under which a deficiency falls rather than whether it is standard or condition level.

- **Survey Information:** Provide a link from the hospice provider Care Compare site information to a “Survey Details” site that provides additional survey details, beginning with a simple list of the Conditions of Participation for which the agency received a deficiency.

¹ <https://www.literacyprojectfoundation.org/>

- Consider a metric on the Care Compare site related to survey results. This could be a comparison rating of the number of survey deficiencies for a hospice compared to the national average and/or state average.
- To provide “next level” transparency to those consumers who are interested, provide a “Review Survey Report” link on the “Survey Details” site so that interested consumers may review the CMS Form 2567. It is imperative that this report include the hospice’s plan of correction. What a consumer currently can see in the drill down to the survey report from the nursing home Care Compare postings is a description of the deficiency only, without indication of if or how the situation was resolved. This leaves consumers with questions that could be addressed by providing the information that closes the loop on the deficiency.
- **Patient Confidentiality:** CMS should work with stakeholders to help identify a process where meaningful survey information is posted that does not include the potential for identifying the patient. We have heard concerns about patient privacy related to posted survey results. It is understood that no PHI is included on the current Form 2567 nor would any such information be publicly posted. However, a description of the survey findings as currently found on many Form 2567 documents includes identifiers such as Patient #1, Staff A, etc. This type of information could be identifying information. This is especially a concern in smaller communities. The Coalition recommends CMS take all of the necessary precautions to protect patient confidentiality.

II. Survey Consistency, Survey Teams, Conflicts of Interest, and Surveyor Training

The Act requires that each state and HHS shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors and that, no later than 10/2021, HHS shall provide for comprehensive training for state, Federal, and Accrediting Organizations (AO) surveyors, including training related to the review of written plans of care. Additionally, the Act specifies that no one may serve as a member of a survey team unless they have completed a training and testing program approved by HHS. State surveyors may not survey programs by which they have been employed/acted as consultant in the previous two years (or in which the surveyor has personal or familial financial interest), beginning in 10/2021. Surveys conducted on or after 10/1/2021 by more than one person must be conducted by a multidisciplinary team (including RN). The Coalition provides the following recommendations in these areas:

- **Surveys as Learning Opportunities:** The Coalition has heard from its members that providers not only experience inconsistency amongst surveyors of state agencies, but also inconsistency in interpretation and application of the conditions of participation and interpretive guidelines between state agencies, CMS Location offices, states and accrediting organizations, and amongst accrediting organizations. The Coalition cannot emphasize enough that surveys are learning opportunities. As such, we strongly urge CMS to revisit the reporting structure and process that state agencies, CMS Location offices, and accrediting organizations utilize to submit questions about the survey process and the interpretation and application of the interpretive guidelines.

- **Survey Consistency:** It is understood that CMS views the survey process as one that holds hospices accountable and ensures quality care. As stated earlier, it is also a learning opportunity for hospices. The process of conducting the survey is different between state agencies and accrediting organizations. For hospices to understand what is expected from the conditions of participation and to deliver care in accordance with these conditions, it is important for the hospices to be surveyed *consistently*. This includes consistent interpretation and application of the interpretive guidelines in the survey process itself and in the citation of deficiencies. CMS Location offices and CMS Headquarters must provide consistent guidance to surveyors. There must be consistency in direction provided to state survey agencies, accrediting organizations and CMS Location offices. CMS should work with surveyors, AOs, CMS Location office staff, CMS Headquarters staff and providers in the development of a program that ensures consistency across **all** these domains.

Furthermore, the survey entities must be held accountable for utilizing the proper processes, interpretation and application of the conditions of participation and interpretive guidelines. The “Look Behind” process is one that CMS utilizes with hospices and other provider types, but it fails for hospices because SA and AO surveyors do not follow the exact same processes and do not have the same interpretations of conditions of participation and interpretive guidelines. This may be a result of different reporting structures and communication and training processes within CMS. We urge CMS to standardize this process.

- **Surveyor Education and Training:** The Coalition recommends that appropriations and resources be dedicated to creating standardized surveyor education and training materials. Education should go beyond distribution of “State Operations Manual Appendix M – Guidance to Surveyors” and should include topics-based classroom (virtual or in-person) training as well as recorded on-demand learning modules. CMS should develop a competency assessment program for surveyors that includes a competency assessment test for each module. As part of this assessment, surveyors should be provided with education on any questions missed/not answered correctly. Training modules should include practical scenarios taken from actual surveys and should be regularly updated.
 - Annual surveyor evaluation should include metrics such as the average number of deficiencies per survey, to identify potential outliers for purposes of providing additional education and training as needed.
 - In addition to annual surveyor evaluation, there should be annual evaluation of survey entities (both SA and AO that includes metrics that would identify outliers).
 - Surveyors should be trained and demonstrate competency specific to service line-type. For example, a Home Health surveyor should not be permitted to survey Hospice providers without completing the hospice specific training/education and demonstrating competency via a competency test. Surveyors should be required to complete a hospice survey at least once every year to maintain competency.
 - A condition of hire for surveyors should be experience working in the hospice field for a minimum of two years, to include direct patient care. Surveyors, whether through the SA or an AO, should not be able to survey an organization for which that surveyor has been an employee

or consultant within the previous two years. For AOs, it is possible that the surveyor may be currently employed by a hospice, in which case such a surveyor also should not be part of the survey team for any hospices serving the same geographic area.

- Survey training and educational materials should be publicly available to hospice providers and interested individuals.

- **Expanding the Survey Team:** The Coalition strongly supports expanding the survey team to include all core members of the hospice interdisciplinary team, including now social workers with Advanced Palliative and Hospice certification (APHSW-C) (preferred) and chaplains with Board Certification with specialty certification in hospice and palliative care (preferred).

All interdisciplinary hospice survey teams minimally consist of a Registered Nurse or Advanced Practice Nurse. The Coalition strongly urges CMS to utilize chaplains and social workers in surveyor training and education, if not the survey team itself. Competency in assessing the quality of spiritual care could include [What is Quality Spiritual Care in Health Care and How Do You Measure It?](#) by the Healthcare Chaplaincy Network.

III. Hospice Special Focus Program

- **Purpose of Special Focus Program: Technical Expert Panel (TEP) Needed**

The purpose of the special focus program should be made clear to hospice providers and the general public. The goal of the Hospice Special Focus Program (HSFP) is to address hospice quality of care issues and risks to hospice patients' health and safety. Hospices may be identified if they substantially fail to meet applicable regulations or have a history of serious deficiencies or substantiated serious complaints. The provider placed in the HSFP has been identified for inclusion to address quality of care issues. Under the HSFP the state survey agency will conduct a full, onsite inspection of all Medicare health and safety requirements every six months and recommends progressive enforcement (e.g., fines, denial of Medicare payment) until the hospice either graduates from the program or is terminated by CMS from Medicare. However, more input is needed from stakeholders about the design, criteria, decisions for entry, and implementation of the special focus program. The Coalition strongly recommends the creation of a Technical Expert Panel (TEP) charged with, among other tasks, informing the creation and details of the HSFP. Content for TEP consideration is detailed below.

- **Definition of hospice meeting special focus criteria and development of criteria**

The Coalition recommends more detail on classifying survey deficiencies by developing a scope and severity grid for hospice deficiencies, where penalties are based on how widespread the problem is and the seriousness of the level of harm. Consideration should be given to whether current condition/standard level designations are the most helpful in determining a hospice's eligibility for the HSFP. Dialogue about the special focus program with stakeholders should include:

(A) The nature of survey deficiencies

- i. Whether the deficiency was widespread or isolated
- ii. Whether the deficiency resulted in patient harm and the severity of the harm

- iii. Number of condition level deficiencies
- iv. Specific conditions
- v. History/pattern of survey deficiencies
- (B) Substantiated serious complaints
 - i. Immediate jeopardy
 - ii. Non-immediate jeopardy
- (C) Other considerations

- **Services provided under special focus program**

The purpose of the HSFP is to offer additional technical assistance, education, resources, and more frequent surveys to hospice providers with serious deficiencies and/or substantiated serious complaints based on criteria developed by stakeholders in collaboration with CMS. The Coalition strongly encourages CMS to take an educational approach — that is, an approach that is not punitive in nature but rather provides additional support for providers to learn hospice best practices and consistent compliance with Medicare regulations. Added survey frequency and supervision will assess the hospice’s progress in this program. If improvement is not seen by reviewers in the special focus program, additional intermediate remedies should be sought. If the hospice has had immediate jeopardy instances where patients are in danger, fines and regulatory actions should be designed to be punitive and could, if necessary, also involve de-certification.

- **Decisions about special focus entry**

For other Medicare provider types with a special focus program, decisions about entry rest with the state survey agency, with a defined number of providers (quota) allowed in the special focus program in each state. This has resulted in inconsistencies among states about which providers are selected for the special focus program and why. We believe that is detrimental to the purpose for the special focus program and may unfairly label some providers in a state that must meet their quota compared to providers in other states. The Coalition strongly supports a standardized, centralized approach, using objective criteria, with no state-level quota system. We believe this will address inconsistencies between states and place comparable hospice providers in the special focus program using the same criteria and standards throughout the country.

- **Graduating from special focus**

The description and procedures for the HSFP must include details that outline the path for exiting the special focus program, as well as define compliance with and time in compliance with hospice regulations before exiting the program.

- **Information on Care Compare**

For the hospice that has entered the HSFP, consideration should be given to the information listed on Care Compare about the hospice. Graphics and details about the special focus program should be carefully developed and discussed with stakeholders to convey information accurately and without undue alarm. CMS needs to also commit to keeping this information as current as possible; if a hospice

is no longer in the special focus program, the information needs to be updated accordingly in a timely fashion.

IV. Intermediate Remedies

Until the CAA became law, CMS, state survey agencies, and accrediting organizations did not have any options for intermediate remedies. The Coalition provides comments and recommendations below for the implementation of intermediate remedies for hospice.

- **Directed Plan of Correction**

For other Medicare provider types, CMS guidance allows for the imposition of a directed plan of correction when a provider is out of compliance with Federal requirements. The state agency can direct that a plan of correction be developed to require specific outcomes to be achieved within a specified time frame. The Coalition recommends that CMS consider the use of a directed plan of correction when a hospice is not able to develop an acceptable plan of correction for condition level deficiencies, with a surveyor focus on additional guidance and technical assistance to the hospice provider to improve compliance and quality of care.

- **Civil Monetary Penalties**

The law allows for civil monetary penalties of up to \$10,000 for each day of noncompliance by a hospice program. The Coalition urges CMS to carefully consider the scope and severity of condition-level deficiencies in the application of civil monetary penalties, as not every condition-level deficiency is at the same severity.

- **Informal Dispute Resolution**

Dispute resolution is an essential component of the implementation process for hospice intermediate remedies. Both nursing homes and home health agencies have an informal dispute resolution process. The Coalition strongly recommends that CMS seeks input from stakeholders on a hospice informal dispute resolution process, to ensure that hospices have due process for the resolution of hospice deficiencies. The Coalition also recommends that a provision be included in the informal dispute resolution process to allow correction of deficiencies within a specific time period.

- **Suspension of all or part of the payments**

The law provides for the provision of payment suspension, for all or part of payments. The Coalition recommends careful consideration of payment suspension. Hospice is different from other Medicare provider types, as more than 90% of payments for hospice services comes from Medicare, and hospice providers have a high volume of new admissions. Suspension of payments should be considered carefully and applied for a limited duration. Coalition members request additional dialogue with CMS about the details of this provision and the circumstances under which this provision would be implemented.

- **Retention of Amounts for Hospice Program Improvements**

The provisions in the new law allow the Secretary to provide that any portion of civil monetary penalties collected under this subsection may be used 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).

The Coalition recommends that ALL civil monetary penalties collected be used to support activities for hospice beneficiaries and their families, including education programs and competency testing for hospice surveyors in state survey agencies and in accreditation organizations.

Thank you for the opportunity to submit comments regarding the implementation of various hospice survey changes. If you or other members of your team are interested in speaking with Coalition leaders and experts on these topics, please contact Amy Melnick, Executive Director, amym@nationalcoalitionhpc.org or 202.306.3590.

Sincerely,

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