COALITION MEMBERS

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)

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August 27, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20101

RE: **CMS-1747-P**, Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; Inpatient Rehabilitation Facility Quality Reporting Program Requirements; and Long-term Care Hospital Quality Reporting Program Requirements

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 above proposed rule. To inform our comments, we drew on the hospice expertise represented within the 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, 10,000 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. We bring a broad, multidisciplinary perspective on hospice care and the changes this proposed rule 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.

1. Accreditation Organizations and Submission of CMS Form 2567

A. AOs to Submit Statement of Deficiencies Using the CMS-2567

CMS is proposing that Accreditation Organizations (AOs) will include a statement of deficiencies (that is, the Form CMS-2567 or a successor form) to document findings of the hospice program Medicare Hospice Conditions of Participation (CoPs). The CMS-2567 form will now be required and will need to be incorporated into the AO's proprietary software so that the survey deficiencies can be reported publicly.

Coalition Comments: The Coalition is very supportive of the standardization of the Accreditation Organization (AO) and State Agency (SA) survey process, where both AOs and SAs submit a CMS-2567 (or its successor) form to report hospice survey deficiencies. Coalition members believe that this will promote consistency for the survey process and assure that hospices have the benefit of a standard survey process, no matter who the survey agency is. We support the requirement that the Form CMS-2567 or its successor be used by all survey entities to document a hospice program's compliance with Medicare Conditions of Participation.

B. Release and Use of Accreditation Survey Results (§ 488.7)

Coalition Comments: The Coalition believes that making survey findings public, no matter who the surveying entity is, assures transparency and consistency of the survey process and provides consumers with the opportunity to see survey results from all hospices. However, the release of the CMS-2567 in its current form is unintelligible to the average consumer.

Coalition Recommendations:

- Technical Expert Panel: The Coalition strongly encourages CMS to appoint a Technical Expert Panel (TEP) that would include national stakeholders, hospice providers, and consumers, to carefully address the data elements needed for a form that is "prominent, easily accessible, readily understandable, and searchable for the general public." [CY 2022 Home Health xxx Proposed Rule, Hospice Survey Reform and Enforcement Remedies sections, June 28, 2021]
- The form that is developed should undergo testing with families, other consumers and members of the general public to ensure that the information is understandable. National

stakeholders and hospice providers should have input into the form's design, data elements, and accurate representation of survey deficiencies.

- The form that is developed should also focus on true, actual patient-level deficiencies that could impact quality of care, rather than technical deficiencies. The Coalition supports the emphasis on deficiencies related to the 4 core conditions of participation:
    - (§418.52) - Patient rights
    - (§418.54) - Initial and comprehensive assessment
    - (§418.56) - Care planning
    - (§418.58) - Quality assessment and performance improvement
- We are concerned that the survey information that is publicly available shows the viewer when a hospice has addressed deficiencies and can show that those deficiencies are resolved. In addition, there should be careful attention to those deficiencies cited under the "see one cite one" directive, which will not represent a trend in survey deficiencies that would be more helpful to the consumer.

C. Identifying Standard Framework to Identify Salient Survey Findings

CMS recognizes the need to develop some type of a standard framework that would identify salient survey findings in addition to other relevant data about the hospices' performance. CMS also recognizes the importance of releasing survey data nationally and that collaboration with industry stakeholders will be essential.

Coalition Recommendation: The Coalition endorses the development of a standard framework to identify survey findings that will impact the quality and safety of patient care. Coalition members and hospice providers pledge to work with CMS to develop such a framework to be used to assure survey consistency across states and across survey entities.

2. <u>Survey and Certification of Hospice Programs</u>

A. Surveys and Toll-free Hotline

CMS is proposing a hotline, as required by CAA 2021, to collect, maintain and update information on home health agencies and hospice programs, to receive complaints and answer questions.

Coalition Comment: The Coalition supports the development of a hotline for HHAs and hospices.

Coalition Recommendation: The Coalition is supportive of this formal requirement for a hotline for hospice questions and complaints. The Coalition requests that CMS clarify that there

will be a single hotline per state and that complaints or questions will be answered by the State in a timely manner if follow up is required.

B. Surveyor Qualifications and Prohibition of Conflicts of Interest (§ 488.1115)

CAA 2021 requires the Secretary of HHS to establish a training and testing program for all surveyors – State, Federal and AO – no later than October 1, 2021, and prohibits a surveyor from surveying a hospice program on or after October 1, 2021, until they have completed the training and testing program. The legislation also prohibits an individual from surveying a hospice program if the individual serves (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the program being surveyed or who has a personal or familial financial interest in the program being surveyed.

1. **Surveyor Qualifications**: Relative to surveyor training, CMS is proposing that all SA and AO surveyors be required to take CMS-provided surveyor basic training currently available, and additional training as specified by CMS. CMS proposes that until the rule is finalized, that CMS will accept AO surveyor training that is currently in place as part of CMS' agreement with each AO, and that SA surveyors should already be in compliance as they must currently complete a CMS-developed training and testing program.

   As part of the rule, CMS has provided additional information regarding the makeup of existing surveyor training modules, underscored that all current training modules are accessible by the public at large, and outlined changes to the training modules that are currently in process and that will place increased emphasis on assessment of hospice quality of care. CMS indicates that the revised training is expected to be implemented soon.

   Coalition Comments: The Coalition strongly supports uniform surveyor testing and training to ensure that all surveyors have an identical knowledge base and to help support greater accuracy and consistency of survey findings. We applaud CMS' movement toward greater transparency over recent years by making surveyor training modules publicly available and are gratified that CMS is well on its way to releasing updated surveyor training modules. We are particularly supportive of CMS' plans, as part of its revisions to the State Operations Manual and training module updates, to place increased focus on quality of care by emphasizing the four "core" hospice program CoPs related to Patient's Rights; Initial and Comprehensive Assessment of the Patient; Interdisciplinary Group, Care Planning and Coordination of Care; and Quality Assessment and Performance Improvement.

   Coalition Recommendations:

   - Given that CMS appears to be very close to completion of its updates to hospice surveyor training modules, we believe it would be optimal for all surveyors to undergo training and testing using the updated modules as soon as they are available. Rather

than having AO surveyors undergo currently available surveyor basic training that may be out of date, we recommend that CMS publish, as part of its final rule on the Survey Reform and Enforcement Requirements for Hospice Programs, information regarding when the updated training modules will be released along with a schedule for when all surveyors must complete the revised training (and undergo competency testing). The schedule should allow sufficient time so that survey entities will not be required to remove a significant number of surveyors from the field at the same time so that the impact on survey backlogs will be minimal.

- We recognize that online training and testing is the most efficient and (in the current environment) safest means for ensuring that all surveyors have successfully completed the required course of study. We also believe that online pretesting, training, and testing have the potential to somewhat degrade the training function. We encourage CMS to consider, when appropriate, offering in-person training opportunities to surveyors to strengthen the impact of the training process and allow for communication and dialogue during the survey process.
- Many surveyors have field experience that helps to guide their determinations, but this experience can, at times, lead to inflexibility and bias. Training and educational materials should emphasize that there may be a variety of ways that a hospice can meet the requirements of the CoPs, and that compliance with the intent of the CoPs should always be at the core of any determination. Various examples of permissible provider actions to meet specific requirements could help to support this concept as part of the training. Further, training should emphasize that survey citations should be based on evidence of trends rather than a single violation.
- All training and educational materials should adequately address psychosocial, emotional, and spiritual components of hospice care. Such materials and training would optimally be developed and performed by hospice-trained social workers, chaplains and counselors.
- Given the new requirement to utilize additional hospice disciplines in cases where more than one surveyor will be used, training and educational materials should be developed with a variety of disciplines in mind.
- We strongly recommend that education and training materials be updated whenever new or revised CoPs or interpretations are released. Hospice surveyors should be required to undergo additional training/testing within a specified time period whenever new or revised training is released.
- We encourage CMS to consider development of surveyor competency requirements that include routine training and/or testing and that ensure a surveyor maintains survey experience specific to the provider type being surveyed. This could include an annual requirement to conduct a minimum number of hospice surveys to retain certification as

a hospice surveyor. Consideration should also be given to a requirement that a surveyor have field experience with a particular provider type to be certified to conduct surveys of that provider type.

2. **Prohibition of Conflicts of Interest:** While CAA 2021 specifically prohibits conflicts of interest on the part of SA surveyors, CMS has indicated that it intends to apply the prohibitions against conflicts of interest to AO surveyors, as well. CMS is proposing to codify existing policy in Section 4008 of the State Operations Manual to address potential conflicts of interest between an organization and the individual conducting a survey, and to utilize the definition of "immediate family member" currently applicable to similar provisions in existing home health regulations.

   Coalition Comments: While we understand that some of the AOs currently have policies that address surveyor conflicts of interest, we appreciate CMS' application of the CAA 2021 provisions to all surveyors, both SA and AO. We believe that this will ensure a uniform standard related to potential conflicts.

   There are some potential conflicts of interest that have not been addressed as part of this Section, including circumstances under which a surveyor may have applied for a position at a hospice it may now be surveying. We have also heard of situations where a surveyor may have worked for or has a financial interest in an entity that is a competitor of a hospice under survey, which could impact the surveyor's view.

   Coalition Recommendations: Given the breadth of potential situations where conflicts of interest could arise, we recommend the following:

   - CMS should develop materials to guide a surveyor in identifying situations in which he/she may have a conflict of interest and guidance for survey entities regarding circumstances under which surveyors should be permitted to disqualify themselves from a survey.
   - CMS should add surveyor conflict of interest to the CMS Hospice Surveyor Training Modules to ensure that the subject is addressed during training.
   - CMS should develop a surveyor "Code of Ethics" or "Attestation" relative to conflicts of interest to convey that surveyors are responsible for maintaining objectivity throughout the survey process. An attestation or agreement to a Code of Ethics should be addressed in the CMS Surveyor Hospice Training Modules and could be signed by the surveyor during the training process.

3. **Multidisciplinary Survey Teams (§ 488.1120):** The CAA 2021 calls for the use of multidisciplinary survey teams when the hospice survey team comprises more than one

surveyor, with at least one person being a RN. CMS is proposing that both SAs and AOs include diverse professional backgrounds among their surveyors to reflect the professional disciplines responsible for providing care to persons who have elected hospice care. Such multidisciplinary teams should include professions included in hospice core services, and "may include physicians, nurses, medical social workers, pastoral or other counselors – bereavement, nutritional, and spiritual." When the survey team comprises more than one surveyor, CMS proposes that the additional slots be filled by professionals from among the interdisciplinary team (IDT). CMS also indicates that it would consider the potential use by survey entities of specialty surveyors (such as a pharmacist or registered dietitian) to address portions of the survey.

Coalition Comments: We understand that a change of this magnitude requires that CMS consider a range of issues, including the current makeup of survey teams utilized by various survey entities and adjustments to the surveyor training to address the review process for all disciplines that could be involved in the survey process. Time may be needed for those entities to come into compliance with the new requirement for survey teams. Our recommendations follow.

Coalition Recommendations: We provide the following comments and requests for clarification regarding this provision:

- Regarding the disciplines that should be drawn from when a hospice survey is conducted by more than one individual, CMS has referenced language from the hospice CoPs related to the hospice IDT being comprised of "….pastoral or other counselors – bereavement, nutritional, and spiritual." While we understand that changes to the CoPs are not under consideration as part of this rule, we suggest that as part of any future efforts related to the CoPs that CMS consider updating its terminology related to the IDT to reflect the specific functions ascribed to the team, which include the provision of spiritual counseling, and ensure that the terminology is reflective of current practice in hospice care, which generally utilizes the term "chaplain" under such circumstances.
- it is not entirely clear from the discussion of this provision in the proposed rule whether CMS will <u>require</u> use of other disciplines from the IDT when multiple surveyors are utilized. CMS' language indicating that survey entities "should" leaves some lack of clarity and promotes confusion about CMS intent. We seek additional guidance around this issue. We strongly support use of multidisciplinary teams when more than one surveyor is utilized for a hospice survey.
- It would also be helpful for CMS to clarify the application of the requirement. It appears from the language that when more than one surveyor is used, the second surveyor could also be a RN (given that nurses are part of the IDT and listed among the disciplines

from which additional surveyors on a team can be drawn). Clarification of this point would be appreciated.

- The use of multiple disciplines as part of the survey process when more than one surveyor is being utilized underscores the need for hospice surveyor training to be designed with various members of the IDT in mind. The training should be constructed using language and concepts that are understandable to all disciplines on the IDT.
- Regardless of discipline, hospice surveyors must meet training and testing requirements and be knowledgeable about end-of-life issues, including cases where “specialty surveyors” may be utilized. When a hospice provides pediatric hospice and palliative care, consideration should be given to identifying surveyors with pediatric serious illness expertise.

4. **Consistency of Survey Results (§ 488.1125):** CAA of 2021 requires each state and HHS to implement programs to measures and reduce inconsistency in the application of hospice program survey results among surveyors. To achieve this end, CMS intends to conduct a random sample (minimum of 5%) of validation surveys of SAs and AOs relative to hospice programs to determine the extent to which SA and AO surveyor findings align with federal requirements. CMS also plans to calculate SAs’ “disparity rates” (currently calculated for AOs and published as part of an annual report to Congress) to identify the percentage of validation surveys that have conditions identified by the SA reviewer that were missed by the AO survey team. Disparity rates would be reported back to each survey entity and, under certain circumstances, require a formal corrective action plan to address disparities as part of the survey entity’s quality assurance program. CMS also plans to develop objective measures of survey accuracy for use as part of its efforts to improve survey consistency.

   Coalition Comments: Lack of consistency of survey results has been a long-standing concern of the hospice community, and we strongly support efforts that will create more consistent understanding of survey requirements and more uniform application of the hospice CoPs. A great many factors play a role in ensuring consistency of survey results, including the training and testing the surveyor has undergone, the amount of field experience the surveyor may have had working for a particular provider type, the amount of experience the surveyor has conducting provider-specific surveys, the surveyor’s professional health training, and the degree to which a surveyor has access to various guidance and policy interpretations, to name a few. The degree to which disparities in surveyor experience can be addressed through other changes that CMS may initiate as part of survey process reforms (including surveyor qualifications) will contribute substantially to improvements in survey consistency.

Coalition Recommendations: Following are some specific recommendations related to CMS' plans to address hospice survey consistency:

- While we understand the importance as part of the survey review process of identifying survey deficiencies that a surveyor may have missed (calculation of a surveyor's "disparity rate"), we believe that as part of the disparity rate, CMS should also assess whether citations that have been imposed are actually warranted based on available evidence. Ensuring that imposed citations are justified along with identification of missed deficiencies will contribute to greater survey accuracy overall.
- CMS should study the prevalence of errors in identification of survey deficiencies to determine whether additional surveyor guidance or enhanced educational modules are warranted relative to particular CoPs.
- Given that validation surveys are generally conducted weeks or months after a survey has been conducted, there is significant concern in the hospice community regarding the ability of validation surveys to accurately identify surveyors' errors relative to identification of deficiencies. For this reason, we strongly recommend that CMS support performance of validation surveys concurrent with, or shortly after, the SA or AO survey. Where concurrent surveys are not possible, performing the validation survey in close succession (within a week or two) or the Sa or OA survey should be encouraged.
- Comprehensive, consistent, and accurate guidance for surveyors is essential to consistency of survey findings. For this reason, we recommend that CMS develop protocols to assist surveyors in identifying deficiencies. Such protocols should indicate that the manner and degree of an offense must be considered when assessing the appropriateness of imposition of a citation. Additionally, such protocols should convey that a certain level of compliance is needed to demonstrate that a hospice has met the goals of the CoPs and that a single instance of non-compliance, such as the practice of "see one, cite one", may not be indicative of a systemic problem. Such protocols must allow some flexibility to allow for surveyor judgment.

5. **Special Focus Program (SFP) (§ 488.1130):** CMS proposes to establish a Special Focus Program (SFP) for poor-performing hospices

   Coalition Comments: The Coalition very much supports additional oversight and technical assistance to the poorest performing hospices to improve the quality of hospice care delivered to the terminally ill. Development and implementation of a special focus program is complex as was identified with the implementation of such program with nursing homes.

The Coalition appreciates that CMS has proposed an SFP that does not include the state quotas and is not exactly the same as the nursing home program. Having an SFP selection system that is not centralized at the federal level leaves open the possibility that a poor performing hospice that should be in the program is not and likewise, that a hospice that may be a poor performer at the state level but not at the lowest performance level nationally will be unnecessarily filling a spot in the SFP.

Coalition Recommendations:

- The Coalition recommends a centralized selection system at the federal level. CMS should ensure that the selection process identifies poor performing hospices are in the program and are selected with the same criteria no matter what state they might be in. The Coalition requests that CMS reconsider the SFP selection process based on State priorities and consider a "level playing field" for selection for the SFP regardless of the hospice's location
- The Coalition strongly recommends the creation of a TEP charged with informing the details of the SFP. CMS has asked for feedback on the possibility of utilizing a TEP to enhance the SFP in terms of selection, enforcement, and technical assistance criteria. Due to the complexity of the SFP and potential long-term impacts, this program should not be implemented until the TEP has completed its work in this area.
- The Coalition recommends that the TEP consider the following details in their deliberations:
    - **SFP Eligibility:** The Coalition recommends consideration be given to whether current condition/standard level designations are the most helpful in determining a hospice's eligibility for the SFP or if 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 may be more appropriate. No timeframe for the substantiated unique complaint survey or the severity of the complaints for the proposed eligibility criteria was identified. This should be a strong consideration in determining a hospice's eligibility as the nature of complaints can vary widely and the time between substantiated complaint surveys could be considerable, i.e., years.
    - **Use of Other Data for SFP Eligibility:** The eligibility criteria for the SFP could be modified in the future to incorporate the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey star rating. Careful consideration needs to be given to this or any other possible eligibility criteria and should include an opportunity for stakeholder input. In addition, the Coalition

recommends that the addition of the CAHPS hospice survey star rating system go through the rulemaking process.

- **SFP Graduation:** When a hospice has had two consecutive surveys under the SFP without a condition level deficiency, the hospice would graduate from the SFP. A hospice that does not improve and does not come into substantial compliance after two consecutive surveys would be put on the termination track. The Coalition recommends that the CMS request should consider TEP input on the length of time between being put on the termination track and actual termination and what steps should be part of this process.
- **Promising Progress:** The Coalition requests that CMS consider TEP input regarding whether 'promising progress' (i.e., sale of the hospice to a company with a strong compliance and quality of care track record) should impact the termination decision, including steps in the process and timeframes.

Services Provided under Special Focus Program

The purpose of the SFP is to offer technical assistance and more frequent surveys to hospice providers.

Coalition Recommendation: The Coalition strongly encourages CMS to take a technical assistance approach first — that is, an approach that is not punitive in nature but rather provides necessary technical assistance 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.

Publicly Reported Information

For the hospice that has entered the SFP, consideration should be given to the information listed on Care Compare about the hospice.

Coalition Recommendation: Any graphics and details about the special focus program should be carefully developed and discussed with stakeholders to convey information accurately and without undue alarm. The Coalition recommends that this issue be on the agenda for the TEP to get stakeholder feedback and concurrence. 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.

It is not clear if the list of hospices eligible for the SFP will be displayed publicly as it currently is for nursing homes. If there is going to be a public list, CMS should commit to ensuring that it is updated timely.

3. **Proposed New Subpart N – Enforcement Remedies for Hospice Programs with Deficiencies**

A. **Proposed Additions to Enforcement Remedies:** Beyond the enforcement remedies required in the CAA 2021, CMS is proposing the addition of a directed plan of correction and directed in-service training. The Coalition appreciates and supports these proposed additions as they may be some of the most effective remedies for long term improvement and it aligns the remedies with those available in home health.

Unlike home health, there is currently no dispute resolution process available to hospices for condition-level deficiencies. Clear guidance for surveyors is also missing on when to cite a hospice at the condition level.

Coalition Recommendation:

Considering the seriousness of the proposed consequences of condition level deficiencies and the history of deficiencies for hospices, the Coalition recommends a dispute resolution process be available to hospices for all deficiencies.

B. **Disparities in Application of Payment Suspension**

Coalition Comments: As proposed, there is some disparity between provider types regarding payment suspensions. Specifically, CMS is proposing at § 488.1240 that it may suspend all or part of the payments to which a hospice program would otherwise be entitled with respect to items and services furnished by a hospice program on or after the date on which the Secretary determines that remedies should be imposed. While this language is consistent with the CAA, it is not consistent with the remedies that are in effect for home health agencies and nursing homes. We understand that the Office of the Inspector General (OIG) recommended in July 2019 that enforcement remedies for hospices be consistent with post-acute care providers.

Coalition Recommendations:

- The Coalition strongly urges CMS to consider when looking at payment suspensions that hospices are different from other Medicare provider types as upwards of 90% of hospice patients are Medicare beneficiaries. Hospices also tend to have more new admissions annually than either nursing homes or other post-acute care providers.
- The Coalition believes that smaller, independently owned hospice providers may be disproportionally burdened financially by imposition of certain remedies as compared with

larger hospice providers or hospice providers that are part of a larger healthcare network. This could negatively impact access to hospice care.

- The Coalition is very concerned about the current and predicted future staffing shortages in hospice. It may not be possible for existing hospice patients to be transferred to another hospice, due to lack of staff to serve additional patients.
- The Coalition shares concern about those states with Certificate of Need (CON) requirements for hospices, or in rural areas where there is only one hospice provider. If payments were suspended, Medicare beneficiaries may not have access to any hospice care because there is only one hospice serving the area.
- The Coalition recommends that every effort be made to work toward performance improvement and the delivery of quality hospice care.

C. Money Collected from Enforcement Remedies Available to be Utilized for Hospice Program Improvements

CAA, 2021 Section 407 provides detailed statutory guidance on the provision for CMP penalties paid by hospices and collected by CMS be available to support activities that benefit individuals receiving hospice care. The statute reads:

> C. Procedures
>
> (i) CIVIL MONETARY PENALTIES …
>
> (II) "Retention of Amounts for Hospice Program Improvements." The statute states: The Secretary may provide that any portion of civil money 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).

Coalition Comments: The Coalition does not see this statutory provision in the proposed rule.

Coalition Recommendation:

- The Coalition strongly urges CMS to add this section to the final rule and to develop specifications for how the penalties collected can be used at the national level and/or state level for hospice program improvements and how a hospice or state agency may access these funds for hospice program improvements.

D. Timeframe and Notification of Enforcement Remedies

Coalition Comments: It is clear from the proposed hospice survey reforms that there would be an established timeframe for when notices of enforcement remedies would be provided to

hospices. There is some concern, however, regarding the possibility that these will not be observed. This is because hospices have reported substantial delays in receiving post-survey reports (i.e., Statement of Deficiency and notices of termination) dating back to pre-pandemic years. There is concern that these delays may continue and occur when enforcement remedies are being applied. In situations of immediate jeopardy, CMS is proposing a notification period of 2 days. It is not clear if this is business days or calendar days. Also, the method of notification is not clear (i.e., USPS, electronic, overnight delivery service), but it is noted that a period of 2 days may not be sufficient to allow for normal

Coalition Recommendations:

- The Coalition encourages CMS to implement processes to resolve the reasons for the existing delays and ensure delays related to notices of enforcement remedies do not occur.
- The Coalition also recommends that if a delay in notification does occur, CMS should allow for the delay in implementation of the enforcement remedy equal to the number of days the notification is delinquent.

E. Consistent Application of Remedies

Coalition Comments: In general, determinations of when enforcement remedies are to be imposed and which remedy to impose are quite subjective. For instance, identifying the number of deficient standards within a condition of participation that would result in a condition level deficiency, providing guidance that one instance of a deficient practice, as hospices experience with the "see one cite one" survey deficiency citation, does not necessarily indicate a systemic problem. Surveyors should further investigate for a trend of instances or pattern of deficient practices before citing a particular deficiency or instructing surveyors to consider citing an additional specified standard/element that is related to a deficiency (i.e., consider citing a deficiency at §418.56(b) when one is cited at §418.56(a)(1)).

Coalition Recommendation:

The Coalition recommends that CMS consider developing additional guidance to the Location offices on when and which remedy(ies) to apply. Additionally, because condition level deficiencies will have far greater consequences for hospices, CMS should consider that it would be beneficial to have a protocol for deficiency citations that would still allow for surveyor judgment.

Thank you for the opportunity to submit comments regarding this proposed rule. 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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Palliative Care Quality Collaborative
Physician's Assistants in Hospice and Palliative Medicine
Social Work Hospice and Palliative Care Network
Society for Pain and Palliative Care Pharmacists