



May 28, 2024

The Honorable Chiquita Brooks-LaSure
Administrator, The Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20101

RE: CMS-2024-0118 Medicare Program: Fiscal Year 2025 Hospice Wage Index and Payment Rate, Hospice Conditions of Participation, and Hospice Quality Reporting Program Requirements

Dear Administrator Brooks-LaSure:

The National Coalition for Hospice and Palliative Care (NCHPC) welcomes the opportunity to provide comments and recommendations from our coalition on CMS-2024-0118 Medicare Program: Fiscal Year 2025 Hospice Wage Index and Payment Rate, Hospice Conditions of Participation, and Hospice Quality Reporting Program Requirements (Proposed Rule). Like the Centers for Medicare & Medicaid Services (CMS), the NCHPC is committed to ensuring that access to compassionate, cost-effective and person-centered health care services are provided in the least restrictive and most appropriate environment possible. To inform these comments, the NCHPC convened experts and professionals from across the interdisciplinary field of hospice and palliative care that comprise our coalition.

The NCHPC represents 14 leading professional organizations dedicated to advancing equitable access to quality care for serious illness. Our member organizations speak for the interdisciplinary workforce that delivers palliative care and hospice care. This includes more than 5,500 physicians, 1,000 physician associates, 11,000 nurses, 5,000 chaplains, 8,000 social workers, researchers, and pharmacists, along with over 1,800 palliative care programs and 5,300 hospices. Our vision is that all patients, their families, and caregivers will have equitable access to quality palliative care and hospice care.

We appreciate the opportunity to provide our recommendations on the Proposed Rule. Specifically, we are providing background on hospice care and feedback on the following CMS provision in the proposed rule:

III. C. Request for Information (RFI) on Payment Mechanism for High Intensity Palliative Care Services

Since the inception of the Medicare Hospice Benefit over 40 years ago, hospice utilization has gradually increased to approximately 50% of those eligible to receive it, signaling both consumer and healthcare professional satisfaction with the value derived from the comprehensive interdisciplinary patient and family centered model of care. The recent report from NORC at the University of Chicago (NORC)ⁱ demonstrated evidence of the cost effectiveness of the hospice benefit, estimating Medicare spending for those who received hospice care during the last six months of life was \$3.5 billion less than it would have been had they not received hospice care. Thus, provision of hospice services during the last six months of life is inherently a value-based intervention, which saves the Medicare program money and enhances the quality of life for the patient. Yet, in recent years, hospice utilization has appeared to stall at or below the 50% mark. To improve access to this benefit so that the physical, emotional, spiritual, and financial values are received by patients, families, and the healthcare system, we must address the barriers and unintended

consequences built into the design of the benefit that excludes large portions of patients who could benefit from the holistic care hospice provides.

Under Medicare payment policy, hospices are responsible for covering all costs related to patients' terminal conditions under a per diem rate. This payment structure has led to a de facto requirement that patients forgo costly therapies—including therapies with “palliative” intent but may be alike or identical to modalities that are life-prolonging—upon enrollment in hospice because the cost is prohibitive. However, in contrast, there is greater flexibility in providing hospice services alongside life-prolonging care in Medicaid, the Veterans Health Administration (VHA), and in other countries' healthcare systems. Often paired with innovative payment models, this concurrent care coordinates practical, psychological, and physical care transitions when patient goals prioritize comfort over cure. For example, allowing simultaneous receipt of hospice care and dialysis for people living with end-stage kidney disease (a group with relatively low hospice enrollment) can act as a bridge to hospice and potentially promote longer lengths of stay.^{ii iii iv v}

One challenge is that healthcare professionals (including hospice and palliative care professionals who are not working with concurrent care through Medicaid or the VHA) are not aware of the flexibilities permitted in **Section 40.2.4** of the Medicare Benefits Policy Manual addressing use of Special Modalities for Palliation in Medicare Hospice Services: “A hospice may use chemotherapy, radiation therapy, and other modalities for palliative purposes if it determines that these services are needed. This determination is based on the patient's condition and the individual hospice's care-giving philosophy. No additional Medicare payment may be made regardless of the cost of the services.” The common perception is that a patient cannot have both hospice and special modality (or high intensity) palliative treatments at the same time, even when these treatments are used solely for palliation of symptoms. As a result, this often means that both hospices and patients face a difficult decision whether to forego palliative treatments or access hospice services. **The NCHPC urges CMS to build better understanding in the healthcare provider community and promote inclusiveness by clarifying its coverage policy regarding the appropriateness of the use of high intensity palliative care services in conjunction with traditional hospice services.**

The NCHPC supports equitable access to quality hospice care for all hospice eligible patients who desire to receive hospice care. This includes patients who are receiving high intensity palliative treatments that do not prolong the patient's life expectancy beyond the requirement of six months or less. For these patients, there may be types of high intensity interventions considered palliative in certain circumstances. However, there are organizational enrollment policies that preclude access to hospice care for eligible patients receiving more complex or high intensity palliative treatments such as interventions not traditionally served by hospices like physical therapy, expensive wound care interventions (vac's), various infusion interventions (blood, immunotherapy, etc.), radiation, total parenteral nutrition (TPN), inotropes, chemotherapy, ventilators, and dialysis. These treatments may provide palliation beyond physical symptoms including emotional and spiritual issues that patients and their families face at end of life.

Hospices are not able to serve all referrals for eligible patients who are receiving or considering receiving high intensity palliative treatments. The costs associated with high intensity palliative treatments can be prohibitive due to the hospice benefit *per diem rate*. One example is that many hospices report they are unable to serve patients living with End Stage Renal Disease, despite the positive benefits related to dialysis and hospice. Costs for provision of palliative dialysis treatments, typically for a period no longer than four weeks (approximately 12 dialysis treatments), are equivalent to a direct cost to the hospice provider of around \$3,600 to \$4,200. Similarly, a patient receiving palliative chemotherapy might receive

multiple treatments, each with a direct cost to the hospice provider ranging from \$500 to upwards of \$10,000 per treatment. Other examples of costly high intensity services that would fall to the hospice providers include: patients receiving immunotherapy (as much as \$20,000 a treatment), chemotherapy (\$5,000 - \$10,000 per month), radiation such as Lutathera (\$72,000 a treatment), some strong antibiotics, frequent paracentesis treatments (including supplies), vacuum-assisted closure of a wound (wound VAC), and blood and/or iron infusions (depending on frequency can be as much as \$20,000 a month). Moreover, these direct costs that would be incurred by the hospice providers for high intensity treatment services do not include additional costs associated with treatment such as transportation, consultations, or visits with the physician specialist, nor any of the costs already associated with the provision of hospice services (i.e., the patient care team visits, medical director services, medications, supplies, durable medical equipment, or general operating expenses).

Beyond the direct costs of these interventions, hospices must engage in contracting with providers for these services and professionally manage them as a part of the patient's plan of care. The expectation is to reimburse the contracted providers for these services out of the hospice per diem reimbursement as covered services. The administration of contracting and payment processes is typically an uncharted, confusing process for the hospices and specialty providers alike. In addition, hospice providers have a limited ability to negotiate contracts with high intensity treatment providers for reasons including a reluctance to reduce costs for hospices compared to other existing reimbursement rates, further limiting access to services for patients who are eligible for the Medicare hospice benefit. **Few hospices are in the financial position to take on the risk of costs associated with high intensity palliative treatments for eligible patients at end of life under the current hospice benefit.**

Also, patients receiving high intensity, complex palliative care services are fragile, requiring a greater number of hospice care team visits and medications. The national average per diem reimbursement for routine home care in the first 60 days is currently \$218.33, dropping to \$172.35 at day 61. This equates to \$6,549 per month in the first two months of service and \$5,170 per month thereafter. In most cases, the cost of providing care for patients receiving complex palliative treatments surpasses the Medicare hospice reimbursement rate. For smaller hospice providers, these costs may be insurmountable. For larger hospice organizations, these costs may be absorbed given there are more hospice patients receiving service. In either case, the high cost of palliative treatments compared to the reimbursement rate creates challenges and potential barriers for eligible patients to access quality hospice care.

Patients and families want and need these high intensity palliative care services. In most cases, Medicare is already paying for these expensive treatments, without the holistic support hospice provides. Allowing the patient to have these high intensity palliative care treatments in combination with hospice services will help more end-of-life patients access quality care. Hospice has one of the highest consumer satisfaction scores of any type of Medicare provider. Patients and families often express that they wish they had known about hospice sooner.

The NCHPC requests that CMS policies encourage hospice election whenever it is appropriate because of its value-based cost savings and the enhanced quality of life provided to the patients and their families. Consistent with the principle that patients should be free to choose the mix of services they receive based on their individual needs, goals, and preferences, the NCHPC supports that patients should be able to access high intensity palliative care services regardless of the level of hospice care they are receiving. To illustrate, there may be cases where patients need higher level continuous home care (CHC) or general inpatient care (GIP) but still require high intensity palliative care services. For example, a patient receiving GIP in a hospital for a crisis of bone pain may receive a dose of radiation for palliation. The

hospital furnishing the radiation would expect to be paid for that radiation administration above and beyond any payment from the hospice for contracted GIP services. Likewise, if a patient receiving routine home care (RHC) required palliative radiation on an outpatient basis, the radiation provider would also need to receive separate payment for the administration. **The NCHPC urges CMS to pursue statutory changes that would ensure that hospice patients have adequate access to high intensity palliative care services.**

In doing so, CMS should adhere to the following principles, which would support the delivery of seamless patient-centered care:

- Patients should be free to choose the mix of services they receive based on their individual needs, goals, and preferences.
- Delivery of high intensity palliative care services should involve both the hospice and non-hospice palliative service provider working together to implement a plan of care; and
- Neither the hospice provider nor non-hospice providers furnishing the palliative services should be financially disadvantaged for providing the care.

While the members of our coalition appreciate that CMS is reviewing a different type of payment to compensate hospices for the provision of high-cost or high intensity services, we have concerns that any changes implemented under the current CMS statutory authority would not sufficiently address the need. Specifically, the statutory requirement that payment changes be implemented in a budget-neutral manner would mean that the introduction of any new payments would have to be offset by reductions to existing payments. This may not be tenable given hospices' financial pressures and the challenges they experience paying for high intensity palliative services under the current reimbursement rates. Before embarking on any policy changes, it would be imperative to collect additional data around utilization of these high intensity services and the length of utilization time, among other important considerations. At this writing, there is not adequate information to formulate a thoughtful opinion related to payment mechanisms. **Therefore, the NCHPC encourages CMS to convene a Technical Expert Panel (TEP) in conjunction with robust data collection to be able to advance those discussions.**

The NCHPC offers the following suggestions that could be evaluated among members of a TEP:

1. To mitigate **financial risks** for hospices that provide complex palliative treatments and higher intensity levels of hospice care, hospices must receive additional payments commensurate with the cost of those services in addition to the payments they already receive. This would not only include the cost of the service or item itself, but also costs associated with the care management and care coordination activities hospices must undertake. As an example, if a hospice provider were to coordinate a transfusion, then they must engage in multiple steps including: identify a community partner willing to furnish the service at a reasonable cost; schedule the appointments; arrange for a blood draw two days in advance for the blood typing and crossmatch; determine the appropriate setting for the transfusion and potentially arrange for transportation; and dedicate nursing services to support patients post-transfusion. For many hospices, these responsibilities are significant burdens on their already limited workforce.
2. Additionally, CMS could pursue opportunities to **reduce the costs** that hospices must bear when providing high intensity palliative services. For example, given that medications represent a significant proportion of the high-cost palliative treatments, CMS could consider developing a national formulary with negotiated rates that hospices could use to procure medications, or seek to leverage Veterans Affairs pharmacy contracts. One instance is tetrabenazine, which is palliative

for Huntington’s disease, that can run anywhere from \$5,000 to \$11,000 for a 30-day supply. Metastatic lung cancer patients now often take erlotinib for palliation, which can cost between \$6,200 and \$8,400 per month. Immunotherapy drugs like pembrolizumab used for palliation for pancreatic cancer can cost more than \$10,000 per month. And inotropes used for congestive heart failure can cost roughly \$4,000 to \$5,000 per month. When monthly hospice payments of roughly \$6,000 to \$7,000 per patient are expected to cover the full range of hospice services, it is unsurprising that hospices often cannot manage to cover these additional costs.

3. CMS could also **explore incentives** to encourage providers to partner with hospices to offer advanced therapies at Medicare fee-for-service rates. Often, hospices must partner with providers to provide advanced therapies due to factors including limited hospice capacity, or the need for specialized expertise that some advanced therapies may require, and/or the specialized equipment that may be required. For example, hospices typically do not own dialysis machines and must contract with dialysis providers for palliative dialysis services. As noted above, many hospices face difficulty in identifying partners willing and/or able to contract for the provision of therapies at reduced reimbursement rates for hospices.
4. Alternatively, since many of the treatments in question are furnished by providers external to hospices (e.g., dialysis or cancer centers) or may be provided through an outpatient pharmacy program, CMS could consider a **carve out** from the scope of hospices’ responsibilities to make payment to such providers or pharmacies separately. Such an arrangement would remove or reduce financial and administrative burdens from hospices. Furthermore, carving out services would address a challenge that many hospices have experienced when they have tried to arrange for services – that is, that community providers require hospices to pay rates that are substantially higher than Medicare fee-for-service, adding to the difficulty of hospices contracting for additional high intensity services.
5. Members of the coalition recognize that a separate definition of palliative services, with regard to high-cost treatments, may have its merits. However, we also suggest that such an effort would be a substantial undertaking requiring broad stakeholder engagement. Given that challenges already exist with terminology along the spectrum of care (from palliative to curative care), as well as confusion between palliative care and hospice care, further definitions of palliative services may make the already confusing terminology worse. While expanding the definition to address high-cost palliative interventions may reflect one way of setting parameters around potential new payments for high-cost treatments, another alternative is that CMS could effectively establish a discrete **high intensity palliative care benefit** within or adjacent to the hospice benefit, which would then be subject to its own rules around coverage and payment. Regardless of the outcome of this question, we would encourage CMS to prioritize an approach for covering services that would increase patients’ quality of life, deferring to hospice providers’ clinical judgement, and providing palliative care for patients transitioning into hospice. In line with this approach, patients should be able to continue utilizing services or treatments for as long as they are eligible for hospice and their physicians determine such services continue to be medically necessary; such services should be allowed for patients not merely on a temporary basis subject to arbitrary time cut offs. Also, policies need to be designed in a way that provides flexibility to account for the evolution of health care. Notably, many medications and services that had historically been used as part of curative treatment regimens have transitioned over time to be used as palliative treatments. For example, with the evolution of non-invasive ventilators, many patients with lung disease or neuromuscular disorders receive ventilatory assistance at home not just to prolong life but to relieve dyspnea and maximize function.

6. The NCHPC strongly **opposes any documentation requirements** that all other palliative measures have been exhausted prior to billing for payment for a higher-cost treatment. When patients receive high intensity services, it is typically in the early stages of hospice care as they transition away from disease-directed treatments. Indeed, the barriers in a hospice’s ability to provide such services may be a driving factor in a patient continuing to pursue disease-directed treatments versus electing hospice. Requiring patients to forego these services during the initial part of their hospice election, when they are relatively high functioning, would prevent hospices from providing care in a patient-centered manner consistent with patients’ needs and goals, contributing to increased burden for hospices and increased suffering for patients. Therefore, such a requirement would undermine CMS’ goals of ensuring that patients have access to high intensity palliative care services during their hospice election. Additionally, the NCHPC would oppose any documentation requirements that would serve as the basis for imposing any prior authorization requirements. While we recognize that coverage criteria would have to be established and documentation would need to support how patients meet criteria, any introduction of prior authorization into the hospice benefit would be problematic given the likelihood that services would need to be provided on an urgent or emergency basis to patients who are near the end of life.
7. The NCHPC offers that there is a need for **reforming the Medicare hospice benefit** to address numerous structural limitations within the benefit including to allow for concurrent access to disease-directed care or treatments while receiving hospice care. Not only would concurrent care address CMS’ concerns about insufficient access to high-cost palliative care services, but it would also increase uptake of hospice care by removing the requirement for patients to waive access to all Medicare services related to their terminal condition. This requirement delays hospice election and deprives many beneficiaries and their families/caregivers of the supportive end-of-life care provided by hospices to which they are entitled. Overall, the NCHPC offers that concurrent care could move the system further towards a future with an expanded, continuous benefit for patients with serious illness, in which patients could access both palliative care services and disease-directed services based on their needs and goals, regardless of their prognosis.

We greatly appreciate the opportunity to comment on CMS-2024-0118 Medicare Program: Fiscal Year 2025 Hospice Wage Index and Payment Rate, Hospice Conditions of Participation, and Hospice Quality Reporting Program Requirements. Our coalition welcomes the opportunity to discuss these views with you. If you have any questions, please contact Jessica Hausauer, PhD, Executive Director, at jessica@nationalcoalitionhpc.org.

Sincerely,
Jessica Hausauer, PhD
Executive Director,
National Coalition for Hospice and Palliative Care

ⁱ Final Report: *Value of Hospice in Medicare*, Presented by: NORC at the University of Chicago, March 2023 (accessible at https://www.norc.org/content/dam/norc-org/pdf2023/Value%20of%20Hospice%20in%20Medicare_Final%20Report.pdf)

ⁱⁱ https://www.nhpc.org/wp-content/uploads/DCI_and_UPMC_Concurrent_Hospice.pdf

ⁱⁱⁱ [‘My Time to Live’: Through Novel Program, Kidney Patients Get Palliative Care, Dialysis ’Til the End - KFF Health News](#)

^{iv} [Concurrent Hospice and Dialysis Care: Considerations for Implementation | Journal of General Internal Medicine \(springer.com\)](#)

^v Wachterman MW, Corneau EE, O'Hare AM, et al. Association of hospice payer with concurrent receipt of hospice and dialysis among US veterans with end-stage kidney disease: A retrospective analysis of a national cohort. JAMA Health Forum. 2022;3(10):e223708. doi:10.1001/jamahealthforum.2022.3708.