



AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

Submitted electronically via www.regulations.gov

June 18, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements [CMS-1714-P]

Dear Ms. Verma:

On behalf of the more than 5,200 members of the American Academy of Hospice and Palliative Medicine (AAHPM), thank you for the opportunity to comment on CMS's recent proposed rule that would update hospice payment rates and the wage index for fiscal year (FY) 2020 as well as modify the hospice quality reporting program. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for patients facing serious illness, as well as their families and caregivers.

AAHPM's members care for our nation's sickest and most vulnerable patients. As such, they are well-positioned to provide feedback on the potential impact of CMS's proposals on beneficiaries with terminal illnesses who have elected the Medicare hospice benefit and not only require, but are entitled to, expert level end-of-life care. Below we offer our feedback on policies included in the proposed rule and how they would impact our Academy members' ability to provide quality care for the hospice patients they serve.

Trends in Medicare Hospice Utilization

CMS notes that, since the implementation of the hospice benefit in 1983, there has been substantial growth in hospice benefit utilization, coupled with changes in diagnosis patterns among Medicare hospice enrollees. While AAHPM is pleased to see increased use of hospice services – which are shown to reduce patients' pain and suffering, improve quality of life, increase patient and caregiver satisfaction, and promote patient dignity – we are concerned that the number of Medicare decedents who access hospice services in a timely manner remains disproportionately low relative to the population that could benefit from hospice services. For

example, in its *2018 Facts and Figures on Hospice Care in America*, the National Hospice and Palliative Care Organization reports that in 2016 less than half of Medicare decedents received hospice care and, of those, roughly 40 percent received 14 or fewer days of hospice care in total.

Given the above, *AAHPM continues to encourage CMS to review and analyze hospice utilization data and changes in diagnosis patterns to determine whether beneficiaries with terminal illness are being appropriately directed to hospice. We also encourage CMS to engage the physician and stakeholder community to increase awareness about the value of hospice and palliative care for Medicare beneficiaries, and we would be pleased to offer our assistance in these efforts.*

Additionally, while CMS did not directly address this issue in this year's rule, we are aware that CMS is concerned about long hospice stays. In analyzing drivers of long length of stay, as well as costs and benefits, *AAHPM encourages CMS to recognize that long length of stay does not, in itself, reflect poor quality of care or inappropriate admissions.* Indeed, patients with a terminal prognosis who elect hospice continue to require and benefit from high-quality hospice care, whether or not that prognosis comes to fruition within an expected 6-month timeframe given the uncertainty inherent in prognostication.

Proposed Rebasing of the Continuous Home Care (CHC), Inpatient Respite Care (IRC), and General Inpatient Care (GIP) Payment Rates for FY 2020

CMS is proposing to rebase the payment rates for CHC, IRC, and GIP based on their estimated FY 2019 average cost per day, and to also reduce the RHC payment rate by 2.71 percent in order to offset the proposed increases resulting from rebasing in order to meet statutory budget neutrality requirements.

AAHPM recognizes the need for payment accuracy, particularly to ensure that hospices have sufficient resources to provide higher levels of care to those patients requiring greater intensity of services. Under current payment rates, hospices routinely lose money when they provide care at the GIP, CHC, and IRC level, leading to underutilization of these services and even disenrollment from hospice when small providers cannot take on the costs needed to provide these higher levels of care. GIP and CHC can be complex, and they often require a breadth and depth of resources that the current rates do not cover. Further, the low IRC and GIP reimbursement rates serve as a barrier, reducing facilities' willingness to contract with hospice agencies for respite or inpatient care.

At the same time, AAHPM is deeply concerned that CMS is taking action prematurely. To begin, CMS is using hospice cost data that continue to be flawed and incomplete. In last year's proposed rule, CMS reported significant problems with obtaining complete and accurate data from hospices, requiring CMS to apply various methodological approaches to "trim" data to pare it down to what might be most reliable. Likewise, for this year's analysis, several exclusions and modifications were again required in order for CMS to reach a sample of cost reports that could be reliably used for its analysis, including the application of Level I Edits. Indeed, CMS reports that data from only 1,098 hospices were used to calculate the costs of providing RHC, compared

to the 3,207 hospices for whom cost reports were submitted. And even fewer hospices' cost reports were used to calculate the costs of providing IRC, GIP, and CHC levels of care, including only 437 cost reports used for calculating CHC costs. The poor quality of reported data raises significant questions about the validity of the data CMS is using to rebase payment rates.

Furthermore, AAHPM is concerned that CMS is not adequately taking into account the costs of providing care in rural and underserved areas, and that applying across-the-board changes in payment, including a 2.71 percent reduction in payment rates for RHC, could have significant harmful effects on rural hospices' quality of care and long-term fiscal sustainability. AAHPM was pleased to see CMS's comment solicitation on improvements to the geographic adjustment of payments to hospice and has provided comments in response further below. AAHPM believes that payment adjustments that more accurately capture and compensate for differences in costs of providing hospice services in rural versus urban communities may first be necessary before CMS rebases payment rates. Without such adjustments, AAHPM is concerned that rural hospices will disproportionately be affected by the reductions in RHC payment rates, and that the policy as proposed will ultimately serve to reduce access to hospice care for small and rural communities across the country.

For these reasons, AAHPM recommends that CMS not finalize its proposal to rebase payment rates for CHC, IRC, and GIP, and to reduce payments for RHC to meet budget neutrality requirements at this time. Instead, AAHPM recommends that CMS take additional time and effort to ensure that hospices are reporting – and CMS is using – meaningful and valid cost reporting data, including through targeted training and education, and that CMS ensure that payment adjustments adequately account for differences in costs based on geography.

We also note that such steps will be critical for protecting against inappropriate incentives for steering patients to higher, more specialized levels of care than required. By taking steps to maximize the accuracy of payment rates, based on reliable and validated data, as well as other adjustments to account for drivers leading to differentiated costs, including geography, CMS will limit the risk of inappropriate steering.

Hospice Wage Index Lag Elimination and Comment Solicitation

CMS proposes to change the hospice wage index methodology from its established policy of using the pre-floor, pre-reclassified acute care hospital wage index from the prior fiscal year as the basis for the hospice wage index, and instead to align with the same timeframe used by the Inpatient Prospective Payment System (IPPS) and other payment systems. ***AAHPM generally supports this proposal, which would use more up-to-date wage index data than currently used in order to set more accurate payments for hospice providers.***

However, in response to CMS's solicitation on concerns stakeholders may have regarding the wage index used to adjust hospice payments and suggestions on possible updates and improvements to the geographic adjustment of hospice payments, AAHPM notes our overall concerns with the hospital wage index on which the hospice wage index is based. ***AAHPM***

questions whether the hospital wage index sufficiently takes into account the labor costs associated with the extensive travel routinely required in the delivery of hospice care. These travel costs are even higher on a per-patient per-day basis for hospices that serve rural populations with large catchment areas, where patients may be located in remote and geographically isolated areas. Likewise, *rural hospices may also experience higher costs related to ambulance transfers due to long distances involved and lack of local services, as well as workflow inefficiencies related to poor cell phone and internet coverage in remote areas, which we do not believe are captured in current geographic adjustments.*

AAHPM continues to believe that CMS should analyze cost data to determine the extent to which costs vary based on geographic setting and should incorporate findings from its analysis into payment through appropriate payment adjustments, in order to protect and promote access to hospice care for rural beneficiaries with terminal illness.

Proposed Election Statement Content Modifications and Proposed Election Statement Addendum

CMS proposes to make changes to the Hospice Election Statement, including providing information about the potential for hospices not to cover some items or services that are unrelated to a patient's terminal illness, about beneficiary cost-sharing responsibilities, and about the patient's right to request an election statement addendum. CMS also proposes to make the presence of the signed addendum in the beneficiary's hospice medical record a new condition for payment, if requested, and specifies several corresponding requirements regarding content, availability, and timing of delivery of the election statement addendum.

AAHPM appreciates and supports CMS's interest in increasing transparency for patients and families regarding the care that is covered by hospice providers, and we recognize this information sharing is central to the care coordination that is a hallmark of high-quality end-of-life care. However, *AAHPM is very concerned with this proposed change, which we believe has the potential to significantly reduce access to hospice care for patients and to increase burden and costs for hospice providers.*

To begin, *AAHPM believes that the requirement to complete the hospice addendum statement within 48 hours after admission would place hospices at significant compliance risk, particularly for admissions that occur after hours or on weekends, which would ultimately reduce access to hospice care.* Often, gathering complete information about a patient's medical conditions to determine whether they are related or unrelated may not be feasible immediately upon admission, when stabilization of acute symptoms is the priority. While CMS rightfully assumes that the work related to determination of related and unrelated care is already being completed, this process almost always takes longer than the 48 hours proposed by CMS. Hospices typically only complete an initial hospice assessment within the first 48 hours, and typically complete a comprehensive assessment to determine unrelated conditions on a longer time frame – often up to 5 days after admission. Additionally, hospice staff must regularly consult with patients' primary and specialty care providers to get a comprehensive understanding of each patient's health status, services,

treatments, supplies, and more. Furthermore, the added requirement of creating the election statement addendum within the proposed timeframe would impose new administrative requirements for which all implicated staff may not be available. For example, medical record staff or authorization staff may need to be involved in the finalization of election statement addenda, but they may only be available during routine work hours. This requirement also does not take into account the fact that many hospice patients receive care in their homes, which could require separate travel – and increased costs – to deliver election statements to patients in the timeframes proposed. As a result of all these challenges, finalizing the proposed requirement to furnish a hospice election statement addendum within 48 hours would increase the risk that hospices delay admissions, leaving vulnerable patients without necessary and appropriate care and placing many at risk of suffering or dying while waiting to be admitted.

AAHPM is also concerned that meeting the proposed requirements would create significant new burdens that (1) would divert resources away from patient care and (2) are not adequately captured in CMS’s burden estimates. For example, the time a registered nurse (RN) may need to extract information from the medical record to the election statement addendum will regularly exceed the 10 minutes on average that CMS calculated in its burden estimates, particularly because patients electing hospice regularly suffer from multiple co-morbidities and have complex health challenges that may need to be documented on the addendum. Additionally, the requirement to provide written clinical explanations “in language the beneficiary and his or her representative can understand” will require additional attention and care, and potentially third-party review, to ensure that this standard is met. The inclusion of required references to relevant clinical practice, policy, or coverage guidelines will also take additional time to obtain and cite. Hospices may also implement final review and sign off from a hospice medical director or hospice physician as part of the interdisciplinary team in order to ensure physician agreement and oversight, though no burden associated with this physician time was included in CMS’s burden estimate. And, in addition to the time and burden associated with initially preparing an election statement addendum, patients in hospice often experience multiple and cascading changes in health status that may occur in compressed timelines and may also need to be captured in the election statement addendum, further contributing to higher burden levels not captured in CMS’s estimates. Moreover, CMS’s proposed requirement to provide updated addenda to beneficiaries and other requesters “immediately” during the course of a hospice election would additionally increase burden, interrupt work flow, and stress hospice staff who should appropriately be focused on delivering high-quality hospice care, and would also be largely infeasible in cases of home-based care where travel would be required. Finally, as noted above, added burden would extend to additional hospice staff (e.g. medical records, authorization, and other administrative staff) and for additional activities (e.g. travel), which are not contemplated in burden estimates.

Overall, AAHPM does not believe that the proposed changes to the hospice election statement, including the election statement addendum, achieve CMS’s goal of increasing transparency and information sharing with patients and caregivers in a manner that supports beneficiary decision-making, maintains beneficiary access to care, and benefits patients and caregivers sufficiently to offset the increased costs and burden the new requirements would impose. Indeed, we see the

potential for greater harm than good to befall patients and their caregivers under these proposed changes. At the same time, AAHPM agrees that there is a need for increased transparency such that hospice patients and their caregivers can better understand and prepare for care that is considered unrelated to their terminal prognoses. Therefore, ***we urge CMS not to finalize its changes as proposed; rather, we ask CMS to work with AAHPM and other stakeholders to identify and implement a more tenable solution to the challenge CMS has identified in a way that minimizes burden, consistent with CMS's Patients over Paperwork initiative, while also ensuring that beneficiaries have meaningful information about covered services to make informed decisions.***

Request for Information Regarding the Role of Hospice and Coordination of Care at End of Life

AAHPM thanks CMS for its interest in better understanding the role of hospice and coordination of care at the end of life, including understanding the interaction of the hospice benefit with Medicare Advantage (MA) plans and other alternative payment and delivery models.

AAHPM recognizes that CMS is seeking to test the management of the Medicare hospice benefit by MA plans as an option under the MA Value Based Insurance Design (VBID) model. While AAHPM appreciates CMS's interest in increasing care coordination for patients with terminal illness or those with serious illness nearing hospice eligibility, ***we urge CMS to approach this model with caution, and in particular, to ensure the model includes sufficient protections to maintain access to a robust hospice benefit for Medicare beneficiaries with full patient choice; limit burden on hospice providers; ensure quality accountability; and maximize the potential for early access to palliative care services for patients with serious illness who may not be eligible or willing to elect the hospice benefit, as detailed below:***

- Loyalty to the hospice benefit
CMS's plan to test the movement of hospice care into the MA program should ensure that MA plans remain loyal to the comprehensive, all-inclusive and multidisciplinary nature of the hospice benefit. ***AAHPM recommends that hospice services remain bundled, and that patients continue to have access to the interdisciplinary care teams that are at the core of hospice care, in order to maintain the same level of care that hospices provide under Medicare fee-for-service (FFS), ensure good care coordination, and drive favorable outcomes for hospice patients subject to the model.***
- Beneficiary and hospice protections
Requiring hospices to contract with MA plans has the potential to create risks for hospice providers and the beneficiaries they serve, for example through potential selective contracting with the biggest and/or lowest-cost hospices that may not offer high-quality care; prior authorization requirements, limited formularies, and opioid management policies that create barriers to hospice services; or other administrative burden. In particular, AAHPM is concerned that plan policies may prevent patients from being able to access critical services and treatments, including medically necessary drugs to manage pain and suffering and/or higher levels of hospice care, such as CHC or GIP, in a timely

manner. AAHPM is also concerned that individual plan policies may result in a patchwork of service delivery, as each plan imposes its own unique set of requirements that will make it difficult for hospices to provide services in a uniform manner. For all these reasons, **AAHPM recommends that the model include appropriate protections to ensure full access to high-quality hospice providers and hospice services, as well as limit burdensome requirements imposed by MA plans on hospice providers.**

- Quality accountability
CMS's model should include a rigorous and transparent accountability structure that holds MA plans accountable for providing high-quality, seamless care, including appropriate and timely referral to hospice. This may also require development of new hospice measures specific to MA plans.
- Access to community-based palliative care services for patients with serious illness
AAHPM appreciates that CMS has prioritized earlier availability of palliative care services for patients with serious illness. AAHPM agrees that moving the hospice benefit into MA plans – while it comes with some risks – does create an opportunity to improve seamless care coordination and care delivery, including allowing MA plans to support the delivery of community-based palliative care services for patients who may not be eligible or willing to elect hospice. AAHPM believes that providing such patients access to palliative care services outside the hospice benefit can improve the care they receive, help to control costs, and facilitate more timely transition to hospice. As such, **AAHPM encourages CMS to ensure that participating MA plans include community-based palliative care services in their benefit packages as an added component of their management of seriously and terminally ill patients.**

Separate from the MA VBID test, AAHPM would also like to thank CMS for its recent announcement regarding the Primary Care First Serious Illness Population (PCF SIP) option, which we believe is an important step in increasing continuity of care for patients with serious illness who may not be eligible or ready for hospice care. AAHPM appreciates many of the elements of the PCF SIP option announced to date, including its focus on patient need rather than prognosis, reliance on interdisciplinary care teams to provide community-based palliative care, requirement for 24-hour coverage, and more. AAHPM believes this model has the potential to greatly increase the quality of care patients with serious illness receive, while also controlling unnecessary spending and increasing the likelihood of timely access to hospice care.

For the PCF SIP option, AAHPM recommends that CMS consider expanding the use of telehealth services, including allowing telehealth services to be used for face-to-face visits eligible for separate reimbursement under the PCF SIP option, including through the waiver of originating site restrictions. AAHPM believes telehealth is of great potential value to patients receiving serious illness care. For example, clinicians can monitor pain and symptom management and can assess for functional decline in “real time,” without having to wait for an office visit. They can also intervene earlier with recommended treatments or solutions. AAHPM also supports broader use of telehealth within the hospice benefit – for example with respect to the hospice recertification encounter – and AAHPM encourages CMS to look for additional opportunities to

expand the use of telehealth services for the seriously ill and hospice-enrolled populations in a clinically appropriate manner, in order to increase access to care for frail and vulnerable beneficiaries.

Finally, as CMS contemplates the role of hospice in Medicare FFS and alternative payment and delivery arrangements, AAHPM encourages CMS to correct an outdated hospice Condition of Participation (CoP) that prevents physician assistants (PAs) from ordering medications for hospice patients. Until recently, PAs were prohibited by statute from serving as the “attending physician” responsible for establishing and periodically reviewing the plan of care for hospice patients. This role was limited to physicians and nurse practitioners (NPs). Federal legislation (the Medicare Patient Access to Hospice Act, enacted as part of the Bipartisan Budget Act of 2018) and, subsequently, CMS regulation have broadened the Medicare definition of hospice “attending physician” to include PAs. As of January 1, 2019, PAs are permitted to provide and manage care for hospice beneficiaries. Despite the statutory and regulatory changes authorizing PAs to serve as a hospice patient’s attending physician, CMS’s reliance on an CoP, 42 CFR 418.106(b), prohibits PAs from carrying out an essential component of the attending physician role, which is ordering medications for hospice patients. The CoP only lists physicians and NPs as being able to order medication, but not PAs. Now that PAs are authorized as attending physicians for hospice, AAHPM believes there is no reason they should be excluded from being able to order medications. PAs are authorized to prescribe in all 50 states and the District of Columbia and have been prescribing to Medicare beneficiaries outside of the hospice benefit for decades. As such, ***we request that CMS take action to allow PAs to fulfill their patient responsibilities as attending physicians, including by reopening the hospice CoPs in order to specify that PAs may prescribe medication to Medicare hospice patients.***

Hospice Quality Reporting Program (HQRP)

Overview

AAHPM appreciates and supports CMS’s effort to identify high-priority areas for quality measurement and improvement through the Meaningful Measures Initiative, in order to improve outcomes for patients, their families/caregivers, and providers, while also reducing burden on clinicians and providers. We also appreciate CMS’s interest in receiving input on new quality measures or measure concepts that could be incorporated into the HQRP.

AAHPM agrees that ongoing development of new, meaningful measures should remain a priority, and that CMS should pursue opportunities to develop measures that assess those facets of care that are most important for hospice patients at the end of life. AAHPM notes that our organization was selected as a recipient of measure development funding provided under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to develop patient-reported quality measures for community-based palliative care that would apply under CMS’s Quality Payment Program. These measures are focused on patient-reported experience of (1) receiving the help they wanted for their symptoms and (2) feeling heard and understood by their providers. Once these measures are developed and established, CMS could consider how to adopt them for the hospice setting.

Other measures focused on patient and family engagement, care coordination, functional status, caregiver burden, and care concordant with patients' wishes could also be explored.

Finally, *AAHPM would also like to express support for CMS's current approach to quality measurement in hospice care, which relies on a mixed portfolio of measures that include outcome measures, patient and caregiver experience measures, process of care measures, and claims-based measures.* Such a diverse portfolio offers a multifaceted way of assessing and understanding the care delivered by hospices, and it also provides a way to safeguard against potential shortcomings of individual measures or measure types.

Claims-Based and Outcome Quality Measure Development

CMS is soliciting public comments and suggestions related to ideas for future claims-based and outcome measure concepts that could be tied to its Meaningful Measures Initiative goals. AAHPM recognizes there are certain benefits associated with the use of claims-based measures, including the lack of provider burden and the use of widely available, standardized data sources. However, CMS rightfully acknowledges that limitations also exist with respect to claims-based quality measures. For example, AAHPM has previously noted that claims-based measures cannot fully reflect the extent to which care provided is appropriate or inappropriate and that it would be difficult to hold performance on claims-based measures to specified standards given the variation in patients' health status, care needs, and treatment preferences across hospices to specify appropriate performance levels.

Given CMS's ongoing interest in the use of claims-based quality measures, however, *AAHPM believes that CMS should devote particular attention to ensuring safeguards are in place when such measures are used, in order to protect against unintended consequences.* As CMS continues to advance the development of these measures, CMS should consider:

- Ensuring that performance on claims-based measures is risk adjusted, to account for differences in severity and complexity of hospice patient populations;
- Ensuring that measures are fully tested, validated, and understood before publicly reporting hospice performance on measures, including understanding how performance on claims-based measures may align with performance on other hospice quality measures;
- Providing clear education on how performance on measures should be interpreted, including education on limitations of measures (including challenges setting performance benchmarks), and encouraging Hospice Compare visitors to refer to other types of measures for the same information; and
- Developing aggregate assessments of hospice quality to report on Hospice Compare that weight results of claims-based measures less heavily than patient and caregiver experience measures.

Specifically with respect to the access to levels of care claims-based measure, AAHPM recognizes the potential for this measure to result in hospices providing higher levels of care than needed. However, AAHPM also believes information on whether a hospice can provide access to higher levels of hospice care should be readily available to patients. Without such access, the only

alternative may be for patients to revoke their hospice status and seek emergency care. As such, *we support CMS's plan to continue developing a claims-based quality measure in this area that could provide this critical information to consumers.*

Update on the Hospice Assessment Tool

In response to a request to change the name of the hospice assessment tool, CMS is seeking public comment on a new name for the hospice assessment tool. *AAHPM offers for CMS consideration the following: Evaluation and Assessment Reporting Tool for Hospice, or EARTH. AAHPM believes this name is suitably descriptive, while also clearly distinguishable from other names or acronyms commonly used in reference to hospice care.*

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey

CMS solicits comments about the CAHPS Hospice Survey questionnaire, to identify changes that would improve its value to hospices for quality improvement and consumers for selecting a hospice. AAHPM believes that the CAHPS Hospice Survey is one of the best tools available to understand the quality of care and support delivered to hospice patients and their families and caregivers, including the extent to which hospices deliver patient and caregiver-centered care that is consistent with patients' preferences. AAHPM also appreciates the value that reporting of CAHPS Hospice Survey data can offer to both hospice providers and consumers. However, AAHPM offers the following recommendations for the presentation of CAHPS data on the Hospice Compare website:

- *CMS should consider ways to account for and report on differences in performance based on rural versus urban settings, including on Hospice Compare.* Rural hospice providers are often physically distant from their patients, which has the potential to affect performance on measures related to rapid response and frequency of visits. This discrepancy may lead patients to believe that rural hospices provide lower quality of care than urban hospices.
- *CMS should consider reporting response rates to CAHPS surveys on Hospice Compare, along with survey results.* When performance on CAHPS measures are based on a small proportion of hospice patients, or a small number of patients overall, then there is a higher likelihood that reported rates are not representative of the quality of care provided by hospices. Providing additional detail on response rates will help consumers of the data better understand how much to weight the information.
- *CMS should explore as a potential future measure concept patient and caregiver perceptions regarding transitions in levels of hospice care.* Given CMS's interest in assessing hospices on whether they provide access to different levels of care, AAHPM believes that it could be helpful to solicit information about the extent to which patients and caregivers were provided information and education about the different levels of care available, and whether they were supported in accessing different levels of care that they believed were necessary to best manage patients' care needs.

Hospice Visits when Death is Imminent

AAHPM appreciates CMS's decision not to publicly report Measure 2 under the Hospice Visits when Death is Imminent measure pair given the failure to meet readiness standards for public reporting. When the measure is ready for reporting, ***AAHPM encourages CMS to ensure that there is sufficient information provided on the Hospice Compare website for the public to understand how to interpret performance on the measure to judge the quality of care delivered by each hospice. Additionally, AAHPM also encourages CMS to address variation in performance on this measure based on rural versus urban settings, as discussed above under the CAHPS survey, as similar concerns may apply.***

Public Display of Information from Other Government Sources

CMS proposes to post information from other publicly available government data, in addition to the data from CMS sources, to the Hospice Compare website at some time in the future. While we recognize that there could be value to sharing additional data on hospices that may not be available through CMS sources, AAHPM is concerned that CMS has not provided sufficient information on what types of data may be used and how that data would be used. As such, ***AAHPM requests that CMS delay a final decision on this rule. Instead, CMS should provide several clear examples of the data that CMS envisions posting to the Hospice Compare website, such that stakeholders may assess this proposal on a more informed basis.***

Thank you again for the opportunity to provide feedback on the important issues addressed in this proposed rule. AAHPM stands ready to collaborate with CMS to address the many challenges discussed here and support delivery of high-quality care for Medicare hospice beneficiaries. Please address questions or requests for additional information to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@ahpm.org or 847-375-4841.

Sincerely,



Joanne Wolfe, MD MPH FAAHPM
President
American Academy of Hospice and Palliative Medicine