AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

Submitted electronically via regulations.gov

June 7, 2021

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements [CMS-1754-P]

Dear Administrator Brooks-LaSure:

On behalf of the 5,300 members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the fiscal year (FY) 2022 Hospice Wage Index and Payment Rate Update proposed rule. 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 key 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.

Summary of Key Messages and Recommendations

AAHPM offers the following key messages and recommendations, which are further detailed in our comments below:

- The hospice population is changing, and new spending and utilization patterns are reflective of such change. CMS should not hold hospices accountable to outdated expectations for utilization of hospice care.
- CMS should monitor and report on the percentage of short hospice stays to develop a better understanding of timeliness of hospice referrals.
- CMS should capture more comprehensive data about the holistic hospice benefit, including through coding changes that allow for reporting of chaplain services and services furnished via telecommunications technology.
- CMS should pursue further opportunities to offer palliative care services upstream of the hospice benefit to fill a coverage and care gap for a growing population of Medicare beneficiaries with serious illness.

- AAHPM appreciates CMS's proposed reforms to the hospice election statement addendum and requests a retroactive effective date of October 1, 2020.
- AAHPM supports CMS's proposed changes to the hospice conditions of participation, which would reduce burden while continuing to support high-quality hospice care.
- AAHPM supports CMS's proposal to remove the seven Hospice Item Set measures from the Hospice Quality Reporting Program.
- AAHPM has significant concerns with CMS's proposal to implement and publicly report the Hospice Care Index measure and recommends alternative mechanisms for sharing HCI data with hospices rather than public reporting, as well as potential refinements to the measure should CMS choose to continue to pursue its implementation.
- AAHPM has several questions and concerns related to CMS's proposal to add CAHPS star ratings to public reporting and believes that CMS should work to address them before implementing star ratings.
- AAHPM requests more frequent updates to claims-based measure calculations and more frequent updates to measure scores on Care Compare, in preview reports, and in confidential CASPER quality measure reports.
- AAHPM appreciates CMS's interest in transitioning to digital quality measurement but reminds CMS of the disadvantages that hospices would experience given their historic exclusion from the Medicare and Medicaid Electronic Health Record Incentive program. We therefore encourage CMS to adopt a thoughtful, long-term plan for moving forward that addresses barriers and minimizes provider burden.
- AAHPM applauds CMS's emphasis on closing the health equity gap and supports expansion of data collection on social determinants of health for hospice providers.

Hospice Utilization and Spending Patterns

CMS provides information on hospice utilization and spending patterns, including information on diagnosis patterns, length of stay, live discharge rates, and spending outside of the hospice benefit. AAHPM appreciates ongoing CMS monitoring and analysis of hospice data, which provide important insights into both the increased uptake of the hospice benefit among Medicare beneficiaries at the end of their lives, as well as the ongoing gap in supportive care for those beneficiaries who do not make hospice elections. We note, however, that CMS does not include any discussion of very short lengths of stay in hospice, which are indicative of poor quality end-of-life care. ***AAHPM recommends that CMS monitor and report on the percentage of short hospice stays (e.g., 3 days or fewer, or 7 days or fewer) in order to develop a better understanding of timeliness of hospice referrals. AAHPM also continues to recommend that CMS review and analyze hospice utilization data and changes in diagnosis patterns to determine whether beneficiaries with terminal illness are being appropriately directed to hospice. Additionally, we 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.***

At the same time, we note that utilization data alone are not sufficient to understand whether high-quality, patient-centered hospice care is being delivered, and indicators focused on length of stay and live discharge rates may lead to unintended consequences to the extent that they create incentives to furnish care in a manner that is inconsistent with patient preferences. While we are aware that CMS and others may be concerned about long lengths of stay and live discharges, in many cases, such outcomes reflect preference-concordant care and outcomes that are in the best interest of beneficiaries. Patients with a terminal prognosis who elect hospice may continue to require and benefit from high-quality hospice care

beyond a 6-month timeframe, even if such duration is contrary to their original prognoses. This is true, for example, for many patients who may experience dementia over an extended period but who continue to face terminal and debilitating illness that is best met by ongoing holistic and multidisciplinary hospice care, as opposed to discharge from hospice. Conversely, subsets of patients may experience improvements in their health conditions or changes in their personal preferences that may fully warrant live discharge. As such, ***CMS should recognize that both long lengths of stay and live discharges are expected and appropriate outcomes for many hospice beneficiaries and that care is needed to mitigate the risk of unintended consequences that excess scrutiny of such indicators may present.***

With respect to related versus unrelated care, as we have previously noted, hospices frequently admit patients with pre-existing conditions that clearly are not related to their terminal illness and for which medications and other medical interventions remain necessary right up to the last days of life. The hospice physician and the interdisciplinary group (IDG) are best positioned to assess and address the complexity and multiplicity of chronic illnesses that are present in the vast majority of beneficiaries electing hospice and the extent and nature of suffering associated with these individuals' non-terminal comorbidities. ***The expertise of the hospice physician and IDG must be what guides any determination as to whether a prescription drug or other medical treatment is related or unrelated to a beneficiary's terminal prognosis.*** These decisions about "relatedness," made during the admission process and subsequent assessments – including to address new hospice election statement addendum requirements – must be made on a case-by-case basis, and a patient's care plan developed accordingly. Indeed, our members report that the new addendum requirements have not had meaningful impact on findings of related or unrelated services, which continue to be determined by the hospice physician and IDG.

Overall, we believe that CMS's concerns around spending outside of hospice, live discharge rates, and long length of stay are driving policy decisions such as the recent requirement to implement the hospice election statement addendum and CMS's proposal to implement the Hospice Care Index (HCI) measure, which we discuss further below. Such policies result in costly additional administrative requirements and seek to use quality requirements to address program integrity concerns, rather than focus on quality accountability and improvement. However, many of these utilization trends that raise concerns for CMS reflect the changing hospice population, with a growing proportion of patients with neurological conditions like Alzheimer's and other dementias. Such patients exhibit different healthcare needs and service utilization patterns than the cancer patients whom hospice providers more commonly cared for in the past. ***We recommend that CMS reframe its consideration of hospice utilization patterns in light of this changing population, rather than hold hospices accountable to outdated expectations of appropriate hospice care.***

We also call attention to what we view as an overemphasis on medical care compared to other core components of hospice care and the hospice benefit. Given the changing patient population, hospice providers have increasingly been required to address patients' and caregivers' social needs, including through reliance on social workers, certified nursing assistants, and respite care, rather than what are typically considered "skilled visits." However, as reflected in the measure indicators selected for the HCI, CMS is placing a greater emphasis on skilled visits rather than the entirety of the hospice benefit – for example, spiritual care, post-mortem care, and bereavement services. Indeed, there is not currently a mechanism for hospices to report the full range of services furnished by hospice providers, including services furnished by chaplains. CMS's emphasis on skilled visits undervalues the comprehensive nature of the hospice benefit and its holistic approach to addressing patient and caregiver needs, and limits visibility into the range of services hospices provide. ***We therefore encourage CMS to consider opportunities to actualize a broader vision and understanding of hospice services, including through data***

collection and performance assessment. As a first step, CMS should adopt coding changes that would allow hospices to report on chaplain services. Likewise, services furnished via telecommunications technology should be reportable via claims in order to document, track, and evaluate the impact of such services on hospice care. With such data, CMS could also consider longer-term opportunities to incorporate the delivery of such services into hospice accountability efforts, including collection and public reporting of quality measures.

CMS also seeks information on the impact of the hospice election statement addendum on care decisions and discussions with beneficiaries. Our members report some benefits of the new election statement addendum requirements; for example, review of medications has helped to identify duplicate prescriptions across the hospice benefit and Medicare Part D, and the addendum has also helped provide additional teaching opportunities for non-physician members of the hospice team. However, as noted above, the addendum has resulted in little change to determinations of related versus unrelated care. Furthermore, very few patients and families are requesting the addendum, such that the positive impacts of the addendum on the patients and families have been limited. Therefore, *on balance, we find that the burdens associated with the election statement addendum outweigh the benefits.* As such, CMS might consider and clarify how discussion about the addendum could reflect the full range of reasons as to why the hospice does or does not cover an item, service or drug during the hospice election — for example, to help patents and families understand what is considered related but no longer medically necessary or what costs may be incurred by the beneficiary if they decline a generic medication and, instead, wish to continue with a brand name medication. In addition, AAHPM supports increasing data exchange and interface between hospices and Part D plans, to verify the enrollee's hospice election and payment for drugs considered related to the terminal illness and associated conditions and to prevent duplicate payment of medications for hospice beneficiaries.

Finally, *we urge CMS to pursue further opportunities to offer palliative care services upstream of the hospice benefit, including through the implementation of a community-based palliative care model.* As the hospice population has experienced changes over time, the health needs of the Medicare population are also evolving, leaving beneficiaries with serious illness to fall into a coverage gap, where existing Medicare benefits do not adequately address their care needs. While they may not have a terminal prognosis, high-quality, multidisciplinary palliative care can provide significant benefits to these patients and their families and caregivers. Availability of community-based palliative care services would address this gap, enabling Medicare beneficiaries with serious illness to benefit from comprehensive, patient-centered care tailored to their needs and preferences.

Proposed Clarifying Regulation Text Changes for the Hospice Election Statement Addendum

CMS proposes several changes to the regulation text for the hospice election statement addendum that clarify associated requirements. *AAHPM thanks CMS for these commonsense changes, which we believe will facilitate administration of the addendum and reduce hospice burden. Additionally, we ask CMS to make the changes retroactive to October 1, 2020.* While this request is particularly appropriate for those policies that CMS specified in preamble language in the FY 2021 Hospice Final Rule but did not include in regulation text, we believe that all the addendum changes CMS is proposing would establish more reasonable compliance standards that should apply with the outset of the hospice election statement addendum requirements.

Hospice Waivers Made Permanent Conditions of Participation

CMS proposes to update its regulations to permit skill competencies to be assessed by observing an aide performing the skill with either a patient or a pseudo-patient as part of a simulation. CMS also proposes to amend its regulations to specify that if an area of concern is verified by the hospice during the on-site visit, then the hospice must conduct, and the hospice aide must complete, a competency evaluation of the deficient skill and all related skill(s), rather than completing another full competency evaluation. ***AAHPM thanks CMS for these changes, which we believe continue to support high-quality patient care while enabling hospices to focus resources on areas of highest need, and we recommend that CMS adopt these changes as proposed.***

Proposals and Updates to the Hospice Quality Reporting Program (HQRP)

Proposal to Remove the Seven "Hospice Item Set Process Measures" from the HQRP beginning FY 2022

CMS proposes to remove the seven individual Hospice Item Set (HIS) process measures from the HQRP, no longer publicly reporting them as individual measures on Care Compare beginning with FY 2022. ***AAHPM supports this change, given the continued use and reporting of the HIS Comprehensive Assessment Measure. However, we encourage CMS to take care when updating the information on the Care Compare site, to ensure that consumers can easily understand the changes in reported data.***

Proposal to Add a "Claims-Based Index Measure," the Hospice Care Index (HCI)

CMS proposes to implement a new claims-based hospice quality measure called the Hospice Care Index (HCI), which is a single measure comprising 10 indicators calculated from Medicare claims data. Each indicator equally affects the HCI score, with hospices eligible to receive up to 10 points on the measure. CMS proposes to begin reporting the measure no earlier than May 2022.

We appreciate CMS's continued effort to identify claims-based quality measures for the HQRP that would minimize burden on hospice providers. However, ***AAHPM has significant concerns about CMS's proposal to implement and publicly report the HCI measure.*** Most importantly, AAHPM is concerned that – as a whole – the measure fundamentally does not reflect the quality of care furnished by a hospice. Rather than providing information on whether hospices are providing care that is concordant with patients' and caregivers' preferences, the indicators largely appear to reflect program integrity considerations – for example, whether hospices are meeting their obligations to furnish all four levels of hospice care or whether they are outliers with respect to live discharge rates. Other indicators, like Nurse Care Minutes per Routine Home Care (RHC) Day or Skilled Nursing Minutes on Weekends, track service utilization for which there is little evidence supporting a relationship between higher duration of care delivery and improved health outcomes; likewise, they do not necessarily reflect the extent to which patients and caregivers want or need such nursing care. And the Per-beneficiary Medicare Spending indicator reflects costs rather than quality, without a clear understanding of the linkage between the two. At the same time, across the indicators, there is overemphasis on medical care and little consideration of other core components of hospice care, such as spiritual care, post-mortem services, or bereavement services. Furthermore, CMS's methodology for providing equal weight across indicators fails to recognize the relative contributions of the indicators to quality of care. Additionally, we are concerned that the measure could lead to unintended consequences – for example, incentivizing hospices to modify their admission practices and limit access for populations that may be more likely to lead to less favorable scores on the HCI.

We are also concerned that the HCI measure and individual indicators are not appropriate for public reporting on Care Compare and that CMS will have significant difficulty developing language that will clearly communicate to consumers what each indicator means and why it should be of importance to their decision-making. Consumers will generally not be familiar with the elements of hospice care that the indicators measure. For example, some consumers may be confused about live discharges or avoidance of general inpatient care, which they may interpret to be favorable outcomes from a hospice stay. Combined with our concerns noted above regarding the overall limits of the measure to reflect high-quality care, these communication challenges could result in public reporting of the HCI measure doing more harm than good.

With respect to the use of claims to calculate the HCI measure, as we noted above, there is not currently a mechanism for hospices to report the full range of services furnished by hospice providers. For example, lack of HCPCS codes and modifiers preclude reporting of services furnished via telecommunications technology or furnished by chaplains and spiritual counselors. To the extent that CMS relies on claims-based measures like the HCI to assess hospice performance, the performance should reflect the full range of hospice services. As such, ***we urge CMS to finalize coding changes that allow for reporting of the full range of hospice services, including chaplain services and services furnished via telecommunications technology.***

Given many of the indicators' utility for program integrity purposes, ***we recommend that CMS pursue alternative mechanisms for sharing this data with hospices and addressing outlier hospices, rather than implementing and publicly reporting of the HCI measure***. For example, CMS could share information through PEPPER reports, as well as work more closely with outlier hospices as part of a special focus program for hospices demonstrating serious deficiencies. We do not believe that broad public reporting of the HCI measure, as proposed, will achieve policy goals of improving compliance and addressing hospices with problematic track records.

To the extent that CMS continues to pursue an HCI measure, ***we recommend that any such measure not be implemented or publicly reported until it receives full endorsement from the National Quality Forum (NQF).*** We believe the NQF endorsement process will lead to refinement of the measure and increased focus on quality of care. ***Additionally, we recommend that CMS provide hospices with their performance data for all HCI indicators far enough in advance to ensure the opportunity for performance improvement. We also ask CMS to wait to implement the measure until the data used for the measure is reflective of care provided by hospices outside of a public health emergency.*** Under CMS's current timeline, we believe that the HCI indicators will likely reflect data collection during the COVID-19 pandemic, with abnormal visit patterns and no documentation of visits furnished via telecommunications technology in claims. ***Finally, we recommend that CMS ensure that – prior to public reporting – the HCI measure be fully tested and studied, including to ensure a high level of consumer understanding.*** We are concerned that there is a significant potential for unintended consequences if the measure is rushed and consumers do not fully comprehend how the measure should be interpreted and used to support decision-making.

AAHPM also offers the following additional considerations for quality measure development for the HQRP. Development of additional claims-based measures should focus on measure concepts that truly promote quality, addressing aspects of care that are meaningful to patients. To this end, we recommend partnering with patients (when possible) and their family members/caregivers to help prioritize the outcomes that are most important to them. We also believe that CMS's best opportunities for future measure development lay with the finalization of the Hospice Outcomes and Patient Evaluation (HOPE) tool, which should provide better information for assessing and reporting hospice quality of care.

Proposal to Add CAHPS Hospice Survey Star Ratings to Public Reporting

CMS proposes to introduce Star Ratings for public reporting of CAHPS Hospice Survey results on the Care Compare website no sooner than FY 2022, applying a cut-point methodology to determine how star ratings are assigned to scores for each measure and also calculating a summary or overall star rating by applying a weighted average of the individual measures. Only the overall star rating would be publicly reported.

We have several questions and concerns with this proposal. To begin, we question whether the methodology that CMS proposes will result in a star rating that accurately reflects patients' experience of care. CMS's cut-point methodology will rely on statistical clustering to assign star ratings, rather than assigning star ratings based on objective performance rates. If the Hospice CAHPS star ratings follow precedents in other programs, this will lead to distribution of star ratings that generally follows a bell curve. It is not clear, therefore, how hospices' performance will translate to star ratings and whether relatively high levels and tight distribution of performance on Hospice CAHPS surveys will distort star ratings. We also note that the cut-point methodology does not result in star ratings that are consistent with consumers' general understanding of how such ratings are calculated in other domains. That is, when reviews of products are displayed online, star ratings generally reflect a simple average of the individual ratings submitted by reviewers. The cut-point methodology that CMS proposes creates added complexity that will therefore confound consumers' understanding of the ratings and the extent to which they reflect hospice quality of care.

We also question CMS's longer-term plans for reporting performance and star ratings for quality measures assessed using the HOPE tool. As noted above, we believe HOPE offers a great deal of promise for assessing and reporting on quality of care, so we believe that any plans for updates to public reporting should take into account a longer-term strategy for introduction of HOPE data, in order to minimize confusion and maximize the utility of reported data.

Finally, we ask that CMS provide ample opportunity for hospices to review preliminary star ratings prior to public reporting. Given the potential disconnect between hospices' absolute performance on the CAHPS survey and the star ratings, hospices will need sufficient time to review and analyze their data and implement any potential changes that may be needed.

Overall, ***while we support CMS's interest in standardizing presentation of data on Care Compare and facilitating consumers' understanding of hospice quality, we believe CMS should work to address the above concerns prior to implementing star ratings for public display of CAHPS performance. Additionally, as with the HCI measure, we recommend robust consumer testing prior to implementation to ensure a high level of understanding, including with respect to how the ratings are calculated and how they differ from other star ratings with which consumers may be more familiar. CMS might also consider creating a tool or video to help consumers checking the Compare site to understand these differences.***

Quality Measures to be Displayed on Care Compare in FY 2022 and Beyond

CMS proposes to update claims-based measures used for the HQRP and to annually refresh claims-based measure scores on Care Compare, in preview reports, and in the confidential CASPER quality measure preview reports. ***AAHPM suggests that CMS should recalculate and share measure performance scores more frequently than proposed – for example, on a quarterly basis – in order to help drive performance improvement.***

Requests for Information

Request for Information – Fast Healthcare Interoperability Resources (FHIR) in Support of Digital Quality Measurement in Post-Acute Quality Reporting Programs

CMS seeks feedback on its future plans to define digital quality measures (dQMs) for the HQRP, as well as on the potential use of the FHIR standard to support digital quality measurement.

AAHPM appreciates CMS's interest in transitioning to use of dQMs and FHIR to streamline data collection and quality assessment and to facilitate interoperable data exchange. However, we remind CMS that many provider types – including hospices – would be at a substantial disadvantage due to limited adoption of certified electronic health record technology (CEHRT). Hospices were among the providers excluded from participation in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, which provided billions of dollars in federal incentives to hospitals and physician practices to adopt and use CEHRT. As a result, few EHR vendors have developed CEHRT that is applicable to hospice settings, and hospices were not able to make the investments in core health information technology (HIT) necessary to support dQMs. Any requirement for digital quality measurement would likely impose substantial costs to implement or upgrade HIT systems, which would serve as a significant barrier to success for many hospices across the country. We also note that the COVID-19 pandemic has taken a heavy toll on providers, with many continuing to face high overhead costs and financial burden, which would further impede hospices' ability to meet new digital reporting requirements.

AAHPM cautions CMS against moving forward with digital quality measurement without addressing such barriers, including financial incentives for hospices to adopt CEHRT to level the playing field for digital quality measurement. Such incentives would not only support quality assessment and improvement efforts, but also lead to improvements in interoperable data exchange that could facilitate seamless care coordination and more effective care management.

We also urge CMS to adopt a thoughtful, long-term transition that recognizes the challenges providers will continue to experience following the COVID-19 pandemic and the barriers that they will have to overcome to adopt necessary HIT and transition to digital quality measurement. CMS should undertake these efforts in a transparent manner that offers providers sufficient lead time for preparation and minimizes unnecessary burden on the provider community.

Request for Information – Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs

CMS seeks public comment on several considerations related to closing the health equity gap in post-acute care quality reporting programs. AAHPM is dedicated to improving quality of life and quality of care for all people living with serious illness, as well as their families and caregivers, regardless of race, gender, gender identity, sexual orientation, age, religion, ethnicity, socioeconomic status, or disability. This includes a commitment to promoting equitable care and tackling systemic discrimination and implicit bias, along with the many other social and physical determinants of health linked to health disparities and adverse outcomes. We therefore applaud and support CMS in its goal to identify and advance efforts to achieve health equity across the Medicare program.

AAHPM recognizes that a first step towards increasing health equity it to better understand how various social and environmental factors are associated with and contribute to differential health outcomes. As such, ***we would support efforts to collect additional data on relevant patient characteristics.*** We are aware

that CMS has already established data collection requirements for social determinants of health (SDOHs) under other post-acute care payment systems, as required by the IMPACT Act of 2014. Expanding collection of such SDOH data – including for race, ethnicity, preferred language, interpreter services, health literacy, transportation, and social isolation – would help to ensure that hospices and other providers are capturing necessary information to document where and how disparities exist. We also note that better data collection on factors such as availability of caregiving, housing scarcity, food scarcity, marital status, and socioeconomic status would further help to improve our collective understanding of the factors that support or impair achievement of positive health outcomes. We note that Z codes are also available to report data on social risk, which may serve as an additional tool for collecting social risk data. At the same time, many providers see little incentive to report these codes and find that reporting of social risks fails to translate into any action to address patients' needs. ***AAHPM therefore encourages CMS consider expanding the use of Z codes for collection of data on social risks, including through provider education and incentives for reporting of Z-codes for either patients or clinical teams.***

Transitioning from collection of data to reporting and applying the data through changes in policy will also be critical. ***AAHPM believes an appropriate next step would be to provide hospices and other providers data on their patient populations through confidential reporting. However, CMS will need to exercise caution when contemplating public reporting of data or application of data, for example through risk adjustment or other policy changes, in order to guard against unintended consequences.***

* * * * *

Thank you again for the opportunity to provide feedback on the FY 2022 Hospice Wage Index and Payment Rate Update proposed rule. AAHPM would be pleased to work with CMS to address our recommendations above. Please direct questions or requests for additional information to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,

Nathan E. Goldstein, MD FAAHPM
AAHPM President