

May 30, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements [CMS-1787-P]

Dear Administrator Brooks-LaSure:

On behalf of the more than 5,600 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) 2024 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 the expanding and diverse population of patients facing serious illness, as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have access to high-quality, equitable palliative and hospice care.

Summary of Key Messages and Recommendations

AAHPM offers the following key messages and recommendations, which are further detailed in our comments that follow.

- With regard to hospice utilization trends, AAHPM believes that – given structural limitations within the Medicare hospice benefit – major reforms to the benefit are required to address many of the challenges that CMS has identified. In particular:
 - CMS should explore changes to the hospice benefit that will ensure that providers receive sufficient payment to furnish necessary services to hospice beneficiaries without requiring hospices to bear undue risk.
 - CMS should update rules regarding continuous home care (CHC), including to reduce the minimum daily requirement to 4 hours and/or eliminate the midnight-to-midnight requirement, so that patients who could benefit from CHC in the evening would qualify.

- CMS should address structural challenges – such as lack of caregiver support and misalignment between costs and payments for rural providers – that contribute to health disparities.
 - AAHPM also believes that hospice eligibility should not be based solely on a specified prognosis or life expectancy; rather, eligibility should be based on patients' needs.
 - AAHPM encourages CMS to work with Congress, to the extent that changes in statute are needed to achieve such reform.
- CMS should explore incentives to encourage non-hospice providers to engage in partnerships with hospices to offer advanced therapies with palliative benefit, as well as to provide higher levels of care, with the understanding that such opportunities may still elude smaller hospices or those in certain geographies.
- CMS should improve its systems to convey hospice enrollment status and engage in provider education efforts for non-hospice providers and pharmacies to prevent inappropriate non-hospice spending for hospice-enrolled beneficiaries.
- Regarding informed decision-making about hospice selection, AAHPM:
 - supports increased transparency and information sharing on aspects of care such as staffing levels, frequency of staff encounters, utilization of higher levels of care, and hospice ownership, in order to empower beneficiaries to make informed choices when selecting hospices.
 - believes that maintaining information in one centralized location like Care Compare is most beneficial.
 - encourages CMS to consider sharing additional data, such as prior hospice ownership, assessment of financial penalties for non-participation in the Hospice Quality Reporting Program (HQRP), and medical director credentials related to board certification in Hospice and Palliative Medicine and/or Hospice Medical Director Certification.
 - believes that, as with any new public reporting, CMS should ensure that patients understand how to read and interpret data, including through user testing. CMS should also provide adequate context to enable consumers to appropriately interpret data.
 - urges CMS, when requiring new collection and reporting of data, to focus on data that clearly reflects a hospice's performance while minimizing reporting burden.
- CMS should acknowledge that long lengths of stay do not necessarily reflect poor quality of care or inappropriate admissions and reframe its consideration of long lengths of stay in light of changing primary diagnoses among hospice enrollees, rather than hold hospices accountable to outdated expectations of appropriate hospice duration.
- CMS should scrutinize hospices whose patients are regularly discharged and then admitted to the hospital shortly thereafter to die – a pattern that reflects a severe lapse in quality and risk for patient harm.
- CMS should pursue all possible administrative options available to support hospices and provide a higher payment update for FY 2024. To the extent that CMS' hands are tied by statutory formulas for updating hospice payments, CMS should work with Congress to effectuate a higher, more sustainable payment update for FY 2024.

- CMS should provide clarification in the final rule regarding the ongoing flexibility that hospices may apply to furnishing services via telecommunications technology as follow-up to in-person care.
- CMS should establish clear mechanisms for hospices to report chaplain services and services furnished via telecommunications technology via hospice claims. CMS should also consider opportunities for incorporating such visits into the HQRP.
- AAHPM supports collection of social risk data for the HQRP, including social determinants of health data aligned with reporting in other post-acute care systems. Collection of additional data, including on factors such as availability of caregiving, housing scarcity, food scarcity, marital status, and socioeconomic status, should also be considered.
- AAHPM appreciates CMS' interest in focusing on both pain and non-pain symptoms as it develops new quality measures using the Hospice Outcomes and Patient Evaluation (HOPE) tool, but we request additional clarification on the measures currently being considered – (1) Timely Reassessment of Pain Impact; and (2) Timely Reassessment of Non-Pain Symptom Impact. We suggest that CMS consider measures that not only focus on timeliness (a process indicator) but also on resulting outcomes, through the use of patient experience and patient-reported outcome measures.
- AAHPM encourages CMS to move forward with changes to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice survey to shorten it and make it available through a web-based mode, in order to improve response rates. CMS should also consider opportunities to align the CAHPS survey process with other CMS efforts to improve health equity. We also recommend that CMS explore mechanisms to collect hospice CAHPS responses from families and caregivers closer to the time of a patient's death.
- AAHPM supports CMS' proposal to require hospice ordering/certifying physicians to be enrolled or validly opted-out of the Medicare program. However, we ask CMS to:
 - clarify that physicians would not be required to select Hospice and Palliative Medicine as a specialty designation (specialty code 17), nor would they be required to specify "Hospice" among the services they are delivering at the time of enrollment.
 - delay implementation of this policy change until October 1, 2024, to provide sufficient time to educate physicians regarding this new enrollment requirement.
 - ensure that hospices can make determinations regarding provider enrollment or opt-out status as easily as possible.
 - pursue higher-impact strategies to address fraud, waste, and abuse under the Medicare hospice benefit (as already identified by AAHPM and other hospice stakeholder organizations) as expeditiously as possible.

Hospice Utilization and Spending Patterns

Requests for Information:

- Hospice Utilization, Non-Hospice Spending, Ownership Transparency, Hospice Election Decision-Making
- Health Equity under the Hospice Benefit

CMS provides information on hospice utilization and related trends before seeking information on multiple aspects of hospice care, including access to hospice services for patients with complex palliative needs, spending on services outside the hospice benefit, and patient education to assist in hospice selection. CMS also requests information aimed at improving health equity under the hospice benefit.

AAHPM appreciates CMS' emphasis on beneficiary access to comprehensive, high-quality, and equitable hospice care and its interest in understanding how to fill gaps in care. However, we are concerned that CMS' language and questions seem to suggest that the gaps can largely be attributed to uninformed, incompetent, or malfeasant hospices. Instead, ***we believe that major reforms to the hospice benefit are required to address many of the challenges that CMS has identified, given the structural limitations within the benefit itself—including excessive risk requirements across small populations, lack of payment mechanisms to accommodate expensive therapies, design based on outdated patient populations, reliance on caregiver availability, and more.*** Our comments address these issues in greater detail.

Patients with Higher-Intensity Needs

CMS asks several questions regarding beneficiary access to – and hospice delivery of – high-intensity palliative care services for patients with complex palliative care needs, including services like blood transfusions, chemotherapy, radiation, and dialysis.

In too many cases – particularly for small hospices and non-profit hospices – the costs associated with providing such higher-intensity services are prohibitive. Hospices take on full coverage and payment risk for providing services related to hospice beneficiaries' terminal illness. However, many hospices serve relatively small patient populations, which does not allow hospices to spread risk. Additionally, hospices do not have any payment policies that protect against outlier costs. As a result, one expensive drug or treatment could decimate a small hospice's budget. Hospices must therefore carefully balance patients' palliative care needs and preferences against their own cost management requirements when developing beneficiaries' palliative care treatment plans.

Further exacerbating the challenges that hospices face is the lack of mechanisms within the hospice payment structure to accommodate the addition of expensive new therapies – most of which were not even available when the hospice Medicare benefit was established – that are in no way curative but may help maintain quality of life. Additionally, some Part D drugs that historically had been used as part of curative treatment regimens have transitioned over time to be used as palliative treatments. Hospices had not been responsible for covering such drugs in

the past, but the shift to palliative applications has contributed to hospices' increased payment responsibility without commensurate changes to hospice payment. Examples of these costly medications include tetrabenazine, which is palliative for Huntington's disease. A 30-day supply can run anywhere from \$5,000 to \$11,000. Metastatic lung cancer patients now often take erlotinib for palliation, which can cost between \$6,200 and \$8,400 per month. Patients taking one of these may also require a number of other expensive drugs. As a result, patients with a life expectancy that would make them eligible for hospice may not access this supportive care because Medicare hospice payment does not allow some organizations to provide all the medications these patients require to control their symptoms and still remain financially viable.

Given the above, ***we urge CMS to explore changes that will ensure that hospices receive sufficient payment to furnish necessary services under the Medicare hospice benefit, without bearing undue risk. To the extent that changes in statute are needed, we encourage CMS to work with Congress to achieve such reforms.*** We also highlight that AAHPM supports reforming the Medicare hospice benefit to allow for concurrent access to disease-directed treatments along with palliative services. We believe such a change could not only help remedy many of the challenges CMS identified, but also address what we see as a significant shortcoming of the current hospice benefit – requiring the difficult choice to waive access to all Medicare services related to one's terminal condition – that delays hospice election and deprives many beneficiaries and their families/caregivers of the supportive end-of-life care to which they are entitled.

In addition to financial constraints, staffing challenges limit hospices' ability to furnish advanced therapies, as this requires a sufficiently robust clinical staff to dedicate the time and resources for such therapies. As it is, many hospices are struggling with attracting and retaining sufficient staff to provide even routine hospice services. Moreover, hospices would require both physicians and nurses with the education and experience to safely manage patients on such therapies, including to address any complications that may arise. Without sufficient resources to support the required level of staffing, hospices will continue to struggle to furnish the services for patients with complex palliative care needs.

Finally, we call attention to the difficulties hospices may experience in partnering with providers that might be able to furnish advanced therapies, given limited hospice capacity. While some hospices have entered into successful partnerships to furnish advanced palliative therapies (see, for example, Providence Hospice of Seattle's partnership with Northwest Kidney Centers¹), many others face difficulty in identifying partners that are willing and/or able to contract for the provision of therapies at reimbursement rates hospices can afford. Such partnerships are particularly necessary given the specialized expertise that some advanced therapies may require. ***We therefore suggest that CMS explore incentives to encourage providers to engage in partnerships with hospices to offer advanced therapies that offer palliative benefit, with the understanding that such opportunities may still elude smaller hospices or those in certain geographies.***

¹ See <https://www.nwkidney.org/news/kidney-dialysis-palliative-care-program-bridging-a-gap-to-hospice/>. Accessed May 15, 2023.

Non-Hospice Spending for Hospice-Enrolled Beneficiaries

CMS asks several questions regarding growth in non-hospice spending for beneficiaries enrolled in hospice. As we have previously conveyed, in many cases, patients will require drugs or other medical treatments that are not related to their terminal prognosis, including when beneficiaries have been taking medications on a long-term basis. And, even though hospices provide the required Patient Notification of Hospice Non-Covered Items, Services, and Drugs and educate patients on what may or may not be covered (with the understanding that hospices cannot anticipate every situation that may arise), there are risks that beneficiaries may seek and obtain services that are outside their plan of care.

The fact is hospices often have limited ability to glean or control the services and medications that beneficiaries receive outside the scope of their hospice care. For example, hospices rarely receive information about the dispensing and billing of Part D drugs for hospice patients and, when they do, it is usually as a result of auditor reviews years later. Unfortunately, physician practices, pharmacies, and emergency settings also are not sufficiently aware of or able to ascertain beneficiaries' hospice status due to limitations in CMS systems, nor do they contact hospices when beneficiaries present to access medical or pharmaceutical treatments. Instead, they often assume that the patient's presence indicates an appropriate reflection of a beneficiary's preference for receiving the requested care, and they furnish services or dispense medications accordingly. To address these scenarios, ***CMS should improve its systems to convey hospice enrollment status and engage in provider education efforts for non-hospice providers and pharmacies to prevent inappropriate non-hospice spending for hospice-enrolled beneficiaries.***

Informed Decision-Making About Hospice Selection

CMS poses questions about information needed to support patients' informed decision-making when selecting hospices to furnish care, including whether additional information should be made publicly available regarding staffing levels, frequency of staff encounters, utilization of higher levels of care, and hospice ownership. Overall, ***AAHPM is supportive of increasing transparency and providing information on these aspects of care to empower beneficiaries in making informed choices, and we generally believe that maintaining information in one centralized location like Care Compare is most helpful for beneficiaries and their caregivers.***

With respect to ownership data, AAHPM believes that such information can contribute to informed decision making. ***We also encourage CMS to consider listing prior hospice ownership, as well as current ownership; reporting whether a hospice has been assessed financial penalties for non-participation in the Hospice Quality Reporting Program; and denoting whether the hospice's medical director is board certified in Hospice and Palliative Medicine and/or holds a Hospice Medical Director Certification credential.***

We offer a note of caution, however, with respect to public release of data on staffing levels and frequency of staff encounters. We are concerned that patients may not understand the metrics and how they translate to high-quality goal-concordant care. We are also concerned that, given existing workforce challenges, publication of staffing data could damage hospices that are

otherwise furnishing high-quality care. To address these concerns, *CMS should ensure that patients understand how to read and interpret given data elements before they are publicly reported, including through user testing. We also believe that CMS should provide adequate context (including around staffing shortages) to enable consumers to appropriately interpret data.*

Finally, while we understand that public reporting of data can support informed choice, we also believe that CMS should be judicious in the material it publishes given the potential for administrative burden. *We therefore encourage CMS to focus on the collection and reporting of data that clearly reflects a hospice's performance while minimizing reporting burden.*

Hospice Utilization Trends

CMS discusses its concerns about trends that continue to appear in hospice utilization data, including a high percentage of hospices that are not furnishing higher levels of care; how longer lengths of stay by patients with neurological conditions may be tied to new provider entrants with a profit motive; and the rate of live discharges varying with ownership status.

With regard to providing higher intensity levels of care, we share CMS' concern that patients may not have access to the care they need during their hospice election. As noted above, AAHPM supports transparency and public reporting on this issue, and we support further efforts to address the gaps in care that exist.

Continuous home care (CHC) can provide significant relief to patients and caregivers during a period of crisis, allowing for the management of acute medical symptoms while a patient remains in their home. However, patients that would benefit from CHC services late in the day do not have access under current Medicare rules. This is because regulations specify that a minimum of 8 hours of care must be furnished on a particular day, defined as midnight to midnight, to qualify as CHC and be reimbursed at the CHC rate. *AAHPM urges CMS to reduce the minimum daily requirement for continuous home care to 4 hours and/or eliminate the midnight-to-midnight requirement, so that patients who could benefit from CHC in the evening would qualify.*

We also note that, as with advanced therapies, many hospices may struggle with contracting for such services and availability of general inpatient (GIP) beds. As such, *we reiterate our request for CMS to explore incentives to encourage providers to engage in partnerships with hospices, in this case to also provide higher levels of hospice care.* At the same time, we are concerned that hospices that do provide GIP are undergoing tremendous scrutiny, and coverage for this care is often denied for the most complex patients who require longer stays at this level of care.

With respect to long lengths of stay, CMS acknowledges that "a beneficiary may be under hospice election longer than 6 months, and the beneficiary is still eligible as long as there remains a reasonable expectation that the individual has a life expectancy of 6 months or less." CMS also notes the expectation is "that the certifying physicians would use their best clinical judgment ...to determine if an individual has a life expectancy of 6 months or less with each

certification and recertification.” AAHPM appreciates that CMS recognizes that some patients will die more slowly than anticipated, however the current regulatory environment seems to reflect a belief that these patients in fact must not be eligible for hospice. No matter how small the percentage of patients who live longer than 6 months a hospice has enrolled, those patients are likely to be found ineligible for hospice upon review by the Medicare Administrative Contractors (MACs).

As we have previously noted, long lengths of stay do not necessarily reflect poor quality of care or inappropriate admissions. Indeed, we believe they are in large part a reflection of how the hospice population has changed over time. The population of terminally ill patients enrolled under the Medicare hospice benefit today is very different than in 1983 when the benefit was established, and the care needs for these patients is also much different.

Forty years ago, hospices were largely caring for cancer patients who had fewer treatment options than they do today and for whom the course of illness was relatively certain. Today, patients with Alzheimer’s disease and related dementias (ADRD) represent a growing portion of hospice enrollees but their disease trajectory is less predictable, and these patients are more likely to have longer stays. Such patients exhibit different healthcare needs and service utilization patterns than the cancer patients for whom hospice providers more commonly cared in the past. As such, we are concerned that an over-emphasis on long lengths of stay is resulting in more restricted access to the hospice services ADRD patients need – and have been shown to benefit from – to manage their conditions, and thus poorer end-of-life experience and outcomes for these patients.^{2,3,4}

We therefore continue to recommend that CMS reframe its consideration of long lengths of stay in light of the changing primary diagnoses among hospice enrollees, rather than hold hospices accountable to outdated expectations of appropriate hospice duration.

For patients with these and similar conditions, we further note that the requirement that eligibility for hospice be contingent on a 6-month prognosis creates a significant barrier to hospice and palliative care. Prognostication is not an exact science, and physicians’ ability to make accurate predictions regarding life expectancy is imperfect. Even so, a beneficiary’s eligibility for the hospice benefit depends on a physician certifying a life expectancy of six-months or less. Patients with an uncertain prognosis are sometimes caught in the middle and prohibited

² Harrison KL, Cenzer I, Ankuda CK, Hunt LJ, Aldridge MD. Hospice Improves Care Quality For Older Adults With Dementia In Their Last Month Of Life. *Health Aff (Millwood)*. 2022 Jun;41(6):821-830. doi: 10.1377/hlthaff.2021.01985. PMID: 35666964; PMCID: PMC9662595.

³ Gianattasio KZ, Moghtaderi A, Lupu D, Prather C, Power MC. Evaluation of Federal Policy Changes to the Hospice Benefit and Use of Hospice for Persons With ADRD. *JAMA Health Forum*. 2022;3(5):e220900. doi:10.1001/jamahealthforum.2022.0900

⁴ Harris, Emily. “For end-stage dementia, Medicare can make hospice harder to access.” *Washington Post*. March 26, 2022. Available at <https://www.washingtonpost.com/health/2022/03/26/medicare-alzheimers-dementia-hospice/> . Accessed May 5, 2023.

from electing hospice, even when those services are clearly what the patients need. ***AAHPM strongly believes that hospice eligibility should not be based solely on a specified prognosis or life expectancy; rather, eligibility should be based on patients' needs.*** Such needs may be associated, for example, with functional decline, high utilization of healthcare services, and/or lack of availability of adequate caregiver or other supports.

Finally, with respect to live discharges, AAHPM notes that live discharges may reflect preference-concordant care and outcomes that are in the best interest of beneficiaries. However, we also recognize risks associated with live discharges when they do not reflect beneficiaries' preferences. We are particularly concerned with cases where patients are discharged from hospice and then admitted to the hospital shortly thereafter to die – most notably when such discharges are from hospices that do not provide GIP level care. While we are aware that CMS tracks this information as part of the Hospice Care Index (Type 2 Burdensome Transitions), we are concerned that this is a practice which reflects a severe lapse in quality and results in significant patient harm. Therefore, ***we encourage CMS to further scrutinize hospices whose patients regularly exhibit this pattern of service utilization.***

Additional Health Equity Considerations

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 believe that increased data collection on social determinants of health (SDOHs) and expanded reporting of Z codes can contribute to improvements in health equity, and we refer CMS to our comments in response to the FY 2022 Hospice Wage Index and Payment Rate Update proposed rule. We also further address collection of SDOH data in our comments on the Hospice Quality Reporting Program (HQRP).

To broaden the lens, however, we note that certain aspects of the Medicare hospice benefit drive disparities in access to hospice care. To begin, the hospice benefit was designed with the assumption that a patient has caregivers at home available to provide around-the-clock support to their loved one. However, the realities of today's family structures and work arrangements mean such at-home care is often unavailable. Many families may find it difficult to fill in the gaps for a loved one enrolled in hospice, resulting in poorer care and outcomes, and patients without family nearby or otherwise socially isolated simply may not elect the benefit. For example, one analysis of Medicare data showed that older adults with cancer receiving 40+ hours of unpaid care per week were twice as likely to receive hospice care at the end of life compared to those who received fewer than six hours per week.⁵ In many cases, rather than electing hospice, Medicare beneficiaries are instead admitted to skilled nursing facilities, inpatient rehabilitation facilities, or long-term care hospitals, where they are able to receive 24-hour nursing support

⁵ Kumar, V.; Ankuda, C.K.; Aldridge, M.D.; Husain, M.; Ornstein, K.A. Family Caregiving at the End of Life and Hospice Use: A National Study of Medicare Beneficiaries. *J. Am. Geriatr. Soc.* 2020, *68*, 2288–2296.

covered by Medicare, but without the palliative and end-of-life support that they would receive through the hospice benefit.

The payment structure of the hospice benefit also may serve to limit access for some patients. For example, hospice availability in rural areas is influenced by the lower Medicare payments made to rural providers compared to urban hospice providers. Rural hospice providers face increased costs due to travel distances and greater difficulties in maintaining staff, remaining capitalized, and overcoming economic disadvantages. This all contributes to reduced access to hospice care in rural settings.

AAHPM believes that substantive reforms are needed to the hospice benefit to address these and other current challenges to delivering on the promise of hospice care.

Proposed FY 2024 Hospice Wage Index and Rate Update

Proposed FY 2024 Hospice Payment Update Percentage

CMS proposes a net hospice payment update percentage of 2.8 percent for FY 2024. AAHPM is concerned that this payment update will again be insufficient to support hospices as they face growing expenses that far outpace the proposed update. In particular, hospices continue to report increased costs associated with staffing, given pervasive recruitment and retention challenges facing the hospice industry. Additionally, hospices are subject to general inflationary pressures that – while less than inflation seen in 2022 – continue to outpace the proposed update; to illustrate, the Consumer Price Index for All Urban Consumers (CPI-U) rose 4.9 percent for the 12-month period ending April 2023.⁶ Paired with only a 3.8 percent hospice payment update for 2023 (in contrast to a CPI-U increase of 6.4 percent for the 12-month period ending January 2023), the compounded effects of the insufficient payment update will create significant financial burden – particularly for small, rural, and/or non-profit hospices – that will further diminish hospices’ ability to furnish comprehensive, high-quality care for Medicare beneficiaries.

Given the above, ***AAHPM again urges CMS to pursue all possible administrative options available to support hospices and provide a higher payment update for 2024. To the extent that CMS’ hands are tied by statutory formulas for updating hospice payments, we ask CMS to work with Congress to effectuate a higher, more sustainable hospice payment update percentage for FY 2024.***

Conforming Regulations Text Revisions for Telehealth Services

CMS proposes to remove regulation text, effective retroactively to May 12, 2023, to align with the anticipated end of the COVID-19 public health emergency (PHE). This change would eliminate the use of technology in furnishing services during a PHE, as allowed under the April 6, 2020, interim final rule titled “Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency.”

⁶ See <https://www.bls.gov/news.release/pdf/cpi.pdf>. Accessed May 11, 2023.

AAHPM is concerned that – without further clarification – this change in regulation text will create uncertainty and confusion for hospice providers, which have long incorporated the use of telecommunications technology into the delivery of care for their patients. In an April 25, 2023, national stakeholder Office Hours call addressing the end of the PHE, CMS staff noted that “there is nothing precluding hospices from using technology that have[sic] follow-up communication with the patient and their family as long as the use of such technology does not replace an in-person visit.”⁷ CMS staff further outlined additional requirements regarding the use of such technology, including documentation in the hospice medical record, use in accordance with standards of practice, and adherence with the hospice’s policies and procedures.

AAHPM believes that such guidance reflects how hospices furnished care prior to the PHE and how they will continue to furnish care now that the PHE has ended. Such virtual “touches” with the patient and caregivers by the hospice care team adds tremendous value to their ability to establish a connection with patients and provide ongoing care management, as well as to patients’ and caregivers’ experience of care. However, the discussion in the proposed rule fails to acknowledge the ongoing availability of services furnished via telecommunications technology as a supplement to in-person care, and clarity regarding this policy is not readily available in writing. Therefore, ***AAHPM requests that CMS provide clarification in the final rule regarding the ongoing flexibility that hospices may apply to furnishing services via telecommunications technology as follow-up to in-person care.***

Reporting and Tracking Use of Telehealth and Chaplain Visits Furnished under the Hospice Benefit

Consistent with comments we have provided in previous years, AAHPM again calls attention to the inability of hospices to report – and of CMS to track – utilization of services furnished by chaplains or services furnished via telecommunications technology. Notably, there are three new Healthcare Common Procedure Coding System (HCPCS) codes for chaplain services that were approved by CMS in late 2022:

- HCPCS Level II code Q9001 “Assessment by chaplain services”
- HCPCS Level II code Q9002 “Counseling, individual, by chaplain services”
- HCPCS Level II code Q9003 “Counseling, group, by chaplain services”

However, it is not clear if or when CMS will utilize these codes on hospice claims or as part of the Hospice Quality Reporting Program (HQRP).

Furthermore, despite the use and benefit of hospice services furnished via telecommunications technology, CMS has not established a mechanism for hospices to report such services via hospice claims. Indeed, the Medicare Payment Advisory Commission has recommended required reporting of telehealth services on hospice claims.

⁷ See <https://www.cms.gov/files/document/transcriptofficehoursendingphe04252023.pdf> and the linked recording. Accessed May 10, 2023.

In order to recognize the important role of chaplain services, as well as to document, track, and evaluate the impact of chaplain and telehealth services for hospice beneficiaries, **AAHPM recommends that CMS establish clear mechanisms for hospices to report chaplain services and services furnished via telecommunications technology via hospice claims. CMS also should consider opportunities for incorporating such visits into the HQRP.**

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

Hospice Outcomes & Patient Evaluation (HOPE) Update

AAHPM remains optimistic about the promise of the HOPE tool to achieve better quality measurement, including through support of relevant, patient-reported (or bereaved caregiver-reported) outcome measures, and we thank CMS for its ongoing work to finalize the tool and keep stakeholders apprised of new developments.

CMS notes that tracking of key demographic and social risk factor items that apply to hospice could support many of its goals, including around quality, interoperability, and health equity. As we have previously noted, **AAHPM supports collection of social risk data for the HQRP, including social determinant of health data aligned with data reporting in other post-acute care systems** – i.e., data on ethnicity, preferred language, interpreter services, health literacy, transportation, and social isolation. We note that, while we also support the collection of data on racial identity, race in itself is not a social determinant but rather is reflective of underlying social inequities; it therefore should not be characterized as a social determinant of health. Furthermore, we highlight the need for race data to be collected based on patient-reported race and not via other methods for assuming or imputing race that can be prone to error.

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. Therefore, **we encourage CMS to consider incorporating data collection on these factors as it finalizes the HOPE tool for proposed rulemaking.**

Future Quality Measure Development

CMS notes that it intends to develop several quality measures based on information collected by HOPE when it is implemented, including at least the following two: (1) Timely Reassessment of Pain Impact; and (2) Timely Reassessment of Non-Pain Symptom Impact. **AAHPM appreciates the need to focus on both pain and non-pain symptoms when considering high-quality hospice care. However, we have several open questions about the current measures under consideration.** For example, what services would count as a “reassessment,” and who would be responsible for conducting the reassessment? Additionally, we question whether the 2-day period for completing a reassessment is a good indicator of high-quality of care; patients often require more immediate relief of their symptoms.

We also are concerned that the contemplated measures may not sufficiently address the appropriate treatment and management of such symptoms. Specifically, ***CMS should be considering measures that not only focus on timeliness (a process indicator), but also on resulting patient outcomes, through the use of patient experience and patient-reported outcome measures,*** which we believe are necessary to lead to meaningful quality improvement.

AAHPM has developed a patient-reported outcome measure, NQF #3666, Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain, which we believe offers a good example of measure that collects patient-reported outcome data that is meaningful to patients. We encourage CMS to consider measures that share the strengths of the Receiving Desired Help for Pain measure as it considers new measures for both pain and non-pain symptom management for hospice beneficiaries. AAHPM would be pleased to work with CMS as it continues to explore and refine measures that can be implemented using the HOPE tool.

Health Equity Updates Related to the HQRP

AAHPM appreciates CMS' ongoing emphasis on efforts to address health disparities and advance health equity across the Medicare program. We refer you to our comments above in response to the HOPE update on the collection of SDOH data in the HQRP.

Consumer Assessment of Healthcare Providers and Systems Hospice Survey Update

AAHPM thanks CMS for its efforts to streamline the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey data collection process. However, we were disappointed that specific proposals were not in this year's proposed rule based on the results of the survey mode experiment. AAHPM believes there is a need to move forward with changes to the CAHPS survey as expeditiously as possible in order to improve response rates and thereby increase our collective understanding of hospices' quality performance. As we noted in our comments last year, ***we believe changes to shorten the CAHPS survey and to make it available through a web-based mode could achieve this goal, and we encourage CMS to move forward with such changes.*** We also note that higher response rates could help more hospices achieve the volume requirements for CAHPS ratings to be reported on Care Compare.

We also urge CMS to consider opportunities to align the CAHPS survey process with other CMS efforts to improve health equity. For example, since response rates differ between English-speaking and non-English speaking families, even when the survey is translated into other languages, CMS should carefully consider how best to ensure that the questionnaire is ethnically and culturally sensitive for the relevant communities and languages into which it is being translated in order to improve response rates from minority populations.

Finally, ***we continue to encourage CMS to explore mechanisms to collect hospice CAHPS responses from families and caregivers closer to the time of a patient's death.*** For example, with a web-based mode, QR codes could be used to allow respondents to easily access survey questions and respond in a timely manner. Additionally, while we understand the challenges of collecting data directly from hospice patients themselves, and of using such data to assess hospices on their

performance, we highlight the importance of hearing directly from hospice patients about their own experiences of care whenever possible.

Proposals Regarding Hospice Ordering/Certifying Physician Enrollment

CMS proposes to require physicians who order or certify hospice services for Medicare beneficiaries to be enrolled in or validly opted-out of Medicare as a prerequisite for the payment of the hospice service in question. AAHPM agrees that this change may assist CMS in addressing fraud, waste, and abuse in the Medicare program. However, ***we ask CMS to clarify that physicians completing the Provider Enrollment, Chain, and Ownership System (PECOS) enrollment application would not be required to list Hospice and Palliative Medicine as their specialty designation (specialty code 17) nor would they be required to specify “Hospice” among the services they are delivering.*** Given existing shortages in the field of Hospice and Palliative Medicine, requiring such a specialty designation would severely restrict patient access to hospice care. Additionally, we know that many types of physicians see patients who may become seriously ill and eligible for hospice care. However, these physicians may not routinely refer patients to hospice and may not anticipate being designated as a hospice attending physician at the time they complete the Medicare enrollment application. If they later choose to serve in this role, it could impact patients’ timely access to vital end-of-life care if hospices find they need to explain to a patient that, based on designations at the time of Medicare enrollment, the physician they selected to serve as their hospice attending physician indeed cannot certify their eligibility or order services and an alternate attending physician must be selected.

In light of the potential implications for patient care, ***we recommend that CMS delay implementation of this new physician enrollment requirement until October 1, 2024, to provide sufficient time to educate physicians who may certify or order hospice services for Medicare beneficiaries regarding the need to enroll in Medicare or validly opt out. We also encourage CMS to ensure that hospices can make determinations regarding provider enrollment or opt-out status as easily as possible.*** While enrollment data may be available online, the ability to search such data should be as intuitive and streamlined as possible to limit burden on hospices.

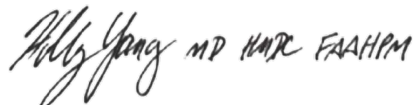
We also note that AAHPM supports a range of policy interventions that could be taken to improve hospice program integrity.⁸ We believe that many of the recommendations supported by our Academy and the broader hospice stakeholder community – including imposition of targeted moratoria on licensure of new hospices where growth is out of line with established need; probationary periods for hospices upon their initial certification; greater scrutiny of hospices identified via “red flags” as high risk; and prohibiting the sale or transfer of Medicare hospice certification numbers for a specified timeframe – would be far more effective than requiring physician enrollment in Medicare when it comes to curbing the most egregious actors and activities. ***We encourage CMS to pursue such higher-impact strategies as expeditiously as possible.***

⁸ See https://aahpm.org/uploads/advocacy/AAHPM_Recommendations_to_U.S._Rep_Blumenauer_-_Hospice_Program_Integrity_FINAL_01-20-23.pdf. Accessed May 15, 2023.

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Thank you again for the opportunity to provide feedback on the FY 2024 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,

A handwritten signature in black ink that reads "Holly Yang MD HMDC FACP FAAHPM". The signature is written in a cursive, flowing style.

Holly Yang, MD HMDC FACP FAAHPM
AAHPM President