AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

*Submitted electronically via regulations.gov*

August 29, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8013

**RE: Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Information Dispute Resolution and Special Focus Program Requirement; Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements [CMS-1780-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 Calendar Year (CY) 2024 Home Health proposed rule referenced above. 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 below.

- AAHPM generally supports CMS' proposal to implement an informal dispute resolution (IDR) process, but we believe further clarification would be beneficial, particularly regarding accountability and transparency around deficiencies resolved through the IDR process. We also note the need to monitor implementation of the IDR process and determine whether an independent third party would be needed to ensure impartial assessments.
- AAHPM appreciates CMS' effort to stand up the hospice special focus program (SFP). However, we believe that stakeholders would benefit from greater clarity regarding the purposes of the SFP, which we view as support to struggling hospices to improve performance around quality of care and patient safety considerations, and not an effort to address fraudulent actors.

- AAHPM continues to recommend that CMS pursue strategies previously recommended by AAHPM and other hospice stakeholder organizations to address fraud, waste, and abuse under the Medicare hospice benefit.
- AAHPM supports CMS' proposal not to incorporate any stratification by geography into its selection process for SFP hospices.
- AAHPM believes there are some key shortcomings of the proposed SFP selection algorithm that should be corrected, including by not doubly weighting the CAHPS hospice survey indicator and by normalizing performance on condition-level deficiencies and substantiated complaints per 100 beneficiaries.
- AAHPM urges CMS to carefully monitor the implementation of the SFP, including for its impact on small and rural hospices and ways that low-performing hospices could avoid detection under the algorithm.
- AAHPM suggests that CMS consider focusing SFP surveys on those elements that address quality of care and patient safety, both with respect to SFP surveys and criteria for graduation out of the SFP.
- AAHPM recommends that CMS exempt SFP hospices from other types of compliance reviews while they are actively participating in the SFP, so they can focus all their efforts on the identified concerns.
- AAHPM requests clarification on several aspects of CMS' proposed SFP methodology, for example around the criteria used to select SFP hospices from the 10 percent of hospices with the highest aggregate score; treatment of hospices under common ownership; timeliness of substantiated complaints; and the type of support and assistance hospices will receive under the SFP.
- AAHPM supports CMS' proposal to publicly report the hospice programs selected for the SFP, as well as the 10 percent of hospices with the highest aggregate scores determined by the SFP algorithm. However, we believe that no further public reporting about historical participation in the SFP is appropriate after the hospice has graduated from the program.
- AAHPM supports CMS' proposal to move initially enrolling hospices and those submitting applications to report any new owner into the "high" level of categorical screening, and to maintain revalidating hospices at the moderate risk-level screening.
- AAHPM supports CMS' proposal to include hospices that have undergone a change in majority ownership under the 36-Month Rule, such that recently-enrolled hospices under new majority ownership would be subject to initial enrollment requirements.

## Hospice Informal Dispute Resolution Process

CMS proposes to make an IDR process available to hospice programs to address disputes related to condition-level survey findings following a hospice's receipt of the official survey Statement of Deficiencies and Plan of Correction. ***AAHPM generally supports CMS' IDR proposal, which we believe can give hospices the opportunity to more efficiently address any misunderstandings or inaccuracies in survey findings. However, we believe further clarification would be beneficial.*** In particular, we would appreciate additional detail on the level of recordkeeping and transparency that would be maintained with respect to deficiencies resolved through the IDR process, as well as accountability measures that would be put in place to ensure that deficiencies are adequately resolved. We are concerned that the use of the process could potentially limit transparency and accountability and/or result in a perception that there is lack of transparency with respect to hospice programs' performance.

Additionally, we note that there is an inherent concern that the IDR process is administered by the same agency that cited the deficiency(ies) being disputed. ***We question whether a more formal process***

*involving an independent third party may be needed to ensure impartial assessment and resolution of the concerns raised through the IDR process, and we believe ongoing monitoring will be important to determine the answer.*

## Hospice Special Focus Program (SFP)

CMS proposes to implement a hospice Special Focus Program (SFP) starting in 2024, under which CMS would identify hospices for participation from among the 10 percent of hospices with the highest aggregate scores, with no stratification (for example based on geography) used in the selection process. Hospices would be included in the algorithm if they (1) are active providers with at least one Medicare fee-for-service claim in the last 12 months and (2) have data for at least one indicator used in the algorithm. CMS would use indicators that reflect the total number of quality-of-care condition level deficiencies, the total number of substantiated complaints received against a hospice, the Hospice Care Index (HCI) overall score, and a CAHPS Hospice Survey Index score focused on four weighted hospice measures, with the CAHPS Hospice Survey Index score weighted twice as much as the scores of the remaining indicators. Hospices included in the SFP would be required to undergo a recertification survey every six months, until they graduate from the SFP or are terminated from the Medicare program. CMS would publicly report, at least on an annual basis, those hospices identified in the top 10 percent of hospices with the highest aggregate scores and those hospices selected for participation in the SFP.

*AAHPM appreciates CMS' effort to stand up the hospice SFP in order to identify and improve the most poor-performing hospice programs.* AAHPM believes that the hospice SFP will be important in supporting struggling hospices that require additional support to improve performance, particularly around quality-of-care and safety considerations, including through technical assistance, education, and training. We understand that it is <u>not</u> intended to – nor able to – sufficiently address egregious actors that fraudulently take advantage of the Medicare hospice benefit and Medicare beneficiaries, and *we strongly recommend that CMS clarify through preamble language this distinction* in order to provide more clarity and certainty to the hospice stakeholder community. Furthermore, while our comments below address the SFP and its quality- and performance-improvement objectives, we note that AAHPM has previously recommended strategies to improve hospice program integrity.[1] *We encourage CMS to pursue these recommendations – 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; and restriction of billing privileges for "non-operational hospices" – in order to curtail the worst of the abuses.*

### Proposed Algorithm

AAHPM recognizes that CMS' proposed algorithm was informed by feedback from the Technical Expert Panel, and appreciates the challenges involved in developing a methodology that best targets the poor performing hospices most in need of assistance. To that end, *we support CMS' decision not to stratify participation based on geography, consistent with recommendations we have previously submitted.* However, we believe that there are some key shortcomings of the proposed algorithm that CMS should correct in any policies it finalizes.

To begin, AAHPM is concerned about the low proportion of hospices with publicly reported data on the CAHPS hospice survey. Particularly if CMS doubles the weight of the CAHPS hospice survey, we are concerned that the algorithm will not treat hospices with and without CAHPS results fairly. *We therefore*

[1] See https://aahpm.org/uploads/advocacy/AAHPM_Recommendations_to_U.S._Rep_Blumenauer_-_Hospice_Program_Integrity_FINAL_01-20-23.pdf

***recommend that CMS not double the weight of the CAHPS hospice survey under the algorithm.***

We also appreciate that CMS sought to standardize performance across the proposed indicators. However, we believe that CMS did not go far enough by not normalizing the number of quality-related condition-level deficiencies and substantiated complaints based on the size of the patient population hospice programs manage. By taking the absolute number of condition-level deficiencies and substantiated complaints, larger hospices will invariably perform worse under the algorithm than smaller hospices based on the size of their respective patient populations. ***AAHPM therefore recommends that CMS normalize the condition-level deficiencies and substantiated complaints before inputting them into the algorithm; that is, these numbers should reflect the counts per 100 beneficiaries enrolled in the hospice program, rather than absolute numbers.*** Such normalization would be consistent with TEP discussions.

## Need for Monitoring and Impact Data

***AAHPM urges CMS to carefully monitor the implementation of the SFP.*** For example, it is unclear how CMS' proposed approach will affect small hospices. For example, will inclusion of hospices with only one claim in the last 12 months (with an average daily census of 0) lead to small hospices accounting for the majority of SFP hospices? If so, we are concerned that that SFP resources may not be best targeted, and that small hospices may disproportionately be forced to close if the demands of the SFP are too great. Alternatively, will small hospices fly under the radar under CMS' proposed methodology and create incentives for hospices to break up into smaller units that may not meet minimum requirements to be evaluated on the CAHPS hospice survey or HCI? Analysis showing the distribution of hospices potentially subject to the SFP under CMS' proposed and final methodologies would be informative, for example by size, rural or urban status, and geography.

## Proposed SFP Surveys and Completion Criteria

Consistent with our understanding that the SFP will be important in supporting performance improvement for hospices, particularly around quality-of-care and safety considerations, ***AAHPM suggests that CMS consider focusing SFP surveys on those elements that address quality of care and patient safety, both with respect to the SFP surveys and with respect to criteria for graduation out of the SFP.*** We are concerned that placing too much emphasis on conditions of payment, for example, rather than quality of care requirements, will dilute the effects of the SFP. We note that a focus on quality-of-care and patient safety survey elements would align graduation from the SFP with the algorithm indicators used to select hospices into the program in the first place.

## Burden Relief for SFP Hospices

Given the SFP's likely focus on poor, but not fraudulent, performers, we also note that hospices selected for the SFP will likely already be struggling to meet the Medicare conditions of participation and to provide high-quality care. However, CMS has indicated that SFP hospices would continue to be subject to standard recertification surveys. ***We recommend that CMS exempt SFP hospices from other types of reviews, such as Targeted Probe and Educate (TPE) audits or Recovery Audit Contractor (RAC) audits, as well as recertification surveys***, as these hospices will already be dedicating significant resources to improving their care processes and graduating from the SFP; additional demands on hospice administration resources as a result of such audits and reviews will place undue strain on hospices and harm their ability to succeed under the SFP. We are worried that hospices will not have the resources to handle multiple audits and surveys at the same time, particularly small and rural hospices, and that such demands could significantly reduce access in already underserved areas. The hospice SFP should provide

opportunity, resources, and assistance for hospices to improve performance, not overwhelm hospices and put them out of business.

### Need for Additional Clarification

***We also ask for additional clarification on several aspects of CMS' proposed methodology.*** For example:

- What criteria will CMS use for selecting the SFP hospices out of the hospices with the top 10 percent highest aggregate scores? AAHPM encourages CMS to apply an equity focus when selecting the SFP hospices to ensure that certain regions or hospice types are not disproportionately harmed by CMS SFP selections.
- How will hospices under common ownership be treated under the algorithm? While we expect CMS will calculate aggregate scores and determine the 10 percent based on unique provider numbers, we believe clarification is important.
- How will CMS ensure the use of timely complaint data to best identify those hospices that should participate in the hospice SFP? We note that, in some states, providers have reported that complaint survey investigations are in arrears by thousands. If that is true, we are concerned that the use of substantiated complaints as an algorithm indicator will not reflect hospices' performance in a timely manner.
- What kind of support or technical assistance will hospices selected for the SFP receive? AAHPM believes such assistance must be an integral component of an SFP in order to support hospices' performance improvement and should be sufficient to support meaningful improvement. We believe that additional detail would be important to help hospices understand what participation in the SFP would entail.

### Public Reporting

Finally, ***we support CMS' proposal to publicly report the hospice programs selected for the SFP, as well as the 10 percent of hospices with the highest aggregate scores determined by the algorithm.*** However, we note that there was discussion in the SFP Technical Expert Report that consumers should be able to see when a provider has a history of being in the SFP. ***AAHPM believes that once a hospice has graduated from the SFP, no further public reporting about historical participation is appropriate.*** For hospice programs that have successfully improved their quality and overall performance, ongoing public reporting of their historical participation in the program could result in long-lasting or permanent disadvantage, based on information that no longer reflects the care they are providing.

## High Categorical Risk Designation for Hospices

***AAHPM supports CMS' proposal to move initially enrolling hospices and those submitting applications to report any new owner into the "high" level of categorical screening, and to maintain revalidating hospices at the moderate risk-level screening.*** We agree that the additional requirements for the high-level screening will help to identify bad actors, thereby protecting against the risk of fraud and abuse they present.

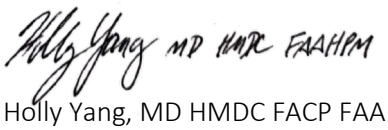
## 36-Month Rule Application to Hospices

***AAHPM supports CMS' proposal to include hospices that undergo a change in majority ownership (CIMO) under the 36-Month Rule, such that recently-enrolled hospices under new majority ownership would be subject to initial enrollment requirements.*** AAHPM believes this change would appropriately require new hospice owners to undergo new enrollment screening, as well as state survey or accreditation from an accreditation organization, in order to reduce risk of fraud and abuse.

*****

Thank you again for the opportunity to provide feedback in response to the CY 2024 Home Health proposed rule. AAHPM would be pleased to work with CMS to address our recommendations above. Please direct questions or requests for additional information to AAHPM's Chief Medical Officer, Joe Rotella, MD MBA HMDC FAAHPM, at jrotella@aahpm.org.

Sincerely,



Holly Yang, MD HMDC FACP FAAHPM
AAHPM President