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HOSPICE AND PALLIATIVE MEDICINE

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Wendy-Jo Toyama, MBA FASAE CAE

May 24, 2024

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1810-P  
7500 Security Boulevard  
Baltimore, MD 21244

RE: Medicare Program; FY 2025 Hospice Wage Index and  
Payment Rate Update, Hospice Conditions of Participation  
Updates, and Hospice Quality Reporting Program Requirements  
[CMS-1810-P]

Dear Administrator Brooks-LaSure:

On behalf of the more than 5,200 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) 2025 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, pharmacists, 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:

- CMS should pursue all possible administrative options available to support hospices and provide a higher payment update for FY 2025. To the extent that CMS' hands are tied by statutory formulas for updating hospice payments, CMS should work with Congress to address this need.
- AAHPM generally supports CMS' proposed regulation text changes that would clarify who may provide initial certification and recertification of terminal illness, and clearly denote differences between the election statement and the notice of election. However, we ask that CMS update regulation language at 42. CFR 418.25(a) and (b) to also allow the physician member of the hospice interdisciplinary group to recommend admission and certify terminal illness, consistent with CMS' other proposed clarifying text changes.
- In response to CMS' request for information (RFI) on a payment mechanism for high-intensity palliative care services:
  - AAHPM agrees that hospice patients should be able to access medically necessary palliative services in a manner that is consistent with their needs and goals and that maximizes their quality of life.
  - While we appreciate that CMS is contemplating a different type of payment to compensate hospices for the provision of high-cost or high-intensity services, we have concerns that any changes implemented under CMS' current statutory authority would not sufficiently address the need. We therefore urge CMS to pursue statutory changes that would ensure that hospice patients have adequate access to high-intensity palliative care services. In doing so, CMS should adhere to the following principles, which we believe will support the delivery of seamless patient-centered care:
    - Patients should be free to choose the mix of services they receive based on their individual needs, goals, and preferences;
    - Delivery of high-intensity palliative care services should involve both the hospice and any non-hospice high-intensity service provider working together to implement a plan of care; and
    - Neither the hospice provider nor non-hospice providers furnishing the palliative services should be financially disadvantaged for providing the care.
  - AAHPM offers two alternative approaches for supporting delivery of high-intensity palliative care services consistent with our principles and shares our thoughts in response to CMS' specific questions.
  - In establishing any policies for coverage and payment of high-intensity palliative care services, CMS should prioritize an approach that would maximize patients' quality of life, defer to hospice physicians' clinical judgement, and provide as seamless a palliative care experience as possible for patients transitioning into hospice.
- CMS should pursue higher-impact strategies to address program integrity risks under the Medicare hospice benefit, as already identified by AAHPM. Additionally, CMS should work with a representative hospice stakeholder community to identify better solutions for addressing program integrity concerns that curb excessive costs and provider burden associated with increased audits and regulatory scrutiny and advance health equity.
- AAHPM supports including two measure concepts addressing timely reassessment of pain and non-pain symptom impact in the Hospice Quality Reporting Program (HQRP). However, we

strongly urge CMS to modify certain measure specifications, including to enable follow-up furnished via two-way telecommunications technology to count for reassessments.

- AAHPM generally supports continued development of quality measures addressing measure concepts of Education for Medication Management, and Wound Management Addressed in Plan of Care, with certain caveats.
- CMS should consider an additional concept for future quality measure development that focuses on hospice patients' access to hospice teams.
- AAHPM is optimistic that the HOPE tool will improve CMS' and hospices' ability to assess performance on metrics that are meaningful to patients and their families/caregivers. However, we urge CMS to implement appropriate transition policies to limit disruption. Additionally, we encourage CMS to pursue changes to the HOPE that would assess the spiritual and psychosocial aspects of the hospice experience.
- AAHPM supports inclusion of housing instability, food insecurity, utility challenges, and transportation items into future HQRP data collection.
- CMS should explore opportunities to incorporate the Area Deprivation Index (ADI) into its disparities analyses.
- AAHPM supports the changes to the CAHPS Hospice Survey questions and administration protocols, but CMS should delay implementation of the changes by 1 year, to start with 2026 decedents.

## Proposed FY 2025 Hospice Payment Update Percentage

CMS proposes a net hospice payment update percentage of 2.6 percent for FY 2025. As with previous years, AAHPM is concerned that this payment update is insufficient to keep pace with hospices' rising costs. In particular, hospices continue to report increased costs associated with staffing, given pervasive workforce challenges that continue to trouble the hospice industry. These challenges are exacerbated by the fact that hospices must compete with other major health care employers in their markets for the same pool of candidates, including hospitals and health systems with substantially more hiring resources at their disposal. As a result, hospices must increase compensation to retain qualified physicians and clinical staff, contributing to sustained increases in costs. ***AAHPM therefore again urges CMS to pursue all possible administrative options available to support hospices and provide a higher payment update for FY 2025. To the extent that CMS' hands are tied by statutory formulas for updating hospice payments, we also ask CMS to work with Congress to address this need.***

## Proposed Clarifying Regulation Text Changes

CMS proposes several technical updates to the hospice regulations to clarify who may provide initial certification and recertification of terminal illness, as well as to clearly denote differences between the election statement and the notice of election. CMS notes that these changes do not reflect changes in policy but are instead intended to increase clarity and consistency. ***AAHPM generally supports these changes and thanks CMS for the clarification.*** Our members report that, based on existing regulation text, hospices have previously been cited in cases when physician members of the interdisciplinary group have provided certification; the updated language will help to protect hospices against similar inappropriate citations in the future. ***However, we also ask that CMS further clarify the regulation text at 42 CFR 418.25(a) and (b); currently, these subsections only identify the medical director or physician designee as able to recommend admission and certify terminal illness, but we believe it is important to also include the physician member of the hospice interdisciplinary group in these regulations (consistent with clarifying***

*regulation text changes that CMS proposes at 42 CFR 418.22 and 418.102), and we ask CMS to update the language accordingly.*

## Request for Information (RFI) on Payment Mechanism for High Intensity Palliative Care Services

In response to feedback from stakeholders noting that the provision of complex and/or high-intensity palliative treatments may pose financial risks to hospices, CMS contemplates alternative payment mechanisms for paying for such services and solicits comment on several related questions.

*AAHPM agrees that hospice patients should be able to access medically necessary palliative services in a manner that is consistent with their needs and goals and that maximizes their quality of life.* This may include services like chemotherapy, radiation, and blood transfusions, which may offer palliation for patients with cancer diagnoses, but also a range of other services for patients who may be suffering from other non-cancer conditions. As we noted in response to the RFI in the FY 2024 Hospice proposed rule, however, the costs associated with providing higher-intensity services are too often prohibitive, particularly for small hospices and non-profit hospices.

*While we appreciate that CMS is contemplating a different type of payment to compensate hospices for the provision of high-cost or high-intensity services, we have concerns that any changes implemented under CMS' current statutory authority would not sufficiently address the need.* Specifically, the statutory requirement that payment changes be implemented in a budget neutral manner would mean that the introduction of any new payments would have to be offset by reductions to existing payments. We do not believe this is tenable given hospices' financial pressures and the challenges they experience paying for high-intensity palliative services under the current reimbursement rates. Nevertheless, we agree that the concerns that CMS has raised should be addressed.

*We therefore urge CMS to pursue statutory changes that would ensure that hospice patients have adequate access to high-intensity palliative care services. In doing so, CMS should adhere to the following principles, which we believe will support the delivery of seamless patient-centered care:*

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

We envision that furnishing new payments to hospices – in addition to what hospices currently receive – could achieve the desired outcomes. Payments would have to align with the costs of furnishing the high-intensity palliative care services, including costs that hospices incur in coordinating with community providers and managing patients' care. Alternatively, a separate approach – under which CMS pays providers of such services or treatments directly, rather than requiring hospices to coordinate and pay for services out of the payments they receive from Medicare – could also address challenges that hospices experience, thereby facilitating access to high-intensity palliative services for hospice beneficiaries.

We highlight that AAHPM supports reforming the Medicare hospice benefit to address numerous structural limitations within the benefit, including to allow for concurrent access to disease-directed treatments. Not only would concurrent care address CMS' concerns about insufficient access to high-cost palliative care services, but it would also increase uptake of hospice care by removing the requirement for patients to waive access to all Medicare services related to their terminal condition. This requirement delays hospice election and deprives many beneficiaries and their families/caregivers of the supportive end-of-life care furnished by hospices to which they are entitled. Indeed, research looking at Medicare hospice patients with access to concurrent care services through the Veterans Administration found that patients receiving concurrent dialysis care had substantially longer hospice lengths of stay than those who did not.<sup>1</sup> A separate study on veterans with concurrent care also found that use of high-intensity palliative care services was fairly limited and that the majority of patients died with hospice-style care at home or in inpatient hospice, rather than in acute inpatient hospital settings,<sup>2</sup> suggesting that the ability to access concurrent disease-directed care does not translate into excessive utilization of such services among patients who have elected the hospice benefit. Overall, we believe that concurrent care could move the system further towards a future with an expanded seamless benefit for patients with serious illness, in which patients could access both palliative care services and disease-directed services based on their needs and goals, regardless of their prognosis.

We offer these thoughts as context for our comments below in response to CMS' specific questions.

**What could eliminate the financial risk commenters previously noted when providing complex palliative treatments and higher intensity levels of hospice care?**

*To eliminate financial risk for hospices furnishing complex palliative treatments and higher intensity levels of hospice care, hospices need additional payments that are commensurate with the cost of furnishing those services that are in addition to the payments they already receive.*

This would not only include the cost of the service or item itself, but also costs associated with the care management and care coordination activities hospices must undertake, which can consume significant resources. Additionally, CMS could pursue opportunities to reduce the costs that hospices must bear when furnishing high-intensity palliative services. For example, given that medications represent a significant proportion of the high-cost palliative treatments that hospices may struggle to provide, CMS could consider developing a national formulary with negotiated rates that hospices could use to procure medications, or seek to leverage Veterans Affairs pharmacy contracts. CMS could also explore incentives to encourage providers to partner with hospices to offer advanced therapies at Medicare fee-for-service rates.

*Alternatively, since many of the treatments in question are furnished by providers external to hospices (e.g., dialysis or cancer centers) or may be provided through an outpatient pharmacy program, CMS could consider carving them out from the scope of hospices' responsibilities and making payment to such providers or pharmacies separately.* Such an arrangement would remove financial risk from hospices while also reducing some administrative burden. Further, it

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<sup>1</sup> Wachterman MW, Corneau EE, O'Hare AM, et al. Association of hospice payer with concurrent receipt of hospice and dialysis among US veterans with end-stage kidney disease: A retrospective analysis of a national cohort. JAMA Health Forum. 2022;3(10):e223708. doi:10.1001/jamahealthforum.2022.3708.

<sup>2</sup> Hemrajani A, Lo SS, Vahlkamp A, et al. Concurrent hospice healthcare utilization in the hematology/oncology patient population at veterans affairs. Journal of Clinical Oncology. 2023; 41(16\_suppl). doi:10.1200/JCO.2023.41.16\_suppl.12125

would address a challenge that many hospices have experienced when they have tried to arrange for services – that is, that community providers require hospices to pay unsustainable rates that are substantially higher than Medicare fee-for-service, making it even more difficult for hospices to afford to furnish.

**What specific financial risks or costs are of particular concern to hospices that would prevent the provision of higher-cost palliative treatments when appropriate for some beneficiaries? Are there individual cost barriers which may prevent a hospice from providing higher-cost palliative care services? For example, is there a cost barrier related to obtaining the appropriate equipment (for example, dialysis machine)? Or is there a cost barrier related to the treatment itself (for example, obtaining the necessary drugs or access to specialized staff)?**

Hospices incur significant costs when furnishing high-intensity palliative care services, including for the service itself as well as for engaging in the care management and care coordination activities required to ensure services are furnished successfully. Often, hospices must partner with providers to furnish advanced therapies due to factors including limited hospice capacity, the need for specialized expertise that some advanced therapies may require, and/or the specialized equipment that may be required. For example, hospices typically do not own their own dialysis machines and must contract with dialysis providers to furnish palliative dialysis services. Unfortunately, as noted above, many hospices face difficulty in identifying partners that are willing and/or able to contract for the provision of therapies at reimbursement rates hospices can afford.

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

To the issue of care management and care coordination activities, hospices can dedicate significant resources when arranging for high-intensity services. To use a simple transfusion as an example, a hospice must first identify a community partner willing to furnish the service at a reasonable cost and arrange for appointments. The hospice must then arrange for a blood draw two days in advance for blood type and crossmatch, determine the appropriate setting for the transfusion and potentially arrange for transportation, and then dedicate nursing services to support patients post-transfusion in case they have any reactions. For small hospices, undertaking these responsibilities can place significant burden on their limited resources.

**Should there be any parameters around when palliative treatments should qualify for a different type of payment? For example, CMS is interested in understanding from hospices who do provide these types of palliative treatments whether the patient is generally in a higher level of care (CHC, GIP) when the decision is made to furnish a higher-cost palliative treatment? Should an additional payment only be applicable when the patient is in RHC?**

*Consistent with our principle that patients should be free to choose the mix of services they receive based on their individual needs, goals, and preferences, AAHPM believes that patients should be able to access high-intensity palliative care services regardless of the level of hospice care they are receiving.* To illustrate, there may be cases where patients need higher level continuous home care (CHC) or general inpatient care (GIP) but still require high-intensity palliative care services. For example, a patient receiving GIP in a hospital for a crisis of bone pain may receive a dose of radiation for palliation. The hospital furnishing the radiation would expect to be paid for that radiation administration above and beyond any payment from the hospice for contracted GIP services. Likewise, if a patient receiving routine home care (RHC) required palliative radiation on an outpatient basis, the radiation provider would also need to receive separate payment for the administration.

**Under the hospice benefit, palliative care is defined as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering (§ 418.3). In addition to this definition of palliative care, should CMS consider defining palliative services, specifically regarding high-cost treatments? Note, CMS is not seeking a change to the definition of palliative care but rather should CMS consider defining palliative services with regard to high-cost treatments?**

AAHPM understands this question to reflect one way of setting parameters around potential new payments for high-cost treatments. That is, by defining what is considered a palliative high-cost treatment, CMS could effectively establish a discrete high-intensity palliative care benefit within or adjacent to the hospice benefit, which would then be subject to its own rules around coverage and payment.

While AAHPM recognizes that a separate definition of palliative services with regard to high-cost treatments may help to achieve that goal, we believe such an effort would be a substantial undertaking that would require broad stakeholder engagement, given the challenges that exist with terminology along the spectrum from palliative to curative care. For example, we hear concerns with calling services “palliative” since many services may also extend life. Likewise, services may be “curative” or “life-prolonging,” but may not extend life more than six months.

*We do, agree, however, that if CMS moves forward to make separate payments for high-cost or high-intensity palliative care services under a modernized hospice benefit, whether as part of additional hospice payments or directly to furnishing providers, greater clarity will be needed around a number of variables, including what services would qualify for the separate payment, what patient or provider criteria would need to be met for the services to qualify, what activities would be under hospices’ responsibility, how payment rates would be established, and how and to whom payment would be made. In establishing such policies, AAHPM would encourage CMS to prioritize an approach for covering services that would maximize patients’ quality of life, deferring to hospice physicians’ clinical judgement, and providing as seamless a palliative care experience as possible for patients transitioning into hospice.* In line with this approach, we believe that patients should be able to continue utilizing services or treatments for as long as they are eligible for hospice and their physicians determine such services continue to be medically necessary; that is, we do not believe such services should only be allowed to be furnished to patients on a temporary basis subject to arbitrary time cut offs. We also highlight that policies will need to be designed in a way that provides for flexibility to account for the evolution of health care. Notably, many medications and services that had historically been used as part of curative treatment regimens have transitioned over time to be used as palliative treatments. For example, with the

evolution of non-invasive ventilators, many patients with lung disease or neuromuscular disorders receive ventilatory assistance at home not just to prolong life but to relieve dyspnea and maximize function.

**Should there be documentation that all other palliative measures have been exhausted prior to billing for a payment for a higher-cost treatment? If so, would that continue to be a barrier for hospices?**

*AAHPM would strongly oppose any requirement that all other palliative measures have been exhausted prior to billing for payment for a higher-cost treatment.* When patients receive high intensity services, it is typically in the early stages of hospice care as they transition away from disease-directed treatments. Indeed, a hospice's ability to furnish such services may be a driving factor in a patient electing hospice versus continuing to pursue disease-directed treatments. Requiring patients to forego these services during the initial part of their hospice election, when they are relatively high functioning, would prevent hospices from furnishing care in a patient-centered manner that is consistent with patients' needs and goals, contributing to increased burden for hospices and increased suffering for patients – assuming they elect to choose hospice at all under such constraints. We believe such a requirement would undermine CMS' goals of ensuring that patients have access to high-intensity palliative care services during their hospice election.

*Additionally, we would oppose any documentation requirements that would serve as the basis for imposing any prior authorization requirements.* While we recognize that coverage criteria would have to be established and documentation would need to support how patients meet criteria, any introduction of prior authorization into the hospice benefit would be problematic given the likelihood that services would need to be furnished on an urgent or emergency basis to patients who are near the end of life.

**Should there be separate payments for different types of higher-cost palliative treatments or one standard payment for any higher-cost treatment that would exceed the per diem rate?**

*If CMS were to provide separate treatment for higher-cost palliative treatments that are in addition to payments hospices already receive in order to enable hospices to furnish these treatments, AAHPM would support separate payments for different types of treatments rather than one standard payment.* Treatment costs may vary widely, and the need for hospices to furnish any given treatment (whether on the more costly or less costly end of the spectrum) will depend on a variety of factors including the patient mix (e.g., distribution of primary diagnosis, age, prognosis at time of election) and patients' treatment preferences. To minimize the shifting of risk onto hospices – particularly small and non-profit hospices – *we believe payments should be aligned with the costs of the services. At a minimum, payments should match Medicare allowable rates, with an add-on amount to account for related overhead costs that hospices assume in coordinating care.* Over time, as CMS collects more cost data, it may be clear that higher payments will be needed if contracting providers demand payment at rates that exceed Medicare allowable amounts, as many hospices have historically reported.

As noted above, an alternative could also be to carve services out from the scope of hospices' responsibilities and to make payment to furnishing providers or pharmacies separately. Services would simply be paid on a fee-for-service basis without shifting additional financial risk to hospices.



## Improving Hospice Program Integrity

As CMS is aware, there has been a recent spotlight on program integrity concerns under the Medicare hospice benefit. In response, CMS undertaken numerous efforts to address vulnerabilities, including to implement new provider enrollment requirements and enhanced oversight of new hospice organizations in targeted states. However, we believe more can and should be done, and we point to recommendations that AAHPM previously made to improve program integrity.<sup>3</sup> ***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.***

At the same time, our members report that hospices have been subject to an excessive level of program integrity scrutiny – and accompanying regulatory burden – in recent years. For example, they report that CMS and its contractors have significantly increased the number of audits hospices must undergo related to the care they furnish. Indeed, a recent survey conducted by the nation’s four largest hospice industry organizations found that more than half of hospice respondents reported undergoing more than one audit simultaneously or in quick succession.<sup>4</sup> This level of scrutiny contributes to increased costs and ties up resources that ultimately constrain hospices’ ability to deliver high-quality patient care and reduce access to hospice care for Medicare beneficiaries – without meaningfully addressing the worst abuses. In light of these impacts, ***AAHPM urges CMS to work collaboratively with a representative hospice stakeholder community to identify better solutions for addressing program integrity concerns while minimizing provider burden, including by focusing less on hospices across-the-board and more on egregious actors.*** We commit to working with CMS on this undertaking in order to improve and expand access to high-quality hospice care.

## Hospice Quality Reporting Program

### Proposal to Implement Two Process Quality Measures Based on Proposed HOPE Data Collection

CMS proposes to adopt the following two process measures to the Hospice Quality Reporting Program (HQRP) no sooner than calendar year (CY) 2027: Timely Reassessment of Pain Impact and Timely Reassessment of Non-Pain Symptom Impact. These measures would be based on data collected through the Hospice Outcomes and Patient Evaluation (HOPE) standardized data collection tool. ***AAHPM agrees that timely reassessment of pain and non-pain symptoms is important in managing hospice patients’ care and generally supports including the two measure concepts in the HQRP. However, we strongly urge CMS to modify the specifications to enable follow-up furnished via two-way telecommunications technology to count for reassessments. This includes services furnished via audio-only modalities when the patient is either unable or unwilling to complete visits using audio-video capabilities.***

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<sup>3</sup> [https://aahpm.org/uploads/advocacy/AAHPM Recommendations to U.S. Rep Blumenauer - Hospice Program Integrity FINAL 01-20-23.pdf](https://aahpm.org/uploads/advocacy/AAHPM_Recommendations_to_U.S._Rep_Blumenauer_-_Hospice_Program_Integrity_FINAL_01-20-23.pdf)

<sup>4</sup> Leading Age, the National Association for Home Care & Hospice, the National Hospice and Palliative Care Organization, and the National Partnership for Healthcare and Hospice Innovation. National hospice audit 2023 survey findings: Report. January 23, 2024. Accessed from [https://www.nhpco.org/wp-content/uploads/Hospice Audit Survey Report.pdf](https://www.nhpco.org/wp-content/uploads/Hospice_Audit_Survey_Report.pdf) on May 10, 2024.

Since the start of the public health emergency for COVID-19, AAHPM members and their patients benefitted from the availability of telehealth and the use of telecommunications technology to furnish care. Particularly for the seriously ill patients our members serve, including those near the end of life, the use of communications technology has facilitated access to timely and high-quality medically necessary care, which experience has shown can be effective in assessing and managing symptoms. To illustrate, clinicians can count respirations, conduct a visual examination, and assess patients' comfort and distress levels based on visual and verbal assessments. Additionally, whether in the home, in domiciliary settings, or – especially – in nursing facility settings, a family member, caregiver, or healthcare provider is usually available to assist in completing assessments, as needed.

Moreover, the ability to conduct reassessments using telecommunications technology would offer numerous benefits. First, it would increase flexibility for hospices, which is particularly urgent in the current milieu when hospices are routinely facing staffing challenges. Allowing reassessments to be conducted virtually would also increase access for patients, as hospice staff would be able to conduct more visits and reach more patients during time that would otherwise be spent traveling. Patients in rural areas, in particular, would benefit from more timely visits. Finally, allowing the use of telecommunications technology for reassessments would also support health equity goals, allowing patients in remote settings to receive services as conveniently as those in metropolitan areas. Likewise, allowing audio-only reassessments when patients are unable or unwilling to complete audio-video visits would also improve health equity, given the lack of broadband access in rural communities.

In addition to modifications to the measure that would allow for virtual reassessments, AAHPM also calls attention to CMS' proposal to apply an exclusion in cases where a patient or caregiver refuses the assessment visit. We are concerned that patient or caregiver refusal of care can be a red flag for quality-of-care concerns, such that excluding refusals from the measure denominator can mask underlying problems. ***AAHPM recommends that CMS calculate measure performance both with the exclusion for refusals and without, to determine whether meaningful differences exist. CMS should also separately monitor those cases where patients refuse reassessments to determine if they are associated with distinct trends in utilization, outcomes, or other quality indicators.***

## Future Measure Development

CMS discusses its plans for future measure development, noting Technical Expert Panel support for the development of two new process measures addressing (1) Education for Medication Management; and (2) Wound Management Addressed in Plan of Care. ***AAHPM generally supports continued development of quality measures addressing these concepts,*** recognizing that they both reflect aspects of hospice care that can have a meaningful impact on patients' experience in hospice. ***However, as CMS explores development of such measures, we urge CMS to take caution when designing measure specifications, including to ensure that the measures have meaningful denominators.*** For example, education would only be required when there is a prescription for a new drug, not each time a drug is dispensed, so the denominator should be specified accordingly. We worry that measures could lead to check-boxing and undue administrative burden if the approach is too broad.

With respect to the Education for Medication Management measure concept, we encourage CMS to ensure that the measure captures education furnished to the patient as well as the caregiver. We also encourage CMS to work with stakeholders when determining what type of education could or should count towards receiving credit for this measure.

Finally, *AAHPM recommends that CMS consider an additional concept for future quality measure development that focuses on hospice patients' access to hospice teams.* Too often, we have heard of situations where patients in crisis required assistance, but hospices were unable to send appropriate clinical staff in a timely manner and instead referred patients to emergency departments or left patients and caregivers to manage on their own. A measure addressing, for example, the percentage of triaged calls that convert to hospice visits could address such scenarios and increase hospices' accountability for providing appropriate and timely follow-up care.

## Proposal to Implement the HOPE Assessment Instrument

CMS proposes to begin collecting the standardized patient level data using the HOPE tool starting on or after October 1, 2025. HOPE would replace the current Hospice Item Set (HIS) and would be collected at admission, up to two hospice update visits (HUVs), and discharge.

Overall, *AAHPM continues to be optimistic that the HOPE tool will improve CMS' and hospices' ability to assess performance on metrics that are meaningful to patients and their families/caregivers.* We believe moving forward with implementation of HOPE is the right move, and we look forward to the insights that it will provide. At the same time, we understand that replacement of HIS with the HOPE tool may create a great deal of disruption to hospices' operations, and *we urge CMS to take proactive steps to minimize or accommodate the challenges hospices experience during the transition period.* This includes offering robust education and training, as well as implementing a reasonable transition period during which hospices learn how best to incorporate HOPE into their workflows. To that end, we believe that CMS should provide a longer period of time during which hospices' performance on HOPE will not be subject to public reporting, rather than just the first quarter of data, as CMS proposes, given the learning curve that hospices will have to undergo.

AAHPM also highlights that the HOPE tool only minimally addresses patients' psychosocial or spiritual needs. While there is a question that addresses whether the patient and/or caregiver was asked about spiritual/existential concerns, there is no further exploration of what those concerns might be or whether concerns are addressed or resolved over time. AAHPM believes patients' spiritual and psychosocial experience can be a core part of patients' experience of hospice and therefore should be included in patient evaluation tools. *We therefore recommend that CMS pursue changes to the HOPE that would assess the spiritual and psychosocial aspects of the hospice experience, in addition to the indicators of physical well-being that are already included therein.*

## Health Equity Request for Input

CMS identifies four domains of social determinants of health (SDOH) that it believes may be suitable for the hospice setting – housing instability, food insecurity, utility challenges, and transportation challenges – and seeks input on their relevance and suitability for hospice patients. CMS also asks if there are additional SDOH domains that would be useful for identifying and addressing health equity issues in hospice.

Overall, *AAHPM agrees that housing instability, food insecurity, utility challenges, and transportation challenges are important SDOH indicators that can have a meaningful impact on the experience of hospice care and encourages CMS to incorporate questions that address these domains in future data collection.*

AAHPM also offers the following SDOH domains for consideration as well:

- *Presence of a caregiver.* Lack of access to a capable and committed caregiver who can provide assistance in the home can be a major barrier for patients to receive home hospice.
- *History of previous incarceration and inclusion on a sexual offenders list.* Hospice patients who have a history of previous incarceration and are included on a sexual offenders list often have difficulty if they need to be placed in nursing facilities, which may refuse to take such patients, thereby disrupting their hospice care.
- *Access to a primary care provider.* Patients receiving hospice for dementia diagnoses may stabilize enough to be discharged from hospice. However, if they do not have timely access to a primary care provider to whom care can be transitioned – for example if they do not have an established primary care provider or if the first available appointment is more than a month out – hospices may be unable to safely discharge patients.

Finally, *AAHPM encourages CMS to explore opportunities to incorporate the Area Deprivation Index (ADI) into its disparities analyses.* AAHPM believes that ADI could provide a more objective metric for assessing social need than patient responses to SDOH indicators.

## Proposed CAHPS Hospice Survey and Measure Changes

CMS proposes numerous changes to the CAHPS Hospice Survey, including to the survey questions and to survey administration protocols, effective for 2025 decedents.

Overall, *AAHPM supports the changes to the survey questions and administration protocols*, which we believe would simplify and streamline the survey and support increased response rates. We believe the proposed addition of the web-mail mode and the extension of the field period will be particularly beneficial. However, we are concerned that the timeline is too aggressive given the substantive changes that are being proposed. *We therefore recommend that CMS delay implementation of the CAHPS Hospice Survey changes by 1 year, to start with 2026 decedents.*

\* \* \* \* \*

Thank you again for the opportunity to provide feedback on the important issues addressed in this proposed rule. AAHPM would be pleased to work with CMS to address our recommendations above. Please direct questions or requests for additional information to Wendy Chill, Director of Health Policy and Government Relations, at [wchill@aaahpm.org](mailto:wchill@aaahpm.org).

Sincerely,



Vicki Jackson, MD, MPH, FAAHPM