NATIONAL COALITION
FOR HOSPICE AND
PALLIATIVE CARE

COALITION MEMBERS

American Academy of Hospice and Palliative Medicine (AAHPM)

Association of Professional Chaplains (APC)

The Catholic Health Association of the United States (CHA)

Center to Advance Palliative Care (CAPC)

HealthCare Chaplaincy Network™ (HCCN)

Hospice and Palliative Nurses Association (HPNA)

National Association for Home Care & Hospice (NAHC)

National Hospice and Palliative Care Organization (NHPCO)

National Palliative Care Research Center (NPCRC)

Palliative Care Quality Collaborative (PCQC)

Physician Assistants in Hospice and Palliative Medicine (PAHPM)

Social Work Hospice & Palliative Care Network (SWHPN)

Society of Pain & Palliative Care Pharmacists (SPPCP)

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June 7, 2021

Administrator Brooks-LaSure
Centers for Medicare & Medicaid Services,
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244–1850

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

Submitted electronically via http://www.regulations.gov

On behalf of the National Coalition for Hospice and Palliative Care, we welcome the opportunity to provide comments and recommendations from our Coalition Members to the Centers for Medicare & Medicaid Services (CMS) on the Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements, Proposed Rule.

To inform our comments, we drew on the hospice expertise represented within the 13 professional organizations that comprise our Coalition. We are pleased to offer the feedback below on behalf of our Coalition.

Our Coalition is dedicated to advancing the equitable access, delivery and quality of hospice and palliative care to all those who need it. The national organizations that form the Coalition represent more than 5,500 hospice programs and their related personnel, 5,200 physicians, 2,500 physician assistants, 11,000 nurses, 5,000 chaplains, 8,000 social workers, researchers, and pharmacists, along with over 1,800 palliative care programs caring for millions of patients and families each year across the United States. As such, we bring a broad, multidisciplinary perspective on hospice care and the changes this legislation will have on the vulnerable population we serve – patients of all ages and families nearing the end of life. These changes have the potential to dramatically impact the delivery of vital hospice services across the nation and ensure an improved understanding of CMS' expectations for hospice compliance with important health and safety standards for patients, family members, hospice agencies and surveyors.

I. Data Analysis and Trends: The Coalition offers some general comments.

Data on the number of beneficiaries using the hospice benefit

The percentage of Medicare beneficiary deaths in hospice is reported to be 52.0% in FY 2019 compared to 43.6% in FY 2010. The Coalition is pleased that the percentage of Medicare decedents continues to increase, due to increased knowledge and acceptance of hospice among patients and families, an increase in access to hospice care throughout the country, and the recognition that patients should be able to access their Medicare hospice benefits regardless of diagnosis.

Parts A, B and D non-hospice spending during a hospice election

Part A and B spending: The Coalition appreciates the CMS data on non-hospice spending during the hospice election. Other than the summary of expenditures by Medicare category in Table 9, however, there is not enough detail about what makes up the expenditure number.

Recommendation: The Coalition requests additional detail on the expenditures so that Coalition members can develop strategies to reduce these expenditures or identify why these expenditures would be appropriate.

Hospice providers report that they are not in full control of services provided to the patient outside of the hospice benefit. The hospice is never aware of the billing by other providers during the hospice election. Hospitals, physician offices and other non-hospice providers of services are either unaware of the billing requirements after the patient's hospice election or continue to bill because there is no flag in the billing system that blocks the payment once hospice is elected.

Physician services: We note that physician services are the highest spend in the Part A and B category.

Recommendation: The Coalition requests CMS provide more detailed information for this category of spending. Is it Part B payments for attending physicians? Consulting physicians? How much of the spending is Part B claims without the hospice-related billing modifiers? With more detail, the Coalition can plan for quick look-up resources for physicians and physician office billers to more accurately bill when services are provided to patients during a hospice election.

Part D spending: Part D expenditures continue to rise outside the hospice benefit, although it is impossible to compare the Part D expenditures by year when the data is provided in the aggregate, rather than by beneficiary. The issue identified is that the Part A and B information system, using HETS and the Common Working File, is incompatible with the Part C and Part D information system, using MARx. In a 2019 study conducted by one large Part D plan, the average time between the Notice of Election (NOE) submission and the Part D knowledge of the hospice election was 22 days. With a median length of stay at 19 days, more than half of hospice patients would have died before the Part D plan was aware of the hospice election. A pilot project initiated by CMS Part D to alert Part D plans of the hospice election in a timelier fashion is underway. The hospice NOE process can be communicated to the Part D plans with a daily data sweep from the hospice, matching patient/enrollee information and providing hospice enrollment to the Part D plan. The Coalition looks forward to the testing phase of this pilot in the summer of 2021.

Maintenance medications. The Coalition notes a continuing CMS reference to "maintenance medications" with an expectation that a hospice should cover them under the Medicare Hospice Benefit. However, no details have been provided about the types of medications and their prescription frequency. Determining whether a maintenance medication is related to the patient's terminal illness and related conditions is patient-specific and should be determined on a case-by-case basis. In this case, as in decisions about relatedness, the hospice physician, in consultation with the interdisciplinary (IDT) team, makes the determination of coverage under the hospice benefit.

II. Feedback requested by CMS

1. **<u>Changes in patient diagnoses and characteristics</u>: The hospice benefit has evolved from originally providing services primarily to patients with cancer, to now serving patients with neurological conditions and organ-based failure. We are particularly interested in how this change in patient characteristics may have influenced any changes in the provision of hospice services.**

   In all of health care, patient care has migrated from hospital to post-acute based care. Patients are no longer hospitalized for extensive stays. They are discharged as quickly as possible, especially when hospice care is being sought. This means families are expected to perform care and many tasks that would have fallen on inpatient staff nurses in the past.

   The patient mix for hospice patients has changed from a primary diagnosis of cancer to a full array of non-cancer diagnoses. Providers report that patients on hospice for a primary diagnosis of cancer (malignancies) often require much more complex care than they did 20 years ago, including pleural drainage or wound vacuums for complex wound management in the home. Patients with nervous system disorders may have longer, more subtle declines. Not all nervous system disorders are the same, and individual variability in disease manifestations combined with an unlimited number of comorbidities can make symptom management more challenging. Demands on family members and other caregivers is much more complex than in years past, as more caregivers show the stress of being a long-time caregiver.

   These changes in the patient population served impact length of stay, live discharge and the complexity of services provided. Patients served today reflect the diagnoses for the Medicare decedent population as a whole and are entirely different than the end-stage cancer patients served by hospices four decades ago. Patients need these person-centered services now more than ever, without the six-month prognosis requirement. This underscores the need to rethink CMS' overall design about some aspects of the Medicare Hospice Benefit by considering options for a set of defined palliative care services. This could provide an array of supportive services provided to patients with advanced illness earlier in the disease process, as well as facilitate appropriate and timely referral to hospice.

2. **<u>Service Intensity Adjustment (SIA)</u>: We are soliciting comments regarding skilled visits in the last week of life, particularly, what factors determine how and when visits are made as an individual approaches the end of life.**

   Providers report that clinician assessments usually detect the sometimes-subtle signs that patients may be nearing the end of life. Standard practice is for nursing follow-up within 24 hours when patients have had a change in condition or symptoms. The nurse will notify the rest of the IDT and may request, if needed and accepted, additional visits from hospice aides, social workers, and chaplains, both in the home and facility environments.

   Often in the last week of life, many patients and their families are interested in a different mix of services than just the RN or social worker. Families may not want any visits at all, preferring to be alone with their loved one in the last few days of life. In other circumstances, a hospice aide or chaplain is preferred in the last days of life to provide personal care to the patient and support to the family. In this circumstance, the services provided by the hospice are not reflected in SIA payments, and visits from the chaplain for example are not reflected on the claim. Each patient's end-of-life experience and wishes are unique to each individual – a "one size fits all" approach to whom and when hospice providers visit is unwise.

3. **<u>Relatedness:</u> There is a continuing trend where there is a potential "unbundling" of items, services, and drugs from the Medicare hospice benefit. We are soliciting comments as to how hospices make determinations as to what items, services and drugs are related versus unrelated to the terminal illness and related conditions. That is, how do hospices define what is unrelated to the terminal illness and related conditions when establishing a hospice plan of care.**

   Determinations of relatedness are increasingly complex. In considering whether an item, service or drug is related to the patient's terminal illness and related conditions, hospice physicians and the IDT must consider each patient's circumstances as they develop an individualized plan of care. All items, services and drugs are carefully considered by the hospice physician in discussion with the team and indicated on the plan of care. Providers report that their practice increasingly is to cover all medications and services as related, while also evaluating which items, services or drugs could be deprescribed because they are no longer medically necessary. Increasingly, the relatedness decisions of the hospice physician and IDT are second guessed or challenged by government reviewers and auditors who claim that particular drugs are related. Improved documentation in the medical record will help with these findings, as well as improved education on the part of medical review staff and auditors about the challenges and indicators for determining relatedness in hospice.

Often hospice providers use the NHPCO-developed tools to help with this determination. The two flow charts help a hospice IDT determine relatedness, one for determining relatedness and one for determining whether a medication is related to the terminal illness and related conditions. In addition, deprescribing is also considered by the hospice physician and the IDT, as they are reviewing the patient's drug profile to determine what drugs continue to be needed and which drugs are no longer medically necessary. NHPCO's Deprescribing Toolkit, published in November 2020, provides details on deprescribing for five major classes of drugs, including tips for dialogue with patients and families.

4. **What services are offered: We are soliciting comments on what other factors may influence whether or how certain services are furnished to hospice beneficiaries.**

   The standard of care for the admission process is that all hospice services are offered to all patients/families based on their individually-assessed needs and wishes. The patient and their family discuss with the hospice team their family's wants and needs; this information is gathered by the RN during the initial assessment and by other members of the IDT during the initial comprehensive assessment. From those assessments, the hospice develops the plan of care. Factors may include, but are not limited to, patient acuity/complexity, family coping, location, caregiver type (self, family, paid caregivers including skilled nursing facility staff).

   Hospice aide services: All patients/families are offered hospice aide services. The IDT continually assesses and may offer again at any time, including an assessment of the frequency of aide services. For example, the team may assess that 1:1 attention at lunch time to assist with feeding would benefit the patient/family and offer that support to the family.
   Social work services All patients/families are offered social work services during the admission process. Social work services are invaluable in talking with patients and families about goals of care and family coping which are vital to the patient and family's hospice experience. Social workers also conduct psychosocial assessments, help coordinate care, provide counseling and psychotherapy, intervene in client crisis situations, and educate clients and families about their treatment plan and the resources and support systems available to them.
   Spiritual care services: Spiritual care is offered to all patients/families. The IDT continually assesses and may offer again at any time. The hospice chaplain or spiritual care advisor can be instrumental in providing a place to discuss life review and closure, family healing, and anticipatory grief. In some situations, the family may rely on the spiritual care provided by their religious institution, either instead of or in addition to the hospice chaplain.

   Services offered to the patient and family focus on the question:
   "What is important to the patient and the family, and what will bring the patient the most comfort and the highest quality of life, based on the patient's own goals?"

5. **<u>Election statement addendum</u>: We are soliciting stakeholder feedback as to whether the hospice election statement addendum has changed the way hospices make care decisions and how the addendum is used to prompt discussions with beneficiaries and non-hospice providers to ensure that the care needs of beneficiaries who have elected the hospice benefit are met.**

   Hospice providers report that the addendum has not changed how care decisions are made, but that the upfront communication with patients/representatives during the admission process has been enhanced as admission staff can talk about what is related and covered. It is important to note that hospice providers represented by our Coalition members have reported that very few patients and their representatives have requested the addendum and that the burden of implementation of the addendum, at this time, seems to outweigh the benefits. The current use of the addendum is for those items, services and drugs that are unrelated to the terminal illness and related conditions, but the communication with patients/representatives and families could be greatly enhanced if the discussion about the addendum reflected the full range of reasons as to why the hospice does or does not cover an item, service or drug during the hospice election: unrelated and not covered, related but no longer medically necessary, and that generic is covered but the difference in the cost of a brand name drug may need to be covered by the beneficiary.

   Recommendation: The Coalition believes that this more upfront communication and transparency with patients and their representatives will eliminate additional bureaucracy with new and different forms that must be developed. The Coalition believes that this simpler approach, using the addendum for communication for the issues described above would be in the best interest of patients, families, and representatives. We request further clarification from CMS on this issue.

III. Hospice Election Statement Addendum Revisions and Clarifications

The Coalition thanks CMS for clarifying many of the outstanding questions and issues hospices are dealing with and supports the proposed revisions to the regulations. CMS has proposed a few conforming regulatory text changes, i.e. beneficiary requests addendum but dies or is discharged prior to signing, “3 days” rather than “72 hours,” allowing a hospice to furnish the addendum within 5 days from the date of a beneficiary or representative request, if the request is within 5 days from the date of a hospice election. CMS is also proposing one new regulatory requirement for hospices to include the date the addendum is furnished in the medical record and on the addendum. Any finalized changes/additions to the hospice regulations are usually effective October 1 of the applicable fiscal year. This date is reasonable for the new regulatory requirement regarding the additional documentation in the medical record and on the addendum of the date furnished.

Recommendation: The Coalition recommends CMS clarify in the final rule that the effective date of the conforming regulatory text changes is October 1, 2020. This date is consistent with the timeframe of informal guidance provided previously by CMS and MACs on all but one issue – the number of days a hospice has to provide an addendum when the request is made within the 5 days from the date of hospice election but not on the day of election. For this issue, an effective date of October 1, 2020, is reasonable and consistent with the timeframe necessary to gather the information and make determinations of unrelated conditions, items, services and drugs.

IV. Hospice Quality Reporting Program (HQRP)

- **Penalty for Not Participating**

Per the Consolidated Appropriations Act of 2021: Beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and beginning with the FY 2024 APU and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.

As shared in previous communications, the Coalition supports this change. January 1, 2022, begins the quality submission period tied to the FY2024 annual payment update.

Recommendation: We recommend that CMS alert hospices before this date about the change via notices and postings to the hospice quality reporting webpages.

- **Hospice Care Index**

The Coalition strongly supports quality of care measures that represent the whole of hospice care in the HQRP and that are publicly reported. The purpose of publicly reporting quality data is to aid the consumer in choosing a hospice. Therefore, the data shared must be understandable and meaningful to the consumer relative to the quality of care a hospice can and should provide. As proposed, the indicators for the Hospice Care Index (HCI) focus on medical services. This overmedicalization of hospice care contributes to the public's limited understanding of the hospice care philosophy and, specifically, the Medicare hospice benefit. Spiritual care services are excluded not just from measures publicly reported but from all HQRP data as of January 1, 2021. In the Hospice Visits When Death is Imminent: Measure Validity Testing Summary and Re-Specifications, report data is shared showing negative correlations with CAHPS Hospice Survey outcomes for chaplain visits. However, there is data from a study completed with Veterans Health Administration (VA) patients indicating that chaplain services along with bereavement services and inpatient hospice care may help improve families' ratings of end-of-life care quality[1]. The HealthCare Chaplaincy Network has proposed to modify existing HCPCS codes for chaplain services provided by the VA for inclusion on claims for all Medicare services. The Coalition supports this modification that will assist in the collection of chaplain visit data in hospice care and continued analysis of the data. This allows for a better-balanced view of hospice care.

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[1] Feder, S. L., Tate, J., Ersek, M., Krishnan, S., Chaudhry, S. I., Bastian, L. A., ... & Akgün, K. M. (2021). The Association Between Hospital End-of-Life Care Quality and the Care Received Among Patients With Heart Failure. Journal of Pain and Symptom Management, 61(4), 713-722.

Recommendation: The Coalition strongly urges CMS to develop codes to identify chaplain visits on claims and to continue analyzing the impact of chaplain visits on hospice quality of care and satisfaction for possible inclusion in future quality measures and/or publicly reported data**.** The Coalition also urges CMS to consider ways to incorporate bereavement care into the HQRP. This is one of the differentiating services of hospice care and a significant benefit of hospice care. Including it and spiritual care in the HQRP – especially in publicly reported measures – more comprehensively reflects the whole of hospice.

Through the National Quality Forum (NQF) Measures Application Partnership (MAP) Measures Under Consideration (MUC) process, CMS indicated that the Meaningful Measure area for the HCI is “End of life care according to preferences”; however, the indictors comprising the HCI do not take into account patient preferences. For instance, patient preference is not part of the indicator calculation for CHC or GIP Provided, Gaps in Nursing Visits, or Skilled Nursing Minutes on Weekends.

Information shared by Abt Associates and CMS during a presentation on the Hospice Care Index concept in 2020 and shared again in the January 2021 MAP committee meeting to review the MUC, indicates that 85% of hospice providers will score well on the HCI. This raises the question of whether the measure will “top out” quickly after implementation. This has been a concern with HQRP measures from the Hospice Item Set (HIS), which CMS proposes in this rule be removed from the HQRP.

Indicators utilized in the HCI should have a high correlation with CAHPS Hospice Survey results and patient satisfaction. No data has been shared in the proposed rule or outside of this rule that shows a correlation between all the indicators comprising the HCI and patient satisfaction or quality of care. Some of this type of information has been shared with the public via reports CMS has posted in the past; however, this is limited to the correlation of some interdisciplinary team member visits only. There is no indication in publicly available information about what the data shows relative to correlation between weekend visits/minutes per visit and CAHPS results, per beneficiary spending and CAHPS results, nurse minutes per routine home care day and CAHPS results, and live discharges and patient level of satisfaction with hospice care.

Many of the indicators seem to be driven by program integrity (PI) practices. Issues of program integrity must be addressed, and the Coalition supports CMS in taking action to do so. CMS has several options available to address these issues. For instance, CMS could continue to collect the HCI indicator data and couple it with the hospice survey deficiency information to target those hospices with poor performance. Targeted action by CMS could be more frequent surveys for these hospices, which would align with the Consolidated Appropriations Act requirement to develop a special focus program as part of hospice survey reforms. The Coalition recognizes that CMS may desire to target poor performing hospices sooner than a special focus program may be feasibly developed.

Recommendation: Therefore, the Coalition recommends that CMS implement the HCI in the HQRP no earlier than May 2022 but suppress public reporting of the HCI at that time. The Coalition supports the sharing of compliance/program integrity data with hospices; however, public reporting of such data prior to there being full transparency of hospice performance data, clearer measure specifications, thorough consumer testing and a dry run with hospice providers of the measure is not consistent with the method utilized by CMS for the development of measures in other quality reporting programs and in the HQRP. CMS has previously provided much more information about measure development and testing prior to public reporting. Again, we reiterate that CMS has other viable alternatives to address hospice program integrity concerns. Some of the areas of concern that are addressed in the HCI have not been shared by CMS (or MedPAC) as areas of concern. These include the Gaps in Nursing Visits, Skilled Nursing Minutes on Weekends, and Nursing Care Minutes per RHC Day. Publicly reporting these measures runs the risk of the unintended consequence of patients receiving more and longer nursing visits regardless of their assessed needs and preferences. Hospices may feel pressured to encourage nursing visits when it is a social worker or chaplain visit that is desired and best suited to patient needs.

The Coalition also is concerned about the average consumer's understanding of this measure and its indicator components as it would appear on Care Compare. Transparency about what the composite score means is critical, and we have concerns, for example, that a consumer may not understand how a high rate of live discharges, which on face value may appear to be a *good* outcome, could help them to identify *poor* performance in a hospice provider. In fact, the majority of the indicators will not be recognized by a consumer as items that contribute to making an informed decision about choosing a quality hospice provider.

With a period of time where public reporting is suppressed but data is shared with hospices on their performance on the indicators and the indicator specifications, hospices have an opportunity to learn about the indicators and how to incorporate them into the existing hospice philosophy of care best practices.

A better platform for initial sharing of hospice performance data is through reports that directly reach the hospice such as the PEPPER or another comparative billing report yet to be developed. Hospices currently do not have data on their performance for the proposed HCI indicators and the technical specifications in the proposed rule are not sufficient for providers to replicate the calculation on their own. It is essential for hospices to have this information on their performance as calculated by CMS, and it is equally important for hospices to be able to replicate the calculation of this data. This will allow them to perform the calculations frequently and routinely so that they have data measurement points upon which to develop and measure performance improvement plans. The PEPPER is only available to hospices electronically and must be downloaded by the hospice. The rates of download have not been as high as would be desired for sweeping improvement in behavior. However, beginning with the 2021 PEPPER hospices receive a notice that the PEPPER is available for downloading which is likely to result in a significant increase in the number of hospices actually receiving the information. In fact, at this time, the large majority of states had a PEPPER retrieval rate greater than forty percent. This is a substantial increase over the number of retrievals at this time last year. Since the PEPPER displays a hospice's performance in CMS-identified areas vulnerable to improper payment (program integrity measures), the hospice will be most aware of its performance and likely to change behavior.

Hospices need to understand the data to utilize it properly in performance improvement. The only specifications provided for the HCI indicator data are through the proposed rule and there are many questions and concerns about this data and calculations, as further detailed below.

No Continuous Home Care (CHC) & General Inpatient (GIP)

- It is understandable that CMS wants to ensure that all hospice providers can deliver all four levels of care that are part of the Medicare Hospice Benefit, and the Coalition agrees that hospices must be able to deliver such care at any given time. We continue to hear that there is a significant number of hospices that do not bill for all four levels of care and especially for the CHC level of care. Due to the stringent CHC billing requirements, many hospices find that they have provided hours of direct one-on-one, intensive care to a patient that is not billable because it does not meet all of the CHC criteria. Measuring whether CHC was or was not billed is not necessarily reflective of the intensity of service the patient is receiving.

- Utilizing survey data in conjunction with claims data for this indicator would be most helpful to informing CMS, hospices and the public of the hospice's ability to provide all four levels of care. Simply billing or not billing for a higher level of care is not an indicator of quality of care, particularly since a focus of hospices is keeping a patient at home and not in an inpatient unit, hospital or Skilled Nursing Facility (SNF) for the general inpatient level of care. Combined with billing information, survey data, specifically whether the hospice provides GIP and respite care directly or has a contract in place to provide this level of care under arrangement and whether the hospice informs patients about the availability of all four levels of care (especially CHC) combined with billing information would be most helpful to consumers. Additionally, whether the hospice has the ability to provide CHC if needed would be most helpful to consumers as compared with whether CHC was billed.

- Hospice provider characteristics have an impact on this indicator and it should be adjusted based on this data. For example, hospices with inpatient units will likely utilize the GIP level of care more than CHC, and those without inpatient units may utilize CHC more than GIP. Also, geographic data on utilization of the higher levels of care would likely indicate that there are marked geographical differences in the utilization of these two levels of care due to culture of the community served as well as possible differences due to patient characteristics (i.e. diagnosis, length of stay, etc.) and possibly hospice characteristics (i.e. inpatient care provided directly or under arrangement).

Gaps in Nursing Visits

- It would be important to define this measure as the 7 days that comprise the accepted Medicare week of Sunday through Saturday. We believe this is CMS' intent; however, it should be defined for clarity. Also, a patient could have a visit on Tuesday one week and Wednesday the following week for several reasons, including for the convenience of the patient/family, without any negative impact on care.

- Hospice is an interdisciplinary service and assesses patient needs and preferences for care on the physical, emotional, psychosocial and spiritual levels, so it is quite possible that a patient may need and prefer more non-nursing visits during their hospice care or at particular times during their care. Therefore, it may be most meaningful to the HQRP to include all discipline visits. Additionally, an overall pattern of delivering care from all disciplines to a patient throughout the course of their hospice stay may be more reflective of the quality of care being provided.

- It is not clear from the specification in the proposed rule if skilled nursing visits (revenue code 055X) will be separated by RN and LPN visits or if both types of visits will be included in this measure. It should be noted that there is the possibility that the majority of patients/families distinguish hospice staff visits by type, i.e. social worker or nurse, chaplain or aide, but do not distinguish further. Specifically, CMS should consider the possibility that patients/families do not distinguish between an RN and LPN but, rather, simply recognize that a “nurse” is making or made a visit. Of course, credentials of the individual making the visit are likely present on a nametag, but this is often not scrutinized by patients/families once they know the individual and, after time, are receiving care from the LPN, RN or NP – the person’s license may not be known or remembered.

  Recommendation: The Coalition recommends CMS consider inclusion of ***all*** nursing visits on the claim.

- During this current pandemic, the effectiveness of telehealth visits /visits furnished via telecommunictions technology has been recognized by many providers. Hospices have been using telehealth visits to supplement in-person visits for some time, and the effectiveness of such care should be considered as part of any visit measure. Telehealth visits are legitimate indicators of care and services provided by the hospice and are related to and ordered on the plan of care. CMS already acknowledges the use of social work phone calls in the quality of hospice care and includes these types of visits on claims.

  Recommendation: The Coalition recommends that CMS recognize all care provided by hospices that impacts quality of care and patient/family satisfaction, and that billing codes should be expanded to include telehealth visits for all disciplines on the claim and included in any visit measure.

Nurse Minutes per Routine Home Care (RHC) Day

- CMS indicates that this indicator was chosen to assess the average number of skilled nursing minutes per day during RHC days to differentiate hospices that are providing assessment throughout the hospice stay. The proposed rule did not include a description of the analysis conducted for this indicator. The Coalition has several questions for CMS and is requesting more information and a response to the following:
  - How was the number of nursing minutes necessary for an assessment determined?

  - We are requesting transparency regarding this and are requesting CMS provide the full analysis for this and other indicators.

- It is not clear from the specifications in the proposed rule if skilled nursing care (055X) will be broken down into RN and LPN visits. It should be noted that many hospices have incorporated LPN and NP visits with RN visits, and all should be included in this indicator.

- This indicator could result in some hospices extending the length of visits unnecessarily and not consistent with patient preferences. It is also contradictory to visit indicators and raises questions as to whether meeting patient's wishes or having a higher number or length of visits is most indicative of quality of care.

- A hospice's performance on this indicator would be better with a greater number of nurse minutes per RHC day, but there is no standard for this and no baseline data that has been shared. There are different types of nurse visits that require different amounts of time, i.e. a quick follow up on a new intervention, a full assessment, administration of an intervention, medication education, etc. What number of minutes would be considered a "good quality of care/best performance/outcome?

- This indicator, like others, is impacted by patient preferences, patient diagnosis, social determinants of health, etc. Baseline data is needed to determine adjustments necessary.

- As mentioned with respect to other indicators, not all hospice interdisciplinary services are being counted in this "minutes per day" indicator, nor is their contribution to quality care being considered.

Early Live Discharges/Late Live Discharges

- Live discharges do not convey quality of care to consumers and could actually create confusion for consumers as higher live discharges and longer lengths of stay could be viewed as beneficial by consumers. Consumers do not for the most part understand and are not familiar with the terminology of "live discharges". CMS and others have concerns about hospices that have a high proportion of live discharges, which is understandable but the public often does not understand these implications. Measures addressing these concerns are more program integrity measures and not quality of care measures.

- A more impactful program integrity measure would be live discharges *after* 180 days (181 days or more) as the 180th day is the last day of the second benefit period.

Burdensome Transitions (Type I)/Burdensome Transitions (Type II)

- These are measures for which hospices have never seen any data on national performance or individual performance.

- In 2018, there was a similar measure under consideration, MUC 18-101 Transitions from hospice care followed by death or acute care. The NQF MAP did not recommend this measure for rulemaking. The MAP recommended adding an exclusion to allow for patient choice, as there are several reasons a patient may choose to transition from hospice such as revocation, having to be discharged because of going outside the hospice's service area or a hospice discharge for cause. All the reasons for discharge are coded on a claim so could easily be separated. The MAP also suggested that CMS consider a dry run of the measure before publicly reporting results and explore the need for a survey of patients with a live discharge from hospice to better understand their reason for discharge and the potential scope of the problem.

Per Beneficiary Spending

- Like several other measures, this is more of a program integrity indicator than a quality-of-care indicator.

Visits near Death

- Analysis utilizing data that includes whether the patient/family desired a visit from the IDG disciplines that are part of a measure or exclusion criteria that removes patients/caregivers who refuse visits offered by these various disciplines in the last days of life from the measure denominator would better reflect quality of care. Collecting and monitoring data of visits in the last days of life is understandable, and the Coalition strongly urges CMS to consider visit data in the context of an individualized plan of care reflective of patient and family wishes.

  Recommendation: The Coalition recommends that CMS consider the regional cultural variations on visit patterns and CAHPS Hospice Survey outcomes and risk adjust for such variances.

It is important to note that the visits on claims have not impacted hospice quality scores in the past, nor have they impacted hospice payment. Therefore, some hospices do not have a robust system of confirming all visits are captured on the claim and instead have focused these efforts on Section O of the HIS. This Section was removed in January 2021. Therefore, CMS should incorporate a reasonable period for adjustment to this change and for claims to accurately reflect visits before publicly reporting the HCI.

The Hospice Outcome & Patient Evaluation (HOPE) instrument will capture data as hospice care is being delivered to patients, a gap in the HQRP that CMS sought to close in recent years. The amount of data and information available not only to consumers but also to CMS and hospice providers from the HQRP is relatively small. The HOPE will bring significantly more data and information to the HQRP which allows for more robust quality measures. It is anticipated that the HOPE will be in use soon by hospices.

Recommendation: The Coalition urges CMS to consider the impact of the measures anticipated from the HOPE on the HCI, and to eliminate any possible future duplication. We also recommend that CMS consider utilizing the HOPE as the source for publicly reported information in the future.

There are questions about the timeframe of the data that would be used for the HCI. We strongly recommend that no 2020 or 2021 data collected during the time of the current Public Health Emergency (PHE) be utilized for publicly reporting the HCI. The PHE has greatly impacted the type and number of visits that can be made to patients and, in fact, has impacted all of the proposed indicators. Should CMS decide to proceed with publicly reporting the HCI utilizing claims for the 2020/2021 dates of the PHE, the Coalition recommends that a notice on Care Compare be added that explains that the data is from care delivered during the PHE and may not be reflective of typical hospice services.

Claims Based Measures

There are four proposals related to calculating and reporting claims-based measures. The Coalition recommends that CMS consider updating these measures more frequently than annually. Submission of claims data does not require a change to current processes for hospices or CMS, and the data are constantly changing as nearly all hospices submit claims at least monthly. Therefore, it seems that quarterly updates to the data are possible and would reflect the most current data.

Recommendation: The Coalition, though, urges CMS to consider suppressing any publicly reported claims data until all the data displayed is post the current PHE.

As stated elsewhere in these comments, the Coalition strongly urges CMS to develop codes for chaplain visits to be recorded on hospice claims and for telehealth visits to be recorded on hospice claims.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Star Rating

CMS proposes to introduce Star Ratings for public reporting of CAHPS Hospice Survey results on the Care Compare or successor websites no sooner than FY 2022. The calculation and display of the CAHPS Hospice Survey Star Ratings would be similar to that of other CAHPS Star Ratings programs such as Hospital CAHPS and Home Health CAHPS with specifics about the methodology for the CAHPS Hospice Star Rating to be posted to the CAHPS Hospice Survey website.

Per the proposal, a hospice needs to have at least 75 CAHPS Hospice Survey responses for the Star Rating to display. This is nearly double the number of survey responses required from home health agencies and more than double the number of responses a hospice must currently have for CAHPS Hospice Survey measures to be reported. In the proposal, the number/percentage of hospices meeting this threshold is not shared. This information, in addition to the full methodology for calculating the Star Rating, should be shared with stakeholders. There should also be an opportunity for stakeholders to provide feedback to CMS on these details.

Unique to the CAHPS Hospice Survey is the fact that it is completed by caregivers not patients. This is a key difference for the hospice Star Rating that should be clearly stated with the CAHPS Star Rating posting on Care Compare so that consumers are not misled. The Star Rating should convey meaningful information in a manner that is consistently understood by consumers and the general public. It should also be based on data that are objective and not subject to manipulation by a provider. CAHPS hospice data currently have a tight distribution and it is not completely clear how this will translate for a star rating. For instance, it is anticipated that most hospices will fall into the middle of the curve and have a 3- or 3.5-star rating. Because of the high scores many hospices receive on CAHPS Hospice Survey measures, it is possible that a hospice with a score in the mid to high 90s (94-97) indicative of a high rate of top box responses would end up with a 3- to 3.5-star rating. This would be confusing to consumers who are accustomed to reviewing and providing star ratings on a wide range of products and services where the overall rating simply represents the average of all the individual consumer ratings. They might therefore interpret 3 stars out of 5 as meaning that the average consumer gave this hospice only 3 stars, when in fact, most consumers gave it the highest rating.

In the description of the Star Rating methodology in the proposed rule, two quarters of CAHPS Hospice Survey data would be utilized. CMS convened a Technical Expert Panel (TEP) in 2020 to inform refinements to the CAHPS hospice survey and such refinements are currently undergoing pilot testing. The Coalition has several key questions that require responses before implementation can move forward.

- Is CMS planning to have timing of the implementation of a revised CAHPS Hospice Survey coincide with data that is part of the debut of the Star Rating?
- Does CMS anticipate that the refinements to the survey will result in the number of returned surveys increasing such that most hospices will be able to meet the threshold of 75 returned surveys?
- How will risk adjustment be incorporated into the Star Rating?

These are just some of the outstanding questions stakeholders have about the plans for the Star Rating.

Recommendation: We urge CMS to allow hospices and other stakeholders, including EMR and CAHPS vendors, a period to review the methodology and an opportunity to ask questions and comment on it prior to implementation. We also ask that CMS incorporate a period prior to publicly reporting the star ratings for hospices to review their data and their Star Rating before they are posted. The typical quality reporting program provider preview period of six months may not be sufficient. Furthermore, we urge CMS to study how consumers perceive and understand the Star Rating system and test the efficacy of any related consumer education and messaging.

Also of concern is the possible inclusion of data for care that was delivered during the current Public Health Emergency (PHE) and these responses being skewed by the situations encountered during the PHE. Therefore, the Coalition recommends that CMS consider suppressing the Star Rating display in Care Compare until the August 2023 refresh so all data included in the calculation is for dates of service past the PHE .

Transition to iQIES

Recommendation: The Coalition recommends a minimum of 6 months' notice to providers regarding the transition and the steps they must take. Experience with this transition in home health highlighted the need to have notices/announcements/information shared via the various CMS and MAC communication platforms to reach the most providers.

Requests for Information

CMS is seeking comment on the possibility of expanding measure development and adding aspects of SPADEs that could apply to hospice and address gaps in health equity in the HQRP.

1) **Recommendation: Improve data collection on Social Determinants of Health, separate or added into the (HQRP, to better understand and intervene with those identified as experiencing underlying *risk factors and social determinants of health* that can contribute to lower quality end-of-life care and inequitable outcomes for hospice patients from underserved communities. Consider offering provider education and incentives for improved SDOH assessment and data collection.**

The current HQRP consists of two reporting requirements: The HIS and the CAHPS survey. HIS collects data on practice behaviors to address physical symptoms, preferences, spiritual/religious concerns and visits when death is imminent. The CAHPS collects data with caregivers following patient's death or discharge form Hospice on perception of hospice team's communication and support. CMS should consider expanding the use of SDOH for collection of data on social risks through the requirement that hospices:

- Implement Assessment tools for initial social work assessment (This may be part of the Hospice Outcomes and Patient Evaluation (HOPE)) currently being tested for use in hospice
- Utilize Z codes with encounter visit data).

2) **Recommendation: Do not exclusively utilize Standardized Patient Assessment Data Elements (SPADEs) for Hospice.**

It is our belief that SPADEs do not fully capture SDOH data and SPADEs have also been previously found to be an inadequate measure for hospice patients in a 2019 report to CMS from ABT Associates and The Rand Corporation. Current SPADEs data suggested to be representative of SDOH (race, ethnicity, preferred language, interpreter services, health literacy, transportation and social isolation) does not comprehensively reflect current understanding of SDOH. These existing data elements need to be expanded to capture what research has suggested are among the most impactful of SDOH's on health outcomes including: socioeconomic status, education level, housing stability, food insecurity, violence and safety concerns.

Upon initial recommendation of the use of SPADEs, hospice patients were categorized as *measure exclusions* from the target population of beneficiaries who were discharged to the community. In a June 2019 report prepared for CMS's Center for Clinical Standards and Quality**,** the justification for hospice patients being part of the groups excluded for inclusion in SPADEs measurement population were reported as:

1. "Patients discharged to hospice care are terminally ill and have very different goals of care compared with non-hospice patients. For non-hospice patients, the primary goal of the PAC (post-acute care) provider is to return to baseline, independent living in the community; death is an undesirable outcome in the non-hospice population. For patients discharged to hospice, the goal is to provide them the opportunity to die comfortably, at home or in a hospice facility.
2. A large proportion of patients discharged to hospice care die in the 31-day window following discharge from the post-acute setting.
3. The hospice agency, not the PAC provider, makes the final decision of discharge to hospice-home or hospice-facility."

3) Recommendation: While current facility quality measures identification of social risk factors should be stratified by race and ethnicity, additional measures that reflect a more comprehensive understanding of SDOH should be considered, along with assessment of how adequately previous measures are able to capture SDOH. (i.e. previous measures utilized such as dual eligibility for Medicare/Medicaid may be misleading).

Dual eligibility (and access to) Medicare/Medicaid for those with chronic or terminal illness may be considered a protective factor due to increased care benefits for those on Medicaid, including long term health care and nursing home benefits. Additionally, due to Medicaid waiver laws for Home and Community Based Services (HCBS) in many states, and spousal refusal exceptions, dual eligibility for Medicare/Medicaid, may not be a reliable measure of socioeconomic insecurity, nor does it reflect housing stability, food insecurity, violence and safety concerns, which have been identified as important predictors for population health. These disparities have been widely noted during the COVID-19 pandemic.

4) Recommendation: Adopt CMS recommendations for using Z codes into hospice reporting systems. Request hospice organizations use SDOH Z-codes to enhance quality improvement initiatives.

Hospice is a program and a philosophy of care that adopts an IDT team approach to whole patient care. Hospice in the United States incorporates the Total Pain model developed by the founder of the hospice movement, Dame Cecily Saunders and the World Health Organization's definition of Palliative Care. In both well-known models of care, hospice embraces the philosophy that equal attention should be given to a person's spiritual, social, emotional and physical suffering. However, current measures of quality care continue to focus on outdated methods of placing primacy on the physical needs of patients, while at the same time making assumptions that social, emotional and spiritual needs will be met with quality care provision without oversight. A recommendation for a more robust data approach related to patients' social needs is critical to a hospice's efforts to improve the outcomes of their patients and families.

Employing a standardized approach to screening for, documenting and coding social needs, perhaps as part of HOPE, will enable hospices to:

- Track the social needs that impact their patients, allowing for personalized care that addresses patients medical and social needs.
- Aggregate data across patients to determine how to focus a social determinants strategy; and
- Identify population health trends and guide community partnerships.

CMS has already created recommendations about how SDOH Z-codes can be utilized to improve outcomes. More information on CMS recommendations for using SDOH Z-codes can be found at: https://www.cms.gov/files/document/zcodes-infographic.pdf

CMS is seeking feedback on the potential use of Fast Healthcare Interoperable Resources (FHIR) for digital quality measures (dQMs) within the HQRP aligning where possible with other quality programs.

Hospices collaborate and exchange information with a variety of practitioners and health care entities across the continuum of care. They and the Coalition remain engaged in the pursuit of interoperability and support the adoption of FHIR and digital quality measures (dQM). Interoperable exchange of health information is a necessary goal to achieve the overarching goal of person-centric longitudinal coordination of care. We believe that standardizing data elements that are part of clinical documents to exchange information based on high-value use will support the case for health IT adoption. For example, there is no standard for the electronic documentation of a face-to-face physician encounter. Consequently, each connection in a network may define the structure and type differently, preventing true information exchange. To advance interoperability, it is necessary to clearly specify the defined set of FHIR-APIs and/or HL7 messages that each health IT vendor must support to meet interoperability standards of practice. This will ensure consistent, objective methods to reliably request and retrieve information from other systems. FHIR could be adopted for new clinical documents that are being developed for HOPE.

Hospice providers were not among the health care providers that were incentivized to adopt The Office of the National Coordinator for Health Information Technology (ONC)-certified Health Information Technologies (CEHRT). While the exact number of hospices utilizing EHR systems today is unknown, it is fair to say that most hospices utilize such a system. For those that do not, significant costs would be incurred if FHIR were adopted or CEHRT was required of hospices. However, we do consider such requirements advancements. Providers already using EHR systems will inevitably incur additional costs, as vendors will be required to implement significant improvements to their solutions and in turn, a percentage of these costs will inevitably be passed along to their provider customers. In addition, providers will require additional staffing and training to support, administer, and configure new software solutions that support interoperability. Incentives to offset these new imposed costs will help sustain adoption rates. Should FHIR, or any other platform, and dQMs be implemented we urge CMS to allow for a minimum of 6 months from the date final specifications are available for EMR and other vendors to respond to any changes in the interoperable exchange of health information.

Thank you for the opportunity to submit comments regarding the FY22 proposed hospice rule. If you or other staff are interested in speaking with Coalition leaders and experts on these topics, please contact Amy Melnick, Executive Director, amym@nationalcoalitionhpc.org or 202.306.3590.

Sincerely,

American Academy of Hospice and Palliative Medicine (AAHPM)
Association of Professional Chaplains (APC)
Center to Advance Palliative Care (CAPC)
Health Care Chaplaincy Network (HCCN)
Hospice Palliative Nurses Association (HPNA)
National Association for Home Care & Hospice (NAHC)
National Hospice and Palliative Care Organization (NHPCO)
National Palliative Care Research Center (NPCRC)
Palliative Care Quality Collaborative (PCQC)
Physician Assistants in Hospice and Palliative Medicine (PAHPM)
Social Work Hospice and Palliative Care Network (SWHPN)
Society of Pain and Palliative Care Pharmacists (SPPCP)