

June 7, 2021



Chiquita Brooks-LaSure, Administrator  
U.S. Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1754-P  
P.O. Box 8010  
Baltimore, MD 21244-1850

**Re: File Code CMS-1754-P, Medicare Program; Fiscal Year 2022 Hospice Wage Index and Payment Rate Update, Hospice Condition of Participation Updates and Hospice Quality Reporting Requirements**

To Administrator Brooks-LaSure:

The Home Care Association of New York State (HCA) is a statewide not-for-profit organization representing nearly 400 health care providers, allied organizations, managed care providers and individuals committed to the advancement of quality hospice and home care services in New York State.

On behalf of our hospice provider members that serve many of the approximately 47,500 Medicare hospice beneficiaries annually in New York, we appreciate the opportunity to provide comments on the U.S. Centers for Medicare and Medicaid Services (CMS) Medicare Program Fiscal Year (FY) 2022 Hospice Wage Index, Payment Rate Update, Hospice Conditions of Participation Updates and Hospice Quality Reporting Requirements proposed rule.

**General Overview of CMS's FY 2022 Proposed Rule**

CMS's FY 2022 proposed rule updates the Medicare hospice payment rates and aggregate cap amount for hospices serving Medicare beneficiaries in FY 2022.

In addition to the payment and cap updates, HCA offers our comments, concerns, requests and/or recommendations on the following other areas of CMS's proposed rule:

- CMS's hospice utilization data analysis, spending outside of the hospice benefit and other issues.
- Revision and rebasing of the labor shares of the hospice payment rates.
- Adoption of the 2018 Office of Management and Budget (OMB) hospice wage index statistical area delineations and the elimination of the 5% cap on wage index decreases.
- Proposed Clarifying Regulation Text Changes for the Hospice Election Statement Addendum.

- Making permanent select regulatory blanket waivers that were issued during the COBID-19 public health emergency (PHE).
- Multiple proposals and changes of the Hospice Quality Reporting Program (HQRP).
- Feedback on the Potential Use of Fast Healthcare Interoperable Resources (FHIR) for Digital Quality Measures.

## **Comments on CMS’s Hospice Utilization Data Analysis, Spending Outside of the Hospice Benefit and Other Issues**

HCA appreciates that CMS has once again continued to incorporate into its proposed FY 2022 hospice payment rule analysis of utilization data that explores hospice Medicare spending, utilization by level of care, lengths of stay, live discharge rates, skilled visits during the last days of life and trends related to hospice and non-hospice spending during a hospice election. This analysis is always helpful in tracking broad trends in hospice utilization.

Once again, CMS has also requested comments on all aspects of the data analysis presented, as well as comments on how changes in the types of patients served by hospice programs have influenced any changes in the provision of hospice services, what factors determine how and when visits are made as an individual approaches the end of life, how hospices make determinations on what items, services and drugs are related versus unrelated to the terminal illness and related conditions, and 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 care needs of beneficiaries are met. HCA offers the following comments on many of these topic areas:

### **General Comments on Utilization and Spending Trends**

One of the first things we concluded after reviewing the utilization and spending trends provided in the proposed rule is how many of the areas CMS has been tracking have remained relatively stable over the last decade, especially considering how the hospice benefit has changed over the same time period (particularly with respect to the shift from care of mostly cancer patients to a larger share of patients with neurological disorders and organ-based failures). This general stability of trends includes:

- Average spending per beneficiary between FY2010 and FY 2019 has risen by only \$1,529 over ten years– from \$11,158 in FY 2010 to \$12,687 in FY 2019.
- Measures of length of stay have remained generally stable.
- Average live discharge rates dropped between 2010 and 2014 and have remained stable at around 17% since 2014.

- Beneficiaries are receiving more skilled nursing and social worker visits during the last days of life since implementation of the service intensity adjustment (SIA) payment.

Based on our review of CMS's utilization and spending trends, we believe that while the hospice benefit and approach to care at the end of life remain unchanged, the change in the characteristics of patients served (particularly the shift from predominantly cancer patients to those with end stage neurological and other conditions) is largely responsible for any significant change in utilization trends and hospice practice that have been presented over the years.

This is understandable given that cancer care has changed considerably since the hospice benefit was created. According to the Centers for Disease Control and Prevention, cancer death rates have steadily dropped (between 1999 and 2019 cancer death rates dropped 27%). Patients now entering hospice following cancer treatment have generally exhausted curative options and chosen to not pursue further treatment, frequently because that treatment will diminish their quality of life. Neurological and organ-based failure disorders generally have a very different disease trajectory that are reflective of variable decline that is much more difficult to predict than that for terminal cancer patients.

### **CMS's Concerns with Hospice Patients with Longer Length of Stay**

CMS and others have expressed ongoing concern regarding patients with longer lengths of stay (LOS). One consequence of caring for patients with longer lengths of stay is that hospice providers are at higher risk for hitting the aggregate cap.

Recent research conducted by Dobson DaVanzo and Associates (DDA) for the hospice industry found that hospices that exceed the aggregate cap serve a larger proportion of patients with non-cancer diagnoses – including neurological disorders and chronic conditions such as diseases of the heart and circulatory system, cerebrovascular disease, respiratory disease, and chronic kidney disease. While there are many factors that are correlated with over-cap hospices, DDA found that by far the strongest driver of over-cap status is the degree to which the hospice's patient case-mix is made up of patients with neurological and other non-cancer diagnoses such that for each percentage point increase in the portion of care-days provided to non-cancer patients, there is an increase in the likelihood of a hospice exceeding the cap by about a half percentage point. This means that if a hospice increases its care days for non-cancer patients by 10%, its chances of exceeding the aggregate cap increase by 5%. Some hospice providers have limited access to additional referral sources (such as hospitals and oncology practices) whose patients could help "balance" cap liability. As a result, these hospice programs' only option for avoiding the aggregate cap may be to deny admission to patients with potentially longer disease trajectories, such as those with neurological disorders, which would deny patients and families access to needed hospice care.

HCA believes that in most cases increases in the overall LOS on hospice care are a function of the evolution of health care treatments and changing causes of mortality in the United States. Unfortunately, concerns about these changes have become significant drivers of

program integrity efforts and policy decisions, which could have a negative impact on access to hospice care.

While HCA and our colleagues at the National Association for Home Care and Hospice (NAHC) support efforts by CMS and other organizations with oversight responsibilities to ensure that fraud and abuse efforts by unprincipled actors are identified and pursued, such measures should be deployed strategically as part of a data-driven oversight approach that is targeted as much as possible on specific program vulnerabilities and high-risk providers.

Unfortunately, there is a growing negative connotation for hospice stays that exceed 180 days, hospice elections that end in live discharge, and longer-stay patients that are cared for by hospice organizations that exceed the hospice aggregate cap, despite the fact that these circumstances in no way, fraudulent or inappropriate hospice behavior.

We also have concerns regarding determinations of relatedness, as applied to coverage decisions connected to terminal prognosis. This is a clinical decision specific to the unique clinical circumstances of each patient and therefore the rule making around relatedness and ultimately coverage by the hospice needs to be empowering to the hospice clinicians (hospice medical director and employed hospice IDT physicians) just as determination of hospice eligibility based upon overall terminal prognosis currently resides in the realm of expertise and authority of the hospice physician.

We believe this growing negative perspective from CMS and other oversight entities could threaten admission to hospice for patients with non-cancer diagnoses for whom establishing a firm six-month prognosis is more challenging. We are very concerned that this will, over time, lead to admission policies that discriminate against patients with non-cancer diagnoses despite their eligibility for this important end-of-life care benefit.

### **Spending Outside of Hospice with Focus on Part D Spending**

Given the activity over recent years related to Part D spending for patients while on hospice care; the efforts that have been put forth by CMS, the hospice community, and other stakeholders to address concerns; and the considerable upheaval and financial costs that the Notice of Election (NOE) timely filing requirement have had on the hospice community at large, we continue to be troubled by data indicating that overall spending under Part D for hospice patients has increased, rather than decreased. CMS attributes this increase to growth in spending for drugs that CMS has identified as “maintenance” drugs, while spending under Part D for drugs that are currently under a prior authorization (PA) requirement (anti-nauseants, analgesics, laxatives, and anti-anxiety medications) appears to be in check.

HCA believes there are many questions that the discussion of spending for “maintenance drugs” under this section raise, and we believe that the release of additional data connected to CMS’s Part D spending analysis would better inform stakeholders and assist in helping to determine what factors may be contributing to these increased Part D expenditures. The following are some of our questions:

- It is unclear from CMS's discussion whether the referenced maintenance medications are for the terminal condition or a related condition or are for a condition that accompanies the terminal illness/related conditions but is not part of the terminal prognosis. If the medications are not for a related condition, they are appropriate for coverage under Part D and should be excluded from consideration since current law specifies that beneficiaries retain the right to treatment for non-related diagnoses outside of hospice under Medicare.
- The synopsis of Part D spending for maintenance drugs provides no insight into the extent to which rapid increases in manufacturers' charges (which has been a significant concern in Part D over recent years) are responsible for growing outlays under Part D for hospice patients. This is of particular concern since some of the drugs previously identified by CMS as maintenance drugs are among those that have had significant charge increases associated with them. Additional data would assist in making determinations of the extent to which the increases in spending represent a change in hospice patterns of practice or are attributable to increases in manufacturers' charges.
- Additional information would also be helpful in identifying whether this Part D spending is more prevalent in certain areas of the country or specific to certain hospice providers. If so, any unusual patterns could and should be addressed directly with hospice providers through educational efforts.

In summary, there are numerous factors that could play a part in increased Part D spending for maintenance drugs, and additional information related to this utilization must be examined to determine what issues are contributory and how best these can be addressed. We also believe that additional action on the part of CMS and stakeholder groups is necessary to maximize use of existing processes that were designed to help clarify responsibility for hospice patient's prescription medication.

### **Has the Election Statement Addendum Changed the Way Hospices Make Care Decisions?**

HCA has reached out to our hospice members for feedback to this question by CMS but has received limited information back to date. We think it's likely that the answer could truly vary for each hospice. Regardless of whether this new requirement has had significant, limited or no impact, we believe it important that CMS should work with hospice stakeholders to develop a cohesive process for notifying beneficiaries of all non-covered items services and drugs and a streamlined and cohesive set of beneficiary rights for non-covered items, services, and drugs. The start of this work could be part of CMS's proposed clarifying regulation text changes for the Hospice Election Statement Addendum.

### **Comments on CMS's Revised Labor Shares**

As part of CMS's FY 2022 rule, CMS is proposing to revise and rebase the labor share for each hospice level of care using 2018 hospice cost report data. This represents a significant departure from current policy under which the labor share portions for Continuous Home

Care (CHC) and Routine Home Care (RHC) have historically been based on the wage / nonwage proportions specified in Medicare's limit on home health agency costs, and for IRC and GIP based on skilled nursing facility wage and nonwage cost limits and skilled nursing facility costs per day. CMS is taking this action now because much work has been done over recent years to expand the amount of cost report data collected from hospices and to generally improve the quality of that data. HCA has numerous observations and concerns regarding CMS' approach to revising the labor shares that we submit for consideration. These include:

- Concerns related to the quality of cost report data utilized by CMS to calculate the labor shares and its applicability to the hospice universe.
- Significant limitations in the cost reporting tool and instructions for calculation of the labor shares portion of the hospice payment rates.
- Failure to provide background methodology and data as to how CMS calculated the "labor share standardization factor" and an inability to judge its impact on overall spending given this lack of information.

### **Concerns on the Quality of the Hospice Cost Report Data**

While HCA understands CMS's desire and rationale for using hospice data to revise the hospice labor shares (and to make other policy changes), we believe it is important to recognize that the data inputs utilized must be appropriate to the task. The hospice cost report in its current form does not suit all data purposes for hospice policy changes and does not fully support calculation of the labor share within each hospice payment rate. Recently HCA participated in multiple meetings with NAHC's Home Health and Hospice Financial Managers Association (HHFMA) workgroup who have identified the following specific concerns related to use of existing hospice cost report data to calculate the hospice labor shares of the payment rates:

- There are several issues surrounding the data used from Worksheet A-1 and A-2, column 7, lines 26 through 37, for total labor costs associated with each respective LOC. Certain costs are not consistently reported by hospices yet are still in compliance with cost reporting instructions. One notable item is mileage paid to staff for use of personal vehicles. Some hospices track mileage allowances in a manner enabling them to be reported on Worksheet A-1 and A-2, while other hospices allocate these mileage reimbursement costs via Worksheet B and B-1 using miles traveled. This inconsistency would impact the calculation of the labor component. **Was any consideration given to this inconsistent, but acceptable, reporting for mileage allowances?**
- Overhead salaries and wages between hospices have been inconsistent for certain types of expenses, e.g., Medicare Directors. In some cases, Medical Directors are employees and, of course, salaries are reported. Other hospices contract for this position. Accordingly, the contracted payments for Medicare Directors are not included in the Overhead Salaries as described in the proposed rule. **Did CMS give**

**any consideration to this inconsistency or other common inconsistencies in the nature of the expense incurred and the appropriate reporting for this expense?**

- The determination of the labor component for GIP and IRC services is based on Worksheets A-3 and A-4; however, any hospices reporting costs on line 25 (contracted services) were not included in the sample used for setting the labor component for GIP or IRC services. HCA recognizes that the inclusion of any costs on line 25 would distort the labor component for these inpatient services; however, our experience indicates that most hospices with inpatient units also contract for some inpatient days with outside providers for a variety of reasons. Additionally, many of these hospice providers have some of the best accounting records in the industry and the methodology for calculating the labor component eliminates the costs of these facilities for consideration. **The proposed rule indicates that 20% of IRC providers were included for the computation and 28% of GIP providers were included. What was the final number of hospices with inpatient units that were used in the calculation of the labor component for both inpatient and respite care rates, and the total universe of IRC and GIP providers?**
- When the cost report was revised in 2014 and hospice payment rates were rebased, some industry experts recommended that CMS develop two separate worksheets for Inpatient Respite Care (IRC) and General Inpatient (GIP). The first worksheet would represent the costs associated with freestanding units operated by the hospice whereas the second worksheet would be for costs associated with contracted services. Had this occurred, CMS would have significantly more reliable data for purposes of calculating a labor component for GIP and IRC services.

**HCA believes CMS might see value in potentially adding these worksheets if, in fact, it intends to calculate labor components for these levels of care based on cost report data going forward. Additionally, to better validate the existence of an inpatient unit, CMS could add a question to the cost report, “Do you operate a freestanding inpatient and/or inpatient respite care facility? A “no” answer would require reporting contracted days and contracted costs or produce a Level 1 edit. This would better allow CMS to isolate the costs of those facilities that truly operate an inpatient unit.**

- There are inconsistencies in reporting medical supply and pharmacy costs on line 10 and line 14 of Worksheet A. Some hospices use Worksheets A-1, A-2, A-3, and A-4 to report all or most of these costs whereas others use lines 10 and lines 14 and report costs as overhead costs. **To be consistent in any labor component computation, especially going forward, HCA as part of NAHC’s HHFMA’s workgroup recommends that CMS look further into reporting all pharmacy and medical supply costs as direct patient care costs on future cost reports. Other acceptable cost reporting methods may be applicable; however, a Level 1 cost report edit is not currently produced if costs are reported in one of the two acceptable locations.**

## **HCA Recommendations**

As referenced above, it is important to recognize that the Hospice Cost and Data Report, when modified, was not designed with the intent of securing information for the determination of a labor component for each of the levels of care. **If data from the Hospice Cost and Data Report is to be used for calculating the labor component by LOC, revisions to the cost report should be proposed to address current inconsistent, but acceptable reporting practices as identified above. Further, changes should be instituted to ensure greater accuracy of the data being used to establish labor shares for GIP and IRC.**

**We further recommend that CMS clarify its intent relative to the frequency with which it intends to revise the labor shares.**

## **Labor Share Standardization Factor Concerns**

As part of the rule's discussion of the Proposed FY 2022 Hospice Payment Rates, CMS references initiation of a wage index standardization factor in conjunction with the FY 2017 hospice final rule and explains that this factor was created to eliminate "the aggregate effect of annual variations in hospital wage data". CMS also describes how it has calculated the wage index standardization factor for use in determining FY 2022 payment rates. As part of that section, the rule also references a new "labor share standardization factor" that will be used to calculate payment rates and indicates it has been calculated by simulating total payments using FY 2020 hospice utilization claims data with the FY 2022 hospice wage index and the current labor shares, and compare it to CMS' simulation of total payments using the FY 2022 hospice wage index with the proposed revised labor shares. CMS does not, however, explain what the purpose of the labor share standardization factor is, although it presumably is designed to ensure budget neutrality in light of imposition of the new methodology for calculation of the labor shares of the payment rates.

## **HCA Recommendation**

CMS's failure to explain the purpose of the labor share standardization factor and to outline the calculations that led to the various factors makes it difficult to analyze whether it will have the intended impact on payments. It is also unclear whether this factor will be applied on an ongoing basis and, if so, if it will vary from year to year. Given that the labor share standardization factor further reduces the labor component for RHC and GIP, we request that CMS provide more explanation (including details related to the calculations) of the labor share standardization factor, its purpose, and any anticipated future use of this factor as part of the final rule.

## **Proposed FY 2022 Hospice Wage Index Update**

### **Background**



In its FY 2021 Final Hospice Wage Index and Payment Rate Update, CMS finalized its plan to integrate revisions published by the OMB in September 2018. While these changes were not expected to have a significant impact on a widespread basis, they did impact specific areas of the country and for FY 2022 CMS is eliminating the 5 percent cap on wage index decreases that were in effect for FY 2021.

CMS is also continuing to calculate the hospice wage index values using the most up-to-date, pre-floor, pre-reclassified acute-care hospital wage index (with new OMB designations) because CMS believes it is the best Medicare wage index data available.

## **HCA Comments/Concerns**

Although CMS has repeatedly dismissed HCA's longstanding request for wholesale revision and reform of the hospice and home health agency (HHA) wage index, we reiterate our support for more far-reaching reforms to the wage index methodology used under Medicare fee-for-service (FFS) programs.

We believe the pre-floor, pre-reclassified hospital wage index is wholly inadequate for adjusting hospice and home health costs, particularly in states like New York, which has among the nation's highest labor costs. The state's phase-in of a \$15 per-hour minimum wage hike will ultimately cost a stunning \$2.5 to \$3 billion for New York hospices and HHAs across all payors (Medicaid, Medicare, managed care, commercial insurance and private-pay). These costs will never be adequately addressed due to CMS's ongoing disposition to continue using the pre-floor, pre-reclassified hospital wage index to adjust home health costs.

Yet another ongoing concern for hospices and other small HHAs is the need for parity with other health care providers (i.e., hospitals, nursing homes, etc.) that draw from the same labor pool. While the same data is used to establish the basic wage index values applicable to most provider types, hospitals receive special consideration in a number of ways, including that they are permitted to seek geographic reclassification from their assigned geographic area (thereby receiving higher wage adjustments to their payments). Hospice providers and HHAs are not afforded these same options yet must compete for the same types of caregiving professionals.

## **HCA's Recommendations**

The time is long overdue for CMS to develop and implement a wage index model that is consistent across all provider types so that all types of providers have a level playing field from which to compete for personnel. Additionally, the model should incorporate some means by which providers are protected against substantial payment reductions due to dramatic reductions in wage index values from one year to the next. While HCA appreciated CMS's inclusion of a proposed 5% cap on losses in wage index values in FY 2021, we believe that the CMS should of either maintained the 5% cap or even lowered it to 3% in order to protect hospice providers who are already operating with negative or razor-thin operating margins. Finally, all providers should be guaranteed that their wage index value does not drop below the rural wage index value applicable in the state of operation.

## **Proposed Clarifying Regulation Text Changes for the Hospice Election Statement Addendum**

### **Background**

In its FY 2020 hospice rule, CMS finalized modifications to the hospice election statement and included a new condition for payment requiring a hospice, upon request, to provide the beneficiary (or representative) an election statement addendum outlining the items, services, and drugs that the hospice has determined are unrelated to the terminal illness and related conditions. Despite this action, a number of questions and concerns remained relative to addendum statement requirements.

HCA is pleased that as part of this FY 2022 proposed rule CMS has addressed a number of these outstanding questions and has modified policies such that hospices will be better able to comply with the election statement and addendum requirements.

Specifically, CMS has indicated the following:

- Clarified that hospices must document that the addendum was discussed whether or not it was requested, in order to prevent potential claims denials related to any absence of an addendum (or addendum updates) in the medical record.
- Proposes to allow the 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 (rather than within 72 hours as previously expected if the addendum is requested after the date of election). For example, if the patient elects hospice on December 1st and requests the addendum on December 3rd, the hospice would have until December 8th to furnish the addendum.
- Aligning regulation changes at § 418.24(c) with sub-regulatory guidance indicating that hospices have “3 days,” rather than “72 hours” to meet the requirement to furnish the addendum when a patient requests the addendum during the course of hospice care.
- Clarifies in regulation that the “date furnished” must be within the required timeframe (that is, within 3 or 5 days of the beneficiary or representative request, depending on when such request was made), rather than the signature date. At § 418.24(c)(10), CMS proposes that the hospice would include the “date furnished” in the patient’s medical record and on the addendum itself.
- In situations where the beneficiary or representative refuses to sign the addendum, CMS clarifies that the hospice must document clearly in the medical record (and on the addendum itself) the reason the addendum is not signed in order to mitigate a claims denial for this condition for payment. In such a case, although the beneficiary has refused to sign the addendum, the “date furnished” must still be within the required timeframe (that is, within 3 or 5 days of the beneficiary or representative

request, depending on when such request was made) and noted in the chart and on the addendum itself.

- Proposes to clarify in regulation that if only a non-hospice provider or Medicare contractor requests the addendum (and not the beneficiary or representative), the non-hospice provider is not required to sign the addendum.
- For instances in which the beneficiary or representative requests the addendum at the time of election but dies prior to signing the addendum, CMS proposes conforming regulatory changes at § 418.24(c) to reflect the current policy that the hospice would not be required to furnish the addendum as the requirement would be deemed as being met.
- If the patient revokes or is discharged within the required timeframe (3 or 5 days after a request, depending upon when such request was made), but the hospice has not yet furnished the addendum, the hospice is not required to furnish the addendum (§ 418.24(d)(4))

## **HCA's Comments and Recommendations**

HCA very much supports the clarifications and regulatory changes that CMS has proposed and is particularly appreciative that CMS has addressed issues related to the time frame for providing the addendum if it is requested after the date of election but within the first five days of care. We also appreciate CMS' clarification that compliance will be by the addendum's "date furnished" rather than date of signature. CMS has also addressed important issues related to situations where the patient or responsible individual has refused or otherwise not been able to sign the addendum and clarified that hospices are not required to secure a signature on the addendum when a non-hospice provider or Medicare Administrative Contractor has requested it. However, we do have some additional comments and requests as it relates to the various effective dates, model sample addendum and financial penalties associated with late signed addendums.

### **Effective Date Concerns**

CMS has proposed many other clarifications and policy modifications to the addendum requirements as part of the proposed rule. Some of these policies were specified previously but were not codified in regulation, while others have been proposed to better ensure that hospices are able to fully comply with the requirements. As part of the rule, CMS has not specified when each of these policy changes/clarifications would be effective. However, given that they are all designed to support hospice practices related to the addendum requirements, which became effective on October 1, 2020, and that medical reviews are not currently being conducted on claims submitted during the PHE, **HCA requests that CMS make these changes effective retroactive to the effective date of the addendum requirement (October 1, 2020). If CMS is not able to make all the changes retroactive, we encourage it to specify an effective date for each of these policies to ensure that they will be applied appropriately during any forthcoming audit.**

## **Model Sample Addendum Request**

Given that CMS is proposing changes that impact the Election Statement Addendum, we respectfully request that CMS provide a modified sample addendum form that reflects the proposed changes.

## **Financial Penalty Concerns**

HCA remains concerned that CMS has not addressed the financial penalty that will be imposed for failing to meet the time frames for provision of the addendum to the patient or representative. CMS' goal for imposition of the addendum requirement is to ensure transparency relative to what items, services, and drugs the hospice has determined are unrelated to the terminal illness and related conditions. Supplying the addendum on a timely basis helps to support such transparency. However, under current policy CMS has determined that if a hospice has failed to provide the addendum within the specified 3- or 5-day time frame, the hospice will be denied payment for the entire claim period subject to review. As a result, hospices will be denied payment for an entire month of service, even if the addendum was provided just a single day late. If a hospice discovers that it is late in supplying the addendum to a patient or representative, that hospice has little incentive to provide the addendum in a timely manner. This level of penalty is far in excess of what is imposed related to late submission of the hospice Notice of Election (NOE). If a NOE is not received timely, those days from admission to the day before the NOE was received are considered non-covered, and the provider is financially liable for those days. HCA requests that CMS revise the penalty related to provision of a late addendum to be consistent with the penalty applicable when a NOE is not received timely.

## **Hospice Waivers Made Permanent & Conditions of Participation**

As part of the rule, CMS is proposing to make permanent two of the COVID-19 PHE Section 1135 waivers under the Hospice Conditions of Participation (CoPs).

## **Use of Pseudo Patients**

Under the current hospice aide competency standard regulations at §418.76(c)(1), a hospice aide's performance must be evaluated by observing an aide's performance of the task with a patient. CMS proposes to make similar changes to these hospice aide competency standards to those already made with respect to HHAs at §484.80(c) by proposing to permit skill competencies to be assessed by observing an aide performing the skill with either a patient or a pseudo-patient as part of a simulation. CMS further proposed to define both "pseudo-patient" and "simulation" at § 418.3 as follows:

- "Pseudo-patient" means a person trained to participate in a role-play situation, or a computer-based mannequin device. A pseudo-patient must be capable of responding to and interacting with the hospice aide trainee and must demonstrate the general characteristics of the primary patient population served by the hospice in key areas such as age, frailty, functional status, cognitive status, and care goals.

- “Simulation” means a training and assessment technique that mimics the reality of the homecare environment, including environmental distractions and constraints that evoke or replicate substantial aspects of the real world in a fully interactive fashion, in order to teach and assess proficiency in performing skills, and to promote decision making and critical thinking.

**HCA strongly supports these proposed changes that would allow hospices to utilize pseudo-patients**, such as a person trained to participate in a role-play situation or a computer-based mannequin device, instead of actual patients, in the competency testing of hospice aides for those tasks that must be observed being performed on a patient.

### **Hospice Aide Training and Evaluation**

Relative to hospice aide training and evaluation, CMS is proposing to amend the requirement at § 418.76(h)(1)(iii) to specify that if an area of concern is verified by the hospice during the RN on-site supervisory visit, then the hospice must conduct, and the hospice aide must complete, a competency evaluation of the deficient skill and all related skill(s) in accordance with § 418.76(c). This proposed change would permit the hospice to focus on the hospice aides’ specific deficient and related skill instead of completing another full competency evaluation. **HCA supports this proposal.**

### **Requests Regarding the Use of Technology-based Visits**

On a related note, early in the COVID-19 PHE, CMS officials noted that there are no requirements under the hospice CoPs that visits outlined on the plan of care must be delivered in person and that services can be delivered using technology as long as they meet the goals of care established by the interdisciplinary team (IDT). On March 30, 2020, CMS issued an Interim Final Rule (Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency – CMS-1744-IFC), which amended the hospice Special Coverage Requirements at 418.204 to allow hospice providers to “provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patient’s terminal illness and related conditions.”

CMS has further clarified on provider information calls that a variety of telecommunications options (including audio only) are permitted for use, provided the technology is included on the plan of care and that the goals of care, as also outlined on the plan of care, are met. This includes potential use of telecommunications technology to complete patient assessments as long as the hospice is able to conduct a thorough assessment using the selected technology; otherwise, an in-person visit may be needed. These visits are part of the per-diem payment for hospice care and do not impact reimbursement. Prior to the COVID-19 PHE, CMS verbally clarified that there are no prohibitions on the delivery of technology-based visits under hospice provided the visits meet the goals of the visits as set out in the plan of care. However, since CMS specifically authorized use of technology for such visits during a PHE under Section 418.204 – Special

Coverage Requirements, this raised some questions about use of technology-based visits on a permanent basis.

**HCA requests that CMS further clarify that technology-based visits are permissible outside of a PHE under the same circumstances and conditions as under a PHE, provided applicable HIPAA requirements are met.**

## **Hospice Quality Reporting Program**

In its proposed rule, CMS makes numerous proposals and provides many updates to the Hospice Quality Reporting Program. HCA offers the following comments on many of these proposals and updates and in some cases makes recommendations or requests.

### **Proposal to Remove the Seven “Hospice Item Set Process Measures” From HQRP Beginning FY 2022 (No Earlier Than May 2022)**

CMS proposes to remove the seven individual Hospice Item Set (HIS) process measures beginning no earlier than May 2022 and replace those seven individual measures with one composite measure. The data for each of these individual measures will still be available publicly via the Care Compare Data Catalog. Currently, the Data Catalog is linked at the bottom of the first Care Compare page that is available when a consumer clicks on a hospice. **When the seven HIS measures are no longer individually reported, HCA requests that CMS include a notice that data on each of the processes can still be accessed from the CMS’s Data Catalog.**

### **New Hospice Care Index Proposal**

CMS is proposing a new measure, the Hospice Care Index (HCI) to provide more information to better reflect several processes of care during a hospice stay and better empower patients and family caregivers to make informed decisions. While the HCI is a single measure it is comprised of the following ten indicators calculated from Medicare claims data:

- CHC or GIP provided.
- Gaps in nursing visits.
- Early live discharges.
- Late live discharges.
- Live discharges from hospice followed by hospitalization and subsequent hospice re-admission.
- Live discharges from hospice followed by hospitalization with the patient dying in the hospital.
- Per-Beneficiary Medicare spending.
- Nurse care minutes per Routine Home Care (RHC) day.
- Skilled nursing minutes on weekends.
- Visits near death.

HCA very much supports quality of care measures that represent the entire hospice benefit in the HQRP and that are publicly reported. The purpose of publicly reported 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 HCI focus only on medical services provided by hospices, specifically nursing and medical social work services. These are only some of the services provided by the hospice interdisciplinary group (IDG). The 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 between CAHPS Hospice Survey outcomes and 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. **HCA encourages 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 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. HCA 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. **HCA 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.

Also unaccounted for on hospice claims and in the HCI indicators are telehealth visits. As stated elsewhere, telehealth visits have been utilized by hospices to supplement care and should be reflected on claims. **HCA appreciates concern about telehealth visits being utilized in place of as opposed to supplementing routine visits; however, identifying telehealth visits on hospice claims could provide data and meaningful analysis about hospice care delivery.**

### **Reduction in Market Basket Update for Hospices Not Compliant with HQRP Requirements**

Beginning with FY 2014 through FY 2023, CMS can reduce the market basket update by 2 percentage points and beginning with the FY 2024 APU and for each subsequent year, by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.

### **HCA Recommendation**

Quality submissions tied to the FY 2024 APU begin January 1, 2022. HCA encourages CMS to prominently display notices and information about this change beginning in 2021 on the CMS hospice quality reporting webpages. This will help alert hospices to the change so that they might make any necessary revisions to processes that will help them achieve full compliance.

### **Claims Based Measures**

There are four proposals related to calculating and reporting claims-based measures. **HCA 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 is 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.

**HCA also urges CMS to suppress any publicly reported claims data until all the data displayed is post the current PHE.** The pandemic is impacting how hospice care is delivered and there are some areas that are more impacted than others.

Finally, as stated elsewhere in these comments, **HCA 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.**

### **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 is objective and not subject to manipulation by a provider. CAHPS hospice data currently has



a narrow distribution scale, 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 may be possible that a hospice with a score in the mid to high 90s would still be in the 3- to 3.5 star rating category. This could be misleading to the public as the public is familiar with star ratings and generally associates a 3- to 3.5 star rating as “average” yet a hospice score in the mid to high 90s would generally be viewed as considerably above average.

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. **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? Are risk adjustments being considered for the Star Rating?** These are just some of the outstanding questions stakeholders have about the plans for the Star Rating. **Therefore, HCA requests that CMS allow hospices and other stakeholders, including Electronic Medical Record (EMR) and CAHPS vendors, a period to review the methodology and an opportunity to ask questions and provide comments on it prior to implementation and to incorporate a period prior to publicly reporting the star ratings for hospices to review their data and their Star Rating before posting. The typical quality reporting program provider preview period of six months may not be sufficient.**

Also of concern is the possible inclusion of data for care that was delivered during the current PHE, and these responses being skewed by the situations encountered during the PHE. Therefore, HCA recommends that CMS suppress the Star Rating display until all data included in the calculation is for dates of service past the PHE.

### **Potential Use of Fast Healthcare Interoperable Resources (FHIR) for Digital Quality Measures (dQMs) within the HQRP Aligning where Possible with Other Quality Programs.**

HCA believes the adoption of FHIR across the healthcare continuum is a laudable goal along with the adoption of digital quality measures (dQM) and the definition proposed for dQM. In many cases, the delivery of quality care, including hospice services, relies on the collaboration and exchange of health information across the continuum of care with physician practices, hospitals, and long-term post-acute care (LTPAC) providers such as skilled nursing facilities and rehabilitation hospitals. Therefore, we believe it is imperative that CMS consider hospice and home health providers as vital partners in the overarching pursuit of interoperable health information exchange across the continuum of care.

HIT and clinical technology are at the core of every aspect of health facility/agency operation; they are integral to service delivery, quality evaluations and outcomes, cost-effectiveness and administration. However, federal, state and private payors have long overlooked hospice and home care in the health IT development area, even though virtually

every new state and federal care model or demonstration project – including value-based payments – requires this kind of technology infrastructure and interoperability to succeed.

Furthermore, HHS and CMS have stated in the past that all individuals, their families, their health care and social service providers, and payors should have consistent and timely access to health information in a standardized format that can be securely exchanged between the patient, providers, and others involved in the individual's care. The secure, efficient and effective sharing and use of health-related IT information, when and where it is needed, is an important tool for settings across the continuum of care, including hospice and home health.

So, while we very much agree with the concepts of FHIR and recognize these are laudable principles; we are disappointed that hospices and home health agencies have not been eligible for various grant monies through the Medicare and Medicaid EHR Incentive Programs.

### **HCA Recommendation**

HCA asks that CMS and/or HHS incorporate funding in the 2022 final rule to invest in HIT and integrated clinical technology for hospice and home care. Such technology investments should be targeted to promote health care quality, cost-effectiveness, care management and integration of hospice and home care within provider systems and between sectors.

### **Conclusion**

HCA thanks CMS for this opportunity to submit comments and respectfully requests CMS's consideration of our concerns and recommendations. I would be pleased to answer any questions or assist CMS staff in any way going forward and can be contacted at [pconole@hcanys.org](mailto:pconole@hcanys.org) or (518) 810-0661.

Sincerely,



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