

June 7, 2021



Chiquita Brooks-LaSure  
Administrator  
Center for Medicare and Medicaid Services  
Department of Health and Human Services  
200 Independence Ave, SW  
Washington, DC 20201

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

Dear Administrator Brooks-LaSure,

On behalf of our over 5,000 members and partners including mission-driven organizations representing the entire field of aging services, 38 state associations, hundreds of businesses, consumer groups, foundations, and research centers, LeadingAge is pleased to offer the following comments in response to the FY2022 Hospice Wage Index and Payment Rule.

#### **HOSPICE UTILIZATION AND SPENDING PATTERNS**

LeadingAge is pleased to see the analysis of hospice spending patterns included in the rule. In the past, we have expressed concerns to CMS about patterns in hospice spending and inconsistent application of the benefit and its intent as delivered to beneficiaries. LeadingAge supports the intent of the benefit to be holistic and to cover substantially all patient and family needs. However, there is reported variation between providers and our not for profit members frequently find that they cover more services, drugs, etc. as “related” than most for profit competitors in their markets. CMS’ data lend support to our members’ observations by reporting \$1 billion dollars in non-hospice spending in FY2019 across the Medicare program and increases in non-hospice A and B spending during hospice elections between FY2016 and FY2019. While different interpretations in what is covered under the hospice benefit are not the only explanation for increased non-hospice spend over time, they are likely a contributing factor.

We appreciate CMS’s goal of intent around having flexibility to define the care plan, but the guidance around “related” and “unrelated” is not clear and leaves too much room to take advantage of the system, rather than cover as much related care as possible. While we appreciate CMS’s intent around having flexibility to define the care plan, the continued insistence that CMS is clear in its guidance around “related” and “unrelated” is not borne out in practice. The agency’s acknowledgment that they receive frequent requests for clarification underscores this reality as does the data presented in this rule. Some hospices cover as much “related” as possible since that is CMS’ stated intent and is aligned with their organizational mission and values. Others take advantage of the gray space and manipulate the system. Still others in their attempt to comply use a structured format like a decision tree. Those decision tree formats typically look at services as indicated in 42 C.F.R. 418.200 that services must be

“reasonable and medically necessary, for palliation and management, and related to the "terminal illness" and "related conditions." What is needed for CMS is engagement with stakeholders and more concrete direction so that consumers can understand what services they will receive and hospices can take a consistent, transparent approach.

Some other concerns that these data raise:

*Billing:* Not all billing is within the hospice’s control. Any utilization of the data presented for program integrity or other purposes should be mined and account for costs that are outside the hospice’s control such as billing by the attending physician.

*CMS’ intent with regard to levels of care:* Over the past number of years and even at points in this rule, CMS encourages the utilization of the non-RHC levels of care. However, program integrity contractors of all stripes have ramped up audit activity for programs that are “outliers” in amount of the non-RHC care they deliver. Our members are seeing this pattern consistently with regard to GIP, especially those with their own inpatient units. Through the HQRP and prior payment policy where the GIP rate was rebased, CMS signals that utilization of GIP (and other non-RHC levels of care) is indicative of quality and holistic hospice care. LeadingAge and our members agree. However, the level of scrutiny on GIP through the various contractors is such that CMS appears to recoup the additional money they put into the GIP program. The contractors are also not using standards for evaluation of GIP care consistent with the law. For example, some of the contractors are using a rule of thumb that any GIP stay over 5 days is an outlier and in need of review. This is not a standard in statute or in regulation. We ask for consistent policy across all parts of CMS with regards to GIP and would welcome discussion to talk about revisiting standards, education, and other efforts to ensure access to this critical service. We are fearful similar patterns would emerge if our members started providing more respite or more CHC.

#### **FY 2022 PROPOSED LABOR SHARES**

LeadingAge acknowledges the rationale for using hospice cost report data for hospice payment. Most significantly, this will reduce reimbursement for many of our members, particularly those who provide more GIP than average.

Further, we have concerns about the quality of cost report data; it should be improved and optimized before it is used for payment purposes. Specifically:

- We recommend that the cost reports be amended to allow for a greater breakdown of costs for contracted vs. hospice-administered inpatient services to apportion the labor share appropriately.
- We request that CMS clarify how frequently they intend to update the labor shares component moving forward and clarify the development and methodology around the “standardization factor.” This includes clarification as to how CMS will adjust the labor share if certain types of hospices are found to provide more services and thus, likely have a larger labor share, but contribute fewer cost reports.

- If the labor shares are going to have a greater weight on CHC, let hospices utilize it effectively. We recommend the current continuous care timeframe change from midnight to midnight to a new time frame of noon to noon and that visits from other providers such as chaplains and home health aides count toward the continuous care timeframe.

#### **PROPOSED ROUTINE FY 2022 HOSPICE WAGE INDEX AND RATE UPDATE**

We support the increase in the wage index and rate update but want to underscore that all programs took on major, ongoing expenses due to COVID-19. While the resources from the government during 2020 and into 2021 have been immensely helpful, the ongoing expenses for PPE and other equipment now have to be worked into hospices' budgets and many of our members' margins were already thin so increased payment over the coming years will continue to be essential. We also encourage CMS to continue to examine policies to help assuage ongoing wage index inequities. We ask that CMS reinstitute the policy that no hospice be paid below the rural floor for their state and consider working with the Congress on policies to reform the wage index such as revisiting MedPAC's 2007 proposal<sup>1</sup> or one that would allow hospices and other post-acute providers to utilize a reclassification board similar to hospitals. Hospice providers are not afforded these same options to adjust their wage indices yet must compete for the same types of caregiving professionals as hospitals.

#### **PROPOSED CLARIFYING REGULATION TEXT CHANGES FOR THE HOSPICE ELECTION STATEMENT ADDENDUM**

We generally support the clarifying changes for the hospice election statement addendum. We recommend that CMS make these changes retroactive to Oct 2020 (which will help future reviewers understand when hospices were supposed to be accountable for complying with these changes). Additionally, we recommend that CMS alter the financial penalty terms related to the addendum such that hospices are only penalized for the days they have not supplied the addendum, as opposed to the entire claim period. As currently structured, the penalty is a negative incentive to furnish the addendum in a timely manner if a hospice misses the initial required timeframe. Finally, we recommend removing the 3-day option to file the addendum; make it a 5-day requirement to align with other reporting requirements.

#### **HOSPICE WAIVERS MADE PERMANENT CONDITIONS OF PARTICIPATION**

We support the proposals to make the outlined waivers permanent. We ask that CMS make telehealth a permanent option for hospices to utilize in routine home care complete with the creation of a modifier so that visits can be tracked. We also ask that CMS consider a glide path for terminating other waivers if they are not extended permanently – we know that HHS proposed notice before the termination of the public health emergency, but ideally providers would have 6 months to wind down the waivers.

#### **PROPOSALS AND UPDATES TO THE HOSPICE QUALITY REPORTING PROGRAM**

*General Comments on HQRP*

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<sup>1</sup>MedPAC, June 2007 Report to the Congress, Chapter 6: An alternative method to compute the wage index. [http://www.medpac.gov/docs/default-source/reports/Jun07\\_Ch06.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/Jun07_Ch06.pdf?sfvrsn=0)

We recommend that CMS consider utilizing multiple data sources to try to capture quality – for example, as a potential alternative to or evolution of a purely claims-based HCI, CMS could combine data from both claims and surveys (focusing on specific survey deficiencies that are most relevant). CMS could look to the PEPPER report (or another alternative data report such as the comparative billing report) as a potentially valuable source for insights into quality. We are aware that CMS has previously stated that not enough hospices download their PEPPER to make them very informative at this time but that there are efforts from CMS and vendors to increase outreach to hospices to remind them to download their PEPPERS.

#### **PROPOSAL TO REMOVE THE SEVEN “HOSPICE ITEM SET PROCESS MEASURES” FROM HQRP BEGINNING FY 2022**

We understand the rationale for the removal of the hospice item set process measures since they will be replaced with a composite measure that provides consumers with the same data. We would ask that CMS be as clear as possible, both with disclaimers and with visual presentation, so that consumers understand how to read the new composite measure on Care Compare and how it compares to the old HIS. CMS should give stakeholders and consumers the opportunity to view the new display and provide feedback before it goes live to make sure as little confusion as possible occurs in the transition.

#### **PROPOSAL TO ADD A “CLAIMS-BASED INDEX MEASURE”, THE HOSPICE CARE INDEX (HCI)**

##### *General Comments on HCI*

Overall, we appreciate CMS and Abt’s work on this measure and engagement with stakeholders. We also believe that the idea of a composite measure is a good one. However, we strongly believe that more work is needed on the individual indicators in this composite measure and that, as it stands, significant revisions are needed before it is ready for use to be sure that the indicators are truly measuring quality of care. With the upcoming HOPE tool, we also wonder if claims-based data might be better utilized for program integrity while waiting for that tool to develop more robust quality measures.

Much of the justification for moving forward with the measure was based on the correlation with CAHPS measures. However, the correlation coefficients between the index measure as a whole and the CAHPS is not strong. There are also no data on differentiation between hospices scoring 8, 9, or 10 which would be a critical point of distinction for consumers. This is particularly true because CMS and Abt indicated in their presentation at the National Quality Forum’s (NQF) Measures Application Partnership (MAP) meeting that about 85% of hospices would score 8 or above which underscores the importance of spelling out the differences between 8, 9, and 10. In addition, we question whether adding another measure to the hospice quality reporting program in which most hospices do well – and will likely be topped out relatively soon after introduction -- is valuable for consumers and for tracking hospice quality writ large.

CMS and Abt indicated that they are not as concerned with flaws with individual indicators because the impact of individual flaws is not as large in the context of a composite index. This may be true if there were one or two small indicator level concerns and it is true that a composite measure is more reflective of quality than a single claims-based measure. However, we think there are sufficient concerns about many of the indicators to make the entire composite flawed.

The HCI as proposed is a mix of program integrity and quality measures. This will be confusing for consumers who will not understand the implications of program integrity-focused indicators. These indicators could still impact change in poor performer behavior via inclusion in the PEPPER reports, but we fear that consumers do not have the knowledge or context to interpret the results. Further, all indicators that are useful for program integrity are not equally valid as quality indicators.

We make the following general recommendations and follow with comments on the specific indicators:

- If CMS moves forward on using claims-based measures, like the HCI, we recommend that they share the claims data at least quarterly. Hospices need more timely data updates to facilitate good continuous quality improvement.
- We recommend that CMS provide clarity on both the descriptions of the indicators and their technical specifications/methodology for their calculation. Both hospices and the EMR vendors need this information so that they can duplicate the measure specifications themselves and calculate where they stand on them.
- We recommend that CMS “pilot” the HCI for a year to collect 12 months’ worth of data that can then be shared with hospices so that they know where they stand on these measures and can get comfortable with reporting this data before it is publicly reported in a way that may mislead consumers.

#### *Comments on Specific Indicators*

1. Hospice provided no Continuous Home Care (CHC) & General Inpatient (GIP) [denominator: all hospices service days]

We recommend that this indicator be an “or” rather than an “and.” The corresponding PEPPER indicator utilizes an “or” so the utilization of “or” here would be consistent with other parts of the program. It is a critical component of the hospice program and a sign of compliance and quality care that hospices provide more intensive care when warranted. However, it is not necessarily a sign of poor-quality care if the hospice only provides continuous home care or only provides general inpatient care. Continuous home care may also be provided but not billed due to longstanding challenges with billing this level of care.

2. Gaps in nursing visits greater than 7 days [denominator: number of elections enrolled at least 30 days].

We agree with the intent of this indicator – it is important for the nurses to have regular contact with patients and at least once every 7 days is generally a good interval (if the patient does not need more consistent with the plan of care). However, hospice is an interdisciplinary team benefit. Reducing it to one medical component (nursing) takes away from measuring quality across the entire benefit. To truly measure a high-quality hospice experience, gaps in visits across the entire core hospice team should be looked at. The psychosocial component of hospice care is a critical component that should not be overlooked. This could be accomplished by looking at gaps in visits for the core team as a whole or by adding indicators that look at gaps in the core services besides nursing. If this indicator remains focused on nursing alone, it should include all types of nursing (RNs, LPNs, and NPs). It should also be consistent with the Medicare defined week.

There should also be consideration of patient choice. While regular nursing visits are a critical part of good care, there will be some patients and families who refuse nursing visits and this needs to be accounted for in the measure specifications. Finally, telehealth visits need to count toward the indicator. The indicator implementation, therefore, would need to be delayed until the creation of codes that indicate a visit via telehealth for all hospice disciplines (currently only the hospice social worker can indicate a remote visit on the claim).

3. Nurse minutes per Routine Home Care (RHC) day [denominator: number of RHC service days].

We reiterate here the importance of the full interdisciplinary team and ask for consideration of inclusion of the entire team in this indicator if it is ultimately included. We do not recommend its inclusion; it is unclear how this indicator can be deployed effectively since there is no standard or evidence that a certain visit length is correlated with quality. As presented, it seems like an indicator that would promote “playing to the test” in terms of capturing time spent rather than focusing on quality visits regardless of length.

4. Live discharges in the first 7 days of hospice [numerator: number of live discharges within 7 days of hospice admission]; 5. Live discharges on or after the 180th day of hospice [numerator: number of live discharges after 180 days of hospice enrollment]; and 9. Per-beneficiary spending [numerator: total payments received by a provider in a year];

All of these indicators are more appropriate as indicators of program integrity than of quality care. We do not think that consumers would view these measures in the same way as a hospice provider or oversight body. For example, why would a beneficiary think that lower per-patient spending was a good thing? Additionally, how is per-patient spending an indication of quality care? With the two live discharge measures, consumers will not understand why live discharges at certain points in the hospice stay may indicate problematic behavior.

Hospices should be given information on these indicators as part of the PEPPER reports and CMS and its contractors should monitor for behavior change. There also needs to be consideration for patient choice; patients have the right to revoke hospice and a hospice should not be penalized for appropriately respecting patient choice. Population-level data mining to see if there are patterns of higher live discharges, including revocations to see if there are any patterns of pressured revocations, is an appropriate program integrity tool. Looking at variations in per patient spending and considering future policy options is also a good tool but is not an indicator of quality care.

We are concerned about the metric on late live discharge because hospices are under immense pressure from CMS and their contractors to discharge at 180 days even if the patient is still appropriate for hospice care. We are concerned that this metric will further scare hospices from keeping patients longer than 180 days, even when that is appropriate. Prognosis is not an exact science and while we agree that a large number of patient stays over 180 days could be a sign of bad behavior, we are concerned this metric will further chill access to care for those beneficiaries that do not “die on time.”

5. Burdensome transitions (Type 1), live discharges from hospice followed by hospitalization followed by hospice readmission [numerator: number of live discharges followed by hospital admission, then hospice re-admission].

These indicators could be used to point to bad behavior by hospices as well as poor quality care. A pattern of churn between hospice and hospital would be an indication for concern for both program integrity and for quality of care. However, a time frame of 2 days is not the appropriate window to look at; we would recommend at minimum 14 days and at maximum 60 days.<sup>2</sup> There also needs to be some consideration made for patient choice – some patients elect to leave hospice to go to the hospital and the hospice should not be penalized for a patient and family’s decision.

6. Receiving visits near death [numerator: the number of decedent beneficiaries receiving a visit by a skilled nurse or social worker in last three days of life].

This indicator is duplicative of an existing measure in the hospice quality reporting program. Is the intention to replace the existing measure. If it is to be included, we ask that revisions be made such as inclusivity of LPNs and other psychosocial visitors in the measure (volunteer, chaplains).

#### **PROPOSAL TO ADD CAHPS HOSPICE SURVEY STAR RATINGS TO PUBLIC REPORTING**

While we understand and appreciate CMS’ intent in creating a star rating for hospice to align with other programs displayed on the *Care Compare* tool, we recommend that the CAHPS Star Ratings reporting be delayed until the implementation of the HOPE tool. The HOPE tool will include more of the outcomes measures CMS has indicated it is most interested in. In the changing health care system, especially with regard to value-based payment, the premature creation of a star rating system could have unintended consequences on hospice programs at a vulnerable moment in their operations – when they are recovering from the pandemic and figuring out their strategies for adapting to the changing landscape.

Prior to the implementation of a CAHPS-based star program, we request that CMS provide its rationale for the 75 survey threshold, and express concerns about how that number would leave out many smaller hospices who could then be negatively impacted as a result of consumer misperception of *Care Compare* information. The minimum threshold of 75 completed surveys in the rule is high for many smaller hospices who would be left out of the reporting if that number remains. We ask that CMS not only provide its rationale for the 75 survey threshold, but also determine a way in which smaller hospices would be able to be included in a star program if it goes forward. This is an issue because a *Care Compare* consumer might perceive a hospice that doesn’t have enough data from CAHPS as a “bad hospice” (when the fact is that they are merely too small to have met the 75 survey threshold).

There are operational challenges with the administration and reporting of CAHPS surveys that will make them hard to adapt for star ratings. One is that unlike in other Medicare settings, the CAHPS is not based on patient reported experience but on family reported experience – so a star program based on hospice

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<sup>2</sup>A report by Milliman commissioned by the National Partnership for Hospice Innovation shows the most spending variations in this timeframe see [https://www.hospiceinnovations.org/wp-content/uploads/2020/05/Hospice\\_Medicare\\_Margins\\_NPHI\\_7-2019-1.pdf](https://www.hospiceinnovations.org/wp-content/uploads/2020/05/Hospice_Medicare_Margins_NPHI_7-2019-1.pdf)

CAHPS is not comparable to other star programs. The timing of the administration of CAHPS in hospice care (after the death of the patient) likely contributes to a low rate of return so we have concerns about the data set being used for something as critical to a hospice's success as a star program.

Before using the CAHPS system as the basis for a star rating program, we would like to see the following changes to make it a more robust tool.

- First, we strongly suggest that there should be a “not applicable” response option available for each question, so that the survey is reflective of the actual care that a patient required, as opposed to generalizing hospice care as a one size fits all. Questions such as “How often did your family member get the help he or she needed for trouble breathing” or “How often did your family member get the help he or she needed for constipation” are difficult for family members to answer if their loved one did not experience issues with those symptoms. In addition, the question “How often did your family member get the help he or she needed from the team for feelings of anxiety or sadness” also sets the expectation that their loved one experienced those emotions. Questions should be reworded to better identify the unique needs of individual patients and experiences. A “not applicable” option for current questions could be implemented as a stopgap measure to allow caregivers to identify the questions which do not apply to them rather than being forced to answer inaccurately. Questions regarding instruction on care of the patient make a huge assumption regarding direct care involvement of the survey respondent. This needs to be clarified.
- Second, we recommend that the total number of survey questions be decreased. The current survey instrument is time-consuming to complete, especially for grieving families, which we believe contributes to a low response rate. Identifying the key 1 or 2 questions in each survey domain would likely improve the overall response rate, which will then provide an improved picture of the quality of care provided by the hospice.
- Third, we strongly believe that the Hospice CAHPS survey risk adjustment methodology should include a variable that captures the differences in patients' and families' perceptions of their care experience. Suggested adjustments include but are not limited to: payer for hospice care, caregiver education, and survey language/language spoken at home.<sup>3</sup>
  - For example, published studies indicate that Chinese speakers are culturally less likely to choose extremes (low or high) on surveys.<sup>4</sup> Additionally, the way the rating question is worded (“what number would you give this hospice” rather than a more explicit question indicating what that rating means) makes it more likely that a Chinese-speaking person will give us an 8 rather than a 9 or a 10. One of our member hospices found that their rating of care began decreasing after they initiated a program serving predominantly Chinese-speaking families and when they examined the scores, they found that respondents from that program were less than half as likely to rate the

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<sup>3</sup><https://www.sciencedirect.com/science/article/abs/pii/S0885392418303671>

<sup>4</sup>Rui Wang, Brian Hempton, John P Dugan, Susan R Komives. Cultural Differences: Why Do Asians Avoid Extreme Responses? Survey Practice, Vol. 1, Issue 3 (September 30, 2008). <https://www.surveypractice.org/article/2913-cultural-differences-why-do-asians-avoid-extreme-responses>



hospice with a 9 or 10. When they looked at the individual surveys and they found that the vast majority of those ratings less than 9 or 10 were 8s. They also found that those who rated the hospice an 8 were very satisfied with our care. Upon further inquiry they found that "8" is a lucky number in Chinese culture and that those who reported 8s were likely intending to indicate a high level of satisfaction. We urge CMS to re-institute risk adjustment of CAHPS results based on language spoken at home (and investigate other factors that impact the survey scores as well), which we understand was adjusted for until 2017 when this was changed due to low numbers of surveys requiring this adjustment. For programs like the one in this example that are greatly impacted by this cultural preference, it seems only fair that this case mix adjustment be re-implemented. This request is also aligned with this Administration's focus on health equity.

#### **PUBLIC DISPLAY OF "QUALITY MEASURES" AND OTHER HOSPICE DATA FOR THE HQRP**

We ask that CMS make the following adjustments related to public display of hospice data for the HQRP:

- If CMS proceeds with posting data publicly, we recommend the addition of a disclaimer on *Care Compare* that the data are two years old and may not reflect the current status of the hospice's operations or quality activity/performance.
- If CMS uses 2020 data on *Care Compare*, please consider an additional disclaimer that notes that this data may not reflect the full operations/activity of the hospice given that telehealth visits will not be reflected and were a huge part of care during the COVID-19 pandemic. In creating such a disclaimer, the language should be careful in how it reflects the utilization of telehealth visits – there should be no indication to hospice consumers that telehealth visits are "bad" or of poorer quality.

#### **RESPONSE TO REQUESTS FOR INFORMATION**

With regards for FHIR resources, we want to underscore two points to CMS. First is our comments under the CAHPS section of this letter. Second is that post-acute providers, including hospice, never received any meaningful use dollars to implement health IT or interoperability resources. If CMS implements new programs, standards, or requirements, we ask that providers receive funding to help with compliance.

We thank you for your consideration of the issues highlighted above. My contact information is below if you wish to discuss any of the recommendations.

Sincerely



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