

May 28, 2024



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-1810-P: Medicare Program; FY 2025 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements Submitted electronically via <https://www.regulations.gov>

Dear Administrator Brooks-LaSure,

On behalf of our more than 5,400 nonprofit and mission-driven aging services providers from across the continuum of aging services, including home health and hospice, and our 36 state partners in 41 states, LeadingAge is pleased to offer the following comments in response to the FY2025 Hospice Wage Index and Payment Rule.

### Proposed FY2025 Hospice Payment Rates

We support the proposed 2.6% increase in the wage index and rate update but want to emphasize that this proposed increase is not sufficient to cover the current needs of hospice providers. Indeed, the proposed rate is below last year's proposed rate increase despite inflation continuing to increase. In the FY2024 Final Rule, CMS staff reviewed the cost pressures for hospice and raised the final rate to 3.1%. We do not believe the cost pressures have changed in the time between the finalizing of the FY2023 rule and the release of the FY2024 proposed rule. Many of our members' margins were already thin; increased payment this year and into the future will continue to be essential. According to the Medicare Payment Advisory Commission (MedPAC), the aggregate margin for nonprofit hospices was 5.2% in 2021 and we would expect to see these margins shrink due to the end of the Public Health Emergency, which granted hospices significant flexibilities.<sup>1</sup>

We have commented for the last several years on the current workforce shortages that have a significant impact on hospice providers and those they serve. Hospice members are still struggling to hire and retain nursing, social work, and hospice aide staff and even physicians due to rising wages and scarcity of professionals. A 2022 national sample survey from the Health Resources and Services Administration (HRSA) found that the nursing workforce is moving away from home health and hospice.<sup>2</sup> This is the first update to the survey since 2018, which also found United States is on track to have a 10% shortfall in the number of nurses needed by 2036.<sup>3</sup> With LeadingAge's role representing the entire field of aging services, we were exceptionally vocal in our opposition to the skilled nursing facility proposed staffing mandates in 2023. We are deeply disappointed that CMS ignored provider feedback and

---

<sup>1</sup> The Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2024 Mar . Chapter 9, Hospice services; Available from: [https://www.medpac.gov/wp-content/uploads/2024/03/Mar24\\_Ch9\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch9_MedPAC_Report_To_Congress_SEC.pdf)

<sup>2</sup> Health Resources and Services Administration, *NCHWA Nursing Workforce Dashboard*. <https://data.hrsa.gov/topics/health-workforce/nursing-workforce-dashboards>

<sup>3</sup> Health Resources and Services Administration, *Nurse Workforce Projections, 2021-2036*. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nursing-projections-factsheet.pdf>

concerns regarding existing shortages of staff. With the Minimum Staffing Standards for Long-Term Care (LTC) Facilities and Medicaid Institutional Payment Transparency Reporting final rule now published, we reiterate our concerns and believe hospices will see a further decline in available nurses as nursing homes work to recruit these individuals' way from the field.

We have repeatedly shared concerns with CMS on the quality of cost report data especially with regards to capturing actual labor costs. Cost reports should be improved and optimized before they are 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 Continuing Home Care (CHC), let hospices utilize it effectively. We recommend that the definition of a day be any 24-hour period or that CMS create a modifier to allow hospices to bill into a second day up to a 24-hour limit.

Insufficient payment increases coupled with staffing mandates that will impact the entire continuum have the potential to decrease access to quality hospice services. **LeadingAge therefore strongly recommends CMS increase the proposed payment rate of 2.6% to at least 3.1% plus inflationary estimates for FY2025 to remain consistent from FY2024.**

#### *Wage Index*

LeadingAge thanks CMS again for the implementation of the 5% cap to wage index reductions as a policy to combat ongoing wage index inequities. However, with CMS' proposal to adjust Labor Market Delineations based on the 2020 census, we reiterate that 5% remains a considerably high cap, especially as nearly 10% of counties in the country will be impacted by these Core Based Statistical Areas (CBSA) changes.

Based on feedback from LeadingAge members, which we presented in our comments on the FY2023 Hospice Wage Index Proposed Rule, we also found that most wage indices do not swing by 5% but even a 2% wage decrease impacts operations. Due to the home-based nature of hospice, we also found agencies can serve multiple CBSAs, and while a 5% cap is helpful to maintain payment stability, agencies serving multiple CBSAs will find it difficult to consistently account for differences across their service area. Hospices and home health agencies are especially vulnerable in the transition CMS is proposing in FY2025. For example, one member that serves the greater Atlanta, Georgia CBSA will not simply contend with a small CBSA change, but potentially 26 different counties being added or removed from the CBSA, which will have significant impacts on the final wage index for their area. Providing a lower cap on decreases will allow agencies serving multiple CBSAs to better predict costs. **We urge CMS to reduce the permanent cap on hospice wage index decreases to 2% during the CBSA transition year of FY2025.**

The current workforce crisis has created access issues across the country for individuals seeking hospice services and rural communities, which have larger portions of the aging population, have been hit

hardest.<sup>4</sup> **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 looking at how MedPAC’s 2022 wage index proposal<sup>5</sup> would impact hospice and working with stakeholders, including Congress, on how to implement a fairer system that also takes into account increased labor costs.**

#### *Adequately Capturing Telehealth in Claims and Cost Data*

LeadingAge would like to reiterate our multi-year recommendation to CMS to capture telehealth information in claims and cost reports for hospice providers. The continuation of pandemic era flexibilities around telehealth for face-to-face visits, as well as the potential for use in the Hospice Outcomes and Patient Evaluation (HOPE) data collection tool, is an unprecedented opportunity for hospices to capture data to evaluate the use of telehealth to serve beneficiaries more effectively. Unfortunately, due to the current limitations of claims and cost reports, hospice use of these flexibilities is not adequately captured. Without data tracked nationwide the administration and public health research cannot effectively assess the outcomes of telehealth on care.

In 2022, MedPAC called on the Department of Health and Human Services to require that hospices report telehealth services on Medicare claims.<sup>6</sup> Additionally, we believe CMS has the ability quickly develop modifiers based on the G-Codes required of home health providers in July 2023.<sup>7</sup> **We strongly recommend that CMS implement G-Codes in line with home health billing codes and create a field on the hospice claim for telehealth visits from any discipline to more accurately represent the full range of visits that hospices provide.**

Furthermore, while hospices can report the total cost of telehealth services on cost reports, the expenses are covered in the non-reimbursable cost centers. In the CY2021 Home Health final rule, CMS gave home health agencies the ability to capture the costs of these services as allowable on cost reports. **We urge CMS to allow hospices broader use of telecommunications technology during routine home care visits and that these costs be considered an allowable administrative cost on the hospice agency cost report.**

#### **Proposed Clarifying Regulation Text Changes**

##### *Medical Director Condition of Participation*

LeadingAge supports CMS’ intention to clarify language in the hospice Conditions of Participation (CoPs) at § 418.102, Medical Director, that now mirror the conditions of payment sections at § 418.22. We agree that this terminology is confusing and limits a hospice’s ability to provide timely care when the designated Medical Director is not available. In addition to CMS’ clarifications, LeadingAge further recommends additional clarifications in the CoPs regarding physician designee, specifically adding “designee” (in red) in the beginning paragraph of § 418.102, added in red in the second sentence. We

---

<sup>4</sup> Hospice News. “Obstacles Persist for Rural Patients to Access Hospice.” Sept. 2021. Available from:

<https://hospicenews.com/2021/09/28/obstacles-persist-for-rural-patients-to-access-hospice/>

<sup>5</sup>The Medicare Payment Advisory Commission. “Wage Index March 2023 SEC. <https://www.medpac.gov/wp-content/uploads/2022/07/Wage-index-March-2023-SEC.pdf>

<sup>6</sup> The Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2022 Mar . Chapter 11, Hospice services; p. 299 – 320. Available from: [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_Ch11\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch11_SEC.pdf)

<sup>7</sup> MLN Matters. “Telehealth Home Health Service: New G-Codes.” July 21, 2022.

<https://www.cms.gov/files/document/mm12805-telehealth-home-health-services-new-g-codes.pdf>

believe that the addition of this word will reference the definition of physician designee in § 418.3 and avoid confusion.

**§ 418.102 Condition of participation: Medical director.**

The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with the hospice. When the medical director is not available, a physician *designee*, designated by the hospice, assumes the same responsibilities and obligations as the medical director.

*Certification of Terminal Illness and Admission to Hospice Care*

LeadingAge supports CMS' clarifications at § 418.22 with the addition of the physician designee language and believes that it will add clarity to the physician's role in certification in each section of regulatory text. In § 418.25, LeadingAge appreciates the addition of "physician designee" to this CoP. However, we note that the language in both (a) and (b) does not include the "physician member of the interdisciplinary group" and we question why this language does not mirror other changes in regulatory text in this proposed rule. The language in question **does** appear in § 418.102 below. The language proposed to be added in § 418.102(b) (in green) that is **not** included in § 418.25 is underlined below.

**418.102 (b) Standard: Initial certification of terminal illness.** The medical director (or physician designee if the medical director is unavailable, as defined in § 418.3 of this section) or physician member of the IDG reviews the clinical information for each hospice patient.

LeadingAge strongly recommends that the following language (in red and italicized) be added to § 418.25 (a) and (b) to avoid ongoing confusion about the hospice admission process.

**§ 418.25 Admission to hospice care.**

- (a) The hospice admits a patient only on the recommendation of the medical director (or the physician designee, as defined in § 418.3) *or the physician member of the IDG*, in consultation with, or with input from, the patient's attending physician (if any).
- (b) In reaching a decision to certify that the patient is terminally ill, the hospice medical director (or the physician designee, as defined in § 418.3) *or the physician member of the IDG* must consider at least the following information:
  - (1) Diagnosis of the terminal condition of the patient.
  - (2) Other health conditions, whether related or unrelated to the terminal condition.
  - (3) Current clinically relevant information supporting all diagnoses.

*Election of Hospice Care*

LeadingAge also supports CMS' proposal to clarify regulatory text regarding the hospice election statement and notice of election (NOE). These terms are often conflated and, upon further review, we strongly agree with CMS' determination that §418.24 does not make clear that these are two separate and distinct documents with separate purposes. CMS proposes to retitle §418.24(b) as "Election Statement" and §418.24(e) "Notice of Election."

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

We want to express our appreciation to CMS for their consideration of our comments in last year's Request for Information (RFI) on Hospice Utilization; Non-Hospice Spending; Ownership Transparency; and Hospice Election Decision-Making and thank you for the opportunity to comment on this year's Request for Information (RFI) on Payment Mechanism for High Intensity Palliative Care Services.

We agree with CMS' conclusion that one of the main barriers to providing high intensity palliative services is financial. The main way that CMS could eliminate financial risk for hospice providers is to provide hospices with more money to pay for these services or provide them with a billing mechanism for which they are not financially at risk. We will answer the remainder of the financial questions with the lens of if the hospice is receiving additional dollars – aka, with the perspective of the hospice being in charge of the dollars.

### Definition

CMS asks whether they should define “palliative services” separately from palliative care as it is defined at 413.3. Our answer is resounding yes. In our conversations with members about this proposal, they found the phrase “high intensity palliative services” to be confusing. We recommend that CMS not use the word “palliative” in the phrase they develop to describe these services because it gets conflated with “palliative care.” While palliative care is, of course, integral to hospice care, it is also used to refer to pre-hospice services and therefore, in this context, will cause confusion. It is also not a word well understood by consumers. We recommend using something that involves the word hospice – especially since the goal of this potential payment change is to increase access to hospice care. “Specified hospice treatments and therapies,” “outlier hospice services,” and “disease directed hospice services” are some of the ideas that came up in conversation but there was no consensus beyond the confusion expressed above.

### Education and Incentives for Referring and Partnering Providers

In last year's RFI, CMS asked about educational efforts that would be needed for hospices to understand the difference between curative treatment and complex palliative treatment for beneficiaries under the hospice benefit. In addition to our comments from last year, we want to underscore that CMS needs to consider the educational efforts for *other* providers, potentially even more than for hospices. If CMS provides the ability for hospice to offer more access to palliative radiation or to palliative dialysis, dialysis centers, nephrologists, oncologists, etc. will need education about the changes to hospice. They would also need to be engaged in conversations about appropriate courses of treatment when the treatment is intended for palliation. For example, there is clinical evidence that fewer fractions of radiation may be appropriate when intended for palliation; hospices will need radiation oncologists to work with them on developing the most appropriate plan of care. In order to do this, the payment and quality incentives need to align across providers. We would also ask that CMS consider looking at corresponding quality measures and incentives to ensure that a referral to hospice (when appropriate) aligns with the goals of these providers.

### Payment Model and Expert Input

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

*Ultimately, our members felt that there needs to be a disease specific pathway that informs payment for these therapies. Ultimately, there needs to be different payment streams because services have different costs. Additionally, providers want the opportunity to holistically assess what therapies might have a palliative intent for a patient and help them in the course of their hospice journey. If there is a single payment, the incentive might be to target patients who would benefit from a certain lower cost therapy and admit those patients – but not those who would greatly benefit from hospice, but need a higher cost intervention in order to elect. The example of neuroendocrine tumors is a good one in this regard – the injection that relieves its horrible symptoms has a very high price tag, but the injection is true palliation. If there is a single payment for “high intensity palliative services,” access for these patients will never increase.*

*Critically important is that CMS bring together a strong stakeholder advisory process that would likely include a technical expert panel (TEP) to talk about what types of therapies and the intricacies of coverage. Coverage determinations would likely need to be updated for hospice but potentially also for other providers that would be referring or administering these therapies in partnership with hospice providers. Analysis of what payment would ultimately look like would be connected to these conversations about clinical criteria. These guidelines would need to be advisory in nature – hospice is very patient-centered and our members underscored the need to be able to assess whether an intervention is right for a particular patient consistent with their plan of care. Additionally, auditors and surveyors would need substantial education to ensure that hospices are not penalized for providing these services.*

*Therefore, in order to jumpstart this policy, we believe a single payment could work for a period of time while CMS engages in the robust process outlined to get at these actual costs and develop a payment mechanism that takes into account ancillary costs, variation in therapies, and that the course of treatment may vary with intent (see below for more detail).*

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

The financial risk depends on the type of treatment. Many of our members cover some or all of the services mentioned by CMS in the RFI in addition to some others that might fit the definition. However, there is not consistency amongst our members or amongst the hospice provider community at large on what is covered and what that coverage looks like. The cost barriers vary based on the type of therapy being offered. We asked members about cost barriers both for the treatments specifically mentioned in this RFI and for others that they see as common barriers to hospice care.

### *Ancillary Services and Costs*

One point that came across clearly in our conversations with members was that, in addition to the cost of the actual therapy or treatment, CMS should take into account ancillary costs that will be incurred to hospices as a result of this potential policy change. Examples include:

- *Transportation:* For example, if hospices were to consistently pay for dialysis, radiation, chemotherapy, and transfusions, they would not be providing these treatments in the home.

They would be transporting the patient to a dialysis center or to the radiation oncologist. The overall payment should take that cost into account.

- *Labs, Imaging, and Drugs:* There are standard labs, imaging, and drugs that accompany these treatments. Ultimately, we recommend that CMS bring together a TEP and stakeholders to figure out what courses of therapy might be appropriate for palliation vs curative administration of these therapies. Through this process, it may become evident that some of these services may not be needed as frequently or even at all with a patient seeking a therapy with a palliative intent as opposed to a curative intent. Until such time that CMS is able to develop disease specific pathways that takes this variability into account, we ask that CMS take into account the cost of the full bundle of costs for the therapy.

### *Other Treatments and Therapies*

Besides the high intensity palliative services specifically mentioned in the RFI, members mentioned the following as therapies that are often barriers to receiving hospice care – either for entering hospice in the first place or for continuing on hospice.

1. Non-invasive ventilation machines, such as the Trilogy machine, are expensive to supply patients despite their ability to provide palliative support. The specific barrier here is the cost of the machine and the additional staff time needed to ensure it is working correctly and provide education and training to the family.
2. Inotropic heart medications (continuous drip). The specific financial barriers here are the cost of the drugs and the additional staff time to administer the drug – members said the staff time for this type of intervention would likely exceed the additional staff time for the non-invasive ventilator which underscores the need for consideration of specific payments depending on the therapy or treatment.
3. Drains/Taps. Thoracentesis and paracentesis are both procedures that hospices cited as common ones needed by patients. If a drain is placed, it is easier to manage in the home environment, but the cost of placing the drain is often prohibitive under the benefit. Many of our members do pay for repeated taps, which involves both ancillary costs (e.g. transportation) and negotiating for the costs of the actual tap.
4. Total Parenteral Nutrition (TPN). The additional costs include additional staff time and the cost of the TPN.
5. High-cost medications. Other examples of high-cost drugs included injections for neuroendocrine tumors – the injection provides symptom relief but costs \$17,000/month. The alternative therapy needs to be injected multiple times per day as opposed to one time per month and is not as effective. There were many other therapies mentioned that fit into this same type of category, but the neuroendocrine example is particularly stark – the drug has no curative effect, simply symptom relief and these patients are frequently not able to access hospice because of the cost.

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

Our members said almost all of these treatments and therapies would occur when the patient is receiving the routine home care level of care. There are, of course, outliers where someone might be

eligible for crisis care for reasons unrelated to the administration of the high intensity palliative services, but that high intensity service might still be appropriate. But generally, most of the costs will occur on Routine Home Care (RHC) days.

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

None of our members felt that this type of structure would be appropriate. People might be accessing high intensity palliative services during different parts of their hospice stay for different reasons. Many will be accessing them as a condition of choosing to elect hospice – for example, a beneficiary might be more willing to come onto the hospice if they do not have to “let go of the rope” by immediately stopping dialysis. However, we have also heard from members that sometimes during the course of a hospice stay, there may be times when a beneficiary may want one of these therapies. It is not clear what “exhausting other options” would mean in relation to these types of interventions and likely would just recreate the access problem that currently exists, but in a different form.

*We once again thank CMS for considering this policy change and support it moving forward – we feel it will increase access to hospice care.*

#### **Proposal to implement two process quality measures based on proposed HOPE data collection**

LeadingAge strongly supports the development of new hospice quality measures. The introduction of the HOPE tool could lead to considerable insights into current hospice quality processes. Data generated from the proposed HOPE tool at this time only supports process measures. The quality measures selected by CMS with the guidance of the TEP are a good beginning and focus on one of the most essential roles of hospice, alleviation of symptoms. We look forward to working with CMS to inform the development of future outcome-based measures in the HOPE.

Regarding the implementation of *Timely Reassessment of Pain Impact* and *Timely Reassessment of Non-Pain Symptom Impact*, our membership generally agreed that best practices indicate in person visits are essential for reviewing symptoms. However, as we mentioned in our response to CMS’ inadequate proposed payment update, we have concerns regarding the workforce available to meet the timeline of these measures. We see the value of telehealth in expanding the ability of the workforce to meet the needs of patients and have consistently been a vocal supporter of the face-to-face recertification via telehealth. In response to CMS’ proposals to implement these measures, **LeadingAge recommends CMS allow for the symptom reassessment visit to be conducted via telehealth, with the condition that CMS include a question on the HOPE to gather data on the mode of the reassessment visit (in-person or telehealth) to better understand the characteristics of hospice providers and patient populations utilizing telehealth.**

After speaking with members, they reiterated that best practice on visit timing and follow up was to conduct two separate visits. They shared that in order to reassess the patient time needs to pass between the initial assessment and the application of any intervention to alleviate the symptoms. They appreciated CMS’ approaching in allowing a visit on the same day as the initial visit. **We support CMS’ decision that the follow-up visit cannot be the same visit as the initial assessment, but it can occur later the same day (as a separate visit).**



However, we have some reservations regarding the initial measures CMS is proposing based on the new tool. While we appreciate all the work of Abt Associates and the hospices that participated in the beta testing process, and we understand the value of monitoring symptom management within the hospice population, the fact remains the beta test included a limited number of hospices to test these measures, and indeed the entire assessment tool. For example, we note these (limitations) of the beta testing process:

- 60 hospices, or less than 1% of current hospices, implemented the beta HOPE in a national field test.<sup>8</sup>
- 38 of the 60 participating hospices, or half of 1% of all hospices, staff including RNs, SWs, and chaplains completed at least one HOPE form.
- 371 patients had at least one element, on one Beta HOPE form, from at least one of the three disciplines completed.
- 901 forms were initiated across disciplines (RN, SW, Chaplain) and timepoints (i.e., admission, symptom reassessment, discharge).

Based on this incredibly small sample size, LeadingAge recommends that these two proposed measures be withheld until the HOPE tool can be fully implemented and all measure testing be re-applied to an actual in-use tool and expanded population. **We request CMS delay reporting on these measures until at least 2028, and after two years or eight quarters worth of data have been collected that CMS retest the validity and reliability of the measures with specific analyses on populations that experience health equity issues as well as exclusion populations.** This is consistent with the publication of data related to the Hospice Item Set (HIS).

### **Proposal to Implement the Hospice Outcomes & Patient Evaluation (HOPE) Assessment Instrument**

LeadingAge is excited for potential inherent in the final proposed Hospice Outcomes & Patient Evaluation (HOPE) tool. Hospice remains one of the only, if not the only, setting with no standardized patient-level data collection tool. Such tools are essential for understanding the population accessing services as well as developing new quality metrics to track care. In this HOPE version 1, we note that the majority of the items are process based; we believe CMS should continue to refine the tool and identify opportunities for outcome measures in the future. Despite our excitement, we have some reservations about the HOPE and a number of outstanding questions and suggested amendments.

#### *Future Use of HOPE*

In the proposed rule, CMS states the HOPE is a “standardized patient level data collection tool” and further describes the purpose to “provide data for the HQRP quality measures and its requirements through standardized data collection; and provide additional clinical data that could inform future payment refinements.” However, in the HOPE manual the stated purpose is much broader, reading, “The primary objectives of HOPE are to provide quality data for HQRP requirements through standardized data collection, support survey and certification processes, and inform future payment and quality improvement refinements.” CMS has not provided information to hospices on how this data collection tool would be used by survey or certification processes and has not discussed how it will inform future payment.

---

<sup>8</sup> Abt Associates. Hospice Quality Reporting Program: Hospice Outcomes and Patient Evaluation (HOPE) Development and Testing. December 18, 2023. <https://www.cms.gov/files/document/hgrp-hospice-outcomes-and-patient-evaluation-hope-development-and-testing-report.pdf>

At this time, we do not believe it is appropriate for CMS make these declarations of intent in a subregulatory document. Not only has CMS clearly indicated this is not an assessment tool for the purposes of payment, like OASIS or MDS, but it has also not provided enough information or opportunity for hospices to weigh in on how the items could be used in payment or survey and certification. The information represented in this tool does not record the comprehensive assessment of patients currently required in the CoPs, nor does it capture services patients receive. Additionally, there is no reference to the types and number of visits from the full interdisciplinary team or any detailed information on patient acuity.

Prior to utilizing the tool to develop payment methodologies much needs to be tested and added, including the most important and most intangible piece: capturing and honoring patient goals and wishes. Hospice is the most unique benefit in the Medicare system, requiring a holistic view of the individual outside of their terminal illness, allowing them to chart their own course and decide what is most important for their final days. For some this could mean support from a chaplain, for others it could be preventing pain, still others it is prolonging life and comfort to make it to the birth of their grandchild. Measuring these disparate, individual goals could be impossible but it is core to the work of hospice and must be represented in any future use of the tool beyond the purpose of data collection.

#### *Implementation Timeline*

CMS proposes to implement the HOPE tool on or after October 1, 2025. We would like to stress the quickness of this timeline. EHR companies, critical partners in the implementation of this tool, need the final HOPE technical specifications before they are able to develop and implement the tool. Despite CMS' recommendation in the proposed rule for EHR vendors to start revising the tool now, most need a minimum of 12 months after the specifications are available for the coding and programming, and to educate providers on implementation in their individual organizations. Prior to the HOPE beta testing, CMS indicated that it intended to incorporate EHR companies into field testing. Unfortunately, this did not happen during any of the testing phases. Based on their lack of involvement, we would anticipate there will be questions from EHR companies as they begin the coding and programming processes and possibly also with the submission of the data to CMS. While we understand the majority of the questions in HOPE align with the HIS, there at least two new timepoints and potentially up to five new assessments to incorporate into systems. **To support a smooth transition from the HIS to the HOPE, LeadingAge strongly recommends that there be a testing period for implementation and submission of the electronic version of the HOPE.**

In the proposed rule, CMS outlines how it will use HOPE data in the HQRP and for public reporting, CMS states in the proposed rule:

*“Typically, the first two quarters of data reflect the learning curve of the providers as they adopt a standardized data collection; these data are not used to establish reliability and validity. We propose that the data from the first quarter (anticipated to be Q4 CY2025, if HOPE data collection begins in October 2025) will not be used for assessing validity and reliability of the quality measures. We propose to assess the quality and completeness of the data that we receive as we near the end of Q4 2025 before public reporting the measures. Data collected by hospices during the four quarters of CY 2026 (for example, Q 1, 2, 3 and 4 CY 2026) will be analysed starting in CY 2027. We propose to inform the public of the decisions about whether to report some or all of the quality measures publicly based on the findings of analysis of the CY 2026 data.”*

**We ask for clarification on whether CMS intends to exclude only one quarter of HOPE data when the first two quarters of data reflect the “learning curve.” Furthermore, we recommend CMS adopt the same timeline for the implementation of the original Hospice Item Set, which allowed two full quarters for a “learning curve.”**

The timeline for implementation of the HIS allowed both hospices and CMS to review the implementation of the tool for learning purposes and time for analysis of the tool’s reliability and validity. Due to the considerable time and effort required to update EHRs with the new data items as well as time points, and the implementation issues experienced in other settings recently, we anticipate hiccups in implementation and submission of the electronic version of the HOPE. While the impact to data remains to be seen, we believe allowing providers two full quarters of “learning curve” would not delay the positive impacts from this tool and its corresponding quality metrics. Following the HIS implementation model would allow for a two quarter “learning period.” This will allow time for CMS to analyse and provide feedback to hospices on how to improve reporting and completion of the tool.

Additionally, like the HIS before it, CMS should finalize a policy to establish an incremental threshold for HOPE compliance over a three-year period. This is consistent with the implementation of the HIS, and while many of the items are the same between the tools, the HOPE includes two additional time points and a potential of three symptom reassessment visits. This is a considerable change from the original two time points in the HIS and could lead many agencies to have issues in timely reporting of data.

	HOPE Recommended Timeline	HIS Finalized Timeline
Learning Period	CY2025 Q4 and CY2026 Q1	CY 2014 Q3 and Q4
Reliability and Validity	CY2026 Q2, 3, and 4	CY 2015 Q1, 2, and 3
Incremental Timeliness Threshold Compliance	CY2027 70% CY2028 80% CY2029 90%	CY2016 70% CY2017 80% CY2018 90%
Public Reporting	CY2028 (8 quarters of data)	CY2017

*Timepoint and Item Clarifications and Amendments*

CMS indicates in the proposed rule that the HOPE will be used to collect information “...for all patients over the age of 18, regardless of payer source, to support HQR quality measures.” The Draft HOPE Guidance Manual states that the HOPE will apply “...to all patient admissions to a Medicare-certified hospice program regardless of the following:

- Payer source (Medicare, Medicaid, or private payer)
- Patient age
- Where the patient receives hospice services (home, nursing home, assisted living facility (ALF), freestanding hospice)
- Hospice LOS”

**We ask CMS to clarify in the final rule whether hospices are to complete the HOPE for all patients or only those over the age of 18.**

**A0215. Site of Service at Admission** – LeadingAge questions whether it was CMS’ intention to leave off Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID). The site was included as

part of A1805. Admitted From. However, according to federal statute §1902(a)(13)(B)<sup>9</sup> individuals residing in these facilities shall have access to hospice services through state Medicaid programs. **We ask CMS to amend A0215. Site of Service at Admission to include ICF/IID facilities.**

**A1910. Availability of Assistance.** We greatly appreciate CMS' intention with this question to address the availability of unpaid caregiving support. Caregivers are critical members of the interdisciplinary team. However, many individuals receive care in skilled nursing facilities/nursing facilities and ICF/IID and the CoPs clearly state at [§418.112\(c\)\(4\)](#), "An agreement that it is the SNF/NF or ICF/IID responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected." **We therefore recommend CMS amend the question to state "excluding hospice and facility staff" to provide clarity to patients on whom would be covered as a caregiver beyond those required by CoPs to support them.**

According to the HOPE manual, the admission timeframe is described as "No later than five calendar days after the effective date of the hospice election." This is consistent with requirements at [§418.54\(b\)](#) that state "**Standard: Timeframe for completion of the comprehensive assessment.** The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with [§ 418.24](#)." **We strongly advise CMS to clarify in all regulations and subregulatory documentation, such as the HOPE manual, that the Admission HOPE and Comprehensive Assessment can be conducted in the same visit.**

Similarly, the HOPE manual states that HOPE Update Visits (HUV) are conducted between days six and 15 and the second HUV is required between days 16 and 30 after election. This is consistent with requirements at [§418.54\(d\)](#) that state "**Standard: Update of the comprehensive assessment.** The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days." **We strongly advise CMS to clarify in all regulations and subregulatory documentation that the HUV and updates to the comprehensive assessment can be conducted in the same visit.**

In the HOPE Manual for item J2025. Symptom Reassessment (SRA) Visit, the states that the Timepoint(s) Items Completed are Admission (ADM) and HOPE Update Visit (HUV). However, as previously stated, CMS intends to not allow the SRA to be conducted on the same visit as the initial symptom assessment, i.e., the ADM or HUV. The way this is written in the manual is confusing. **If CMS finalizes their intention to not allow the SRA at ADM or HUV, we recommend CMS include an additional timepoint for the SRA.**

While the HOPE includes at least two more patient touch points, and potentially three more with the SRA, we were surprised and concerned no HUVs were included outside the first 30 days of hospice services. According to MedPAC's 2024 Report to Congress, the length of stay for hospice patients in the 90<sup>th</sup> percental was 275 days, meaning that for a quarter of all hospice patients, despite being on hospice for nearly a year, the HOPE tool would only collect one months' worth of data on their care. In the FY2022 Hospice Wage Index, CMS shared hospice spending and utilization patterns which found the top

---

<sup>9</sup> 42 U.S.C. 1396(a)(13)

reported principal diagnosis in FY2019 was Alzheimer’s disease followed by chronic obstructive pulmonary disease. The average length of stay for decedents with neurological conditions was 159 days and 135 days for patients with chronic obstructive pulmonary disease.<sup>10</sup> As the HOPE tool is proposed now, for the two most common diagnoses, only 30 days’ worth of data will be collected. **Based on this information, we strongly encourage CMS to include a third HUV timepoint at the first patient recertification and start of their second benefit period.**

In the proposed rule, CMS states the intention of the HUV as “a subset of HOPE items addressing clinical issues important to the care of hospice patients as updates to the hospice plan of care.” Despite this, when reviewing the items in the HOPE manual indicated for the HUV, we found seven administrative items that were not critical to clinical issues or updating the plan of care. These items were static values such as the individual’s date of birth, legal name, or their gender. Requiring hospice staff to collect this information on admission and again at the HUV is counter to CMS’ stated purpose for this timepoint. **Therefore, we request CMS remove the following administrative items from the HUV timepoint assessment to be consistent with the clinical and care planning nature of the timepoint:**

- Facility Provider Numbers
- Admission Date
- Legal Name of Patient
- Social Security and Medicare Numbers
- Medicaid Number
- Gender
- Birth Date

As we mentioned previously, we are excited for the potential of the HOPE tool items and their ability to follow patients’ needs throughout their stay in hospice, including their social needs. LeadingAge has a deep commitment to health equity and building diversity, equity and inclusion within our member organizations. For the last three rule making cycles, CMS has requested feedback on ways to enhance their ability to capture and evaluate health equity in the hospice space. We believe the HOPE tool represents a new opportunity and are grateful for the inclusion of the following items and sections in the final proposed tool:

- A1905. Living Arrangement
- A1910. Availability of Assistance, and
- Section F: Preferences for Customary Routine and Activities

While this is a great step in the direction of health equity, we believe it is essential to not simply capture this on the admission HOPE but to continuously capture information on the changes individuals experience during their time in hospice. For example, the under A1910, CMS provides an example of a daughter moving into their mother’s home to provider 24-hour care. While this is an excellent example, we recognize that on admission oftentimes families have not made these arrangements and it takes time to establish a cadence of caregiving to support their loved one. Asking this question between day six and 15 will provide more information on how families are adapting to hospice caretaking responsibilities. Similarly, we know that patients at admission may be living on their own but soon move in with loved ones or into a congregate home to be supported. Finally, regarding preferences for care, the beta test found that patients’ preferences were consistently followed, but also that preferences

---

<sup>10</sup> The Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2024 Mar . Chapter 9, Hospice services; Available from: [https://www.medpac.gov/wp-content/uploads/2024/03/Mar24\\_Ch9\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch9_MedPAC_Report_To_Congress_SEC.pdf)

changed over time. The item tested in the beta test was not the same as the final items included in the proposed tool, these are the original preferences questions from the HIS. Our members have shared that consistently capturing preferences is critical and that these do change over time. Understanding the change in preferences will be critical information for hospices and CMS to evaluate and understand. **Therefore, we request CMS include these items in the HUV timepoint assessment.**

### **Proposed CAHPS Hospice Survey and Measure Changes**

LeadingAge commends CMS for conducting mode experiments for the hospice CAHPS survey aimed at improving the survey's response rate. We particularly support proposals to shorten the survey, simplify survey language, and expand the delivery mode and administration of survey. While we support the analysis from CMS and its contractor, we have several concerns about the proposals.

#### *Implementation Timeline*

Our first and primary concern is CMS' proposed timeline for implementing the survey. We are equally as eager as CMS to see the mode experiments increase the number of respondents to the survey, however the reality is that survey vendors will not be able to adjust processes, including new pre-notification letters, whole systems for online completion, and adjustments to current survey information in the short time between the final rule, likely August 2024, and January 1, 2025. Not only will survey vendors need to adjust to meet the new survey administration requirements but hospices will need to update their EHRs to capture caregiver email addresses and put in place new requirements on intake forms as well as training staff. **LeadingAge recommends CMS move the implementation date for the updated CAHPS Hospice survey back to January 1, 2026, to allow survey vendors, EHR vendors, and hospices adequate time to develop the web-mode of delivery, which is a key change to the survey, to update EHRs to capture email addresses, and to train hospice staff. This delay should also push back the star ratings and public reporting of the new and revised measures to November 2028.**

#### *Survey and Measure Changes*

LeadingAge greatly appreciates CMS' work to further clarify the questions asked on the CAHPS hospice survey to make them easier for families to answer. Additionally, we agree with CMS' determination that removed measures, the current multi-question item "Getting Hospice Care Training" and the item under "Hospice Team Communication" regarding confusing or contradictory information, were appropriate to clarify and streamline the survey. Many members shared they did not understand the intent or goal of the items and what they were attempting to identify. Additionally, we strongly support the addition of a clearer, single question item on "Getting Hospice Training" and the two-question item on "Care Preferences." Hospice is a deeply personal benefit and providing families with the opportunity to share how their family members' last wishes were respected, or not, is critically important to determining the quality of care. **LeadingAge supports CMS' survey measure changes but encourages CMS to continue to pare down the number of questions in the survey to make it easier for families to respond.**

#### *Impact to Special Focus Program*

While CMS analysed the impact of the updated question language on public reporting and star ratings, CMS did not mention assessing the impact on the Special Focus Program (SFP) for hospices. LeadingAge has significant concerns that CMS has not properly evaluated the impact of the proposed CAHPS changes on the Special Focus Program algorithm. Unlike the CAHPS Hospice scores and Star Ratings, which include a calculation of all eight measures, the SFP algorithm only selected four measures from the survey, including "Hospice Team Communication." While CMS states changes to the "Hospice Team

Communication” measure (removing one item and slight wording changes) are non-substantive (that is, would not meaningfully change the measure), CMS still proposed that scores and star ratings would be calculated by combining scores from quarters using the current and new survey. A similar transition was not proposed for the SFP algorithm to account for any changes. With only four items making up the CAHPS hospice portion of the algorithm, the impact could be significant; additionally, the weighting of the CAHPS Hospice survey is two times that of any other element in the algorithm. **Due to this, and our ongoing concerns about the SFP algorithm generally, LeadingAge recommends that the implementation of the SFP be delayed to accurately assess the impact of the CAHPS Hospice item changes and properly inform providers of the outcome.**

### *Survey Administration Changes*

LeadingAge appreciates CMS’ foresight to analyse a web-mail mode for this survey. The unique structure of the CAHPS hospice survey means that it is the patient’s family, not the patient themselves, answering the questions. As the population continues to age, we would anticipate seeing more respondents, in particular younger respondents, who are more comfortable with technology and prefer to answer the surveys via web-mode. **LeadingAge supports the proposal to add a web-mail mode.**

In addition to a new web-mail mode, CMS proposes a pre-notification letter to be sent one week prior to the actual survey, regardless of mode (webmail, mail, telephone, or mixed). While there is precedent for CMS to require a pre-notification letter for CAHPS surveys, and the mode administration experiment did identify a small increased response rate (2.4 percentage points), the other surveys in the CAHPS family that utilize this process have considerable differences. For the In-Center Hemodialysis CAHPS (ICH CAHPS) survey the pre-notification letter is sent 14 days prior to all survey modes, whereas the MA CAHPS survey pre-notification letter is sent within one week of the pre-notification letter and only for mixed mode data collection. Additionally, the ICH CAHPS survey was launched in 2014 one year prior to CAHPS hospice survey in 2015 and started requiring the pre-notification letter in 2023. On the other hand, the MA CAHPS Survey has been in use since 1998 and just this year launched the pre-notification letter meaning the letter’s effectiveness is untested. **LeadingAge believes the CAHPS Hospice Survey is more closely aligned with the ICH CAHPS survey and recommends CMS extend the pre-notification letter timeline to 14 days prior to sending the survey.**

### **Health Equity Updates Related to HQRP**

LeadingAge strongly supports CMS’ efforts to meaningfully incorporate health equity measures in the Hospice Quality Reporting program. LeadingAge and its members are leading advocates for affordable seniors housing funding, programs, and policies. We work to expand, preserve, and improve the supply of affordable senior housing and better connect residents to the services and supports they need to age in community. We are grateful to CMS for acknowledging the critical importance of housing in healthcare.

At this time, hospices do not necessarily have the capacity to help remediate many of these experiences captured in the items suggested for inclusion. There are no action steps for providers after these questions are asked. Presumably, one would not be asking questions if one was not able to intervene in some way to help address problems identified. A recently published study of a healthcare program that screened patients for housing instability in Boston, Massachusetts, saw marked improvements in healthcare utilization for individuals enrolled in the program and received housing interventions based on their screenings.<sup>11</sup>

---

<sup>11</sup> [Primary Care–Based Housing Program Reduced Outpatient Visits; Patients Reported Mental And Physical Health Benefits](#)

We would like to caution that these measures not be used as process or outcome measures unless CMS is prepared to support hospices in providing resources for housing referrals and interventions on behalf of patients. Not only is there no guarantee that the hospice would be able to mitigate the existing issue for the patient and their family, but there may also be a risk for the individual in responding such as risk of mandatory reporting and risk of condemning their current living space with no alternative – outcomes that would violate the trust the hospice is trying to establish through its services. Until such a time, these questions should simply be an opportunity to gather more information on populations accessing hospice services.

### *Housing Instability*

*Are these items relevant for hospice patients? Are these items relevant for hospice caregivers?*

The questions proposed are appropriate and relevant for both hospice patients and caregivers. With the majority of hospice patients receiving care in private homes, the risk of issues within an individual home or the risk and emotional burden of losing housing is significant.

*Which of these items are most suitable for hospice?*

Both questions under Housing Instability are relevant to the hospice patient and family's experiences. For the first item under the housing section, many hospices already note experiences with these issues but again, lack the ability to help mitigate the issues. One LeadingAge member, shared an experience with a woman on hospice and her husband living in a deeply mice infested home. There was no way for the hospice to remediate the infestation without moving both the patient and the husband out of the home, unfortunately with no other place to go that option was not realistic. The hospice team could not prevent mice from biting the patient and did everything they could to routinely change the patient's bandages from the bites to keep her comfortable.

*How might the items need to be adapted to improve relevance for hospice patients and their caregivers?*

*Would you recommend adjusting the listed timeframes for any items? Would you recommend revising any of the items' response options?*

LeadingAge recommends the following question from the Accountable Health Communities Health-Related Social Needs Screening Tool be added. While this question is similar to a question on PRAPARE, it speaks to someone's present housing stability vs. their concern about losing currently stable housing, which is helpful but does not allow for someone who already has no stable housing).

#### Living Situation

1. What is your living situation today?

- I have a steady place to live.
- I have a place to live today, but I am worried about losing it in the future.
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park).

### *Food Insecurity*

*Are these items relevant for hospice patients? Are these items relevant for hospice caregivers?*



These three questions are relevant for hospice patients and their families. According to Feeding America, over 5 million seniors were food insecure in 2021.<sup>12</sup> We caution that many communities do not have food pantries or soup kitchens, or they are inaccessible to individuals with limited mobility or homebound individuals. The Children’s Health Watch item may not be a representative question for all hospice patient populations.

*Which of these items are most suitable for hospice?*

The items in the “Hunger Vital Sign” seem most relevant to hospice patients and their families.

*How might the items need to be adapted to improve relevance for hospice patients and their caregivers? Would you recommend adjusting the listed timeframes for any items? Would you recommend revising any of the items’ response options?*

The range for the second question on “Hunger Vital Sign” should be changed to a smaller range of six months or two weeks. A smaller range of time will give a better idea of when the household was last struggling. Often, individuals, especially those who live alone, may also struggle with food safety issues, consuming out-of-date or spoiled items. That can have significant consequences when in hospice care. CMS should consider additional items that look at the health and safety of the foods being consumed.

### *Utility Challenges*

*Are these items relevant for hospice patients? Are these items relevant for hospice caregivers?*

Paying for utilities is part of paying for housing and is directly tied to being healthy. The cost of DME can also have an impact on utility bills and make them most costly.

*Which of these items are most suitable for hospice?*

Each of the questions is suitable for hospice patients. The questions do not have significant variation so a single question on the topic would be best. The Health Leads-Social Needs Screening Toolkit item seems most effective to evaluate the immediacy of need for the hospice patient.

*How might the items need to be adapted to improve relevance for hospice patients and their caregivers? Would you recommend adjusting the listed timeframes for any items? Would you recommend revising any of the items’ response options?*

LeadingAge recommends the following question from the Accountable Health Communities Health-Related Social Needs Screening Tool be added.

#### Utilities

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- Yes
- No
- Already shut off

While this question is consistent with the Health Leads – Social Needs Screening Toolkit, LeadingAge recommendation would be to shorten the time frame of the question as was suggested in the food security domain. This will allow hospice teams to better understand the immediate needs of the individual and their family. Finally, LeadingAge would also recommend expanding the definition of utility

---

<sup>12</sup> Feeding America. *Senior Hunger Facts*. <https://www.feedingamerica.org/hunger-in-america/senior-hunger-facts>

to include phone service (cell phone or landline) and internet. Given the critical importance of technology and ability to access care teams around the clock for emergent issues in hospice care, understanding the patient’s communications utility challenges is critical to the work.

### *Transportation Challenges*

*Are these items relevant for hospice patients? Are these items relevant for hospice caregivers?*

Transportation challenges can be a critical issue for many hospice patients but not necessarily all. As CMS understands, the majority of hospice care is still conducted at home in the United States. While transportation is important, further upstream to access health related supports and doctor’s appointments, it is not common for individuals to have routine doctor’s appointments while on hospice. In fact, the Office of Inspector General and CMS have been looking for ways to curb Part B spending outside the hospice benefit since a report in 2022 found Medicare paid \$6.6 billion to nonhospice providers over a 10 year period.<sup>13</sup> However, if CMS moves forward with payments for “high intensity palliative care treatments”, transportation will be a critical factor as most homes cannot support in-home radiation or chemotherapy. Beyond the medical necessity to travel, many hospice patients do need support to leave home especially for items that are critical to their goals in hospice care such as traveling to a wedding or graduation.

*Which of these items are most suitable for hospice?*

While we have concerns regarding focusing on healthcare related transportation specifically, the AHC HRSN tool does expand beyond just doctor’s appointments to include meetings, work, and activities of daily living in which many hospice patients still participate. Additionally, the second item from Borders seems relevant to the role of caregivers in hospice services. Despite many hospice patients not necessarily needing doctor’s appointments while enrolled in hospice, the access to family support for travel during emergencies or to other planned events like weddings or graduations is important to achieving the goals of many individuals on hospice. Additionally, if an individual answers no to this question, the hospice could utilize the answers to provide volunteer support to the individual in the form of transportation.

*How might the items need to be adapted to improve relevance for hospice patients and their caregivers? Would you recommend adjusting the listed timeframes for any items? Would you recommend revising any of the items’ response options?*

The two items from AHC HRSN and Borders could be adjusted to meet a broad range of transportation needs. Also, as discussed in other items above, the timing for the question may be too broad as most hospice patients are not on service for a year. Revisions could look like the following:

- Has lack of reliable transportation kept you from appointments, meetings, work or from getting things needed for daily living?
- Are you regularly able to get a friend or relative to provide you transportation?

### *All Domains*

*Are these items relevant for hospice patients? Are these items relevant for hospice caregivers?*

The last “All Domains” item is easy to ask and easy to answer, if people are inclined to share. However, the focus is being able to afford and pay for certain services. For individuals asking for transportation

---

<sup>13</sup> Department of Health and Human Services, Office of Inspector General. “Medicare Payments of \$6.6 Billion to Nonhospice Providers Over 10 Years for Items and Services Provided to Hospice Beneficiaries Suggest the Need for Increased Oversight” <https://oig.hhs.gov/oas/reports/region9/92003015.pdf>

help from loved ones, that is not an expense. Additionally, there are situations where an individual may be at risk of eviction or losing utilities not because of an inability to pay but other extenuating circumstances such as the building being condemned or the individual breaking a lease agreement. Since this question does not consider other extenuating circumstances beyond paying for needs, we recommend not using this measure.

### *Additional SDOH Domains*

#### **Family Caregivers**

LeadingAge is grateful for CMS' recognition of the critical role of outside assistance in the delivery of hospice by the inclusion of A1910. Availability of Assistance. For all of these questions outlined above, each is equally salient to family caregivers. Is the caregiver at risk of losing housing, running out of food, losing utilities, lacking transportation access to get to their loved one? Given the unique role of family caregivers in hospice we would strongly encourage CMS to consider a separate caregiver assessment to help hospices understand the vulnerabilities faced by these critical members of the hospice team and how it may impact the care of the hospice patient.

#### **Home Accessibility**

For people who might return home from an inpatient hospice stay or more likely receive hospice at home, another line of housing questioning also seems important: accessibility. Especially, as one of the core benefits of hospice is access to DME to support the patient, this seems like a very relevant and actionable item for hospice providers.

Questions could include:

- Does your home require steps to get into it?
- Does your home have doorways wide enough for walkers or wheelchairs or a hospital bed?
- Does your home have an accessible first floor bathroom, accessible switches and outlets, and appliances you can use?

Each of these questions sheds light not only on the needs of the patient and family but on what hospice staff could expect when coming into the home. Will the individual need bed baths because they cannot access a bathroom. Will the staff be unable to provide a hospital bed due to the narrow doorways, or will the bed need to be placed in the living room where the door is widest?

#### **Health Literacy**

This is a critical domain for the majority of health settings but was not included in the proposed HOPE tool. Understanding healthcare information is especially difficult for individuals for whom English is not their first language. In the most recent revision to the OASIS tool in home health, health literacy was added.

## B1300: Health Literacy

<b>B1300. Health Literacy</b> (From Creative Commons ©) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	
<b>Enter Code</b> <input type="text"/>	<ol style="list-style-type: none"><li>0. Never</li><li>1. Rarely</li><li>2. Sometimes</li><li>3. Often</li><li>4. Always</li><li>7. Patient declines to respond</li><li>8. Patient unable to respond</li></ol>

According to the OASIS-E manual<sup>14</sup>:

- Similar to language barriers, low health literacy interferes with communication between provider and patient.
- Health literacy can also affect the ability for patients to understand and follow treatment plans, including medication management.
- Poor health literacy is linked to lower levels of knowledge of health, worse outcomes, and the receipt of fewer preventive services, higher medical costs, and rates of emergency department use.

Adding this question to address SDOH could be a practical way for hospices to understand not only the health literacy of their patient population but also how to amend their documentation and communication to patients to help them better understand their health situation.

### Special Focus Program

LeadingAge would like to take this opportunity to reiterate our ongoing concerns with the finalized Special Focus Program (SFP) for poor performing hospices. Our most significant concern is around program transparency of which hospices will be selected for the program. CMS details the methodology regarding an algorithm to highlight the 10% of hospices that will be eligible for the SFP. However, there is no detail as to how CMS will select from that bottom 10%. How does CMS plan to narrow down from the 10%? What criteria are being used? This is a critical point into which we are provided no insight (nor are beneficiaries). In LeadingAge's comment letter on the CY2024 Home Health Proposed Rule, we asked that CMS provide additional information regarding how they will narrow down from the bottom 10% to those that will actually be in the SFP.<sup>15</sup> While some additional information was shared, CMS stated in the final rule and on multiple occasions afterwards, that hospices should know their standing based on their Condition Level Deficiencies, CAHPS, and Hospice Care Index scores.

We strongly disagree with CMS' assessment of the current transparency, based exclusively on the poorly executed transition of hospice survey reports from the CASPER system to the QCOR system. CMS explicitly states that, "A hospice might be selected to participate in the SFP if: [...] 4. It is not currently under CMS enforcement action." Without the public availability of the most recent data for all providers' (not just a subset) surveys and enforcement actions, providers are unable to determine if they are part of a pool that could be selected for the program.

<sup>14</sup> The Centers for Medicare and Medicaid Services (CMS). Outcome and Assessment Information Set (OASIS-E1 Manual). April 28, 2024. <https://www.cms.gov/files/document/draft-oasis-e1-manual-04-28-2024.pdf>

<sup>15</sup> LeadingAge Home Health Comments on CMS-1780-P. Comments relating to Medicare Program; 2024 Home Health Prospective Payment System Proposed Rule. August 29<sup>th</sup>, 2023. <https://leadingage.org/wp-content/uploads/2023/08/LeadingAgeHHCommentsFINAL2023.pdf>

We ask again that CMS work to:

- Improve the SFP algorithm methodology prior to its planned implementation on January 1, 2024, especially reconsidering the weighting of CAHPS given the forthcoming changes and the recommendation of the TEP.
- Suppress public posting of SFP results and the 10% list for at least the first two years of the program. Hospices should be provided interim reports of their performance ranking under the updated SFP algorithm metrics. The elements used to come up with the lists – both the 10% and the actual candidate list- should be fully available to the public.
- Release the data elements that are used to run the algorithm in an accessible and free format so that the algorithm can be accurately recreated and we can have an informed conversation with CMS about fixes to the algorithm that are apples to apples.

Being selected for the SFP is consequential, as it should be. We strongly believe that CMS should get this program right. A program that ends up in the SFP undeservedly will suffer reputational damage that may not be easily repairable. More importantly, the goal of the program is to look at the poorest performing programs; using all available resources to be sure that the right hospices are in this program is important for the hospice industry, CMS, and beneficiaries.

Sincerely,



Katy Barnett

Director, Home Care and Hospice Operations and Policy

[kbarnett@leadingage.org](mailto:kbarnett@leadingage.org)

***About LeadingAge:*** We represent more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information, visit [leadingage.org](http://leadingage.org).