



May 31, 2022

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-1773-P: Medicare Program; FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting 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 FY2023 Hospice Wage Index and Payment Rule.

Proposed Permanent Cap on Hospice Wage Index Decreases

We support the proposal to impose a permanent cap on hospice wage index decreases. However, we believe the percentage cap should be lower than the proposed 5% and the cap should be applied in a non-budget neutral way and be made retroactive for all provider types. Applying the cap in a non-budget neutral way will ensure that when significant economic downturns occur, all hospices will be protected from significant reductions. Based on feedback from LeadingAge members, 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 Core Based Statistical Areas (CBSA), 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. Providing a lower cap on decreases will allow agencies serving multiple CBSAs to better predict costs. We supported CMS' original decision announced in 2021 to place a one-year cap on wage indices decreases of more than 5%. However, that cap was only extended for a second year to hospitals which should be rectified with a retroactive application of the permanent wage index cap proposal to FY2022 payments. **We urge CMS to finalize the permanent cap on hospice wage index decreases to 2% in a non-budget neutral way and retroactively apply this policy to FY2022 hospice payments.**

We also encourage CMS to continue to examine policies to help assuage ongoing wage index inequities. The current workforce crisis has created access issues across the country for individuals seeking hospice services but rural communities, which have larger portions of the aging population, have been hit hardest.¹ **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**

¹ 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/>

MedPAC's 2007 proposal² 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 and with hospitals.

Proposed FY2023 Hospice Payment Rates

We support the increase in the wage index and rate update but want to emphasize that the proposed 2.7% increase is not sufficient to cover the current needs of hospice providers. 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 personal protective equipment (PPE), increased costs for gas, and other increased expenses now have to be worked into hospices' budgets and many of our members' margins were already thin so increased payment this year and into the future will continue to be essential.

The current workforce shortages have significant impacts on hospice providers and those they serve. Many LeadingAge Hospice members are struggling to hire and retain nursing and hospice aide staff due to rising wages and scarcity of professionals. Burnout and stress continue to add significant strains on existing nurses with more than one-third of nurses in a recent survey saying it is very likely they will leave their role by the end of 2022.³ Regardless of the factors driving the current shortage, the United States is on track to have a shortage of 3.6 million nurses for 82 million aging adults due to demographics by 2030.⁴ Hospice's are experiencing similar issues with aide shortages. Due to these factors, it is likely that this average wage has increased since the staffing shortages continue to get worse.⁵

We have repeatedly shared concerns with the quality of cost report data especially with regards to capturing actual labor costs. Cost reports 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

² Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy [Internet]. Washington (DC): MedPAC; 2007 June. Chapter 6, An alternative method to compute the wage index; Available from: http://www.medpac.gov/docs/default-source/reports/Jun07_Ch06.pdf?sfvrsn=0

³ Incredible Health. *STUDY: 34% of Nurses Plan to Leave their Current Role by the End of 2022*. <https://www.incrediblehealth.com/blog/nursing-report-covid-19-2022/>

⁴ American Association of Colleges of Nursing. *Fact Sheet: Nursing Shortage*. <https://www.aacnursing.org/news-information/fact-sheets/nursing-shortage>, U.S. Department of Health and Human Services, *Supply and Demand Projections of the Nursing Workforce: 2014-2030*. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nchwa-hrsa-nursing-report.pdf>

⁵ Kaiser Health News. "Pandemic Fueled Home Health Care Shortages Strand Patients." <https://khn.org/news/article/pandemic-fueled-home-health-care-shortages-strand-patients/>

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.

Adequately Capturing Telehealth in Claims and Cost Data

The public health emergency provided flexibilities to hospices in a multitude of areas, but the flexibility to allow expansion of telehealth is one of the most impactful. This 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 and without data tracked nationwide the administration and public health research cannot effectively assess the outcomes of telehealth on care.

The FY2022 Omnibus Appropriations bill extended the authority for hospices to conduct the face-to-face recertification via telehealth. The CARES Act enabled hospices to do the required face to face recertification at 180 days (and every subsequent recertification) via telehealth. This recertification must be done via video-audio technology; it cannot be done using audio-only technology. The FY2022 omnibus spending package extended this flexibility for 151 days starting the first day after the end of the public health emergency (PHE). Additionally, MedPAC called on the Department of Health and Human Services to require that hospices report telehealth services on Medicare claims.⁶ **We strongly recommend that CMS implement a modifier or HCPCS code 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 expense 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.**

Request for More Information on Health Equity

We applaud the Biden-Harris Administration on their sweeping commitment to health equity. In 2021, LeadingAge made a commitment in to increase focus on governance, diversity, equity, and inclusion

⁶ 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

within LeadingAge member organizations.⁷ To achieve this work we have launched a series of initiatives including member networking opportunities, education on equity, diversity, and inclusion for member organizations, and supporting public policy to make aging services responsive to underserved populations.

The LeadingAge LTSS Center @UMass Boston published a research brief in late 2021 with insights about diversity, equity, and inclusion from leaders of LeadingAge member organizations.⁸ While many of our hospice members have worked carefully to identify barriers within their own communities, the efforts are made more difficult without a nationally recognized and required assessment tool like all other post-acute settings have.

Hospice has historically been behind all other settings in the Medicare program on quality measurement. Abt Associates is currently conducting research and development for CMS on the HOPE tool which is long overdue. However, it will not be completed and formally implemented in the program for several more years. CMS and Abt Associates should ensure the HOPE tool contains the means to measure impact on social determinants of health and that it is consistent with efforts in other settings, creating standardization across post-acute care providers. Given this ongoing tool development, implementing a structural measure with requirements for hospices to track health equity and underserved populations along with other self-reported demographics is an undue burden and should be paused until an evidence-based assessment tool which collects this critical data is in place.

We look forward to partnering with CMS on this important work and hope there will be more opportunities to comment on health equity. This is a critical learning opportunity for providers across the continuum of aging services but unfortunately the playing field is not yet level for all providers including hospices. Some providers may need to start at square one with differentiating social determinants of health from race and ethnicity and understanding the root causes of health inequality including racial bias and racism. We hope as this work advances there will be time and investment provided to support all hospices to improve health equity without penalty regardless of a provider's current efforts.

Structural Composite Measure

Again, LeadingAge strongly supports CMS' efforts to improve health equity and we recognize the patient populations who access hospice care often do not reflect the diversity of Medicare enrollees. We also recognize hospice is not the only setting in Medicare looking at the implementation of structural measures for health equity. Both hospital and skilled nursing facility proposed regulations included proposals for a health equity structural measure. The structural measure that CMS proposed for hospitals and skilled nursing facilities had significant stakeholder input including a Technical Expert Panel process. The National Quality Forum's Measure Application Partnership (MAP) also reviewed the

⁷ LeadingAge. LeadingAge 2021-2023 Strategic Plan. Dec. 2020. Available from: <https://leadingage.org/sites/default/files/2021%20LeadingAge%20Strategic%20Plan.pdf>

⁸ LeadingAge LTSS Center @UMass Boston. Creating a Diverse, Equitable, and Inclusive Workforce Culture: Perspectives of LeadingAge Members. Nov. 2021. <https://www.ltsscenter.org/research-how-are-leadingage-members-advancing-dei-values/>

measure and only provided a conditional approval. The MAP suggested: 1) a commitment from CMS to look at outcomes in the future, 2) providing more clarity on the measure and supplementing interpretations with results, and 3) verifying attestation provided by the accountable entities.⁹ We echo the MAP's concerns regarding introducing a structural measure which does not measure the quality of care received or assess whether health equity efforts improved care delivery. **We request CMS work towards measures developed with the MAP's 2021 suggestions and develop a TEP specific to hospice to help develop a health equity structural measure.**

We also have significant concerns regard the reporting burden of this proposed structural measure. CMS has indicated hospices would be able to submit information attesting to the completion of components of the structural measure through a portal. This could be an undue administrative burden for many hospices to collect and collate many diverse sources of documentation of health equity efforts. We also believe CMS should ensure hospices have equal access to trainings on culturally and linguistically appropriate services and other health equity training programs to educate their staff. CMS can help hospices access this training by hosting regional opportunities, webinars, and vetting qualified evidence-based trainers like the Augustus A. White Institute.¹⁰ We have several outstanding questions on the proposed information submission process: Who will review the reported information? Who will assess the quality of the reported information? How will hospice submissions be compared to other agencies? What is considered a completed action?

Scoring Structural Measure Domains

We believe, given the newness of these health equity efforts, hospices should receive credit on the proposed health equity composite structural measure for any actions, even if partial. So, if a hospice achieves one of the three measures under a domain, they would receive one of three possible points for that domain and that would be added up across the other domains.

Proposed Structural Measure Domains

Domain 1

The first domain is on its face an achievable measurement opportunity for hospice organizations and would provide CMS detail on how hospices engage in their communities. Given the conditions of participation for hospices regarding bereavement care and volunteer services, LeadingAge members have comprehensive plans to work with their communities. Non-profit hospices, including many LeadingAge members, provide free services to support their communities during times of immense grief such as natural disasters or mass shootings. Additionally, our members provide grief counseling support, such as grief groups and grief camps, to their communities regardless of if an individual's loved one utilized hospice services.

⁹ Measure Applications Partnership 2021-2022 Considerations for Implementing Measures in Federal Programs: Clinician, Hospital, and Post-Acute Care Long-Term Care, Final Report. March 2022. https://www.qualityforum.org/Projects/i-m/MAP/MAP_2021-2022_Considerations_for_Implementing_Measures_Final_Report.aspx

¹⁰ The Augustus A. White III Institute for Healthcare Equity. <https://aawinstitute.org/what-we-do/>

We do want to caution CMS against measures in this domain that could be considered “check box” measures. Simply having a strategic plan or meeting with community members regarding care disparities does not necessarily contribute to outcomes for patients. CMS should continue to look for meaningful ways in partnership with hospice stakeholders.

Domain 2

This domain looks at hospices’ education and training plans and resources for board members, staff, and volunteers.

One concern is the cost of the training for board members, certain staff, and volunteers. Currently, costs for hospice bereavement staff and volunteers are not allowable administrative expenses. Adding additional training costs for these services would be a burden to hospices.

Another concern is the evidence-based quality of training and training resources. How will CMS determine if the content is evidence-based and leading to quality training outcomes for hospice patients? If this is simply implemented as a structural measure, will CMS have the authority to reject an attestation that does not clearly show the education and training provided was evidence-based?

Domain 3

In this domain, CMS looks at how “leaders and staff could improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting organizational culture of equity” however, the bulleted examples of attestation are all regarding health equity focused hiring practices. We understand CMS’ goal of moving hospices to become inclusive and diverse workplaces reflecting their communities, but hiring practices are not the only place these efforts can be promoted. Given the ongoing health care workforce shortage, we do not believe these suggested attestations are appropriate to evaluate a hospice’s commitment to health equity. Additionally, one of the measures proposed for both hospital and skilled nursing facility settings, Hospital Commitment to Health Equity measure, does not include any attestations to hiring practices. We encourage CMS to consider using the following modification of the hospital measure language for this domain:

“Question. Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Please attest that your hospice engages in the following activities. Select all that apply:

- Our hospice senior leadership, including chief executives and the entire hospice board of trustees, annually reviews our strategic plan for achieving health equity.
- Our hospice senior leadership, including chief executives and the entire hospice board of trustees, annually reviews key performance indicators stratified by demographic and social factors.”

Publicly Reporting Health Equity Structural Measure

We support CMS’ interest in providing information on health equity to the public. However, we do not believe as proposed now, this structural measure would be able to help families navigate care compare

and identify a hospice with the unique skill to provide care to their loved ones. CMS proposes to “display descriptive information from the data hospices provide,” given the broad opportunities to attest to health equity efforts this could be anything from sharing information on their strategic plan to what trainings they have provided for employees making it difficult to compare hospices. It’s simply more information for families to wade through. **CMS should not publish information on this proposed health equity measure on Care Compare until such time as the HOPE tool, if it contains the means to measure impact on social determinants of health consistent with other settings, is available and other metrics of health equity have been tested in hospice and other additional Medicare settings of care. Any implementation of this structural measure should be voluntary at first, similar to the quality reporting program implementation.**

Update on Advancing Health Information Exchange

We appreciate CMS’ update on this important work, but we wanted to note that the data element libraries did not have any relevant library for hospice. It is essential the Office of the National Coordinator for Health Information Technology (ONC) formalize data collection standards for hospices. The development of the HOPE tool could certainly advance this effort and now is the critical time, since Abt Associates is finalizing beta testing this year, to convene a specific work group to review potential hospice data elements.

Additionally, 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, LeadingAge would advocate for the establishment of initiatives to encourage and accelerate the adoption of interoperable EHRs, particularly among smaller, stand-alone, and rural hospice providers. Such initiatives might include state and federal legislation authorizing grants or low-interest loans to assist with initial health IT investments. Regulatory agencies would be encouraged to provide ongoing payment incentives to providers that adopt these technologies and demonstrate that they meet certain quality and cost measures.

Update Hospice Survey and Enforcement Procedures

We appreciate CMS’ update on the hospice survey and enforcement procedures and the decision establish a Technical Expert Panel to further develop a proposal on the methodology for establishing the hospice Special Focus Program (SFP) for poor-performing hospice programs. We support the Congress and CMS in their efforts to try to identify poor performers and provide them with a targeted program for improvement prior to termination. How this program functions, its goals, its metrics for entrance and exist – these are all critical factors to actually promoting quality improvement. We want this program to be as effective as possible. **We reiterate our asks from the CY2022 Home Health Prospective Payment System proposed rule that the SFP not be implemented until this TEP finishes its work and the work is publicly reported to all stakeholders.**

Promoting Transparency

LeadingAge supports the Administration’s efforts to promote competition and transparency in our nation’s health care system. The recent public release of multiple years of data on mergers, acquisitions, consolidations, and changes of ownership for Medicare enrolled hospitals and nursing homes is the first

step in creating a better understanding of consolidation's impact on the health care system. Researchers, state governments, and consumers will now have more tools to evaluate prices, the quality of care, and make thoughtful decisions about their personal health.

Much like hospital and nursing home ownership trends, recent research has shown:

- In the last three decades, the hospice industry has transitioned from mostly non-profit ownership to nearly two-thirds of all agencies being for-profit.^{11, 12}
- In 2012, 11% of Medicare hospice enrollees received care from for-profit hospices. By 2019, 16% Medicare hospice enrollees received care from for-profit hospices.¹³
- From 2011-2019, there were 653 for-profit transactions and acquisitions of hospice agencies.¹⁴

LeadingAge members are transparent in their ownership structure and board governance and are held accountable to their local communities and government at all levels. We value these obligations of transparency and accountability because they strengthen our organizations and communities that we serve, especially when receiving taxpayer monies for the delivery of services to our vulnerable seniors.

We ask CMS to make data on mergers, acquisitions, consolidations, and changes of ownership public for Medicare certified hospices.

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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¹¹ 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

¹² Stevenson DG, Dalton JB, Grabowski DC, Huskamp HA. Nearly half of all Medicare hospice enrollees received care from agencies owned by regional or national chains. *Health Aff (Millwood)*. 2015;34(1):30-38.

¹³ Braun RT, Stevenson DG, Unruh MA. Acquisitions of Hospice Agencies by Private Equity Firms and Publicly Traded Corporations. *JAMA Intern Med*. 2021;181(8):1113–1114. doi:10.1001/jamainternmed.2020.6262

¹⁴ Ibid.