



June 7, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8010
Baltimore, Maryland 21244-1850
Via Electronic Mail

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

Dear Administrator Brooks-LaSure:

The Pennsylvania Homecare Association (PHA) is a statewide membership association with approximately 700 home health, homecare and hospice members across Pennsylvania. On behalf of our hospice provider members, we appreciate the opportunity to offer comments on the Medicare Program FY 2022 Hospice Wage Index, Payment Rate Update, Hospice Condition of Participation Updates and Hospice Quality Reporting Requirements proposed rule.

Hospice Utilization and Spending Patterns

At the outset, we noted that much of the data reviewed by CMS showed a fair amount of stability, with average spending per beneficiary increasing only about \$1,500 over ten years, lengths of stay remaining stable, and average live discharge rates remaining around 17% since 2014.

At the same time, characteristics of hospice patients have changed quite a bit over the years, as cancer treatment has changed dramatically since the hospice benefit was created, and neurological diseases have a very different, and often less predictable, course.

Our members are aware of CMS concerns regarding patients with longer lengths of stay, including the increased risk of reaching the aggregate cap. Studies have shown that the most significant contributor to exceeding the aggregate cap is the extent to which a hospice's patient case mix includes patients with neurological and other non-cancer diagnoses.

PHA strongly supports meaningful efforts to curb fraud and abuse. The mere fact that a hospice stay exceeds 180 days, exceeds the aggregate cap, or may end in live discharge, however, does not support any conclusion of inappropriate behavior. To the contrary, focusing too much on these benchmarks could threaten access to much-needed hospice care for patients with non-cancer diagnoses who are every bit as deserving and in need of this care benefit.

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Spending Outside of Hospice

CMS has asked for feedback on spending outside of the hospice benefit. As you know, hospice providers are often not in control of services provided to patients outside the hospice benefit and how they are billed.

We believe that additional information is necessary to better evaluate the increase in spending outside of the hospice benefit, including:

- How much of the Part B spending is for physicians? How much relates to Part B claims without the hospice-related billing modifiers?
- Are the “maintenance medications” referenced for the terminal condition or a related condition, or are they for a condition that accompanies (but is separate from) the terminal diagnosis?
- How much are Part D increases due to increased manufacturer charges?
- Are there regional differences in Part D spending increases, or other patterns that have emerged?

Other challenges identified by providers include:

- Lengthy delays between the NOE submission and the Part D knowledge of hospice election; and
- Long-term care or mail order pharmacies with auto-refill options can cause Part D to be the payer of first resort, even if the hospice has contracted with the pharmacy to be billed for medications for the terminal illness and related conditions.

Service Intensity Add-On (SIA)

PHA supports the increase related to the SIA so that additional skilled nursing visits and social worker visits are provided. In a patient’s final days, however, it is critical that patient and family choice be paramount. Some families do not want any visits; others have a strong preference for a hospice aide or chaplain, rather than an RN or social worker.

Relatedness for Development of Hospice Plan of Care

Determinations of relatedness are complex and unique to individuals. In considering whether an item, service or drug is related to the patient’s terminal illness and related condition, hospice physicians and the interdisciplinary team must consider each patient’s circumstances in the development of an individualized plan of care. Providers report that their common practice is to try to cover all medications and services as related, but also find themselves in disputes with medical review and auditors over these determinations.

New treatments that are considered related, unique and/or more effective frequently become available and create new challenges. These treatments are expensive, and a hospice may not cover them with the Medicare hospice per diem because of the projected expense. This can result in a patient being declined for hospice services; it can also pressure hospitals to consider alternatives to the Medicare hospice benefit.

Rebase and Revise the Labor Share – 2018 Medicare Cost Report Data for All Levels of Care

This proposal is a significant change from current policy, based on the additional work to expand cost data reporting in recent years. Members remain concerned, however, about whether reporting on the hospice cost report is sufficiently consistent to support this change at this time. Issues/concerns include:

- Inconsistent reporting on certain costs associated with each LOC, including how hospices report mileage allowances and reimbursements;
- Certain positions, such as Medical Director, being contracted (not salaried), and the impact that would have on reporting;
- Inconsistent reporting on medical supply and pharmacy costs.

The proposed rule also does not specify how frequently the labor component of the rate will be recalculated.

Hospice Wage Index Updates

As we have mentioned in prior comments, hospices and home health agencies continue to be challenged by the ability for hospitals to seek geographic reclassifications (resulting in higher wage adjustments to their payments). Hospices and HHAs compete for the same caregivers and professionals; this disparate treatment only compounds the already existing workforce challenges for both hospices and HHAs. CMS's wage index model must be consistent across all provider types, so that all providers operate on a level playing field. We also believe that providers should continue to be protected against substantial payment reductions due to reductions in wage index values from one year to the next.

Hospice Election Statement Addendum Revisions and Clarification

PHA members appreciate the clarifications provided in the proposed rule, including the issues related to the timeframe for providing the addendum if it is requested after the date of election but within the first five days of care. We also appreciate clarification that compliance will be measured by the "date furnished" rather than the date of signature, and the additional guidance when the patient or responsible individual refuses to sign.

Additional questions and comments include:

- Effective date of policy changes/clarifications. We believe the clarifications in the proposed rule should be retroactive to the addendum requirement date, October 1, 2020.
- Model Sample Addendum. Given the proposed changes, we respectfully request that CMS provide a revised sample addendum form that reflects the proposed changes.
- Penalties for late addendum. Under current policy, if a hospice fails to provide the addendum within the specific 3- or 5- day timeframe, the hospice will be denied payment for the entire claim period subject to review (a month of service). This penalty for an addendum that is even one day late is disproportionate to the harm and is far in excess of the penalty imposed for late submission of a Notice of Election (NOE). It also provides no incentive for a provider to correct the error in a timely manner. We request reconsideration of this penalty and believe that it should be in alignment with penalties for untimely NOEs.

1135 Waivers to be Permanent

PHA strongly supports allowing hospices to utilize pseudo-patients to meet competency standards. We likewise support the provision that would allow hospices to focus on and address an aide's specific deficient skill(s) when addressing deficiencies.

We further request clarification/confirmation from CMS that after the COVID-19 public health emergency ends, telecommunication options (including audio only) are permitted for use, provided the technology is included on a patient's plan of care, the goals of care, as also outlined on the plan of care, are met, and the service is HIPAA compliant.

Hospice Quality Reporting Provisions

Proposal to Remove Seven HIS Process Measures From HQRP

CMS is proposing to remove the seven Hospice Item Set (HIS) process measures from HQRP beginning FY 2022. PHA requests that CMS maintain the display of the HIS measures to increase transparency about the content of the composite measure and the meaning of the composite score until the HOPE assessment data is available for public reporting.

New Hospice Care Index Proposal

CMS is also seeking comments on the proposal to add the composite Hospice Care Index (HCI) to the HQRP beginning in FY 2022 and adding it to the program for public reporting no earlier than May 2022. PHA strongly supports quality of care measures that represent the full spectrum of the hospice benefit in the HQRP. All data shared must be understandable and meaningful to consumers.

As proposed, the HCI primarily relates to medical services. It does not measure or consider spiritual care services, which are important when considering quality hospice care. We recommend that telehealth visits be identified/reported as an important data collection point and that CMS develop a HCPCS code for spiritual care professionals.

Update on the HVLDL and Hospice Item Set V3.00

Hospice providers have asked for additional clarification on the Hospice Visits in the Last Days of Life measure and ask that CMS provide CASPER QM reports to providers as soon as possible, with delayed public reporting to February 2023 if possible, so that providers can review data trends, contributing care process, and develop performance improvement strategies, as needed. Additional requests include:

- Clarification on the “reporting period” and the dates that would be captured for the first public reporting refresh.
- That the description of this measure on the Care Compare website be as clear and simple as possible, so that the average consumer understands it.
- Six-month notice prior to the implementation of the iQIES system, as experience with this transition in home health highlighted the need to have communications shared widely on many platforms.

Claims-Based Measures

PHA supports the development of outcomes and process measures related to HOPE assessment data. We urge CMS to thoughtfully choose data that reflects meaningful quality of care outcomes and have the following recommendations:

- We ask that CMS be transparent with and provide notice to providers about the development of the Timely Reduction of Pain Impact, Reduction in Pain Severity, Timely Reduction measures, and other HOPE-related measure considerations, and allow for provider and stakeholder feedback.
- We believe that CMS should consider spiritual, psychosocial, plan of care goal achievement, and health equity as potential outcome measure concepts.
- We believe that CMS should develop codes for both chaplain and telehealth visits to be recorded on hospice claims.
- We urge CMS to suppress any publicly-reported claims data until all of the data would be post-COVID-19 PHE.

Proposal to Add CAHPS Hospice Survey Star Ratings to Public Reporting

PHA supports the development of Star Ratings, with the following requests and recommendations:

- We ask that hospices and other stakeholders be given a period to review the methodology, ask questions, and provide comments prior to implementation.
- We also request an extended period of implementation without public reporting, so that hospices can review and understand how the rating system will be implemented.
- We request consideration of lowering the 75-survey completion requirement to ensure that smaller hospices will be able to receive a star rating. Related to that, it must be clearly explained to the public if surveys are completed by caregivers, not patients.
- Data provided during the PHE should not be considered/shared publicly as part of the star ratings.

Data Collection During a PHE

PHA agrees with the CMS proposal for the public reporting display schedule with fewer than standard number of quarters due to the COVID-19 PHE. We believe that CMS should include a statement on the Care Compare website explaining the change.

Public reporting for CAHPS Hospice Survey-based Measures due to PHE Exemption

Providers ask that CMS provide a data report more than once per year, using a rolling timeframe. This will allow providers to engage in continuous quality improvement. We also recommend that CMS shorten the data timeframe for claims-based data and public reporting of claims measures in general, so that the data is more accurate in terms of present performance.

Potential Use of Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measures (dQMs) in Post-Acute Care Quality Reporting Programs

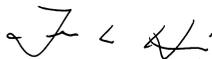
PHA supports the adoption of FHIR across the healthcare continuum, as well as the use of digital quality measures. Unfortunately, home health and hospice agencies have not been eligible for much of the grant funding through the Medicare and Medicaid HER Incentive Programs. We ask that CMS and HHS include funding in the 2022 final rule to invest in HIT and integrated clinical technology for hospice and home care. These technology investments should be targeted to promote health care quality, cost-effectiveness, care management and integration of hospice and home care within provider systems and across the healthcare continuum.

Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs

Improving data collection on Social Determinants of Health is a critical goal for hospice patients and relating to end-of-life care, and we would expect hospice organizations to assist with data collection and participate in quality improvement programs to improve equitable access to quality care and other related needs.

Thank you again for the opportunity to submit comments on these important issues. Please let us know if we can provide any additional information.

Sincerely,



Teri L. Henning, CEO
Pennsylvania Homecare Association
thenning@pahomecare.org
(717) 649-6498