

June 4, 2021

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1754-P,
P.O. Box 8010,
Baltimore, MD 21244-1850

Re: Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule in regard to its effects on those living with serious illness.

C-TAC is a national non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high- quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC is made up of over 150 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving serious illness care in the U.S.

Here are our comments on those aspects of this proposed rule most pertinent to serious illness:

Hospice Waivers Made Permanent Conditions of Participation- Workforce

We support the proposed changes in hospice aid training and want to point out that such staffing flexibility during the COVID-19 pandemic showed that this may also a good idea going forward. One specific option is that whenever nurses are mentioned in this proposed rule, it is always specific to registered nurses. However, CMS might explore the possibilities of broadening that to also include licensed practical nurses, LPNs, where appropriate since many hospices employ such nurses as well. This would provide further staffing flexibility for hospices. Additionally, given the workforce shortages among essential workers like nursing aides and assistants, it would be helpful to see if there is the opportunity to further increase flexibility in the hospice regulations around that role and training as well.

Beyond these workforce changes, C-TAC continues to advocate for permanency of routine home care telehealth flexibility due to the strong potential it holds to improve patient care and

satisfaction after the end of the pandemic. We appreciate that this, and the continuation of audio-only advance care planning, may require legislation and are separately pursuing that route with Congress.

Hospice Quality Reporting Program

We understand the interest in shifting from the seven “Hospice Item Set process measures” to the Hospice Care Index, but have the following concerns with this proposed change:

- There needs to be more time allowed for hospices to make this change administratively given its magnitude. Hospices should also be given more time to work with this data internally before it is publicly posted, and our members tell us that and the information technology system changes also required will need an additional two years to process.
- We appreciate the concerns about hospice program integrity driving this measure shift but do not want the focus on live discharges to exacerbate the current trend towards patients enrolling in hospice only in the last few days of lifeⁱ. For most people with terminal illness and their families, optimal hospice care should be weeks to months long, versus just days, and so we urge you to ensure that this measure change does not inadvertently discourage appropriate longer lengths of stay.

Future Measure Areas

We support the goal of exploring patient preferences for symptom management, addressing patient spiritual and psychosocial needs, and medication management in outcomes of care in developing quality measures going forward. These are all important aspects of the holistic care hospice provides. We encourage you to work with the hospice industry to develop additional holistic measures, vs piecemeal ones since hospice patients’, and their families’, experience of hospice care is not broken up into different elements or categories. The final outcome of the HOPE process underway is not yet clear to all our hospice members. Some will also need additional capital investment to transition their IT systems to handle this new process, similar to a Health Information Technology for Economic and Clinical Health (HITECH) effort for hospice.

CAHPS Hospice Survey and Star Ratings

We appreciate the efforts to modernize this instrument but our hospice members have expressed concern that the current Star ratings methodology forces ratings into a traditional bell curve and, therefore, may mathematically alter the performance of some hospices to fit this curve. This has always been an issue with Star ratings, but is increasingly so with the move to public reporting of these ratings for hospice.

Requests for Information (RFIs)

Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in Post-Acute Care Quality Programs

Here is our response to this RFI’s pertinent question:

- *In what ways could we incentivize or reward innovative uses of health information technology (IT) that could reduce burden for post-acute care settings, including but not limited to hospice?*

We need to invest in and support the use of IT among community-based organizations that address patients' social needs as such organizations need to be able to better coordinate with health care organizations and information. At present, many of these organizations lack the financial resources or expertise to invest in such IT systems on their own but, as they are an important part of the post-acute world, they need to have interoperable IT to fully participate.

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

- *Comment on suggested parts of SDOH SPADEs adoption that could apply to hospice in alignment with national data collection and interoperable exchange standards. This could include collecting information on certain SDOH, including race, ethnicity, preferred language, interpreter services, health literacy, transportation and social isolation. CMS is seeking guidance on any additional items, including SPADEs that could be used to assess health equity in the care of hospice patients, for use in the HQRP.*

We support the implementation of the standardize SPADEs assessment for hospice and recommend that it be expanded to include culture, spiritual beliefs, and family caregiver attitudes and burden as these also drive hospice care decisions and use. Ideally, we also need to gather self-reported information from those in disadvantaged communities to allow their voices to be heard about their personal experience of health care, since data shows they use hospice less and later than other populationsⁱⁱ.

- *Ways CMS can promote health equity in outcomes among hospice patients. We are also interested in feedback regarding whether including facility-level quality measure results stratified by social risk factors and social determinants of health (for example, dual eligibility for Medicare and Medicaid, race) in confidential feedback reports could allow facilities to identify gaps in the quality of care they provide.*

We support gathering facility-level quality measures stratified by social risk factors and social determinants of health. Many of the hospices serving them are in disadvantaged neighborhoods. These factors combine to cause care disparities and inequities and so should all be monitored on a facility basis. Allowing hospices to safely identify gaps in care, without being initially penalized for them, would allow CMS to both learn more about the reality of equity issues and then help the hospices with resources and plans to address them.

Focusing on the dual eligibility population, many of whom have serious illness, is another way to track such data although, depending on the state where they live and the resources for Medicaid in their state, some "duals" may have better access to hospice care and less disparities than in other states. State and geographic factors, therefore, also need to be factored into health equity monitoring and action plans.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact Marian Grant, Senior Regulatory Advisor, C-TAC, at 443-742-8872 or mgrant@thectac.org.

Sincerely,

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https://www.researchgate.net/publication/7752335_Are_We_Referring_Patients_to_Hospice_Too_Late_Patients%27_and_Families%27_Opinions

ii <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6598325/>