



June 7, 2021

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

RE: Comments on the Proposed FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements Rule [CMS-1754-P]

Dear Administrator Brooks-LaSure,

The National Partnership for Healthcare and Hospice Innovation (NPHI) is pleased to submit the following comments on the U.S. Department of Health and Human Services (HHS) Proposed FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements Rule [CMS-1754-P].

NPHI is a collaborative of over seventy-five of the nation's most innovative, community-based, not-for-profit hospice and palliative care providers that serve as a critical safety net in communities across the United States. Our members collectively serve approximately 120,000 patients daily. Of the almost 5,000 hospice providers in the United States, only 21 percent are not-for-profit and willingly care for the sickest and most vulnerable patients. NPHI members are deeply embedded in their communities and have decades of experience providing the highest quality care for people facing serious illness. This includes providing a comprehensive scope of care to meet each patient's goals, values, and wishes, regardless of the patient's financial situation or prognosis.

The proposed rule, issued by the Center for Medicare and Medicaid Services (CMS) on April 8, would provide routine updates to the hospice base payment rates, wage index, and aggregate cap amount for FY 2022. The proposed rule would also clarify multiple regulatory text changes to the modified Hospice Notice of Election (NOE) Statement and Addendum and proposes to make certain blanket waivers applied to hospice programs due to the ongoing COVID-19 Public Health Emergency (PHE) permanent. Additionally, CMS is proposing a host of changes to the Hospice Quality Reporting Program (HQRP) including the addition of a claims-based Hospice Care Index (HCI) measure and a Hospice Visits in the Last Days of Life (HVLDL) measure for public reporting, along with the removal of the seven Hospice Item Set (HIS) measures in favor of a more streamlined approach. Lastly, among the major proposals, is the inclusion of a Star ratings system into the HQRP no sooner than FY 2022 for public reporting of CAHPS Hospice Survey Results.

Based on these changes, we would like to highlight the following general comments and themes:

- NPHI welcomes CMS's assessment of the hospice industry as one that is rapidly changing both in terms of the providers offering the benefit and the Medicare beneficiaries making use of it. Below we highlight potential areas of concern between how and to what degree the benefit is being offered by different types of providers. More specifically, we agree with CMS's concerns

regarding increasing costs to the Medicare program outside of the MHB, increasing live discharge rates, and the differences in beneficiary characteristics by provider type. We believe CMS should continue to explore the potential inputs that lead to these outcomes.

- NPHI is pleased that CMS has proposed to make permanent two regulatory flexibilities initiated due to the ongoing COVID-19 public health emergency (PHE) and we support these proposals. Furthermore, as CMS considers how to address other regulatory waivers put in place due to the PHE, we encourage them to create a unified and aligned timeline for their removal or modification so that hospice programs can transition operations and patient care in a smooth and efficient manner. We offer further comments, specifically related to telehealth services, below.
- NPHI supports the development of composite measures that reflect the holistic patient and family experience of hospice care. That said, we are concerned that the Hospice Care Index (HCI), as proposed, may not provide patients and families with an accurate or accessible level of differentiation between the quality of different hospice programs. We offer additional, specific commentary on the HCI measures of concern below.

NPHI recognizes the important and timely changes made in the proposed rule and values the opportunity to offer the unique perspective of not-for-profit providers with respect to these specific proposed changes. We offer additional detail and comments on specific policies below.

1. CMS Analysis of Hospice Utilization and Spending Patterns

CMS offers an analysis of hospice utilization and spending patterns such as utilization by level of care, lengths of stay, live discharge rates, and skilled nursing visits during the last days of life. Based on this analysis, CMS highlights that the number of Medicare beneficiaries receiving hospice services has nearly tripled over the course of the past 18 years, from 584,438 in FY 2001 to over 1.6 million in FY 2019. Likewise, expenditures allocated to the Medicare Hospice Benefit (MHB) have risen from \$3.5 billion in FY 2001 to almost \$20 billion in FY 2019. Similar to the increase in Medicare decedents utilizing hospice services, the total number of hospice organizations in the market has increased substantially in recent years, with nearly all the growth coming from for-profit providers. In FY 2019, 68 percent of hospices were for-profit, and 21 percent were not-for-profit. For-profit organizations provided nearly 60 percent of all hospice days, while not-for-profits provided 31 percent of all hospice days while caring for disproportionately more expensive and acute patients.

CMS also indicates that it continues to be concerned about non-hospice spending during an ongoing hospice election by a Medicare beneficiary. Spending for non-hospice Part A and Part B items and services has increased from \$538 million in FY 2016 to \$692 million in FY 2019, an increase of nearly 20 percent. These changes in spending patterns contribute to rising beneficiary cost-sharing amounts of \$170 million for Parts A and B services. CMS continues to believe it would be unusual and exceptional to see services provided outside of the MHB for those approaching the end of life.

NPHI shares CMS's concerns regarding these issues and also the alarming increases in live discharge rates for Medicare beneficiaries who elect hospice and non-hospice spending during a hospice election. Our members have raised similar concerns based on local market patterns and practices over several

years. Therefore, in 2019, NPHI commissioned a similar analysis of hospice utilization data as performed by CMS using the actuarial and consulting firm Milliman¹. The purpose of the report was to analyze how hospices' Medicare margins relate to the characteristics of the Medicare patients served and the characteristics of the hospice itself, focusing on ownership status (i.e., for-profit, non-profit, and governmental).

Our report found that there are several key trends and utilization patterns within the overall hospice industry, including when measured between ownership types. Namely, the report found that:

- Non-profit hospices' average case mix included patients whose terminal diagnoses fell under the following categories: Cancer (31.4%), heart/circulatory system (other than brain) (17.2%), degenerative diseases of nervous system (15.2%), respiratory system (11.6%), and the remaining diagnoses (25%) falling under several other categories.
- For-profit average case mix included patients whose terminal diagnoses fell under the following categories: Degenerative diseases of nervous system (21.9%), cancer (21.9%), heart/circulatory system (other than brain) (20.2%), respiratory system (11.2%), and the remaining diagnoses (25%) falling under several other categories.
- For-profit hospices had an overall live discharge rate of 21%, whereas non-profit hospices had an overall live discharge rate of 12%.
- Patients who were discharged alive from for-profit hospices incurred 40% higher daily Medicare Part A costs in the first two weeks post-discharge than patients who were discharged alive from not-for-profit hospices.

With respect to the patient case mix, we would like to highlight the average percentage of patients with a terminal diagnosis of cancer (31.4%) alongside the average percentage of patients with a neurodegenerative disease (15.2%) that non-profit hospices admit to their programs. By contrast, we note that the average percentage of patients that for-profit hospices tend to admit with a terminal diagnosis of cancer (21.9%) alongside with the average percentage of patients with a neurodegenerative disease (21.9%). There may be several reasons for these differences, including geographic trends, but we believe CMS should further explore the potential inputs that lead to these outcomes and the various potential explanations for rising live discharge rates and Medicare Part A and B spending outside of an ongoing hospice election.

2. Proposed Labor Shares

We neither support nor are opposed to the proposed changes to the calculation of labor shares for the four levels of hospice care. That said, given the inherent differences in the provision of the MHB between different types of hospice providers, we would recommend that CMS monitor any significant disparities in the distribution of labor and non-labor inputs across the hospice industry by program characteristics. We would become concerned, for instance, if data indicates that some providers offer significantly fewer hours of professional interdisciplinary team (IDT) care yet make up a disproportionate

¹ https://www.hospiceinnovations.org/wp-content/uploads/2020/05/Hospice_Medicare_Margins_NPHI_7-2019-1.pdf

percentage of providers filing cost reports. This could lead to unintended negative consequences for those providers fulfilling the true spirit and intent of the benefit. Put simply, if cost reports and other data indicate a widening gap in labor inputs between for-profit and not-for-profit providers, then CMS should investigate this trend further.

3. Clarifying Changes for the Hospice Election Statement Addendum

Since the addendum statement's implementation on October 1, 2020, CMS has received additional inquiries from stakeholders asking for clarification on various aspects of the requirements. CMS has offered six clarifying changes to the regulations regarding the hospice addendum statement:

- CMS proposes to allow the hospice to furnish the addendum within 5 days from the date of a beneficiary or representative request if the request is within 5 days from the date of a hospice election.
- CMS proposes to clarify in regulation that the "date furnished" must be within the required timeframe (that is, 3 or 5 days of the beneficiary or representative request, depending on when such request was made), rather than the signature date.
- CMS proposes that if a patient or representative refuses to sign the addendum, the hospice must document clearly in the medical record (and on the addendum itself) the reason the addendum is not signed in order to mitigate a claims denial for this condition for payment.
- CMS proposes to clarify that a non-hospice provider is not required to sign the addendum if they request the addendum, rather than the beneficiary or representative.
- CMS proposes to clarify that if the patient revokes or is discharged within the required timeframe (3 or 5 days after a request, depending upon when such request was made), but the hospice has not yet furnished the addendum, the hospice is not required to furnish the addendum. Similarly, CMS proposes to clarify that in the event that a beneficiary requests the addendum, and the hospice furnishes the addendum within 3 or 5 days (depending upon when the request for the addendum was made), but the beneficiary dies, revokes, or is discharged prior to signing the addendum, a signature from the individual (or representative) is no longer required.
- CMS proposes to clarify that hospices have "3 days," rather than "72 hours" to furnish the addendum when a patient requests it during the course of a hospice election.

NPHI generally supports these changes as they provide hospices with more operational flexibility to meet the requirements of furnishing the addendum statements. However, we would like to highlight three concerns with the proposed changes:

- Regarding the scenario where a patient or their representative refuses to sign the addendum, the current proposal states that the hospice would need to document the reason for the refusal in both the medical record and on the addendum itself. Given that Medicare Administrative Contractors (MACs) will request both the medical record and the addendum in any retrospective

review, the requirement to document the refusal in two distinct places appears unnecessarily burdensome.

- Regarding the proposal to clarify that hospices have 3 days, as opposed to 72 hours to furnish the addendum, NPHI would like CMS to further clarify whether this includes the election date itself. If so, NPHI would advocate for the date of election to be counted as day 0. Additionally, we are asking CMS to provide additional clarification as to whether “3 days” means 3 working days.
- Should the changes proposed in this rule be adopted in final rulemaking, we would suggest they be applied retroactively so that all potential claims are audited off the same standard by the MACs. We would also suggest to CMS that the associated financial penalty for failing to provide the addendum statement be related only to the days the addendum was requested but not furnished (beyond the specified allowable timeframe) so as not to place an undue financial burden on the entirety of a patient’s claims history.

Separate but related, NPHI continues to seek additional guidance and clarity from CMS on the parameters by which CMS and its audit contractors will determine compliance with the addendum requirement as a condition of participation and a condition for payment.

4. Hospice Waivers Made Permanent Conditions of Participation

CMS proposes to make permanent two regulatory waivers associated with the COVID-19 PHE: (1) the ability to use pseudo-patients for hospice aide competency training and (2) a complementary proposal to allow hospices to address specific deficiencies in a hospice aide’s training.

NPHI appreciates and welcomes CMS’s efforts to begin to phase in certain Section 1135 waiver flexibilities as permanent parts of the hospice benefit. We strongly support both proposals. Relatedly, NPHI 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 PHE.

Generally, there are three broad themes CMS should consider when determining which COVID-19 flexibilities to make permanent, terminate, or otherwise modify:

- The emergence of telehealth technology has been a great resource to complement the core strengths of the hospice benefit. Telehealth in hospice should be permanently enabled and regulations and quality measures should recognize and credit the delivery of telehealth visits. However, CMS and HHS should create guardrails to limit the potential for diluting the core aspects of the hospice benefit.
 - We might suggest, for instance, that an initial plan of care (POC) needs to be established in-person when possible. Once a POC has been established, then more frequent virtual touches could be expected to enhance the quality of care and support provided to family members. However, once there is any change in the POC, an in-person visit(s) should be expected until the new POC is established. This process would need to be repeated whenever there is a need for a change in the POC.

- When considering the end and phase out of certain COVID-19 flexibilities, we encourage HHS and CMS to recognize that hospice programs may continue to care for terminally ill COVID-19 positive patients beyond the end of the PHE and the disease may continue in perpetuity on a seasonal basis. Therefore, hospices should continue to have access to COVID-19 regulatory flexibilities for a duration of time (e.g., six to twelve months) after the PHE declaration is allowed to expire.
- For phasing out certain flexibilities we also encourage HHS and CMS to create a unified and aligned timeline for their removal so that hospice programs can transition operations and patient care in a smooth and efficient manner. Aligning the phase-out dates for hospice flexibilities will also help reduce any confusion and administrative burden.

5. Proposals and Updates to the Hospice Quality Reporting Program

a. Proposal to Remove the Seven Hospice Item Set Process Measures from HQRP Beginning FY 2022

We support removal of the individual components of the HIS Comprehensive Assessment Measure from Care Compare. Simultaneously, we suggest that CMS not report any aspect of the HIS measures due to concerns around whether the measures are a true indicator of a hospice’s quality of care. More generally, we encourage CMS to move away from process measures influenced by administrative decisions and towards outcomes-based measures. We look forward to future rulemaking regarding the HOPE assessment as a tool to potentially enable this migration.

In the case of the HIS measures, we feel that CMS is equating the performance and documentation of seven processes during a single point in care as a measure of quality. Achieving a score of 100% on each individual measure is relatively straightforward for many hospices because their electronic health record (EHR) forces clinical staff to answer the question before they are able to sign and lock their visit note. On the other hand, some EHRs are not set up with automatic stops so staff may simply miss filling in a blank after performing the process. This does not mean that one hospice assessed the measure, and another did not perform. Instead, it indicates disparities regarding EHRs and documentation that exist at individual hospices.

In addition, the HIS measures are captured only at a single point in time. They fail to show that a hospice provides ongoing comprehensive assessments. CMS indicates that the HIS Comprehensive Assessment Measure “continues to provide value to patients, their families, and providers.” This may be true for a single point in time but does not indicate the quality of care over the entire hospice election period. We suggest that CMS note on the Care Compare website that the measure is captured only at admission and may not be reflective of subsequent care.

b. Proposal to Add a “Claims-Based Index Measure”, the Hospice Care Index

As part of its broader changes to the HQRP, CMS proposes to add the Hospice Care Index (HCI), which would be a new composite quality measure. CMS indicates the purpose of the HCI would be to “provide more information to better reflect several processes of care during a hospice stay, and better empower patients and family caregivers to make informed health care decisions.” As proposed, the HCI is a single measure comprising of ten indicators calculated from Medicare claims data. The maximum (“best”)

score on the measure is ten while the lowest (“worst”) score is zero. A hospice would receive a score of either zero or one on each indicator and each indicator is weighted equally.

NPHI generally supports the addition of composite measures that reflect the holistic patient and family experience of hospice care from an interdisciplinary care team. However, the HCI as proposed is not likely to provide patients and families with an accurate or easily understandable level of differentiation between the quality of hospice programs. The complexity of multiple numerators and denominators that result in unique binary scores which are then aggregated creates a complicated matrix for consumers to digest.

We are generally concerned with six areas of the HCI:

- Based on an Abt Associates analysis of the correlation between projected hospice scores on the HCI and the percentage of caregivers who would “definitely” recommend a hospice, there is not a sufficient amount of differentiation between hospices that score a ten on the HCI and a seven or less. Based on the correlation, patients are only three percent more likely to recommend a hospice that scored a ten on the HCI compared to a hospice that scored a seven or less.
- Additionally, based on the same analysis, 85% of hospices would score an eight or higher on the HCI using FY 2019 data. This does not indicate that the index would be a reliable resource for beneficiaries to use to differentiate between hospice programs since the HCI is already approaching “topped-out” status.
- The significance of a difference in scores between two hospices (e.g., Hospice A scores an eight and Hospice B scores a seven) is not clear from a statistical perspective. This will be significant if the measure is publicly displayed as patients will be more likely to choose higher scoring hospices despite the possibility that there may not be a significant difference between a higher and lower score.
- We have issues with the sub-specifications of several of the indicators that make up the HCI. We understand that a hospice’s performance on any one indicator should not be an issue as there are a total of ten; but several indicators need further refinement and in the absence of this refinement we believe hospice performance will not be accurately captured using the HCI.
- CMS suggests that the ten indicators included in the HCI are a combination of measures focused on patient quality of care and program integrity. The HCI would be more useful to patients if these two types of measures were separated out and applied under different contexts, separating utilization and cost measures from clinical intervention measures.
- The HCI currently seeks to measure certain aspects of patient quality of care through an analysis of claims data, when in some cases claims data may not be an appropriate source. We would like to highlight that CMS is currently testing the Hospice Outcomes and Patient Evaluation (HOPE) assessment to standardize the patient assessment and outcomes information. The HOPE assessment may be a more appropriate tool to collect patient quality of care information instead of claims data.

Below we offer specific comments on certain measures found in the HCI:

- Gaps in Nursing Visits Greater Than Seven Days
 - We agree with the significance of measuring how often hospice stays contain gaps of eight or more days without a nursing visit. This is an essential practice to help hospices understand how to better serve patients. We recommend that telehealth visits should also be counted towards this measure due to the ongoing pandemic and the likely increased use of telehealth by hospice programs in the long-term. Currently, CMS does not allow hospices to report telehealth visits on claims which presents a barrier to measuring the frequency and adequacy of telehealth visits. This measure should include these telehealth visits. We would also recommend that Licensed Practical Nurse visits be included into the measure of “nurse” visits.
 - Additionally, the measure’s claims-based approach limits the ability to which hospices can recognize that patients may have chosen to decline a visit. Hospices can document and acknowledge a patient’s preference in their medical record but would be penalized under this measure because claims data currently cannot capture this patient preference.

- Nurse Minutes Per Routine Home Care (RHC) Day
 - We agree with the significance of measuring the degree to which nurses play a role in the care of a hospice patient and their family. However, by only measuring the role of the nurse, this indicator takes on the form of a program integrity measure rather than a comprehensive assessment of patient quality of care. The MHB is an interdisciplinary benefit that uses a number of different professionals, such as social workers and chaplains. If this indicator is intended to help patients understand quality of care, we recommend that it capture a much broader array of visit types and that it focuses on the provider’s capacity to complete any type of visit by the IDT, not that it relies specifically on nurse minutes.

- Live Discharges in the First Seven Days of Hospice and Live Discharges on or After the 180th Day of Hospice
 - We agree with the intent and significance of measuring the rate of live discharges as hospices who are outliers may have questionable practices. However, this measure falls under the category of program integrity and would be better suited in a different context than the HCI. We would also like to recommend that revocations be excluded from this measure as revocations are the explicit right of a patient and should not be counted against the performance of an individual hospice on this measure.
 - As an example of the above, an acutely ill patient may be transferred to a hospice inpatient unit (IPU). Once symptoms are managed, the family may opt for placement in a skilled nursing facility (SNF) because they are no longer able to care for the patient at home. The SNF recommends use of the Medicare Part A SNF benefit so that the patient will have no out-of-pocket expenses for at least 20 days. From a financial standpoint this is clearly the best option, so the patient chooses to revoke their hospice election. In this case, the patient’s choice to revoke the hospice benefit is not a reflection of the quality of hospice care provided. That said, some industry bad actors may employ a strategy of

hiding or otherwise manipulating revocations to mask live discharges; CMS should remain vigilant of this possibility.

- Burdensome Transitions (Type 1 And Type 2)
 - In a similar vein and with consideration for the nuances mentioned above, we would also recommend for this measure's specifications to also exclude patient revocations. Additionally, we believe the timeframe for transitions to a hospital and back to a hospice to be extended from two days to seven days. This would align with past NQF MAP recommendations on transitions of care.
- Medicare Spending Per Beneficiary (MSPB)
 - We do not agree with the inclusion of this indicator as there are several factors that influence overall spending per beneficiary that are not necessarily tied to patient quality of care. Additionally, this measure is better suited for program integrity purposes rather than inclusion in a patient quality of care index. From a patient perspective, there may be a significant number of individuals who correlate higher spending with higher quality of care and thus may misinterpret the intent of this indicator.
- Percentage of Nurse Minutes on Routine Home Care (RHC) Days Performed on Weekends
 - We agree with the intent of including this measure as hospices should make available the appropriate staff during any day of the week. However, this claims-based measure cannot capture patient preferences when a family may not want a weekend visit that they view as a disruption. Often a patient's family has more availability on a weekend due to work schedules, thus there is less need for hospice visits. Instead, the HOPE assessment may be a more appropriate source of information to capture whether hospices significantly deviate because of potential failure to make staff available for weekend visits.
 - In addition, we request that CMS allow reporting of nursing phone calls. Many symptom management issues can be, and are best, handled by phone because it allows prompter administration of medications and other interventions. A nurse can provide instructions and then follow up with a second phone call to ensure resolution of symptoms and achieve the same outcome. As with other measures, we are concerned that visits by other members of the IDT are not included. As an example, patients and their families may be better cared for by having a social worker visit on Saturday or Sunday and those visits ought to be included in this measure.
- Visits Near Death
 - We agree with efforts to increase the likelihood that a hospice patient will be visited near death. However, we maintain our fundamental concern that predicting the timing of death is often unclear to the provider and can happen suddenly without their knowledge. This measure is further complicated by the fact that some families do not want visits from hospice staff during such an intimate time. In this case, we propose that the day of death be excluded from the calculation of this measure.

c. Proposal to Add CAHPS Hospice Survey Star Ratings to Public Reporting

NPHI agrees with CMS's goal of creating a more consumer friendly version of the HQRP and we would like to further discuss an additional set of improvements to the overall display of Care Compare. However, NPHI is concerned with the current methodology for calculating a program's Star ratings. Namely, the current methodology would create relative benchmarks to determine which programs receive a certain Star rating. In the absence of fixed benchmarks, hospice programs will not have any insight into the level of effort they must undertake to improve their publicly reported ratings. CMS should strive to create a more consistent set of expectations about when and how programs can achieve a particular Star rating. Furthermore, to ensure that hospices do have insight into the potential impacts of a new consumer-facing quality measure, we would suggest that calculations be made available to hospices before they are publicly reported.

One potential solution would be to calculate an initial set of relative benchmarks for hospice performance and then update them on a multi-year frequency. This would blend the need for a consistent set of benchmarks with the need to evaluate performance relative to an industry benchmark. For example, CMS could calculate the cut-off points for certain Star ratings using a benchmark year and apply those cut-off points for the next three to five performance years. After the end of the three to five performance years, CMS could then recalculate the cut-off points to reflect improvements in industry standards. Additionally, to encourage consistency among measures and in terms of measuring performance and improvement over time, CMS could consider aligning all quality measures with the same one-year timeline.

An additional area of concern for NPHI member programs is that CMS proposes to report a Star rating for hospices with at least 75 completed surveys. Considering an average return rate of less than 35%, an individual hospice would need at least 215 surveys mailed to reach the 75-survey threshold. For the generic hospice with an average daily census (ADC) of 10-15, we are concerned they would be unable to meet this requirement. We would suggest CMS consider lowering the total number of completed surveys required across the board, or specifically for hospice providers with an ADC below a certain number.

6. RFI on Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in Post-Acute Care Quality Reporting Programs

We appreciate the opportunity to provide feedback to CMS on FHIR in support of dQM in the hospice industry. Unfortunately, the hospice industry writ large is currently burdened by disparate EHR platforms that do not support technological capabilities across all post-acute service lines on a single platform, nor integrate palliative care services.

These challenges inhibit hospices' ability to integrate information seamlessly and securely across communities and collaborate on the most effective treatments to continually enhance outcomes for those in their care. Without a unified platform, the time and resources that would be required to capture and deliver complex health information with the ease and flexibility of those currently used by the rest of the health care industry would create a significant operational burden and would require the use of dollars otherwise used for supporting a hospice's clinical mission. Notwithstanding that, in order to optimize patient care, many hospice providers currently share information with other health care

providers by paper, phone, secure email, or fax despite the limitations associated with adopting Certified EHR (CERT) technology.

We would suggest, simultaneous to efforts targeted at hospice providers, that CMS work to incentivize providers of technology and service solutions in the design, development and delivery of CERT solutions and platforms for the hospice industry before pursuing efforts to implement dQM. Below we offer comments on some of the specific questions posed by CMS.

- Prompt: What EHR/IT systems do you use and do you participate in a health information exchange (HIE) Department of Health and Human Services. National Health Quality Roadmap. May 15, 2020. Available at: <https://www.hhs.gov/sites/default/files/national-health-quality-roadmap.pdf>
 - Response: There are a variety of EHRs in use in the hospice industry including, Suncoast (Complia), Netsmart, Casamba, WellSky, Matrix Care, etc., among others. Participation in an HIE is not common for hospices. Of the states that do have an active HIE and have invited hospices to participate, adoption has been slow due to the fact that most hospices have not seen a significant advantage given that many patients choose to see only the hospice physician. Also, some hospice EHRs have not been set up to make the connection to the HIE.
- Prompt: What ways could CMS incentivize or reward innovative uses of health information technology (IT) that could reduce burden for post-acute care settings, including but not limited to hospices?
 - Response: CMS could provide grants for the initial implementation of an EHR for a hospice. The use of an EHR for many small hospices is cost prohibitive and once implemented, it may be difficult for the provider to allocate the necessary staff resources to remain proficient with the system. Training of staff and system maintenance both require time and valuable resources. We would suggest that CMS provide grant support to hospices of all sizes, but especially those with a smaller ADC, to subsidize the cost of purchasing and maintaining devices (laptops, tablets, etc.) for clinical staff.

7. RFI on Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs

We welcome CMS's commitment to and interest in closing the health equity gap among beneficiaries in post-acute care settings, specifically hospice. Our member programs have decades of experience as safety-net providers in their respective communities treating underserved and disadvantaged populations. It is the mission of our not-for-profit member organizations to serve anyone, at any time, regardless of their ability to pay. Promoting health equity and ensuring patient access have been cornerstones of our mission for years and we support the same philosophy being developed within the regulatory apparatus that hospice providers operate. Below we offer comments on some of the specific questions posed by CMS.

- Prompt: Recommendations for quality measures, or measurement domains that address health equity, for use in the HQRP.
 - Response: Given the inherent commitment by NPHI member programs to the IDT approach to care, these hospices are well equipped to and have traditionally

assessed and managed the whole person. It is natural that quality measures relating to SDOH be addressed with the goal of eliminating disparities in end-of-life and advanced illness care. Quality measures focused on these issues should be expanded to include the caregiver in some instances.

- The following measurement domains should be considered:
 - Social Needs:
 - Care coordination
 - Food insecurity
 - Transportation
 - Health literacy and understanding
 - Cultural competence
 - Behavioral Health Needs:
 - Screening as necessary for distress, anxiety, anticipatory grief
 - Social isolation
 - Medical needs:
 - Advance directives
 - Medical and clinical care
- Prompt: 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.
 - Response: We suggest that CMS reconsider the use of the SPADEs acronym, as it has historically racial undertones that relate to the Black and African American communities (Tinsley-Jones, H. (2003). Racism: Calling a Spade a Spade. *Psychotherapy: Theory, Research, Practice, Training*, 40(3), 179–186.)². As CMS is working to address health equity, attention should be paid to acronyms and program names which may need to be examined and reviewed for any negative historical connotations.
 - In addition to adding standardized elements for SDOH, the hospice industry and CMS need to improve data collection on patient characteristics such as, race, ethnicity, language/preferred language, gender preferences/identity, and sexual orientation. Having access to these data elements will help to identify gaps in populations served.
- Prompt: Methods that commenters or their organizations use in employing data to reduce disparities and improve patient outcomes, including the source(s) of data used, as appropriate.
 - Response: Some organizations are utilizing Medicare claims data and race, ethnicity, and language data as resources to measure disparities and then creating specialized programs that are culturally sensitive and appropriate based on the specific racial, ethnic, or underserved group. These could include faith-based initiatives, language specific initiatives, or other program development initiatives intentionally and

² <https://doi.org/10.1037/0033-3204.40.3.179>

thoughtfully prepared for specific demographic groups.

- Prompt: Given the importance of structured data and health IT standards for the capture, use, and exchange of relevant health data for improving health equity, the existing challenges providers' encounter for effective capture, use, and exchange of health information, such as data on race, ethnicity, and other social determinants of health, to support care delivery and decision making.
 - Response: SDOH-related Z codes can be utilized. These Z codes range from Z55-Z65 and are the ICD-10-CM encounter reason codes used to document SDOH data. Utilizing Z codes would help to standardize data across providers, identify gaps, and ultimately improve quality and raise health equity.

Conclusion

Thank you again for the opportunity to provide comment on CMS's proposed regulation regarding the FY 2022 Hospice Wage Index and Payment Rate Update. Moreover, we would like to thank CMS for its leadership and essential efforts throughout the ongoing COVID-19 PHE. As always, NPHI appreciates the opportunity to provide insight and commentary into how various proposed regulatory, compliance, and quality reporting changes may impact the not-for-profit hospice and palliative care provider community. If you have any questions concerning these comments or would like to discuss these issues further, please contact NPHI President Carole Fisher at carole@hospiceinnovations.org.

Sincerely,

A handwritten signature in blue ink that reads "Tom Koutsoumpas". The signature is fluid and cursive, with the first name "Tom" written in a larger, more prominent script than the last name "Koutsoumpas".

Tom Koutsoumpas
Founder and CEO
NPHI