May 27, 2021

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

Submitted electronically to http://www.regulations.gov

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

Dear Administrator Brooks-LaSure:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the opportunity to comment on this Medicare hospice proposed payment rule. Our comments will focus on the comment solicitation regarding hospice utilization, proposed changes to the hospice conditions of participation regarding hospice aide competency evaluation standards, aspects of the hospice quality reporting, and the requests for information regarding the support of digital quality measurement and closing the health equity gap in quality reporting programs.

Comment Solicitation on Analysis of Hospice Utilization and Spending Patterns

AARP supports the intent of the Service Intensity Add-On (SIA) payment to reflect the higher costs associated with the last 7 days of life when direct patient care is provided by a registered nurse (RN) or social worker. The increased payment is intended to help ensure beneficiary and family access to RN and social worker visits and the important care and support they provide at the very end of life. The trends are not encouraging, as the data over several years continue to show modest improvement in the number of beneficiaries receiving these visits and in the intensity of these visits (as measured by average number of minutes) during the last days of life, while the SIA payments have almost doubled. We urge CMS to evaluate the reasons why this policy has not been as effective as designed and whether future payment modifications to the policy are warranted. In addition, CMS should review the correlation between the use of the SIA payment with the new Hospice Visits in the Last Days of Life quality measure.

Hospice Waivers Made Permanent Conditions of Participation

AARP opposes CMS revising its hospice regulations at §418.76(c)(1) to permit skill competencies to be assessed by observing an aide performing the skill with either a patient or a
pseudo-patient as part of a simulation. We prefer to maintain the current regulations that require the aide to be evaluated by observing an aide’s performance of the task with a patient. While we understand the need to waive this requirement to permit more flexibility during the COVID-19 public health emergency (PHE), we believe more evaluation and study is needed to determine whether allowing a pseudo-patient to replace a patient observation as a permanent policy would best serve patients and protect patient health and safety. There is insufficient information in the proposed rule to make this determination. For example, what proportion of aides are already certified prior to hire and to what extent does their training involve direct patient care? We also are concerned about the potential variation in training received by hospice aides given that most aides are usually trained by an employer, such as a hospice, home health agency, or nursing home. We urge CMS to reconsider this policy. In addition, given the hospice focus on quality of life and person-and family-centered care, there may be intangibles and interpersonal aspects of care that are best evaluated with actual patients.

For similar reasons, AARP also opposes CMS’ proposal to allow the hospice to focus on the hospice aides’ specific deficient skill(s) (if an area of concern for a hospice aide is identified during an on-site visit) instead of completing a full competency evaluation as defined at §418.76(h)(1)(iii). Again, this policy while more appropriate during the COVID-19 PHE, needs additional study and further consideration before making this change permanent. We have concerns about weakening competency requirements and more compelling information is needed to evaluate whether such a proposal would be in the best interests of beneficiaries. If, for example, an aide has multiple deficiencies would it be more prudent to conduct a full evaluation? This proposed policy also assumes competencies are equal in weight whereas failure in a certain competency could be so egregious that a hospice aide should be required to complete a full competency evaluation. For these reasons, we urge CMS to reconsider this policy and conduct further study on this issue before moving forward.

Hospice Quality Reporting Program

AARP supports CMS’ commitment to the Meaningful Measures Initiative and developing quality measures that provide a comprehensive overview of the quality of care furnished by a hospice. We support CMS’ proposal to add a claims-based measure, the Hospice Care Index (HCI) that will provide information about several care processes that are important to beneficiaries and their families when selecting a hospice provider. We believe the HCI measures focused on nursing care, including skilled nursing minutes on weekends (HCI Indicator Eight), will help focus hospices to ensure providing critical hospice services. AARP urges CMS to include not only the final HCI score on Care Compare, but to consider making the component indicators available for those who may be interested in that information. We also support CMS’ proposal to remove the seven Hospice Item Set (HIS) process measures and instead use the HIS Comprehensive Assessment Measure (NQF #3235) which differentiates hospices’ overall quality for assessing both physical and psychosocial needs at the time of admission.

AARP appreciates CMS’ commitment to make hospice quality measure data available to the public and supports CMS’ proposal to provide additional information on Care Compare (formerly Hospice Compare). We also believe that the CAHPS Hospice Survey provides
invaluable information and support CMS’ proposal to introduce Star Ratings for public reporting of CAHPS Hospice Survey results on Care Compare. We appreciate that CMS will use a star rating system similar to what is used for reporting other CAHPS programs, including the Home Health CAHPS, but it is essential that CMS focus test the star ratings for the Hospice CAHPS to ensure the system is understood by consumers seeking information about hospices. We also appreciate CMS’ efforts to update the CAHPS Hospice Survey measures and minimize the impacts related to reporting information during the COVID public health emergency. We support CMS’ proposal that will allow CMS to begin publicly reporting data from the third and fourth quarter of 2020, along with data from the first quarter of 2021, in February 2022.

**Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in CMS Quality Programs**

AARP appreciates the agency’s planning for transformation to a fully digital quality enterprise. As part of this effort, we continue to believe that it is important to strengthen recognition, inclusion, and support of family caregivers in Medicare. Family caregivers should be identified in electronic records (as well as paper records) of the person they are assisting so they can appropriately be part of their loved one’s care team if a care or service plan depends on having a family caregiver. In some cases, this may mean identifying a primary family caregiver and/or other caregivers (including a health care agent or guardian) who take on particular roles or assist their loved ones with specific tasks. This is especially relevant in hospice, which is providing services and support directly to the Medicare beneficiary and their family. Family caregiver identification facilitates engagement, communication, and coordination with the caregiver, as well as the provision of caregiver support, as appropriate. Including this information would be an important step for further development of quality measures related directly to family caregivers. The individual (or their representative, if appropriate) would be given the opportunity to identify their family caregiver(s).

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

AARP commends CMS for examining ways in which measurement in its quality reporting programs can close the health equity gap. The COVID-19 PHE has highlighted the stark racial and ethnic disparities affecting health outcomes for communities of color across the country. While there is a growing body of data that shows African Americans/Blacks, Hispanics, and American Indians and Alaska Natives are disproportionately impacted by the pandemic with higher rates of infection and death, more complete racial and ethnic data is still needed. Furthermore, there is insufficient data to fully demonstrate the impact of COVID-19 on Asian American and Pacific Islander (AAPI) communities, but some disaggregated data show mortality rates that are disproportionately high among some populations. While racial and ethnic disparities long existed before this crisis, the ongoing coronavirus pandemic has sent a clear message—perhaps louder than ever—that now is the time to work collectively to address the
systemic inequities, discrimination, and harmful social determinants of health that have led to these disparities.

In order to address health inequities across the country, including those occurring within hospices and other long-term care facilities, it is important that the federal government gather data and publicly report its quality metrics broken down into multiple demographic categories—while protecting patient privacy. This could include race, ethnicity, age, socioeconomic status, sexual orientation, gender identity, spoken/written language, and disability. Collection, analysis, and regular public reporting of the detailed disaggregated information will help policymakers effectively understand and respond to disparities that have been exacerbated by the COVID-19 PHE.

AARP firmly believes that ensuring health care equity promotes better quality for all older Americans. We also believe that lessons learned during the PHE can help inform development of measures that will begin to close the health equity gap in post-acute care quality programs. The fundamental importance to good policymaking of collecting data that are accurate, comprehensive, and actionable is unassailable. In this regard, the experience of AARP’s Public Policy Institute in tracking the COVID-19 PHE’s impacts is informative. We have found that state public reporting of COVID-19 data by race and ethnicity has been fraught with incomplete information, missing data, and inconsistencies in labeling racial and ethnic groups. We strongly recommend that development of any measure that involves race and ethnicity rest on the following principles:

- Data definitions must be valid, clear, and uniformly applied to facilitate data collection and ensure data reliability. A good place to start for developing categories of race is the U.S. Census Bureau;
- Race and ethnicity are distinct constructs and should be separately reported;
- Measure specifications must be clearly designed and readily applied in a consistent manner (e.g., explicit inclusion and exclusion criteria, not implied);
- Rates rather than raw numbers are necessary for proper data analysis and meaningful comparisons; and
- Transparent reporting of the volume of missing data (e.g., percent unknown or otherwise absent data points or responses) is critical to accurate analysis and justifiable conclusions.

While we believe that a first important step is identifying and measuring disparities, CMS also needs to better understand the reasons why hospice utilization is lower for racial and ethnic beneficiaries compared to White beneficiaries. Almost 90 percent of beneficiaries in nonprofit hospices, for example, are White compared with only 7 percent Black and less than 2 percent for Hispanic and Asian beneficiaries. In addition, a recent study showed racial differences in the use of hospice services between black and white individuals with cardiovascular disease with black

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individuals less likely to receive hospice care.\textsuperscript{2} A better understanding of the factors that may impede access or create reluctance to use hospice services is necessary to develop policy and payment solutions. These factors are likely complex and multifaceted and may include cultural aspects, such as the role of a family caregiver.

AARP appreciates the opportunity to comment on this important proposed rule. We urge CMS to keep the needs of hospice patients and their families front and center as you finalize this rule and make longer-term policy decisions. If you have questions, please contact me or Rhonda Richards (rrichards@aarp.org) on our Government Affairs staff at (202) 434-3770.

Sincerely,

David Certner
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Government Affairs

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