Missouri Alliance for **HOME CARE**

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NAHC ANALYSIS OF THE FY2022 HOSPICE PAYMENT RULE

Despite the continuing Public Health Emergency (PHE) generated by COVID-19, the Centers for Medicare & Medicaid Services (CMS) is pushing forward with significant changes for hospice as evidenced by release of Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements.

In addition to a proposed payment update projected at 2.3% and aggregate cap value of $31,389.66, the expansive rule contains a wide variety of proposed changes and solicits feedback on a number of far-reaching issues, including:

- Feedback on CMS hospice utilization data, spending outside of hospice, determinations of relatedness/unrelatedness, visits in the last week of life, and other issues
- Revision and rebasing of the labor shares of the hospice payment rates
- Clarifications to the regulations governing the election statement addendum requirement that was implemented on October 1, 2020
- Making permanent select regulatory blanket waivers that were issued during the COVID-19 PHE
- Inclusion of a new claims-based Hospice Care Index (HCI) measure as part of the Hospice Quality Reporting Program (HQRP)
- Removal of the seven Hospice Item Set (HIS) measures
- Updates on progress related to development of the HOPE assessment instrument
- Details on modified plans for refresh of data due to the COVID-19 PHE exemptions
- Addition of a CAHPS Hospice Survey star rating
- A Request for Information (RFI) on adoption of a standardized definition of Digital Quality Measures (dQMs) across Quality Reporting Programs and the potential use of Fast Healthcare Interoperable Resources (FHIR) for dQMs within the HQRP (FHIR is an open source standards framework used in both commercial and government settings created by Health Level Seven International that establishes a common language and process for all health information technology)
- A Solicitation of Comments to assist in transformation of CMS' quality measurement enterprise to be fully digital
- A RFI on closing the health equity gap in post-acute care quality reporting programs
- A Solicitation of Public Comment on whether activities related to measures adopted as the result of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act should be expanded for potential utilization under the HQRP (like aspects of SPADES)
- Changes to the Home Health QRP

This article will provide the National Association for Home Care & Hospice's (NAHC's) initial, high-level summary of the proposed rule. Many portions of the rule require additional analysis, which we will be providing at a later date.

In the interim following are links to relevant resources that may be useful:

- Proposed Rule Permalink
- FY2022 Proposed Wage Index Tables

Section III.A: Hospice Utilization and Spending Patterns

As is usually the case, as part of the proposed rule, CMS provides analysis of hospice spending and utilization patterns. However, CMS is continuing to analyze the effects of the COVID-29 PHE, so its data analysis is limited to the most complete data available from FY2019. While numerous items were covered as part of this section, there are particular items of note, including that hospice average length of election, median lifetime length of stay, and average lifetime length of stay have all increased between FY2018 and FY2019. Average live discharge rates remain stable at approximately 17% per year, with 37.5% of live discharges being attributable to revocations and 37.2% due to the beneficiary being determined no longer eligible for hospice care.

Service Intensity Add-on payments applicable to the final week of life have increased from $88 FY2016 to $150 million in FY2019, although total amount of minutes of care provided by skilled nurses and social workers in the last 7 days of life have changed only modestly from CY2015 to CY2019. Medicare paid over $1 billion for non-hospice spending under Parts A, B, and D during hospice elections in FY2019, representing an increase in non-hospice spending under Parts A and B of 18.7% between FY2016 and FY2019. Non-hospice spending for Part D drugs increased from $353 million in FY2016 to $499 million in FY2019.

CMS references a notable increase of spending for Part D drugs that CMS classifies as "maintenance" drugs. These data are of note because CMS believes that some spending outside of hospice while patients are on service represents potential "unbundling" of hospices' responsibilities under the benefit.

CMS is seeking comments on all aspects of the utilization analysis provided in the proposed rule, including:

- How changes in patient characteristics may have influenced any changes in the provision of hospice services
- Skilled visits in the last week of life and particularly what factors determine how and when visits are made as an individual approaches the end of life
- Information surrounding hospices' determinations as to what items, services, and drugs are related versus unrelated to the terminal illness and related conditions, and on what other factors may influence whether/how certain services are furnished under hospice

- Whether the hospice election statement addendum has changed the way hospices make care decisions and how the addendum is used to prompt discussions with beneficiaries and non-hospice providers to ensure beneficiary care needs are met

Section III.B. FY2022 Proposed Labor Shares

In recent years CMS has indicated an interest in potential changes to the labor/non-labor shares of the hospice payment rates, particularly given the collection of expanded data as part of the revised hospice cost report. As part of the FY2022 rule, CMS is proposing to rebase and revise the labor shares for Continuous Home Care (CHC), Routine Home Care (RHC), Inpatient Respite Care (IRC), and General Inpatient Care (GIP) using 2018 cost report data for freestanding hospices. CMS elected not to use provider-based cost reports because few providers passed the Level I edits, so these reports were not usable. CMS plans to maintain separate labor shares for each level of care, and base them on the calculated compensation cost weights for the particular level of care.

As part of its proposed methodology, CMS is proposing to derive a compensation cost weight for each level of care based on five major components:

1.) Direct patient care salaries and contract labor costs – costs associated with medical services provided by medical personnel including physicians, RNs, and hospice aides

2.) Direct patient care benefits costs

3.) Other patient care salaries – salaries attributable to patient transportation, labs, imaging services, and other services

4.) Overhead salaries and

5.) Overhead benefits costs

Total compensation costs for each provider would be calculated by summing costs of the five components listed above for each level of care.

In order to develop the compensation cost weights, CMS identified a sample of providers that met the Level I edits, then further trimmed the sample to meet certain data standards depending on the level of care. CMS only used cost report data from hospices that provide inpatient services directly through their own facilities. Then, to derive the proposed compensation cost weights for each level of care for each provider, CMS divided the compensation costs for each level of care by total costs for each level of care, and trimmed the data for each level of care to remove outliers.

CMS arrived at the following proposed labor shares by level of care, as compared with current labor shares:

	Proposed Labor Shares	**Current Labor Shares**
Continuous home care	74.6 percent	68.71 percent
Routine home care	64.7 percent	68.71 percent
Inpatient respite care	60.1 percent	54.13 percent
General inpatient care	62.8 percent	64.01 percent

NAHC will be conducting further analysis of the appropriateness of the proposed changes to the labor shares.

Section III.C: Proposed Routine FY 2022 Hospice Wage Index and Rate Update

As part of the FY2021 Hospice Wage Index final rule, CMS incorporated changes from recent OMB bulletins that impacted wage index values for hospice and other providers of sufficient magnitude that CMS imposed a 5% cap on any decrease in a geographic area's wage index between FY2020 and FY2021. There are no such changes anticipated or proposed for FY2022, although hospice providers must take note that the 5% cap on any reduction in the wage index value (applied for FY2021) will be lifted for FY2022, and the full impact of the FY2021 changes will be felt.

CMs has indicated that, as part of the FY2022 IPPS (Hospital) rule the agency is proposing to rebase and revise the IPPS market baskets (upon which the hospice wage index is based) to reflect a 2018 base year. Additional information will be available when the hospital rule is published.

The proposed hospice payment update percentage for FY2022 is based on the current estimate of the proposed inpatient hospital market basket update of 2.5%, less the economy-wide productivity adjustment currently estimated at 0.2 percentage points.

The proposed hospice payment update percentage for FY2022 is currently estimated at 2.3%. If more recent data becomes available prior to publication of the final hospice payment rule this summer, these values will be subject to change.

Based on the estimated 2.3% payment update, CMS is proposing the following payment rates for FY2022*:

Description	FY2021 Payment Rates	Proposed FY2022 Payment Rates
Routine Home Care (days 1-60)	$199.25	$203.81
Routine Home Care (days 61+)	$157.49	$161.02
Continuous Home Care	$1,432.41 ($59.68/hour)	1,465.79 ($61.07/hour)
Inpatient Respite Care	$461.09	$474.43
General Inpatient Care	$1,045.66	$1,070.35

*Hospices that fail to comply with the HQRP reporting requirements will be subject to a 2% reduction of the above rates. Further, these rates do not reflect the 2% Medicare sequester.

The proposed hospice cap amount for FY2022 is $31,389.66. As with the hospice payment rates, this value is subject to change between now and the final rule.

Section III.D: Proposed Clarifying Regulation Text Changes for the Hospice Election Statement Addendum

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484), CMS finalized modifications to the hospice election statement and included a new condition for payment requiring a hospice, upon request, to provide the beneficiary (or representative) an election statement addendum outlining the items, services, and drugs that the hospice has determined are unrelated to the terminal illness and related conditions. (See the most recent information about these changes in this NAHC Report article.) A signed addendum connotes that the hospice discussed the addendum and its contents with the beneficiary (or representative).

Additionally, in the event that a beneficiary (or representative) does not request the addendum, CMS expects hospices to document, in some fashion, that an addendum has been discussed with the patient (or representative) at the time of election, similar to how other patient and family discussions are documented in the hospice's clinical record. In this FY2022 proposed rule CMS states that it is necessary for the hospice to document that the addendum was discussed and whether or not it was requested, in order to prevent potential claims denials related to any absence of an addendum (or addendum updates) in the medical record.

NAHC is pleased that as part of this proposed rule CMS addressed some of the outstanding questions and issues about the election statement addendum that NAHC brought to the agency's attention. Specifically, NAHC shared with CMS that the addendum is sometimes not requested at the time of election but is requested within the five days after the effective date of election. In these situations, the request is considered to be made during the course of care, requiring the hospice to provide the addendum within three days. This may actually require the hospice to provide the addendum before the five-day comprehensive assessment period ends. This places unnecessary burden on the hospice and the beneficiary to complete the assessment prior to when it would otherwise be completed. NAHC recommended CMS consider revising guidance for situations where the addendum is not requested at the time of election, but is requested within the five days after the effective date of election.

CMS is proposing 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. For example, if the patient elects hospice on December 1st and requests the addendum on December 3rd, the hospice would have until December 8th to furnish the addendum.

The election statement and addendum regulations require that the beneficiary/legal representative sign the addendum and any updates to the addendum. There is not a specific timeframe for signature in the regulation, but CMS stated in the FY2021 final rule that it expects that beneficiaries or their representative would sign the addendum at the time it is provided. Since implementation of the addendum in October 2020 NAHC and providers have shared with CMS examples of situations in which the date that the hospice furnished the addendum to the beneficiary (or representative) may differ from the date that the beneficiary or representative signs the addendum. There are many instances where the hospice provides the requested addendum within the required timeframe (either 3 or 5 days) but the beneficiary/representative does not sign it timely (i.e. the addendum has to be mailed/emailed, beneficiary/representative requests time to review the addendum, representative requests the addendum be left at the beneficiary's residence but the representative does not retrieve the addendum for some time, etc.).

CMS proposes to clarify in regulation that the "date furnished" must be within the required timeframe (that is, within 3 or 5 days of the beneficiary or representative request, depending on when such request was made), rather than the signature date. At § 418.24(c)(10), CMS proposes that the hospice would include the "date furnished" in the patient's medical record and on the addendum itself.

In situations where the beneficiary or representative refuses to sign the addendum CMS clarified that 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. In such a case, although the beneficiary has refused to sign the addendum, the "date furnished" must still be within the required timeframe (that is, within 3 or 5 days of the beneficiary or representative request, depending on when such request was made), and noted in the chart and on the addendum itself**.

CMS also proposes to clarify in regulation that **if only a non-hospice provider or Medicare contractor requests the addendum (and not the beneficiary or representative) the non-hospice provider is not required to sign the addendum**.

Other proposals related to the addendum include:

- For instances in which the beneficiary or representative requests the addendum at the time of election but dies prior to signing the addendum, CMS proposes conforming regulations text changes at § 418.24(c) to reflect the current policy that the hospice would not be required to furnish the addendum as the requirement would be deemed as being met.
- 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 (§ 418.24(d)(4))
- 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 (§ 418.24(d)(5)). CMS would continue to expect that the hospice would note the date furnished in the patient's medical record and on the addendum, if the hospice has already completed the addendum, as well as an explanation in the patient's medical record noting that the patient died, revoked, or was discharged prior to signing the addendum.
- Conforming regulations text changes at § 418.24(c) in alignment with subregulatory guidance indicating that hospices have "3 days," rather than "72 hours" to meet the requirement to furnish the addendum when a patient requests the addendum during the course of hospice care. This means that hospice providers must furnish the addendum to the beneficiary or representative on or before the third day after the date of the request. For example, if a beneficiary (or representative) requests the addendum on February 22nd, then the hospice will have until February 25th to furnish the addendum, regardless of what time the addendum was requested on February 22nd.

Section III.E: Hospice CoP Waivers Made Permanent

The current hospice aide competency standard regulations at § 418.76(c)(1) requires the aide to be evaluated by observing an aide's performance of the task with a patient. CMS proposes to make similar changes to hospice aide competency standards to those already made with

respect to HHAs (see § 484.80(c)) in the hospice regulations at § 418.76(c)(1)), which describes the process for conducting hospice aide competency evaluations, and propose to define both "pseudo-patient" and "simulation" at § 418.3. Specifically, **CMS is proposing 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**. The proposed definitions are as follows:

- "**Pseudo-patient**" means a person trained to participate in a role-play situation, or a computer-based mannequin device. A pseudo-patient must be capable of responding to and interacting with the hospice aide trainee, and must demonstrate the general characteristics of the primary patient population served by the hospice in key areas such as age, frailty, functional status, cognitive status and care goals.
- "**Simulation**" means a training and assessment technique that mimics the reality of the homecare environment, including environmental distractions and constraints that evoke or replicate substantial aspects of the real world in a fully interactive fashion, in order to teach and assess proficiency in performing skills, and to promote decision making and critical thinking.

These proposed changes would allow hospices to utilize pseudo-patients, such as a person trained to participate in a role-play situation or a computer-based mannequin device, instead of actual patients, in the competency testing of hospice aides for those tasks that must be observed being performed on a patient.

Relative to hospice aide training and evaluation, CMS is proposing to amend the requirement at § 418.76(h)(1)(iii) to specify that if an area of concern is verified by the hospice during the RN on-site supervisory visit, then the hospice must conduct, and the hospice aide must complete, a competency evaluation of the deficient skill and all related skill(s) in accordance with § 418.76(c). This proposed change would permit the hospice to focus on the hospice aides' specific deficient and related skill(s) instead of completing another full competency evaluation.

These are changes NAHC has long advocated for and is pleased to see CMS propose. The changes align with the home health aide competency, training and evaluation requirements making operations more efficient for those providers utilizing aides in both hospice and home health.

Section III.F: Proposals and Updates to the Hospice Quality Reporting Program

This section of the proposed rule covers a wide range of topics related to the HQRP and goes into extensive detail in some of these areas. An overview of the areas addressed and explanation of each are below. NAHC will continue to analyze this section of the proposed rule in particular and provide a more in depth analysis in the coming days.

CMS is making the following proposals and clarifications related to the HQRP:

- Proposal to remove the seven "Hospice Item Set process measures" from HQRP beginning FY 2022

o NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen

o NQF #1634 Pain Screening

o NQF #1637 Pain Assessment

o NQF #1638 Dyspnea Treatment

o NQF #1639 Dyspnea Screening

o NQF #1641 Treatment Preferences

o NQF #1647 Beliefs/Values Addressed (if desired by the patient)

CMS implemented the NQF #3235 Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission on April 1, 2017. In this FY2022 proposed rule CMS details why it believes the "composite measure" is a better measure than the seven individual measures.

- Proposal to add a "claims-based index measure", the Hospice Care Index (HCI). The HCI is a single measure comprising ten indicators calculated from Medicare claims data. The index design of the HCI simultaneously monitors the following ten indicators:

o Continuous Home Care (CHC) or General Inpatient (GIP) Provided – identifies hospices that provided at least one day of hospice care under the CHC or the GIP levels of care during the period examined

o Gaps in Nursing Visits – identifies whether a hospice is below the 90th percentile in terms of how often hospice stays of at least 30 days contain at least one gap of eight or more days without a nursing visit.

o Early Live Discharges – identifies whether a hospice is below the 90th percentile in terms of the percentage of live discharges that occur within 7 days of hospice admission during the fiscal year examined.

o Late Live Discharges – identifies whether a hospice is below the 90th percentile in terms of the percentage of live discharges that occur on or after the 180th day of hospice.

o Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission (Burdensome Transitions Type I) – identifies whether a hospice is below the 90th percentile in terms of the percentage of live discharges that are followed by a hospitalization (within 2 days of hospice discharge) and then followed by a hospice readmission (within 2 days of hospitalization) during the FY examined

o Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital (Burdensome Transitions Type II) – identifies whether a hospice is below the 90th percentile in terms of the percentage of live discharges that are followed by a hospitalization (within two days of hospice discharge) and then the patient dies in the hospital

o Per-beneficiary Medicare Spending – identifies whether a hospice is below the 90th percentile in terms of the average Medicare hospice payments per beneficiary

o Nurse Care Minutes per Routine Home Care (RHC) Day – identifies whether a hospice is above the 10th percentile in terms of the average number of nursing minutes provided on RHC days during the reporting period examined

o Skilled Nursing Minutes on Weekends – identifies whether a hospice is at or above the 10th percentile in terms of the percentage of skilled nursing minutes performed on weekends compared to all days during the reporting period examined.

o Visits Near Death – identifies whether a hospice is at or above the 10th percentile in terms of the percentage of beneficiaries with a nurse and/or medical social services visit in the last 3 days of life

While supportive of a composite measure, in general, NAHC has expressed concerns about some of these indicators to CMS since the HCI concept was introduced to hospices last year.

- Update on the Hospice Visits in the Last Days of Life (HVLDL) and Hospice Item Set V3.00 – CMS announced at the end of 2020 that it was replacing the Hospice Visits When Death is Imminent (HVWDII) measure with a re-specified version of the measure, the Hospice Visits in Last Days of Life (HVLDL). The data source for the HVLDL measure is hospice claims which eliminates the need for hospice visit data to be gathered from the Hospice Item Set (HIS). Therefore, CMS revised the HIS-Discharge by removing Section O. These changes were approved by the Office of Management and Budget (OMB) on February 16, 2021. The HIS Manual V3.00 became effective on February 16, 2021 and expires on February 29, 2024.
- Proposal to Revise § 418.312(b) Submission of Hospice Quality Reporting Program data – this would revise regulations to include administrative data as part of the HQRP, and correct technical errors identified in the FY 2016 and 2019 Hospice Wage Index and Payment Rate Update final rules.
- Update regarding the Hospice Outcomes & Patient Evaluation (HOPE) development – The draft HOPE has undergone cognitive and pilot testing, and will undergo field testing to establish reliability, validity and feasibility of the assessment instrument. CMS anticipates proposing the HOPE in future rulemaking after testing is complete
- Update on Quality Measure Development for Future Years – CMS is soliciting public comment on the HOPE- and claims-based quality measures, which are outlined in the proposed rule, to distinguish between high- and low-quality hospices, support healthcare providers in quality improvement efforts, and provide support to hospice consumers in helping to select a hospice provider. CMS is also considering developing

hybrid quality measures that would be calculated using claims, assessment (HOPE), or other data sources. Hybrid quality measures allow for a more comprehensive set of information about care processes and outcomes than can be calculated using claims data alone. CMS is also seeking public comment on hybrid quality measures.

- CAHPS Hospice Survey Participation Requirements for the FY 2023 APU and Subsequent Years – CMS proposes to introduce Star Ratings for public reporting of CAHPS Hospice Survey results on the Care Compare or successor websites no sooner than FY 2022 utilizing calculations and displaying results similar to other CAHPS Star Ratings programs. This is not new as CMS has indicated it expected CAHPS Star Ratings to be part of the HQRP at some point in the future but had not previously identified a date.
- Form, Manner, and Timing of Quality Data Submission – The Consolidated Appropriations Act requires that, beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and then beginning in FY 2024 and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.
- Updates on Transition to iQIES – Hospices are currently required to submit HIS data to CMS using the Quality Improvement and Evaluation System (QIES) Assessment and the Submission Processing (ASAP) system. The FY2020 Hospice Wage Index and Payment Rate Update final rule finalized the proposal to migrate to a new internet Quality Improvement and Evaluation System (iQIES) that will enable real-time upgrades. CMS is designating the iQIES system as the data submission system for the Hospice QRP. It will notify the public about any system migration updates using subregulatory mechanisms such as web page postings, listserv messaging, and webinars. Home health migrated to iQIES in 2020.
- Public Display of "Quality Measures" and Other Hospice Data for the HQRP – CMS proposes to publicly report the HVLDL no earlier than May 2022 and to publicly report the HCI, another claims-based measure no earlier than May 2022. CMS also propose that, in the COVID-19 PHE, it would use 3 quarters of HIS data for the final affected refresh, the February 2022 public reporting refresh of Care Compare for the Hospice setting. For CAHPS Data, CMS proposes to continue to report the most recent 8 quarters of available data after the freeze, but not to include the data from the exempted quarters of Q1 and Q2 of 2020

As part of the proposed rule, CMS is requesting information on Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in Post-Acute Care Quality Reporting Programs. A goal of the HQRP is to improve the quality of health care for beneficiaries through measurement, transparency, and public reporting of data. The HQRP contributes to improvements in health care, enhancing patient outcomes, and informing consumer choice. In October 2017, CMS launched the Meaningful Measures Framework. This framework captures CMS' vision to address health care quality priorities and gaps, including emphasizing digital quality measurement (dQM), reducing measurement burden, and promoting patient perspectives, while also focusing on modernization and innovation.

The scope of the Meaningful Measures Framework has evolved to Meaningful Measure 2.0 to accommodate the changes in the health care environment, initially focusing on measure and

burden reduction to include the promotion of innovation and modernization of all aspects of quality. CMS sees a need to streamline its approach to data collection, calculation, and reporting to fully leverage clinical and patient-centered information for measurement, improvement, and learning. Therefore, CMS is seeking feedback on future plans to define digital quality measures for the HQRP.

CMS are seeking feedback on the potential use of Fast Healthcare Interoperable Resources (FHIR) for dQMs within the HQRP aligning where possible with other quality programs. FHIR is an open source standards framework (in both commercial and government settings) created by Health Level Seven International (HL7®) that establishes a common language and process for all health information technology.

The proposed definition of a digital quality measure for the HQRP is – digital Quality Measures (dQMs) are quality measures that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems. A dQM includes software that processes digital data to produce a measure score or measure scores. Data sources for dQMs may include administrative systems, electronically submitted clinical assessment data, case management systems, electronic health records (EHRs), instruments (for example, medical devices and wearable devices), patient portals or applications (for example, for collection of patient-generated health data), health information exchanges (HIEs) or registries, and other sources. As an example, the quality measures calculated from patient assessment data submitted electronically to CMS would be considered digital quality measures.

Over the past two years in other programs, CMS has focused on opportunities to streamline and modernize quality data collection and reporting processes, such as exploring HL7® FHIR® (http://hl7.org/fhir) for quality reporting programs. One of the first areas CMS has identified relative to improving its digital strategy is through the use of FHIR-based standards to exchange clinical information through application programming interfaces (APIs), allowing clinicians to digitally submit quality information one time that can then be used in many ways. CMS believes that in the future proposing such a standard within the HQRP could potentially enable collaboration and information sharing, which is essential for delivering high-quality care and better outcomes at a lower cost.

CMS is also requesting information closing the health equity gap in post-acute care quality reporting programs. Specifically, CMS is requesting information on expanding several related CMS programs to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable for providers and patient. As part of the explanation CMS provided for this area in the proposed rule, CMS states that its ongoing commitment to closing the health equity gap in the HQRP is demonstrated by the sharing of information from the Medicare PAC PUF on Care Compare and seeking to adopt through future rulemaking aspects of the standardized patient assessment data elements (SPADEs) that apply to hospice which include several social determinants of health (SDOH).

While hospice is not included in the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014), CMS is looking at measures adopted based on that Act, like SPADES and if aspects apply to hospice then CMS would consider including it in the HQRP. CMS reasons that this helps with continuity of care since patients may transition from different PAC settings to hospice and it would address a gap in hospice care. Therefore, CMS is seeking comment on the possibility of expanding measure development, and adding aspects of SPADEs that could apply to hospice and address gaps in health equity in the HQRP.