



May 31, 2022

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

RE: Comments on the Proposed FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Rule [CMS-1773-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 Fiscal Year (FY) 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Rule [CMS-1773-P].

NPHI is a collaborative of 80+ not-for-profit, community-integrated hospice and palliative care providers dedicated to ensuring patients and their families have access to care that reflects their individual goals, values and preferences. Representing providers from 34 states and the District of Columbia, NPHI and its members help design innovative and effective models of care, advocate for comprehensive and community-integrated care customized to meet each person's unique needs, and build collaboration between national thought leaders and policy makers.

The proposed rule, issued by the Centers for Medicare and Medicaid Services (CMS) on March 30, would provide routine updates to the hospice base payment rates, wage index, and aggregate cap amount for FY 2023. The rule also discusses the inclusion of the new Hospice Outcomes and Patient Evaluation (HOPE) tool in the Hospice Quality Reporting Program (HQRP), proposes the establishment of a permanent mitigation policy to minimize the impact of annual reimbursement changes due to the hospice wage index, and expands on the quality measures that will be in effect in FY23. The rule also contains a Request for Information (RFI) on the CMS Health Equity Initiative within the HQRP and input on a potential future structural measure.

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. Request for Information related to the HQRP Health Equity initiative

NPHI greatly appreciates and is broadly supportive of CMS's efforts to advance health equity initiatives and reduce inequities in care delivery, experience of care, and patient outcomes. 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 care for anyone, at any time, regardless of their ability to pay. Below we offer general feedback and responses to some of the specific questions and domains proposed by CMS.

The RFI included in the proposed rule references the fact that, “health inequities persist in hospice and palliative care.” This is an unfortunate reality and one that many NPHI member providers are passionately engaged in rectifying. The fact is that hospice use varies by racial and ethnic group, with higher use rates among White decedents than other racial and ethnic groups, according to MedPAC. Moreover, complex cultural and linguistic traditions and expectations for what occurs at the end-of-life can have significant implications on the desire to elect hospice by different ethnic and cultural communities. Regardless of these differences, the wide gap in utilization amongst different racial and ethnic groups is clearly, at least partially, tied to a lack of prior investment in inclusive and accessible hospice and palliative care services. CMS’s efforts to effect change in this regard are welcomed and encouraged by NPHI and our members.

Efforts to support providers in quality improvement activities to reduce health inequities, enable beneficiaries to make more informed decisions, and promote provider accountability for health care disparities are all important components of a comprehensive strategy to improving health outcomes for all individuals. In our comment letter regarding the health equity RFI included in the FY22 Hospice Wage Index proposed rule, we provided comments related to different Social Determinants of Health (SDOH) measurement domains, data use methods, and standardized claims codes to identify and document SDOH data.

In this year’s proposed rule, CMS is requesting comment on a potential, “structural composite measure based on information already collected by hospices”. Specifically, CMS states that the structural composite measure could include organizational activities to address access to and quality of hospice care for underserved populations. To achieve this, CMS lays out three domains comprised of organizational activities to address access to and quality of hospice care for underserved populations.

Regardless of any concerns or questions raised below, NPHI believes this initiative and these domains are a necessary starting point in improving health equity. Below are general comments on the contents of the RFI followed by specific feedback for each of the three proposed domains.

- General feedback:
 - The value of process metrics, as proposed in the RFI, are questionable; any organization can fulfil the initial obligation and complete the attestation as a singular event without reliable correlation to outcomes. Consequently, organizations could attest to everything as proposed without any measurable difference in patient experience or care. This would be a disservice to the concepts and principles of health equity. Thus, CMS should consider deeper exploration of the issue with a focus on domains that include key performance indicators which could be established and utilized to measure outcomes and impacts.
 - It may be difficult to create a neutral composite health equity measure that accounts for regional variation in all sorts of social determinants. For instance, the needs of communities in urban Boston differ dramatically from those of communities in rural North Carolina. Characteristics such as patient mix, location of care, and cultural differences all vary widely between hospice providers.
 - If attesting to the components of the domains below requires hospices to submit qualitative documentation (strategic plans, training materials, etc.) there is likely to be significant variation in terms of what they receive and the utility of it in comparison to what other providers submit. Materials such as these are likely to be different depending on the needs of the community the provider serves.

- There is a critical provider distinction between being certified in understanding and addressing implicit bias and being non-certified but trained in doing so.
 - CMS could consider creating a certificate program focused on health equity for hospice leadership to standardize the education and reporting processes.
 - CMS should include a requirement that providers indicate how the health equity component of their strategic plan was implemented. For instance, providers should specify who was educated, who completed the training, and what exactly the method of delivering the education was.
 - The use of official CLAS materials is not common among many hospices. CMS would need to offer a period of time for the respective hospice leaders to become familiar with this specific approach before requiring reporting.
- Domain Three:
 - In domain three, CMS proposes a set of actions regarding providers' willingness to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity.
 - Given current staffing challenges, many providers are forced to hire nearly every applicant that applies for a clinical position, thus limiting the impact that equity considerations can have in the day-to-day operation of human resources management.
 - It may be difficult to consider equity in the hiring of senior staff or board members if there is a preference for individuals located in and familiar with the specific region that the provider is located thus limiting the applicant pool.
 - Developing a culture of equity is clearly important and cannot be achieved by only focusing that consideration on certain positions when hiring. Despite this, equity considerations during the hiring of direct patient care staff are more directly correlated to the experience of the patient and ensuring they feel comfortable and safe.
 - The posting of jobs in deliberate spaces, boards, locations, etc. helps to attract diverse candidates. If jobs are only posted to forums where predominately white individuals see them then a diverse pool of applicants is unlikely and staff diversity may suffer as a result. This consideration could be included as a potential component of domain three.

2. Establishing Hospice Program Survey and Enforcement Procedures Under the Medicare Program; provisions update.

In our response to the CY22 Home Health Prospective Payment System proposed rule, NPHI stated its support for the, "concept of a Special Focus Program (SFP) that provides additional oversight and technical assistance to providers requiring supplementary help." We also stated our support for the establishment of a Technical Expert Panel (TEP) to inform the creation of the SFP. We were pleased that CMS determined this was an appropriate course of action and are glad that CMS plans to use the TEP findings to further develop a proposal on the methodology for establishing the hospice SFP. We would like to reiterate our perspective that the TEP should represent the hospice community as currently constructed, meaning at

least one member should be a representative of a not-for-profit hospice provider. In addition, CMS must ensure that the voices of rural providers are heard throughout the process.

In many, if not most instances, not-for-profit hospices serve a critically important function as safety-net providers. The very nature of not-for-profit hospice providers frequently leads them to focus on priorities that are different but no less important than for-profit organizations. Their patient care and administrative practices also tend to differ. Failing to include this important voice on the TEP disadvantages the efforts of CMS to create a valuable and effective SFP that can effectively assist underperforming hospices. It is NPHI's position that no design or implementation of the proposed SFP should occur before the TEP is allowed to complete its work.

We look forward to continuing to work with CMS on the development of and eventual future rulemaking proposal for a hospice SFP informed by TEP findings.

Conclusion

Thank you again for the opportunity to provide comment on CMS's proposed regulation regarding the FY 2023 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's Policy Director, Ethan McChesney, at emcchesney@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