

NHPCO Talking Points

FY 2023 Hospice Wage Index and Quality Reporting Proposed Rule

Link to proposed rule: [Federal Register, April 4, 2022](#)

Comments due: May 31, 2022

To file comments: Go to [Regulations.gov](https://www.regulations.gov) and enter CMS-1773-P in the search box. Click on the “Comment” button and follow the instructions for filing comments. Ensure your comment letter is signed and is saved as a pdf.

The following are talking points for each section of the proposed rule. In each section, there is a “**NOTE**,” which gives suggestions on how to personalize the comment letter with specific comments on the impact of the proposal for your hospice or state.

1. PAYMENT

NHPCO will be making comments on the rate increase of 2.7%, with comments focused on the increases in the cost of doing business and that 2.7% is not enough for the coming year. Below are some bullet points that can be used to support a higher rate increase.

a. **Payment rate increase of 2.7% is not fiscally sustainable**

- **Reasons for concern**
 - **Workforce issues:** Hospices, as every other healthcare provider, are facing significant staffing shortages, including nurses, social workers, aides, and other members of the interdisciplinary team. Hospice providers compete with hospitals and other healthcare providers in the community for staffing. As a consequence, salaries have increased significantly.
 - **Inflation:** As the US economy’s inflation rate has now reached 8.3%, these inflationary pressures also affect hospice providers.... Including gas, purchases
 - **PPE and other COVID-19 Expenses:** Hospice providers can attest that the expenses of COVID-19 continue, including personal protective equipment (PPE) and staffing adjustments. The COVID pandemic is not yet over, and hospice providers are not yet in full recovery mode.
 - **Sequestration:** Sequestration will again be fully implemented by July 2022, further impacting the 2.7% rate increase. In reality, the rate increase is .7% with sequestration.
- **Statutory requirement:** CMS is statutorily required to use the hospital market basket update in hospice rate setting. However, if CMS is considering other alternatives to the hospital rate update that would consider costs and challenges due to the COVID-19 pandemic and inflation, updates for hospitals due to inflation and other factors, then this should flow to the hospice rates.

- **NOTE:** Include 2-3 anecdotal quotes about staffing shortages, \$\$ increases, sign on bonuses, etc. Add other reasons for the cost pressures on your hospice so details of the impact of rising costs can be demonstrated.
- b. **5% maximum decrease in the wage index value.**
 - **Statement from proposed rule:** CMS is proposing a permanent approach to smooth year-to-year changes in providers' wage indexes by applying a 5-percent cap on wage index decreases. This proposed policy increases the predictability of hospice payments for providers and mitigates instability and significant negative impacts to providers resulting from changes to the wage index.
 - **Comments:**
 - We believe hospice providers in affected areas will appreciate the dependable, maximum drop in the wage index value and the impact it has on rates.
 - We support applying a 5% cap on wage index decreases to ensure less volatility in hospice rates for those impacted areas.
 - **NOTE:** If your hospice or a Core Based Statistical Area (CBSA) in your state has experienced a drop in the wage index value in recent years resulting in much lower rates, add comments here on how the drop impacted your hospice for that year.

2. QUALITY

- **HVLDL:** Providers have expressed interest in providing comments on the Hospice Visits in the Last Days of Life (HVLDL) measure, although it is not part of the proposed rule. Some possible comments follow.
 - The last days of life are often with extensive symptom burden and high stress for the family. Hospices must provide all support requested by the family during this time.
 - Only a registered nurse (RN) or social worker (SW) are covered as eligible interdisciplinary group (IDG) members for satisfying the measure. Evidence that spiritual care needs are enhanced at end of life both for the person experiencing the dying process and for their caregivers. Visits by a spiritual care provider should be added to the disciplines that would meet the measure requirements.
 - The measure is constructed to encourage and require hospices to provide visits in the last three days of life. Providers have expressed concern the RN and SW visits are required, whether the patient and family need them or want them.
 - Currently the HVLDL measure does not allow telehealth visits. Some families prefer the telehealth option to allow support from the IDG without unnecessary intrusions. We suggest including a well-defined telehealth option, which includes all members of the IDG, which expands the focus from only the medical component of care.
 - **NOTE:** Use examples of visits in the last days of life that meet family needs and wishes.
- **Spiritual care:** Hospice providers are concerned there is no way to track spiritual care visits, including those in the last days of life. The HVLDL measure does not include spiritual care as an option, although many families request chaplain services at that time.

- **Telehealth visits:** Comment on developing a code for telehealth visits, as recommended by MedPAC.
- **Hospice Outcomes & Patient Evaluation (HOPE) Update:** Many providers not participating in the Beta testing request more information sharing before the introduction of the HOPE tool in rulemaking and progress reports along the way. We look forward to continued engagement with CMS, including the opportunity to get updates about HOPE and ask questions.
- **Hospice CAHPS® Survey:**
 - Hospice providers congratulate the CAHPS Hospice team for testing the possibility of a web-based mode for the CAHPS Hospice Survey. We believe having a web-based option for survey completion will increase survey response rates and allow hospices to target their areas for improvement. NHPCO encourages CMS to implement the web-based survey as soon as possible, as we believe it will improve response rates.
 - Hospices are also pleased to see the Hospice CAHPS team is considering a shortened survey, as many respondents have commented about the length of the survey as a reason for not completing it.
- **NOTE:** Providers and state organizations should use hospice-specific or state-specific information to support and enhance the points above.

3. Request for Information Related to the HQR Health Equity initiative

In this section, CMS states the Administration’s ongoing commitment to “achieving equity in health care outcomes for our beneficiaries by supporting providers in quality improvement activities to reduce health equities, enabling beneficiaries to make more informed decisions, and promoting provider accountability for health care disparities.” CMS is soliciting public comment on the following questions specific to hospice. See the “NOTE” section for ideas to personalize your hospice or state’s response.

1A. What efforts does your hospice employ to recruit staff, volunteers, and board members from diverse populations to represent and serve underserved populations?

Some hospice providers have made progress in employing and recruiting diverse staff to better represent and serve underserved populations. However, it is important to note many smaller organizations need additional resources and support to implement the same methods larger organizations are able to utilize.

- **NOTE:** Add comments specific to your hospice or state organization with best practices that have been used.

Best practices include:

- **Job marketing, education, and community outreach:**
 - Open recruitment, creating kiosks for applications in communities with no access to computers, creating employee resource groups, and providing employees the opportunity to conduct remote work for those who want to stay in their community.

- Use of educational efforts, such as partnering with historically Black colleges and universities to recruit minority healthcare leaders, making use of apprenticeship programs enacted by state legislatures, creating a “ladder” program providing education for underserved communities, and providing scholarships for current staff members to continue education.
- Work with multicultural associations to advise them of employment and leadership opportunities, as well as working with informal community leaders about applicable choice of language when discussing hospice with diverse populations.

1B. How does your hospice attempt to bridge any cultural gaps between your personnel and beneficiaries/clients?

- Implement board development training focused on diversity and inclusion training and as a standard agenda item during board meetings. This is integral in educating leadership staff to bridge cultural gaps between personnel and beneficiaries.
- For staff, hospices host performance improvement meetings, attend webinars, complete educational modules, create diversity committees, celebrate diversity with annual Diversity Day programs, and discuss diversity and inclusion with all new hires.
- Hospices include diverse, inclusive, and equitable goals and values in their mission and philosophy statements, utilize and fundraise for a Hospice Care Fund for the uninsured, work to allow for choice of patient and family accommodations are met, and matches caregivers to patients based on culture.
- Engage with the community through different programming efforts, including annual children’s grief camps, annual lectureships for the community, annual memorial services, continuing grief and support services, and involvement in weekly farmers’ markets and faith-based and minority outreach programs.
- Employ robust Diversity and Outreach teams and community liaisons to participate in community gatherings as well as work with social services agencies and community centers.
- Work with local educational institutions and provide education to local hospitals, nursing homes, and assisted living facilities.
- **NOTE:** The list above includes examples of how some hospices answer this question. Use these bullet points to include your hospice’s or state’s experience with this question or add your own comments to personalize your response to this question.

1C. How does your hospice measure whether this has an impact on health equity?

- Many NHPCO providers have noted difficulty in data collection and analysis to measure the impact of diversity, equity, and inclusion efforts on health equity outcomes. Providers have mentioned the utilization of the CAHPS survey and trend service issues. There is a need for more data among hospices to better understand methods that have garnered the largest positive effects on health equity.
- NHPCO supports the development of a universal database that will be accessible across the government and will enable programs to accurately assess the extent of the disparities and barriers that exist today and to measure progress made by the government in promoting health equity over time. This database should be informed by stakeholder feedback to ensure the

identification of the right key metrics, encourage data standardization, and incentivize investment in data collection and submission, e.g., investment by electronic medical record (EMR) and electronic health record (EHR) vendors to require interoperability when collecting these important data points. This would also require substantial investment in home and community-based providers' access to the technology necessary to assure interoperability.

- **NOTE:** Discuss how your hospice or hospices in your state measure health equity and the progress being made on health outcomes based on diversity, equity, and inclusion efforts.

2A. How does your hospice currently identify barriers to access in your community or service area? What are barriers to collecting data related to disparities, social determinants of health, and equity?

- Providers are discussing patient experiences at team meetings with a focus on cultural barriers as perceived by hospice recipients.
- Data collection barriers include:
 - Limited resources and consistent and sustained organizational efforts. Providers have noted data collection may not be a priority due to limited staff members available to administer data collection.
 - Poorly suited Electronic Medical Record (EMR) systems. EMR systems may not be well suited to collect accurate information on gender and racial identities. For example, it only asks participants to choose “one” option out of several races and ethnicities, which overlooks those of mixed races and ethnicities. Sex is also still binary, disregarding patients who may identify as non-binary.
 - Limitations and lack of DEI specificity in the CAHPS survey. Further, while providers have indicated the utilization of CAHPS report, they also noted a need to develop more data collection methods to analyze and qualify impacts on health equity. Having the CAHPS survey only as a mail or phone survey is a larger barrier to collecting data. CAHPS email availability would increase responsiveness for some, but at the same time may be a barrier to others. Having email and mail options would be ideal.
- **NOTE:** Add your hospice or state’s specific barriers to access or data collection.

2B. What steps does your hospice take to address these barriers?

- Hospice providers have noted the importance of staff training and raising awareness to address barriers.
- Providers have partnered with EMR vendors for data collection to add more survey fields related to diversity, equity, and inclusion and prepare reports on health equity after data is collected.
- Hospices employ community liaisons to connect with patients informally right after admission.

3. How does your hospice collect self-reported data such as race/ethnicity, veteran status, socioeconomic status, housing, food security, access to interpreter services, caregiving status, and marital status used to inform its health equity initiatives?

- NHPCO recommends considering the following domains of data when collecting information on hospice beneficiaries:

- Inclusion of language other than English data collection, e.g., bilingual services, language competency, diversity of staff and language capabilities, music therapy in other languages, preferred language, type of interpreter services available (phone, video, or in-person).
- Inclusion of a question in data collection on whether culture was respected (this could be added to the CAHPS® Hospice Survey).
- Inclusion of sexual orientation and gender identity.
- Expansion of demographic categories to capture more detailed information, e.g., Asian Americans broken down by region of national origin (East, Southeast, South, and other Asians) and Pacific Islanders broken down to four groups (Melanesians, Micronesians, Polynesians, and other Pacific Islanders).
- Hospices have also indicated a strong need for more methods to collect information on social determinants of health (SDoH) including socioeconomic status, housing, food security, access to interpreter services and caregiving status.
- **NOTE:** Add what your hospice or hospices in your state are doing today to collect this data and how it may impact the delivery of care. Add your thoughts on how you collect information today on SDOH.

4. How is your hospice using qualitative data collection and analysis methods to measure the impact of its health equity initiatives?

- Many hospices have not noted they have not yet implemented initiatives to measure the impact of their health equity initiatives through qualitative data collection and analysis methods. There is a need to provide some guidance to encourage better data collection, analysis, and examples of how actions can measure the impact of these health initiatives.
- **NOTE:** Add any experience your hospice or state has in collecting qualitative data, analyzing it, and using it for measurement.

4. Structural Composite Measure

- A composite measure on health equity must be thoughtfully considered, including all considerations for the additional provider administrative burden.
- Before a measure is considered, providers must have the necessary tools to implement a focus on health equity, with various component parts as described above.
- NHPCO strongly recommends the development of a Technical Expert Panel (TEP) to discuss the details of designing and implementing a meaningful structural composite measure.
- Providers are concerned about provider burden or that meaningless data will be collected and never used.
- **NOTE:** The three domains for the structural composite measure are listed below. A “questions to answer” bullet has been added for each domain to provide some focus for responses. Add your comments on each of the domains, including whether your hospice or hospices in your state would be able to provide responses to the possible measures in each domain.

- o **Domain 1:** Hospice commitment to reducing disparities is strengthened when equity is a key organizational priority. This Candidate 1 domain could be satisfied when a hospice submits data on their actions regarding the role of health equity and community engagement in their strategic plan.
 - **Questions to answer:**
 - How would a hospice show equity as a key organizational priority?
 - What should be recommended to meet this domain requirement?

- o **Domain 2:** Training board members, leaders, staff, and volunteers in culturally and linguistically appropriate services (CLAS), health equity, and implicit bias is an important step hospices take to provide quality care to diverse populations. Candidate Domain 2 could focus on hospices’ diversity, equity, inclusion and CLAS training for board members, employed staff, and volunteers by capturing actions in the reporting year. Submission of relevant data for all elements could be required to qualify for the measure numerator.
 - **Questions to answer:**
 - How would a hospice collect data on DEI and CLAS training for board members, staff, and volunteers?
 - How would a hospice make this a meaningful as well as measurable domain?

- o **Domain 3:** Leaders and staff could improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. This candidate domain could capture activities related to organizational inclusion initiatives and capacity to promote health equity. Examples of equity-focused factors include proficiency in languages other than English, experience working with populations in the service area, experience working on health equity issues, and experience working with individuals with disabilities.
 - **Questions to answer:**
 - What data could be collected to measure an organization’s culture of equity?
 - Can you provide additional examples that would indicate an organization’s commitment to diversity, equity, and inclusion?

5. **SPECIAL FOCUS PROGRAM**

- We applaud the CMS decision to establish a Technical Expert Panel (TEP) and look forward to the appointment of members with hospice experience to the TEP.

For any questions about writing or submitting a comment letter on this proposed rule, please reach out to Regulatory@NHPCO.org and with “Help with writing comment letter” in the subject field. NHPCO will be happy to help.