NATIONAL COALITION FOR HOSPICE AND PALLIATIVE CARE

COALITION MEMBERS

American Academy of Hospice and Palliative Medicine (AAHPM)

Association of Professional Chaplains (APC)

The Catholic Health Association of the United States (CHA)

Center to Advance Palliative Care (CAPC)

HealthCare Chaplaincy Network™ (HCCN)

Hospice and Palliative Nurses Association (HPNA)

National Association for Home Care & Hospice (NAHC)

National Hospice and Palliative Care Organization (NHPCO)

National Palliative Care Research Center (NPCRC)

Palliative Care Quality Collaborative (PCQC)

Physician Assistants in Hospice and Palliative Medicine (PAHPM)

Social Work Hospice & Palliative Care Network (SWHPN)

Society of Pain & Palliative Care Pharmacists (SPPCP)

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May 31, 2022

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20101

RE: **CMS-1773-P Medicare Program; FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements**

Dear Administrator Brooks-LaSure:

On behalf of the National Coalition for Hospice and Palliative Care, we welcome the opportunity to provide comments and recommendations from our Coalition members on **CMS-1773-P Medicare Program; FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements.** To inform our comments, we drew upon the hospice expertise represented within the professional organizations that comprise our Coalition. We are pleased to offer the feedback below on behalf of our Coalition.

Our Coalition is dedicated to advancing equitable access, delivery and quality of hospice and palliative care to all those who need it. The thirteen national organizations that form the Coalition represent more than 5,500 hospice programs and their related personnel, 5,200 physicians, 1,000 physician assistants, 10,000 nurses, 5,000 chaplains, 8,000 social workers, researchers, and pharmacists, along with over 1,800 palliative care programs caring for millions of patients and families each year across the United States. We bring a broad, multidisciplinary perspective on hospice care and the changes this proposed rule will have on the vulnerable population we serve – patients and families nearing the end of life.

The Coalition will focus its feedback and consensus comments on payment, quality, equity and the special focus program.

1. PAYMENT

Hospice providers have experienced significant challenges with the increase in the cost of providing care. These challenges include general inflation (now reported at 8.3%) and workforce shortages and the increase in the cost of staffing. In addition, hospices are facing decreases in payments with the phase in of Medicare sequestration cuts, which are set to reach -2.0% in July 2022. We have received input from hospices across the United States that the proposed payment increase of 2.7% is not fiscally sustainable due to these economic conditions and forces outside the hospice's control. Hospice providers have detailed their concerns below:

A. Proposed 2.7% Hospice Payment Update

- **Workforce issues:** Staffing shortages now include 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. A hospice cannot compete with the sign-on bonuses offered by hospitals and health systems but are attempting creative solutions to attract qualified candidates. Several hospices currently report the sign-on bonuses for nurses considering employment in their health systems is exceeding $20,000. Consequently, salaries have significantly increased.
- **Inflation:** As the US economy's inflation rate has now reached 8.3%, these inflationary pressures directly affect hospice providers, including for gas and mileage reimbursement, medical supplies, purchases for operations, and more.
- **Hospice proposed rate increase compared to other Medicare providers:** Hospice providers have commented that the low proposed payment update is particularly troubling given the announcement that the final rates for the Medicare Advantage (MA) program is estimated to see an increase of 8.5 percent in net revenues, based on a 2023 growth rate set at 4.88 percent, as detailed in the rate announcement for FY 2023 compared to FY 2022.[i]
- **Sequestration:** Following a period of reprieve enacted by Congress in response to the COVID-19 public health emergency, 2% Medicare sequestration reductions will again be fully implemented by July 2022, further offsetting the 2.7% rate increase. In reality the rate increase relative to payments at the beginning of FY 2022 is 0.7% with sequestration.
- **PPE and other COVID-19 expenses:** Hospice providers 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.
- **Survey of hospice providers:** Coalition Member, the National Hospice and Palliative Care Organization (NHPCO), conducted surveys of NHPCO hospice providers in May 2022 to determine the impact of cost increases. 97.6% (n=458) stated their patient costs have increased since 2019 and 96.8% (n=185) expect their costs to increase in fiscal year 2023. Most providers shared they have seen an approximate cost increase in the range of 3 to 10% in the last year.

- **Best available data:** The Coalition believes CMS should use the best available data for rate setting to ensure that payments keep pace with hospices' costs, including to account for costs attributable to COVID, inflation, and other factors. To the extent that CMS considers alternatives to account for these factors in setting the final hospital payment update, the Coalition recommends that CMS consider applying the same updates for the hospice rates.

  Coalition Recommendation: The Coalition recommends that CMS consider alternatives for the final hospice payment update comparable to rate setting alternatives in the final hospital payment update.

B. 5% maximum decrease in the wage index value.

CMS is proposing a permanent approach to smooth year-to-year changes in providers' wage indexes by applying a 5 % 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.

The Coalition and its members appreciate the consideration of a maximum 5% cap on wage index reductions. We believe hospice providers in affected areas will appreciate the dependable, maximum drop in the wage index value and believe it will allow hospice providers to maintain financial stability when year-to-year wage index values change. We note, however, that CMS extended the 5% cap policy to hospitals with a wage index decrease value change of more than 5% in 2022. Hospice providers should be given the same consideration.

We do not see any discussion in the proposed rule about alternatives to the 5% maximum. Even a 2 or 3 percent reduction in the wage index value, and its impact on rates, will be challenging for hospice providers to withstand. An analysis of the impact of various cap percentages would be a helpful addition to the final rule.

Our analysis of the impacted rural areas and CBSA wage index values shows the following:

Table 1: Number of CBSA and Rural Area Wage Index Values that Would Be Subject the Cap on Wage Index Decreases, Based on Value of Cap

Percent of Maximum	**FY 2023 (proposed) compared to FY 2022 CBSAs and Rural Areas**	**FY 2022 compared to FY 2021 CBSAs and Rural Areas**
5%	10	18
4%	27	24
3%	46	37
2%	85	74

Coalition Recommendation:
The Coalition commends CMS for the proposal to implement a maximum cap to stabilize the impact of changes in the wage index year over year. We also recommend that CMS extend the wage index decrease cap to CBSAs and rural areas who experienced a wage index value decrease of >5% in 2022. In addition, we recommend that CMS provide additional analysis and information on the impact of and the number of rural areas, CBSAs, and hospices potentially affected by the 5% cap in 2023 and publish an impact analysis of other maximum cap percentages, such as 2%, 3%, and 4% in 2023.

2. QUALITY

The Coalition heard from hospice providers about the topics included in the quality portion of the proposed rule. Our comments follow.

- **Hospice Outcomes & Patient Evaluation (HOPE) Update:** Many providers that are not participating in the HOPE Beta testing request more information sharing before the next proposed rule, as well as progress reports along the way. The Coalition and its members look forward to continued engagement with CMS, including the opportunity to receive updates about HOPE and ask clarifying questions. The Coalition would be pleased to host or co-sponsor an educational webinar serving to educate hospice providers, staff and patient advocacy groups before HOPE is implemented.

  As our Coalition began working on comments for the health equity section of the proposed rule, we also began questioning whether the data being collected through the HOPE tool would be adequate for hospice providers to analyze their progress on health equity goals. We recognize that additional and specific data collection with a health equity focus is pivotal as hospice providers learn more and implement equity programs. The Coalition requests that CMS address this issue in the comments accompanying the final rule.

Coalition recommendation: We ask that CMS review the data elements to be collected in the HOPE tool to ensure that sufficient data is available for hospices to assess their progress on health equity goals.

- **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 that having a web-based option for survey completion will increase survey response rates and allow hospices to target their areas for improvement. The Coalition encourages CMS to move with all deliberate speed on the implementation of a web-based survey. Hospices are also pleased to see that the CAHPS® Hospice team is considering a shortened survey, as many respondents have commented about the length of the survey as a reason for not completing it.

  As we discussed in the section of our comments on the HOPE tool above, the Coalition recognizes that the data collected in the current CAHPS® Hospice Survey will not be sufficient for hospice providers who are beginning to address differences in CAHPS® Hospice Survey responses based on family racial, ethnic and cultural diversity. The Coalition requests that CMS address this issue in the comments accompanying the final rule.

  Coalition Recommendation: The Coalition requests that the data collected in the current CAHPS Hospice Survey be carefully reviewed so that survey responses will be detailed enough to be informative for the hospice provider's health equity goals.

- **CAHPS® Hospice Star Ratings:** As hospices prepare for hospice Star ratings to be publicly reported on Care Compare in August 2022, they are expressing concerns shared below:
  - With the challenges associated with low return rates, many hospices have expressed that the volume requirement will keep them from having Star ratings reported in Care Compare, which would reflect badly on their hospices and could cost them referrals. Many hospice providers note a difference in response rates between English speaking families and families that speak other languages. English-speaking families respond to the survey, while those speaking another language do not, even when the survey is translated into their language. The Coalition requests that CMS review relative responses of English and non-English speaking individuals in other CAHPS surveys. If the same differences are present as in the hospice CAHPS survey, we request that CMS meet with stakeholders to examine methods that would encourage higher response rates for non-English speaking families in hospice.

    - As the Coalition looked at the CAHPS® hospice survey through an equity lens, we are increasingly concerned that the survey might be asking the wrong questions for some ethnically diverse families. The Coalition recommends that great care be given to having ethnically and culturally sensitive and competent questions as the survey is translated into other languages.

Coalition Recommendation: The Coalition expresses concern about the impact on low volume respondents for the CAHPS hospice survey and how it will impact public reporting in Care Compare. In addition, the Coalition recommends that CMS review the response rates for English and non-English speaking respondents in other surveys. If there is a difference in responses, the Coalition recommends review of methods that would encourage higher response rates for non-English speaking families. Careful review of the questions asked on the CAHPS survey must include a review of ethnically and culturally sensitive questions for diverse hospice families.

- **Telehealth visits:** The Coalition supports the development of codes or modifiers for telehealth visits to be added to the hospice claim form, as recommended by MedPAC.

- **Spiritual care:** One of the Coalition's members, the Healthcare Chaplaincy Network, has been working to establish HCPCS codes for chaplains in Medicare for the last two years. The Coalition believes that, as a member of the hospice interdisciplinary team, the chaplain is the only discipline that does not have a way to track the amount of spiritual care that is provided to patients and families. The Healthcare Chaplaincy Network has re-submitted their request to the HCPCS committee this spring. Recently, CMS released its preliminary recommendation on their application for a HCPCS code to track spiritual care. The preliminary recommendation is that the codes not be approved. Part of the rationale is "CMS is still not aware of a claims processing need on the part of other insurers for reporting chaplain activity." We submit that there should be no claims processing need "on the part of other insurers for reporting chaplain activity" in hospice because 90% of our patients are Medicare beneficiaries. We believe that chaplain visits in hospice should be captured along with every other discipline. Reasons include:
    - Spiritual care is included in the comprehensive assessment of the patient conducted during the first 5 days of hospice care.
    - Spiritual care is included in the description of the bereavement assessment, to determine what spiritual care services are needed for the family and loved ones after the death of the patient.
    - Spiritual care is one of the core services that must be offered by the hospice.
    - Information should be collected on visits made by every member of the interdisciplinary team. Currently, chaplains are the only discipline without visit information.

  - Chaplain visits should now be viewed through an equity lens to assess the utilization of chaplains in hospice by ethnically and culturally diverse families.
  - Quality measures in hospice should allow chaplains to be included, such as the measure currently being considered by NQF on Hospice Visits in the Last Days of Life.

Coalition Recommendation: The Coalition supports the creation of HCPCS codes for chaplains; we would be willing to discuss further.

- **Hospice Visits in the Last Days of Life (HVLDL):** The Coalition recognizes that discussion of HVLDL is not part of the FY 2023 Hospice Wage Index and Quality Reporting proposed rule, but our members feel strongly that comments on this measure should be included.
  - There is clear evidence that the last days of life for a hospice patient can be times of high symptom burden. Both patients and family caregivers can have high needs in all domains of care. If the patient and family desire a visit from hospice staff, it is certainly within the hospice's role and responsibility to deliver it. The evidence does suggest that all hospices may not be meeting this goal reliably and there appears justification for a quality measure to help improve this situation. CMS has been using the Hospice Visits in Last Days of Life (HVLDL) measure in the HQRP.
  - The measure used to incentivize hospices to make these visits at the end of life should be of high quality and patient-centered. As stated in previous comments submitted by the Coalition to CMS and to the National Quality Forum on the HVLDL, this measure, as currently constructed, does not meet this goal. The Meaningful Measure area for the Hospice Visits in Last Days of Life measure is "Person Centered Care" and the Healthcare Priority is "Strengthen Person & Family Engagement as Partners in their Care". The proposed measure does not fit within this area or priority. This measure incentivizes hospices to impose RN and social worker visits on patients and families who may not want them and where a visit from a different member of the hospice interdisciplinary group, such as a chaplain or an aide, may be more appropriate.
  - Hospice providers are concerned that 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.
  - In these times of critical staff shortages, especially for nurses, hospices have turned to LPNs to provide some visits, including visits during the last week of life. However, LPN visits, while important to the patient and their family, do not count for the HVLDL measure. The Coalition requests consideration for the LPN discipline to meet the measure requirement during this difficult staffing shortage time.
  - The HVLDL measures do not allow virtual telehealth visits that some families prefer.

- The measure discourages hospices from meeting the end-of-life spiritual and religious needs of patients and families by focusing heavily on only the medical portion of the interdisciplinary team.
- Hospice social workers have reported challenges meeting hospice incentive for HVLDL due to large case load sizes. Some hospice social workers reported caseloads as high as 60-90 patients and primarily focused on crisis intervention rather than social work process of assessment, engagement and establishing trust for the development of a counseling relationship.

3. EQUITY

The Coalition appreciates CMS' attention to improving population health for all hospice patients, a population which is at times overlooked due to terminal status of the patient population. The Coalition shares the following understanding of health inequity as: *health differences which are systemic, unnecessary and avoidable, while also considered unfair and unjust*. The Coalition strongly supports CMS's overall approach and goal of addressing health inequities as a foundational element across the agency and appreciates the thoughtful and intentional approach recommended in this proposed rule within the Hospice program.

The Coalition supports embedding the principles of health equity in the design, implementation, and operationalizing of policies and programs to improve health and reduce disparities for all people served by the Medicare program. We look forward to being partners with you in this work. In response to your specific questions, the Coalition worked across organizational members (and with many individual hospices themselves) and with our new Equity and Inclusion Workgroup to develop the following responses. The Coalition supports intentionally thinking about utilization rates within hospices to ensure that all diverse qualifying individuals and populations regardless of gender, race, ethnicity, identified or expressed gender, orientation, culture, beliefs and practices, and/or faith affiliation have access to and receive needed hospice services at the end of life.

In addition, the Coalition supports health equity principles for patients of all ages, including pediatric patients that may be covered by Medicaid or private insurance. Hospices must apply the principles of health equity and design programs and systems to reduce disparities for all patients. In the pediatric population, the Coalition recommends applying these principles in working with state Medicaid programs.

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 that many organizations need additional resources and support to implement some of the methods of organizations more advanced in recruiting diverse populations. Many hospices are dealing with financial constraints that hinder them from utilizing recruitment strategies targeted to diverse populations. In addition, the pandemic has sharply reduced the number of hospice volunteers. However, most hospices are eager to learn and improve their efforts in this arena.

Hospice best practices include but are not limited to:

- **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 opportunities to conduct remote work for those who want to stay in their community. Hospices continue to improve recruitment of multilingual and multicultural staff.
- **Educational efforts:** Use of educational efforts, such as partnering with Historically Black Colleges and Universities (HBCU's) to recruit minority healthcare leaders, making use of apprenticeship programs enacted by state legislatures, creating a program that provides opportunities and funding for education and advancement to people in underserved communities who would like to pursue a degree in healthcare, and providing scholarships for current staff members to continue their education.
- **External groups to promote employment and leadership opportunities:** Working 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?

Hospice providers shared that the following best practices have been used to bridge cultural gaps and address cultural humility.

- **Board development and training:** Implement board development training focused on diversity, equity and inclusion, along with implicit bias training and as standard agenda items during board meetings. This is integral in educating leadership staff to bridge cultural gaps between personnel and beneficiaries.
- **Staff training and focus:** For staff, create diversity committees, establish opportunities for peer-lead cultural leadership expert trainings on how to raise awareness and reduce implicit bias, host performance improvement meetings, co-develop and attend webinars, and complete relevant educational modules. Multiple programs and activities should be held throughout the year that offer opportunities to raise awareness of

implicit bias, engage in respectful curiosity among colleagues which leads to community building, peer support and an organizationally embedded culture of inclusion.

- **Goals and values in mission and philosophy statements:** Hospices include diverse, inclusive, and equitable goals and values in their mission, vision and values statements. Use consistent language in all communications, respecting culture and diversity. One suggestion is to carry out this vision through fundraising and access to Hospice care funds for the uninsured or those that require additional support in alignment with their cultural/faith traditions. Attention is paid as best as possible to match caregivers to patients based on culturally and linguistically appropriate services (CLAS).
- **Engage with the community:** 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.
- **Diversity and outreach teams:** Employ Diversity and Outreach teams and community liaisons to identify areas of the community where additional outreach and education is needed. The care team could be expanded to include community health workers or doulas or other para-professionals that are from the communities served. The outreach would include materials designed specific to those communities, paying special attention to language, visual graphics, participating in community gatherings, and working with social services agencies and community and faith centers.
- **Provide education widely:** Work with local educational institutions and provide education to local hospitals, nursing homes, and assisted living facilities.
- **Community advisory board:** Establish community advisory boards and steering committees with lay, faith and health leaders who can shed light on needs and gaps in their respective communities. Through active listening hospice and palliative care organizations can improve care delivery to unique and diverse communities. In addition, community gatherings through these committees can help raise awareness of health resources, advance care planning and hospice and palliative care. Potential outcomes of this type of engagement include improved health literacy, health equity and earlier access to appropriate care options.

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

Many providers have noted difficulty in data collection and analysis to measure the impact of diversity, equity, and inclusion efforts on health equity outcomes.

- **Use of CAHPS survey:** Providers have mentioned the utilization of the CAHPS survey as a way to gather diversity, equity and inclusion information to analyze feedback from the family after the patient's death. However, there is a need for more data to be gathered so hospices can identify service trends and better understand methods that have garnered the largest positive effects on health equity. Currently, the CAHPS survey does not include any information to directly assess health equity.

  If the CAHPS survey is considered for this use, the survey must include enough detail and nuance to ensure inclusivity of different identities (e.g. gender identity, multiracial and ethnicity options, socioeconomic status, etc.) and strategies to address social determinants of health (SDOH). While assessment of the current domains (i.e. communication skills of providers, ease of access to health care services and patient experience) are very important for delivery of quality care, these measures need to be able to be compared across relevant demographic information. As recommended by the Institute for Healthcare Improvement[ii] , each hospice should collect, at a minimum, race/ethnicity, socioeconomic status, gender, and a measure of geography such as zip code or US Census tract.
- **Development of universal database:** We support 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 hospice 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 post-acute providers' access to the technology necessary to assure interoperability.
- **Community assessment:** Hospices should be able to compare the demographics of the hospice's patient population to local population data to determine the hospice's reach in the community, and to identify areas for improvement and assess quality of care measures as they are rated by diverse racial and ethnic groups, diverse SES groups and diverse sexual orientation.

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?

Many hospices have increased their focus on the cultural barriers perceived by hospice patients and families by discussing patient experiences and perceptions at team meetings and identifying steps to take to address them.

- Hospice providers report significant barriers in data collection, including:
    - **Limited resources and lack of 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 and analyze it.
    - **Poorly suited Electronic Medical Record (EMR) systems:** EMR systems may not be well suited to collect accurate and detailed information on gender, sexual orientation, SES, race/ethnicity and 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. Gender is also still binary, disregarding patients who may identify as non-binary.
    - **Limitations and lack of DEI specificity in the CAHPS survey:** While providers have indicated the utilization of CAHPS report, they also noted a need to develop more data collection methods to analyze and quantify 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. Utilizing email, phone and mail options may increase participation.

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

Hospices have begun working on ways to address barriers identified in their communities. Reports from hospice providers include:

- 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.
- Increase the involvement of social work staff to engage in QI projects to address identified SDOH barriers to care. Social workers are trained in research and evaluation in their training programs and should be encouraged to engage in SDOH QI projects either individually or in consultation with other members of the interdisciplinary team.
- Additionally. Z codes are available to report data on social risk, which may serve as an additional tool for collecting information on SDOHs. However, many providers see little

incentive to report these codes and find that reporting of social risks fails to translate into any action to address patients' needs.

Coalition Recommendation: The Coalition recommends that CMS request that hospice organizations use SDOH Z-codes (particularly Z-55 to Z-65) to enhance quality improvement initiatives.

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?**

The Coalition and its members recommend considering the following domains of data when collecting information on hospice beneficiaries:

- **Languages other than English:** Inclusion of language other than English data collection e.g., bilingual services, language competency, diversity of staff with multilingual and multicultural capabilities, music therapy in other languages, preferred language, type of interpreter services available (phone, video, or in-person).
- **Was culture respected question:** Inclusion of a question in data collection on whether culture was respected (potential addition to the Hospice CAHPS® Survey).
- **Sexual orientation and gender identity:** Inclusion of sexual orientation and gender identity.
- **Expand demographic categories:** Expansion of demographic categories to capture more detailed race and ethnicity 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)).
- **Include a measure of SES: This** could be measured by income, education and insurance status.
- **Geographic data: Report** geographic data for assessment of outcomes based on community deprivation index or similar measure.

Hospices have also indicated a strong need for more methods to collect information on SDOH including socioeconomic status, housing, food security, access to interpreter services, and caregiving status.

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

   Many hospices have 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.

   - Some hospices have reported the use of a patient advocate or a patient experience staff member with the role of contacting patients and families while enrolled in hospice to received feedback on care which can be communicated to staff for any identified unmet needs or concerns with care.

5. **Structural Composite Measure**
   The Coalition encourages dialogue with stakeholders about the development of a structural composite measure for health equity to ensure all components are included and the reporting of such measures are meaningful and actionable while not being overly burdensome to hospice providers. We believe hospices must ***LEARN*** how to incorporate much of the health equity framework into their daily practice before data collection for a structural composite measure is considered. Because this is such an important focus area for Medicare and hospice providers, the Coalition strongly recommends the development of a Technical Expert Panel (TEP) to consider the identification of appropriate measures in each domain and their implementation. We also recommend that as this measure is developed, data be gathered from hospices with feedback provided before any public reporting is considered.

   We note the three domains identified as components of the structural composite measure do not adequately address social determinants of health, which must be considered as the focus on health equity increases. Some examples of SDOH include access to healthcare, neighborhood safety, housing stability and income level. Research estimates up to 80% of health outcomes are impacted by social determinants of health. SDOH has been shown to impact healthcare utilization and cost, health disparities, and health outcomes. Research has shown social interventions targeted at beneficiaries can result in improved health outcomes and significant savings to the health care sector (Lipson, 2017)[iii]. We provide the following feedback on each domain:

- **Domain 1: Hospice commitment to reducing disparities is strengthened when equity is a key organizational priority.**

The Coalition believes that making equity an organizational priority includes addressing areas where gaps in access to agency services are identified. The Coalition recognizes the importance and complexity of addressing social determinants of health to improve health equity and we encourage hospice organizations to consider identifying key staff to lead health equity efforts. These key staff, including social workers and others, facilitate communication among healthcare providers and community partners that can offer critical social supports for a patient's disease management. Additionally, this team can employ a person-in-environment approach to meet with people in nontraditional settings, creating access for the most marginalized segments of our population and for those who otherwise might not be able to reach care.

- **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.**

  We appreciate the CMS discussion of staff training needed for culturally and linguistically appropriate services (CLAS) and culturally sensitive care mindful of SDOH. However, we ask CMS to also stress that efforts to improve cultural sensitivity will be different from efforts to improve SDOH. Better measures of SDOH can assist hospices with targeting social problems that can be changed to improve health equity. Targeted social interventions can help prevent or delay beneficiaries needing high cost inpatient care and can facilitate community integration while on hospice.

  Common examples of SDOH which are often used as data points in research include: access to healthy foods, neighborhood safety, housing stability, Income level, education quality, transportation availability. Many of these circumstances are not fair, and the differences in the social determinants of health lead to poorer health, and in the case of hospice outcomes, can lead to determinants of poorer end-of-life care outcomes. As recommended by the Institute for Healthcare Improvement, each hospice could collect, at a minimum, race/ethnicity, socioeconomic status, gender, and a measure of geography such as zip code or US Census tract. Hospice social work expertise in systems thinking and community engagement may be helpful to assist with screening both for hospice data collection and planning for interventions.

- **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.**

  The Coalition suggests leadership in hospice organizations should make health equity a strategic priority and communicate this priority to all staff, patients and families, and the larger community. Health equity should be addressed in hiring practices for senior leadership, as well as clinical and administrative positions. An organizational culture of equity can also improve connections to the community and can benefit hospices and hospice patients in several ways, including improving individual experiences of care, improving the health of diverse populations served by hospice and reducing the per capita cost of care for populations. Hospices can develop structure and processes to support health equity work through such methods as establishing a governance committee to oversee and manage equity work, and dedicating staff and resources to support equity work.

  Hospices cited two resources of particular help in setting an organizational culture of equity. The Augustus A. White Institute for Healthcare Equity[iv] has useful resources to address implicit bias. The book *Doorway Thoughts: Cross-Cultural Health Care for Older Adults*[v] has a cultural assessment tool that has been valuable in board, staff, and volunteer education.

6. **SPECIAL FOCUS PROGRAM**

   The Coalition appreciates the decision to appoint a Technical Expert Panel (TEP) to help CMS with the detailed implementation of the Special Focus Program (SFP). In considering the roles and responsibility of the TEP, the Coalition encourages CMS to consider the following:

   Coalition Recommendations:

   - The Coalition strongly recommends that nominations from the public be made available to serve on the TEP and that the proceedings of the TEP be as transparent as possible, including multidisciplinary and patient/caregiver perspective.
   - The Coalition recommends that the TEP be charged with advising CMS on the details of implementation of the SFP, including the terms of selection, enforcement, and technical assistance criteria. Due to the complexity of the SFP and potential long-term impacts, this program should not be implemented until the TEP has completed its work in this area and has had the opportunity to consider SFP Eligibility, use of other data for SFP eligibility, and SFP graduation.

Thank you for your consideration of the Coalition's comments on this proposed rule. If you have questions about our comments, we would be pleased to convene experts from our Coalition to speak with you or your staff. Please contact Amy Melnick, Executive Director, National Coalition for Hospice and Palliative Care at 202.306.3590 or amym@nationalcoalitionhpc.org

LIST OF ORGANIZATIONS

American Academy of Hospice and Palliative Medicine
Association of Professional Chaplains
Health Care Chaplaincy Network
Hospice Palliative Nurses Association
National Association of Home Care & Hospice
National Hospice and Palliative Care Organization
National Palliative Care Research Center
Palliative Care Quality Collaborative
Physician's Assistants in Hospice and Palliative Medicine
Social Work Hospice and Palliative Care Network
Society for Pain and Palliative Care Pharmacists

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[iv] Augustus A. White III Institute for Healthcare Equity, https://aawinstitute.org

[v] Doorway Thoughts: Cross-Cultural Health Care for Older Adults, published by the American Geriatrics Society, Editors: Sharon Brangman, MD, FACP, AGSF; Vyjeyanthi S. Periyakoil, MBBS, MD, (2014)