



2022 Technical Expert Panel and Stakeholder Listening Sessions: Hospice Special Focus Program Summary Report

**Contract No. 75FCMC18D0014
Task Order No. 75FCMC19F0001
Deliverable 4-27**

April 28, 2023

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Table of Acronyms

AO	Accrediting Organization
CAA	Consolidated Appropriations Act
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CHC	Continuous Home Care
CLDs	Conditional-Level Deficiencies
CMS	Centers for Medicare & Medicaid Services
CoPs	Conditions of Participation
COVID-19	Coronavirus disease of 2019
CY	Calendar Year
FR	Federal Register
FY	Fiscal Year
GIP	General Inpatient Care
HCI	Hospice Care Index
HH PPS	Home Health Prospective Payment System
HVLDL	Hospice Visits in the Last Days of Life
MAC	Medicare Administrative Contractor
MedPAC	Medicare Payment Advisory Commission
NPRM	Notice of Proposed Rulemaking
OIG	Office of Inspector General
PAC-PUF	Post-Acute Care Public Use File
PDC	Provider Data Catalog
PHE	Public Health Emergency
RHC	Routine Home Care
SA	State Agency
SFF	Special Focus Facility Program (Nursing Home)
SFP	Special Focus Program (Hospice)
SLDs	Standard Level Deficiencies
SOG	Survey Operations Group
TA	Technical Assistance
TEP	Technical Expert Panel

Background

The Consolidated Appropriations Act (CAA) of 2021 authorized the Secretary of Health & Human Services to create a Special Focus Program (SFP) which aims to address issues that place hospice beneficiaries at risk for poor quality of care through increased oversight and/or technical assistance. The SFP will help to ensure hospices in the program are held accountable for poor quality of care. The Centers for Medicare & Medicaid Services (CMS) discussed the SFP in the Calendar Year (CY) 2022 Home Health Prospective Payment System Final Rule (HH PPS) (86 FR 62240). Although CMS proposed a specific methodology and criteria to identify hospices for enrollment in the program in that rule, they did not finalize the SFP based on public comments to seek Technical Expert Panel (TEP) feedback to inform development of the SFP. CMS agreed with public comments and reiterated this intention in the Fiscal Year (FY) 2023 Hospice Wage Index and Payment Rate Update (87 FR 45669).

CMS contracted with Abt Associates, Inc. (Abt), an independent research company, to support the development of the hospice SFP. To gain input from key stakeholders on various aspects of the SFP, Abt convened a TEP comprised of a wide range of hospice experts and also held four listening sessions with additional stakeholder groups. The TEP and stakeholders opined on the SFP methodology to identify poor performing hospices and other components of the program, including additional oversight and technical assistance to hospices selected for the program to enable continuous improvement.

TEP and Stakeholder Listening Sessions Overview

The purpose of convening a TEP is to seek ideas and input from a diverse group of experts through thoughtful discussion. After a 30-day solicitation period, Abt chose nine hospice experts to serve on the SFP TEP. Members included individuals from hospices, both for-profit and not-for-profit, state and national hospice associations, and caregiver representatives (see Appendix I). This wide range of expertise ensured the TEP included diverse perspectives.

Abt convened the TEP in four meetings held between October and November 2022. The TEP objectives were to provide input and expertise on a wide range of areas, including the SFP methodology, public reporting requirements, and entrance and exit criteria for the program.

After the TEP sessions, four additional listening sessions were held with groups of stakeholders including industry representatives, accrediting organizations, federal experts, and patient advocates. Abt shared an overview of what was presented to the TEP with stakeholders to provide an opportunity for additional perspectives for consideration.

TEP and Stakeholder Discussions and Summary

SFP Data Sources and Methodology

The CY 2022 HH PPS Final Rule proposed a selection methodology for the SFP. However, based on critique of the methodology in public comments, CMS did not finalize the proposed methodology. Abt and CMS developed a revised preliminary methodology to identify poor performing hospices based on the methodology and public comments described in the CY 2022 HH PPS Final Rule. The revised preliminary methodology incorporates a variety of hospice data sources, including hospice survey data (condition-level deficiencies [CLDs] and substantiated complaints), the Hospice Care Index (HCI) (which uses Medicare claims data), and consumer evaluations from the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) Hospice Survey Star Rating. The measures from each data source are

aggregated, and the resulting score is adjusted based on the number of available data sources for a given hospice. Based on this revised preliminary methodology, a higher score indicates poorer quality.

Multiple TEP members supported the methodology's use of several data sources; however, they also expressed concern about potential data source limitations (e.g., not all hospices have a CAHPS® Hospice Star Rating, etc.). These concerns led to discussions about other data sources and/or indicators that could be used, such as individual CAHPS® survey items.

Using the revised preliminary methodology developed, Abt obtained scores for all active hospices and presented the data to the TEP applying four different stratification approaches to identify SFP candidate hospices:

1. No stratification (i.e., hospice agencies with the worst overall scores nationally would be on the candidate list)
2. Stratification by hospice size (i.e., hospices would be sorted into quartiles based on their number of Medicare beneficiaries¹, with a certain number chosen from each quartile for the candidate list)
3. Stratification by CMS Location (i.e., a certain number of hospices would be chosen from the 10 CMS geographic locations)
4. Stratification by state (i.e., a predetermined number of hospices would be chosen from each state)

The TEP supported stratifying by hospice size or CMS Location, and even supported not stratifying at all. However, the TEP did not support stratifying by state, as they wanted to ensure the poorest performing hospices were included on the candidate list regardless of their geographic location. Overall, the TEP expressed support for candidate hospices to be identified based primarily on quality scores over geographic location or agency size.

SFP Survey Frequency

As indicated in the CAA 2021, once in the SFP a hospice should be surveyed “not less than once every six months.” TEP members were asked to consider whether six months was an appropriate length of time or if that duration should be lengthened. Based on the TEP discussion, members agreed that the six-month survey timeframe for hospices in the SFP was reasonable. Most TEP members expressed wanting the six-month surveys to be carried out solely by state survey agencies (SAs) and not by accrediting organizations (AOs). Only one member felt that the burden of more frequent surveys could be split between the SAs and AOs (as applicable). Finally, the TEP discussed having a transition period for hospices graduating from the SFP program, whereby those hospices would be surveyed annually for some period after graduation to ensure continued compliance, before returning to the typical three-year hospice survey cycle.

SFP Technical Assistance

TEP members were asked to discuss whether technical assistance (TA) should be provided to hospices in the SFP program. All TEP members agreed that TA should be provided to hospices in the SFP and that it should come from a third party (i.e., not an SA or AO surveying hospices in the program) to avoid conflicts of interest and undue burden on surveyors. To ensure the quality and consistency of the TA provided, the TEP suggested that CMS craft standards and measures for TA providers to use. Lastly, the

¹ Medicare beneficiaries includes those enrolled in Traditional Medicare (i.e., fee-for-service) or a Medicare Advantage plan.

TEP discussed how TA could be funded either through retaining a portion of civil monetary penalties or funds from monthly claims reconciliation for recouped overpayments.

SFP Graduation Criteria

The CY 2022 HH PPS Final Rule discussed that a hospice could graduate from the SFP when the hospice has two consecutive six-month surveys without any CLDs. TEP members were asked to consider this proposed criterion and discuss any additional requirements for consideration. The TEP generally agreed that a hospice should have two consecutive surveys with no CLDs, no substantiated complaints, and less than a certain number of standard-level deficiencies (SLDs). As noted above, once graduated, the TEP suggested a transition period of annual surveys before returning to the three-year survey cycle.

SFP Termination Criteria

For hospices in the SFP program that fail to meet the graduation criteria (i.e., two consecutive six-month surveys with no CLDs), the CY 2022 HH PPS Final Rule considered placing them on a Medicare termination track, but this was not finalized. The TEP generally agreed that a hospice should face progressive enforcement actions while in the SFP before being placed on a termination track. These actions could include denial of a percentage Medicare payments for new admissions and civil monetary penalties. The TEP suggested that a hospice should be placed on the termination track if it failed to improve after 18 to 24 months (three to four six-month surveys). The TEP suggested that this criterion would apply to all hospices, even if the termination of a provider may cause access issues in certain geographic areas, noting that, in their opinion, beneficiaries would be better off if there was no hospice available, rather than be served by a poor-quality hospice. The TEP also noted that any service gaps that occurred due to such terminations might encourage other hospice providers to deliver care in that area.

Public Reporting of the SFP

Once CMS selects hospices for the SFP, the SFP status must be clearly communicated to patients and caregivers so they can make an informed decision about their hospice care. The main source of hospice quality information is Care Compare, a CMS website. TEP members were asked to consider what information to include on Care Compare to inform caregivers and beneficiaries about hospices in the SFP.

Generally, all TEP members agreed that Care Compare should clearly identify all SFP hospices with an icon next to their name. They also noted that the language on Care Compare explaining the SFP to consumers should be easy to understand and visible (i.e., a user should not have to hover over an icon or click a link to see the explanation). The TEP also believed that key details about a hospice's SFP status (e.g., candidate, enrolled, etc.), the most recent full Statement of Deficiencies and Plan of Correction (CMS-2567) survey report, and survey date should be readily available on the site. Lastly, the TEP broadly agreed that the SFP data should be contained within a single spreadsheet on the Provider Data Catalog website so that consumers can easily access it.

Special Focus Program (SFP) Background

According to the 2022 Medicare Payment Advisory Commission (MedPAC), more than 1.7 million patients received hospice services in 2020 at a cost of \$22.4 billion to Medicare (MedPAC, 2022). The hospice industry is growing rapidly, with the number of Medicare-participating hospices increasing by more than 44 percent in the past decade (5,058 in 2020 compared to 3,498 in 2010; MedPAC, 2022). Quality hospice care at the end of life is associated with better patient satisfaction, pain control, decreased intensive care unit use, and decreased hospital mortality (Kleinpell et al., 2019). However, a recent report indicated that 18 percent of hospices fail to meet the health and safety standards Medicare requires for participation in the hospice program (OIG, 2019), potentially endangering patients.

In addition to surveying hospices in the Medicare program to ensure they meet the hospice Conditions of Participation (CoPs), the Centers for Medicare & Medicaid Services (CMS) is creating a Special Focus Program (SFP) to address hospice care issues as authorized by the Consolidated Appropriations Act (CAA) of 2021. This increased oversight of hospices will identify issues that place hospice patients at risk for poor quality of care. The SFP expects to include hospices identified as substantially failing to meet applicable Medicare requirements or other indicators of poor performance, based on a set of criteria and measures. These hospices would be subject to additional oversight, which may result in additional enforcement remedies, including termination from the Medicare program (CAA, 2021).

CMS contracted with Abt Associates, Inc. (Abt), an independent research company, to convene a Technical Expert Panel (TEP) to inform the development of the SFP program, including the methodology to identify candidate SFP hospices. The TEP also provided feedback on important aspects of the SFP program such as graduation criteria and public reporting of SFP status.

SFP Legal Authority and Regulatory Summary

Congress first authorized CMS to develop the SFP in December 2020 and CMS discussed the SFP in subsequent rulemaking. Authority for SFP planning and implementation is covered by:

- **[Consolidated Appropriations Act of 2021 \(CAA 2021\)](#)**: Congress authorized the Secretary of Health & Human Services to create an SFP for hospice programs identified as having substantially failed to meet applicable requirements of the CAA 2021. Hospices in the SFP would be subject to additional surveys that would take place no sooner than once every six months.
- **[CY 2022 Home Health Prospective Payment System \(HH PPS\) Notice of Proposed Rulemaking \(NPRM\) \(86 F.R. 35874\)](#)**: CMS proposed a specific methodology and procedures to identify low-performing hospices for the SFP. The proposed criteria noted that candidate hospices would have a history of condition level deficiencies (CLDs) on two consecutive standard surveys, two consecutive substantiated complaint surveys, or two or more CLDs on a single validation survey following a complaint or standard survey that cited a CLD.

This NPRM proposed that hospices meeting the specified criteria would be added to a candidate list that would be submitted to the State Agency (SA) and the CMS Survey Operations Group (SOG). These groups would work together to select a subset of hospice programs for SFP enrollment based on state priorities and capacity (with the possibility of no SFP enrollment in a certain state if no hospices in the state meet the SFP criteria). The subset selected for the SFP would be subject to surveys every six months with the possibility of additional enforcement remedies, including termination, for continued failure to meet requirements. Hospices would graduate from the SFP once they completed two consecutive six-month SFP surveys with no CLDs. Hospices that did not meet the criteria for graduation would be placed on a termination track.

However, CMS did not finalize the proposed methodology and procedures for the SFP ([86 F.R. 62240](#)) and instead stated that they would collaborate with hospice stakeholders to further inform program development.

- **[FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements \(87 F.R. 45669\)](#)**: CMS affirmed their intention to seek hospice TEP input on the

structure and methodology of a SFP, as well as their intent to propose a final version of SFP methodology and procedures in upcoming rulemaking.

Public Comments

Individuals and organizations responded to rulemaking proposals via public comments that are summarized below to identify areas of agreement and disagreement with CMS' proposals regarding the SFP:

- **[CY 2022 HH PPS Final Rule \(86 F.R. 62240\)](#)**: Many commenters expressed concern that the proposed criteria for candidacy are subjective and could lead to inconsistencies across SAs and between SAs and Accrediting Organizations (AOs). Specific suggestions included using claims-based indicators and considering the number, scope, and severity of deficiencies cited on surveys. Additionally, commenters overwhelmingly expressed that selection for the SFP should not rely on a state-based selection process but rather a national capture of the lowest performers.

Beyond the selection methodology, some public commenters suggested that CMS provide relevant tools and education to assist SFP-selected hospice providers in improving quality and compliance before placing providers on a termination track. Others asserted that CMS should be cautious in using the suspension of payment as an enforcement remedy and suggested using this only as a last resort.

Finally, commenters generally agreed that CMS should use a TEP both to assist in developing a comprehensive methodology that would include metrics other than just survey performance and to provide input on the public reporting of SFP participants. Commenters placed emphasis on keeping publicly reported information as current as possible and updating that information in a timely manner (e.g., if a hospice graduated from the SFP). They also expressed that details about the program should be carefully developed to convey current and timely information in a way that is accessible and easily understandable to the public, and is fair and equitable across all hospice programs.

- **[FY 2023 Hospice Notice of Proposed Rulemaking \(87 F.R. 19442\)](#)**: Commenters generally supported CMS' efforts to establish an SFP and engage the hospice experts and industry stakeholders through a TEP. Many supported CMS considering a wide range of stakeholders for TEP membership, including hospice representatives from for-profit and not-for-profit, rural and urban, and small and large hospices, as well as individuals who directly interact with patients and surveyors.

A few commenters once again encouraged CMS to avoid using a state selection process such as used for the nursing home Special Focus Facility (SFF) program. The commenters expressed that decisions about hospices and their inclusion in the SFP should be centralized and standardized, and should be based on their overall performance and not location. A few others expressed support for standardizing the hospice survey process, including surveyor training, before fully implementing the SFP to ensure alignment in how SAs and AOs implement the survey process.

Technical Expert Panel and Stakeholder Listening Sessions Overview

TEP Composition

Abt solicited nominations for and subsequently formed a TEP to provide input into developing the hospice SFP. Recruitment began in July 2022 with a 30-day call for nominations. CMS and Abt disseminated the call for nominations through the CMS website, social media, and various industry listservs to solicit nominations from a diverse group of hospice experts, including providers, patient advocates, members of national and state associations, other hospice staff members, and patients and caregivers. After the nomination period closed, nine nominees with diverse backgrounds and a range of perspectives and expertise were selected.

The final TEP members included representatives from not-for-profit and for-profit hospices, national and state hospice associations, and caregivers. Table 1 lists the name and profile of the final TEP members. Additional member information is provided in Appendix I.

Table 1. SFP TEP Members

Name	State	Organization Type	Relevant Experience
Ken Albert, RN, Esq.	Maine	Not-for-profit	SFP program; regulations
Rita Choula, MA	Maryland	Consumer advocacy organization	Patient/caregiver, national consumer policy advocate
Torrie Fields, MPH	California	Independent consultant	Patient/caregiver, health services researcher, health economist
Barbara Hansen, MA, RN	Oregon	State association	Hospice management; regulatory and compliance issues
Margherita Labson, BSN, MSHSA, CCM, CPHQ	Washington, DC	National association	Home care; accreditation surveys; regulatory and compliance issues
Judi Lund Person, MPH, CHC	Virginia	National association	Technical assistance; hospice enforcement remedies
Edward Martin, MD, MPH, FACP, FAAHPM	Rhode Island	Not-for-profit	Hospice physician; national regulatory experience; education
Terrie Speaks, BSN, RN, CHPN	North Carolina	For-profit	Regulatory and compliance issues; for/not-for-profits; accreditation surveys
Gabrielle Winther, LCSW	New Jersey	Not-for-profit	Social work; inpatient and outpatient palliative care

TEP Responsibilities

The SFP TEP objectives were to:

- Provide input on the SFP methodology to identify hospices that have substantially failed to meet applicable Medicare requirements based on identified criteria.
- Suggest potential public reporting requirements for the SFP (e.g., candidate list, SFP program participants, graduates, terminations, etc.) and methods to communicate this information in a manner that is prominent, readily accessible, understandable, and searchable by the general public.
- Provide input on specific aspects of the SFP program, such as entrance and exit criteria, technical assistance expectations for SFP participants, and survey frequency.

The TEP met four times between October and November 2022 to discuss the relevant aspects of the SFP. The TEP was also able to e-mail Abt after each meeting if they wanted to provide additional information or comments for consideration.

Stakeholder Listening Sessions

After holding the four TEP sessions, Abt conducted four additional stakeholder listening sessions to provide a high-level overview of the information presented to the TEP. The stakeholder groups included federal experts, hospice consumer/patient advocates, AOs, and industry representatives. The federal experts included leaders with experience in hospice surveys, quality measurement, health and safety, monitoring, and oversight. The goals of these sessions were: 1) to ensure stakeholder awareness of the key concepts and ideas related to the SFP and 2) to allow stakeholders to share their perspectives for consideration.

The listening sessions provided stakeholders a 40-minute overview of the TEP discussion topics, followed by approximately 20-30 minutes for comments. The topics covered included data sources, methodology, survey frequency, technical assistance, graduation criteria, termination criteria, and public reporting. Stakeholders were given the option to e-mail Abt additional comments after the listening sessions.

TEP Discussions and Stakeholder Comments Summary

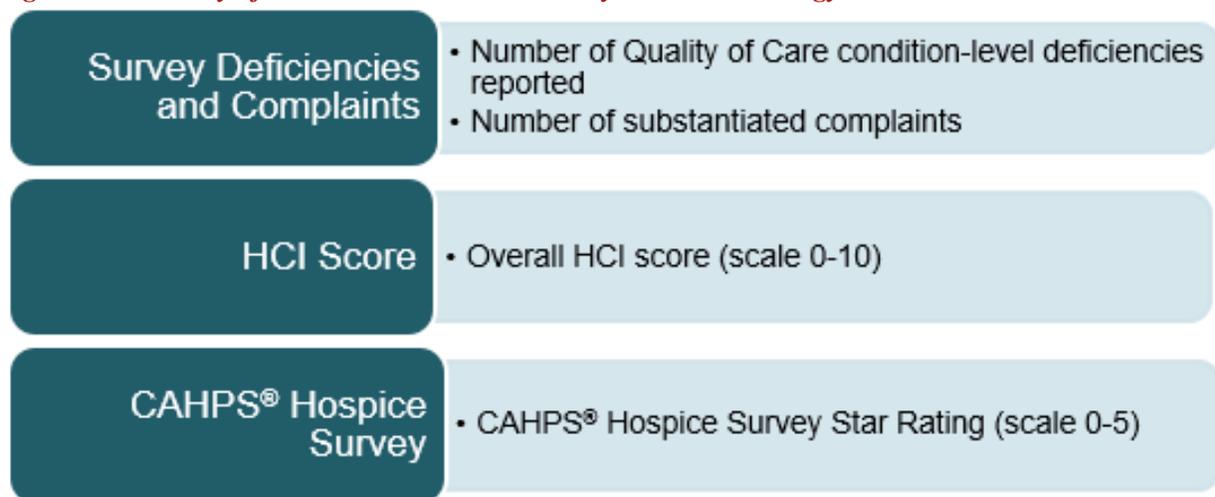
SFP Methodology, Part I: Data Sources

Background

The CY 2022 HH PPS NPRM (86 F.R. 35874) proposed an SFP selection methodology based on the nursing home SFF program approach, but that SFP methodology was not finalized (see Appendix IV). In the SFP’s initial proposed methodology, SFP candidate hospices would have condition-level deficiencies (CLDs) on two consecutive standard three-year surveys, two consecutive substantiated complaint surveys, or two or more CLDs on a single validation survey following a complaint or standard survey that cited a CLD. Hospices meeting the proposed criteria would be submitted to the SAs and CMS’ Center for Clinical Standards and Quality’s SOG. The SA and CMS SOG would then select a subset of these hospice programs for SFP-enrollment based on state priorities and capacity.

Based on public comments on the proposed rule’s methodology and further review of hospice data, CMS and Abt developed an alternate SFP methodology to identify poor performing hospices. Abt presented this methodology for TEP discussion. The methodology incorporated hospice quality measures from three data sources: survey data (CLDs and substantiated complaints), the Hospice Care Index (HCI) score (a claims-based measure), and data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey Star Rating (see Figure 1).

Figure 1. Summary of Data Sources in Preliminary SFP Methodology



The survey data contains information on both substantiated complaints and survey deficiencies. The survey deficiencies are classified as standard level deficiencies (SLDs) or CLDs with appropriate “tags” for the specific requirements or CoPs not met by the hospice. Rather than using all CLDs, the preliminary methodology only used CMS recommended CLDs based on CoPs that are directly related to quality of patient care (see Appendix III for a Quality of Care CoP listing).

The Abt-developed SFP methodology shared with the TEP used substantiated complaints rather than all complaints filed against a hospice. Substantiated complaints represent the subset of all complaint allegations an onsite validation survey upheld. These result in citations for CoP noncompliance and the SA records the findings as deficiencies on a hospice’s survey record. Approximately one-third of all complaint allegations are substantiated (Stevenson & Sinclair, 2018).

The CMS and Abt-developed SFP methodology also used the HCI, an index measure based on Medicare claims data (Abt Associates, 2022). CMS calculates the HCI score using 10 quality indicators that describe hospice care processes, with the hospice earning a “point” for each indicator for which criteria are met. HCI scores are not reported publicly for small or new hospices, so HCI scores for these hospices were not included in the preliminary methodology.

Finally, the CAHPS[®] Hospice Survey responses submitted by the caregivers of deceased patients includes eight measures. These data represent caregiver experiences and evaluation of the scope and quality of the hospice care the patient received. Beginning in August 2022 on Care Compare, the scores of the eight measures are consolidated into an overall CAHPS[®] Hospice Survey Star Rating. The CMS and Abt-developed SFP methodology used the CAHPS[®] Hospice Survey Star Rating rather than individual CAHPS[®] measures. The CAHPS[®] Star Rating is publicly reported for all hospices with 75 or more completed CAHPS[®] Hospice Surveys over the reporting period. The preliminary SFP methodology did not include CAHPS[®] Hospice Survey Star Rating data for those hospices without a publicly reported Star Rating.

TEP Discussion

Multiple members of the TEP preferred using a methodology that incorporates the three data sources identified: surveys, HCI, and CAHPS[®]. However, members were concerned by the limited availability of data, particularly since only one-third of hospices had a publicly reported CAHPS[®] Hospice Survey Star Rating. Members also expressed concern that providers would not be “on the same playing field” based on data availability. TEP members did not support other suggested data sources, such as Hospice Visits in the Last Days of Life (HVLDDL), which captures only one aspect of hospice care, or the Post-Acute Care Public Use File (PAC-PUF), which captures demographic and utilization information rather than quality of care data.

Surveys

The TEP supported the use of survey deficiencies as an SFP methodology component. Although members generally felt survey deficiencies were a good source of information, some expressed concerns about surveyor reliability or state variability in survey policy interpretation when citing deficiencies. One member suggested that it would be helpful to select the deficiencies to focus on (e.g., only priority or Quality of Care CLDs in the preliminary methodology). Additionally, while the preliminary methodology only used a provider’s most recent standard survey, a few members suggested incorporating a provider’s past two survey results (covering a period of up to six years).

The TEP generally supported the use of substantiated complaints in the SFP methodology. However, one member suggested using “substantiated severe complaints” (identified in a 2019 OIG report) rather than all substantiated complaints. According to the 2019 OIG report, “severe complaints are those at the two highest severity levels; these complaints allege situations of immediate jeopardy (i.e., likely to cause serious injury, harm, impairment, or death to a patient) or non-immediate jeopardy high priority (i.e., likely to involve substantial noncompliance with one or more CoPs).”

HCI

The TEP supported the inclusion of HCI data in the preliminary methodology as a measure of care during a hospice stay (Abt Associates, 2022). Some members found it acceptable to use the entire HCI measure because it is based on Medicare claims data, providing evidence of care delivery decisions and actions at a hospice (Abt Associates, 2022). Others suggested pulling out certain indicators rather than using the HCI measure in its entirety. These members thought that some individual HCI indicators were not as

important, because even if they were not met, a hospice could still be providing high quality care (e.g., per-beneficiary spending). Overall, eight of the ten HCI indicators were suggested as potential stand-alone inputs into the methodology, including:

1. No Continuous Home Care or General Inpatient Provided
2. Nursing Visits on Weekends
3. Live Discharge
4. Burdensome Transitions (Type 1) – Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission
5. Burdensome Transitions (Type 2) – Live discharges from hospice followed by hospitalization with the patient dying in the hospital
6. Gaps in Skilled Nursing Visits
7. Visits Near Death
8. Skilled Nursing Care Minutes per Routine Home Care Day

CAHPS® Hospice Survey

TEP members strongly believed that CAHPS® Hospice Survey data are critical to include in the SFP selection algorithm because those data capture family and caregiver experiences. However, members were concerned by CAHPS®' limited availability. Specifically, CAHPS® measures are not reported for hospices with fewer than 50 CAHPS® survey responses and Star Ratings are not reported for hospices with fewer than 75 CAHPS® survey responses over the reporting period. As a result, many small and new hospices are exempt from reporting and do not have a Star Rating. Multiple members expressed support for using a few key CAHPS® measures rather than the Star Rating, as this approach increases the number of hospices for which data are available. The TEP identified the most important CAHPS® Hospice Survey measures for the SFP as:

- Help for pain and symptoms
- Getting timely help
- Willing to recommend this hospice
- Rating of this hospice

Listening Session Comments

Surveys

Stakeholders voiced concern about the various lags in publicly reported data, noting that a hospice can significantly improve in one or two years. One stakeholder suggested mitigating the risk of placing a recently improved hospice in the SFP with a “focus visit”. This visit would confirm that there is still cause for concern before placing the hospice in the SFP. One stakeholder suggested that a “live pilot” of the methodology be conducted prior to implementation. This would entail testing the methodology on hospices that are due for a survey to determine whether it accurately identifies poor performing providers.

Some stakeholders flagged that SAs sometimes are unable to follow up on complaints in a timely manner, citing cases where agencies are still working on substantiating complaints from 2017 and 2018. Stakeholders also raised concerns about the COVID-19 public health emergency (PHE) and the effect of the PHE on complaints and deficiencies.

HCI

Due, in part, to concerns that inter-surveyor differences can make survey data more subjective and less reliable, many stakeholders supported the inclusion of the HCI measure in the SFP algorithm. Since the

HCI is based on claims data, it objectively captures information on care processes that did or did not occur at a hospice, so the TEP did not share the same concerns about reliability of the data as they did for survey data. One stakeholder spoke in favor of the HCI, noting that it is a good measure for program integrity and that a provider that scores poorly on the HCI likely has several potential concerns.

CAHPS[®] Hospice Survey

Many stakeholders expressed concern about the small proportion of hospices for which publicly reported CAHPS[®] Hospice Survey Star Ratings are available. Additionally, one stakeholder expressed that Star Ratings can be misleading since a provider can have a three-star rating but get four- and five-star reviews from their patients. Another stakeholder explained that there are providers in their area that may choose to pay the financial penalty rather than participate in CAHPS[®] reporting due to the challenge of collecting enough survey responses.

One attendee added that many patients receive services in nursing homes and assisted living facilities, and caregivers could be asked to respond to multiple CAHPS[®] surveys reflecting their experience with different providers. Patients and caregivers can find it difficult to identify which providers are specifically associated with the hospice. Additionally, one stakeholder noted that for smaller hospices that just barely make the CAHPS[®] reporting cutoff, one or two reviews can significantly impact their score.

Additional Data Sources

Across listening sessions, stakeholders inquired about additional data sources that could be used for the SFP selection methodology. Stakeholders asked if data from medical review audits, claim investigations, or the list of hospices who did not receive their Annual Payment Update (APU) due to non-compliance with the [Hospice Quality Reporting Program](#) (HQRP) were considered. They also mentioned additional data sources, such as the [Program for Evaluating Payment Patterns Electronic Report](#) (PEPPER) or other reports from the CMS' [Center for Program Integrity](#). One stakeholder highlighted that the preliminary SFP methodology did not include any input from the Medicare Administrative Contractors (MACs), noting that there are likely differences between state regulators and MACs perspective. Another stakeholder countered that using MAC data would require CMS to wait for the MACs decisions to be reviewed, appealed, and validated, which could take years.

Key Takeaways and Implications

The TEP supported a methodology that incorporates HCI and CAHPS[®] data, in addition to select CLDs and substantiated complaints from hospice survey data. However, some TEP members suggested pulling out certain CAHPS[®] measures and HCI indicators rather than using both those measures in their entirety. TEP members did not support other suggested data sources, such as HVLDL or PAC-PUF, as they are too narrow in scope or do not focus on quality. The listening session comments generally supported the data sources of the Abt-developed SFP methodology but noted that additional data that is not publicly available may be useful to further inform or validate poor performance and the SFP candidate list.

SFP Methodology, Part II: Score Calculation

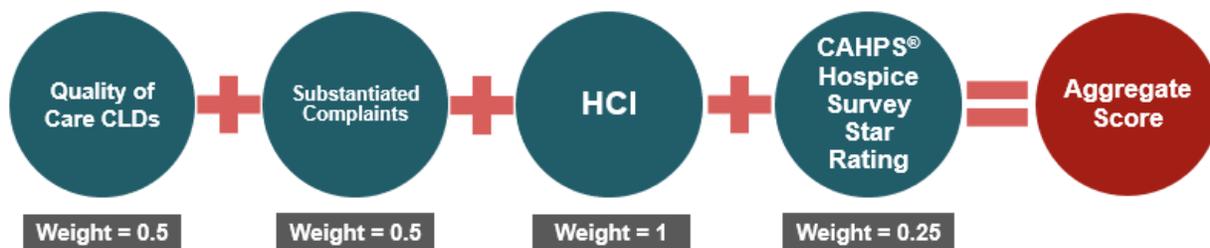
Background

The CMS and Abt-developed SFP methodology uses a scoring method where a higher score indicates worse performance on quality measures and a lower score indicates better performance. The score sums measures from the three data sources, and adjusts the aggregate score based on the number and combination of data sources available for a given hospice (see Figures 2 and 3). The methodology sums

the scores after multiplying each by their weight in the model. Therefore, if a score has a weight of 0.5, its overall impact in the model is half of what it would be if it was unweighted (weight=1.0). The components of the preliminary SFP candidate methodology and their weights are as follows:

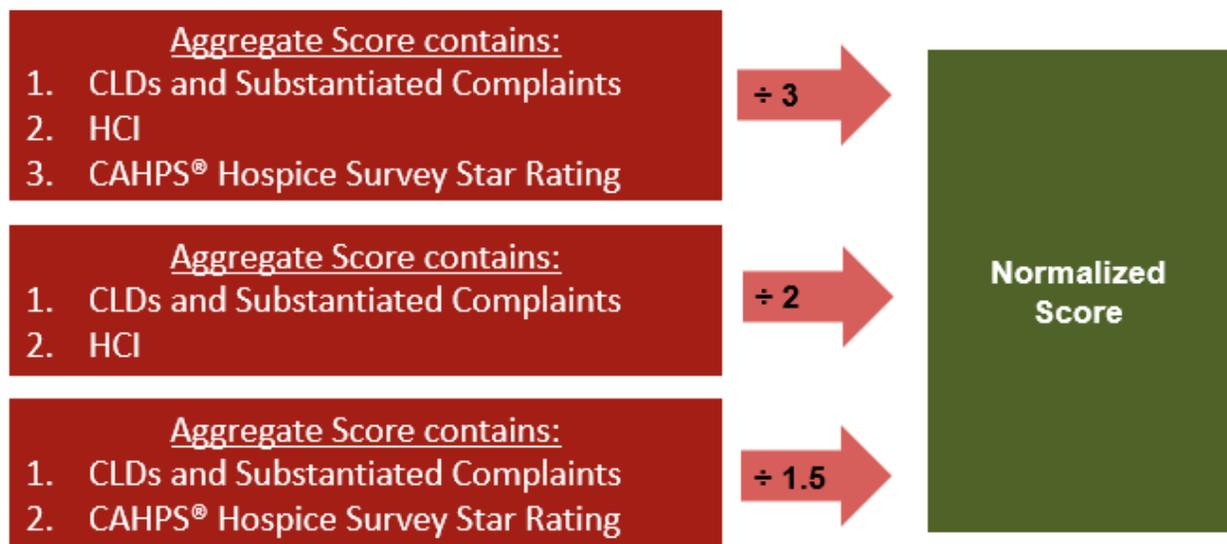
- Number of Quality of Care CLDs and number of substantiated complaints. Both Quality of Care CLDs and substantiated complaints were scaled as CLDs/Substantiated Complaints per 100 beneficiaries served, except for hospices in the smallest size quartile (less than 57 beneficiaries, in this instance) for which the raw number was used. This was to ensure that larger hospices were not at a disadvantage compared to smaller hospices. Quality of Care CLDs and substantiated complaints were both weighted at 0.5 (i.e., multiplied by 0.5) for a combined weight of one in the model.
- Overall HCI score. The HCI scores are based on a scale of 0-10, with higher numbers indicating better quality (Abt Associates, 2022). These scores were reversed to a scale of 1-11 so that higher HCI scores indicated worse performance to support the SFP methodology. HCI was unweighted, therefore its score is multiplied by 1 in the model.
- CAHPS® Hospice Survey Star Rating. The Star Ratings are on a scale of 0-5, with higher numbers indicating higher quality (CAHPS® Hospice Survey, 2022). These scores were also reversed to a scale of 0-5 so that higher Star Ratings indicated the worse performing hospices to support the SFP methodology. CAHPS® Star Rating was given a lower weight of 0.25 (i.e., multiplied by 0.25 in the model) because approximately two-thirds of hospices do not have a CAHPS® score reported.

Figure 2. Summary of Preliminary Methodology Weighting and Aggregation



To account for hospices with missing data, the Abt-developed methodology adjusts for missing values (Figure 3). For example, when hospices have all three values, the aggregate scores are divided by three, denoting the presence of all three data sources. When hospices are missing a CAHPS® Hospice Survey Star Rating, the aggregate of HCI and Quality of Care CLDs and substantiated complaints are divided by two. When hospices are missing HCI, the aggregate of their CAHPS® Hospice Survey Star Rating, Quality of Care CLDs, and substantiated complaints are divided by 1.5 to reflect the CAHPS® Star Ratings lower weight of 0.25. In this SFP methodology, only hospices that had a value for Quality of Care CLDs and/or substantiated complaints were included in the analytic file. In this way, the scores are standardized so a missing value for an input will neither help nor hurt a hospice in the algorithm.

Figure 3. Summary of Preliminary Adjusted Score



In general, using this methodology, the highest scoring (i.e., ‘poorest performing’) hospices had their scores driven by poor HCI performance. These same hospices generally did not have a high number of substantiated complaints and Quality of Care CLDs, pointing to a lack of correlation across these dimensions. Providers with the top ten highest scores all had fewer than 100 beneficiaries and none had CAHPS® Star Ratings available. The methodology presented to the TEP was preliminary and intended as an example of what the final methodology could look like and the characteristics of the candidate hospices that could be selected based on variations in the methodology.

TEP Discussion

TEP members did not object to the use of an additive scoring algorithm but did discuss the weighting of each component. As discussed in the data sources section, a few TEP members suggested incorporating a provider’s past two survey results (covering a period of up to six years) to increase the amount of data available for the methodology. Citing the large amount of time that can elapse between surveys, some TEP members favored weighting the most recent survey more heavily while others favored weighting them equally if two survey cycles are used. Some TEP members argued that the valuable perspectives of family and caregivers on the CAHPS® Hospice Survey justified weighting it more than other data sources (e.g., weighting it at 2.0). Other TEP members voiced concern about that approach, noting that small and new hospices may be disadvantaged due to the limited or no CAHPS® data.

Listening Session Comments

Stakeholders asked whether the Abt-developed SFP algorithm excluded any data or used measures to specifically include or exclude certain types of hospices, such as those in rural areas or those with significant service diversification. The Abt team confirmed that all hospices regardless of geographic location or services provided were included, as the TEP wanted to ensure all hospices were held to the same quality of care standards.

Key Takeaways and Implications

Broadly, TEP members and stakeholders were supportive of the general scoring methodology presented, including how the data sources are added together and the use of weighting. While some TEP members discussed increasing the weight given to the CAHPS® Hospice Survey Star Rating to reflect the

importance of family and caregiver perspectives, other TEP members had mixed opinions about increasing its weight due to the limited availability of the CAHPS® survey data.

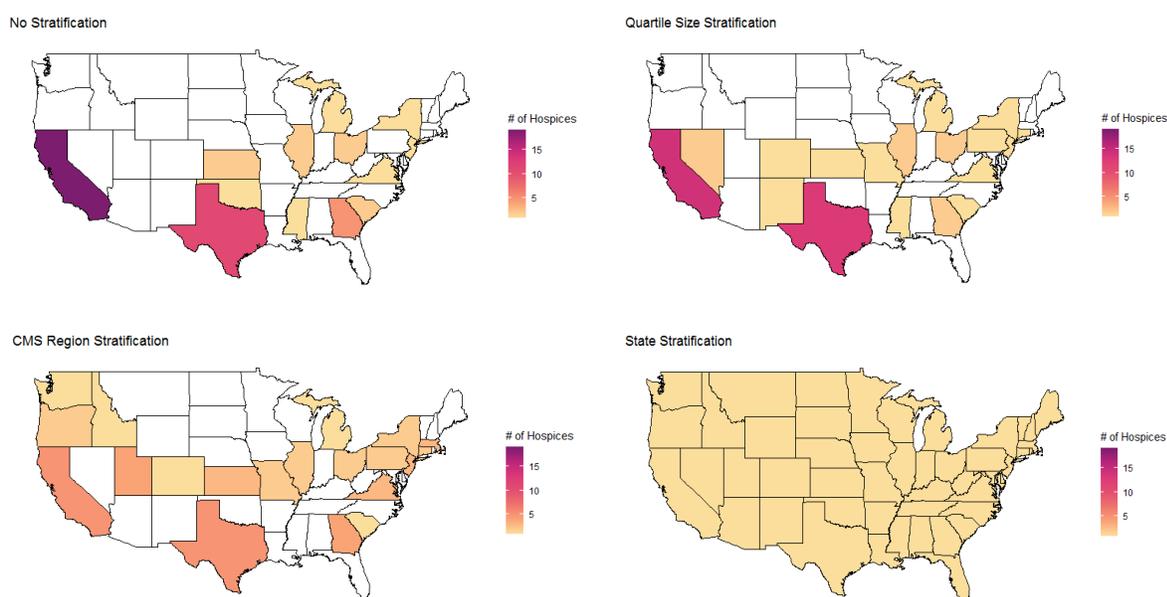
SFP Methodology, Part III: Stratification and Selection

Background

Due to the nature of the available data, any selection methodology may introduce bias. For instance, hospice size, age, and location can influence who conducts surveys (i.e., an SA or AO), potentially impacting results, and whether data is publicly available (i.e., smaller, newer hospices have fewer data points with which to construct scores). Stratification of the candidate list can mitigate some of this bias by ensuring that hospices with a diverse range of sizes or locations are selected. Abt selected 50 hospices (as an arbitrary number for discussion purposes) from the full list of active hospices with scores to model how different stratification and selection approaches would identify hospices for the SFP (Figure 4). Four stratification approaches resulted in four different lists of 50 hospices, demonstrating the potential effect each stratification method could have on hospices for candidacy in the SFP:

- No stratification reflected the 50 absolute highest scorers based on the described SFP methodology, indicating they are the poorest quality hospices. Hospices included were typically small and had no CAHPS® data. A high volume of these hospices was concentrated in a few states.
- Quartile size stratification sorted all hospices based on the number of beneficiaries served into four groups based on patient volume (57 or fewer beneficiaries, between 57 and 149 beneficiaries, between 150 and 390 beneficiaries, and 391 or more beneficiaries). Twelve-to-thirteen hospices with the highest SFP methodology scores within each quartile were included in this list of 50 SFP hospices. Hospices included on this list had quality measures with scores well above average, indicating some high-quality hospices were included. Some of the hospices included had CAHPS® data. Relative to no stratification, this method increased the diversity of hospice sizes selected and increased the geographic spread to some degree but not completely.
- CMS Location stratification (five candidates per location) selected hospices with above average quality measures scores. Relative to no stratification or size stratification, a higher volume of hospices with quality measure scores near average were selected over those with higher quality measure scores in more hospice dense regions, suggesting more poorer quality hospices were included. Geographic diversity was greatly increased.
- State stratification (one candidate per state) selected the single worst scoring hospice in each state. Although these hospices were distributed evenly across states, the state-based listing included hospices with above average quality measures that were ranked relatively low on the list of poorest performing hospices by the methodology compared to other stratification approaches. This suggests some high-quality hospices were included using this stratification method.

Figure 4. Geographic Distribution of 50 Hospices in SFP based on Four Stratification Approaches



TEP Discussion

The TEP's expressed priority was identifying hospices with the worst overall quality scores regardless of hospice characteristics (e.g., size, location, ownership or profit status). To this end, the TEP took issue with a state stratification approach, in which higher quality hospices would be chosen for the SFP because of a pre-specified state quota. An Abt TEP facilitator asked whether it is important for the SFP to have a presence in each state so that people are informed about poor quality hospices in their state. In response, one member noted that there is already plenty of information about hospice quality on CMS' Care Compare website and that the true priority of the program should be to identify the poorest performers nationally in the SFP. However, at least one TEP member suggested that the candidate list should not be stratified in a way that puts all the facilities in only a few locations so as not to overburden the SAs responsible for overseeing the poor performing hospices. Although the no stratification method selects the hospices with the worst scores, it also concentrates most candidate hospices in a few states. Overall, TEP members generally supported no stratification, the size quartile, or CMS Location stratification approaches.

Other Considerations

Overall, the TEP believed it was important that all hospices be held to the same standards, and that hospices should not be allowed to avoid SFP participation or possible termination based on their patient volume or geographic location. However, some TEP members suggested that the hospice should serve a minimum number of patients per year to qualify for potential inclusion in the SFP, since putting resources into hospices with very few patients would likely limit the impact of the SFP. Members suggested that CMS could determine such a low-volume threshold based on trends in hospice beneficiary data; however, others cautioned that this approach could make it easy for some small agencies to avoid the program. Similarly, some TEP members expressed that the SFP selection process should not overlook rural hospices, since many of them are small. The TEP generally agreed it was equally important to identify low performing hospices in rural areas to ensure the standard of care is comparable relative to urban areas.

Listening Session Comments

Multiple stakeholders across listening sessions were concerned with state stratification because it may not target the poorest performing hospices. One stakeholder expressed that the SFP should only be used in states where it is necessary. Another stakeholder raised concerns that requiring one hospice in the SFP from each state, where one state has 30 hospices and another state has 300 hospices, increases the likelihood that the state stratification method will omit many poor performing hospices. Multiple stakeholders voiced that newer and smaller hospices should be considered for the SFP and that they have the potential to benefit most from receiving TA as a hospice in SFP. Another stakeholder suggested beginning with the no stratification method and phasing in stratification to eventually include hospices in the SFP for each state.

Key Takeaways and Implications

In selecting hospices for SFP candidacy based on preliminary algorithm scores, the TEP supported no stratification, size quartile stratification, and CMS Location stratification but did not support a state stratification approach. Listening session stakeholders also did not support a state stratification approach. TEP members discussed whether small or rural hospices should be given special consideration, but overall felt that all hospices should be held to the same standards to ensure that the SFP is protecting the health and safety of all hospice beneficiaries.

SFP Survey Frequency

Background

TEP members were asked to consider survey frequency for hospices in the SFP and whether it should be greater than once every six months considering the added burden that would be placed on hospice surveyors. According to CAA 2021, "...the Secretary shall conduct surveys of each hospice program in the special focus program not less than once every six months." Additionally, the CY 2022 HH PPS Final Rule stated, "...those hospice programs would be surveyed every six months." For background, the SFF program surveys nursing homes every six months (Quality, Safety & Oversight Group, 2022). Lastly, the CAA 2021 also authorized CMS to provide training for surveyors to help standardize surveys conducted by SAs and AOs.

TEP Discussion

TEP members discussed survey frequency, who should conduct the surveys, and surveyor burden. The TEP believed that surveying SFP providers every six months was appropriate even if it caused potential burden to hospices and surveyors. The TEP also suggested a transition period for SFP providers who have improved enough to "graduate" from six-month surveys. These SFP providers could be surveyed the year following their graduation to demonstrate sustained improvement before returning to the standard three-year survey cycle. Some TEP members suggested providers submit a self-assessment in addition to participating in formal surveys. Self-assessments would provide additional data facilities could use to self-monitor, though the self-reporting would need to be verified by surveyors so as not to overstate progress.

There was some disagreement among TEP members over which entities should conduct the SFP surveys. Multiple members strongly believed that SFP hospices should be surveyed by SAs rather than AOs. They noted this would more accurately measure improvements in SFP hospices by providing a more equal survey experience across SFP providers. They further expressed concern that surveys conducted by AOs might be systematically different from those conducted by SAs. However, one TEP member expressed that both AOs and SAs should be implementing the SFP, including identifying low performing facilities.

TEP members noted surveyor burden may be a factor as many SAs are experiencing a backlog of surveys from the required three-year survey cycle due to the PHE and other delays, and adding additional surveys could make this worse. If many SFP hospices are concentrated in a few states, the burden on those SAs would be greater.

Listening Session Comments

Stakeholders from the four listening sessions did not have any additional comments regarding survey frequency.

Key Takeaways and Implications

TEP members agreed that SFP hospices should be surveyed every six months while in the program. Most TEP members expressed that SAs should conduct the surveys instead of AOs to avoid systematic differences in survey results; however, one TEP member preferred that both AOs and SAs conduct SFP surveys. Lastly, it was discussed that CMS consider a transition period wherein SFP providers who have graduated from the six-month survey process are surveyed annually before returning to the three-year survey cycle to ensure continued improvement. TEP members suggested that CMS consider state surveyor burden when considering the addition of annual surveys post-SFP graduation.

SFP Technical Assistance

Background

According to the CY 2022 HH PPS Final Rule, the hospice SFP is meant to address issues that place hospice beneficiaries at risk for poor quality of care by increasing hospice oversight and/or technical assistance. Of note, there is no required technical assistance (TA) via the nursing home SFP program at the present time; however, nursing homes can engage with the CMS Quality Improvement Organizations to demonstrate a good faith effort towards quality improvement (Quality, Safety & Oversight Group, 2022). TEP members were asked to consider whether TA should be provided to hospices in the SFP.

Discussion

TEP members strongly suggested that TA be mandatory for hospices that are part of the SFP for the duration of their time in the program. The TEP noted that there would be conflicts of interest if the SFP surveying entity (e.g., the SA) also provided the technical assistance. This would add additional time and responsibility to surveyors who are also expected to complete hospice (and other) surveys. Thus, the TEP suggested a list of approved TA providers, on which state and national hospice associations should be included. TEP members noted that national standards should be developed and shared with the SFP TA entities to ensure consistency in application of the TA.

TEP members discussed different ways of procuring TA funding, such as civil monetary penalties or by applying the cost of TA to monthly claims reconciliation based on a low percentage that would have a minimal impact on cash flow. Another TEP member noted that providing TA aligns well with value of quality improvement and providers could budget for it.

Listening Session Comments

One stakeholder voiced support for TA being provided in a way that makes it clear what hospices must do to graduate.

Key Takeaways and Implications

All TEP members agreed that TA should be provided to SFP hospices. In terms of who should provide the TA, the TEP generally agreed that it should be a group different from surveying entities to avoid conflicts of interest and unnecessary surveyor burdens. The TEP also mentioned that CMS should craft

the TA standards and measures to promote consistency across the SFP. Lastly, the TEP discussed how funding for TA could be procured via civil monetary penalties or monthly claims reconciliation methods.

SFP Graduation Criteria

Background

The CY 2022 HH PPS Final Rule discussed an SFP hospice can graduate from the SFP once they have completed two consecutive six-month standard surveys with no CLDs cited. This is the same procedure used by the SFF program (Quality, Safety & Oversight Group, 2022). TEP members were asked to consider whether they would change this proposed requirement, and what criteria they would include for graduation. TEP members were also asked to consider how TA, if provided, would factor into the graduation criteria.

TEP Discussion

The TEP supported the requirement of two consecutive six-month surveys without any CLDs as an SFP graduation criterion. However, the TEP also suggested additional criteria, including consideration of SLDs and substantiated complaints.

Some TEP members suggested that the SFP require hospices be limited to a maximum number of SLDs on the two six-month surveys to graduate. One member cited the SFF policy that allows a maximum of 12 SLDs for graduation and suggested that, while an expectation of no SLDs is unrealistic, 12 may be too many for graduation eligibility in the context of hospice. Several TEP members also discussed that the number of substantiated complaints be considered as a graduation requirement. They suggested hospices could be required to have no substantiated complaints within the same timeframe (i.e., one year, or two six-month survey periods) to graduate. However, the discussion also acknowledged that the time needed to substantiate complaint allegations may vary.

TEP members discussed the possibility of including the non-survey data sources used for selection into the SFP (i.e., HCI, CAHPS® Hospice Survey) as components of graduation criteria. However, the TEP concluded that the rate at which these data are updated is too slow or variable to fit into the SFP graduation/monitoring process.

In addition to graduation criteria, the TEP members suggested that SFP graduation be a progressive or stepwise process, with hospices “graduated” to a transition phase once they have met the criteria discussed above. Some members suggested a three-year timeframe, with newly graduated hospices moving from six-month surveys to yearly surveys as a provisional step before returning to the standard three-year survey schedule if they continue to meet graduation requirements. These stages could have specific names (e.g., “preliminary graduate”) to indicate to consumers where hospices are in the process. Within this structure, facilities would not be considered true graduates until they are back on the normal three-year survey cycle.

TEP members believed that consumers should be able to see when a provider has a history of being in the SFP and the steps they have taken to improve. To this end, members suggested that SFP hospices be clearly identified via public reporting as new or preliminary SFP graduates. Some TEP members also indicated that a provider’s SFP history should be publicly reported even after they have fully graduated to the standard three-year survey cycle.

Finally, TEP members discussed the role that TA should play in the SFP graduation criteria and process. Multiple members expressed that TA, if provided, should not factor into the graduation requirements. Moreover, at least one member noted that TA should not extend past initial graduation from the SFP into the transition phase, particularly if some or all the cost of TA is borne by the provider.

Listening Session Comments

One stakeholder suggested that data sources beyond survey results be taken into consideration for graduation, such as HCI and CAHPS® Hospice Survey measures. Another stakeholder reported that providers are concerned that the only way to graduate from the SFP would be to have no CLDs, making graduation highly dependent on which surveyor is assigned to the provider. One stakeholder was concerned that being in the SFP will make consumers leery of receiving care from that hospice. As a result, the hospice could experience diminished revenue that is needed for care or organizational improvements (e.g., increased staffing, computer system upgrades, or building improvements).

Key Takeaways and Implications

The TEP generally agreed that to graduate from the SFP, hospices should have no CLDs for two consecutive six-month surveys. TEP members also suggested SFP hospices should have no substantiated complaints and less than a pre-defined number of SLDs on two consecutive six-month surveys to graduate. TEP members discussed the idea of additional data sources, such as CAHPS®, but ultimately decided against including them as components of the graduation process due to the lag in the data becoming publicly available. Some stakeholders still argued to include non-survey measures since they are more objective and noted that if TA is provided or required, this should not factor into the graduation criteria.

TEP members suggested a stepwise graduation process, beginning with a preliminary graduating after completion of two consecutive six-month surveys in accordance with all graduation requirements. Following preliminary graduation, hospices would enter a transition phase and be subject to yearly surveys to ensure sustained improvement, before being deemed as graduated from SFP. If the hospice graduates from SFP, the hospice could return to the standard three-year survey cycle, as long as SFP graduation standards are maintained.

SFP Termination Criteria

Background

Per the CY 2022 HH PPS Proposed Rule, CMS proposed that hospices in the SFP program who do not meet the requirements to graduate (two consecutive six-month surveys without any CLDs) would be placed on a termination track. This could lead to the hospice being removed from the Medicare program. However, CMS did not finalize this proposal in the CY 2022 HH PPS Final Rule. In the SFF program, CMS is continuing to establish criteria that may result in a nursing home's termination from the Medicare and/or Medicaid programs. The SFFs with deficiencies cited at a scope and severity level of immediate jeopardy on any two surveys are considered for this discretionary termination (Quality, Safety & Oversight Group, 2022). TEP members were asked to discuss criteria proposed in the rule and to suggest other considerations for SFP termination as requested by public comments, including the length of time before a hospice would be placed on the termination track and how "promising progress" (i.e., visible efforts resulting in care improvements that still fall short of SFP graduation criteria) might play into termination decisions.

TEP Discussion

Based on what was stated in the CY 2022 HH PPS Final Rule and criteria implemented in the SFF program, TEP members discussed whether providers in the SFP who fail to improve should experience progressive enforcement. This could mean starting with "minor" remedies such as civil monetary penalties or denial of a percentage of Medicare payments. If a SFP provider continues to show little to no improvement, they could face additional and/or increased financial penalties, such as no Medicare

payments for new admissions. Another remedy suggested by the TEP was assigning temporary management for a SFP provider.

Ultimately, TEP members generally agreed that SFP providers should be given no more than 18 to 24 months to improve before being placed on the termination track that would result in removal from the Medicare program. A few TEP members voiced support for termination criteria for SFP hospices being the same as for hospices outside of the SFP, namely when a provider fails to correct the most serious violations of federal health and safety requirements within a required time frame ([42 CFR 489.53](#)).

Members additionally expressed concern that terminating a hospice could cause undue harm in a geographic area if, for example, it was the only hospice. However, all TEP members agreed that there should be no exceptions or special treatment for hospices, such as rural hospices, even if terminating that provider would lead to a lack of hospice services in a geographic area. They noted that, in their estimation, beneficiaries would be better off if there was no hospice available rather than be served by a poor quality one. Also, it was thought that gaps that occurred due to such terminations might encourage other hospices to provide services in that area.

Listening Session Comments

One stakeholder was supportive of terminating hospices that fail to improve in the SFP, noting that a provider who does not improve in 12 months should not be allowed to continue serving patients.

Key Takeaways and Implications

Based on the discussion, the TEP generally agreed that progressive enforcement should be used for SFP hospices to encourage change before placing them on the termination track. While the TEP did not land on specific remedies, possible penalties discussed included civil monetary penalties, denial of Medicare payments, and denial of Medicare payments for new admissions. Members also broadly agreed that after 18 to 24 months (three-to-four SFP surveys), if a hospice in the program shows little or no improvement, they should be placed on the termination track. This was echoed by stakeholders. This guideline would hold firm for all hospices in the program who do not show improvement, regardless of whether the provider's termination would cause access issues in a geographic area.

Public Reporting of the SFP

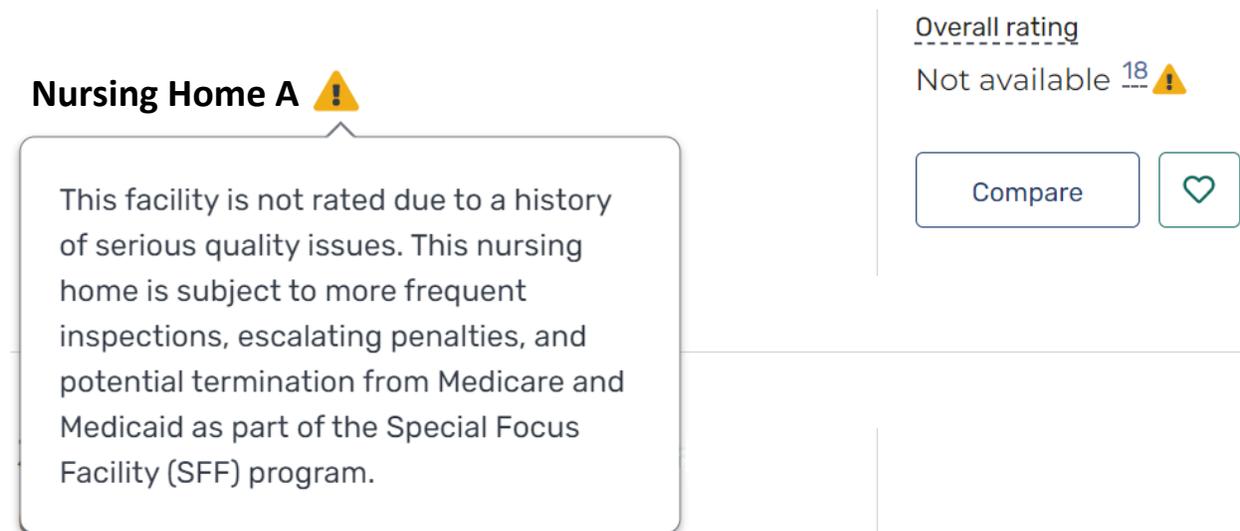
Background

One key aspect of the SFP is public reporting such that the public can find information about the SFP and the hospices in the program. The CAA 2021 mandated that surveyor findings be “prominent, easily accessible, readily understandable, and searchable for the general public and allows for timely updates” (CAA 2021). The statutory requirement provides clear objectives for publicly sharing SFP information and survey findings.

Currently, information regarding hospice quality can be found on CMS [Care Compare](#). Patients and caregivers can search Care Compare for hospices in a specific geographic area and see outcomes on a variety of quality indicators, such as CAHPS® Hospice Survey measures and claims-based measures (e.g., HCI and HVLDDL). One can also search for similar information about nursing homes and other health care providers such as home health agencies and hospitals. The nursing home Care Compare pages also include indicators and outcomes related to the SFP program. For example, nursing homes currently in the SFP program are marked with a yellow warning icon and have their quality ratings suppressed (Figure 5). Site users receive additional information as they hover their mouse over the yellow warning icon. The nursing home section of Care Compare thus served as a useful starting point for the TEP to discuss public reporting for the SFP.

TEP members were asked to consider the filters, icons, and associated language they would like to have on Care Compare for the SFP. They were also asked to consider which nursing home compliance attributes should carry over to hospice, and any additional information about the SFP that should be included on both the hospice Care Compare and an individual hospice’s page.

Figure 5. An Example of the Indicator Used on Care Compare for Nursing Homes in the SFF Program



Discussions

TEP members generally agreed that SFP information presented on Hospice Care Compare should be presented in a user-friendly way for a consumer to follow (e.g., plain language). Many TEP members suggested basic information should be highlighted (e.g., quality ratings) and more detailed data of less interest to the typical consumer (e.g., building inspections or environmental health) be less prominent.

When asked about public reporting icons, TEP members urged that a large, prominent icon be displayed next to each SFP hospice. Some noted that the current icon used for the nursing home page is too benign and could be misinterpreted (e.g., a website error), however others noted the importance of maintaining consistency with the SFF program by using the same icon. Regardless of the icon used, TEP members generally agreed that the icon-associated language, and any other relevant footnotes, should parallel those for the nursing homes on the Care Compare site and include a brief explanation of the SFP program. The TEP broadly agreed that this description should be available to consumers without needing to “hover” over the icon, such as with a footnote. Unlike the SFF for nursing homes, the TEP noted that the description should omit mention of termination as a possible consequence of the SFP to not cause undue concern for consumers.

TEP members did not come to agreement about whether quality ratings should be suppressed for SFP hospices, as is done for the SFF program. TEP members supporting suppression argued that keeping them may mislead consumers if, for example, a hospice has a high-quality rating for a specific metric (e.g., HCI) but is in the SFP. Those who argued for not suppressing the data noted that there may be value in letting consumers see the quality indicators to help differentiate between various hospices in the SFP. Additionally, there was discussion about allowing consumers to filter hospices by the hospice SFP status assuming information about what is meant by “SFP” is readily accessible.

TEP members also discussed a variety of additional details that could be added to a hospice's individual page on Care Compare. While these ideas provided helpful insights, the feasibility of reporting them is limited by the data CMS collects. The suggestions included:

- The range of time the hospice has been in the SFP (e.g., 1-6 months, 6-12 months, 12+ months, etc.)
- The number of Quality of Care CLDs that are directly related to patient care delivery
- Most recent survey results
- Status in the SFP (e.g., candidate, currently enrolled, graduate, etc.)
- Hospice staff ratios
- Size of hospice service area
- Penalties and complaints levied against the hospice, including any information about resolution of the complaints
- Date of the last compliance survey
- Ownership information (e.g., not-for-profit, for-profit, chain/independent, etc.)

TEP members discussed that the above information could be included in the details section, near a definition of the SFP and SFP's goals. There was some disagreement over whether entire hospice surveys (i.e., the [CMS-2567](#)) should be shown for all hospices or those in the SFP, but most TEP members agreed that, at a minimum, the survey information should be displayed for SFP hospices.

Lastly, TEP members discussed the [Provider Data Catalog](#) (PDC) and noted that an explanation of the SFP and each SFP category should be added to the Hospice PDC site. TEP members suggested that the SFP should have its own data file inclusive of the data publicly displayed for hospice on Care Compare.

In addition to the Care Compare discussion, the TEP also talked about other ways to inform the public about the SFP. Many TEP members strongly believed that information about the SFP should be shared with community groups, hospital discharge teams, and key organizations in the hospice space that can help explain the program to consumers. Some TEP members also thought that SFP providers should be required to inform new patients of their SFP status and what that means for them as patients; some also suggested providers referring patients to SFP hospices should make their patients aware of what the program means. While there was concern that this may appear as bias from some providers, TEP members agreed that many consumers rely on their providers for hospice referrals and represent a key source of information beyond Care Compare.

Listening Session Comments

One stakeholder suggested that the hospice's SFP status on Care Compare be updated monthly to ensure timely and accurate information for consumers and providers.

Key Takeaways and Implications

Public reporting is a key aspect of the SFP, ensuring that patients and caregivers are adequately informed of hospices with quality-related issues. The TEP broadly agreed that hospices in the SFP should be clearly identified, both by an icon and with precise and easy-to-understand accompanying language. The TEP did not reach consensus on which icon to use or if hospices in the SFP should have their quality measures suppressed, but they generally agreed that SFP information should be prominent and not require Care Compare site visitors to "hover" over icons or click on additional links. The TEP also suggested that Care Compare include information that could provide additional useful insight to a consumer (e.g., candidate status, date of last survey). Additionally, this information should include the full text of a

hospice's CMS-2567 (without protected health information) to inform consumers of the reasons why the hospice is in the SFP.

In terms of the PDC, the TEP agreed that the SFP-related information should be contained within one data file for easy access and download. Lastly, most of the TEP strongly agreed that the information should be shared with consumers through consumer advocacy organizations and referring providers in addition to Care Compare.

Conclusion

Key Findings

TEP discussions and listening sessions with stakeholders yielded key considerations regarding the development of the hospice SFP:

- **SFP Algorithm:** The TEP supported the use of an algorithm that incorporates the HCI, CAHPS[®] Hospice Survey data, surveyor-cited Quality of Care CLDs, and substantiated complaints. The TEP agreed that no stratification, size quartile stratification, or CMS Location stratification were preferred to a state-based stratification approach. Overall, the TEP felt that all hospices should be held to the same standards regardless of their size or geographic location.
- **SFP Survey Frequency:** The TEP agreed that hospices in the SFP should be surveyed once every six months while in the program with most TEP participants suggesting these more frequent surveys be conducted by SAs only, as opposed to AOs. The group also suggested including a transition period, whereby after a hospice graduates from the SFP, the hospice is surveyed annually before returning to the standard hospice survey frequency of once every three years.
- **SFP Technical Assistance:** The TEP urged that TA be provided to all hospices in the SFP, with CMS setting the guidelines and metrics for TA agencies to follow. The TEP indicated that these TA agencies should not be the surveying entities, but third parties to ensure objectivity and timeliness/availability of TA. Ideas for financing the TA included using funds from civil monetary penalties or monthly claims reconciliation methods.
- **SFP Graduation Criteria:** The TEP suggested that to graduate from the SFP, hospices should have no CLDs for two consecutive six-month surveys, no substantiated complaints, and less than a certain number of SLDs. Once graduated, SFP hospices could then enter a transition period where they would be subject to annual surveys before returning to the three-year survey period.
- **SFP Termination Criteria:** The TEP generally agreed that the SFP should use progressive enforcement, starting with actions such as civil monetary penalties and/or denial of a percentage of Medicare payments. If, after 18 to 24 months, a hospice did not improve enough to graduate from the SFP, the hospice would be placed on the termination track.
- **Public Reporting:** The TEP would like the SFP clearly defined on Care Compare's hospice page, and SFP hospices marked with a noticeable icon. There was also agreement that a hospice's individual page should include additional information about the SFP and the hospice's full survey information. The information should be easy-to-understand and not require consumers to have to search the website for pertinent information.

The considerations from the TEP, stakeholder listening sessions, and public comments provide valuable insights.

Limitations

In addition to the key findings, the TEP identified limitations and future considerations for the SFP, including, but not limited to:

- Absence of data for certain quality indicators for hospices due to small patient populations and/or public reporting requirements (e.g., HCI, CAHPS[®] Hospice Star Rating)
- HCI not capturing the entirety of the care continuum and overlooking other important aspects of quality

- Limited availability of up-to-date survey data, largely due to COVID-19 PHE related backlogs
- Standard surveys are only conducted once every three years, resulting in a lack of up-to-date survey data for some hospices
- Variability in how SAs and AOs conduct surveys
- State-to-state variability in survey policies, such as time limits given to investigate complaints and when complaints are substantiated
- Absence of a substantiated complaint does not necessarily imply a high-quality hospice as few hospices receive more than one complaint
- Differences in the number and size of hospices among and within states could cause resource challenges (e.g., one state may have more hospices in the SFP than others)
- Lack of consumer access to Care Compare, particularly those without internet access
- CMS resource constraints that could limit the number of hospices that can be placed in the SFP

Future Considerations

The TEP discussed future actions that could address potential limitations or benefit the methodology over time, such as:

- Consider additional indicators for the SFP as new measures are added to the HQRP
- Standardize SA and AO surveyor training to ensure consistency when identifying condition-level and standard-level deficiencies
- Consider ways to encourage the dissemination of a hospice's SFP status to consumers (e.g., via enforced provider disclosure, consumer advocacy groups, trade organizations, etc.)
- Consider creating an informal dispute resolution process and/or expanding the list of corrective actions available for SFP hospices

Throughout the TEP and listening sessions, TEP members and stakeholders identified various challenges and considerations regarding the design and implementation of the hospice SFP. In the context of these challenges, the TEP and others recognized that the initial decisions and approaches discussed represent a starting point. As new data become available and as the hospice industry continues to change, the experience gained during SFP implementation will refine the program that could lead to improved quality of care for Medicare hospice beneficiaries nationwide.

Appendix I. TEP Member Background Statements

Ken Albert, RN, Esq.

Ken Albert is the President and Chief Executive Officer for Androscoggin Home Healthcare and Hospice. Prior to his appointment in June of 2016, Ken served as the Director and Chief Operating Office of the Maine Center for Disease Control and Prevention, and the Director for the Division of Licensing and Regulatory Services within the Maine Department of Health and Human Services. Before joining the Department in March 2012, Ken practiced law for several years in Maine specializing in health law, professional licensing, and regulatory and compliance law. Ken was elected to the National Association for Home Care & Hospice in 2019 and again in 2021, where he now serves as Chairman of the Board of Directors. In addition to his service with NAHC, Ken is the Chairman of the Board of Trustees for the Maine College of Health Professions.

Ken's background is rich in medical experience, including seventeen years as a Registered Nurse practicing in emergency and intensive care settings. In that time, Ken served as Director of Emergency Services at Central Maine Medical Center, as the Administrator of the affiliated Occupational Health Center, and as the Site Manager for LifeFlight of Maine. Additionally, Ken spent five years as a traveling critical care nurse working in metropolitan, rural and tribal communities across the United States. He also served for several years as an adjunct faculty member at New England College where he taught Legal Issues in Health Care Administration.

Rita Choula, MA

Rita B. Choula, MA is the Director of Caregiving at the AARP Public Policy Institute. In her role, she drives content expertise on family caregiving initiatives, both within AARP and in partnership with a range of external stakeholders. Her work bridges policy and research to practice, centered on identifying and supporting needs of diverse family caregivers across ethnicities, cultures, and generations. Rita advances equitable, culturally-responsive policies and practices by elevating the unique nature of each caregiving experience.

Torrie Fields, MPH

Torrie Fields is the Founder and serves as the Chief Executive Officer of Votive Health, a company expanding access to care for people with serious illnesses by facilitating value-based arrangements between payers and preferred providers. Prior to Votive Health, Torrie oversaw serious illness strategy and value-based care at Blue Shield of California and Cambia Health Solutions. Her experience has encompassed work as an economist and population health researcher in a variety of settings, including health plans, health delivery systems, and local and federal health departments. She has deep expertise in policy development and implementation, translating evidence-based research into legislative concepts and regulatory change. Torrie holds a Master of Public Health from Oregon Health & Science University.

Barbara Hansen, MA, RN

Barb received her BS in Nursing from OHSU and an MA in Interdisciplinary Studies from Oregon State University with a focus on Gerontology, Community Health, and Adult Health Education. She has worked in end-of-life care in many roles since 1986: Home Health/ Hospice Nurse Case Manager, Clinical Coordinator, Home Care Surveyor for the Joint Commission, Wound, Ostomy, Continence RN, and Director of a Hospice, a Hospice Inpatient Unit, and a Home Health program. Since July of 2015, Barb has served as the CEO of the Oregon Hospice and Palliative Care Association and Executive Director of the Washington State Hospice & Palliative Care Organization. Nationally, Barb serves on the NHPCO Regulatory Committee and the Council of States Steering Committee. Within Oregon, Barb serves on the Oregon POLST Coalition, the Palliative Care and Quality of Life Interdisciplinary Advisory

Council, the Oregon Psilocybin Advisory Board, and the Advance Directive Advisory Committee. In Washington state Barb serves on the POLST Task Force and the Washington Serious Illness Care Coalition.

Margherita Labson, BSN, MSHSA, CCM, CPHQ

Margherita Labson is a well-known expert in the home care industry who has extensive knowledge in the legal, regulatory and accreditation requirements for the scope of care and services provided in the home. A registered nurse by profession, is currently certified in healthcare quality and case management.

A former associate professor in the College of Nursing at the University of Akron, she continues to work in the home care industry as clinician, educator, consultant, and advisor. Her experiences include serving as a clinician during the exploration and development of hospice home care as well as the provision of infusion therapy in the home. She was a surveyor for the Joint Commission and rose through the ranks to become the executive director in 1998 where she helped grow the program to the largest program by volume. Subsequently, she resumed her post-master's education and now serves to advise multiple providers and organizations in the spectrum of services provided in the home. These organizations include but are not limited to the National Partnership for Healthcare and Hospice Organizations, The Haynes-Shiley Institute for Palliative Care at California State University, The Home Centered Care Institute, Meta-Health, and the Community Health Accreditation Partner, the Florida Palliative Care Coalition and HealWell. She is a published author and frequent speaker who continues to maintain an active clinical practice as an independent case manager for vulnerable health care consumers in their homes.

Judi Lund Person, MPH, CHC

Judi serves as a key contact with the Centers for Medicare and Medicaid Services, interfacing with hospice payment policy, Part D, survey and certification, contractor management, and program integrity functions, among others. She also represents hospice and palliative care with the Government Accountability Office (GAO), the Medicare Administrative Contractors (MACs), the Drug Enforcement Administration (DEA) and other federal agencies and many national organizations. Recent issues include working with the GAO on a study for elder abuse and neglect in hospice, discussions with CMS on the implementation of the HOSPICE Act, including surveyor training and enforcement remedies, advocating for a new process for Part D notification of hospice election, addressing confusion about attending physicians, and ongoing work with the Medicare Administrative Contractors on hospice payment policy issues.

She works daily with hospice providers and state hospice organizations on the ever-increasing array of regulatory and compliance issues and translates complex regulatory language into actionable “plain English” for hospice providers. She works with her team at NHPCO to develop regulatory and compliance tools for hospice providers each year, including the new Hospice Survey Readiness and Response Toolkit, State/County Wage Index and Rates each year, and the refresh of the regulatory pages of the NHPCO website, creating the NHPCO Regulatory and Compliance Center.

Judi graduated with honors from the University of North Carolina at Greensboro with a degree in Sociology and has a Master in Public Health from the University of North Carolina at Chapel Hill. She holds a Certification in Healthcare Compliance.

Edward Martin, MD, MPH, FACP, FAAHPM

Dr. Martin is the Chief Medical Officer at HopeHealth in Providence Rhode Island. He has served on the Regulatory Committee of the National Hospice and Palliative Care Organization. He is a member of the

American Academy of Hospice and Palliative Medicine where he has served on a number of committees and provided education on regulatory topics at annual meetings.

He is Professor of Medicine at the Brown Alpert School of Medicine, the Section Chief of Palliative Medicine and former director of the Hospice and Palliative Medicine Fellowship at Brown. He has been teaching about hospice and end of life care for the past 35 years.

Terrie Speaks, BSN, RN, CHPN

Terrie Speaks is currently the Associate Vice President of Regulatory Affairs for Gentiva Health Services Hospice and Palliative Care Divisions. She previously served with the Accreditation Commission for Health Care (ACHC) as a corporate surveyor and lead preceptor for Hospice, Home Health, Private Duty, Behavioral Health, and Life Safety Code. She surveyed organizations of all sizes across the nation for compliance with the Conditions of Participation, state regulations, and National Fire Protection Association (NFPA) Life Safety Code. She has participated in CMS State Surveyor Training for Hospice, Home Health, and the NFPA Life Safety Code Training. She is currently an ACHC Certified Consultant for Hospice, Home Health, and Private Duty.

Terrie has worked in Hospice and Home Health since 1992 with roles including direct patient care, compliance, and clinical management. Her experience includes the Certificate of Need process, development of a 40-bed Hospice Inpatient Unit, development of a Hospice Pharmacy, and participation in a National Institute of Health consortium focused on end stage CHF and COPD. She co-created an end-stage CHF and COPD program that was published in the 2004 Journal of Palliative Medicine, which showcased the program development: *Improving End of Life Care for Patients with Congestive Heart Failure and Chronic Obstructive Pulmonary Disease*.

Gabrielle Winther, LCSW

Gabrielle Winther earned her Master's in Social Work from Rutgers University, New Brunswick, NJ. Gabrielle started her career as a hospital social worker, later worked in oncology and hospice. Gabrielle is currently a Palliative Care Social Worker in Western NJ at a community hospital. Gabrielle earned her Post-Master's certificate in Palliative Care through the CSU Shiley Institute for Palliative Care. Gabrielle is an active member in both NASWNJ and SWHPN, regularly presenting on topics of end of life, advocacy, and caregiving.

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Appendix III. Quality of Care Conditions of Participation List

Quality of Care CoPs

[§418.52 Condition of participation: Patient's rights.](#)

[§418.54 Condition of participation: Initial and comprehensive assessment of the patient.](#)

[§418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services.](#)

Associated Quality of Care CoPs

[§418.60 Condition of participation: Infection control.](#)

[§418.76 Condition of participation: Hospice aide and homemaker services.](#)

[§418.102 Condition of participation: Medical director.](#)

[§418.108 Condition of participation: Short-term inpatient care.](#)

[§418.110 Condition of participation: Hospices that provide inpatient care directly.](#)

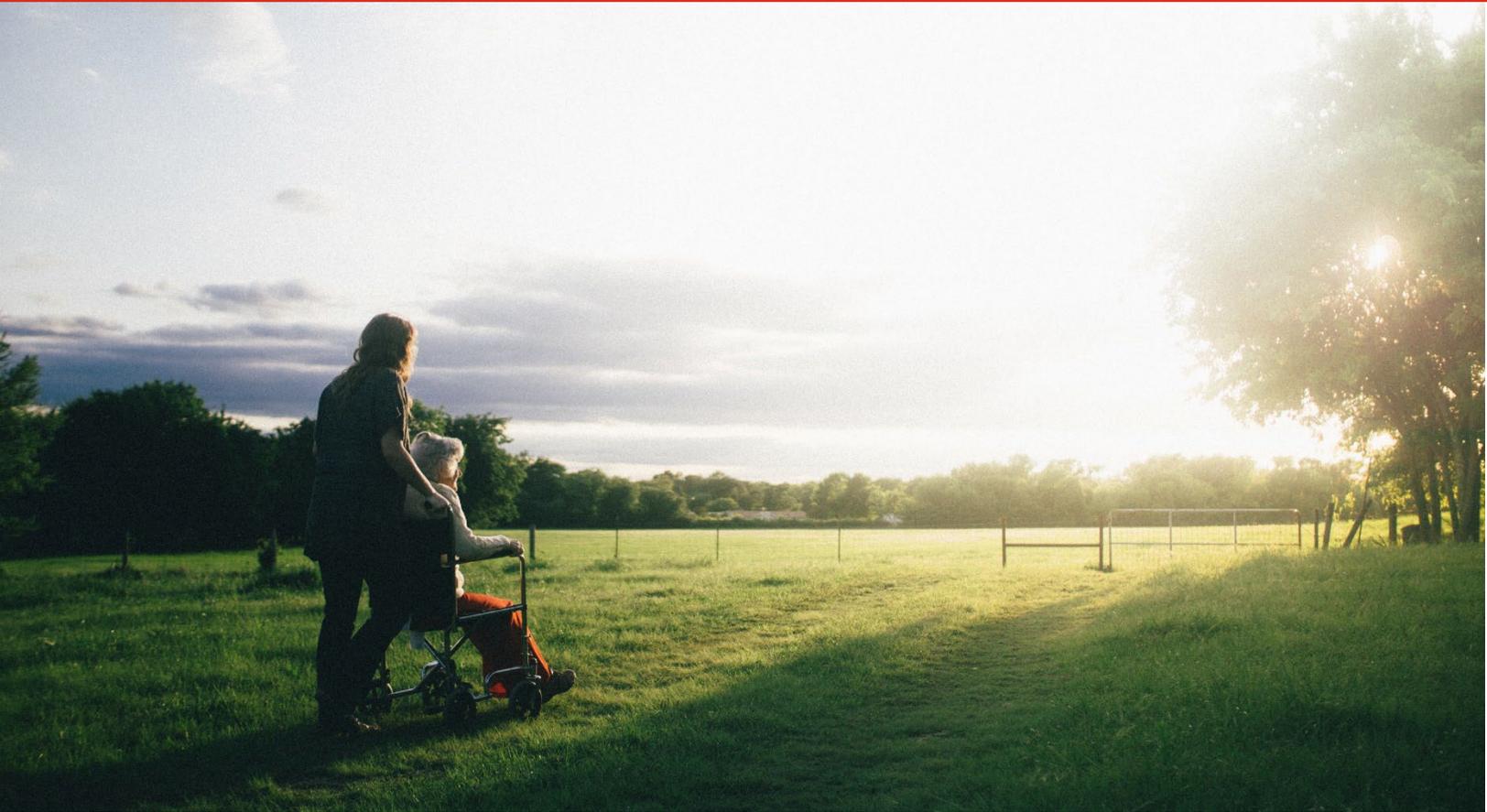
[§418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID.](#)

Appendix IV. Information Gathering Report



Information Gathering Report

Hospice Special Focus Program – 2022



Contract No. 75FCMC18D0014
Task Order No. 75FCMC19F0001
Deliverable 4-22

September 22, 2022

Submitted to:
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Submitted by:
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**The authors used iThenticate software to confirm this document represents an original work and, where applicable, has properly cited the work of others.*

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Table of Acronyms

ALF	Assisted Living Facility
AO	Accreditation Organization
CAA	Consolidated Appropriations Act
CAHPS®	Hospice Consumer Assessment of Healthcare Providers and Systems
CLDs	Conditional-Level Deficiencies
CMS	Centers for Medicare & Medicaid Services
CoPs	Conditions of Participation
COVID-19	Coronavirus disease of 2019
CY	Calendar Year
EOL	End-of-Life
FR	Federal Register
FY	Fiscal Year
GIP	General Inpatient Care
HCI	Hospice Care Index
HH PPS	Home Health Prospective Payment System
HIS	Hospice Item Set
HOPE	Hospice Outcomes and Patient Evaluation
HVLDL	Hospice Visits in the Last Days of Life
ICU	Intensive Care Unit
NH	Nursing Home
NPRM	Notice of Proposed Rulemaking
NQF	National Quality Forum
OIG	Office of Inspector General for the U.S. Department of Health and Human Services
POC	Plan of Correction
PEPPER	Program for Evaluating Payment Patterns Electronic Report
PUF	Public Use Files
SA	State Agency
SFF	Nursing Home Special Focus Facility Program
SFP	Hospice Special Focus Program
TEP	Technical Expert Panel

Executive Summary

Background

In 2020, more than 1.7 million Medicare patients received hospice services, with the Centers for Medicare & Medicaid Services (CMS) spending \$22.4 billion on these services and the industry continues to grow (MedPAC, 2022). To continue to help ensure that these patients are receiving quality hospice care, CMS is creating a Special Focus Program (SFP) that will include poor-performing hospices, as identified based on selected measures, which will be placed under additional oversight to ensure identified issues are corrected.

To gain input from key stakeholders on the structure and methodology of the SFP, CMS has contracted with Abt Associates to convene a Technical Expert Panel (TEP) made of up of industry experts, hospice providers, patients and caregivers, and policy experts. The TEP is expected to provide input on specifics for the SFP, including an algorithm for identifying poor-performing hospices, entrance and exit criteria, and public reporting requirements for the SFP.

To help inform TEP members and other interested individuals about key information and guidelines related to the SFP, this report examines existing literature on hospice quality, including information on:

- The legal background for the SFP, including procedures proposed via rulemaking.
- Strengths and weaknesses of existing hospice measures, such as hospice compliance and complaint surveys, consumer caregiver surveys, and claims-based quality measures.
- Characteristics of high-performing and low-performing hospices based on factors including quality metrics and consumer reviews.
- The Nursing Home Special Focus Facility (SFF) program to improve poor-performing nursing homes, which operates under a similar directive as the planned Hospice SFP.

SFP Legal Authority

The Consolidated Appropriates Act (CAA) of 2021 authorized the Secretary of Health & Human Services to create an SFP for hospice programs identified as having failed to meet Medicare Conditions of Participation. CMS further described the SFP in the Calendar Year 2022 Home Health Prospective Payment System Final Rule (86 F.R. 62240), where CMS proposed a specific methodology and criteria for the program. However, CMS did not finalize the proposed methodology and procedures, and instead, stated the intention to establish a TEP to further inform development of the methodology and procedures for the SFP. CMS affirmed that a TEP is necessary to weigh in on the SFP in the Fiscal Year 2023 Hospice Notice of Proposed Rulemaking (87 F.R. 19442), with CMS also stating their plans to propose a final version of SFP methodology and procedures in FY 2024 Hospice rulemaking.

This section of the report also includes a brief overview of the public comments received by CMS in response to the proposed and final rules to indicate areas of public agreement and disagreement regarding the SFP.

Existing Data to Identify Hospices for the Special Focus Program

Currently there are four main sources of data that can provide insights into hospice quality: 1) compliance and complaint surveys; 2) caregiver surveys of their experiences with hospice; 3) Medicare Fee-For-Service claims; and 4) the Hospice Item Set (CMS, 2022b). This section gives a description of each of these data sources, as well as an overview of their strengths and weaknesses. It also includes a

description of other measures that are collected from hospices to provide a full picture of available data for determining which hospices should be candidates for the SFP.

The key data sources for hospice information related to quality and compliance come from the following places:

- Compliance surveys: These surveys review a hospice’s compliance with Medicare requirements on a triennial basis. Surveys, either conducted by a state agency or accrediting organization, can cite a hospice with a condition-level (more serious) and/or standard-level (less serious) deficiencies. Survey data is useful in identifying areas of concern in hospices, yet there are issues of timeliness (due to the three-year compliance survey timeline), subjectivity (e.g., human error), and studies which have shown that issues are occasionally missed by surveyors (OIG, 2015; OIG, 2019a; OIG, 2019b).
- Complaint surveys: A complaint can be made by patients, caregivers, and healthcare providers, upon which the state agency conducts an investigation survey to substantiate the complaint. Formal CMS complaints against hospices are rare and the lack of a complaint against a hospice does not mean that a hospice is high quality or that no complaint-worthy issues exist (Stevenson & Sinclair, 2018).
- Consumer Assessment of Healthcare Providers and Systems® (CAHPS): The CAHPS® measures include eight patient experience measures, calculated from survey responses by caregivers of deceased patients, which reflect the caregiver’s subjective experience in multiple areas of care and service by a hospice. Starting in August 2022, a CHAPS® summary star measure also began being reported, providing another way for consumers to assess the quality of a hospice. However, CAHPS® data are limited due to an exemption for small and new hospices because of small sample sizes.
- Medicare Fee-For-Service Claims-Based Measures
 - Hospice Care Index (HCI): The HCI is a single measure based on Medicare claims data that comprises ten indicators to comprehensively represent distinct aspects of hospice service throughout the hospice stay. Most hospices earn high HCI scores, with more than 85 percent of hospices scoring an 8 or above on the 1 to 10 scale. While not earning a point in any one of the indicators does not signify a serious problem with the hospice’s quality, not earning a point across multiple indicators could indicate a concerning pattern of service for that hospice (Plotzke et al., 2021).
 - Hospice Visits in the Last Days of Life (HVLDDL): The HVLDDL measure is a Medicare claims-based measure updated annually that represents the proportion of patients who received in-person visits from a registered nurse or medical social worker in at least two out of the final three days of a patient’s life (CMS, 2021a).
- Hospice Item Set (HIS): The HIS is a single measure calculated quarterly and captures the proportion of patients for whom the hospice performed seven key care processes, if applicable, during the admission process. The single HIS measure has limited ability to separate high and low performers due to its homogeneity on most components and these scores are “mostly topped out” and may eventually be completely phased out (MedPAC, 2021).
- Post-Acute Care and Hospice Provider Utilization and Payment Public Use Files (PAC PUF): PAC PUF presents information on services provided to Medicare beneficiaries by hospices and other healthcare service providers taken from Medicare enrollment and fee-for-service final claims data, including the demographic and clinical characteristics of beneficiaries served (CMS, 2021b).

- Program for Evaluating Payment Patterns Electronic Report (PEPPER): PEPPER is a report that summarizes provider-specific Medicare data statistics for CMS-identified target areas that are potentially at risk for improper Medicare payments (PEPPER, n.d.).

Additional Hospice Quality Information and Research

Overall, there are few academic research articles that relate directly to the topic of hospice quality, although the field is growing. The Abt team’s literature review found quality characteristics differ between not-for-profit hospices and for-profit hospices, including consumer-based and claims-based measures.

Studies have found that those hospices that were in the top quartile for both CAHPS® and HIS were more likely to be A) medium-sized (91 to 200 patients per year), B) in business for 20 years or more, and C) served rural areas. Smaller independent nonprofit and government hospices were more likely to provide better patient- and family-centered care (as indicated by higher CAHPS® performance), while being a large, for-profit hospice predicted lower CAHPS® scores (Anhang et al., 2020; Hotchkiss, 2022). Looking at negative outcomes, for-profit hospices received more consumer online complaints related to suboptimal communication, while non-profit hospices received more comments about the role of hospices and misperceptions related to the role (Brereton et al., 2020).

There is a clear trend in this work that identifies for-profit hospices as performing worse on quality indicators than non-profit hospices. For example, in examining hospice complaints, researchers found that for-profit hospices were 1.33 times more likely to have a complaint allegation compared to for non-profit hospices (Stevenson & Sinclair, 2018) and for-profit hospices were more likely than non-profit hospices to discharge patients prior to death, to discharge patients with dementia, and to have higher rates of hospital and emergency department use (Aldridge, 2021). Lastly, looking at hospices that did not participate in the CMS’s Hospice Quality Reporting Program, they were more likely to be for-profit and have no accreditation (Hsu et al., 2019).

Nursing Home Special Focus Facility (SFF) Program

This report section includes a summary of the SFF program used for nursing homes to provide background on a similar CMS program that addresses poor performance. The SFF program uses a combination of results from standard surveys (conducted every 9-15 months), complaint investigations, and revisits to identify poor performing nursing homes. With this information, CMS compiles a monthly candidate list for each state consisting of the poorest performing nursing homes, from which each state selects which nursing homes should be in the SFF program based on their own state-specific criteria. Once a nursing home is placed in the SFF program, the state must survey the nursing home at least once every six months. If the nursing home shows improvement over two survey periods (i.e., a year), the nursing home can “graduate” from the program. If they fail to graduate at this point, the nursing homes are subject to increased enforcement actions, including termination from the Medicare program.

The SFF program has been in operation since 1998 and has undergone various updates since then to ensure its relevancy and to address issues raised by Congress, the Government Accountability Office, and the White House, including concerns about the transparency and timeliness of the program. The program is currently undergoing changes in response to reforms proposed by President Biden (The White House, 2022), due to growing concerns about private-equity owned nursing homes (Gupta et al., 2021) and weaknesses shown by the COVID-19 pandemic (NASEM, 2022).

Background and Significance

In 2020, more than 1.7 million patients in Medicare received hospice services, with the Centers for Medicare & Medicaid Services (CMS) spending \$22.4 billion on these services (MedPAC, 2022). The hospice industry is growing rapidly, with the number of Medicare-participating hospices increasing by more than 44 percent in the past decade (5,058 in 2020 compared to 3,498 in 2010; MedPAC, 2022). Quality hospice services benefit patients as hospice care at the end of life is associated with better patient satisfaction, pain control, decreased intensive care unit use, and decreased hospital mortality (Kleinpell et al., 2019). However, recent reports indicate that many hospices fail to meet the health and safety standards Medicare requires to participate in the program (OIG, 2019a), potentially endangering patients.

To address these concerns, in addition to surveying hospices in the Medicare program to ensure they meet federal Conditions of Participation (CoPs), CMS is creating a hospice Special Focus Program (SFP) to increase oversight of hospices with identified issues that place hospice patients at risk for poor quality of care. The SFP will include hospices identified as substantially failing to meet applicable Medicare requirements, based on a set of selected criteria and measures. These hospices will then be subject to additional oversight, which may result in additional enforcement remedies, including termination from the Medicare program (Consolidated Appropriations Act, 2021).

As part of the SFP structure and methodology development process, CMS's aim is to include a full SFP proposal in Fiscal Year (FY) 2024 rulemaking. CMS has contracted with Abt Associates to convene a Technical Expert Panel (TEP) to inform the development of the SFP program, including the algorithm CMS will use to identify candidate SFP hospices. The TEP will also inform the development of program specifics such as selection and graduation criteria and SFP-related public reporting requirements.

To help inform TEP members and other interested individuals about key information and guidelines for development of the SFP, we conducted a literature search to answer the following key questions:

- What **legal guidelines** have been published through rulemaking with respect to the SFP?
- What are the **existing measures** that examine various aspects of hospice care and/or quality? What are the **strengths and weaknesses** of these measures?
- What **other information and research** exists that CMS could use to identify poor-performing hospices?
- How does the **Nursing Home Special Focus Facility (SFF) program work** and how has it **evolved over time**?

Literature Review Methods

The Abt team searched for both peer-reviewed academic articles and grey literature. Key stakeholders also supplied additional resources that were relevant to the topic, such as CMS regulations and other federal publications. For the literature review, the Abt team used pre-determined search terms specific to the topic in the MEDLINE/PubMed® database. For grey literature, the Abt team referenced a pre-established list of well-known resources (see below) and applied key words from the pre-determined search terms to search those sources for relevant information (see Appendix I).

The Abt team limited results to articles within the past five years (2017-2022), that were published in English and that were based in the United States. Articles related to developing new measures for hospices were excluded as outside the scope of this report and project.

Once articles were identified from the database search, their titles and abstracts were first reviewed for relevance to the topic and sorted into three categories: relevant articles, somewhat relevant articles, and insufficiently relevant articles. The first category (relevant articles) contained articles that were deemed applicable to the report based on inclusion and exclusion criteria, the second category (somewhat relevant) contained articles that needed further review, and the third category (insufficiently relevant) contained articles that were deemed not relevant based on inclusion and exclusion criteria. After this first sorting of articles, those sources in the relevant or somewhat relevant categories had their full texts reviewed to ensure their applicability. Additional articles were moved to the insufficiently relevant category if, upon full review, it was determined that those articles were not applicable. The remaining articles were all deemed relevant for this report and are included in the literature review table (see Appendix II).

For the grey literature search, the Abt team reviewed the following healthcare and/or hospice sites for relevant information:

- Center to Advance Palliative Care
- Institute for Healthcare Improvement
- Joint Commission
- Robert Wood Johnson Foundation
- The Commonwealth Fund
- Kaiser Family Foundation
- National Academy of Medicine
- National Coalition for Hospice and Palliative Care
- Hospice and Palliative Care Nurses Association
- American Academy of Hospice and Palliative Care
- National Hospice and Palliative Care Organization
- Visiting Nurses Associations of America
- Pew Trusts
- RAND Institute
- National Bureau of Economic Research

The Abt team reviewed the search results within each site and downloaded any articles or reports relevant to the topic using the same inclusion and exclusion criteria used in the peer-reviewed literature search. Because some of the sites listed above require a membership to access particular articles or reports, some

resources could have been excluded from the search. The articles identified during this search were then fully reviewed and added into the literature review table.

Throughout the process, the Abt team worked with key stakeholders to clarify the purpose of the literature review and the resulting report, and to confirm expected information sources.

Regulatory History

Congress first authorized the SFP in December 2020 and CMS discussed the SFP in subsequent rules and proposals. SFP-related legislation and proposals include:

- **[Consolidated Appropriations Act of 2021 \(CAA 2021\)](#)**: Congress authorized the Secretary of Health & Human Services to create an SFP for hospice programs identified as having substantially failed to meet applicable requirements of the CAA 2021. Hospices in the SFP would be subject to additional surveys that would take place no sooner than once every 6 months.
- **[Calendar Year \(CY\) 2022 Home Health Prospective Payment System \(HH PPS\) Final Rule \(86 F.R. 62240\)](#)**: CMS proposed a specific methodology and procedures to identify low-performing hospices for the SFP. The proposed criteria noted that candidate hospices would have a history of condition-level deficiencies (CLDs) on two consecutive standard surveys, two consecutive substantiated complaint surveys, or two or more CLDs on a single validation survey following a complaint or standard survey that cited a CLD.

Of the hospices meeting the proposed criteria, a candidate list would be submitted to the state survey agency and the CMS Survey Operations Group, and these groups would work together to select a subset of hospice programs for enrollment in the SFP based on state priorities and capacity (with the possibility of no SFP enrollment in a certain state if no hospices in the state met the SFP criteria). The subset selected for the SFP would be subject to survey every six months with the possibility of additional enforcement remedies, including termination, for continued failure to meet requirements. Hospices would graduate from the SFP once they completed two consecutive six-month SFP surveys with no CLDs. Hospices that did not meet the criteria for graduation would be placed on a termination track.

However, CMS did not finalize the proposed methodology and procedures for the SFP, and instead, stated that they would establish a TEP to further inform program development.

- **[FY 2023 Hospice Notice of Proposed Rulemaking \(NPRM\) \(87 F.R. 19442\)](#)**: CMS affirmed their intention to use a TEP to provide input on the structure and methodology the SFP and their plans to propose a final version of SFP methodology and procedures in the FY 2024 Hospice rulemaking.

Public Comments

Individuals and organizations responded to rulemaking proposals via public comments, which the Abt team has summarized below to show areas of agreement and disagreement with CMS's proposals regarding the SFP:

- **[CY 2022 HH PPS Final Rule \(86 F.R. 62240\)](#)**: Many commenters expressed concern that the proposed criteria for candidacy, based solely on survey data, were subjective and could lead to inconsistencies across state agencies and between state agencies and accrediting organizations. Specific suggestions included the use of claims-based indicators, and consideration of the number, scope, and severity of deficiencies cited on surveys. Additionally, commenters overwhelmingly expressed that selection for the SFP should not rely on a state-based selection process, but rather a national capture of the lowest performers.

Beyond the selection algorithm, some public commenters suggested that CMS provide relevant tools and education to assist SFP-enrolled hospice providers in improving quality and compliance before placing providers on a termination track. A few others asserted that CMS should be cautious in using suspension of payment as an enforcement remedy and recommended using this only as a last resort.

Finally, commenters generally agreed that CMS should use a TEP both to assist in developing a comprehensive algorithm that would include metrics other than just survey performance and to provide input on the public reporting of SFP participants. Commenters placed emphasis on keeping publicly reported information as current as possible and updating that information in a timely manner if a hospice graduated from the SFP. Commenters felt that details about the program should be carefully developed to convey information in a way that is accessible and easily understandable but does not cause undue alarm.

- **[FY 2023 Hospice NRPM \(87 F.R. 19442\)](#)**: Commenters were generally supportive of CMS's efforts to establish an SFP and engage the hospice industry through a TEP. Many supported CMS considering a wide range of stakeholders for TEP membership, including representatives from for-profit and not-for-profit hospices, rural and urban hospices, small and large hospices, and individuals who directly interact with patients and surveyors.

A small number of commenters once again encouraged CMS to forgo the use of a state selection process, as the SFF program for nursing homes uses, for the new SFP. The commenters felt decisions about hospices and their inclusion in the SFP should be centralized and standardized so that hospices are selected based on their performance overall and not on their location. A few other commenters expressed support for standardizing the hospice survey process, including standardizing surveyor training, before fully implementing the SFP to ensure there are no discrepancies in how state agencies and accrediting organizations implement the survey process.

Existing Data to Identify Hospices for the Special Focus Program

As the hospice industry has expanded, so too has hospice quality oversight. Hospice quality is assessed in many ways, and each option for evaluating hospice quality and compliance has distinct benefits and limitations. The following section provides an overview of the prominent hospice measures, including both quality and compliance measures, some or all of which can inform the selection of hospices for nomination to the SFP.

Hospice Surveys: Types and Trends

There are two types of hospice surveys: 1) compliance surveys; and 2) complaint surveys.

Compliance Surveys

Compliance surveys assess whether a hospice meets all requirements for participation in the Medicare program, known as Conditions of Participation (CoPs). These CoPs represent required health and safety standards that hospices must meet to participate in Medicare. CoPs comprise conditions, which include the requirements for core services, such as nursing, medical social services, physician services and volunteer services. The hospice CoPs are further broken down into standards that detail how the hospice should establish and update the plan of care, for example, requiring an initial assessment of a patient within 48 hours of election to hospice care. A surveyor may cite a hospice with various condition-level and/or standard-level deficiencies during the survey process. Condition-level deficiencies are the most serious type of deficiency and indicate non-compliance with an entire condition such as [§418.54 - Initial and Comprehensive Assessment of the Patient](#). Depending on the services offered, hospices must meet between 240 and over 300 elements of compliance (CMS, 2020b).

Compliance is monitored through surveys conducted by state agencies (SAs) or accreditation organizations (AOs). Initially, CMS did not establish a timeframe for these surveys, and as a result, they were infrequent, with gaps of six or more years between surveys for many hospices (NAHC, 2019). However, the [Improving Medicare Post-Acute Care Transformation Act of 2014](#) required all hospices to be surveyed for compliance at least every three years. The routine cycle of triennial surveys began during 2015, with one third of all hospices being surveyed each year²(NAHC, 2019). Although not yet fully implemented, the [CAA 2021](#) and [CY22 HH Final Rule](#) made further changes to the survey process, requiring the use of multidisciplinary survey teams, prohibiting surveyor conflicts of interest, expanding CMS surveyor training to AOs, and requiring the AOs to begin use of the Form CMS-2567, which discloses the specific deficiencies cited, if any, and use of this form by AOs will expand the publicly available data for privately accredited hospices.

When a hospice receives a Statement of Deficiency, it must be prepared to develop and implement a Plan of Correction (POC). This POC must describe the corrective action a hospice will take to remedy the deficiency and come into compliance. Hospices are allowed some flexibility to address the deficiencies, as CMS recognizes some deficiencies may require more time than others, but a general expectation is that deficiencies will be corrected within 60 days. In some instances, CMS may also require a revisit by the SA or AO, especially if a deficiency relates to patient care, to ensure corrective actions are being successfully implemented (NHPCO, 2015). A hospice may appeal a determination of non-compliance,

² The COVID-19 pandemic has created issues with the ability to survey all hospices in a timely manner beginning in 2020.

but a pending appeal does not delay the effective date of the POC and CMS will automatically reduce the civil monetary penalty amount by 35 percent if the hospice waives its appeal right ([86 F.R. 62425](#)).

Survey data is not without drawbacks. Due to the survey frequency of once every three years, outdated data may present an issue, and deficiencies cited several years prior may no longer be present. Additionally, the nature of surveys creates room for subjectivity and human error; there may be discrepancies cited between different SAs and there may be discrepancies in deficiencies cited between AOs compared to SAs. Additionally, the high number of survey-assessed compliance items may increase the likelihood that a high-quality hospice may be deficient in at least one element (NHPCO, 2019). These potential sources of error suggest that considering the number, scope, and severity of deficiencies may give a clearer picture of noncompliant hospices.

A clean survey without a deficiency citation does not necessarily indicate that issues are not present. As one example, in an audit of a New York hospice surveyed by an AO, the Office of the Inspector General (OIG) identified several instances of noncompliance with staffing requirements that the AO had not documented on the hospice’s survey. The OIG concluded that CMS’s reliance on compliance surveys alone could not ensure the quality of care that the hospice provided (OIG, 2015; OIG, 2019a; OIG, 2019b).

Compliance Survey Deficiency Trends

Reviews of compliance survey trends indicate that deficiencies in hospice care are common. Table 1 shows the top ten CMS survey deficiencies cited in 2018 (NHPCO, 2019). From 2012 to 2016, over 80 percent of hospices had at least one care deficiency and 20 percent had a condition-level deficiency (OIG, 2019a). In an analysis of data from 2005 to 2006, nearly half (45 percent) of all surveys resulted in a deficiency citation. While the total number of deficiency citations and rate of deficiencies cited per hospice dramatically increased over this period, the proportion of surveys that resulted in a deficiency and number of deficiencies cited per complaint survey remained relatively stable. Of these deficiencies, issues related to care planning (24 percent), aide and homemaker services (9 percent), and clinical assessments (9 percent), quality assessments (8 percent), and patient assessments (8 percent) featured most prominently. Notably, the proportion of privately accredited hospices increased from 15 to 39 percent, driven largely by increased use of private accreditation by for-profit hospices (Stevenson & Sinclair, 2018).

Table 1: CMS Top Ten Hospice Survey Deficiencies in 2018

Order Cited	Survey Deficiency Name	Code	L-Tag
1	Plan of care	§418.56(b) Standard	L543
2	Drug profile	§418.54I(6)	L530
3	Supervision of hospice aides	§418.76(h) Standard	L629
4	Content of the plan of care	§418.56I Standard	L545
5	Content plan of care	§418.56I(2) Standard	L547
6	Prevention	§418.60(a) Standard	L579
7	Level of activity	§418.78I Standard	L647
8	Bereavement	§418.54I(7) Standard	L531
9	Timeframe for completion of the comprehensive assessment	§418.54(b) Standard	L523
10	Coordination of services	§418.56I(2) Standard	L555

SOURCE: National Hospice and Palliative Care Organization. (n.d.). CMS Top Ten Hospice Survey Deficiencies Comparison. <https://www.nhpc.org/wp-content/uploads/2019/05/Survey-Deficiencies.pdf>

Complaint Surveys

Hospice complaints can originate from a variety of sources, including patients, caregivers, and healthcare providers (CMS, 2020a). Complaints are typically reported to and investigated by state agencies and, although standards exist, there can be significant differences in state processes and the amount of time before an investigation is completed (Stevenson & Sinclair, 2018). CMS categorizes complaints by severity level and for more severe complaints, CMS requires the state agency to conduct an onsite complaint investigation survey within a specified timeframe ranging from two days for issues where immediate jeopardy may be present to 45 days for other concerns (CMS, 2020a). Complaint *allegations* include all reported instances of harm or unsatisfactory care in any complaint, including those that are not substantiated by follow-up investigations. Complaint *deficiencies* are complaint allegations that are substantiated through a complaint survey, and result in citations against the hospice for non-compliance with CoPs (Stevenson & Sinclair, 2018). It is important to note that because complaints are so rare (Stevenson & Sinclair, 2018), the lack of a complaint against a hospice does not mean that a hospice is high quality or that no complaint-worthy issues exist.

Complaint surveys are a specific type of survey used to substantiate complaint allegations filed against hospices. Formal CMS complaints against hospices are rare and, as Stevenson and Sinclair (2018) note, this is often because the burden of filing a complaint is outweighed by the potential benefit of reporting the alleged harm. From 2005 to 2015, complaint allegations were only filed against 12 percent of all hospices nationwide. Complaint allegations most often centered on quality of care (45 percent) and patients' rights (20 percent). Of these allegations, only 34 percent were substantiated by surveyors and resulted in complaint deficiencies. Complaint deficiencies most often fell into the areas of care planning (29 percent), clinical records (12 percent), administrative concerns (10 percent), delivery of core services (10 percent), and issues with patients' rights (10 percent). Notably, the rate of complaint allegations per hospice increased by around 27 percent during the 2005-2015 study period. However, the rate of complaint deficiencies cited per hospice decreased slightly (Stevenson & Sinclair, 2018).

Key Publicly Reported Hospice Measures

Over the last decade, CMS has expanded efforts to improve hospice quality oversight and ensure a standard quality of service for hospice beneficiaries. CMS launched Hospice Compare in 2017 and subsumed it into Care Compare in 2020. Care Compare is the official CMS website for publicly reporting quality measures for hospices and other healthcare service providers. The data displayed on the website are derived from three main sources: caregiver surveys of their experiences with hospice, Medicare hospice claims, and the Hospice Item Set (HIS) (CMS, 2022b).

Consumer Assessment of Healthcare Providers and Systems® (CAHPS) (NQF #2561)

The CAHPS® measures include eight National Quality Forum (NQF)-endorsed patient experience measures, calculated from CAHPS® Hospice Survey responses by the caregivers of deceased hospice patients. The measures are calculated quarterly using top-box scores, which refer to the percentage of caregiver respondents who selected the most positive response option for a given question out of 47 total questions (CMS, 2021a). The measures consist of two individual measures (overall rating of hospice care and willingness to recommend the hospice) and six composite measures (communication with family, getting timely help, treating patient with respect, emotional and spiritual support, help for pain and symptoms, and training family to care for patient). The CAHPS® Hospice Survey directly reflects the caregivers' subjective experience in multiple areas of care and service by the hospice provider, rather than assessing a hospice's compliance with regulations or specific care procedures. However, the reporting of CAHPS® data is limited because of an exemption for small and new hospices due to small sample sizes.

Beginning with the August 2022 refresh of Care Compare, a CAHPS® Family Caregiver Survey Rating is also publicly reported for all hospices with 75 or more completed surveys. This summary star measure is calculated as the weighted average of the star ratings for each of the CAHPS® measures mentioned above and ranges from 1 to 5 stars (CAHPS® Hospice Survey, 2022), providing another way for consumers to assess the quality of a hospice.

CAHPS® Data Trends

As discussed above, CAHPS® measures reflect caregiver experience across a range of care areas and include six composite scores and two individual scores. CAHPS® composite scores have high reliability and validity. Together, the six composites are responsible for 48 percent of the variance in caregivers' overall ratings of hospices and 44 percent of the difference in willingness to recommend the hospice. Hospice team communication is the best predictor of both the CAHPS® overall rating and willingness to recommend, with the scores for treating your family member with respect and getting emotional and spiritual support the next strongest predictors of both outcomes (Anhang et al., 2018). Overall, the getting help for anxiety or sadness item, within the symptom palliation composite, is typically scored lowest, along with receipt of training for management of agitation and side effects of pain medication, within the training for family members composite (Anhang et al., 2018).

CAHPS® scores follow similar patterns overall and for patients with different diagnoses. For instance, in looking at decedents with dementia or cancer, the CAHPS® measures with the highest overall quality scores for patients with these diagnoses were getting emotional support (91 for dementia and 89 for cancer) and treating family members with respect (90 for dementia and 90 for cancer). Meanwhile, the measures with the lowest overall quality scores for patients with dementia or cancer were getting hospice care training (69 for dementia and 75 for cancer) and getting help for symptoms (75 for dementia and 75 for cancer).

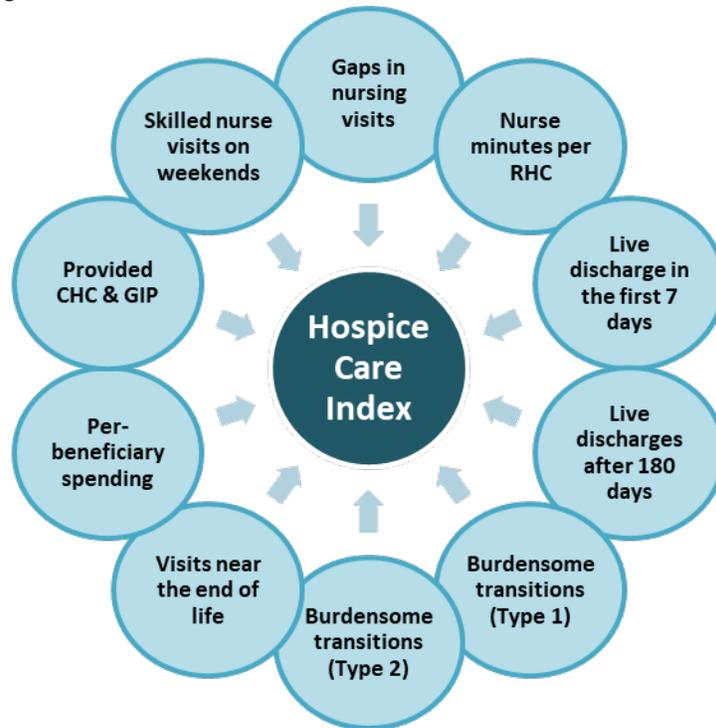
When looking at different care settings, several studies have found that CAHPS® data reflects quality discrepancies between care settings (Quigley et al. 2020; Parast et al. 2021a, 2022). Caregivers rated care quality highest in the inpatient setting, followed by the home setting. The nursing home (NH) setting received lower scores than the home setting for all measures, with the largest differences in hospice team communication (-12 points from home) and getting help for symptoms (-10 points). The assisted living facility (ALF) setting received lower scores for six of seven measures (no difference in emotional support), with the largest differences in communication (-11 points) and help for symptoms (-7 points).

Medicare Hospice Claims-Based Measures

Hospice Care Index (HCI)

The HCI is a single measure based on Medicare claims data that is updated annually. HCI comprises ten claims-based indicators to comprehensively represent distinct aspects of hospice service throughout the hospice stay. HCI indicators reflect several facets of care and hospice services including: the level of care provided, the frequency and timing of clinical visits, transitions to and from hospice care, and Medicare spending (see Figure 1). Hospices earn a “point” for each indicator criterion they meet but HCI scores are not reported publicly for small hospices due to small sample sizes (CMS, 2021a; Abt Associates, 2022). The HCI shows that services are taking place as required but does not necessarily reflect the quality of those services.

Figure 1. HCI Indicators



SOURCE: National Association for Home Care & Hospice. (2021). New Publicly Reported Quality Measures: Hospice Care Index & Hospice Visits in Last Days of Life [Presentation]. https://www.nahc.org/wp-content/uploads/2021/11/WebEvent_21-11-30-1200_Handout.pdf

HCI Data Trends

Findings from Plotzke et al. (2021) indicate that most hospices earn high HCI scores, with more than 85 percent of hospices scoring an 8 or above on the 1 to 10 scale. Not earning a point in any one of the indicators does not signify a serious problem with the hospice’s quality, but not earning a point across multiple indicators could indicate a concerning pattern of service for that hospice.

The HCI appears correlated to CAHPS[®], as hospices with higher HCI scores tend to have better CAHPS[®] ratings. For hospices with an HCI score of 10, 85 percent of CAHPS[®] respondents would recommend the hospice, but only 83 percent of CAHPS[®] respondents would recommend a hospice with an HCI of 7 or lower (Plotzke et al., 2021).

Hospice Visits in the Last Days of Life (HVLDDL) (NQF #3645)

The HVLDDL measure is an NQF-endorsed Medicare claims-based measure updated annually that represents the proportion of patients who received in-person visits from a registered nurse or medical social worker in at least two out of the final three days of a patient’s life (CMS, 2021a).

Hospice Item Set (HIS) (NQF #3235)

The HIS Comprehensive Assessment at Admission is a single measure calculated quarterly from HIS-Admission and HIS-Discharge records that are submitted by the hospices. The HIS measure captures the proportion of patients for whom the hospice performed all seven care processes, if applicable, during the admission process. These processes include addressing beliefs and values, discussing treatment preferences, screening for pain and dyspnea screening, and ensuring that a bowel regimen is initiated for those patients treated with a scheduled opioid (CMS, 2021a).

HIS Data Trends

HIS scores are typically high but specific scores vary between measures. In a 2018 review of national HIS data, Zheng et al. (2018) found that hospices nationally had a mean score of 90 percent or above for six of the seven processes. The remaining process, pain assessments, had a mean score of 78 percent with just 11.5 percent of hospices scoring a perfect 100 percent (which indicates that all patients received a pain assessment). Overall, the single HIS measure has limited ability to separate high and low performers due to its homogeneity on most components and according to a 2021 MedPAC Report, these scores are “mostly topped out” and may eventually be completely phased out.

Other Publicly Reported Hospice Information

These additional publicly reported quality measures come from other data files and offer different data points for consumers to consider when looking for hospice care providers.

Post-Acute Care and Hospice Provider Utilization and Payment Public Use Files (PAC PUF)

PAC PUF presents information on services provided to Medicare beneficiaries by hospices and other healthcare service providers taken from Medicare enrollment and fee-for-service final claims data (CMS, 2021b). These include demographic and clinical characteristics of beneficiaries served (e.g., type of Medicare coverage), professional and paraprofessional services utilized (e.g., routine home care), submitted charges, and payments at the provider, state, and national levels. The PAC PUF is updated annually, with the most recent update covering CY 2020 (CMS, 2021b).

Program for Evaluating Payment Patterns Electronic Report (PEPPER)

PEPPER is a report that summarizes provider-specific Medicare data statistics for CMS-identified target areas that are potentially at risk for improper Medicare payments (PEPPER, n.d.). These target areas, include, but are not limited to, discharge counts, average lengths of stay, and the average number of Medicare claims for beneficiaries (PEPPER, 2022). Hospices can use PEPPER data to compare their data to aggregate national or local data to identify risk areas where they may be potentially receiving overpayments or underpayments. Not all hospices have available or complete data, as data are not made available for a given target area if the numerator or denominator count is less than 11 (PEPPER, n.d.).

Additional Hospice Quality Information and Research

In addition to the existing measures listed above, additional research has looked at other characteristics of hospices and how they may be related to the quality and performance of a hospice.

Hospice Characteristics and Quality

Several studies have explored the characteristics most indicative of high-quality hospice care based on existing CMS quality measure data such as that from CAHPS[®] and HIS. In a sample of 2,746 hospices, Anhang et al. (2020) found that those hospices that were in the top quartile for both CAHPS[®] and HIS were more likely to be A) medium-sized (91 to 200 patients per year), B) in business for 20 years or more, and C) served rural areas. Smaller independent nonprofit and government hospices were more likely to provide better patient- and family-centered care (as indicated by higher CAHPS[®] performance), but large for-profit chain hospices performed better on process measures assessed through chart documentation (as indicated by higher HIS performance). Providing professional staff visits in the last two days of life was associated with high performance on both quality domains – CAHPS[®] and HIS (Anhang et al., 2020).

Hotchkiss (2022) later corroborated these quality characteristics. In that study, the investigators looked at a novel measure of quality rating from the website Glassdoor and how it correlated with CAHPS[®] Composite (the mean of all eight CAHPS indicators). Glassdoor scores, profit status, and acquisition status predicted CAHPS[®] scores and explained 44 percent of the variation in the CAHPS[®] Composite. Being a large, for-profit hospice predicted lower CAHPS[®] scores while non-profit hospices had significantly higher Glassdoor and CAHPS[®] scores than for-profit hospices. Market share, as a measure of a hospice company's size and influence, showed some association with lower CAHPS[®] but did not remain a significant predictor in all models. Within a sample of the 50 hospices with the largest market share, the authors also found that Glassdoor scores for communication and responsiveness were the strongest indicators of overall hospice quality. The study concluded that hospice quality and hospice profits are not necessarily mutually exclusive and that skeleton hospice staffing models must give way to more realistic models that place value on company culture and employee satisfaction. (Hotchkiss, 2022).

While previous studies examined what characteristics were related to high quality performers, Brereton et al. (2020) examined the major themes of negative online reviews of hospices in the United States. The sample was selected from a Hospice Analytics, Inc. database. For each US state, one for-profit and one non-profit hospice were randomly selected from the category of extra-large hospices (i.e., serving more than 200 patients). Of the one-hundred hospices in the study sample; 67 had 1-star reviews of which 33 (49.3 percent) were for-profit hospices, and 34 (50.7 percent) were nonprofit hospices. Of 137 unique reviews, 68 (49.6 percent) were for-profit hospices and 69 (50.4 percent) were non-profit hospices. A total of five themes emerged: discordant expectations, suboptimal communication, quality of care, misperceptions about the role of hospice, and the meaning of a good death. For both for-profit and non-profit hospices, quality of care was the most frequently commented-on theme (55.2 percent of comments). For-profit hospices received more communication-related comments overall (26.2 percent) while non-profit hospices received more comments about the role of hospice (69.7 percent) and the quality of death (48.5 percent). The findings indicate that patients, their families, and caregivers need thorough guidance on what they can expect from hospice staff, hospice services, and the dying process (Brereton et al. 2020).

There is a clear trend in this work that identifies for-profit hospices as performing worse on quality indicators than non-profit hospices. For example, in examining hospice complaints, Stevenson and

Sinclair (2018) found that for-profit hospices were 1.33 times more likely to have a complaint allegation and were 1.53 times more likely to have a complaint deficiency found when compared to non-profits hospices. Aldridge (2021) provided evidence that for-profit hospices provide fewer community benefits, including training, research, and charity care. For-profit hospices were more likely than non-profit hospices to discharge patients prior to death, to discharge patients with dementia, and to have higher rates of hospital and emergency department use. In one analysis of 355 hospices, 90 percent of those with the lowest spending on direct patient care (e.g., patient home visits) and the highest rates of hospital use were for-profit hospices. The author concludes that to safeguard hospice quality, regardless of tax status and ownership, we need timely and transparent data with financial consequences for poor performance (Aldridge, 2021).

Lastly, nonparticipation in CMS's Hospice Quality Reporting Program (HQRP) could both be a sign of low hospice quality and that a hospice is overburdened/understaffed. All hospices are required to participate in HQRP, or else the hospice faces reductions in their annual payment updates.³ In their study of nonparticipation in Medicare's HQRP, Hsu et al. (2019) found that among 4,123 eligible hospices only 6 percent (259) did not participate. Those that did not participate were for-profit, had no accreditation, had few nurses per patient day (i.e., lower nurse staffing ratios), provided no General Inpatient Care, and were in competitive markets. This suggests that the resource burden of reporting data, the potential cost of public reporting low quality care, and market pressure may influence or bias the hospice sample and data available to consumers through Hospice Compare. Thus, consumers should be aware that low-quality hospices may not be represented on Hospice Compare, or have indicators missing, as they may elect to face the penalty rather than report low quality outcomes publicly (Hsu et al., 2019).

³ The CAA of 2021 included an increase in the annual payment update penalty from 2% to 4% to take place in FY 2024. Hospices can be granted exemptions only for extraordinary circumstances, defined as disasters that prevent timely submission of quality data.

Nursing Home Special Focus Facility (SFF) Program

CMS created the SFF Program in 1998 to address poor performing nursing homes. The methodology the SFF program uses to identify these poor performers is based on a combination of results from standard surveys, complaint investigations, and revisits. These surveys are very similar to those used in hospices, whereby standard surveys are used to ensure nursing homes meet federal quality standards, complaint investigations focus on specific allegations (e.g., from a resident, family member, or nursing home staff), and revisits ensure nursing homes are correcting identified issues. Two key differences are that state survey agencies survey nursing homes annually (on average, every 9-15 months), compared to once every three years for hospice programs, and that private accrediting organizations do not play a role in certification of nursing homes for participation in Medicare/Medicaid.

When a survey – either standard or complaint – identifies a deficiency in a nursing home, each deficiency is classified by its severity (immediate jeopardy, actual harm, potential for more than minimal harm, and potential for minimal harm) and scope (isolated, pattern, and widespread) (see Figure 2 below). Although not all deficiencies result in a finding of noncompliance (e.g., Box A), most deficiencies require the nursing home to prepare a plan of correction and undergo revisits, if needed, to ensure the nursing home corrected the deficiencies. When a serious issue is identified from a survey, CMS requires a follow-up visit to verify that the facility has made corrections and is back in compliance with the CoPs. Most issues are resolved within one revisit; however, some require multiple revisits, and these facilities are assigned additional points for those revisits which are added into the final SFF score (CMS, 2022a).

Figure 2. Special Focus Facility Deficiency Scoring Rubric

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J 50 points* (75 points)	K 100 points* (125 points)	L 150 points* (175 points)
Actual harm that is not immediate jeopardy	G 20 points	H 35 points (40 points)	I 45 points (50 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D 4 points	E 8 points	F 16 points (20 points)
No actual harm with potential for minimal harm	A 0 point	B 0 points	C 0 points

SOURCE: Centers for Medicare & Medicaid Services. (2022). Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide. <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/downloads/usersguide.pdf>

The SFF program ultimately takes information from the last three standard health survey cycles, the last three years of complaint surveys, and revisits as applicable, and assigns points to each deficiency based on the grading rubric for a total score (CMS, 2022a). This score gives more weight to more recent survey results than those from earlier in the three-year survey cycle. With this information, CMS compiles a monthly candidate list for each state consisting of the poorest performing nursing homes in the state. The list can range from a minimum candidate pool of five to a maximum of 30 nursing homes per state. This candidate list is meant to reflect the nursing homes with the largest number and/or most severe deficiencies in each state. CMS notifies nursing homes of their presence on the SFF candidate list via the monthly preview of the *Five-Star Quality Rating System*.

From the candidate list, each state then selects which nursing homes should be in the SFF program based on their health inspection rating domain scores. Currently, each state has a different number of nursing homes they must choose for the program, based on the number of total nursing homes in their state; this ranges from one to six nursing homes in each state⁴ and results in no more than 88 nursing homes being in the program at one time nationally. This number is based on the federal budget available to support the SFF program and this number has not changed since 2014. (Survey & Recertification Group, 2017).

Once CMS places a nursing home in the SFF program, the state must survey the nursing home at least once every six months. If the nursing home shows improvement over two survey periods (i.e., a year), the nursing home can “graduate” from the program. If the nursing home fails to graduate after two surveys, the nursing home is subject to increased enforcement actions including developing a plan of correction in collaboration with the SA and the CMS location, and/or establishing an extensive quality improvement program (ex., a Systems Improvement Agreement, Temporary Management, or Directed Plan of Correction). If after being put into the SFF program, they fail to improve after three standard surveys (i.e., over 18 months), the nursing home can be terminated from the Medicare program (Survey & Recertification Group, 2017).

SFF Program Evolution

The SFF program has gone through various changes and updates since its inception in 1998. In response to a report by the U.S. Government Accountability Office in 2009, CMS amended the SFF program to include notifying nursing homes if they are on the candidate list, not just if they have been selected for the SFF program, and removing nursing homes in the SFF program from the candidate list once they have been placed in the SFF to ensure states have an ample number of nursing homes for potential inclusion in the program. Then, in 2008, CMS began identifying SFFs on the Nursing Home Care Compare website to alert consumers who are searching the site for nursing homes in their local areas, using a warning icon next to the hospice’s name (a yellow triangle with an exclamation mark). Lastly, in 2019, CMS began posting the candidate list online to increase transparency of the program (“Letter from Seema Verma”, 2019).

Most recently, in 2022, President Biden proposed reforms to ensure that “poorly performing nursing homes are held accountable for improper and unsafe care and immediately improve their services or are cut off from taxpayer dollars and the public has better information about nursing home conditions” (The White House, 2022). Part of the proposed reforms include overhauls for the SFF program to try and increase the performance of the nursing homes over a shorter time period. Facilities that fail to improve will also face progressively harsher enforcement actions, still ending in termination if needed. While these recommendations have yet to be implemented, they indicate areas of concern around nursing homes in the SFF program, such as facilities that remain in the program without improving or not sustaining improvements after graduation. Additional studies and reports have noted other issues that might be considered to improve the SFF program in the future (NASEM, 2022; Gupta et al., 2021; Braun et al., 2021).

⁴ The two exceptions are Alaska and the District of Columbia, which have no SFFs due to the low number of nursing homes in the state/district.

Conclusion

Hospice quality is assessed through several existing measures and each measure approaches quality in a different manner. Key among these measures are survey and complaint deficiencies, which provide a regulatory compliance perspective; CAHPS® scores, which provide a caregiver experience perspective; and the HCI and HVLDL measures, which provide insight into the scope/integrity of hospice care services based on Medicare claims. Each indicator has its advantages and disadvantages that TEP members should consider when thinking about how to accurately identify and assess poor-quality hospices compared to high-quality hospices.

From the existing literature on hospice quality, trends have emerged between the characteristics of hospice agencies and the type and quality of hospice care these agencies typically provide. Notably, these trends are not clear cut, and the hospice characteristics associated with providing high- or low-quality care change and sometimes conflict depending on how quality is measured. For example, the trends become more complex when the interaction between profit status, chain status, and size are examined in relation to the key quality measures. Overall, it is hard to predict the type of hospice that is most likely to be identified for SFP candidacy, but the literature suggests that for-profit hospices may be at higher risk of quality issues.

The nursing home SFF program offers some examples about how the SFP could be structured, but there are key differences between nursing homes and hospices related to quality oversight. Most significantly, the fact that hospices have a different survey cycle and use accrediting organizations to conduct compliance surveys offers unique challenges for the SFP to consider.

Ultimately, the goal of this report is to serve as a resource for the TEP to inform discussion of the SFP. However, it is important to note that the SFP will continue to evolve as the field of hospice care quality/assessment grows and evolves.

Appendix I. Literature Review Results

Search Terms

((“hospice” OR “hospice care”) AND (“quality” OR “quality indicators” OR “quality metrics”))

Search Date: 6/29/2022

Search Filters applied: 5 years; English; U.S. based

Results

Total Articles: 353

Title/Abstract Rejections: 340

Article Rejections: 5

Total Relevant Articles: 8

Search Terms

((“hospice” OR “hospice care”) AND (“complaint”))

Search Date: 6/29/2022

Search Filters applied: 5 years; English; U.S. based

Results

Total Articles: 13

Title/Abstract Rejections: 9

Article Rejections: 1

Total Relevant Articles: 3

Search Terms

((“hospice” OR “hospice care”) AND (“deficienc*”))

Search Date: 6/29/2022

Search Filters applied: 5 years; English; U.S. based

Results

Total Articles: 25

Title/Abstract Rejections: 23

Article Rejections: 0

Total Relevant Articles: 2

Search Terms

((“hospice” OR “hospice care”) AND (“accreditation” OR “quality accreditation”))

Search Date: 6/29/2022

Search Filters applied: 5 years; English; U.S. based

Results

Total Articles: 30

Title/Abstract Rejections: 25

Article Rejections: 2

Total Relevant Articles: 3

Search Terms

((“hospice” OR “hospice care”) AND (“survey” OR “quality survey”))

Search Date: 6/29/2022

Search Filters applied: 5 years; English; U.S. based

Results

Total Articles: 239
Title/Abstract Rejections: 235
Article Rejections: 2
Total Relevant Articles: 2

Search Terms

((“hospice” OR “hospice care”) AND (“audit”))
Search Date: 7/1/2022
Search Filters applied: 5 years; English; U.S. based

Results

Total Articles: 41
Title/Abstract Rejections: 35
Article Rejections: 5
Total Relevant Articles: 1

Search Terms

((“hospice” OR “hospice care”) AND (“oversight”))
Search Date: 7/1/2022
Search Filters applied: 5 years; English; U.S. based

Results

Total Articles: 14
Title/Abstract Rejections: 12
Article Rejections: 0
Total Relevant Articles: 2

Search Terms

((“hospice” OR “hospice care”) AND (“enforcement”))
Search Date: 7/1/2022
Search Filters applied: 5 years; English; U.S. based

Results

Total Articles: 10
Title/Abstract Rejections: 8
Article Rejections: 1
Total Relevant Articles: 1

Search Terms

((“hospice” OR “hospice care”) AND (“remed*”))
Search Date: 7/1/2022
Search Filters applied: 5 years; English; U.S. based

Results

Total Articles: 6
Title/Abstract Rejections: 6
Article Rejections: 0
Total Relevant Articles: 0

Search Terms

((“hospice” OR “hospice care”) AND (“corrective action”))

Search Date: 7/1/2022

Search Filters applied: 5 years; English; U.S. based

Results

Total Articles: 0

Search Terms

((“hospice” OR “hospice care”) AND (“termination”))

Search Date: 7/1/2022

Search Filters applied: 5 years; English; U.S. based

Results

Total Articles: 11

Title/Abstract Rejections: 9

Article Rejections: 1

Total Relevant Articles: 1

Search Terms

((“hospice” OR “hospice care”) AND (“penalt*”))

Search Date: 7/1/2022

Search Filters applied: 5 years; English; U.S. based

Results

Total Articles: 5

Title/Abstract Rejections: 4

Article Rejections: 0

Total Relevant Articles: 1

Results Summary Table in Report	
Search Dates	6/29/2022 & 7/1/2022
Total Peer-Reviewed Articles	747
Total Peer-Reviewed Articles (excludes duplicates)	642
Title/abstract rejections	609
Article rejections	17
Final articles	16

Appendix II. Literature Review Table

Full Citation	Objective	Methods	Results	Conclusions
<p>Stevenson, D., & Sinclair, N. (2018). Complaints About Hospice Care in the United States, 2005-2015. <i>J Palliat Med</i>, 21(11), 1580-1587. https://doi.org/10.1089/jpm.2018.0125</p>	<p>To describe hospice complaint trends, characterize state investigation practices, and assess the relationship between complaints and hospice traits of interest</p>	<p>Retrospective analyses merged hospice complaints (allegations & deficiencies) from 2005 to 2015 with hospice characteristics from Medicare Cost Reports (hospice ownership + number of patient days/year) and Provider of Service Files (accreditation & certification info)</p>	<p>Between 2005 and 2015, there were 12,931 complaint allegations and 6,710 deficiencies.</p> <p>Mean between when a complaint was received and then investigated was 67 days</p> <p>34 percent of complaints were substantiated showing wide variations by states (FL and TX had highest per hospice per year complaint allegations; FL and DE had more than 0.5 deficiencies per hospice per year)</p> <p>For-profit hospices more likely than not-for-profits to have a complaint allegation (1.33x), deficiency (1.53x)</p>	<p>Overall rate of complaints is low and has been steady over time and most focus on things that directly impact patients/families. Not sure why for-profits have higher likelihood of complaints. Study shows greater need for perspective of patients in considering hospice care quality. Creates concern around how some states are ineffective when it comes to investigating complain allegations (timeliness issue) and may be reflective of larger state quality of care issues</p>
<p>Zheng, N. T., Li, Q., Hanson, L. C., Wessell, K. L., Chong, N., Sherif, N., Broyles, I. H., Frank, J., Kirk, M. A., Schwartz, C. R., Levitt, A. F., & Rokoske, F. (2018). Nationwide Quality of Hospice Care: Findings From the Centers for Medicare & Medicaid Services Hospice Quality Reporting Program. <i>J Pain Symptom Manage</i>, 55(2), 427-432 e421. https://doi.org/10.1016/j.jpainsymman.2017.09.016</p>	<p>To look at national hospice HIS quality data</p>	<p>Calculated seven quality measures using HIS data using data from 3,922 hospices from October 1, 2014, to September 30, 2015, to characterize outcomes at the hospice level. Used provider of services file for hospice characteristics</p>	<p>National means for 6/7 indicators were more than 90 percent – the only exception was pain assessment, for which the national mean score was 78.2 percent.</p> <p>The most common indicator a hospice would have a 100 percent on was discussing treatment preferences (53.5 percent); the least common was pain assessment (11.5 percent)</p> <p>A small number of hospices (4 percent) had perfect scores for all 7 quality measures</p>	<p>Most hospices conduct critical assessments and discuss treatment preferences with patients at admission, although few have perfect scores.</p> <p>The measures overall have limited ability to separate high/low performers, but pain assessment is the least met indicator</p>

Full Citation	Objective	Methods	Results	Conclusions
<p>Hsu, S. H., Hung, P., & Wang, S. Y. (2019). Factors Associated With Hospices' Nonparticipation in Medicare's Hospice Compare Public Reporting Program. <i>Med Care</i>, 57(1), 28-35. https://doi.org/10.1097/MLR.000000001016</p>	<p>To examine the factors associated with hospices' nonparticipation in Hospice Compare</p>	<p>Identified "nonparticipant" hospices that did not submit any quality measure data to CMS 2016 Hospice Compare. Used multivariate logistic regression to estimate the association between hospice market characteristics (e.g., ownership, size, nurse staffing ratio, and market competition intensity) and non-participation.</p>	<p>Among the 4123 eligible hospices (certified hospices subject to penalty from nonparticipation), 259 (6 percent) did not participate in Hospice Compare. Four states had participation rates lower than 80 percent. Hospices that were for-profit, had no accreditation, had few nurses per patient day (i.e., lower nurse staffing ratios), provided no inpatient care (i.e., no GIC provision), and were located in competitive markets were less likely to participate than other hospices. Decreasing participation rates associated with increasing market competition were more prevalent among for-profit hospices compared with their nonprofit counterparts</p>	<p>Most hospices participated in Hospice Compare. Nonparticipants were more likely to be smaller, have lower quality of care, and in be counties with more intense competition. This suggests that resource burden of reporting data, potential cost of public reporting low quality care, and market pressure may influence or bias the hospice sample and data available to consumers through Hospice Compare. Hospice Compare data should be interpreted cautiously as low-quality hospices may not be represented.</p>
<p>Stevenson, D., Sinclair, N., Krone, E., & Bramson, J. (2019). Trends in Hospice Quality Oversight and Key Challenges to Making it More Effective, 2006-2015. <i>J Palliat Med</i>, 22(6), 670-676. https://doi.org/10.1089/jpm.2018.0445</p>	<p>To illuminate the current hospice quality oversight process (particularly efforts to assess compliance with Medicare/Medicaid conditions of participation) and discuss its role alongside other government monitoring and public reporting efforts.</p>	<p>Retrospective analysis (longitudinal data from 2006–2015) of hospice accreditation status, deficiency trends, survey frequency and deficiency outcomes, and termination from the Medicare program.</p>	<p>Between 2006-15, less than 25 percent of hospices were surveyed in a given year and 45 percent of all surveys resulted in deficiency citations. While the <i>proportion</i> of surveys that resulted in a deficiency (45 percent) and number of deficiencies cited per survey remained stable, the total number of deficiencies cited increased by 81 percent and the combined rate of deficiencies per hospice increased 35 percent. Of these deficiencies, issues around care planning, aide & homemaker services, and clinical assessment featured most prominently. Only 28 hospices were terminated from the Medicare program – most of these hospices were for-profit and unaccredited.</p>	<p>By requiring hospice recertification to occur at least once every three years, the IMPACT Act addressed one of the most visible shortcomings in hospice oversight (i.e., lack of assessment).</p>

Full Citation	Objective	Methods	Results	Conclusions
<p>Parast, L., Tolpadi, A. A., Teno, J. M., Elliott, M. N., & Price, R. A. (2021). Hospice Care Experiences Among Cancer Patients and Their Caregivers. <i>J Gen Intern Med</i>, 36(4), 961-969. https://doi.org/10.1007/s11606-020-06490-x</p>	<p>To examine hospice care experiences among decedents (people who have died) with a primary cancer diagnosis and their family caregivers, comparing quality across settings of hospice care.</p>	<p>Analyzed data from CAHPS® (217,596 respondents; 32 percent response rate; 1,667 hospices). Top-box outcomes (0-100) were calculated overall and by care setting, adjusting for survey mode and patient case mix. Tested for differences in quality between settings by fitting a weighted regression model with the measure score as the outcome and setting of care as the main predictor, with home as the reference group.</p>	<p>Quality measure scores ranged from 74.9 (Getting Hospice Care Training) to 89.5 (Treating Family Member with Respect). Measure scores varied significantly across settings and differences were large in magnitude, with caregivers of decedents who received care in a NH or ALF setting consistently reporting poorer quality of care. These settings had symptoms scores as low as 48.2 (NH) and 49.9 (ALF) for the item assessing whether the patient got needed help for feelings of anxiety or sadness.</p>	<p>Important opportunities exist to improve hospice care for symptom palliation (i.e., getting help for symptoms) and providing training for caregivers. Efforts to improve care for cancer patients in the NH and ALF setting are especially needed.</p>
<p>Hotchkiss, J. (2022). Hospice Glassdoor and CAHPS® Scores- Glassdoor Scores and Hospice Financial Characteristics Predict Hospice Consumer Assessment of Healthcare Providers and Systems Scores. <i>Am J Hosp Palliat Care</i>, 10499091221099475. https://doi.org/10.1177/10499091221099475</p>	<p>Explore the relationship between Glassdoor hospice employee recommendation data, hospice financial characteristics, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores among the 50 largest US hospices.</p>	<p>A regression analysis was used to evaluate relationship between Glassdoor scores, financial parameters (i.e., profit status, etc.), and CAHPS® scores of the 50 US hospices with the largest market share.</p>	<p>Being a large, for-profit hospice in acquisition status each predicted lower CAHPS® scores. Non-profit hospices had significantly higher Glassdoor and CAHPS® scores than for-profit hospices. CAHPS® Composite and CAHPS® Star Rating have potential as global indicators to inform customers of a given hospice’s overall quality on the Hospice Compare website of CMS.</p>	<p>Hospice leaders seeking improvements in CAHPS® scores are encouraged to seek feedback on whether their own employees would recommend their hospice to a friend. Communication and responsiveness were the strongest indicators of overall hospice quality. Hospice quality and hospice profits are not necessarily mutually exclusive.</p>

Full Citation	Objective	Methods	Results	Conclusions
<p>Anhang Price, R., Tolpadi, A., Schlang, D., Bradley, M. A., Parast, L., Teno, J. M., & Elliott, M. N. (2020). Characteristics of Hospices Providing High-Quality Care. <i>J Palliat Med</i>, 23(12), 1639-1643. https://doi.org/10.1089/jpm.2019.0505</p>	<p>To examine the association between hospice characteristics and care processes and performance on measures of hospice care quality</p>	<p>Under the HQRP, hospices must submit HIS measure data and contract with a survey vendor to collect the CAHPS® Hospice Survey</p>	<p>5.6 percent of hospices were in the top quartile of performance for both CAHPS® and HIS and were more likely to be medium-sized (91 to 200 patients per year), in business form 20+years, and serve rural areas. Hospice characteristics associated with being in the top quartile for CAHPS® included being a nonprofit or government hospice, smaller size (<200 patients per year), being in the South, serving a rural area, and providing professional staff visits in the last two days of life to 71.1 percent or more patients. Characteristics associated with being in the top quartile of HIS performance included being a for-profit chain, hospice age of 20+years, larger size (91+patients per year), having <40 percent of patients in a nursing home, and providing professional staff visits in the last two days of life to 71.1 percent or more patients</p>	<p>Hospice characteristics associated with strong performance on HIS measures differ from those associated with strong performance on CAHPS® measures. Providing professional staff visits in the last two days of life is associated with high performance on both quality domains.</p>
<p>Christian, T. J., Hassol, A., Brooks, G. A., Gu, Q., Kim, S., Landrum, M. B., & Keating, N. L. (2021). How Do Claims-Based Measures of End-of-Life Care Compare to Family Ratings of Care Quality? <i>J Am Geriatr Soc</i>, 69(4), 900-907. https://doi.org/10.1111/jgs.16905</p>	<p>Assess whether frequently used claims-based end-of-life (EOL) measures are associated with higher ratings of care quality</p>	<p>Linked Medicare administrative data for deceased cancer patients with data from a survey conducted after the patient’s death of their family/caregivers as part of the evaluation of CMS’s Oncology Care Model</p>	<p>Family rated EOL care as excellent less often, if within 30 days before death the cancer patient had inpatient admissions, ICU use, ED, or elected hospice within 7 days before death. Among hospice enrollees, family more often reported that hospice began at the right time if it started at least 7 days before death</p>	<p>Claims-based measures of EOL care for cancer patients that reflect avoidance of hospital-based care and earlier hospice enrollment are associated with higher ratings of care quality by bereaved family members.</p>

Full Citation	Objective	Methods	Results	Conclusions
<p>Kleinpell, R., Vasilevskis, E. E., Fogg, L., & Ely, E. W. (2019). Exploring the association of hospice care on patient experience and outcomes of care. <i>BMJ Support Palliat Care</i>, 9(1), e13. https://doi.org/10.1136/bmjspcare-2015-001001</p>	<p>To examine the association of the use of hospice care on patient experience and outcomes of care. Promoting high-value, safe, and effective care is an international healthcare imperative. However, the extent to which hospice care may improve the value of care is not well characterized.</p>	<p>A secondary analysis of variations in care was conducted to abstract organizational characteristics for 236 US hospitals to examine the relationship between hospice utilization and a number of variables that represent care value including hospital care intensity index, hospital deaths, ICU deaths, patient satisfaction, and a number of patient quality indicators.</p>	<p>Hospice admissions in the last 6 months of life were correlated with a number of variables including increases in patient satisfaction ratings and better pain control, and reductions in hospital day, fewer deaths in the hospital, and fewer deaths occurring with an ICU admission during hospitalization.</p>	<p>The results of this investigation demonstrate that greater utilization of hospice care during the last 6-months of life is associated with improved patient experience of care including satisfaction and pain control, as well as clinical outcomes of care including decreased ICU and hospital mortality.</p>
<p>Quigley, D. D., Parast, L., Haas, A., Elliott, M. N., Teno, J. M., & Anhang Price, R. (2020). Differences in Caregiver Reports of the Quality of Hospice Care Across Settings. <i>J Am Geriatr Soc</i>, 68(6), 1218-1225. https://doi.org/10.1111/jgs.16361</p>	<p>To examine variation in reported experiences with hospice care by setting.</p>	<p>The CAHPS® Hospice Survey was sent to caregivers 2 to 3 months after the patient's death and administered using either mail only, telephone only, or mail with telephone follow-up.</p>	<p>Caregivers of decedents who received hospice care in a nursing home reported significantly worse experiences than caregivers of those in the home for all measures. Assisted living facility scores were also significantly lower than home for all measures, except providing emotional and spiritual support. Differences in nursing home and assisted living facility settings compared to home were particularly large for hospice team communication and getting help for symptoms. Consistently across all care settings, hospice team communication, treating family member with respect, and providing emotional and spiritual support were most strongly associated with overall rating of care.</p>	<p>Important opportunities exist to improve quality of hospice care in nursing homes and assisted living facilities. Quality improvement and regulatory interventions targeting these settings are needed to ensure that all hospice decedents and their family receive high-quality, patient- and family centered hospice care.</p>

Full Citation	Objective	Methods	Results	Conclusions
Parast, L., Elliott, M. N., Haas, A., Teno, J., Bradley, M., Weech-Maldonado, R., & Anhang Price, R. (2021). Association between Receipt of Emotional Support and Caregivers' Overall Hospice Rating. <i>J Palliat Med</i> , 24(5), 689-696. https://doi.org/10.1089/jpm.2020.0324	Examine the association between reported emotional support and caregivers' overall rating of hospice care, overall and by race/ethnicity/language.	Linear regression models to examine association between caregiver-reported receipt of emotional & spiritual care and overall rating of hospice using CAHPS® survey data between 1/2017-12/2018	Most common response to all three sub-questions was “right amount” and least was “too much”; those who answered “too little” tended to rate hospice lower as did those who responded “too much” but at a lower rate and varies by racial/ethnic group	Overall receiving the right amount of support is strongly associated with a caregiver’s hospice rating and receiving too little is associated with a much poorer rating
Plotzke, M., Christian, T., Groover, K., Harrison, Z., Abdur-Rahman, I., & Massuda, C. (2021). Construction and Performance of the Hospice Care Index and Claims-Based Quality Measure. <i>Innov Aging</i> , 5(Suppl 1), 62. https://doi.org/10.1093/geroni/igab046.239	Determine how the hospice care index (HCI) is constructed and identify broad trends in the measures	HCI calculated from Medicare FFS claims from 10/1/2018-9/30/2019	Most hospices earn a high HCI score – over scores of 8+; 10 percent scored 7 and 4.9 percent scored 6 or lower On average hospices with higher HCI scores have better CAHPS® ratings (85.1 percent of caregivers reported they would definitely recommend the hospice vs 82.9 percent of caregivers receiving treatment from hospices with a score of 7 or less)	HCI can be used to assess hospices across a broad set of indicators Not earning a point for 1 indicator does not indicate a serious problem but not earning a point for multiple indicators suggests a concerning pattern of service
Aldridge, M. D. (2021). Hospice Tax Status and Ownership Matters for Patients and Families. <i>JAMA Intern Med</i> , 181(8), 1114-1115. https://doi.org/10.1001/jamainternmed.2020.6300	Why is profit maximization theoretically problematic for hospice care?	Commentary	For-profit compared with nonprofit hospices provide narrower ranges of services to patients, use less skilled clinical staff, care for patients with lower-skilled needs over longer enrollment periods, have higher rates of complaint allegations and deficiencies, and provide fewer community benefits, including training, research, and charity care. For-profit hospices are more likely than nonprofit hospices to discharge patients prior to death, to discharge patients with dementia, and to have higher rates of hospital and emergency department use. In one analysis of 355 hospices, 90 percent of those	To safeguard hospice quality, regardless of tax status and ownership, we need timely and transparent data with financial consequences for poor performance

Full Citation	Objective	Methods	Results	Conclusions
			with the lowest spending on direct patient care (e.g., patient home visits) and the highest rates of hospital use were for-profit hospices	
<p>Anhang Price, R., Stucky, B., Parast, L., Elliott, M. N., Haas, A., Bradley, M., & Teno, J. M. (2018). Development of Valid and Reliable Measures of Patient and Family Experiences of Hospice Care for Public Reporting. <i>J Palliat Med</i>, 21(7), 924-932. https://doi.org/10.1089/jpm.2017.0594</p>	<p>To develop and evaluate standardized survey measures of hospice care experiences for the purpose of comparing and publicly reporting hospice performance.</p>	<p>Used data submitted by 2500 hospices participating in national implementation of CAHPS®. Assessed item performance and constructed composite measures by factor analysis, evaluating item-scale correlations and estimating reliability. Regressed overall rating and willingness to recommend the hospice on each composite to assess key drivers of overall experiences.</p>	<p>Hospice Team Communication is the strongest predictor of overall rating of care and willingness to recommend, with Treating your Family Member with Respect and Getting Emotional and Spiritual Support the next strongest predictors of both outcomes. Of the 22 evaluative items that comprised the composites, there were 11 for which less than 80 percent of respondents endorsed the most favorable response category. These included items regarding getting needed help for feelings of anxiety or sadness (59 percent), receipt of training for management of restlessness/agitation, side effects of pain medicine, and trouble breathing (59 percent, 65 percent, and 77 percent, respectively), and keeping family members informed of the patient condition (75 percent).</p>	<p>Analyses provide evidence of the reliability and validity of CAHPS® Hospice Survey measure scores. Results also highlight important opportunities to improve the quality of hospice care, particularly with regard to addressing symptoms of anxiety and sadness, discussing side effects of pain medicine, and keeping family informed of the patient’s condition.</p>

Full Citation	Objective	Methods	Results	Conclusions
<p>Brereton, E. J., Matlock, D. D., Fitzgerald, M., Venechuk, G., Knoepke, C., Allen, L. A., & Tate, C. E. (2020). Content Analysis of Negative Online Reviews of Hospice Agencies in the United States. <i>JAMA Netw Open</i>, 3(2), e1921130. https://doi.org/10.1001/jamanetworkopen.2019.21130</p>	<p>To identify the most frequently cited complaints in negative (i.e., 1-star) online reviews of hospices across the United States</p>	<p>This qualitative study conducted a thematic analysis of online reviews of US hospices posted between August 2011 and July 2019. The sample was selected from a Hospice Analytics database. For each state, 1 for-profit (n = 50) and 1 nonprofit (n = 50) hospice were randomly selected from the category of extra-large hospices (i.e., serving >200 patients/d) in the database.</p>	<p>Of hospices in the study, 67.0 percent had 1-star reviews and 49.3 percent were for-profit. A total of 5 themes emerged during the coding and analytic process, as follows: discordant expectations, suboptimal communication, quality of care, misperceptions about the role of hospice, and the meaning of a good death. For-profit hospices received more communication-related comments overall (26.2 percent] vs 11.0 percent), while nonprofit hospices received more comments about the role of hospice (69.7 percent vs 61.3 percent) and the quality of death (48.5 percent vs 38.7 percent)</p>	<p>The findings indicated that patients and their families, friends, and caregivers require in-depth instruction and guidance on what they can expect from hospice staff, hospice services, and the dying process. Several criticisms identified in this study may be mitigated through operationalized, explicit conversations about these topics during hospice enrollment.</p>
<p>Parast, L., Tolpadi, A. A., Teno, J., Elliott, M. N., & Price, R. A. (2022). Variation in Hospice Experiences by Care Setting for Patients With Dementia. <i>J Am Med Dir Assoc</i>. https://doi.org/10.1016/j.jamda.2022.03.010</p>	<p>Characterize quality of hospice care for patients with dementia and their caregivers based on CAHPS® data across various hospice settings (home, NH, ALF, ACH, free-standing)</p>	<p>Data from caregivers with family members who died in 2017-18 across 2,829 hospices in the US</p>	<p>Across all settings, the CAHPS® quality measures with the lowest scores were:</p> <ul style="list-style-type: none"> • 58.6 – getting help for feelings of anxiety or sadness when needed • 69.0 – getting hospice care training for caregivers • 72.0 – getting help for constipation when needed • 74.5 – getting help for symptoms overall <p>Getting emotional support (90.9) and treating family members with respect (90.0) received the overall highest ratings. The setting with the highest scores were either @n the home or inpatient unit, while NHs, ALFs, and ACHs had the lowest scores for all outcomes</p>	<p>While focused on decedents with dementia, the study does characterize quality issues identified by caregivers. In particular, training and symptom treatment issues were the most common. The study also identifies differences between care settings which could be of interest.</p>
<p>Office of Inspector General. (2015). <i>CMS's Reliance on Accreditation Surveys Could Not Ensure the Quality of Care</i></p>	<p>The objective of this review was to audit a NY hospice ("Community") to determine the reliability of their existing private accreditation</p>	<p>N/A</p>	<p>CMS's reliance on accreditation surveys could not ensure the quality of hospice care that Community provided. Community</p>	<p>CMS work with CHAP and the health department to ensure that Community meets all Federal and State requirements for criminal</p>

Full Citation	Objective	Methods	Results	Conclusions
<p><i>Provided to Medicare Hospice Beneficiaries by the Community Hospice, Inc.</i> (A-02-11-01027). https://oig.hhs.gov/oas/reports/regi-on2/21101027.asp</p>	<p>survey. The authors concluded that CMS's reliance on accreditation surveys could not ensure the quality of hospice care that Community provided. Community did not meet certain Federal and State requirements for staff documentation. However, their CHAP accreditation survey did not find any of these types of deficiencies.</p>		<p>did not meet certain Federal and State requirements for staff documentation, including background checks, health assessment, licensing, training, and performance evaluations. However, the CHAP accreditation survey did not find any of the types of deficiencies identified in this report.</p>	<p>background checks, health assessments, professional licensing and experience, training, and performance evaluations.</p>
<p>Office of Inspector General. (2019). <i>Hospice Deficiencies Pose Risks to Medicare Beneficiaries</i> (OEI-02-17-00020). https://oig.hhs.gov/oei/reports/oei-02-17-00020.asp</p>	<p>This article summarized deficiency and complaint data from surveys between 2012-2016. Over 80 percent of hospices had at least one deficiency and 20 percent had a serious (condition-level) deficiency. One-third had complaints filed against them and 15 percent had severe complaints. The authors identified 313 hospices as poor performers, based on the agencies having at least one serious (condition-level) deficiency or one substantiated severe complaint in 2016.</p>	<p>N/A</p>	<p>From 2012-2016, 87 percent of hospices had at least one deficiency; 20 percent had a serious (condition-level) deficiency. Of hospices that had a deficiency in 2016, most (70 percent) had multiple deficiencies, and many had multiple deficiencies within the same year. The most common types of deficiencies involve poor care planning, mismanagement of aide services, and inadequate assessments of beneficiaries. 33 percent of hospices had complaints filed against them; 15 percent had complaints classified as severe (46% of those with complaints). The most common complaints were about quality of care, patient's rights, and administration issues. 32 percent of the complaints filed against hospices were substantiated. However, substantiating investigations may take place months or years after the complaint is filed.</p>	<p>CMS should: 1. Analyze claims data to inform the survey process 2. Analyze the deficiency data to inform the survey process 3. Seek statutory authority to establish additional, intermediate remedies for poor hospice performance 4. Include on Hospice Compare deficiency data from surveys, including information about complaints filed and resulting deficiencies</p>
<p>Office of Inspector General. (2019). <i>Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm</i></p>	<p>This report looked at 12 specific cases of harm to hospice beneficiaries to identify vulnerabilities in the hospice</p>	<p>N/A</p>	<p>The main areas of vulnerabilities identified included: <ul style="list-style-type: none"> •Insufficient reporting requirements for hospices </p>	<p>Based on the findings, OIG made six recommendations for CMS: 1. Seek statutory authority to establish additional, intermediate</p>

Full Citation	Objective	Methods	Results	Conclusions
<p>(OEI-02-17-00021). https://oig.hhs.gov/oei/reports/oei-02-17-00021.asp</p>	<p>system in 2016. These 12 were selected out of a sample of 50 for their severity of harm. The cases of harm came both from the hospices providing poor care and from abuse with the hospice failing to intervene. None of the hospices included in the report faced serious consequences and surveyors did not always cite immediate jeopardy in their surveys.</p>		<ul style="list-style-type: none"> •limited reporting requirements for surveyors •barriers for beneficiaries and caregivers to make complaints <p>The instances of harm included pressure ulcers resulting in gangrene and a leg amputation, maggots around a feeding tube, and prescribed services not being provided by the hospice. Abuse included sexual assault, theft of medications, or abuse by a family member. In some instances (e.g., providing essential pain medication) a state surveyor did not cite immediate jeopardy even when warranted. Also, plans of correction are used to address specific circumstances and not underlying problems. CMS cannot impose penalties other than termination to hold hospices accountable.</p>	<p>remedies for poor hospices</p> <ol style="list-style-type: none"> 2. Strengthen requirements for hospices to report abuse, neglect, and harm – specifically by revising the CoPs 3. Ensure hospices are educating staff to recognize signs of abuse, neglect, and other harm 4. Strengthen guidance for surveyors to report crimes to local law enforcement 5. Monitor surveyors’ use of immediate jeopardy citations 6. Improve and make user-friendly the process to make complaints <p>CMS agreed with first five recommendations; said it would investigate ways to improve process within regulator constraints and resources for #6</p>
<p>National Association for Home Care & Hospice. (2019). <i>Hospice Performance on Health and Safety Surveys – Concerns and Considerations</i>. https://www.nahc.org/wp-content/uploads/2019/09/HOSPICE-PERFORMANCE-ON-HEALTH-SAFETY-SURVEYS-Concerns-Recommendations.pdf</p>	<p>A briefer that covers the background behind hospice and the surveys, in addition to the two 2019 OIG reports. Also includes NAHCH commentary and recommendations</p>	<p>N/A</p>	<p>N/A</p>	<p>NAHCH identified four key areas of reform related to the hospice survey process:</p> <ol style="list-style-type: none"> 1. Expand educational support and target increased oversight to foster hospice quality of care 2. Additional patient/family support through an ombudsman program 3. Increasing transparency of survey information/support informed consumer choice 4. Improve the quality and consistency of the survey process by addressing weaknesses at SA, AO, and CMS regional and federal levels

Full Citation	Objective	Methods	Results	Conclusions
National Coalition for Hospice and Palliative Care. (2019). <i>Hospice Program Integrity Initiatives</i> . https://www.nationalcoalitionhpc.org/wp-content/uploads/2019/11/Coalition-Hospice-Integrity-Initiatives-10-23-19.pdf	Specific hospice integrity recommendations from the Coalition in response to the 2019 OIG reports	N/A	Provide 13 recommendations across multiple program integrity categories addressed to CMS	1. Intermediate Sanctions – instead of CMPs, put hospices on action plans w/specific timeframes and target dates; increase survey frequency to show progress 5. Survey frequency – annual surveys for initial certification and poor performers 6. Education for surveyors – include competency evaluations 7. Share survey results – from AOs and SAs
National Hospice and Palliative Care Organization. (n.d.). <i>CMS Top Ten Hospice Survey Deficiencies Comparison</i> . https://www.nhpco.org/wp-content/uploads/2019/05/Survey-Deficiencies.pdf	Contains the top 10 hospice survey deficiencies between 2014-18 cited during Medicare hospice recertification surveys annually.	N/A	L-Tag Order (2018): L543, L530, L629, L545, L547, L579, L647, L531, L523, L555	N/A

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