CMS Hospice Forum

November 14, 2023

>> Ketchum: Good afternoon, everyone. Thanks for joining today's "CMS Hospice Forum" webinar. During today's webinar, CMS subject matter experts will share hospice-related updates surrounding the Calendar Year 2024, Medicare Home Health Perspective Payment System final rule that was published on November 1. And these updates will include the finalized and formal dispute resolution process and the finalized Hospice Special Focus Program, including selection, public reporting, enforcement, completion, and termination. The presentation will then be followed by a question-and-answer session, where attendees will have an opportunity to ask questions and CMS subject matter experts will address as many questions as time allows. The recording, slide deck, and transcript from today's presentation will be posted on CMS' website in the coming weeks.

Now, I will turn it over to Melissa Rice, who is the technical advisor for CMS' Division of Continuing and Acute Care Providers to get us started. Melissa?

>> Melissa Rice, CMS: Thank you, Matt, and thank you for joining today's forum. On behalf of CMS, I would like to thank Ketchum for their work for supporting this webinar. Next slide.

Okay, And before we kick off the presentation, let me go through the disclaimer slide. This presentation presented today is current at the time of presentation. Medicare policy is subject to change, so links to the program, webpages that have been provided as supplemental resources are for your reference. This presentation is prepared as a service to the public and it is not intended to grant rights or impose obligations. The presentation and any supplemental resources provided may contain references or links to statutes, regulations, or other policy materials. And the intent of the information provided is to be a general summary and not to take the place of either the written law or regulations. And we encourage attendees today to review the specific statutes, regulations, and other materials provided, and their contents. Next slide.

Okay, so today, as Matt had discussed in the opening, we're going to discuss the Calendar Year 2024 Home Health Perspective Payment System final rule, hospice provisions, the hospice Informal Dispute Resolution process, and the Special Focus Program. And after this presentation, we will leave time for questions. Next slide.

Okay. This slide just gives an overview of the acronyms and the abbreviations that you may see during the presentation today, and we've defined them here. Next slide.

Okay. So, first, I'm going to briefly discuss the Calendar Year Home Health final rule as it relates to the hospice provisions. So, next slide.

The final rule was displayed in the Federal Register on November 1st of 2023. And it was published yesterday in the Federal Register, November 13th, 2023. It can be found on the Federal Register webpage, provided on this slide, as well as available on CMS's Hospice Regulations and Notices webpage on cms.gov. Next slide.

Okay. So, the first of two proposals that were finalized in the rule was the Hospice Informal Dispute Resolution. The second provision that was finalized was the hospice Special Focus Program. And as we mentioned in the beginning, there was specific criteria that was also finalized along with the Hospice Special Focus Program to include selection into the program, survey and enforcement criteria, completion criteria, termination criteria, and public reporting of the Special Focus Program, status, and lists. Next slide.

Okay. So, an overview of the IDR. The purpose of the IDR is to – sorry, next slide.

The purpose of the IDR is to provide an opportunity for hospices to dispute condition-level findings on their standard 36-month survey before it gets to the formal hearing or appeals process. The IDR is used to dispute condition-level findings and it may not be used to dispute standard-level findings or refute enforcement actions or selection into the SFP. Next slide.

When hospices receive their survey findings from the form CMS 2567 or the statement of deficiencies form, they will also be notified of their right to request an IDR to dispute any condition-level findings. Hospices must submit their request for an IDR within the 10-day calendar time limit allowed for submitting the plan of correction. After reviewing the request, if the state or CMS removes or revises any of the findings, the form CMS 2567 will be updated along with any related enforcement action as necessary. Next slide.

Okay. So, next, we'll discuss the Hospice Special Focus Program and I would like to pass it to Thomas Pryor who is a nurse consultant in our Division of Continuing and Acute Care Providers.

>> Thomas Pryor, CMS: Thank you, Melissa. Next slide.

So, the SFP was created to identify and address poor-performing hospices through increased regulatory oversight. All active hospices will have an algorithm score calculated that includes both Hospice Quality Reporting Program, or HQRP, data as well as inspection survey data. If a hospice has a high score indicating they are a worse performer, they may be identified as a potential SFP candidate. All candidates will then be reviewed, and those already under enforcement action and/or for which they are already on a termination track will be removed, and a number of those hospices remaining will then be considered for selection for the SFP. Once in the SFP, hospices will be surveyed every six months within an 18-month timeframe until they either complete the program or are considered for termination from the Medicare program. Each part of the SFP will be described in additional detail in the following slides. Next slide.

This slide provides an overview of the SFP from its conception in the Consolidated Appropriations Act of 2021 through the initial rounds of rule-making for specifically the CY22 Home Health Proposed Rule in which there was public comment asking to consider claims data as well as the creation of a technical expert panel, or TEP, for which we did at that time, to the present day which includes the final criteria finalized in the CY24 Home Health final rule. Next slide.

All active hospices with at least one data indicator included in the algorithm are eligible for the SFP. Eligibility means that they will be assigned the score body algorithm. This also includes providers in U.S. districts and territories. Next slide.

As mentioned, the SFP algorithm will be used to assign each SFP-eligible hospice provider a score with a higher score indicating poor performance. The algorithm includes data from two sources, the HQRP and inspection survey data. Next slide.

From inspection survey data, the first indicator is the number of quality-of-care condition-level deficiencies cited on standard and complaint surveys. This data observed quality – includes, excuse me, observed quality issues from both state agency surveyors and accrediting organization surveyors. Three years of data will be included so that each active hospice will have at least one survey due to the 36-month certification or accreditation survey cycle. 11 of the 23 conditions of participation, or CoPs, are used in those that have been identified as those more directly related to quality-of-care. More information on these CoPs can be found in the State Operations Manual Appendix M and in the final rule. Next slide.

And as I just alluded to in the previous slide, the 11 CLDs reflected here on this slide are what are being used for the algorithm. Next slide.

The second indicator used from inspection survey data is the total number of substantiated complaint surveys for each hospice. These are complaints where an allegation was investigated and affirmed or substantiated by an on-site survey. This indicator also uses three years of data to align with the other survey indicator. Next slide.

From the HQRP, the next data indicator used in the SFP algorithm is the Hospice Care Index, or HCI. The HCI is based on Medicare claims data, which all hospices submit, and is composed of 10 indicators of care provided throughout the hospice stay. Next slide.

The last indicator used in the algorithm also comes from the HQRP and is CAHPS Hospice Survey data. CAHPS Hospice Survey data represents the family and caregiver experience that at a hospice and was deemed to be one of the more important indicators of quality to include by the SFP TEP.

Four CAHPS survey measures were chosen to be included as the most relevant to hospice quality as identified by the SFP TEP.

And those four measures are help for pain and symptoms, getting timely help, willing to recommend the hospice, and overall rating of the hospice.

These four measures are combined to create the CAHPS index, a score used only for the SFP algorithm.

The CAHPS index uses the fully adjusted bottom box scores of each measure because these scores represent reported problematic care experiences.

To create the CAHPS index, the two measures that represent overall assessments of hospice care, willing to recommend the hospice and the overall rating of the hospice, are multiplied by 0.5 as they assess similar concepts.

The other two measures will be weighted at 1.0 each, as they assess different aspects of hospice care.

Then, all four bottom-box values are added together to create one value, the CAHPS index.

Next slide.

To be able to combine all four indicators, quality of care CLDs, digital-level findings, substantiated complaints, the HCI, and the CAHPS index, each indicator must first be standardized.

This means each indicator is mathematically transformed so that they all have the same unit which makes the different measures comparable to each other.

For example, the number of CLDs and substantiated complaints the hospice could have is theoretically limitless.

There is no maximum number a hospice could have of either indicator.

However, both the HCI and CAHPS index have a maximum score.

Therefore, it would be inappropriate to simply add the survey measures to HCI or CAHPS because the two scales are not comparable.

To standardize them, we use the form that we've seen on this slide which subtracts the overall average of each individual indicator from each individual hospice's score for the indicator.

The number is divided by the overall standard deviation of that indicator which is a typical measurement of variability.

This calculation results in a hospice receiving a value for each indicator that tells us how, for example, a hospice's HCI score compares to the average hospice's HCI score.

A positive number indicates the hospice's score that is above average and a negative number indicates that a score is below average.

This also means that the average value becomes zero for each indicator, meaning it is zero standard deviations away from the average.

Next slide.

After each value is standardized for the hospice's missing data, there are two ways that missingness is addressed.

The first way is used for missing HCI and survey data.

While every hospital submits claims data, hospices do not have publicly reported scores, they are too small, meaning that they have fewer than 20 claims over two years, or new, meaning that they do not have the full two years of data needed to calculate the HCI.

While every hospice should have a standard survey, there may be cases where a hospice does not have a survey recorded due to issues such as the survey backlog.

As for the hospice's missing HCI scores or inspection survey data, the hospice is assigned the average value for each indicator.

Due to the standardization process, this value is equivalent to zero.

This method was chosen to handle HCI and survey missingness because in reviewing the available data for each indicator, the majority of hospices with data are clustered or centered around the average value.

This indicates that given the data available, it is likely that a hospice would also fall around the average if they had data for either indicator.

For example, from the preliminary data used to develop the SFP algorithm, the average HCI score was 9 our of 10, and roughly 90% of hospices had an HCI score of 7 or higher.

Due to the high clustering of hospices around the average HCI score, we conclude that it is reasonable to assume that a non-reporting hospice's HCI would be close to the average score. Next slide.

A different algorithm approach was selected for handling CAHPS Hospice Survey data. Because CAHPS data is qualitatively different from the HCI and the survey data, there's a higher level of missingness for CAHPS Hospice Survey data than for HCI and survey data. The missingness in the CAHPS Hospice Survey data is due to the higher reporting requirements required for the public reporting of CAHPS data. This means that many more hospices are exempt from reporting because they are new, and therefore, granted an automatic exemption or too small, again, meaning they do not have enough survey participants to include. Because of the high missingness, we feel it is not appropriate to make assumptions about what the missing values for those providers might look like. So, to generate scores for all providers, without making assumptions, two versions of the algorithm model were created, one that includes the CAHPS index for hospices with the data available and one that does not include the CAHPS data for those missing the data. Each version is then divided by the total number of inputs so that their scores can be compared between the two versions. Both versions will be shown on a later slide, but this method allows us to avoid making assumptions about what the CAHPS hospice data might be for a hospice without the data while ensuring that there is no incentive for a hospice to choose not to report CAHPS data to try and avoid SFP selection. Next slide.

Lastly, each indicator assigned the weight according to their relative importance for hospice quality is discussed by the TEP. Each indicator is weighted at 1.0, with the exception of the CAHPS index, which is weighted twice as heavily as the other data inputs. This is to acknowledge the special importance of caregiver feedback to hospice quality and the SFP program. This weighting means that the CAHPS index makes up 40% of the hospice's score when a provider reports CAHPS, while the other three indicators make up 20% of the score each. In the version of the algorithm without the CAHPS index, each data makes up 33% of the final score. Next slide.

This slide gives a visual representation of the two versions of the algorithm that I've mentioned, the top version shows the algorithm with the CAHPS index included divided by five due to the double-weighting of the CAHPS index, meaning it is essentially added twice in the algorithm. The lower version shows the algorithm without the CAHPS index included divided by three. I'll now pass the presentation back to Melissa for the rest of the slides.

>> Melissa Rice, CMS: Thank you, Thomas. Next slide.

SFP Selection. So, as described in the prior slides, each active hospice will receive a score from the SFP algorithm. A higher score represents hospices with poor quality of care as related to the included quality indicators. And CMS will identify a subset of 10% of hospices based on the highest aggregate scores determined by the algorithm. The number of hospices will be determined in the first quarter of each calendar year. And from this 10% subset of hospices with the highest aggregate algorithm scores, CMS will make the final selection to participate – of hospices to participate in the SFP. We will select the poorest performing hospices from the 10% subset in sequential order, which may include up to 1% of hospices from that subset based on available resources. The hospices selected into the SFP will be notified by CMS by way of a letter. And as the focus of the SFP is to encourage improvement through increased oversight, not all hospices already own an enforcement path. Hospices that are under an enforcement and active enforcement action for which they are already on a termination track or subject to other remedies would not be considered for selection into the SFP for that designated period. Also, to note, hospices selected for the SFP with deemed status from an accrediting organization will be placed under CMS or state agency oversight during their time in the program. And this is consistent with CMS survey and enforcement processes. Next slide.

Public reporting. Hospices that are chosen for participation in the SFP will be included on a list that will be posted to the SFP website on CMS.gov. This list will be updated at least annually. And as hospices move through the program, the list may be updated more frequently to include the latest status information. To note, the website will also include a list in addition to those actually selected into the SFP, it will also include the list containing the 10% of hospices with the highest algorithm scores for public consideration. Program guidance and any other relevant information regarding the SFP will also be provided on this website. Next slide.

Survey and enforcement. So, once a hospice is selected into the SFP, they will be surveyed at least every six months. Issues that are cited during the survey may lead CMS to enact progressive enforcement remedies as appropriate and as determined by CMS. Next slide.

Completion criteria. To complete the SFP, participating hospices must have no condition-level deficiencies cited from any two of the SFP surveys or any pending complaint surveys that are triaged at an immediate jeopardy or condition level within the 18-month period. So, this means that a hospice must return to substantial compliance with all requirements in that 18-month SFP period. A hospice will be notified of their completion from the SFP via a letter from CMS. And, after completing the SFP, the hospice will receive a survey one year after the completion date of the SFP which will restart their standard 36-month survey cycle. Next slide.

Termination. For any hospice unable to meet the completion criteria over an 18-month period, they will be placed on a termination track. So, this means that the hospice that fails any survey in that 18-month period, by having uncorrected condition-level deficiencies who are not returning to substantial compliance is considered for termination. Next slide.

Okay. The next slides are going to discuss the next steps for the IDR and SFP. Next slide.

The IDR process for hospices will be effective as of January 1, 2024. The SFP selection process will begin in the fourth quarter of Calendar Year 2024. And as noted in the final rule, CMS will closely monitor the SFP and the algorithm and make changes as necessary going forward. Next slide.

Right. This slide contains resources where additional information about both programs can be found. Also, to note, if there are additional inquiries, they can be sent to the CMS resource mailbox at cms_hospicesfp@cms.hhs.gov. Okay, next slide.

Alright. So, I want to thank you for attending the hospice forum. I am going to turn the floor back over to Ketchum at this point.

>> Ketchum: Alright, thank you, Melissa. And thank you as well, Thomas. So, as Melissa said, we're going to go ahead and get started with the Q&A portion of the webinar. And as a reminder, we won't be taking live audio questions today. So, if you would like to ask a question,

you are just going to need to submit it through the Q&A box, as many of you have already been doing. And again, CMS will address as many questions as time allows.

Alright. To get us started, the first question asks, "Why is CMS creating the Special Focus Program?"

>> Melissa Rice, CMS: Thanks, Matt. I'll take this one. So, Congress mandated CMS to create a program to identify poor-performing hospices based on defined quality indicators, in which CMS will select those hospices for increased oversight to ensure that they meet the Medicare requirements. This mandate was part of the Consolidated Appropriations Act of 2021. And hospices selected into the SFP, as we just discussed, will receive an SFP survey, which means they will get a standard survey performed after they're selected into the SFP and this will be – this survey will be conducted every six months within an 18-month timeframe.

>> Ketchum: Great. Thank you, Melissa.

Alright, moving on to the next one. The next question asks, "What kind of hospices are likely to be included in the SFP?"

>> Melissa Rice, CMS: Sure, I'll take this one.

So, based on preliminary data used to develop the final algorithm, there were more than 5,900 hospice providers that were both currently active and had at least one of the four algorithm inputs. So, accounting for about 98% of all active providers. So, this means that the scores that were generated for all of those 59 hospices, of those – of these hospices, only those that have the 10% highest score among all of those will be identified as possible participants for the SFP so that's what will generate that 10% subset, and then CMS will select less than 1% of that 10% subset to be included in the Special Focus Program. So, as a result, to be identified in either the 10% or the 1% list requires poor performance across all the inputs and identified providers will either need to perform exceptionally poor on one measure or quite commonly poor across multiple measures.

>> Ketchum: Great, thank you for that information.

Alright. So, moving on. The next question asks, "When will the SFP start?"

>> Thomas Pryor, CMS: Yeah, Matt, this is Thomas. I'll take this question. Do you hear me okay?

>> Ketchum: Yes.

>> Thomas Pryor, CMS: Great.

So, as Melissa already kind of mentioned, so the CY2024 Home Health Payment Final Rule published November 13th of 2023, and while the effective date is January 1, 2024, as she had mentioned, the SFP selection is expected probably to begin in late Calendar Year 2024. And just reiterating, the number that we looked to initiate this program with is less than 1% of the eligible hospice providers.

>> Ketchum: Great. Thank you so much, Thomas.

Alright, moving on. The next question asks, "What will CMS be monitoring from the program and the algorithm?"

>> Thomas Pryor, CMS: Yeah, this is Thomas, I will take this.

So, excuse me. We plan to monitor the algorithm inputs for changes to the measures, including the addition or removal of measures from the hospice quality reporting program that may affect the SFP program or the algorithm in the future. This will include monitoring the providers that opt out of reporting quality measures and the inputs that may exhibit signs of topping out, large swings and summary statistics, distributions in the input outliers, and provider recidivism. The SFP is really overall intended to, you know, improve overall provider performance with those

providers that are delivering poor care to the beneficiaries and is not intended to be arbitrarily enrolled providers that will perform. As part of our continued monitoring, I think what we're going to also want to evaluate how potential SFP providers will be differentiated from providers that do not meet this additional intention. As the proposed SFP improves care delivery across providers, we may also consider changing components of the program such as the SFP-eligible providers for the number of SFP participants, if warranted. So, the bottom line is we will continue to be, you know, monitoring. And as it was mentioning before, as a necessary, adjusting in the future.

>> Ketchum: Great. Thanks so much, Thomas.

The next attendee question we have asks, "Why is CMS publishing the 10% list?"

>> Melissa Rice, CMS: Thanks, Matt. I'll take this.

So, we're publishing the 10% subset because we feel this information will be useful to the public for consumers that are looking for hospice care. We want to ensure that this information is available to them and that it's out there in a way that's transparent and searchable and accessible.

>> Ketchum: Great, thank you so much.

Okay. So, the next question we have asks, "Will the algorithm result be able to be replicated by the general public?"

>> Melissa Rice, CMS: Sure, I'll take this one.

So, the SFP algorithm methodology will assist with approximating scores but will not be fully replicable, as the algorithm uses survey data that differs from the publicly available survey data. Additionally, there's differences in when the data are updated, accessed, or published, which may lead to differences in component scores for the publicly available measures.

>> Ketchum: Great. Thanks so much, Melissa.

Alright, moving on. The next question asks, "Why is the algorithm different from what was proposed to the technical expert panel?"

>> Thomas Pryor, CMS: Matt, I'll address this question.

Excuse me. So, the purpose of convening the SFP TEP was to seek ideas and input from a diverse group of hospice experts through thoughtful discussion on all aspects of the SFP to include in the CY 2022 comments, public comments that were received about using different data claims indicators, what have you, for the algorithm. So, from all of that, and the feedback provided by the SFP TEP, along with the feedback received from additional stakeholder listening sessions, we held helped to inform the development of the proposed SFP methodology and other criteria. Based on that feedback, decisions were made regarding the final specifications, you know, to the proposed SFP to ensure they best used available data.

>> Ketchum: Great. Thank you so much.

Okay, so our next attendee question asks if additional guidance will be provided on the IDR process.

>> Melissa Rice, CMS: Yeah, thanks, I'll take this one.

Yes, CMS will provide guidance for the hospice IDR process and we're actually currently working on updating our State Operations Manual, or SOM, chapter 10 to provide guidance for the hospice IDR which will be similar to the guidance established for the home health agency IDR process. And so, that's currently underway at this time.

>> Ketchum: Thank you so much.

Okay, so, the next question asks, "How does the IDR affect selection for the SFP?"

>> Melissa Rice, CMS: Sure, I'll take this one.

So, just to go back, you know, the IDR process allows providers to dispute condition-level findings upon receipt of their 2567. The algorithm then utilizes the survey data from the finalized survey reports. So, these are the reports used in the algorithm that are not pending IDR or subject to disputes at that point. So, SFP selection will be based on the algorithm that utilizes the survey data from those finalized reports, not pending IDR or subject to any further disputes.

>> Ketchum: That's great information. Thank you so much, Melissa.

Alright, moving on. The next question asks, "Who will be conducting these extra SFP surveys?"

>> Thomas Pryor, CMS: Matt, I'll take this one.

So, at this point, CMS is exploring the third-party surveyor entity. And this is based on the TEP recommendations.

>> Ketchum: Great, thanks so much.

Okay, so the next question asks, "What kind of things will CMS be looking for when finalizing the selections?"

>> Melissa Rice, CMS: Thanks. Yeah, I'll take this one.

So, when we generate the 10% subset list of poorest-performing hospices, when we make our selection, up to potentially 1% of hospices for the SFP, we're essentially going in sequential order. So, the poorest performing on that list in order. However, we will be looking, as I said in the presentation, to ensure that there's no hospices selected that are under current or active enforcement actions. So that will be taken into consideration.

>> Ketchum: Wonderful. Thank you so much, Melissa.

Okay, moving on. The next question asks, "Why is technical assistance not being provided?"

>> Thomas Pryor, CMS: Matt, I'll address this one.

So, while CMS is not providing direct technical assistance, we do anticipate and ensure that the SFP hospices are aware of different other resources and tools that will be able to assist them in providing improved quality as well. Some of that also will be linked to our SFP webpage in the future as well for additional resources.

>> Ketchum: Alright, thanks, Thomas.

Okay, the next question that we have asks, "What kind of enforcement remedies will be utilized prior to termination?"

>> Thomas Pryor, CMS: I'll get this one again.

So, enforcement remedies could be imposed for SFP hospice for condition-level findings on the SFP survey or the complaint survey while they're in a program. So, these enforcement remedies can be imposed instead of or in addition to termination of the hospice program's participation in the Medicare program. Remedies include civil monitoring penalties, or CMPs as they're called, directed in-service training, directed plans of correction, suspension of all our product payments, and appointment of temporary management to oversee operations are those that are additional enforcement remedies that might be considered. Thanks, Matt.

>> Ketchum: Great. Thank you for the information, Thomas.

Okay, so the next question asks, "Will CMS consider other factors outside the algorithm measures and score when making selections?"

>> Melissa Rice, CMS: Thanks, Matt.

And I think this is similar to a question we just answered that we will take into consideration hospices and not include hospices under an active enforcement action for which they could already be on a six-month termination track or subject to other remedies for that designated time period.

>> Ketchum: Great, thank you.

So, I'm hoping you all can answer the next one which asks, "Will CMS be considering the impact on consumers before terminating hospices?"

>> Thomas Pryor, CMS: Matt, this is Thomas.

So, again, I think as current processes, CMS would certainly provide public notice and follow current requirements that we currently do for any transition of hospice patients that may be affected by a terminated hospice to alternate sources of care, ultimately in a timely and safe manner.

>> Ketchum: Great.

Okay, so, this next attendee is asking if there is a way to appeal selection into the SFP.

>> Thomas Pryor, CMS: So, I'll get this one again.

As far as the SFP goes itself, there's no appeal process for selection into the SFP.

>> Ketchum: Okay, thank you so much.

The next question we have asks, "How frequently will the public information be updated on the website?"

>> Melissa Rice, CMS: Sure, I'll take this one.

So, in terms of the public list, the 10% and 1% list, they will be reported annually on the hospice SFP website on CMS.gov. And we will additionally publish periodic updates as hospices complete the program.

>> Ketchum: Great. Thank you so much, Melissa.

Alright. So, another question we have asks, "Are all condition-level deficiencies counted in the algorithm?"

>> Thomas Pryor, CMS: Matt, I'll take this one.

So, again, early in the presentation, I had mentioned that the algorithm looks at the 11 condition-level deficiencies, highlighted on that previous slide, that are related to the quality of care as part of the survey data input, so it's just those specific 11 that would be considered as part of the algorithm.

>> Ketchum: Right, thank you so much, Thomas.

Alright, moving right along. The next question asks, "How is CMS handling hospice providers and missing CAHPS data?"

>> Melissa Rice, CMS: Sure, I'll take that.

So, there are two different versions of the algorithm that are being used to produce comparable scores. For hospice providers with and without CAHPS Hospice Survey data, the two versions of the algorithm allow us to generate scores without making assumptions about the values of

missing CAHPS scores since there is not enough information about what those missing CAHPS scores might be to make reasonable assumptions.

>> Ketchum: Great, thank you so much, Melissa.

So, the next question asks, "Why do some providers not have HCI scores?"

>> Thomas Pryor, CMS: Matt, I'll take this one.

So, to recap, so for most providers missing HCI scores due to, again, small size, fewer than 20 claims or too new, fewer than eight-quarters of claims. So, hospice providers will not have an HCI score and data it if they fail to meet the minimum number of claims required for public reporting. Or they say – or if they have less than the required eight-quarters of data. Missing HCI can also result if for any reason that one of the 10 indicators could not be calculated. So, those are, you know, essentially some of the reasons why they may not have one.

>> Ketchum: Great, thanks for the explanation, Thomas.

Okay, so, the next question we have asks, "Why is CMS not scaling CLDs or substantiated complaints by hospice size?"

>> Thomas Pryor, CMS: I'll take this one too.

Excuse me. So, again, recapping the analysis that was done with the algorithm and the CLD data did not indicate that larger hospices were more likely to have quality-of-care CLDs cited. This is likely because providers of all sizes receive the same number of accreditation and certification surveys. So, when surveyors identify non-compliance, they cite based on the amount they agree with the non-compliance regardless of the hospice size. We found that there was no statistical relationship between the number of patients the hospice serves and the number of CLDs identified in the survey data. Actually, scaling the CLDs by size would be inappropriate in that it would cause each CLD citation to negatively affect the algorithms for

smaller hospices by more than what it would affect larger hospices. Large hospices do have more opportunities to receive complaints than smaller ones, but we are also only counting those substantiated complaints where surveyors found evidence to support that the claim of a quality care issue occurred or is ongoing. We also note that the majority of hospices, including larger hospices had zero substantiated complaints. So, many substantiated complaints is indicative of a quality care issue. But we continue to monitor the relationship between the substantiated complaints and size as we move forward with this program.

>> Ketchum: Great. Thanks so much for the comprehensive answer, Thomas.

Okay, moving right along. The next question asks, "Why are you assigning hospice providers who are missing an HCI score or the average score?

>> Thomas Pryor, CMS: Thanks, Matt.

So, the HCI scores of all providers in the data were strongly clustered around the average HCI score, meaning that most providers had similar scores to one another. More than 86% of the hospice providers had an HCI score of eight or more in 2021 publicly reported data. This high degree of clustering really means that when a provider is missing their HCI, it's reasonable to assume that it would have an HCI similar to other hospices. This assumption is also made based on the way we know missing HCI scores are generated, either providers are missing HCI scores because they are new so they'll have an observable, excuse me, HCI score once they have the eight-quarters of claims. Or because they are exceptionally small. But there is presently no evidence to suggest newness or size is strongly related to the overall quality of care of those providers.

>> Ketchum: Great. Thank you again, Thomas. Much appreciated.

Okay, so, the next question we have in our queue asks, "Why is CAHPS weighted more heavily in the algorithm?"

>> Melissa Rice, CMS: Yeah, I'll jump in here.

So, CMS convened the technical expert panel as well as the series of stakeholder listening sessions. And both groups consistently emphasized the importance of incorporating the unique caregiver perspective into the SFP algorithm above the claims-based measures and survey data. So, the CAHPS Hospice Survey is the input that most directly captures this perspective on hospice quality of care, and therefore, CMS decided to weigh it twice as much as the CLD substantiated complaints or HCI.

>> Ketchum: Great. Thank you, Melissa.

Alright, on to the next question. This one asks, "Is CMS creating an incentive to not report CAHPS Hospice Survey data by giving it a heavier weight in the algorithm?"

>> Melissa Rice, CMS: So, I'll take this one.

No. Because suppressing CAHPS data does not decrease the probability that a hospice provider will have an algorithm score in the SFP eligible range. Providers with and without CAHPS scores are equally likely to fall into the bottom 10%. Our preliminary analysis suggests that voluntary non-reporting is rare. Nearly 98% of hospices that did not report the CAHPS Hospice Survey data was due to a result of being sufficiently small or a new provider. Additionally, for eligible hospice providers, failure to report CAHPS data would trigger a 4% reduction on the provider's annual payment updates. But we will monitor the rates of the exemption and non-reporting of CAHPS Hospice Survey data and evaluate any changes to the algorithm as deemed necessary should these rates drastically increase.

>> Ketchum: Great. Thank you, Melissa.

Okay, so, the next question asks, "What complaints are counted in the algorithm?"

>> Thomas Pryor, CMS: Yeah, Matt, can you hear me?

>> Ketchum: Yes.

>> Thomas Pryor, CMS: So, any substantiated complaint is counted toward the total if it was substantiated within the last three years. A substantiated complaint includes allegations that were submitted to the state agency or accrediting organization ultimately were affirmed following an on-site investigation survey such that would have been defined as being substantiated or not.

>> Ketchum: Great. Well, thank you for that differentiation there, Thomas.

Alright, so, let's move on to the next question. This one asks, "Is a hospice provider that does not have CAHPS Hospice Survey scores more or less likely to be placed in the SFP?"

>> Melissa Rice, CMS: Sure, I'll take this one.

And, you know, as we stated in a question just recently, just above, our analysis finds that hospice providers with and without CAHPS data are equally likely to have an algorithm score that makes them eligible for the SFP. This is also consistent with the intent of using the two different versions of the algorithm to produce comparable scores for the hospice providers with and without CAHPS Hospice Survey data. There's no evidence to suggest that having or not having CAHPS Hospice Survey data is in any way related to the overall care delivery of that provider and thus, we would expect the average provider with CAHPS Hospice Survey data to deliver a similar level of care to data providers without CAHPS survey data. Additionally, the preliminary analysis that we've done demonstrates that this expectation is reflected in the algorithm scoring when using the two-version approach.

>> Ketchum: Great. Thank you so much, Melissa.

Okay, so, the next question we have asks, "For hospice providers assigned the average HCI score due to missingness, why is that number transformed into zero?"

>> Thomas Pryor, CMS: Matt, I'll address this.

So, the missingness HCI scores are assigned to the average score after the algorithm inputs have been standardized to allow the four indicators to be compared to one another. Standardization is done, again, by subtracting the overall average of each input, from each provider's observed score and then dividing the result by the standard deviation of the inputs across all the providers. So, after standardization, the average score of the standardized input is always set at zero. So, we assign the providers with missing HCI inputs a value of zero which is equivalent to assigning them the average score. Thanks.

>> Ketchum: Great. Thank you so much for that, Thomas.

Okay, so, another question we have asks, "Why do approximately half of all active providers not report on CAHPS data?"

>> Melissa Rice, CMS: Sure, I can take this.

And there are a couple of factors to account why half of hospice providers do not publicly report CAHPS data. One, you know, the public reporting thresholds are high for the hospice – the CAHPS Hospice Survey data to protect the anonymity of respondents, the confidentiality of their responses, and, you know, to assure that no single respondent exerts undue influence on the CAHPS scores. You know, another factor is response rates from caregivers tend to be low. So, this means that most small providers are not able to meet these thresholds. Also, due to the eight-quarters of data reporting requirements, new hospice providers are not eligible to report CAHPS. So, some of the factors of why approximately half do not report CAHPS.

>> Ketchum: Alright, thank you, Melissa.

This next question asks, "How is the CMS addressing issues of surveyor burden and inconsistency between surveyors?"

>> Thomas Pryor, CMS: Yeah, Matt, I'll address this one.

So, CMS has made multiple improvements to survey our training guidelines. This started with the revised State Operations Manual or Appendix M. This was published and fully implemented as of May 2023. And we continue to monitor surveyor training to ensure that it is updated with regulations or requirements. So, along with the revised SOM Appendix M, we also created a new basic training if you will for hospice providers. And now, again, in conjunction with the CA 2021 provisions, all accrediting organizations and state surveyors are required to take the updated surveyor training. And we have actively identified a process for identifying and remedying those inconsistencies through our training, and then ultimately are also doing additional training in the development of surveyor skills review training to test surveyor competency, and that will start in 2024 as well.

>> Ketchum: Great. Thank you so much, Thomas.

So, I think we are getting close to 2 o'clock. I think we have time for about two or three more questions. So, we'll go ahead and get through those before we end for the day. So, the first of those questions asks, "Does using CAHPS as a data source disproportionately impact providers serving historically underserved communities?"

>> Thomas Pryor, CMS: Yeah, Matt, I'll address this one.

So, there's presently no evidence to suggest that the way the CAHPS Hospice Survey data is conducted disadvantages providers serving said historical underserved populations. Both of our preliminary analysis and the scholarly literature on the CAHPS Hospice Survey find that hospices that serve a higher percentage of non-White beneficiaries or dual eligible beneficiaries have lower adjusted CAHPS Hospice Survey scores. However, the research literature did not find that providers of comparable quality that they served different populations receive different adjusted CAHPS scores, essentially indicating that providers receive lower scores due to having poorer quality. Ultimately, the goal of the SFP is to improve the hospice care and delivery for

all beneficiaries. And differences in adjusted CAHPS scores are reflective of real differences in the quality of care.

>> Ketchum: Great. Thank you so much, Thomas.

Okay. So, I'll ask a couple of questions but the first of those two asks, "Is a hospice provider that does not have a publicly reported HCI more likely to be placed in the SFP?"

>> Thomas Pryor, CMS: Matt, I'll grab this one as well.

So, the initial response is no, our preliminary analysis suggests that hospice providers who did not have publicly available HCI score were less likely to have an algorithm score that made them eligible for the SFP placement. Or that we believe that hospices that did not have a publicly reported HCI score due to not having the eight-quarters of complaints data will have a score once they, you know, ultimately receive – get to this reporting threshold.

>> Ketchum: Great. Thank you so much.

And we may have time to squeeze in two more questions, but we'll see once we get to this question right here. This question asks, "What elements of the CAHPS survey are being considered in the SFP algorithm?"

>> Melissa Rice, CMS: Sure, I'll take this one.

The four CAHPS Hospice Survey elements considered in the algorithm are help for pain and symptoms, getting timely help, willingness to recommend the hospice, and overall rating of the hospice.

>> Ketchum: Great. Thanks, Melissa.

Since you did get through that one pretty quickly, I think we can squeeze in this final question here for the day. And this question asks, "How is CMS accounting for duplicated CLDs and/or substantiated complaints?"

>> Thomas Pryor, CMS: Matt, I'll grab this one as well.

So, there is a possibility that a substantiated complaint might be counted twice as part of the calculation if a specific complaint is investigated by both the state agency or accrediting organization on separate dates. We will be monitoring the data, as I mentioned before, to determine that the incidence of such an occurrence and to evaluate whether changes to the algorithm will be necessary to future rule-making as we continue to monitor.

>> Ketchum: Great. Thank you so much, Thomas and Melissa.

Unfortunately, we are – we've run out of time for today's webinar, so, that will conclude the Q&A portion of the webinar. I would like to thank everybody for all of your questions. If you have additional questions or comments, you're encouraged to contact CMS by email at cms_hospicesfp@cms.hhs.gov. And that email address can be found on slide 33. And just as a second reminder, a recording of today's webinar as well as a transcript and a downloadable copy of the slides will all be available on CMS's website in the coming weeks. But that is it for today. Thank you all for joining us. We hope you all have a wonderful afternoon. Bye, now.