Public Comment Summary Report

Project Title:

Development of the *Transitions from Hospice Care, Followed by Death or Acute Care* Measure for the Hospice Quality Reporting Program

Dates:

- The Call for Public Comment ran from March 27, 2018 to April 25, 2018
- The Public Comment Summary was made available on August 31, 2018

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has contracted with RTI International to develop quality measures for the Hospice Quality Reporting Program (HQRP). The purpose of this project is to supplement the existing HQRP measure set, which includes quality measures based on the Hospice Item Set (HIS) and the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®), with measures that address additional identified gaps in hospice quality measurement. The measure currently under development, *Transitions from Hospice Care, Followed by Death or Acute Care*, uses Medicare fee-for-service (FFS) claims data to assess potentially concerning patterns of care after hospice live discharge. The contract name is Hospice Quality Reporting Program Measure Development, Maintenance, and Support. The contract number is HHSM-500-2013-13015I.

Project Objectives:

- To develop a claims-based quality measure which measures the rate of potentially inappropriate live discharges from hospice care, defined as live discharges followed by death within 30 days or acute care within 7 days.
- To develop and finalize elements of the measure specifications, such as inclusion/exclusion criteria, the measure numerator, and risk factors included in the risk-adjustment model.

Information about the Comments Received:

- Website used: htsstps://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/PC-Currently-Accepting-Comments.html
- Public comments were solicited by the following methods:
    - Posting a Call for Public Comment on the CMS Public Comment website
    - Posting an announcement on the Hospice Quality Reporting Program Spotlight & Announcements webpage
    - Notifying stakeholders via CMS email list
- Volume of response received: CMS received 30 comment letters. These comment letters were submitted by a range of stakeholder types, including hospice providers and clinicians, provider associations, patients and family members, and researchers with technical expertise in quality measurement.

Stakeholder Comments:

1. **Introduction**

The Centers for Medicare & Medicaid Services (CMS) posted a *Draft Measure Specifications: Transitions from Hospice Care, Followed by Death or Acute Care* document for public comment from March 27, 2018 through the end of the business day April 25, 2018[1], and received 30 comment letters from individual hospice providers, hospice associations, and other stakeholders, including members of the public. CMS thanks the commenters for their detailed comments. Some of the comments supported the intent of the draft measure, and many offered constructive suggestions for changes to the draft measure specifications that could improve the measure. Others provided suggestions for provider training and education, phased implementation, and the need for thorough vetting of any subsequent draft measure specifications. A few commenters explicitly stated that they have significant concerns about the draft measure specifications and recommended against its future implementation.

The purpose of this document is to summarize the comments received during the *Transitions from Hospice Care, Followed by Death or Acute Care* public comment period, and to provide additional details and responses to the concerns that commenters raised during the comment period. CMS thanks the commenters for their many thoughtful comments; public comment periods on draft measures provide a valuable opportunity for CMS and measure developers to receive input during the measure development process.

Measure Development Process:

This public comment period is part of the Measures Management System Blueprint v 13.0 process for measure development.[2] The purpose of the public comment period is to provide transparency to the public about measure development efforts, and to seek comment on draft measure specifications. Comments received during the public comment period will inform additional measure development activities, thereby improving the measure specifications. Additional measure development efforts will focus on addressing all the measure criteria against which the measure will be assessed in the future through review by the Measures Application Partnership (MAP) and the endorsement review by the National Quality Forum (NQF). In addition, prior to any implementation of new Quality Measures (QMs) in Hospice Quality Reporting Program (HQRP), CMS would undergo the notice of proposed rulemaking and public comment period prior to finalizing any measure for adoption in the HQRP. For more information on measure development processes, please refer to the Fiscal Year (FY) 2017 Final Rule[3].

[1] Centers for Medicare & Medicaid Services. *Public Comment Page: Currently Accepting Comments.* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/PC-Currently-Accepting-Comments.html#0326.

[2] Centers for Medicare & Medicaid Services. (2017): Centers for Medicare & Medicaid Services: Blueprint for the CMS Measures Management System. Version 13.0. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Blueprint-130.pdf. Accessed May 3, 2018.

[3] https://www.federalregister.gov/documents/2016/08/05/2016-18221/medicare-program-fy-2017-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting

Measure Intent:

The intent of the Transitions from Hospice QM is to assess negative outcomes following hospice live discharge, including acute care use shortly after discharge, as these outcomes represent potentially burdensome transitions to patients and families.

Concerns over live discharges *that are followed by patient death in a short time window or those that result in burdensome transitions and negative outcomes such as hospitalization or ED use* are not new. As described in the public comment document, avoiding unnecessary hospital and Emergency Department (ED) admissions and re-admissions was identified by NQF as a high priority measurement opportunity for hospice.[4] In addition, the Medicare Payment Advisory Commission (MedPAC) suggests that while there are many reasons for live discharges, including patient preference driven revocations (for example, to seek a second opinion or additional tests or treatments that are not necessary to treat the terminal diagnosis), problematic patterns of live discharges followed by negative outcomes could signal a quality of care issue.[5,6]

Although a patient leaving a hospice is not always under the hospice's control – a patient can revoke, move out of the service area, etc. – in these instances, the hospice should ideally work with the patient/family prior to their discharge to help coordinate care to avoid burdensome transitions where at all possible. Although some burdensome transitions are inevitable and lie outside the hospice's control, higher than normal rates of these transitions may represent quality of care issues, such as systematically poor care coordination and discharge planning.[5] In addition, there is evidence that not all of these patient-initiated transitions are truly patient-initiated. In some cases, these burdensome transitions are a direct result of actions by the hospice that are driven by financial motives, not by care needs of the patients (e.g., several commenters mentioned instances where hospices "encouraged" patients to revoke for no reason other than that the hospice did not want financial responsibility for higher-cost care or they were close to their aggregate cap). For these types of discharges in particular, discharges followed shortly by death or hospital or ED use could be an indicator that the hospice was discharging patients who were close to death to avoid going over the hospice aggregate cap.

We recognize that patients can always choose to leave hospice care, and some live discharges are inevitable and not under the hospice's control. We also recognize that despite the best planning and care coordination, patients do sometimes unexpectedly die or seek care in the ED or are hospitalized. The Transitions from Hospice Care QM is not intended to measure a "never event"; some rate of live discharge from hospice followed by death, ED use, or hospitalization is appropriate. Although some live discharges followed by death or acute care are unavoidable, from a quality of care perspective, hospices with a substantially higher rate of live discharges followed by hospitalization or ED use may have quality of care issues that warrant attention.

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[4] Measure Applications Partnership, "Performance Measurement Coordination Strategy for Hospice and Palliative Care" (National Quality Forum, 2012)

[5] MedPAC, Report to the Congress: Medicare Payment Policy. March 2018. Available from: http://medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf?sfvrsn=0

[6] MedPAC, Report to the Congress: Medicare Payment Policy. March 2017. Available from: http://www.medpac.gov/docs/defaultsource/reports/mar17_medpac_ch12.pdf?sfvrsn=0

Regulatory reform and reducing regulatory burden are high priorities for CMS.[7,8] Specifically related to this measure, CMS desires to promote effective communication and coordination of care, and to reduce unnecessary cost and burden (including provider burden of collecting and reporting data), increase efficiencies, and improve beneficiary outcomes and experiences of care. Incentivizing care coordination and reducing unnecessary cost are key in this age of shifting to value-based care and alternative payment models that include shared accountability for the care of patients with serious illness and those nearing end-of-life.

High-level overarching themes from comments received:

Many commenters voiced support for *the intent* of the draft QM and supported CMS's efforts to develop a measure that captures "undesirable outcomes after discharge, rather than focusing on hospice transition rates alone". At the same time, they pointed out concerns about whether the measure as currently specified is a quality measure versus a utilization measure or program integrity measure. They pointed out concerns that the measure as currently specified would not be sensitive enough to distinguish live discharges followed by care transitions that are a result of quality of care issues, versus those that are aligned with patient and family preference or choice.

Further, commenters were concerned that the results of the measure would not be understood by consumers for purposes of healthcare decision-making, and that the measure results similarly would not be helpful to hospices to inform their quality improvement efforts. Importantly, commenters were concerned that the measure might be confusing to hospices, given their access to other performance indicators related to live discharges available in the Program for Evaluating Payment Patterns Electronic Report (PEPPER). Commenters suggested that various potential unintended consequences of publicly reporting this QM would outweigh the potential benefits. In addition, commenters were concerned that because the measure is claims-based, it would lack sensitivity and would not represent quality of care for the entire hospice population because it would only capture fee-for-service (FFS) patients for whom CMS has claims.

Commenters discussed the wider policy implications and regulatory context for the measure and the complexity of hospice practice in the context of the tension between quality of care and compliance requirements. They offered suggestions for changing and improving the measure specifications, including changes to the numerator and denominator specifications and details of the risk adjustment methodology and provided suggestions for provider training and considerations for how the measure might be implemented in the future to ensure hospice providers are successful in addressing any quality issues. Finally, several commenters requested additional details of the measure development process be shared by CMS and commented that the measure should be fully vetted and endorsed by NQF prior to implementation.

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[7] Medicare Program; FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements, 42 C.F.R. § 418.

[8] Centers for Medicare & Medicaid Services (April 2018). *Meaningful Measures Hub*. Retrieved from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html

The Transitions from Hospice Care QM would be the first claims-based measure to be potentially implemented in the HQRP. CMS acknowledges commenters' statements about the potential drawbacks of a claims-based measure to capture hospice transitions, including concerns over the potential lack of sensitivity of the measure to reflect discharges that are the result of patient preferences and goals. The sections that follow provide detailed summaries of the public comments received and responses to the concerns and suggestions that commenters raised.

2. Measure Intent

Summary of Comments Received: Several commenters supported CMS's continued efforts to develop and expand the HQRP and expressed support for CMS's efforts to develop a measure that captures undesirable outcomes after discharge, rather than focusing on hospice transition rates alone. Several commenters agreed that high live discharge rates followed by certain care transitions are concerning and that hospices with relatively higher rates than their peers might have quality of care concerns. Some commenters noted that they have observed inappropriate discharges as a way for hospices to avoid the financial responsibility of higher-intensity care or treatments for their patients, or when hospices are approaching their aggregate cap. One commenter noted this measure could also help identify hospices that systematically do not provide certain levels of hospice care to their patients. Commenters encouraged CMS to address patterns of inappropriate hospice discharges, including hospice-initiated revocations.

However, many commenters pointed out that despite the positive intent of the QM, it would fall short in addressing the underlying policy and regulatory reforms needed to change the fundamental reasons for live discharges and burdensome transitions. *We summarize these comments in greater detail and provide a response in Section 9 below.* Commenters also pointed out the shortcomings of a claims-based measure to incorporate patient and family preferences, and fairly measure transitions in care. They worried that this measure is not so much a quality measure as it is a utilization or program integrity measure, or a measure that assesses both quality and program integrity issues without clearly distinguishing the two. Commenters stated the measure would be ineffective or inconsequential because the overall small number of live discharges from hospice in general, and the relatively short median lengths of stay in hospice. They questioned the importance of this measure and its ability to affect care for the entire population of hospice users.

Commenters suggested this measure would be better suited as a practice indicator in PEPPER (or perhaps through other direct-to-hospice reporting), as opposed to being implemented for public reporting. One commenter recommended the Transitions measure be implemented as a precursor to a different measure that could be more directly linked to quality outcomes. This staged approach, could further the hospice industry's understanding of the concerns that this measure is trying to address.

Many commenters urged CMS to ensure that this measure undergo proper vetting through the MAP and NQF processes. Commenters also strongly encouraged the measure be tested and validated before public reporting. Several commenters encouraged CMS to offer additional opportunities for the hospice community to provide feedback throughout the measure development process, and to work closely with stakeholders to prepare for any potential public reporting on Hospice Compare.

Response: CMS appreciates the comments in support of this measure and the measure's intent. We also acknowledge stakeholders' concerns regarding the measure and its use.

CMS wholeheartedly agrees that respecting patient and family choice is vital to providing high quality care, and applauds hospices for their efforts to ensure patient and family preferences for care are met. The aim of this measure is to reflect patterns of care that reflect potential quality of care issues related to live discharges resulting in burdensome transitions and patient outcomes such as death and hospitalization and ED use. We would like to emphasize that this measure is not intended to assess a "never-event", and that some level of live discharges and acute care use that result from patient/family choice are expected.

CMS recognizes that the measure will not reflect the quality of care for the majority of patients receiving hospice care because the majority of hospice patients die under hospice care and do not experience a live discharge. However, while many patients have a short length of stay and die under hospice care, there are also many patients with much longer lengths of stay, and in more than a quarter of hospices, live discharge rates exceed 30%.[9] Thus, we believe live discharges (or a subset of live discharges) can be used to measure quality. MedPAC has expressed support for the use of live discharges as a quality measure.[10]

Quality measures are distinct from utilization indicators, such as those included in PEPPER. Utilization measures report statistics on services provided and billed to Medicare, and have a primary goal of protecting the integrity of the Medicare program. That said, certain practice areas may be related to the integrity of Medicare program and have significant implications on patient and family care outcomes and experience. Developing quality measures around those areas is a more effective strategy to ultimately improve quality of care. The literature on hospice care transitions supports the linkage between this measure concept and the quality of hospice care. Care transitions at the end of life are burdensome to patients, families, and the health care system at large because they are associated with adverse health outcomes,[11, 12] lower patient and family satisfaction,[13] higher health care costs,[14, 15] and fragmentation of care delivery. Live discharges that are followed shortly by death or acute care utilization represent an outcome that is potentially related to the quality of care furnished during a patient's hospice stay. Substantially higher rates of live discharge followed by undesirable outcomes may signal providers' inability to meet patient and family needs. Further, care transitions themselves can represent disruptions in continuity of care at a time when patients and families are extremely vulnerable.

While providers cannot control the preferences of their patients, hospices can often minimize the risk of these undesirable outcomes through providing high quality care, which includes post-discharge care planning and patient/family education.

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[9] MedPAC (March 2018). "Report to the Congress: Medicare Payment Policy." (Chapter 12: Hospice Services): 323-352.
[10] MedPAC (March 2018). "Report to the Congress: Medicare Payment Policy." (Chapter 12: Hospice Services): 323-352.
[11] Aldridge, M. D. P., MBA; et al. (2016). "The Impact of Reported Hospice Preferred Practices on Hospital Utilization at the End of Life " Medical Care 54(7): 657-663.
[12] Phongtankuel, V., et al. (2015). "Why Do Home Hospice Patients Return to the Hospital? A Study of Hospice Provider Perspectives." Journal of Palliative Medicine 19(1): 51-56
[13] Dolin, R. et al. (2017). "Factors Driving Live Discharge From Hospice: Provider Perspectives". Journal of Pain and Symptom Management.
[14] Carlson, M. D. A., et al. (2009). Hospice characteristics and the disenrollment of patients with cancer. Health Services Research. 44: 2004+.
[15] MacKenzie, Meredith A., and Alexandra Hanlon. "Health-Care Utilization After Hospice Enrollment in Patients With Heart Failure and Cancer." American Journal of Hospice and Palliative Medicine® (2017): 1049909116688209

CMS would like to clarify the difference between this measure and the information currently provided to hospices via the Hospice PEPPER. While there are some similarities between this measure and the live discharge metrics included in the PEPPER, the measure is intended to serve a different purpose than the PEPPER. The PEPPER is intended for a hospice's internal use to identify areas which require more monitoring or auditing.[16] If the Transitions measure were implemented for public reporting in the HQRP, it would be displayed with other hospice QMs and provide prospective patients, caregivers, and other stakeholders with information to make decisions for their care. Because this measure is intended for public reporting, it has been refined to narrow its focus on live discharges that may be inappropriate based on patterns of care or death following discharge, to provide more specific information to patients. The measure will also incorporate risk adjustment, which is not included in any of the metrics in the PEPPER.

CMS recognizes the similarities between this measure and the PEPPER metrics but believes that this measure provides valuable information to hospices, as well as patients and caregivers. At the same time, CMS also recognizes that providers might encounter difficulties in interpreting PEPPER metrics and results of this QM; provider outreach and education approaches will be critical to the success of any future measure implementation efforts. Hospices should continue to monitor their own performance in live discharge metrics relative to other hospices in the PEPPER. The measure may be used to complement the information provided in the PEPPER. Like the PEPPER, the measure focuses on indications of potentially problematic live discharges, and CMS does not believe that the measure would be at odds with any of the metrics provided in the report. We have summarized the unique features of PEPPER indicators and the Transitions from Hospice QM in the table below.

Category	Hospice PEPPER Indicators	HQRP Transitions QM
Measure Focus	Hospice utilization	Patient outcomes
Type of Information	Utilization indicators and statistics for purposes of auditing and monitoring activities. The indicators are not publicly reported.	Quality measure for purposes of comparing and publicly reporting hospice performance.
Specific Indicators and Measure* Compared	Live Discharge – Revocations; Live Discharge – No Longer Terminally Ill; Live Discharge – Length of Stay 61-179 days; Live Discharges by Type (No longer terminally ill, Revocation, Moving out of service area, transfer, For cause)	Live discharges followed by death within 30 days or Acute care within 7 days
Risk Adjustment	No	Yes

[16] TMF Quality Institute. (2017). Hospice Program for Evaluating Payment Patterns Electronic Report: User's Guide, 24th Edition. Retrieved from https://www.pepperresources.org/Portals/0/Documents/PEPPER/ST/STPEPPERUsersGuide_Edition24.pdf.

Category	Hospice PEPPER Indicators	HQRP Transitions QM
Reporting	Hospices can view their own performance on the Hospice PEPPER. Their performances are reported as both scores and percentiles relative to national hospices. Hospices with scores at the 80th percentile or above (indicating higher utilization) have their scores in **red bold** and are informed that they are in the upper quintile for indicator performance (high utilizer).	If the measure is implemented in the future, hospices could potentially view their own performance on the provider confidential reports (CASPER QM Reports) and view other hospices' performances on Hospice Compare.

*The PEPPER also contains indicators related to patient length of stay, patient diagnosis, and hospice provision of services such as CHC or GIP. Only indicators related to the Transitions QM are listed. https://www.pepperresources.org/Portals/0/Documents/PEPPER/HOSPICE/HospicePEPPERUsersGuide_Edition7.pdf

We also appreciate the commenters' input and support of the NQF endorsement process. We seek to adopt measures for the HQRP that promote patient-centered and high-quality care. Our measure selection activities for the HQRP take into consideration input from the MAP, convened by the NQF, as part of the established CMS pre-rulemaking process. Additionally, while this measure is not currently NQF-endorsed, we recognize that the NQF endorsement process is an important part of measure development and plan to submit this measure for NQF endorsement in the future.

3. Limitations of Claims Data

Summary of Comments Received: Some commenters appreciated CMS's efforts to reduce administrative burden on providers by using claims data. However, a few comments noted the limitations of claims as a data source for this measure. Commenters stated that claims are not sufficient for capturing the complexity of hospice practice and the "tension" between quality and compliance requirements. Additionally, claims are limited in capturing patient and family preferences. Finally, commenters pointed out that claims would only reflect care for patients in FFS hospice benefit election, and therefore would not necessarily be representative of a hospice's quality of care or a representative sample for the QM. They also pointed out that reporting a claims-based measure that reflects FFS patients only would be at odds with the other QMs in the HQRP which report on all patients, regardless of payer. Several commenters said that the measure should not exclude hospice patients enrolled in Medicare Advantage (MA), as the experience of MA patients should be given the same consideration as the experience of Medicare FFS patients. They noted that other hospice measures, such as the Consumer Assessment of Health Providers and Services (CAHPS®) measure and the Hospice Item Set (HIS) measures, do not have this exclusion, and this may lead to inconsistency in interpretation of the quality measures on hospice care. One commenter stated that including MA patients could provide insights to the ways in which outcomes among MA and FFS patients might differ.

One commenter described the difficulty of measuring this outcome in cases where hospices choose to continue providing services without billing Medicare. Other commenters were concerned about how discharges due to a change in insurance would be perceived, or how the calculation of risk adjustment variables would be handled given the CMS sequential billing requirements.

Response: CMS acknowledges that there are limitations of using claims as a data source for measure development. For example, claims data provide limited data which can be used to capture patient preference. To compensate for some of these limitations, this measure anticipates incorporating factors such as unusually high prior acute care utilization, which may indicate patient or caregiver tendency towards use of hospital or emergency services in a crisis.

Despite some limitations to using claims data, there are several advantages. Claims measures place minimal burden on providers as they do not require additional data collection and data submission. Claims data are available for all hospice providers that submit claims to CMS, unlike data from surveys which are dependent on hospice or patient/caregiver participation as well as the ability of participants to accurately and reliably complete the assessment. Other settings, such as the Inpatient Quality Reporting Program (QRP) and the post-acute care (PAC) QRPs, have adopted claims-based measures, and the NQF has endorsed claims-based measures and believes they can capture quality even when not directly assessing clinical care.

CMS also acknowledges the importance of MA enrollees as a patient population, particularly as the proportion of hospice patients who are enrolled in MA continues to increase, and we acknowledge the concerns that the measure wouldn't reflect the care of patients in MA. While all Medicare-eligible patients enrolled in hospice are enrolled in Medicare FFS for the duration of their hospice stay, the risk adjustment of this measure requires information from claims for 365 days prior to hospice admission and for 7 days following discharge if discharged alive. *Information from MA patients is currently unavailable through traditional claims data.* Both the CAHPS® and HIS measures do not rely on Medicare claims data and are therefore not subject to the same data availability restrictions.

The measure will not capture services provided without billing Medicare as it relies on Medicare claims billing information, but we believe this to be a rare occurrence. Furthermore, patients who are discharged and readmitted due to an insurance change will not be included in the measure, as the measure denominator is limited to patients with continuous Medicare FFS enrollment for the 365 days prior to hospice admission, throughout the entire patient stay, and for at least 7 days following discharge if discharged alive. Only stays that have ended in the measurement period are included in the measure denominator, and each period of measurement will be finalized before risk-adjustment begins on the measure for that period.

4. **Potential Unintended Consequences of the Measure:**

Summary of Comments Received: Commenters were concerned that the measure as currently specified would result in harmful unintended consequences that outweigh the potential benefits of the measure. As a result, they recommended against future implementation of the measure. Specific concerns raised included the fact that the measure assess outcomes that are determined by patient/family choice and are beyond hospices' ability to control. They worried about the measure's potential impact on patient choice and other central tenets of the hospice philosophy of care, and worried that the measure could reduce access to hospice care. Specific unintended consequences mentioned by commenters are discussed in greater detail below.

Avoiding discharge

Commenters raised concerns that the measure may incentivize hospices to pressure patients to remain in hospice to avoid live discharge, including patients with an extended prognosis who may be ineligible for

hospice. One commenter stated that patients should instead be supported in their right to revoke hospice or move out of their hospice's service area. Another commenter noted the fine line between a discharge for non-eligibility and a premature discharge. Balancing these two outcomes could lead providers to avoid discharging patients who are no longer eligible for hospice. The commenter explained the uncertainty often associated with patient decline and prognostication and discussed how the recertification process for determining continued hospice eligibility involves large amounts of clinical judgment that depends on the training and experience of hospice physicians. The commenter urged CMS to provide training and guidance to develop a common understanding of the criteria needed to establish ongoing hospice eligibility.

Selective enrollment or "cherry-picking" of patients

Commenters expressed concern that the measure would lead hospices to selectively enroll patients, either by encouraging or avoiding admission of certain types of patients. One commenter stated hospices would have the incentive to only admit patients who are unlikely to revoke or move out of the hospice service area, and whose conditions are unlikely to stabilize. Another commenter discussed how hospices may choose to delay enrollment of patients who have preferences for "full code", as the patient or their caregiver may be more likely to panic and revoke hospice to seek acute care. The commenter suggested accounting for hospice revocations in the measure calculation to prevent against selective enrollment. Another commenter expressed concern that the measure may lead hospices to delay patient admission to avoid insurance-driven discharges. The commenter explained that their software vendor requires patients to be discharged and readmitted when they have a change in insurance because of benefit period restrictions.

Unintended consequences of public reporting

One commenter expressed concern about potential HIPAA (Health Insurance Portability and Accountability Act of 1996) issues related to public reporting for small hospices. Others were concerned about unintended consequences of the public's potential for misunderstanding the measure. Others were concerned that consumers would find the measure difficult to understand and might interpret low scores as those belonging to hospices that do not respect patient choice.

Response: CMS appreciates commenters' concern over potential unintended consequences of this measure that may lead to hospices selectively enrolling and/or discharging their patients. We acknowledge and recognize the importance of commenters' concerns and intend to conduct ongoing monitoring of the possible unintended consequences related to this measure.

We would like to note that the risk adjustment methodology applied to this measure will help mitigate providers' incentive to selectively enroll patients to improve their measure performance. We have included patient characteristics in the risk adjustment model that have demonstrated in our analysis to be associated with higher rates of live discharge. Therefore, providers' performance on this measure will be adjusted for the characteristics of their patient population and "level the playing field" across providers. Additionally, this measure does not assess a "never event" outcome, and providers' performance is evaluated among their peers after adjusting for difference in patient case-mix across hospice providers. Finally, additional measure testing and refinement, including a potential measure dry run will aim to further address the potential unintended consequences of the measure. For more information on measure dry runs, see Section 8.

We understand that there may be greater difficulty in determining eligibility for some patients more than others depending on patient condition. The risk-adjustment model is intended to mitigate risks posed by different patient case-mix. Furthermore, patients who are truly no longer eligible for hospice should present

a lower risk for either of the two measured outcomes, death or acute care utilization. CMS and partnering organizations will continue to provide training to providers which explain CMS policies and quality measures.

Regarding the concern that hospices may delay patient enrollment because of discharges resulting from changes in insurance, this measure is unlikely to impact enrollment practices in the situation described because the measure denominator only includes patients who are continuously enrolled in Medicare FFS in the 12 months before hospice admission and the 7 days after discharge.

Commenters' concerns over unintended consequences related to public reporting are addressed more comprehensively in Section 8, Usability and Use, below.

5. Measure Specifications.

Many commenters provided feedback on the measure specifications, including measure numerator, denominator, and denominator exclusions. CMS will take the commenters' concerns and suggestions into the next steps of the measure developments and refinement and keep examining the technical specifications for this measure.

5.1 Measure numerator and measure denominator: reasons for live discharge

Summary of Comments Received: Many commenters were concerned that this measure would penalize hospices for live discharges and subsequent outcomes that are beyond their control. One commenter expressed agreement with the Draft Measure Specifications' statement that live discharges can be influenced by a range of factors, including patient and family preferences. However, this commenter suggested that because "confounding factors" can impact discharges from hospice, the measure outcome should be refined to only include discharges that are within hospices' control. Another commenter wondered whether there would be two separate measures, one related to patient/family-initiated revocation and a second related to discharges initiated by the hospice. The commenter stated that patient/family preferences to leave hospice do not always correspond to poor hospice quality of care. Many commenters suggested that live discharges for the following three reasons be removed from the measure numerator or be excluded from the measure denominator: 1) patient and family-initiated revocations, 2) patient moving out of the service area, and 3) discharge for cause. In line with this set of comments, some commenters suggested that this measure focus on live discharges for cases when patients are no longer terminally ill. In contrast to these suggestions, a commenter recommended focusing this measure only on revocations, and another commenter suggested excluding live discharges from the measure when patients are no longer terminally ill. Another commenter suggested applying statistical weights to account for patients who were discharged for revocation as an alternative to excluding these discharges from the measure outcome. Contrastingly, one commenter stressed the importance of preventing provider-initiated hospice revocations and re-enrollments. One commenter suggested excluding or creating a separate measure for patients that are discharged within a week of hospice admission. The commenter expressed concern that patients with short lengths of stay and late hospice enrollment are more likely to revoke hospice and seek acute care, as these situations are often beyond hospices' control and result from systems-level issues that lead to late hospice enrollment.

Response: CMS appreciates the comments regarding how reasons for live discharges should be used in the measure specifications. Reason for live discharge was one of the major parameters that CMS considered to use for defining the measure outcome, i.e. the measure numerator.

In general, there are some concerns about the provider-reported reasons for live discharges. The 2018 MedPAC report pointed out that some reported patient-initiated live discharges may be related to the

hospice provider's business practices or quality of care.[17] Anecdotal evidence from commenters supports this as well. One commenter stated that "hospices urge, pressure and persuade patients to revoke their hospice certification prior to a hospitalization, and re-enroll them after discharge, for financial reasons". Other commenters suggested that some patients are unaware of their right to choose whether or not to revoke hospice, particularly when hospices initiate the revocation or attempt to discharge patients just before or as they are entering acute care. Empirical analyses of hospice discharge patterns support the anecdotal evidence. For example, empirical evidence showed that rates of live discharges, both beneficiary revocations and discharges because beneficiaries are no longer terminally ill, increase as hospice providers approach or surpass the aggregate cap.[18] Also, the rate of live discharge associated with the beneficiary moving out of the service area and the beneficiary revoking hospice increased slightly between 2015 and 2016.[19]

In the development of the measure specifications, CMS and their contractor convened a national TEP to discuss how the measure outcome should be specified. The TEP Summary Report is available here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.html. One of the questions the TEP discussed was whether there should be exclusions from the measure based on the reported reasons for live discharges. Specifically, the TEP discussed two types of patient- and family-initiated hospice discharges: revocation and patient moving out of service area. The TEP suggested that patient revocation may reflect patient or caregiver dissatisfaction with the quality of care. There is also general concern that hospice revocations may not always be truly patient-initiated. The TEP also discussed whether live discharges due to patient moving out of the service area should be excluded from the measure numerator because moving out of the hospice service area may be a matter of patient preference. The TEP noted that from a quality perspective, the hospice can act to ensure continuity of care and a safe transition. The TEP recommended excluding only patients who re-enrolled in a hospice within two weeks after discharge. TEP members also suggested that we conduct analysis to validate cases where the reason for discharge is because the patient moved out of the service area, although this cannot be done for all cases because of data limitations. CMS and their contractor looked at hospice reenrollment in two weeks and found that only about a third of hospice stays where patients were discharged due to moving out of service area ever received hospice care in a separate geographic area, which raises concern about data validity. Additionally, less than 1% of all stays ended with "moving out of service area" as the reason for discharge, thus excluding these stays is expected to have minimal impact on measure outcomes.

CMS recognizes that there are hospices whose practice is aligned with the hospice discharge guidelines. At the same time, there is concern that higher rates of live discharges followed by death or burdensome transitions may signal quality of care concerns. Live discharges followed by these outcomes have potential adverse impact on patients and families and lead to unnecessary burden at the end of life. Thus, CMS decided to not exclude the patient-initiated discharges from the measure. This will also safeguard hospices who are acting appropriately in their handling of true patient-initiated discharges, e.g. revocations, as well

[17] MedPAC (March 2018). "Report to the Congress: Medicare Payment Policy." (Chapter 12: Hospice Services): 323-352.
[18] Plotzke, Michael, et al. (2015) "Medicare Hospice Payment Reform: Analysis of How the Medicare Hospice Benefit is Used." *Centers for Medicare & Medicaid Services* 1-102.
[19] MedPAC (March 2018). "Report to the Congress: Medicare Payment Policy." (Chapter 12: Hospice Services): 323-352.

as protect consumers from the burden associated with transitions resulting from a hospice-encouraged revocation.

Regarding the suggestion to exclude patients with short lengths of stay, we would like to clarify that patients who die shortly after hospice admission are not included in the unadjusted measure numerator (unless they are discharged alive first). CMS recognizes that many patients are referred to hospice or elect hospice later in their disease trajectory than would be preferred. Therefore, many patients start hospice at a time when effective communication and care coordination are most crucial to ensure positive patient and family experience of hospice care.

5.2 Measure numerator and measure denominator: excluding patients that are transferred to another hospice

Summary of Comments Received: A few commenters suggested excluding stays that involve transfers between hospices. The commenters described two scenarios to support this recommendation, one in which a patient decides to change hospices and the other in which a patient is transferred to a contracting hospice to receive general inpatient care (GIP) or Continuous Home Care (CHC). The commenter explained that hospices can either decide to initiate a transfer or a live discharge in these situations. Another commenter requested further information about how hospice transfers are classified in the measure, noting that transfers are not discussed as a form of live discharge in the measure specifications. The commenter pointed out that it is not uncommon for hospices to document a transfer as a live discharge because of confusion about when it is appropriate for hospices to initiate a transfer rather than discharge the patient. Another commenter also suggested excluding discharges to VA and psychiatric hospitals, as some hospice patients plan to be transferred to these settings to receive care if they can no longer be cared for with hospice at home.

Response: CMS appreciates the feedback and comments on some types of hospice transfers that may happen under different circumstances. In general, this measure does not distinguish hospice transfers from other types of live discharges, as transfer is one of the reasons for hospice live discharges. Reason for live discharge is not used as a parameter to determine if a hospice live discharge should be included in the measure numerator.

When a patient is transferred to a hospice for GIP level of care, as some commenters suggested, it may indicate that the patient is receiving the level of care that they need. CMS discussed with the TEP about excluding the transfers for GIP level of care from the measure numerator. The TEP opposed excluding patients transferred for GIP level of care from the measure, because hospices are required to provide access to GIP services, and failing to do so would violate the Conditions of Participation, which reflects the minimum quality standard. In addition, we note that such transfers to a hospice for GIP level of care is rare, occurring in less than 0.25% of hospice stays. [20]

5.3 Measure numerator: time window between hospice discharge and acute care admission or death

Summary of Comments Received: Several commenters requested further rationale for or suggested changes to the post-discharge time window in which measure outcomes are captured. A commenter suggested that the 30-day time frame for death following live discharge seemed lengthy given that many hospice patients

[20] RTI analysis of 2013-2014 Medicare claims data.

survive for only a short time after hospice admission. Another commenter suggested reducing the time frame for measuring acute care outcomes from 7 days to 1 day, as providers have more control of the time directly following discharge. The commenter also suggested reducing the time frame for measuring death from 30 days to 7 or 14 days, as patients who appear stable may enter a sudden decline within weeks of being discharged for no longer eligible for the hospice benefit.

Response: CMS appreciates the commenters' suggestions regarding the time window between hospice discharge and two measured outcomes: acute care admission and death.

The time windows, as currently specified, between discharge and acute care or death were discussed at the TEP, and the current specifications were adopted at the TEP's suggestion, after their review of available data and discussion of clinical rationale. The TEP acknowledged the difficulty of prognostication for patients near the end of the life and recommended a 30-day window over a longer window for capturing death following live discharge. The TEP also recommended a 7-day window for capturing acute care utilization rather than a longer time window, due to consideration of attributing post-discharge outcomes to the discharging hospices.

CMS also acknowledges the difficulty of prognostication for patients near the end of life; however, despite the difficulty, 30 days was considered a fair time window for prediction. Even patients who appear to have stabilized to the point of being no longer eligible for hospice can benefit from effective care coordination during discharge to ensure that they continue to receive appropriate care following discharge to maintain their stability. CMS also appreciates the suggestions for time windows for acute care following discharge. Our analysis showed that most acute care utilization occurs shortly after discharge; more than 75% of hospitalizations and more than 40% of ER visits occur on the day of hospice discharge or on the day after discharge.[20]

CMS and its measure developer will continue conducting data analysis to identify other time windows that are potentially more clinically appropriate.

6. Risk Adjustment

Summary of Comments Received: Several commenters expressed support for using risk adjustment in this measure. One commenter appreciated CMS' inclusion of risk adjustment variables that were recommended through past rulemaking activities. The commenters believed the risk adjustment would "level the playing field" for hospice providers and encouraged CMS to monitor and refine the variables on an ongoing basis. Several commenters raised concerns over the risk adjustment approach for this measure. Specifically, commenters were concerned that the approach does not adequately take into account the differences in patients, particularly in regard to patient preferences and choices. One commenter questioned whether prior care utilization adequately predicts patient preferences and decision-making at EOL.

Commenters also recommended additional patient-level risk adjustment variables be added to the model, including socioeconomic status, language spoken at home, level of hospice care at discharge, hospice rurality, cognition, functional status, and presence of a "do not resuscitate" code. Commenters also suggested controlling for hospice size and presence of state certificate of need laws. A commenter suggested that social risk factors be included in the risk adjustment model because social risk factors may also contribute to differential outcomes among hospices, leading to poorer performance for hospices that disproportionately serve low-income beneficiaries.

One commenter was concerned that geographic and demographic variation would create "lopsided" and "skewed" findings, although the commenter noted this could potentially be modified through provider education. Commenters raised concern over variation in state-level regulations that could lead certain states to have relatively higher rates of hospice live discharge. They wondered how the risk adjustment method would account for the potential impact of these differences in state policy.

Response: CMS appreciates commenters' support of risk adjustment for this measure and suggestions for additional variables to include in the risk adjustment model. We recognize that FFS claims data are limited in capturing patient preferences, and do not reflect care received by all people receiving hospice care (e.g. those in MA plans, or otherwise insured).

The risk adjustment model was developed based on the existing literature and methodology, to align with the approaches developed and applied to other NQF-endorsed claims-based hospital readmission measures used in the inpatient and PAC QRPs. The risk adjustment approaches being developed and tested for this measure are comprehensive and capture a wide range of hospice patient case-mix characteristics, including patient demographic characteristics, social risk factors, terminal diagnosis, length of hospice stay, setting of care while receiving hospice care, and prior health care utilization (acute care and hospice care).

Regarding concerns over the ability of prior utilization to predict decisions at EOL, existing evidence suggests that care patterns prior to hospice use are associated with hospice outcomes, and some care patterns are risk factors for live discharges.[21, 22] For example, hospice patients who had fewer hospitalizations prior to hospice enrollment were more likely to have live discharge from hospice, regardless of his/her terminal diagnosis. Care patterns prior to hospice can be identified through claims data in a reliable manner.

Regarding social risk factors in risk adjustment, CMS understands the important role that the social risk factors play in the care provided to patients. A few quality measures that were developed by CMS and its measure developers were included in NQF's two-year trial period in which the measures under NQF endorsement review were assessed to determine if risk adjusting for social risk factors was appropriate. CMS will continue to follow the NQF recommendations on inclusion of social risk factors in the risk adjustment model for this measure.[23] CMS will also routinely monitor the impact of social risk factors on providers' performance on this measure.

We agree with comments to consider risk adjustment for functional status, cognitive status, and care preferences. Currently, no patient-level data is available that could be used for developing and testing risk

[21] Kaufman, B. G., Sueta, C. A., Chen, C., Windham, B. G., & Stearns, S. C. (2017). Are Trends in Hospitalization Prior to Hospice Use Associated With Hospice Episode Characteristics?. *American Journal of Hospice and Palliative Medicine®*, *34*(9), 860-868.

[22] Teno JM, Gozalo PL, Bynum JPW, et al. Change in End-of-Life Care for Medicare Beneficiaries: Site of Death, Place of Care, and Health Care Transitions in 2000, 2005, and 2009. *JAMA.* 2013;309(5):470–477. doi:10.1001/jama.2012.207624

[23] National Quality Forum (July 2017). Social Risk Trial Final Report. Available from: https://www.qualityforum.org/Publications/2017/07/Social_Risk_Trial_Final_Report.aspx

adjustment of the measure based on these factors, however, CMS will refine the risk adjustment variables as other types of data sources become available

Regarding the level of care patients received at discharge, we have concerns about the endogeneity issue of including this variable as a risk factor because the level of care received at the end of hospice stay is correlated with burdensome transitions after live discharge. In other words, a potential reason why some patients are discharged alive and admitted to hospital or ER is that the hospice is not providing a higher level of care (e.g. GIP or CHC) that the patient needs. These cases may signal poor quality of care, and the disparity in quality of care between hospices who provide the higher levels of care and those who do not will be less apparent after adjusting for the level of care received at discharge. Adjusting for level of care at discharge would make this measure less likely to detect concerning care practices.

We acknowledge commenters' concern over the potential impact of state-level policies that may affect the measure outcome differently across geographic areas. However, we also have concerns about holding providers to different standards for burdensome transitions based on states or geographic regions. Because practice patterns often cluster within an area yet vary across areas, adjusting for state-level policies could inadvertently mask disparities or minimize incentives to improve the outcomes of patients in some geographic areas. We are conducting ongoing testing of this measure and will closely examine the impact of state variation in the measure outcome.

We would like to reiterate that the goal of this measure is to examine patterns of care related to undesirable outcomes, which might reflect suboptimal quality of care provided by hospices during a patient's stay. The intent of the measure is not to determine whether individual care transitions or live discharges are appropriate. The purpose of this measure is to identify hospices that have notably higher rates of live discharges followed shortly by death or acute care utilization, when compared to the average hospice with the same patient population. Thus, rates of live discharge alone are not what drive hospice-level performance on the measure. Instead, the undesirable outcome that this measure captures is live discharge *followed shortly by patient death or acute care utilization*. This means that a hospice with high rates of live discharge but few "undesirable outcomes" following live discharge could still perform well on the measure. This contrasts with a hospice that may have a smaller number of live discharges at their hospice, but has a higher proportion of those discharges followed by an undesirable outcome; this hospice could perform worse on the measure. The measure is risk-adjusted so that a hospice's patient case mix or certain individual patient preferences are not "counted against" the hospice. For example, if a patient has a pattern of prior care utilization with higher rates of hospital use (which could be an indicator of patient preference for using acute care services), this would be controlled for and would not count against the hospice's score. Other factors that are controlled for in this manner are age, gender, race/ethnicity, original reason for Medicare entitlement, setting of care, length of stay, hospice principal diagnosis, and prior ER visits and hospice admissions within a year of the current hospice stay. Furthermore, for some important information like patient and family preferences, we expect that to be evenly distributed across providers. Since this measure is to identify outlier practices for which the patient and family preferences are not the driving factor, the data availability issue is less of a concern. In addition, patient preference may be related to other patient characteristics that are captured in the current risk adjustment model, e.g. age, gender, race/ethnicity, etc. The risk adjustment model will be able to address the concerns to this extent.

7. Statistical Approach

Summary of Comments Received: Some commenters expressed concern over the complexity of the measure calculation and statistical approach. One commenter stated that the complex method poses challenges to hospices who wish to validate their measure scores by replicating the calculation. Another commenter requested clarification about several parts of the statistical methodology used to calculate the measure. Specifically, the commenter requested more information and clarification regarding how the "hospice effect" is conceptualized and calculated and quantitatively defined and asked the definition of ωj in the mathematical equation. The commenter asked if the "hospice effect" should be conceptualized as random yet in a normal distribution, and questioned if LOS is skewed or it is mostly a Poisson distribution how can it be random and normally distributed? The commenter thought the proposed 'measures' continue to be proxies that are biased as they are rooted in the patient, but are also conceptualized, defined, and explained as a measure of structure. The comment stated that a patient's demographics and diagnoses has nothing to do with the quality of transitions or quality of hospice care, or even the quality of hospice care received while in acute care.

Response: We appreciate the comment. The measure of quality, in this case, transitions after live discharge, is done indirectly. It starts with a model of the outcome for each patient that predicts the probability of a person's transition as a function of many characteristics, demographic, health conditions, prior health care utilization, etc. By itself, this equation would predict the probability of a transition for a hospice patient with those characteristics across all hospices. To allow for the possibility that the practices of a hospice may contribute to the probability of an outcome, and that this "hospice effect" affects all its patients, terms are added to capture this. These are the ω_j terms in the equation. Each ω shifts the probability prediction for all patients treated by that hospice. In the modeling, the patients are considered clustered in a hospice and have some commonality. The values of the hospice effect ω_j could be estimated like the other variables in the equation, but using the hierarchical approach treats the hospice affects differently and allows the effects to be estimated with adjustment for the precision related to the estimate because of sample size. This is the result of treating the hospices as having effect values that are normally distributed around the average. With this bell-shaped curve, extreme values have low probabilities of occurring. It is the hospice effects that are considered normally distributed, not the outcome probabilities. The distribution of LOS is not relevant here either. A hospice which would otherwise be estimated to be contributing strongly positively or negatively to its patients' outcome, but which has an imprecise effect estimate because it has a small number of patients, will have its effect estimate drawn toward the average to reflect the low probability of being truly very different.

The ω_j are not reported directly. The measure uses them in the computation of the numerator of the final measure expressed as a Risk Standardized Rate of Transition.

8. Usability and Use

Summary of Comments Received: Some commenters indicated concern regarding how the measure would be understood by the public if and when its results are made available on Hospice Compare. Commenters noted that the measure is complex and that it might be misunderstood by patients, caregivers, and other stakeholders. Commenters were also concerned about the ability of consumers to make informed choices based on the information provided on Hospice Compare. One commenter stated that the complexity of the

measure calculation would make it difficult for the public to understand, and that the fact that low scores are better would add to confusion, since the other Hospice QMs are set up such that higher scores are better.

Several commenters noted that the measure's complexity would also make it difficult for providers to understand the measure, validate the measure data prior to public reporting, and know how to use the results to improve their performance. One commenter agreed that a high rate of post-hospice death/hospitalization could indicate poor quality but was concerned about users' ability to distinguish quality of care among hospices with low or moderate transitions rates.

Another commenter indicated that further information would be needed regarding an appropriate benchmark, and what level of outlier performance would trigger additional scrutiny. One commenter noted that many factors affect live discharge rate, and that it may be more appropriate to compare hospices to other hospices in the local area, rather than the national rate. This would be important from patient and caregiver perspective, as well as from providers' perspective.

Some commenters suggested that this measure be reported to hospices through PEPPER or another direct-to-hospice report, rather than being publicly reported on Hospice Compare. They stated that reporting through PEPPER would provide an opportunity for the industry to better understand the quality and program integrity concerns associated with the measure, and that initial reporting through PEPPER would afford CMS an opportunity to consider a measure that is more directly linked to quality outcomes. Reporting through PEPPER would also provide hospices information they need to identify and correct potential issues.

Response: We appreciate the commenters' concerns regarding the usability and use of this measure. We agree that it is critical to ensure that quality measures can be understood and used by various stakeholders including patients and caregivers, as well as hospices, especially before any public reporting of a measure begins. As such, all measures developed and implemented in the HQRP undergo rigorous testing to ensure that they are understandable to providers and patients and families.

Usability by Consumers and Other Stakeholders:
We agree that ensuring reported data are understood by the public is critical to ensuring Hospice Compare contains meaningful and actionable information for consumers. Although we agree that the Transitions measure is complex compared to other current HQRP measures, we believe this measure has the potential to provide valuable information to consumers as the burdensome transitions that this measure intends to capture have potential significant negative impacts on patients and families. As with any other HQRP measure, the measure will undergo rigorous analyses to determine whether it is eligible for public reporting. Beyond these analyses that CMS regularly conducts for all HQRP measures, however, we realize special attention may need to be paid to how the data for this measure is presented to ensure it is readily understood by consumers. There are design aspects of existing Compare sites that CMS could adopt for the reporting of this measure to address some of these concerns. For example, we could display along with measure results whether lower or higher scores indicate better performance. Additionally, instead of reporting rates or scores, CMS can display relative data that is more easily interpreted, such as "no different than the national rate", "better than the national rate", or "worse than the national rate". CMS will continue to collaborate with stakeholders and engage in testing to ensure any data reported on Compare is understood by the public.

In response to the concern that comparing hospices of different sizes might result in unbalanced comparison, it is true that some quality measures have shown trends in quality for larger or smaller hospices. However, we believe that this is an important measure of quality for both large and small hospices. For measures publicly reported on Hospice Compare, we plan to use all eligible stays for the measure calculation, but will not publicly display measure results of hospices that do not meet a minimum threshold of hospice stays (e.g. 20 eligible stays during the measurement period for currently implemented HIS-based quality measures). This is because estimates for hospice providers with small numbers of eligible stays are likely to fluctuate due to random variation. CMS has not yet determined a minimum reportable case size for the Transitions measure. Measure scores for hospices with small sample sizes will be excluded from public reporting, thus measure scores from hospices with small sample sizes will not be publicized. In addition, we would like to clarify that patient-level data is not publicly reported for any hospice. This will also help address some commenter's concern regarding HIPPA violation.

Usability by Hospice Providers:
Regarding providers' understanding of the measure, CMS would like to clarify our current approach to measure implementation and rollout for claims-based measures vs assessment-based measures, as the HQRP at present does not contain any claims-based measures.

For claims-based measures, CMS often supplements the approaches used for assessment-based measure implementation because claims-based measures are more complex than assessment-based measures (calculated using complex modeling and have robust risk-adjustment strategies). In addition to training and education, CMS often uses a national dry run prior to the implementation of claims-based measures. Dry runs serve the purpose of minimizing unintended consequences of measures, building provider knowledge of the measure, and identifying any issues prior to full-scale implementation. During a dry run, measure results would be calculated and distributed to providers via a separate CASPER Report. CMS would provide educational opportunities to address the knowledge gaps mentioned by commenters. Finally, CMS would offer structured opportunities for providers to share input on the measure calculation, specifications, and reporting – before they are finalized for full-scale implementation.

CMS believes that – in addition to our usual processes for determining a measure's readiness for public reporting (see FY 2017 Hospice final rule (81 FR 52183 through 52184) for more information) - a robust dry run approach could help determine whether the measure is appropriate for public reporting. As mentioned in Section 2, we believe this Transitions measure provides different information than similar measures in the PEPPER reports and thus would provide value to providers – and potentially patients and their families – but a robust dry run would help inform this assumption.

We anticipate that for public reporting, a hospice's performance would be compared to the national average, rather than to a pre-determined benchmark. The scores would be accompanied by information about whether the hospice's score is better than the national rate, no different from the national rate, or worse than the national rate.

9. <u>Medicare hospice benefit policy and regulatory context</u>

<u>Summary of Comments Received:</u> Several commenters expressed frustration and a desire for policy changes to the Medicare hospice benefit Commenters expressed concern that the benefit's design prevents those who do not have a clear six-month prognosis but could benefit from hospice care, from accessing hospice services. Commenters expressed that hospice eligibility rules and the aggregate payment cap have

contributed to an increase in live discharges, particularly for patients with uncertain prognoses or terminal diseases with a longer course of illness. Several commenters described how the hospice benefit rules makes it difficult to care for EOL patients and their families with "slow declines", such as patients with Alzheimer's, who may fail to meet the benefit's eligibility criteria upon recertification. These patients who are discharged alive in accordance with Medicare rules may then experience subsequent unnecessary care transitions and possibly death, precipitated by the adjustments involved with transitioning.

One commenter thought the measure could provide useful information on premature hospice discharges and acute care use following discharge and stated that the measure should be used to inform policy change rather than to penalize providers. Another commenter characterized the system as having "dysfunctional elements" that are "baked in" to the way hospice care is paid for and providers choose to care for patients with uncertain trajectories, concluding that this measure does not help the situation. One former hospice clinician expressed frustration over Medicare's requirement that patients' hospice eligibility be renewed with a face-to-face visit. The commenter stated this requirement created an unwanted change in her role as a hospice physician and placed a significant strain on her clinical practice and leadership.

A commenter requested clarification on how the measure would approach patients with uncertain prognosis who must be discharged when they fail to meet recertification requirements but may experience sudden decline after live discharge.

Response: We appreciate comments received regarding concerns over the Hospice benefit design and policy. The focus of this public comment period is to address comments related to the specifications of this measure under development. Therefore, comments related to Medicare policy design are outside of the scope of this current project, which is operating under the current rules for the Medicare hospice benefit and the statutory requirements surrounding the benefit.

Regarding the comments about our approaches to handling patients with uncertain prognoses, CMS appreciates and shares the same understanding of the potential impact of uncertain prognoses on the hospice discharge outcome. Due to the variation in level of difficulties of precise and accurate prognostication and disease trajectories, patients with different terminal diagnosis have different likelihood of being discharged alive from hospice care. CMS and measure developer take this into consideration in specifying the measure by including terminal diagnosis as a risk factor in the risk adjustment model. For more information about risk adjustment, please refer to section 6.

10. Future Measure Development

Summary of Comments Received: Some commenters suggested CMS develop other quality measures. These included recommendations to focus on developing ways to include patients' and families' spiritual needs and preferences in the measure, and to focus on highly-specific cultural and spiritual care. Others suggested measuring patients' and Medicare spending per beneficiary in the 30 days after live discharge from hospice. One commenter suggested CMS develop a suite of care coordination measures that address the role of each provider involved in a patient's care.

Response: We thank the commenters for their suggestions regarding potential future quality measures. We agree that these are important areas of hospice and will consider these suggestions in future HQRP measure development efforts.

Preliminary Recommendations:

CMS and the measure developer contractor appreciate the comments received for the *Transitions from Hospice Care, Followed by Death or Acute Care* measure. The comments about the intent of the measure, the eventual implementation of the measure, and the measure specification elements such as the outcome definition, risk adjustment and exclusions were informative and will continue to be considered in the measure development process.

Updates to the measure specifications

CMS and the measure developer contractor will take the suggested modifications in to consideration, continue to conduct data analysis, and discuss with national experts and stakeholders to determine potential measure modifications.

List potential changes to the measure specs based on public comment feedback

CMS and the measure developer contractor will perform further analysis to test the effects of several recommendations, such as excluding hospice patients who were discharged for reasons other than being no longer terminally ill and exploring potential methods for including Medicare Advantage patients. CMS and the measure developer will also consider feedback requesting further training and explanation about how the measure will eventually be implemented.

Public Comment Verbatim Report:

The following table details the verbatim comments received. We did not make any changes or edits to the content.

ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	Email Address
1	3/27/2018	Good morning. I'm excited to see what the measure will end up encompassing. Since HQRP is used in providing quality data to consumers, I would love to see the following information considered: 1) Did the hospice continue to provide services not billed? Rationale: As a hospice, we may elect to provide services to patients and not bill Medicare. Given the fact that this measure will come from billing information, it would not be clear when a patient has an event such as death, that the hospice was still providing services. 2) For what reason did the patient discharge from hospice? Rationale: As a consumer, it would paint a different picture if the patient revoked to have aggressive treatment vs. being discharged for extended prognosis. Also, for both hospices and consumers, there may be value in knowing that the patient transferred to another hospice or moved out of the service area. Perhaps there are gaps that would be identified in the transition of these patients. 3) What was the patient's diagnosis? Rationale: From a consumer standpoint, if I was being admitted with a particular diagnosis, I would be interested in having information related to how the hospice managed that diagnosis. From a hospice standpoint, I would want to see if there are trends related to certain diagnoses. Do we, as a hospice community, need to provide additional teaching or support to certain diagnoses? 4) How long was the patient on hospice services prior to the discharge? Rationale: As a hospice, I would like to see comparative data related to a combination of how long the patient is on service and events after discharge. Is the issue more prevalent for long stay patients or early discharges? This information could also be correlated with the CAHPS	Rachelle E. Mallory, RN MSN CHPCA Quality and Compliance Team Leader Hospice of the Valley	remallory@hov.org

ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	Email Address
		data to see if there was a specific area that the hospice fell short on that led to an acute care stay.		
2	3/27/2018	I am excited to see that this problem is being tackled. If we can decrease healthcare costs and ***in so doing*** greatly improve care to patients, what could be better? I am a nurse practitioner and am currently completing my doctoral studies. My capstone project focuses on decreasing live discharges from hospice in the Orthodox Jewish community by addressing cultural barriers. I was able to show that by mitigating cultural challenges, patients were more likely to remain on hospice, rather than calling an ambulance and getting admitted to the hospital. Staff were also positively impacted (and this is where my project focused) as they were able to deliver care with far greater ease once the cultural challenges were addressed. I would urge you to include strong consideration of measures that will focus and improve cultural and spiritual care that is highly specific. Although all hospice patients will be offered some general spiritual support, this is very different from being given specific attention informed by knowledge of potential challenges. An Orthodox Jew may have different religious needs (and related worries) from a less religious Jewish person. A devout Catholic from Ireland may have different religious needs than a devout Catholic from Haiti. Addressing and acknowledging these in practical and ***specific*** ways can make all the difference. This is where my research interest is focused. If I can be of any assistance I would be honored to participate!	Ian Sherman, RN AGPCNP-BC DNP-Candidate	ephraimeliyahu@gmail.com
3	3/27/2018	I believe that this proposed measure is a solid one; however, I am concerned that the number of acute care measure transitions would create HIPAA issues with smaller hospices. I suggest that this be changed to average Medicare (on-indexed) spending post 30 days per live discharge.	Richard Chesney Healthcare Market Resources, Inc.	rchesney@healthmr.com
4	3/27/2018	I want the committee to know that in my years as a Health Facilities Evaluator Nurse and Manager, I have become aware that hospices urge, pressure and persuade patients to revoke their hospice	Kathryn Saunders-Wood, RN BSN MPA, District Office	Kathryn.saunders-wood@cdph.ca.gov

ID	Date Posted	Text of Comments	Name, Credentials, and Organization of Commenter	Email Address
		certification prior to a hospitalization, and re-enroll them after discharge, for financial reasons. Safeguards need to be put in place to prevent this practice.	Manager California Department of Public Health	
5	3/30/2018	I understand the interest in developing this measure but I hope that there are considerations given to the following. Revocations: Patients have the right to revoke their benefit at any time and the hospice must observe this right. I feel revocations should be excluded from the sample. This may occur because a family member not originally involved in the decision is now involved and influences the patient to revoke the benefit to seek additional/aggressive treatment. It may also occur during a crisis situation in which the family/patient panics regardless of the hospice's efforts. These measures are well intended but these decisions are often made during very emotional times and usually in the evening or weekend hours.	Jim Petrus, Chief Executive Officer Peachtree Hospice	jpetrus@pthfs.com
6	4/3/2018	In re Draft Measure Specifications for Transitions from Hospice Care, Followed by Death or Acute Care: I am very encouraged to see this effort. I would not have retired from hospice care when I did, were it not for the grave job dissatisfaction that occurred with the Medicare requirement that recertification for hospice care required a face to face MD or NP visit to document continued eligibility for the hospice benefit. With this requirement, my job, clinically, changed from useful and pertinent patient visits to largely unnecessary visits, dictated by the calendar, not the patient's condition. I had been seeing all newly admitted hospice patients who did not have their own PCP in their homes within a few days of their admission. This visit was all important to a thorough medical assessment of the problems and the treatment plan, and a familiarity with the patient and his/her circumstances that informed decision making with day to day nursing care and IDT assessments. I would then revisit patients as new problems arose, or interventions ceased being useful. I personally knew most of the patients, under the "pre face to face" days, especially the sickest and most clinically	Elin S. Kropp, MD	elinkropp@hotmail.com

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		challenging. In the "post face to face" era, there were not enough physician hours to do more than rare really needed visits, I no longer personally knew many of the patients who came on program and died within 6 months (i.e., the sickest patients). My feeling that my skills were optimally used, and that my patients benefited fully from my medical leadership of the team deteriorated. At the same time, I and my team agonized over those patients who were chronically ill, on slow declines, with no hope for recovery, for example, the very well cared for end stage Alzheimer's patient. Very often the strict criteria for hospice benefit recertification could not be met to continue providing home hospice care for such patients. Patients were necessarily discharged, leaving distraught families with no recourse other than a 911 call in the event of a serious change in the patient's condition. These patients were sometimes referred back to us months later, with hours left to live and no time to do a good job providing real comfort in those last hours. I feel strongly that recognition that home hospice care, properly done, remains by far the treatment of choice for many patients who will never improve, but may take a long time time to die. For patients and families who do not wish aggressive care, or further hospitalization or medical interventions, home hospice care is often the only solution that stands between these patients and such unwanted care. I believe that the end points of death in 30 days or acute care in 7 days will fail to capture a lot of these sad stories, but I feel that beginning to look more carefully at who suffers when the hospice benefit is withdrawn is very important to Medicare's objective to provide the best care for America's people as they near the ends of their lives, and when conventional medicine no longer is in their best interest.		
7	4/6/2018	• The numerator should *not* include patients who revoked the Election of the Medicare Hospice Benefit, because it is their right to do so at any time.	Chris Lasley, Hospice Quality Specialist	lasley.c@ghc.org

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		o This includes patients who decide to "revoke" their MHB because they want to go get a 2nd opinion or go have a test (e.g. MRI or CT scan) and the Hospice does not feel it is clinically indicated in order to treat the patient's symptoms (i.e. the patient and family "just want to know what the tumor is doing" but this result will not change any symptom management plans.) Patients have the right to go seem more aggressive treatment. They then have the right to sign back onto hospice, if that is their choice. • The numerator should *not* include patients who were discharged for moving out of a hospice's service area. Patients do occasionally move—this is their right—and if they decide to go to an emergency room or are hospitalized while they are in the process of re-locating to a new area, this should not be "held against" the hospice program which had been serving the patient. • The numerator should *not* include patients who are discharged for cause. A hospice may discharge a patient because the home is unsafe for hospice staff to visit or because the patient and family refuse to participate in the agreed-upon plan of care. (E.g. they call 911 frequently or go see specialists without discussing this with the hospice team, etc. and they refuse to "revoke" their Medicare Hospice Benefit. (From Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance, page 12: When a hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired, the hospice can consider discharge for cause. • Therefore, the ONLY category of "discharged" patients which should be included in the numerator is patients who are	Kaiser Permanente Washington	

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		discharged because they are no longer terminally ill. (The NGS instructions regarding which code to use for this situation state: Beneficiary is no Longer Terminally Ill: In the case of a discharge when the hospice determines the beneficiary is no longer terminally ill, *report the NUBC approved discharge status code that best describes the beneficiary's situation*. Do not report OC 42. • In general, we do not like this measure, as it is at odds with the Live Discharge red flags on the Hospice Pepper Report. What we mean is that if your live discharge rate is high, CMS considers this a red flag, yet if you discharge patients in a timely manner when they no longer meet eligibility criteria and they die within 30 days or seek acute care within 7 days, then it appears as a blemish as well. It really puts Hospice agencies in the category of "you are damned if you do and you are damned if you don't."		
8	4/10/2018	As we are reviewing the measure, a few questions arose and we are wondering if additional information about the measure's development may be available, including: 1. The report from the TEP on this measure 2. Data from the measure analysis for – a. Patients discharged live from hospice who died within 30 days: Data related to length of stay on hospice prior to live discharge and location of care (residence, nursing home, assisted living) b. Patients discharged from hospice who were admitted for acute hospital treatment (ED/inpatient/observation) within 7 days: location of hospice care (residence, nursing home, assisted living)	Theresa M. Forster, VP of Hospice Policy and Programs National Association for Home Care and Hospice	tmf@nahc.org
9	4/10/2018	I have some concerns regarding this proposed measure, and wondering if patients would be excluded if: 1. The patient elects to revoke (which hospice has no control over), to get a 2nd opinion or to have a "test" that is determined by the hospice to be not clinically necessary, etc.	Janice Fortier	JaniceF@samhealth.org

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		2. The patient is discharged due to moving out of the hospice's service area; the patient decides to go to the ER or are hospitalized while they are in the process of re-locating to a new area. 3. The patient is discharged "for cause" (disruptive behavior, abusive, uncooperative, etc.) These patients may very well end up in the ER or hospital within 7 days of discharge It seems reasonable the numerator should only include those patients who are discharged "due to being no longer terminally ill". Would the other categories listed above be filtered out as non-qualifying?		
10		After doing some research on the development of the Draft Transitions from Hospice Care, Followed by Death or Acute Care Measure for the Hospice Quality Reporting Program I wanted to take a moment to comment on the proposed measurements, specifically what has been include in the is draft for the numerator section. The numerator should not include patients who revoked the election of the Medicare Hospice Benefit, because it is their right to do so at any time. CMS should properly differentiate between revocations and other types of hospice discharges. This includes patients who decide to revoke their hospice benefit because they would like to have a test of seek the advice of a different provider. Patients have the right to go seek more aggressive treatment. They also have the right to sign back onto hospice, if that is their choice. The numerator should not include patients who were discharged for moving out of a hospice's service area. Patients do occasionally move and this information should not be used against the hospice program which has been serving the patient. Finally, the numerator should not include patients who are discharged for cause. Patients who are discharged for cause might very well end	Topher McClellan, Executive Director Walla Walla Community Hospice	cmcclellan@wwhospice.org

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		up in a hospital within 7 days of the discharge. This should not be held against the hospice which has been serving the patient. Discharged patients that should be included in the numerator are patients who are discharged because they are no longer terminally ill.		
11	4/11/2018	I am a neurologist providing palliative care in Canada. The measure you propose may be helpful to inform the system regarding premature discharge from hospice. It may also inform the system regarding acute care utilization by former hospice enrollees. This may be helpful if the information is used to change policy rather than as a punitive measure. Given the hospice enrollment requires that patients have a life expectancy of 6 months, many patients who would potentially benefit from hospice (and thereby avoid acute care hospitalizations and ICU utilization) are not able to access these services. As those with clear life expectancies (cancer patients) are the minority of all-cause mortality in the US, making criteria that addresses those with chronic conditions that may not have a clear cut 6-month life expectancy would result in overall system savings.	Janis Miyasaki, MD, MEd, FRCPC, FAAN Director, Parkinson and Movement Disorders Program and Co-Director, the Complex Neurologic Symptoms Clinic (Neuropalliative Care) Professor, University of Alberta	miyasaki@ualberta.ca
12	4/11/2018	My understanding of the primary goal of the proposed quality measure is to assess patterns of inappropriate hospice discharge. I support this goal. However, I do not believe that the benefits of this proposed quality measure outweigh the harms, so do not support this quality measure because of the risk of unintended consequences. Excelling at a quality measure should indicate excellent care. Although a very high rate of post-hospice death/hospitalization could indicate poor quality care, good quality care may result in low or moderate rates without any useful distinction between hospices at all. Hospices are incentivized to excel at quality measures. The primary incentive of this quality measure is to keep patients on hospice service once admitted. Terminally ill patients who leave hospice care for any reason are likely to die or receive acute care. The proposed measure incentivizes negative behaviors aimed to keep patients on service.	Rochelle Webster, FNP ACHPN CPHQ, Quality Control Coordinator Asante	Rochelle.webster@asante.org

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		Instead, patients should be supported in their right to revoke hospice or move out of the service area. Hospices should be careful to avoid wasteful spending by discharging patients with extended prognosis, but this measure incentivizes the opposite. If the goal is to reduce the total number of hospice admissions then this measure may be effective. Hospices seeking excellent scores may try to admit only patients who are certain they will not change their mind (or move away) and are unlikely to stabilize. Better sources of information to assess hospices for patterns of inappropriate discharge would be the PEPPER report or chart reviews.		
13	4/12/2018	Appreciate your taking comments on this planned new publicly distributed measure. I am concerned that we are counting insurance change driven discharges in this measure. If we are judged on this rate when we have no control over patient's decision to change insurances, it will not be a reasonable measure. We do not want to delay admission to hospice just because a patient might change insurances. Our software vendor is not able to allow leaving the patient on service due to benefit period restrictions. So we have to discharge and readmit. This is a major imposition to the hospice and the patients/caregivers, requiring resigning paperwork. But there is no alternative at this time. We have spoken to our software vendor with no solution. We need a way to ensure these patients are not counted in the discharge measures.	Pam Walden, RN Hospice Clinical Auditor and Educator Adoration Hospice	pwalden@adorationhealth.com
14	4/12/2018	Proposed Measure – Rate of live discharges from hospice that are followed by death within 30 days or a hospitalization/ER visit/observation stay within 7 days of hospice discharge The Draft Measure Specifications paper acknowledges the potential unintended consequences of the measure including avoiding discharge of patients who are no longer eligible, and reducing the willingness to	Christine Nidd, MSW PMP CPHQ Manager of Quality and Compliance Hospice of the Northwest	CNidd@hospicenw.org

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		enroll patients with certain attributes. I would like to expand upon each of these in turn. Avoiding discharge of patients who are no longer eligible It is a fine line between non-eligibility and premature discharge. I whole-heartedly agree with the assertion that care transitions are burdensome to healthcare providers and especially to our patients and caregivers. We are very careful to document decline in a patient, and if no decline is noted in any certification period, we discharge. If a patient has a fall or other event post-discharge, we encourage families to inform us so we may re-admit if indicated, regardless of time elapsed from the discharge. However, as noted in the Draft Measure paper, families are often upset by a discharge and can be reluctant to come back on service. Prior to the implementation of this measure, further guidance should be given to frame the amount of decline necessary for establishment of ongoing eligibility. For example, a patient with a primary diagnosis of Alzheimer's Disease, dependent in all ADLs, a BMI of 15.1, and a PPS of 30%, could live for a couple years or more, or they could die within 2 months. If they go 60 days in their third or later certification period without losing weight and there are no medication changes or falls, should they be discharged? This is a very gray area and relies extensively on the experience and training of the hospice physicians. What kind of support will be offered to provide consistent training to hospice physicians across the country in order to ensure we are working from the same set of guidelines? The LCDs provide some general guidelines, but by themselves are open to wide interpretation. Recommendation: Both live and web-based training should be widely offered by each Medicare Contractor to explore ongoing eligibility criteria and ensure a common understanding.		

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		Reducing the willingness of hospices to enroll patients with certain attributes The paper acknowledges diagnoses and care settings as factors that may increase likelihood of the measured outcome. I suggest that the problem is far broader than this. For example, what about patients who are full code? I believe it would cause hospices to hesitate taking people onto service who have not yet fully embraced the hospice philosophy, thereby restricting access to this valuable service. Often people come onto service as full code, and as they gain trust with the hospice team, transition to a more comfort-focused goal of care. However, there are those who panic and revoke in order to go to the hospital for emergency treatment. If the patient wants no further hospitalization, but the caregiver indicates an unwillingness to forego CPR, the hospice may choose to delay admission until the likelihood decreases of the caregiver revoking and calling 911. Recommendation: Exclude revocations from the formula, or at least include a statistical weighting that reduces the impact of all revocations on the measure outcome. We do not have our own inpatient program, but work with a Hospice House in the area. While we have GIP contracts for short stays to stabilize out of control symptoms, these symptoms often come at end of life (e.g. terminal agitation and aggression, intractable nausea and vomiting, uncontrolled pain). When we believe that these symptoms are preceding an imminent death, we may choose to move that patient to a Hospice House where they will not require any additional moves in lieu of a hospital stay under GIP. A hospital admission may result in another move as soon as the symptoms are stabilized, even though death is imminent. While this seems like the right thing to do for our patient, it could predictably result in a transition (transfer) followed by death within 30 days.		

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		Recommendation: Exclude transfers to another hospice where that hospice is initially providing inpatient GIP.		
15	4/13/2018	As an existing patient and potential patient for various medical procedures i want my information to be transferred between medical entities as easily as possible. I am not a terminally ill patient at this time but even so it is virtually impossible to get my medical information shared as necessary. This is stupid ! Even if i am conscious and making a request with proper identification or one of my doctors is requesting it legitimately this had not been done. What kind of care is that ?! This whole situation i've mentioned is absurd and needs to be changed!	Terry Fisher	neckist2@aol.com
16	4/20/2018	Please see below my comments in regards to the above cited request. I am responding to this request for public comments as a citizen who recently lost family who elected Medicare Hospice Care. I am also responding as an experienced professional and health care administrator, and finally as a one that does research on the topic at hand. I hope that my insights and questions are helpful in providing better care for our citizens, patients, and ultimate families. Please find below my comments and related text. "…and the degree to which each hospice has an effect on the outcome that differs from that of the average hospice. The hospice effect can be assumed to be randomly distributed around the average (according to a normal distribution). When computing the hospice effect, hierarchical modeling accounts for the known predictors of the outcome, on average, such as patient characteristics, the observed hospice rate for this outcome, and the number of hospice stays eligible for the measure. The estimated hospice effect will primarily be	Maximiliano Mendieta, Ph.D.	maxmend@umflint.edu

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		determined by the hospice's own data if the number of stays is relatively large, as the estimate would be relatively precise." (Page 7/11 of the PDF) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Development-of-Draft-HQRP-Transitions-Measure-Specifications.pdf Comment: The cited text above is not clear. Not sure that the "hospice effect" should be conceptualized as random yet in a normal distribution. This is too much of a proxy or axiomatic. If LOS is skewed or it is mostly a Poisson Distribution how can this be? We can correct the distribution or normalize it, but the bias or noise this introduces takes away from what we are asked to do here. Measure quality. Comment: The equation cited in page 7/11 (PDF cited above) does not specify ωj; ωj which is important in a public comment request as well as scientifically. Please discuss it and define it. "The sum of the probabilities of transitions from hospice care, followed by death or acute care of all patients in the measure, including both the effects of patient characteristics and the hospice, will be the "predicted number" of transitions from hospice care, followed by death or acute care after adjusting for case mix." (Page 7/11 of the PDF) Comment: What is the 'hospice effect'? It needs to be quantitatively defined so we can measure it. It seems that the proposed 'measures' continue to be proxies that are biased as they are rooted in the patient, but are also conceptualized, defined, and explained as a measure of structure. A patient's demographics and diagnoses has nothing to do with the quality of transitions or quality of hospice care, or even the quality of hospice care received while in acute care. The way this idea reads, it implies or states that the dying patient is ultimately responsible for the quality of care they receive rather than the provider of care being responsible.		

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		I look forward to see these comments addressed and resolved as per the APA.		
17	4/20/2018	Brief Measure Description Transitions from Hospice Care, Followed by Death or Acute Care will estimate the risk adjusted rate of transitions from hospice care, followed by death within 30 days or acute care use within 7 days. Specifically, the measure reflects the rate of live discharges from hospice that are followed by death within 30 days or a hospitalization/emergency room visit/observation stay within 7 days of hospice discharge. The measure is risk adjusted to "level the playing field" to allow comparison based on patients with similar characteristics between hospices. The purpose of this measure is to capture hospice live discharges that are potentially inappropriate or followed by undesirable outcomes. It is important to recognize that live discharges from hospice and post-discharge care transitions are not considered "never events." Live discharge from hospice can be appropriate, and the circumstances that lead to these events can be complex and are influenced by a range of factors including patient and family preference. Therefore, the goal of this risk adjusted measure is to identify hospices that have notably higher rates of live discharges followed shortly by patient death or acute care utilization, when compared to their peers. From the Brief Measure Description: Specifically, the measure reflects the rate of live discharges from hospice that are followed by death within 30 days or a hospitalization/emergency room visit/observation stay within 7 days of hospice discharge. My comments regarding the Numerator: Measure Outcome (Unadjusted Numerator) Number of live discharges that are followed by death within 30 days or a hospitalization/ emergency room visit/observation stay within 7 days of hospice discharge.	Barb Hansen, MA RN CWON CEO Oregon Hospice	hansen@oregonhospice.org

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		1. I am concerned that no differentiation will be made regarding the types of Hospices discharges which can occur. A Hospice Revocation is very different than a Hospice discharge because the patient is no longer terminally ill. The numerator should not include patients who revoked the Election of the Medicare Hospice Benefit, because it is their right to revoke the Hospice Medicare Benefit at any time. The reason the patient may choose to revoke their Hospice Medicare Benefit may be because they wish to seek more aggressive treatment, whether this is in a hospital or an emergency room. This category includes patients who decide to "revoke" their MHB because they want to go get a 2nd opinion or go have a test (e.g. MRI or CT scan) and the Hospice does not feel the test or scan is clinically indicated in order to treat the patient's symptoms. Patients have the right to go seek more aggressive treatment or to have more testing done; they may choose to do this despite a hospice program's best efforts to avoid unnecessary care transitions. Patients then have the right to sign back onto hospice, if that is their choice. 2. The numerator should also not include patients who were discharged for moving out of a hospice's service area. Patients do occasionally move and if they decide to go to an emergency room or are hospitalized while they are in the process of re-locating to a new area, this should not be "held against" the hospice program which had been serving the patient. 3. The numerator should also not include patients who are discharged for cause. (From Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance, page 12: When a hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to		

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		operate effectively is seriously impaired, the hospice can consider discharge for cause.) Patients who are discharged for cause might very well end up in an ED or a hospital within 7 days of the discharge. This should not be held against the hospice who tried to serve the patient. 4. Therefore, it is my opinion that the ONLY category of "discharged" patients which should be included in the numerator for this measure is: patients who are discharged because they are no longer terminally ill. I very much agree with the statement above in the Brief Measure Description: "Live discharge from hospice can be appropriate, and the circumstances that lead to these events can be complex and are influenced by a range of factors including patient and family preference." There are so many confounding factors which can influence hospice discharges. How can hospice programs be held responsible for "managing" all patient and family preferences? I hope more consideration is given to refining the types of hospice discharges included in this proposed measure.		
18	4/20/2018	The National Hospice and Palliative Care Organization (NHPCO) is the largest membership organization representing the entire spectrum of not for profit and for profit hospice and palliative care programs and professionals in the United States. We represent over 4,000 hospice locations and more than 57,000 hospice professionals in the United States, caring for the vast majority of the nation's hospice patients. NHPCO is committed to improving end-of-life care and expanding access to hospice care with the goal of creating an environment in which individuals and families facing serious illness, death, and grief will experience the best that humankind can offer. Live transition patterns in hospice have been under scrutiny for several years. While the authors of this measure acknowledge that overall, the national rate of live discharges from hospice has declined, they express	Edo Banach, JD President and CEO National Hospice and Palliative Care Organization	JLundPerson@nhpco.org

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		concern regarding 25% of hospice providers with a live discharge rate greater than 30%. In 2016, these providers demonstrate a higher live discharge rate than the preceding three years. NHPCO shares this concern about hospice providers with a high percentage of live discharges. While the measure focuses on an important aspect of care, claims alone do not provide sufficient information to accurately represent the complexity of hospice practice and the overlap, and sometimes tension, between quality and compliance requirements. NHPCO's comments on the 2018 project Development of the Draft *Transitions from Hospice Care, Followed by Death or Acute Care* Measure for the Hospice Quality Reporting Program reflect our commitment to the needs of beneficiaries with advanced serious illness who are transitioned from the hospice benefit. There may be a number of reasons for that transition, including a live discharge, initiated by the hospice, and revocation, initiated by the beneficiary for whatever reason. Even when the patient has a live discharge from hospice, there may be reasons outside the control of the hospice. We note that there is no distinction made in the measure for the various reasons for a live discharge and expect that some hospices that are reviewing the measure specifications may be confused. We want to ensure that hospices are not penalized for discharge issues beyond their control in the introduction to the measure specifications. **NHPCO Recommendation:** We recommend that CMS include an explanation in the "Background" section of the measure specifications that discusses why all types of live discharges are included, including revocations. We want to ensure that the hospice provider that is being held accountable has control over what the live discharge measure measures. We also recommend the inclusion of a "plain English" discussion of how the risk adjustment process will normalize the discharge issues beyond the control of the hospice.		

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		Live Discharges and Transfers In our review of the draft measure specifications, we note that transfers are not mentioned as a form of live discharge. A standard practice for many hospices is to "live discharge" rather than transfer, even when a transfer would be appropriate. Provider billing staff are often confused about the requirements for transfers, or do not use the option often enough to be skilled at determining the difference. In the case of a transfer, the provider will enter the appropriate 3-digit numeric type of bill code: 81C - Hospice (Nonhospital-Based) Change of provider or 82C - Hospice (Hospital-Based) Change of provider. The patient does not lose days in a benefit period with a transfer, while a discharge starts a new benefit period. NHPCO has worked with the three Medicare Administrative Contractors (MACs) to develop hospice educational materials on transfers, to help hospices understand the process and the implications of both. If transfers between hospices are not considered a live discharge, it will be important to renew and increase our educational offerings about the reasons to use either a transfer or a live discharge. **NHPCO Recommendation:** We recommend that a discussion on transfers be included in the "Background" section of the measure specifications. If transfers are not included as a live discharge for this measure, this may be an opportunity for additional training on the use of transfers and their value. **Risk Adjustment Methodology** NHPCO appreciates the effort that CMS and the measure developer have made in developing a sophisticated risk adjustment methodology, which takes into account many of the variables recommended in last year's rulemaking. We believe it levels the playing field for all hospice providers and is an important consideration for providers, particularly for this measure.		

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		NHPCO Recommendation: We thank CMS and the measure developer for their careful and thorough risk adjustment strategy. We encourage CMS and the measure developer to review the variables on a regular basis to ensure that new variables can be considered as appropriate. **Considerations for Denominator Exclusion** NHPCO believes that there may be at least one category of live discharge that should be considered for removal from the denominator of all live discharges. At least two scenarios apply. When a patient is changing hospices, the hospice can either "live discharge" them or transfer them. 1. A patient may decide to change hospices. The patient is discharged alive from Hospice A, selects Hospice B and begins to receive care from Hospice B. Hospice A can either live discharge the patient or transfer them. A live discharge where hospice care continues the same day or the following day should be removed from the denominator because hospice care continues to be provided. 2. A hospice provider (Hospice A) may contract with another hospice provider (Hospice B) for inpatient or residential (RHC) care, when Hospice B has a facility. Hospice A can choose whether to transfer or live discharge the patient so that the patient can receive General Inpatient Care (GIP) or routine home care (RHC). The patient is still receiving hospice care, just from a different provider. Since Hospice A is not required to transfer the patient to the inpatient or residential facility, the discharge should not be counted in the denominator of all discharges. A hospice provider shares their story about this issue. "We do not have our own inpatient program, but work with a Hospice House in the area. While we have GIP contracts for short stays to stabilize out of control symptoms, these symptoms often come at end of life (e.g. terminal agitation and aggression, intractable nausea and vomiting, uncontrolled pain). When we believe that these symptoms		

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		are preceding an imminent death, we may choose to move that patient to a Hospice House where they will not require any additional moves, in lieu of a hospital stay under GIP. A hospital admission may result in another move as soon as the symptoms are stabilized, even though death is imminent. While this seems like the right thing to do for our patient, it could predictably result in a transition (transfer) followed by death within 30 days." **NHPCO Recommendation:** Exclude live discharges or transfers when the patient continues to receive hospice care, but from a different provider. Exclude this live discharge or transfer to another hospice where that hospice is continuing to provide hospice care. We appreciate the opportunity to comment on behalf of our members and the hospice patients and families they serve. We recognize that the level of complexity of this measure far surpasses any other quality measures that hospices currently use. NHPCO will be willing to share questions as members begin to read about this quality measure and would be pleased to help with ongoing educational efforts. We look forward to ongoing dialogue about this measure and others as they are developed.		
19	4/23/2018	The Hospice and Palliative Care Association of New York State (HPCANYS) appreciates the opportunity to provide comments on the *Draft Transitions from Hospice Care, Followed by Death or Acute Care Measure for the HQRP*. HPCANYS would like to commend CMS in its continuing efforts to expand and fine tune quality reporting for hospice programs through the Hospice Quality Reporting Program. *Transitions from Hospice Care followed by Death or Acute Care* can identify programs inappropriately discharging patients. Any program with a higher than average discharge alive rate should be examined for the reasons why. HPCANYS supports this effort.	Carla Braveman, BSN RN M.Ed CHCE Hospice and Palliative Care Association of New York State	bmahar@hpcanys.org

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		HPCANYS supports the Draft Measure in principle, and support having risk adjustment within the measure, but we have comments and concerns about some parts of the measure. Our first concern, likely unique to New York, is an issue with hospice and Medicaid long term care programs. If a patient wants to take advantage of additional custodial care through a Managed Long Term Care Program (MLTCP), NY State Regulations require that the patient not be on hospice, and if they are, they must discontinue hospice, be assessed and accepted into the MLTCP, then may reenroll into hospice at a later time. Families and patients who need that additional level of custodial service must revoke hospice and wait to be processed into the MLTCP before reelecting hospice care. This increases the number of 'live discharges' in our population. How will the risk adjustment take this situation into account? Second, within the body of the draft measure, there is no differentiation between revocation on the part of the patient/family versus discharge by the hospice program. Under the Medicare Conditions of Participation, the hospice can only discharge a patient for limited reasons- death, no longer terminally ill, moved outside of the area and for cause. There needs to be more clarity in this measure to differentiate between these two terminations types from hospice. Will you have two measures- one for discharge and one for revocation? When a patient and family exercise their right to leave hospice for any reason, it does not always indicate a quality concern for the hospice program. Third, there is an opportunity here to look at length of stay within hospice—specifically, the days to death from hospice admission when the patient is discharged alive. Length of stay is listed in the preliminary risk adjustment variables on page 8. The median length of stay in hospice is very low- about 2 weeks based on what data you are looking at. This means that, for whatever reason, patients are		

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		admitted to hospice very late in the course of their disease. We have seen in clinical practice, patients with extensive disease, very near end of life, admitted to hospice and then revoke to return back to the hospital. This is not necessarily a failure on the part of the hospice program, but on the systems that have patients identified so late in the course of their illness. The stress that a late referral to hospice as one is dying is very difficult for the patient and family to cope with. There is not adequate time in some of these instances to keep the patient from revoking to go back to where they have been treated. To accommodate for this situation, we suggest that any patients discharged within one week of their admission to hospice be excluded from the data or segregated into a different measure. Fourth, we have grave concerns with the use of the phrase "terminally ill" in the following: *Page 2- Paragraph 2- Though some patients can be discharged alive from hospice because their clinical status improves or stabilizes, live discharges among patients who are still considered terminally ill can be potentially concerning.* The word terminally ill in this line should be expanded or clarified. Almost all of the patients discharged alive from hospice are terminally ill- some may have one year left to live, some longer but they all have chronic diseases that will take their lives. Is the intent of the measure to identify patients who are discharged alive and still have a 6-month prognosis or patients who have more than 6 months when they are discharged? It is our obligation under the Conditions of Participation to bill Medicare only for patients who are eligible for Medicare Hospice Care. "In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and certified as being terminally ill by a physician and having a prognosis of 6 months or less if the disease runs its normal course." Progressive decline must be documented in the clinical record and be part of the judgement to recertify patients. There are some patients in which		

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		there is no documentable decline and the programs must discharge them. In some cases, they do die. Prognosis is not an exact science! Please clarify how the patients will be treated in this measure who are deemed by the physician and IDT as not having a 6-month prognosis at the time of live discharge, then have an exacerbation and either go to the hospital or die. Patients with COPD, CHF and dementia often fit into this category. Thank you for your attention to this measure and seeking input from the hospice community.		
20	4/23/2018	Hosparus Health appreciates the opportunity to provide comments regarding the **Development of the Draft Transitions from Hospice Care, Followed by Death or Acute Care Measure for the Hospice Quality Reporting Program** currently under review by the Centers for Medicare and Medicaid Studies and RTI International. Hosparus Health is one of the nation's largest **non-profit** hospice and palliative care organizations with a current daily census of over 1200 hospice and palliative care patients. Our 37 county footprint spans over 11,000 square miles in Kentucky and Indiana including 9 urban, 17 mostly rural, and 11 completely rural counties as described by the US Census Bureau. Our interdisciplinary teams have garnered national acclaim for innovative and compassionate end of life care, including Kourageous Kids, our long standing pediatric palliative and hospice program. In 2015 we began piloting an innovative adult advanced illness care program in 22 Kentucky counties and expanded this program throughout our footprint in 2018. Our explosive and continued growth spanning 40 years qualifies us as a credible influencer to pioneer improved access to care and enhance cost savings to our healthcare system. The proposed addition to the Hospice Quality Reporting Program regarding transitions from hospice care followed by death or acute measures is highly concerning to Hosparus Health. Based upon the	Dr. Bethany Snider, MD Gwen Cooper, MPA, VP/ Chief Medical Officer SVP/Chief external Affairs Officer Hosparus Health	gcooper@hosparus.org

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		proposed qualitative measures we believe the results do not accurately reflect the nature of live discharges from hospices. Electing hospice care is a deeply personal decision which differs from patient to patient based on their personal beliefs, values, and preferences. Placing hard, qualitive measures upon a subjective choice in patient care is an ineffective model of analysis, and stands to harm both patient's and hospice providers. Patients choose to revoke hospice care for many reasons, including continuing to pursue more aggressive treatments, ultimately continuing to incur costly healthcare services and potentially resulting in declining health conditions. Basing qualitative measurements, and ultimately funding decisions, upon a patient's decision to pursue treatment is a perverse incentive and is not an illustration of patient centered, value based care. As stated in the request for comments: *Live discharge from hospice can be appropriate, and the circumstances that lead to these events can be complex and are influenced by a range of factors including patient and family preference.* And while we understand that the perceived goal of this risk adjusted measure is to identify hospices that have notably higher rates of live discharges followed shortly by patient death or acute care utilization, when compared to their peers; the use of this measure in a public reporting format will only tell part of the story for consumers regarding the quality care they can receive from various hospices. The hospice compare website is fraught with inconsistencies when one hospice is compared with another hospice without consideration of hospice size. This additional measurement will add to the unbalanced comparison among organizations and will not provide enough information for a consumer to make an informed choice. Death cannot be defined by science and statistics alone, which is why it is so difficult for practioners to prognosticate the last six months of		

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		death. Attempting to base measures impacting providers ability to serve patients on what, for most in the hospice community, is a personal choice would be an inaccurate reflection of quality in hospices. This is especially so because the measurements do not consider the 10% of patients who die of acute incidents unrelated to any long term or advanced illness, whether the patient is currently a hospice beneficiary or not Furthermore, the median length of stay in hospice has fallen to 23 days, indicating that a vast majority of patients die quickly upon electing hospice. With lengths so short, measuring live-discharges seems an inconsequential and ineffective qualitive indicator. Hosparus Health ardently supports rational, qualitative measures that incentivize high quality patient care and efficient, effective administration. Unfortunately, the Development of the Draft Transitions from Hospice Care, Followed by Death or Acute Care Measure for the Hospice Quality Reporting Program does not appear to be such a measure. We fear that it will impose burdensome regulations upon patients who should be making their end-of-life decisions based upon their own wishes, beliefs, and values, not government disincentives. We encourage CMS and RTI to look in other directions for more accurate, data-based measures to ensure the highest quality in hospices around the country.		
21	4/23/2018	Hello, I wanted to voice my thoughts about the new proposed Hospice Quality Measure: "Transitions from Hospice Care, Followed by Death or Acute Care." It is my opinion that the numerator should **not** include patients who revoked the Election of the Medicare Hospice Benefit, because it is their right to do so at any time. I believe if a patient is exercising their right to revoke hospice care and pursue curative treatment, it should not be held against the hospice they revoked from.	Luke King, MSW LCSW ACHP-SW Quality and Compliance Manager Lumina Hospice and Palliative Care	luke.king@luminahospice.org

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		It is my opinion that the numerator should **not** include patients who were discharged for moving out of a hospice's service area. Patients sometimes move or travel, and they have a right to do so, and if they decide to go to an emergency room or are hospitalized while they are in the process of traveling to a new area, this should not be held against the hospice that was previously serving them. It is my opinion that the numerator should **not** include patients who are discharged for cause. Discharging a patient for cause is typically a rare event, but when it happens, it is usually because there are serious safety issues that could not be resolved. Patients who are discharged for cause may likely seek services at an ED or a hospital within 7 days of the discharge, and this should not be held against the hospice who tried to serve the patient but could not due to serious safety issues.		
22	4/24/2018	Since 1982, the National Association for Home Care & Hospice (NAHC) has been the leading association representing the interests of hospices, home health, and home care providers across the nation, including the home caregiving staff and the patients and families they serve. Our members are providers of all sizes and types -- from small rural agencies to large national companies -- and include government-based providers, nonprofit voluntary hospices, privately-owned companies and public corporations. As such, we welcome the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') Draft Hospice Quality Reporting Program (HQRP) Transitions Measure Specifications. Stakeholder input is a vital element of the measure development process, and we look forward to a continuing dialogue on this and other important efforts as part of the HQRP. Development and Dissemination: The Draft Transitions from Hospice Care, Followed by Death or Acute Care Measure (Transitions Measure) is CMS' first foray into development of a claims-based hospice measure; its intent is to quantify the proportion of patient stays that end with live discharges and subsequent burdensome transitions	Theresa M. Forster, VP of Hospice Policy and Programs National Association for Home Care and Hospice	tmf@nahc.org

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		(defined as a hospitalization/ED/observation stay within 7 days, or death within 30 days). Depending on how a hospice rates on this measure, it is believed that the findings may be an indicator of the quality of care being provided by the hospice. We understand the many concerns related to both quality and program integrity that prompted a focus on these areas. However, because the measure involves considerable assumption, it falls short of providing a direct indicator of quality of care. This raises concern, particularly relative to use of this measure for public reporting. There is considerable potential for misunderstanding of this measure, and consequent unintended negative consequences. For this reason, it is of particular importance that any claims-based measure that will be utilized in the HQRP – including the Transitions Measure -- must be properly vetted to ensure that the measure relates directly to quality of hospice care so as to reduce the incidence of inappropriate conclusions that might be drawn. Proper vetting, as laid out by Congress in the Affordable Care Act, requires that HQRP measures are: "… endorsed by the consensus-based entity"…. except that: "in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the consensus-based entity, the Secretary may specify measures that are not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus-based organization…" Use of a claims-based measure that does not meet this requirement is not in compliance, nor is it in keeping with, CMS' stated paramount concern of "…successful development of a Hospice Quality Reporting Program (HQRP) that promotes the delivery of high quality healthcare services." As part of the draft specifications for the Transitions Measure CMS has not outlined the process it intends to use to move this measure forward, or the time frames. In the absence of that, we urge that CMS ensure this measure receives a thorough vetting by way of the		

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		Measures Application Partnership (MAP) at the National Quality Forum and opportunity for public notice and comment. It is only through the most rigorous consideration by experts in the field that the appropriateness of this measure for use can be discerned. Further, in our previous comments on development of measures for the HQRP, we have noted that many claims-based measures more closely resemble practice indicators, as opposed to measures of quality performance. Practice indicators are most useful when they are accompanied by more direct examination of clinical and other circumstances surrounding care. In recent years as CMS has publicly shared increasing amounts of data related to hospice practice and how individual hospice programs compare with their peers or with expectations laid out by the Medicare program, hospice providers have demonstrated a significant capacity for behavioral change. We have seen widespread, in-depth examination of patterns and practices that are resulting in improved performance and better understanding of programmatic requirements. We also anticipate that, as conceived and given the geographic and demographic variation in live discharge rates and subsequent hospital care utilization, the Transitions Measure will result in somewhat lopsided findings. These skewed findings may modify over time if accompanied by provider education. We strongly advise that CMS use the Transitions Measure instead as a practice indicator and supply it to hospices by way of the PEPPER Report or other direct-to-hospice reporting, accompanied by education about the concerns associated with outlier scores. We believe that this approach has the potential to improve the entire industry's understanding of quality and program integrity concerns associated with the measure. Initial use of the Transitions Measure in this way may also provide CMS additional opportunities to further consider a measure that can be more directly linked to quality outcomes and thus better suited to public reporting.		

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		Live discharge can be influenced by many factors outside the control of the hospice (including the level of understanding/acceptance of the hospice care model, care provided prior to hospice care, amount of advance care planning conducted, adequacy of education, patient and family expectations and disease progression). Hospices do not have complete control over patient decisions or many of the other factors that contribute to the patient/family decision to revoke hospice care and resultant live discharge transition. Subsequent need for hospital care (or even the occurrence of death) can be anticipated for some terminally ill patients who leave hospice care, either due to loss of hospice supports and limited availability of services to adequately address patient needs or as part of the disease progression. Further, in recent years the regulatory environment has shown an increasing intolerance for ambiguity in hospice care. Hospices are finding that they must discharge patients they believe to be eligible because they may be denied upon review by a CMS or other contractor. These patients frequently need more complex care to manage their treatment and often enter hospitals following discharge. We believe that creation of the Transitions Measure in isolation, and not as part of a group of measures that are designed to evaluate coordination of care across provider settings, will ultimately have a limited impact on quality of care. For this reason we believe CMS' development of a "suite" of care coordination measures that address the role of each provider involved in the patient's care is an advisable undertaking. For example, Joint Commission hospitals with certified palliative care programs or an emergency/ambulance service that identifies a patient as on hospice and alerts the hospice that they are in transport to a hospital can play a pivotal role in supporting meaningful coordination of care and reducing burdensome transitions. We recognize there are challenges associated with securing service data for patients enrolled in Medicare Advantage (MA), but we also believe that the experiences of these patients are a critical element to any discussion of live discharge and should not be excluded. On a		

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		global level hospices would benefit from insights into ways in which the live discharge experience of their patients may differ depending on coverage status (MA or fee-for-service). MA plans, as well, would benefit from this information. And as it relates to this measure, the comparison may lead to insights that result in a more deliberate coordination of care that respects patient preferences. We recommend that CMS initiate development of a set of hospice/MA care coordination measures on a track parallel with what we have suggested for fee-for-service earlier in these comments. These measures sets should be rolled out together for public use. Components of the Measure/Exclusions: CMS plans to examine rates of live discharge accompanied by hospital care within 7 days, or death within 30 days. The specifications do not explain CMS' choice of time frames linked to the subsequent transitions. We believe that access to data and additional information considered by CMS that explains use of hospital care and death as the major components would be helpful. While we understand that hospitalization is a concern from multiple perspectives, including hardship on patient/family and additional spending under Medicare, an explanation of all of the factors that led to use of hospitalization would be enlightening. Further, any data that explains arrival at the 7-day time frame for the hospital care transition would be instructive. Similarly, it would be helpful to have further explanation of CMS' choice of the 30-day time frame for death following live discharge. Given that half of all hospice patients are on service only 18 days prior to death, the 30-day time frame seems somewhat lengthy. Again, more detail surrounding these decisions would be helpful to our understanding of CMS' choices. CMS has not indicated how it will define "live discharge". In hospice care there are various discharge codes depending on the reason that the patient is leaving service. Patients may revoke service or be discharged because they have moved out of the area or gone for an extended stay with family members. Patients may be discharged		

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		because they (without knowledge of the hospice) admitted themselves to a hospital at which the hospice may not have a contract and cannot continue to treat the patient. Veterans may decide to be served at a VA facility, which requires discharge from hospice care. Patients may also be discharged because they are determined to be no longer eligible for hospice services. Further, cause for discharge may vary widely depending on market and/or geographic factors. These factors have the potential to dramatically impact some hospices while having little to no impact on others in a different area of a state, region or the country. CMS should consider excluding certain types of live discharges and circumstances surrounding them, including discharges for cause, revocations, and discharges due to the patient moving out of the service. All of these are, in large part, beyond a hospice's control. Rates for the measure are benchmarked at the national level. As referenced in comments above, we believe that variations in hospice practice by geographic area and agency demographics will produce skewed results for this measure that could reduce its usefulness. We believe it is advisable for CMS to consider benchmarking at the national and state levels as that will provide a much clearer picture of comparison among peers as has been demonstrated through PEPPER data provided at the national and state levels. It would also be helpful to know if the data considered by CMS reflects variability related to timing of the hospital care following discharge from hospice. For example, are there different factors at play if a patient discharges direct to a hospital stay (for active curative care) versus a discharge to home, nursing home or ALF followed by several days and then the need for hospital care? Risk Adjustment Variables: As referenced above, there is a significant pool of factors that contribute to a patient's live discharge from hospice care and subsequent need for hospital care or death. It is essential that the risk adjustment mechanism adequately account for		

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		those factors. CMS has indicated that the following preliminary risk adjustment variables are included in the measures as currently constructed: • Age • Gender • Original reason for Medicare entitlement (age, disability or ESRD) • Race/ethnicity • Hospice principal diagnosis (ICD-9 diagnosis codes are used for claims prior to October 2015 and ICD-10 diagnosis codes are used for claims during or after October 2015. The model presented in this document groups principal diagnosis based on the Clinical Classification Software method. We are testing alternative grouping methods, including broader groupings at the body-system level.) • Setting of care at end of the hospice stay • Length of hospice stay (categorical) • Prior healthcare utilization in the year prior to hospice admission: – Prior hospitalization – Prior ED visits and observational stays – Prior hospice utilization We are interested in receiving clarification on some of these measures and believe that the list should be expanded to include other items, as well. Our comments are as follow: Race/Ethnicity: We believe this is an important factor but also believe it may need to be expanded to include additional cultural factors, such as language spoken. Socioeconomic Status: We believe that this may be contributory to a patient's level of comfort with hospice care and/or tendency to use hospital services. This might be included based on whether or not the patient is dually eligible for Medicaid/Medicare, or through some other factor.		

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		Setting of Care at End of Hospice Stay: We believe that this is designed to identify whether the patient is living in a private home or in a nursing facility or ALF, but that is not entirely clear. If that is the case, did CMS also consider whether the level of hospice care at discharge (or aggregate use of GIP and/or CHC while on hospice) should be included as part of the risk adjustment methodology? Geographic Area – Rural/Urban/Mixed: In the interest of addressing market factors that could impact patient care and patient choice of care, we'd like to know more about the potential for including some type of risk adjustment factor related to geographic area and the health care practice and service availability in the area. Request for TEP Report/Data: As may be evident from our comments, we believe that a great many factors can contribute to the transitions that follow live discharge from hospice care. This measure is a considerable undertaking, and it is vital that it reflect properly on the quality of care delivered by the hospice if it is to be represented as such. We appreciate this request from CMS for initial input and would anticipate that, as the measure develops, the hospice community will have a number of additional opportunities for comment; we expect to remain actively involved. In that vein, the hospice community would find great value in CMS' sharing of the findings of the Technical Expert Panel (TEP) on this measure that was referenced in the specifications, as well as detail related to the data that was considered in initial development of the measure. We believe that increased transparency relative to this information by CMS will provide stakeholders a more thorough understanding of the work that has been done thus far on the measure, and help us to engage at a deeper level as the process moves forward. Many thanks, once again, for the opportunity to comment on the draft specifications for the Transitions Measure. Please let us know if our comments prompt require any clarification, or if we can be of assistance in any way.		

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23	4/25/2018	I am writing to raise substantial concerns about the merits of the draft measure "Transitions from Hospice Care, Followed by Death or Acute Care." I understand the hospice usage patterns that are troubling and that this metric would be expected to detect serious outliers and partially correct their practices, but the metric would have substantial adverse effects that will increase over time. If it is implemented, its measure steward should watch these adverse effects closely and recommend its discontinuation when they become substantial. However, on balance, I believe that it should not be implemented. The special strength of hospice is the comprehensive care offered through to the end of life. Patients and families often report that having hospice involved provides a great reduction in fear and anxiety because "the hospice experts know what they are doing and won't abandon us, no matter what comes up." That promise is undercut by a practice of substantial numbers of live discharges. For the first dozen years of hospice in the U.S., there were almost no live discharges, except for persons moving out of the area to be with family, or a very few who found they were not comfortable with the hospice team or model of care. This reliability through to the end of life is part of what gave hospice such a strongly positive public opinion. Unfortunately, the way that hospice was put together encourages some dysfunctions when hospices undertake to provide care for persons with long-term fragile health (rather than aggressive cancers). The hospice eligibility requirements and the aggregate cap require that hospices that try to serve this population will have a substantial discharge rate – not because the discharged patients became healthier but simply because these patients did not yet encounter the minor stress that will lead to death, given their ongoing fragile health. The timing of their deaths remains uncertain until very	Joanne Lynn, MD Director of Program to Improve Eldercare Altarum	Joanne.Lynn@altarum.org

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		close to death, even though their statistical likelihood of living 6 months is clearly less than 50% and thus they are eligible for hospice. For some of these patients, the very fact of hospice discharge and the adjustments that this transition requires might well precipitate a sequence of events that lead to death, and the absence of the trusted hospice team might well lead the family to go to the hospital when the patient's situation changes. These dysfunctional elements are "baked in" to the way CMS funds hospice care and the willingness of hospices to provide care for persons who qualify for hospice care and are living with long-term disabling illnesses such as organ system failures, neuromuscular diseases, dementias, and frailty. I believe that these dysfunctions require reforms, but the engineering of those reforms is not helped by this quality measure. Within the current "system," these hospice discharges are a predictable side effect of trying to serve these patients. The practice that CMS legitimately needs to disrupt is the pattern of care in which the hospice is pushing for discharge of patients who are headed toward hospitalization (or any other costly treatments, like high-cost medications). Some hospice programs "work out" a discharge from hospice before nearly all hospital admissions in order to limit their financial and clinical liability. There are times that set of actions is appropriate – because the patient (or family) really has decided to pursue aggressive care, and therefore, the patient is no longer eligible for the hospice program. But a hospice that is doing this regularly is probably arranging cues so as to manipulate the patient and family into revoking hospice in a way that is timely for hospice finances. If this is happening, it would seem to affect patients with a wide variety of hospice stays, whereas the discharges for living too long are likely to show a pronounced concentration near and beyond 180 days. It may be possible for CMS and RTI to examine whether this practice can be directly detected in the claims data. Of		

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		course, hospice programs that are engaging in both practices could have diffuse patterns that are harder to detect. In the midst of all this, having a metric that is tied to the national average poses additional challenges. Even if it works well at first and reduces the likelihood that hospices endeavor to discharge people who might otherwise run up large costs, the effect later on will be adverse because the "bad actors" will have corrected their practices under scrutiny, and then CMS will be penalizing hospice programs that try to care for the persons with long-term fragile health, since they will have higher rates (even with the risk adjustment proposed). It is not clear that CMS does a good thing to penalize sites through quality measures when they are trying to support persons dying with the less predictable fatal illnesses. There probably needs to be a substantial reform to address the needs of this population, but implementing this measure is not an appropriate approach. Indeed, it is predictably dysfunctional over time. Furthermore, the measure is very challenging to understand and will be widely misunderstood if it is ever published on a CMS "compare" website. In short, this measure would require a great deal more work to be a reasonable reflection of quality in hospice over the long term.		
24	4/25/2018	Thank you for the opportunity to comment on Draft Measure Specifications for "Transitions from Hospice Care, Followed by Death or Acute Care." The Illinois HomeCare and Hospice Council (IHHC) is a trade association representing hospice, home health and home services providers (and allied vendors) serving patients in Illinois. IHHC members are keenly interested in the development of measures based on meaningful data that improve the quality of hospice care and help patients and families make informed decisions.	Cheryl Adams, President Illinois Home Care and Hospice Council	katharineeastvold@ilhomecare.org

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		IHHC members understand that high numbers of live discharges from hospice can indicate an issue with hospice quality. However, there are many possible reasons a live discharge may have occurred, including: 1) Patient no longer eligible for hospice (live discharge due to determination that six-month terminal prognosis is not accurate/no longer accurate) 2) Discharge for cause, not preventable by the hospice 3) Personal decision by the patient, unrelated to the quality of hospice care, to begin or resume curative treatment 4) Patient/family dissatisfaction with quality of care IHHC does not believe that the draft methodology adequately accounts for and screens out reasons for live discharge other than low patient/family satisfaction. We also question whether this is a measure that prospective patients and family members will find comprehensible and meaningful as they compare hospices. The Draft Measure Specifications propose a numerator resulting from an adjustment of the number of live discharges from hospice followed by death within 30 days or hospitalization, emergency department visit or observation stay within seven days. This does not necessarily limit the patients addressed in the numerator to those who revoked their Notices of Election. Terminal prognosis is not an exact science, and a certain number of patients determined to be no longer eligible for the hospice benefit will die or be cared for in a hospital within the time frames the measure specifies —even, in some cases, for reasons unrelated to the terminal diagnosis. This scenario is not within the hospice's control, since Medicare rules prohibit a hospice from billing Medicare for services provided to a patient who is no longer eligible for the benefit. Discharges for cause likewise may not serve as indicators of hospice quality. A particular family situation, living situation or behavioral		

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		scenario may make it impossible for a beneficiary to take advantage of the hospice benefit and may even put hospice personnel at risk. A hospice that has taken steps to document and resolve a problem that ultimately cannot be resolved, through no fault of hospice personnel, and leads to a discharge for cause should not be penalized. Thus, IHHC recommends that the number adjusted to produce the numerator be limited to live discharges who have revoked their Notices of Election, not pursuant to a discharge for cause, and for whom discharge is followed by death within 30 days or acute care within seven days. IRK would appreciate additional details on the data regarding factors that affect care preferences, including racial and ethnic demographics and prior care utilization. While we support the practice of risk-adjustment in order to avoid unfairly rating hospices that care for types of patients more likely to fall within the measure's unadjusted numerator, we are concerned that the extant data on care preferences are not sufficient and not narrowly related to the specific area the measure addresses: decision-making on end-of life questions when the patient is already on hospice care. We question, for example, whether patients' previous level of care utilization (particularly prior to the terminal diagnosis) correlates with their end-of-life care utilization preferences, or whether general end-of-life preferences correlate well with decision-making at the end of a hospice stay. IHHC's hospice members know that patient and family decision-making at the end of life is personal and not always predictable on the basis of prior behavior, and we want to ensure that risk-adjustment is based on narrowly applicable data. More broadly, IHHC is concerned that this quality measure as currently drafted is potentially at odds with the core hospice philosophy of patient choice. While hospice providers are proud to offer a continuum of services many patients want at the end of their lives, in		

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		settings most patients prefer, they also respect the dignity of each patient, and that includes respecting the patient's right to try or resume curative treatment, even when this is likely to result in the patient's death in a hospital setting. IHHC hospice members believe that a measure that associates some patient choices with poor quality care, whether or not a dissatisfaction with the care provided by the hospice was the patient's reason for revoking the benefit, runs counter to this philosophy. Finally, IHHC does not think patients, family members and other members of the public will find this measure easy to understand when comparing hospices based on their performance on quality measures. Comprehending this measure will require understanding what a live discharge from hospice is and under what circumstances it may occur. It will necessitate considering the role of patient choice and individual care preferences in hospice transitions. Without a sense of which factors are and are not within a hospice's control, someone seeking care could give the rating on this measure too much weight; alternatively, without delving into the risk adjustment process, a member of the public might fail to find the measure meaningful. While understanding the intent, IHHC believes it is difficult to communicate clearly to the care-seeking public a measure capturing this concept. IHHC appreciates the opportunity to comment and looks forward to further refinements of new developments in the Hospice Quality Reporting Program.		
25	4/25/2018	Thank you for the opportunity to comment on the measure currently under development for the hospice quality reporting program. As stated, the project objective is to obtain additional stakeholder input on the measure concept, specifications, and implementation for Transitions from Hospice Care, Followed by Death or Acute Care. I have reviewed the Draft Measure Specification in formulating my feedback.	Eugenia Smither, RN BS CHC CHP CHE Vice President of Compliance and Quality Bluegrass Care Navigators	ESmither@bgcarenav.org

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		The CMS contractor's efforts in conducting the environmental scan and convening a Technical Expert Panel in the process of developing this measure is appreciated; however, the measure specifications do not address all the elements and steps that the National Quality Forum uses to evaluate measures for potential use in quality reporting, therefore this is a needed step prior to implementing this and any future measure for HQRP. The Topic of Live Discharges in hospice care has been highlighted for many years and monitored through the Program for Evaluating Payment Patterns Electronic Report (PEPPER) which appears to be a more suitable place to add this claim based measure of this complexity. This is not an outcome measure, but a utilization metric. This is a statistical calculation with varied methodologies embedded. it is at best a process measure- you are performing multiple math processes and formulating an output not an outcome. There are too many assumptions: 1. *Most patients express a wish to die at home and outside of the hospital, and patients discharged alive from hospice are more likely to die in a hospital than patients who receive hospice care up until death.* There are many cultures who are opposed to having family die in their home. The study referenced was conducted on hospitals in one state and the study acknowledged the need for subjective patient-centered data as an adjunct to the healthcare encounter data and further acknowledged limitations regarding patient and caregiver preferences for end of life care and place of death. 2. *Live discharges from hospice are expected, for example, in cases where survival improves or patient and family preferences change. However, live discharges from hospice*		

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		followed shortly by acute care utilization or death represent potentially avoidable and undesirable outcomes, and may indicate potential quality concerns. You list patient and family preferences for the change as an example of an expected hospice live discharge, however do not account for those preferences driving the acute care utilization which would negate it being avoidable or undesirable and assuming death in a hospital is a quality concern. 3. *The purpose of this measure is to capture hospice live discharges that are potentially inappropriate or followed by undesirable outcomes. it is important to recognize that live discharges from hospice and post-discharge care transitions are not considered "never-events." Live discharge from hospice can be appropriate, and the circumstances that lead to these events can be complex and are influenced by a range of factors including patient and family preference. Therefore, the goal of this risk adjusted measure is to identify hospices that have notably higher rates of live discharges followed shortly by patient death or acute care utilization, when compared to their peers.* This may be a compliance metric that needs to be captured and in the hospice PEPPER report which also compares high-risk areas with comparisons to peers including state, Medicare Administrative Contractor jurisdictions and national categories. This is not a quality metric it is a utilization metric and could be categorized as underutilization compliance risk area. It should be monitored and reported to the hospice, not the public. 4. *Reducing unnecessary care transitions for hospice patients by promoting effective communication and coordination of care.*		

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		This is assuming care transitions are unnecessary and unavoidable. In some areas of the country hospitals and nursing facilities refuse to contract with hospices therefore the need to discharge a patient is out of the hands of the hospice despite any communication and coordination that would be deemed effective. Additionally, some rural areas a patient may transfer to a hospital in an area in which is hospice is not licensed to practice necessitating discharge. This does not account for any literacy and health literacy barriers a hospice may face when dealing with patients and families in areas that are underserved by healthcare generally. 5. *Unadjusted Numerator Number of live discharges that are followed by death within 30 days or a hospitalization/ emergency room visit/observation stay within 7 days of hospice discharge.* This assumes every hospitalization; emergency room visit and observation stay is not part of the patient's preference and is avoidable, If the local healthcare institution fails to contract or accept hospice payment for services, the patient must be discharged as out of the service area. Patients may require procedures as part of their course of care that cannot be delivered in the home. If the hospice is fortunate enough to have a contract with a nursing facility that meets the requirements for providing GIP level of care for hospice patients, they too may not have the ability to provide all procedures a hospice patient may require as part of their course of care. 6. *Adjusted Numerator: The construction of the risk adjusted numerator uses a statistical model estimated on the national data for all included hospice stays.* There is so many variables and statistics involved that could not be validated by the hospice without consultation to a statistician or epidemiologist or specific statistical software it is unfair to assume hospice providers have resources to do validation, yet are given the opportunity to		

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		comment and make recommended changes to data prior to it being publicly available. Currently, the hospice compare website has flaws, errors and miscalculations with much simpler explainable measurements that should be resolved prior to attempting to publish any measure with so much complexity to the calculation. Current CAHPS data does not allow for accurate validation by hospice programs if they choose to use their data in a true performance improvement processes- all surveys not statistical sampling for example. 7. *Adjusted Denominator: The denominator for this measure is computed the same way as the numerator, but the hospice effect is set at the national average.* Nope then it's not the same its computed differently to establish the "hospice effect". So, you are making assumptions somehow that "hospice effect" is different in the denominator than the numerator within the same measurement. Once I had to digest the pages and pages of statistical information and read it over and over so I could try and translate into an understandable way for my team, it was evident that this is not meant for public consumption. There is no way someone can explain this simply enough for the public to understand that data is going to *be* pulled, ran through a computer and hospices are going to be identified as "outliers" for services they are no longer able to control/case manage etc. There were over two pages of attempted explanation of what was going to happen to determine a score. Then you get a score and low score is better which is totally opposite of any other hospice quality measures published on the compare site just to add to the confusion. Then it gets calculated through an algorithm that has six steps of formulas.		

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		Feasibility Yes, claims data is readily available — hospice claims data has its built-in problems with sequential billing so the timing of the calculation may be considering claims that will require adjustment. How often is this data going to he produced? Is there going to be re-measurement to consider sequential billing? Quality measure feasibility for specific providers is generally captured in clinical care they are providing but that is not the case in this proposed measure. Usability and Use Hospice Compare — you never mention that this data could be misused and misunderstood by consumers since low is better, and even if they understood that concept they can take this data to mean that a hospice with a low score will not allow you to have a strong voice in you care choices. It also fails to mention that this can impact hospice's willingness to accept patients who have not yet decided on their advance directives. For a quality measure for a specific provider type to be usable and actionable it generally could be acted upon and responded to, that is not the case in this proposed measure. Importance For Measures to drive improvement they generally effect large populations. Live discharges in hospice constitute less than 17% of the hospice population. In fact, the most recent PEPPER report lists an all live discharges for the Medicare Administrative Contractor region to be less than 15% for the most recent reporting period. This measure is not designed for a large population and is designed in an		

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		area of the hospice benefit that allows a patient or family to resend at any time without restrictions. Scientifically acceptable I have no doubt the method is acceptable I just don't know that the measure is scientifically acceptable and would request that it be Evaluated by NQF prior to implementation. A more suitable hospice quality outcome measure would be how many hospice patients have an advance directive upon admission, and how many hospice patients have an advance directive at discharge. As stated previously, a more suitable place to develop this utilization measure would be within the construct of the hospice Program for Evaluating Payment Patterns Electronic Report (PEPPER). This report already addresses Live discharges in a multidimensional way including: • Live discharges no longer terminally ill • live discharges due to patient revocation, • live discharges that occur between 61-179 days, • a global summary of live discharges by live discharge type. In all cases there is a comparison to the Medicare Administrative Contractor Jurisdiction. There are also national comparisons on most measures with percentile thresholds to assist the hospice provider in identifying potential issues with suggested monitoring and auditing activities. The CMS contractor who manages this process has experience in weeding through the potential for multiple claims submissions that may occur for the same dates of service due to the sequential billing requirements in the presence of pm-established benefit periods that can be shortened by the patients choosing to revoke their hospice benefit. This *can* become very complex and difficult in the *presence* of a person who		

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		chooses to return to the hospice benefit and chooses a different hospice to come back onto that hospice benefit.		
26	4/25/2018	The National Partnership for Hospice Innovation (NPHI) is a collaborative of many of the nation's most innovative, community-integrated, not-for-profit hospice and palliative care providers that serve as a critical safety net in communities across the United States. In coming together, we work to identify, enhance, and spread the best practices in which our members are engaged. NPHI members have decades of experience in providing the highest-quality hospice and palliative care to those facing the final stages of their lives. Of the over 4300 hospice providers in the United States, only 29 percent are not-for-profit,1 but they serve the sickest and most vulnerable patients in our communities and refuse to turn any patient away regardless of their terminal condition or ability to pay, while still providing a comprehensive scope of care to meet each patient's goals, values, and wishes during their last stage of life. Many of our programs have their own inpatient units, serve patients who have no caregivers themselves and even have programs serving the homeless—playing a critical role at the end of life for those who have no alternative supports and who could otherwise go without care during this critical time. This commitment to serve as needed and high-quality safety net providers for those in our communities who need hospice care is not only fundamental to our mission, but also distinguishes us as leaders in hospice whose innovative programs reflect the original intent of the Medicare Hospice benefit. Our members are longstanding and integrated members of their communities and have participated in the Medicare Hospice benefit since its inception. They are committed to the continued improvement and mission of the Medicare hospice benefit. In support of this collective mission, we are pleased to offer the following comments on the development of the draft *Transitions*	Tom Koutsoumpas, President and CEO National Partnership for Hospice Innovation	jrichardson@hospiceinnovations.org

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		from Hospice Care, Followed by Death or Acute Care measure for the Hospice Quality Reporting Program. **Comment on measure development process** We urge CMS to submit this measure to the National Quality Forum (NQF) endorsement process, as it has for all but one of the measures currently in use for the Hospice QRP. The measure's specifications will be improved by going through NQF's transparent, scientifically rigorous, and consensus-based endorsement process. Before the measure is deployed, we assume CMS will use the standard regulatory notice-and-comment process to seek (in a proposed rule) and respond to (in a final rule) public comments on the measure's final specifications and intended use in the Medicare program. **Comments on measure specifications** We agree that the concept of measuring the rate of live discharges is appealing. Our hospices and others that carefully enroll patients who meet the Medicare hospice benefit eligibility criteria, and then deliver end-of-life care that is consistent with the patient and family's expressed preferences and the rules of the benefit, should have relatively low rates of live discharges. These high-integrity hospices, like those who are members of NPHI, make sure that their patients who have made a hospice election are well educated on their options and what hospice election means. In contrast, hospices with relatively high rates of live discharges are likely enrolling patients who do not meet the benefit eligibility criteria or are failing to provide palliative care in a way consistent with patients' preferences. *The proposed specifications mix together quality of care and program integrity measurement* We believe that the measure as proposed would capture both quality of care and program integrity issues. These are two entirely different concepts and should be reported separately. In reviewing the measure		

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		specifications, the fundamental question is which kinds of discharges should be included and which should be excluded? More specifically, which kinds of discharges indicate that a hospice may be providing sub-par quality of care as opposed to a hospice with poor adherence to the Medicare hospice benefit's eligibility and enrollment rules? Both kinds of performance are important to measure, but the first is a *quality of care* measure and the second is a *program integrity* measure. As proposed, the measure specifications do not differentiate between these two kinds of activity. The following suggested changes would focus the measure on quality of care rather than on program integrity. If CMS decides that it is appropriate for the measure to capture both types of activity, we urge the agency to add it as a measure in the Program for Evaluating Payment Patterns Electronic Report (PEPPER), not in the Hospice Quality Reporting Program. As a PEPPER measure, this could provide actionable insights into potential program integrity issues, such as compliance with hospice eligibility requirements and ability to provide access to all levels of care under the Medicare hospice benefit. *Discharges initiated by the patient should be excluded* A quality measure should reflect actions that are (or should be) under the control of the provider being measured. In this case, this principle means that live discharges that are the result of a patient revoking his or her election of the hospice benefit or moving out of the hospice's service area should not be included in the proposed measure. It is not clear from the measure specifications if the measure numerator would include discharges that result from beneficiary revocations. The Medicare hospice regulations are clear that "an individual or representative may revoke the individual's election of hospice care at any time during an election period." (42 CFR §418.28(a)) Despite counseling and recommendations from the		

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		hospice, patients continue to have a right to revert to the traditional Medicare benefit at any time. Their choosing to exercise that right should not be a direct reflection on the quality of care provided by the hospice. Similarly, when a patient is discharged after they choose to move outside a hospice's service area, those discharges also should be excluded from the measure. However, every day our members see other hospices in their service areas engaging in poor behavior that may result in a "beneficiary revocation" and we appreciate CMS's attempt to quantify this behavior in a measure. For example, Medicare Payment Advisory Commission (MedPAC) makes note in its most recent report that a CMS contractor recently found live discharge rates increased among some hospice providers as these providers approached or surpassed the hospice aggregate payment cap.2 Some of these live discharges are coded as "beneficiary revocations" based on those providers' not providing a full continuum of care under the hospice per diem but preferring instead to counsel patients that discharge to another setting would be better for them (and for the hospice's bottom line). The patient therefore revokes their hospice election in order to access care aligned with his or her goals and preferences rather than having it provided by the hospice. We strongly urge CMS and its program integrity contractors to use this behavior as an indicator of problematic behavior that warrants monitoring and investigation. We do see the pattern of discharging alive rather than providing a holistic scope of care as an indicator of poor quality, but the measure being proposed to identify this behavior is not sensitive enough to be used as an indicator of quality at this time. We stand ready to work with you to implement the suggestions in this letter and on other tools to measure that type of quality. *Period for discharges followed by inpatient hospital admission should be shortened* Discharges from hospice followed by an inpatient hospital admission may occur for a variety of reasons, some of which may be related to		

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		the hospice's quality and some of which may be due to factors beyond their control, such as the refusal of hospitals in their service area to contract with them for beds to provide General Inpatient Care (GIP). One way to focus the measure on factors closer to a hospice provider's control would be to reduce from 7 days to 1 day the period during which an inpatient hospital admission, ED visit, or observation stay would be counted in the measure numerator. This approach still would not completely account for the contracting practices of the hospitals in a hospice's service area. This issue underscores the point that the proposed measure is at best a crude measure of care quality because it will be next to impossible to adjust for all the factors that are beyond a hospice's control. *Period for discharges followed by death should be shortened to 7 or 14 days* Hospices must carefully evaluate their patients' clinical conditions when deciding whether to admit them and periodically thereafter to make sure they continue to meet the benefit's eligibility criteria. Some patients' conditions improve while they are receiving hospice care to the point where they no longer meet the eligibility criteria but are still severely ill and medically fragile. Our members' experience is that a significant portion of their patients appear to be relatively stable, are therefore discharged from hospice for no longer meeting the eligibility criteria, and then die within a matter of a few weeks. Many of these patients would be captured in the 30-day post-discharge period of the current measure specifications, which does not seem to be a fair measure of the hospice's quality of care. This is particularly true in the current regulatory environment, in which Medicare contractors' erroneous interpretation that patients must be experiencing continuous decline in order to be hospice eligible is forcing live discharges from hospice that are not consistent with the intent or letter of the law or regulations. A shorter period, such as 7 or 14 days, to observe post-discharge deaths would still capture inappropriate discharges of medically unstable patients, while excluding patients		

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		who are discharged in relatively stable condition but still seriously ill and facing imminent end of life. *Discharges to certain inpatient provider types, such as VA and psychiatric hospitals, should be excluded* Certain discharges from hospice to an inpatient hospital followed by death may be planned and in accordance with the patient's plan of care. One of our member hospices is a preferred provider for the local Veterans Administration health system, and many patients referred by the VA are admitted to this hospice with a plan for the hospice agency to care for them at home for as long as possible and then to transfer them to the palliative care unit of a local inpatient VA facility for their final days. This would of course appear to Medicare as a live discharge followed by death within 30 days. We recommend excluding patients discharged to palliative care unit of an inpatient VA hospital so as not to penalize hospices who have a relationship with their local VAs and would be more likely to admit patients with this sort of plan for end of life. **Comments on risk adjustment methodology** *Risk adjustment methodology should include language spoken at home* We appreciate that the risk adjustment methodology CMS and RTI propose would include several patient-level risk factors that are outside hospice providers' control but that can influence the measurement results, such as age, gender, race/ethnicity, and principal diagnosis. Based on our members' experience with culturally diverse patient populations, we suggest including "language spoken at home" as a risk adjustment variable. For example, one of our members has a program for Russian-speaking patients and a program for Chinese-speaking patients, and they observe markedly different preferences for live discharges followed by acute care utilization among these groups compared to patients in other ethnic groups. The language spoken at home would be a proxy for the cultural beliefs and		

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		practices that influence individuals' use of hospice care at the end of life. A potential data source for this variable is the U.S. Census Bureau American Community Survey (ACS) county-level data on "Detailed Languages Spoken at Home and Ability to Speak English for the Population 5 Years and Over: 2009-2013"3 and subsequent updates. The risk adjustment algorithm could include a variable of the concentration (either absolute percentage or an index relative to the national average) of non-English languages spoken at home in each county in a hospice's service area. While the Hospice CAHPS survey includes language spoken at home questions, our members' experience is that this information is not consistently reported, and it would not be a reliable data source for this purpose. 3 Data at https://www.census.gov/data/tables/2013/demo/2009-2013-lang-tables.html (accessed April 24, 2018). 4 Data at http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx (accessed April 24, 2018). *Risk adjustment methodology should include variable indicating State Certificate of Need (CON) law* State CON laws can affect whether a hospice provider must discharge a patient who has been admitted to a nearby inpatient hospital that is outside of the hospice's service area. We suggest RTI explore the impact of adding a binary (yes/no) variable to the risk adjustment algorithm reflecting the presence of a State CON law that includes hospice providers. *Risk adjustment methodology should include presence of patient "DNR" code* The presence of a "Do Not Resuscitate" (DNR) code for a hospice patient is another variable beyond a hospice's control that should be included in the risk adjustment methodology. All else being equal, a patient's DNR code would affect a hospice's rate of deaths within 30		

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		days following discharge. It is our understanding that DNR codes are not included in Medicare claims data, but we urge RTI to investigate if other Medicare data sources that capture whether a beneficiary had a DNR code could be added to the measure's risk adjustment formula. **Comment on public reporting of measure results** *Public reporting should compare providers' live discharge rates to state or regional average* Utilization of Medicare hospice services varies significantly across states and regions of the United States.5 This fact and our members' experiences suggest that rates of live discharges from hospice also vary considerably from region to region, state to state, and even within a state, such as between a state's urban and rural areas. A quality measure that is publicly reported to help individuals make decisions about where to seek care should be displayed in a context that helps the consumer of the information make sense of the results. A live discharge rate that appears high compared to the national average may be near or below the live discharge rates for all the other hospices in the local area. Simply put, comparing an agency's rate only to the national average may not be helpful to beneficiaries seeking local hospice care. If the intent of the measure is to highlight when a hospice's rate of live discharges is significantly higher than the national average, that would raise program integrity issues and should be addressed as such. **Conclusion** We appreciate the opportunity to provide these comments and we look forward to working with CMS and RTI on further developing this important measure of hospice quality.		
27	4/25/2018	***Proposed Measure - Transitions from Hospice Care, Followed by Death or Acute Care*** ***Proposed measure:*** *will estimate the risk-adjusted rate of transitions from hospice care, followed by death within 30 days or acute care use*	Beverly Montoya, RN CHPN, Clinical Process Specialist for Hospice	bmontoya@txhha.com

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		within 7 days. Specifically, the measure reflects the rate of live discharges from hospice that are followed by death within 30 days or a hospitalization/emergency room visit/observation stay within 7 days of hospice discharge. The measure is risk adjusted to "level the playing field" to allow comparison based on patients with similar characteristics between hospices. ***Goal of this measure:*** *identify hospices that have notably higher rates of live discharges followed shortly by patient death or acute care utilization, when compared to their peers.* **Denominator Statement and Details** *Eligible Stays (Unadjusted Denominator)* • The eligible stays for this measure are discharged hospice stays among all Medicare FFS patients not excluded for reasons listed in the report. In addition to the ones mentioned, we recommend that these reasons be added to the proposed types of live discharges to be excluded from the calculation list: o Revocations o Moved out of service area o Transfer to another hospice We recommend excluding these reasons because: • The ***Transitions from Hospice Care, Followed by Death or Acute Care*** *HIS* measure infringes on the Medicare beneficiary protections that allow for patients to "choose" their hospice agency and to revoke the benefit if desired or needed. Medicare Beneficiaries have the right to revoke the hospice benefit at any time during their care. Hospices do not have control over the patient's decision to remain on hospice, and revocation of the benefit or the right to choose to transfer to a different hospice due to a move (moving to live close to or with a family member for additional end-of-live support) is indicative of an opportunity to improve their quality of life and minimize discomfort. Additionally, patients living in rural/underserved areas may seek ER/hospital		

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		care due to limited alternatives for care providers once discharged from hospice. • Medicare acknowledges the patient's right to change course and seek definitive treatment. This action by the patient requires discharge from hospice, as this is no longer a palliative course. There will be some patients who do not benefit from their renewed treatment and may require hospitalization or possibly die from their decision to seek treatment. How will this situation be detected among the live discharge data of a hospice? • Therefore, we recommend that the live discharge reasons related to "revocation of the hospice benefit" and "transfer to another hospice due to a move" be a "carve-out" from the calculation of the Transitions measure. These reasons do not accurately reflect on the quality of care provided to the hospice patient. Beneficiaries have no choice but to revoke their hospice benefit when being admitted to hospitals/facilities which refuse to contract with the hospice provider. **Risk Adjustment Variables and Usability and Use** Despite Risk adjustment to "level the playing field' and accounting for discharges across hospices as stated, this indicator is misleading to the public and does not represent a true "quality of care" measure as much as it represents a utilization measure. It is not clear how the hospice should take these results and effectively use them to "improve their performance" in this measure. • The ***Transitions from Hospice Care, Followed by Death or Acute Care*** HIS measure does not reflect the improved quality of care provided by the hospice. Many patients experience an improvement following admission to hospice care due to better control and management of debilitating symptoms. This can result in longer life expectancies and appropriate discharges from hospice. Hospice patients that are discharged for extended prognosis within certain disease processes may suddenly die, even		

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		though the hospice physician and interdisciplinary group believes that the disease trajectory has "flattened out" or plateaued. • The ***Transitions from Hospice Care, Followed by Death or Acute Care*** HIS measure is misleading to the public and misrepresents the value of the high quality of care delivered as opposed to poor quality. This is counter-intuitive to the purpose of the measures to assist potential patients and families to make informed choices in their selection of a hospice. In addition, hospice agencies could potentially screen patient histories of repeated revocations and ER visits/hospitalizations, and decline to admit these "high risk" patients onto hospice services, restricting these patients' equal access to hospice services. Ex: COPD patients with history of multiple revocations to seek emergent aggressive care.	AccentCare, Inc.	
28	4/25/2018	AseraCare Hospice provides hospice and palliative care services to patients and their families in multiple states. We welcome this opportunity to provide input to CMS as you develop a measure examining the transitions from hospice care. As the authors of this measure point out, while live discharge rates from hospice have declined over the last few years, approximately 25% of providers nationwide report a live discharge rate in excess of 30%. While we share CMS' concern with these numbers, we urge you to proceed carefully in adopting this measure, closely vetting and reviewing it to ensure it accurately reflects the quality of care provided. Initially we would point out that there are numerous reasons why hospice beneficiaries are transitioned to another setting, including those involving a live discharge, which in many instances may include a revocation by the beneficiary. Some live discharges then, result from reasons entirely outside the control of the hospice provider. Because there is no distinction made in the measure for the various reasons which trigger the live discharge, we urge CMS to include additional language explaining why all live discharges, including revocations, are reflected in the measure.	Candy Bartlett, Government Relations Consultant AseraCare	Robin.Bartlett@goldenliving.com

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		Secondly, we note that confusion continues to abound in the provider community regarding the use of live discharge when a transfer may more accurately reflect the reason for a patient's transition. As you are aware, this is significant because a patient being transferred loses no days in their benefit period while a live discharge triggers a new benefit period. We suggest that discussion of the differences between and consequences of the use of a transfer versus a live discharge be included in the materials accompanying the new measure. Third, AseraCare Hospice has participated in the development of comments being presented on this measure by both the National Association for Home Care and Hospice (NAHC) and the National Organization for Hospice and Palliative Care (NHPCO). We urge you to give careful consideration to their comments. Finally, because of the impact this measure will have upon hospice providers, hospice patients, their families, and patients considering hospice services, we urge CMS to provide as much transparency around the development of the measure as possible, disclosing all data reviewed. Thank you for your attention to the concerns of AseraCare Hospice.		
29	4/25/2018	Kaiser Permanente offers the following comments on the draft Hospital Quality Reporting measure. We appreciate the opportunity to provide feedback. The Kaiser Permanente Medical Care Program is the largest private integrated healthcare delivery system in the U.S., delivering health care to nearly 12 million members in eight states and the District of Columbia.1 Kaiser Permanente is committed to providing the highest quality health care; we believe that appropriate quality measures, sound methodology and a well-structured quality rating system will help consumers make informed choices in selecting health coverage through the Exchanges.	Patrick T. Courneya, MD Executive Vice President Kaiser Foundation Health Plan	Lori.Potter@kp.org

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		CMS has requested input on a new Hospice Quality Reporting measure, specifically, an adverse outcome measures that looks at the percent of fee-for-service (FFS) patients who die within 30 days or who have a hospitalization/emergency room visit/observation stay within 7 days of hospice discharge. It is limited to FFS patients only, because the variable/s to link discharge with death or readmission, as well as some of the variables used for risk-adjusting, are taken from FFS claims data. Kaiser Permanente believes that a measure of death following live discharge from hospice will provide valuable insights for an overlooked patient population. All current HQRP measures include all payers, so we encourage CMS to look for alternative data methodologies, as the current proposed methodology would provide insights for only a subpopulation of hospice patients, and may not be generalizable to all live discharges. This definition (deriving data from Medicare FFS only versus all payers) creates an inconsistency with the other publicly reported measures on *Hospice Compare* that may confuse users who want to compare among measures; RTI/CMS may want to consider the use of Hospice CAHPS or similar survey for the live discharge patient population as a means of obtaining additional insights to this population of patients. **CONCLUSION** Kaiser Permanente looks forward to working with RTI/CMS to support QRS development and implementation. Thank you for considering our comments.		
30	4/25/2018	On behalf of the more than 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on the Draft Hospice Quality Reporting Program measure "Transitions from Hospice Care, Followed by Death or Acute Care." AAHPM is the professional organization for physicians	Tammie E. Quest, MD FAAHPM, President American Academy of Hospice and Palliative Medicine	kast@aahpm.org

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		specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, and other health and spiritual care providers deeply committed to improving quality of life for patients facing serious illness, as well as their families and caregivers. AAHPM appreciates the effort CMS has made to implement a new outcome measure to assess hospice performance under the Hospice Quality Reporting Program. Indeed, in response to a solicitation last year regarding a measure on potentially avoidable hospice care transitions, AAHPM encouraged CMS to consider measures like this one that assess undesirable outcomes after discharge, rather than focusing on hospice transition rates alone. This new measure may assist in identifying hospices that have not provided certain levels of care to any patient, as demonstrated by table 12-8 in the March 2015 *Report to the Congress: Medicare Payment Policy* from the Medicare Payment Advisory Commission (MedPAC). Highlights from this table include (Source: MedPAC analysis of 2013 Medicare claims data from CMS): • 28% of all hospices provided no general inpatient care for any patient • 58% of all hospices provided no continuous home care for any patient • 25% of all hospices provided no inpatient respite care for any patient • 19% of all hospices provided no general inpatient care or continuous home care • 12% of all hospices provided no general inpatient care, continuous home care, or inpatient respite care It is our hope that data from a measure such as “Transitions from Hospice Care, Followed by Death or Acute Care” may pinpoint those hospices who did not provide the necessary services (general inpatient care, continuous home care) to patients in hospice who are closer to end-of-life or are imminently dying. We also appreciate CMS’ interest		

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		in minimizing administrative reporting burden by hospices. At the same time, AAHPM has some reservations about this measure and some potential unintended consequences that may arise. To begin, the measure specifications clearly state that the outcomes captured by this measure are not considered "never events." We agree with this statement and have concerns that it may complicate assessment of hospices based on their performance on this measure. It is not clear what the appropriate performance rate should be and whether individual hospices' performance reflects the quality of care they deliver or, for example, differences in patient and caregiver needs or preferences. Likewise, social risk factors may also contribute to differential outcomes among hospices, leading to poorer performance for hospices that disproportionately serve low-income beneficiaries. And while we recognize that this measure seeks to address those hospices that "have notably higher rates of live discharge followed shortly by patient death or acute care utilization, when compared to their peers," CMS does not specify what level of outlier performance would flag a hospice as requiring additional scrutiny. Rather, CMS states that "lower scores indicate better quality," which would not necessarily be true at the low end of the distribution. We are also concerned about the unintended consequences that may accompany this measure. Given the measure's focus on individuals discharged from hospice, the measure could create incentives for hospices to pressure patients to remain in hospice, which would not support the patients' right to choose regarding end-of-life care. Additionally, as CMS notes, this measure may also lead to patient selection by hospices, reducing their willingness to enroll patients with certain diagnoses or residing in certain care settings. While risk adjustment may address this issue in part, there have long been shortcomings in risk adjustment for seriously ill patients, such that risks for patient selection will likely remain. For example, the proposed risk adjustment methodology does not include information on important factors such as cognition, functional status, or		

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		socioeconomic status – all of which can have significant impacts on patient outcomes. In addition to concerns about the validity and unintended consequences of this measure, we are also concerned about how this measure would be communicated to the public on Hospice Compare – a challenge that was not addressed in the solicitation. The measure specifications and results are complex, and the lack of information on an appropriate benchmark further complicates the effort to explain this measure to consumers. **Given all of the above, AAHPM urges CMS to implement this measure in a measured and cautious manner.** We believe that significant additional information is needed to understand whether the measure is valid and reliable (including its use of risk adjustment), what the target performance rate should be, and whether the measure creates the right incentives to provide high value care. **We believe that this will require multiple years of testing and validation prior to its readiness for public reporting.** Once the data support the use of this measure, **we urge CMS to work closely with stakeholders to ensure that performance on the measures can be translated into reliable, meaningful, and actionable information for reporting on Hospice Compare.** Thank you again for this opportunity to provide feedback. We look forward to further engagement on this important issue.		