

## **Hospice Quality Reporting Program (HQRP) Forum**

August 5, 2020

Hello, everyone. Thank you for joining today's Hospice Quality Reporting Program Forum. During this webinar, CMS and their measure developer Abt Associates will discuss the new composite quality measure concept, the Hospice Care Index. At the end of the webinar, there will be a question and answer session. We will address questions received via the questions tab and over the phone line, and we will address as many questions as time allows. Please note the slides from today's presentation will be posted on the Hospice Quality Reporting Training website in the coming weeks. Now I will turn it over to Cindy Massuda, Hospice Quality Reporting Program Coordinator at the Centers for Medicare & Medicaid Services.

Thank you very much, and welcome everybody. I am Cindy Massuda, the Coordinator for the Hospice Quality Reporting Program, or HQRP, at CMS's Center for Clinical Standards and Quality. Welcome to today's Hospice Quality Reporting Program Forum. CMS is interested in creating a balanced measure portfolio for the HQRP comprising different measure types and data sources. Today, we will discuss a new claims-based composite quality measure concept that CMS is considering including in the Hospice Quality Reporting Program. The new measure concept is referenced in this presentation as the Hospice Care Index. Next slide, please.

On behalf of CMS, I want to thank Ketchum for their outstanding work supporting this webinar. To discuss this quality measure concept, I'm joined by two Abt associates that are part of the Hospice Quality Reporting Program team members. Abt Associates is the contractor supporting the Hospice Quality Reporting Program, which includes the development of the Hospice Care Index, or HCI. Our first Abt speaker is Zinnia Harrison, a Senior Associate at Abt, and TJ Christian, a Senior Associate and the Hospice Quality Reporting Program Quality Measures Lead. Next slide.

Yes, on this slide -- we're on slide 4 -- you're able to see all the acronyms that we're going to be using during today's presentation. They're defined here. Next slide.

I'm now going to turn it over to Zinnia. Thank you very much.

Thank you, Cindy. Good afternoon, everyone. We'd like to begin by providing some background for the new Hospice Care Index quality measure concept. The concept and idea we're sharing today because we're interested in your perspective, your ideas, and sharing how your hospice might use claims data for the purpose of quality measurement. Next slide, please.

As many of you have heard through the past HQRP Forum webinars or communications, CMS designed HQRP to be comprehensive and holistic for measuring hospice performance, encompassing the many aspects of hospice care and the interdisciplinary team. This way, HQRP can help hospices focus on providing the best possible care for their patients, specifically under development as a patient assessment instrument and quality measures that take the patient, family, or caregiver electronic health record or other health IT into account. Next slide.

The Social Security Act established HQRP as a pay-for-reporting program to promote the delivery of patient-centered high quality care. Currently, the HQRP is calculated using data collected from the Hospice Items Set, or HIS,

and the Consumer Assessment of Healthcare Providers and Systems Hospice Survey, or Hospice CAHPS. Let's take a closer look at each of these components. Next slide.

The HIS measures, the process at admission and discharge. The process includes the interdisciplinary team's approach. In addition to this aspect, the CAHPS Hospice Survey data is used to measure patient and caregiver experiences with hospice care among those patients who died under hospice. Together, these two components make up HQRP. We have the processes at admission and discharge, and also the overall experience after the patient has passed away. Next slide.

In looking at HIS in more detail, we can see on the slide, for example, there are specific process measures capturing the preferences, beliefs, and values, as well as the clinical aspects, such as pain and dyspnea, or shortness of breath. These process measures where the interdisciplinary team processes are captured. On the right side of the slide, as I mentioned, CAHPS Hospice Survey measures the primary caregiver's experience and perspective after death. More specifically, there are measures related to how the interdisciplinary team contributed to the hospice experience. CAHPS asks about the willingness to recommend the hospice, communication with the family, getting timely help, and being treated with respect, as a few examples of the contributions of the interdisciplinary team. Because the CAHPS Hospice Survey collects the primary caregiver's perspective directly, this is considered the gold standard. Next slide.

I'd like to turn your attention to the graphic on this slide. Our team assessed where there are gaps in quality measures. HIS-based quality measures capture the hospice team's process at admission and discharge noted at the bottom of the graphic. For CAHPS Hospice Survey, there are measures to reflect the patient, family, and caregiver experience after the hospice stay. Therefore, HQRP has a quality measure gap during the hospice stay depicted by the yellow arc in the graphic. To bridge this gap, we looked at available data sources that could support developing a measure. Claims data is the best available data for measuring care during the hospice stay. Claims data is readily available, reducing provider burden for implementation. Claims also account for care delivery decisions and actions as they occur, giving consumers a more timely reflection of care quality and other existing measures. Other measures, such as HIS and CAHPS, are administered at or after discharge and asked about care after it's been delivered. Because claims data serve the interests of these diverse stakeholders, many other Medicare programs already utilize claims-based quality measures. As part of the gap analysis, we also considered -- Oh, I'm sorry. Next slide.

As part of our analysis here, we considered the non-hospice quality reporting programs to inform our work. There are 11 quality programs that have at least one claims-based measure noted on the left. To give an example of how claims are used for these quality reporting programs, we see claims data used for readmission quality measures and Medicare spending measures. The Hospice Quality Reporting Program is the only Medicare program without a claims-based measure at this time. Next slide.

So, why specifically is CMS interested in developing a claims-based index measure? In the fiscal year 2020 hospice rulemaking, CMS discussed the transition measure and access to levels of care measure, as well as public comments in the two measure concepts. The comments discuss the limitations

of claims-based measures that are single-measure capacity that do not depict all circumstances. The Hospice Care Index assesses a broad and holistic set of hospice care processes, not otherwise addressed in the HQRP measures. That is, there could be more explanations for a hospice's score performance for that single measure in claims information to convey. So, in considering the public comments in the development of a claims-based measure, CMS developed a measure concept that does not rely on a single measure based on claims. Rather, the Hospice Care Index measure concept that is based on multiple claims-based indicators as a composite or an index. And using the multiple indicators helps identify differences or variability between hospices. This composite concept is not new. The current HIS base comprehensive assessment measure is also a composite. Next slide.

So, at this point, I'd like to turn to TJ to dive deeper into this concept.

Thank you, Zinnia. Hi, guys. It's TJ Christian. Before we get started, we noticed a lot of people were asking about accessing the slide materials, and I was just asked to mention that all materials will be posted to the HOPE webpage after today's webinar, so you should be able to access them through there. Okay, great. So, as Zinnia had alluded to just now, our objective in designing this measure is to implement a framework by which CMS can capture many aspects of hospice care through a new set of claims-based indicators which represent various dimensions of care. Since the index is a composite of indicators or individual measures, you could think of it as the existing comprehensive assessment measure in the HQRP right now calculated from HIS records. Next slide, please.

Great. So, for the Hospice Care Index itself, we believe its indicators, like the individual measures that comprise the comprehensive assessment measure, will add value to the quality reporting program by filling in the gaps that Zinnia mentioned. This index will complement the existing measures in the quality reporting program, provide additional information that is useful and important to caregivers and families. Lastly, because the claims data is already collected, as Zinnia mentioned, the program would be able to add this value without additional burden to patients or providers. Claims data is a rich source of information about the services hospices provide patients. We are seeking info why and how this information can be used to measure the quality of care hospices provide to patients and caregivers, and venues like this are an important means by which we hope to gain feedback and suggestions.

We had previously heard from hospices that claims data can provide insights into their utilization patterns and practices, which can help to differentiate among hospices when consumers are looking to make a choice for care. Insights from claims data can also help hospices identify practice concerns and facilitate their own internal quality improvement efforts. So, lastly, I would mention quickly about our testing strategy, and for developing this measure, that would be to verify that the final index score for a hospice aligns with patient and caregiver perspectives as captured by the hospice's CAHPS outcome scores. We view this as an important step to ensure we're producing a useful measure for the public. We want to be sure that the care processes captured by this index measure are those that resonate with patients and caregivers. We view that alignment between this index measure score and CAHPS responses -- it would support this linkage, that alignment. And that itself will support this index's validity as a construct. Next slide, please.

Great. So, we had mentioned that potential indicators would be calculated from claims data. So, potential topics of interest for the index that claims could provide information on include, in the graphic here, but certainly not limited to: the extent and frequency of visits provided by various hospice staff, the amount of resources and services utilized per beneficiary, access to all levels of hospice care, and examining transitions after leaving hospice and/or readmissions back. So, I would like to very much underscore that these are just some potential topics that could be observed in claims data. And there's certainly other topics and we are very much seeking input on that and suggestions from you. So, particularly, if there are other ideas you may have or even among these topics, if you have opinions on whether or not they might be helpful to consumers. Next slide, please.

Great. Thank you. So, I'm on slide 16, for folks following along on the audio. Let's consider the design concept and how the index is actually scored. As I mentioned, there would be a number of indicators collected using claims information. Also says we get scored individually on each of their indicators. Then each indicator would have a defined criterion, which triggers a score. Among all the indicators, we would score a hospice provider as the number of indicators that the hospice met of the threshold's criterion. So, for this index, hospices scoring below the threshold is a good thing, since it means it didn't meet the particular threshold.

So, if we use a graphic as an example, let's say that there were four indicators, and each thermometer here represents a different indicator of the four. For this hospice, we see that out of the four indicators, only one met the threshold as represented by the red thermometer. The other three thermometers represent three other indicators, and the hospice did not meet the threshold criterion for each of these three indicators, represented by them not being red. So, in effect, the Hospice Care Index would count only the number of red thermometers that each hospice has, and that count would be the particular hospice's score. So, again, in this example, this particular hospice has one of four total indicators above the threshold. So, thus, the hospice would be given an index score of 1. If there were, in this example, two red thermometers, the score would be 2. If all were red, the score would be 4. Conversely, the hospice could also score zero if there were no red thermometers at all. And kind of last thing to point out, this particular example has four indicators, but we could certainly have as many or as few indicators as there were claims-based topics worthwhile to include, and that would also mean that they were shown to sort of validated well and aligned with patient, family, and caregiver input. Next slide, please.

And I'm on slide 17. So, to further our hypothetical example, let's check with sort of the previous graphic and say we have four indicators. We envision designing meaningful thresholds that would very likely be, by design, rarely crossed. And thereby, we anticipate most hospices would perform very well. Sort of in the products of the previous example had few to no red thermometers. This would be represented by the darker blue section of the 89.5% of hospices, which scored between zero and three indicators, or red thermometers present. So, definitely note that this is illustrative, but we anticipate a significant majority. So, to get in that lighter blue section of the pie, a hospice would have to meet multiple indicator thresholds criterion consistently every time. This would happen more rarely. By design, we anticipate the index helps differentiate, between the dark and light blue, the 9 and 10 majority of hospices that perform well from that rarer segment that have room for improvement. Those rare hospices, again,

represented by the lighter blue section, met the indicator threshold of the red thermometer for all four of their hypothetical indicators, again, meaning they underperformed across multiple dimensions of hospice care simultaneously. Next slide, please.

Great. So, it's on 18 now. I think at this point, Zinnia, Cindy, and I would like to start an open dialogue with you all. I guess we can go to the next slide, too, please.

And just really to get us started, we have come up with a few discussion questions which we would like you to consider and which we're particularly welcoming your perspective on. So I'll just kind of read through these very briefly.

Essentially, we're interested in what are your thoughts about this Hospice Care Index measure concept? If you have any thoughts on an index measure that captures several aspects of care simultaneously, compared to a measure looking at just one topic individually? What kinds of claims-based indicators might you like to see included in the Hospice Care Index? What aspects of hospice care that are not already included in the Hospice Quality Reporting Program do you think CMS should measure that consumers would find useful? And as a hospice, does your organization use claims data to measure quality? And if so, how? So, you're welcome to submit any additional thoughts or questions that you might have through the webinar's chat function. But at this point, I would like to turn the presentation over to our colleagues at Ketchum to begin the question and answer session.

Great. Thanks, TJ. So, as TJ mentioned, we will now begin the question and answer portion of this webinar. So, to ask a question, you can use the hand-raising icon, and that will enable us to unmute your line and you can ask your question over the phone. Or you can type your question into the questions box, and we will read your question aloud. Just a reminder, we will address as many questions as time allows.

So, our first question is, "How will data on non-billable discipline visits be captured as part of the quality care assessment process?"

This is TJ Christian. I will take this. So, I think essentially the data would be from Medicare claims. I guess the information that we'd have available to us would have to be recorded on Medicare claims. If it wasn't recorded on claims, I think we wouldn't be able to include such a topic in this measure. So essentially -- if that answers the question. The topics of things we could focus on would essentially have to be those things recorded on hospices claims.

Okay, great. Moving on to our next item in the questions box. So, we have received just a few suggestions to potentially review the color-coding concept of the scoring system. The few submitters mentioned that red should be an alert, yellow -- caution -- to pay attention to the measure, and then green is that you achieved the measure.

That's very helpful. The thermometer -- please don't consider this was going to be the final indicator. To be honest, it might have been a little bit more for just presentation purposes. I do think we want to make it easy to digest for consumers, kind of final indicator. So, we certainly welcome that input, and maybe we could develop that a little bit further.

And our next question is a clarifying question, and they ask, "So, meeting an indicator is a bad thing?"

It depends on how the indicator is defined. But I think that's sort of how we're envisioning it. These would be sort of the rare instances of hospices having a particularly high rate across them -- threshold on some particular indicator. And we envision that doing that less frequently would be better. So that clarifying question is correct. Yep.

Thanks. And our next question is, "How will the thresholds be set?"

Yes, that's a good question. In terms of what the particular threshold would be, it might depend on the topic. So, it could be that -- Because there's a couple ways to do it. It could be the complete absence of a particular service might trigger thresholds. That could be more of an absolute setting. It may be that hospices in a more kind of rare segment of the distribution. So, depending on what the indicator is, looking at a certain rate of an indicator across the population of hospices, for those hospices, which we could have some kind of percentile setting. So, for instance, the top 10%, those hospices which are in the furthest extremes might trigger the thresholds just based on being the top or bottom 10%. Again, it might depend on the particular topic we're looking at, but those were a couple of things we kind of thought about in terms of how to set a threshold.

Thanks. And our next attendee just submitted a general comment, I believe, and stated, "If you only provide the index scores for the hospice, then the hospice will not know where they need to improve."

That is a very good point. I think what we could, in fact, and should do would be to -- whether or not it's publicly reported, I think for the hospices themselves, we would want them to see how they scored on the particular indicators and not just the index. Definitely, I think we want hospices to understand how the scores came from. We don't want it to be a black box. Like, very much the opposite. So, we'd want hospices to understand how they're scoring, and essentially, the point would be to be useful and provide as much information as possible. So, if this isn't provided publicly, the individual indicators, definitely it would be provided to hospices on some sort of report in some manner.

We will move to some phone line questions, as we see those have come in. So, Tracey Gregory, your line is now unmuted, if you would like to ask your question. And, Tracey, your line might be self-muted. So, if you would like to unmute yourself to ask your question, that would be great.

Okay. Can you hear me now?

Mm-hmm.

Okay, thanks.

Yes, we can hear you.

So, my question is I'm a little confused as to exactly what it is that you want to measure. That's what I thought this was going to actually be about, unless I misunderstood. Without knowing what it is that you're looking to measure, what you think is not already being captured.

This is TJ again. Absolutely. That makes sense. I think what we're trying to do today was more to provide a framework and give a sense of if that makes sense. We're very much soliciting ideas for things that could be measurable into claims. I don't know if folks online have any ideas of what sort of indicators that could be developed from various services, certainly, we're very interested in ideas that folks might have.

I'm just wondering if what CMS was thinking was not being captured that we need to add additional measures.

This is Cindy. Hi. As you saw in the presentation, right now, we're collecting at admission and at discharge. So, we're looking to look at measures we can capture throughout the hospice stay, so between admission and discharge. And this kind of a measure, using claims data, allows us to look at the multi-disciplines over multiple aspects of the hospice stay. And that's a gap area that we've identified that we thought this measure would be useful. We'd be interested in your feedback and any additional input you have, and others on this call. Thank you.

Okay. So, I guess my question in the measuring is given that each patient's care plan is so individualized, how would you look at what disciplines were involved with what's appropriate for that case? Would that be somehow a detrimental measure?

I'm sorry. This is TJ. Can you repeat that one more time?

So, I'm wondering -- I understand you're looking at how many disciplines we're in, but since each patient's care plan is individualized, say, if one patient only had two services and one had all of our services, how would that be weighed apples to apples? Like, the patient who has max services, would that somehow be, like, a detriment, even though it's appropriate for their plan of care?

Absolutely. I think, again, the idea might be to do this more at the hospice level. So, it wouldn't be so much comparing patient to patient, but more hospice to hospice, if that makes sense. So, for example, if we're looking at the rate of service provision, it would be whether or not a certain hospice would have -- crossing threshold of, let's say, infrequent or low-level service provision relative to other hospices. Does that answer your question?

That makes sense. If certain hospices were underutilizing volunteers. That kind of thing?

For example, things that could be measured in claims, but that's the right idea.

Right, okay. Alright, thank you very much.

You're welcome.

Alright, next we have Melissa Calkins. Melissa, your line is now unmuted, if you would like to ask your question.

Yes, my question was just kind of based on -- it appears like this index will be similar to what a PEPPER Report looks like. Will Medicare -- CMS be

planning on using it solely for Hospice Compare and HQRP, or will it also trigger external audits and contracted auditing activities?

This is Cindy again. The purpose of this measure is for our quality measure program, and that's the use of it. The whole purpose of our quality program is to be identifying quality issues in the hospice program. And this would be part of our whole group of measures that we have and group of measures that we're looking to bring in in the future to have a full plate of useful measures for the industry. So... Does that help you?

Yes, sure. Thank you.

Thanks. And our next question is from Ronda Velazquez. Ronda, your line is now unmuted, if you'd like to ask your question. Ronda, you may have your line self-muted, so if you could please unmute yourself, please. Apologies about that, Ronda. We were getting a bit of feedback from your line. So we'll come back to your question.

But next I will move to Lynn Brougham. Lynn, your line is now unmuted, if you'd like to ask your question. Lynn, you might be on mute.

I'm sorry. I guess I was a little confused by the thermometers and the pie graph just because it looked kind of the opposite of what made sense to me, that the higher was actually -- it was a negative high, you know, rather than it just -- I'm not sure. If it's not clear to us, I'm not sure how clear it will be to the beneficiary or the consumers.

This is Cindy. I mean, I hear you very loud and clear. And we can honestly - - we can switch the way we measure this. I mean, we can make meeting the threshold 100%, so that if these different indicators show that you are appropriately meeting these different indicators, you would then be, let's just say, green, and green would then recognize you as 100%, and therefore you'd get full credit. And so, 90% of the hospices from that slide earlier, where we were showing, would be in the green, which is where they are now. So we would recognize when it's meeting 100% or something like that when we score it. And maybe that would make much more sense than the way we're describing it. But that is the point of the measure. But appreciate that kind of feedback because it's helpful thinking about it.

Alright. We will move to our next online question, which comes from Fran Bell. Fran, your line is now unmuted.

Alright. Hello, everyone. Thanks for this presentation. I was wondering, have y'all considered comparing hospices within different regions of the United States? The reason I ask that is because different regions have different mindsets or different values that may differ from place to place. For instance, in the rural areas, a lot of people enjoy their privacy. And so, when you have privacy, and then on top of that, you have COVID-19 as the public health emergency, then they really want their privacy because they want to keep their loved ones safe and healthy, as opposed to perhaps another area where privacy is not held as such a value in their minds. So, have you considered regional comparisons, as opposed to just the entire US?

Hi, there. This is TJ. Thank you so much for your comment. I think that's a very important consideration. There is a lot of variation in preferences and sort of just in general, the way hospice is nationwide. I probably should mention we had kind of that same suggestion to kind of consider this

variation. I guess I'd be kind of interested in how it would play out. To be honest, I think as was mentioned, the kind of end vision for this would be essentially Hospice Compare. So, I think as to what I was thinking, most folks would be looking, like, locally. So it would be a very rare person to go to Hospice Compare and do more of a nationwide search. So you're probably not looking at a hospice in San Francisco versus New York. You're probably looking within your city or zip code or maybe state. It could be true that some people are doing a little bit more of a wider search. So I think probably, just given how often kind of the regional variation came up, I think we do want to consider that a little bit more. But if there's kind of other thoughts about that and how people would actually -- sort of the range of geographies people look at, we certainly appreciate that.

Okay. Thank you.

Thank you.

Okay, Maria Luisa Rodriguez, your line is now unmuted, if you'd like to ask your question.

Hi. Good morning. I don't think it's a question for me, but it's more of the measures that we can use or indicators during the hospice stay, that gap. I think from the admission measures, those measures that can be applicable for those days, while the patient is on the service, the hospice stay, we can tweak a little bit, though, aside from those indicators. Maybe we could add the volunteers, actually, because that is big deal, right? We really would want to use volunteers and psychosocial, like, supportive care staff -- the chaplains, spiritual counselors, and social workers. So, I think it's just, like, more of a continuation of what we have, the measures that we've been using for admission. And it could be done, like, every 14 days for our comprehensive assessment and the same measures and indicators.

This is TJ. Thank you so much for that. We appreciate any suggestions, honestly, for the quality reporting program in general. So thanks for your comments. And my colleagues kind of noted to me that we're getting some suggestions kind of submitted and just wanted to kind of give an appreciation for all of those, as well. We really value all input for suggestions, other things that could be reported and looked at for the quality reporting programs. So thank you all.

Okay, I think we will go back to the Q&A box to read off a few questions from there. So, our next question -- "Would these be solely used for HQRP Hospice Compare, or will they also trigger contracted auditing activities?"

This is Cindy again. As we talked about, these measures are for the purpose of the quality measure program. And I just want to say, as part of the quality measure program, the impetus for developing this kind of measure actually came from you, our hospice stakeholders, from attending national conferences, and there's more than one that we've heard this from. It was you, our hospice providers, who wanted us to be able to develop a measure much like this, asking us to be able to identify hospices who are really underperforming in the industry across the board on multiple measures, multiple indicators at the same time that really recognizes underperforming hospices and wanting us to be able to publicly report that information in order to benefit the whole hospice community so that it's recognized that 90% or more of the hospice community does an outstanding, or very appropriate rate job, and we really value that and appreciate it, especially

during this time of the COVID pandemic, recognizing the awesome job that the hospices are doing out there. But it was you, the hospices, that really wanted this kind of measure so that the 90% or more of you that are out there doing such outstanding work can be recognized for what you're doing. And that's the purpose behind -- and it's part of our whole portfolio of measures, that this would be a kind of measure that can really distinguish those hospices from the significantly underperforming hospices. Thank you.

Our next question -- "Since hospice is not only medical care, it would be critical to include not only skilled nursing visits, but also the combination of social work, spiritual care, and hospice aide care. Would that be a possibility?"

This is TJ. I just muted myself by accident. Yeah, so, many of those would be. On the hospice claims, I do not believe that spiritual care is recorded, but nursing visits, social worker, and aides are. So all those could be looked at potentially.

And just to add to it, we also are working, when we validate this measure, we work with the CAHPS Survey, which is family caregivers, so we do have the input there, which gets into spiritual and other aspects of care. So, from that perspective, we do capture those aspects in this measure.

We do have another phone line question from Julie Sanchez. Julie, your line is now unmuted if you'd like to ask your question. Julie, your line may be self-muted. Okay, we will try to come back to Julie.

I'll go to another question that we received in the inbox. "Could we have an explanation on how this might appear in Hospice Compare?"

This is Cindy. So, the way it would appear in Hospice Compare -- I mean, I think the best way to think about it is much like the comprehensive assessment measure that we currently have on Hospice Compare, which is also a composite measure. And when we show that measure, we show how you're performing on that measure, and then there's a dropdown box to the individual indicators. In the case of the hospice comprehensive assessment measure, we show you the seven HIS measures that you're all familiar with that make up that composite measure. In a similar fashion, we can do that with this measure, the Hospice Care Index, where we can show you your score and then have a dropdown box to the different indicators so you can see how you're performing on the individual indicators. So that's how it can show on Hospice Compare. And we're open to ideas there on how you'd like to see it presented. And obviously, you'd get your confidential quality measure reports outside of the Compare so that your hospice can also see how you're performing in that way, which is another way you can be reviewing for QAPI or other ways for quality improvement for measures. Thank you.

Thanks, Cindy. Moving on to our next question. You may have touched on this a little bit earlier, but this person is asking, "How do you see COVID impacting this?"

I think that's part of what -- I'm kind of wondering what the person asking the question is getting at because I think the measure is looking at performance through claims data. So, we're able to look at the claims data over many years, to be able to look at it from before COVID, during COVID, after COVID to be able to see changes and identify issues with how hospices

are performing. But if that person would like to discuss it more, please raise your hand on the chat box so we can hear you live. Thank you.

It looks like we have a follow-up question from Fran Bell on the phone line. Fran, your line is unmuted.

Thank you. Would the reporting of these measures be in real-time or near-about there, as opposed to lag time?

Hi, this is TJ. I mean, there would be some amount of lag in terms of the claims data being collected. So, they'd have to typically -- the information of these measures come in through claims data, so we'd have to wait for the claims to come in. They would have to typically -- perhaps there's corrections or edits to information, or some come in a little late. So, it wouldn't be precisely real-time. I guess it depends on what the standards are, but it would probably be comparable to other CMS's programs that use claims data for measures.

Okay. And, TJ, one other thing, if I may.

Sure.

Thank you. If there is any possibility to include other types of services like the music therapist, the art therapist, things like that, I think that would go a long way in showing the differences in the quality between certain types of hospices. I know that would be difficult, but if you could just keep that in the back of your mind maybe for future plans.

Fran, thank you so much. We'll definitely pass that along.

Thank you.

And I believe Tracey Gregory may have a follow-up question on the phone line. Tracey, your line is now unmuted. Tracey, your line might be muted.

I'm sorry. I hit the wrong button again. I just thought it was an excellent point to bring up if the measures are going to look at urban versus rural communities and cultures and even racial disparities and take those things into account.

Thank you, guys. Thank you so much. I agree. I think we're very much in the development stage for this. I think that kind of our due diligence would be to, once indicators start being calculated and we kind of have some data to work with, we probably want to do exactly what's been mentioned. Look at how hospices score just based on their patient profiles or where they fall geographically, region-wise, or even kind of urban-rural. And if we see distances there, kind of think about if and how to accommodate those. But, yeah, absolutely. I think there's certainly -- We're hearing loud and clear there's a lot of potential for differences there, and I think we'll want to take a close look at that in the data. We so very much appreciate these points.

Yeah, that was an excellent one. It'll be interesting to see how the data actually pans out as far as patterns and different geographical areas.

Absolutely. Absolutely. I agree. Thank you.

And we have another phone line question from Lori Steblein. Lori, your line is now unmuted.

Hi, there. Can you hear me?

Loud and clear.

This is actually Michael Berlowe with Maggie's Hospice, and I guess my question revolves around the lag time, again, with the Hospice Compare website. I think in my mind, the intent of the website is for a family to be able to, obviously, choose a quality hospice. But if I go onto that website right now, I'm looking at data from June of 2019. So, we all know that in a year's time, caregivers come and go, and certainly, quality care can be based on the quality of your caregivers, your nurses, your CNAs. So, I think one of the biggest things that would be of help to families moving forward would be to have data on that website that more accurately reflects a current time frame. That's all I have. Thank you.

This is Cindy. I appreciate your comment and want to say that we do try to use the most current data we can, recognizing that in order to use claims data, we have to have it at a certain level of claims that we've received. Just to give you a sense, we use a full set of a year's worth of claims, which takes a year plus about six months in order to have a year's worth of claims all in the system. So, just to give you a sense of -- There's different levels of claims data that we can use, but there's just a natural need to have a lag time in order to get the claims data to capture all the hospices within a given time frame. And that's why there's a lag time. If we use the most immediate data, there would be issues with that data. So, in order to have the data, something that can be reported on, by definition, there is going to be some lag time. We try to keep it as limited as possible, but it's just the nature of how it's necessary for public reporting. So I hope you appreciate that, but we also do appreciate trying to get the data as current as possible.

Great. And our next question is another phone line question from Meg Lutze. Meg, your line is now unmuted.

Thank you. Can you hear me okay?

We can.

Yes, we can hear you.

So, one thing -- I'm sure this is on your radar, but I just want to mention it and make sure that it is. I just want to make sure, you know, there are things other than simply geographic area that could impact a hospice's claims data. So, for example, at my hospice, we specialize in working with patients from different cultures. So, we have a Russian cultural program. We have an Asian program. We have a Latino program. And because of the demographics of the patients that we're serving as a result of having those programs, it certainly has an impact on our claims data. It impacts all sorts of things from what disciplines they're willing to accept to the likelihood that they would revoke. And I'm conscious of how a measure like this might impact my hospice because that's very specific to our organization, and it wouldn't apply to other hospices in our same geographic area that consumers would be comparing us against. And so, I know with the CAHPS data, there's a lot of adjusting that's put into it to make sure

everything has that case mix adjustment so that certain things don't impact the data. And I wonder if there'd be anything like that, or if you guys have given any thought to that.

Hi, this is TJ. Absolutely. And thanks for bringing up that point about language issues. That and other things. I think again, as we kind of continue to develop, we want to kind of consider as many possibilities for adjustment that's needed for all measures that will be developed. I think these points are very valid, and the issues are real. Especially information that we have can also collect from administrative records. I think we want to consider that and look for differences. So, I think this is all to say that, you know, thank you for mentioning your issues and the ones that you rose, as well as other folks that brought up other potential for differences. I think definitely we're taking stock and taking note, and I think we're going to want to look at as many as possible once we start developing this and kind of calculating some numbers. So, thank you.

You're welcome. Yeah. I mean, I feel like there's so many things that could impact this, and we obviously want to make sure that we're not creating a system where hospices are not wanting to care for a specific type of patient or seeking out caring for another type of patient because they know that it'll have a positive impact on their claims data, because that would ultimately have a negative impact where we want this to have a positive impact.

Yeah, no, absolutely.

It's excellent you're considering that. That's really great.

No, absolutely. And apparently -- That's a good point. If for that and anything else, if there's any unintended consequences that you might see, I think definitely, please, we certainly welcome that. We really want to make sure we have a useful and valid measure. So, thank you for raising any potential unintended consequences or things where this could be off because we want to make sure we develop a good, sound measure that's useful for everybody. Thank you.

I believe we have time for one more question, and this comes from Lisa Mulvany. Lisa, your line is now unmuted, if you'd like to ask your question. Lisa, your line is unmuted, if you'd like to ask your question.

Well, we will actually just take one more question from the questions box, then. So, our last question -- "How will the Hospice Care Index be linked with the HOPE tool?"

This is -- Go ahead. Go ahead, TJ.

No, Cindy. Please, you. Sorry.

So, the Hospice Care Index is a claims-based measure. And it's part of our portfolio of measures that we're looking at as we're developing the HOPE tool. We're looking for, obviously, a portfolio of measures that include our claims-based measures, obviously the HIS measures that we have currently, along with the outcome and other kinds of measures we're looking to develop through HOPE. But HOPE is something that will be coming in future rulemaking. And so, we're looking at measures that we can bring on during this time between now and in coordination with HOPE in the future and

recognizing that once HOPE is in place, we can coordinate between claims-based measures and information we're able to collect through HOPE as a way to develop hybrid kind of measures or other kinds of measures, in addition to outcome measures. So, you have to look at it as the Hospice Quality Reporting Program as a portfolio of measures that includes the Hospice Items Set, CAHPS, claims-based measures, HOPE-based measures, and measures that are a combination of different kinds of measures -- you know, a combination of claims and measures we can pull from HOPE data or other ways we can pull data. So, that's the coordination between the Hospice Care Index or other kinds of claims-based measures and HOPE. Thank you.

Alright, thank you, Cindy. So, I believe that concludes the Q&A portion of today's webinar. So, Cindy, we will pass it back over to you to close the call.

Thank you very much. And I want to thank everybody for attending today's Hospice Quality Reporting Program Forum about the Hospice Care Index and playing-space measures in general. And also want to thank all of our attendees, especially all the input you gave and questions through the chat box. We will be responding to those, for those we didn't get to today. So thank you very much. It's very helpful.

And as you know, the Hospice Care Index is a claims-based index to create a more robust and comprehensive set of quality measurement tools for the Hospice Quality Reporting Program. We're grateful for your feedback during today's discussion and hope you found this presentation helpful for understanding the current state and future direction of the Hospice Quality Reporting Program. So, if you have any feedback about the Hospice Quality Reporting Program, please, please recognize that you can contact us any time at the link that's on this last slide -- the [hospiceassessment@cms.hhs.gov](mailto:hospiceassessment@cms.hhs.gov). These slides and the recording will all be available for you on our website, and you'll be getting a listserv message and it'll be listed on our Spotlight page. So, please be looking for that, as you can have access to today's presentation. Thank you very much for your interest and support and joining us today for this webinar. That concludes today's webinar. Thank you.