Hospice Regulatory & Quality Reporting Update

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National Hospice and Palliative Care Organization
Oct 2021

1 Leading Person-Centered Care

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FY 2022 Hospice Wage Index and Quality Reporting Final Rule

2 Leading Person-Centered Care

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Rates

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Rate and Cap Information

- The final rate increase for FY 2022 is **2.0%**.
- The final hospice cap amount for FY 2022 is **$31,297.61**.
- NHPCO has prepared the FY 2022 FINAL Wage Index State/County Rate Chart, which is found on the Regulatory Medicare Reimbursement page of the website for members.
  - **Please note:** This chart represents the final rates for FY 2022, beginning on October 1, 2021. **These rates are final may be used for budget planning.**
- The CMS files with the final FY2022 wage index values can be found on the CMS website.

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Final FY 2022 Hospice Payment Rates (With Quality Reporting)

Code	Description	FY2021 Payment Rates	Wage Index Standardization Factor	FINAL FY 2022 Hospice Payment Update	FINAL FY 2022 Payment Rates
651	**Routine Home Care (days 1-60)**	$199.25	X 1.0002	X 1.02	$203.40
651	**Routine Home Care (days 61+)**	$157.49	X 1.0001	X 1.02	$160.74
652	**Continuous Home Care Full rate = 24 hours of care**	$1,432.41	X 1.0006	X 1.02	$1,462.52 ($60.94 per hr.)
655	**Inpatient Respite Care**	$461.09	X 1.0014	X 1.02	$473.75
656	**General Inpatient Care**	$1,045.66	X 1.0019	X 1.02	$1,068.28

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Final FY 2022 Hospice Payment Rates For Hospices That **DO NOT** Submit The Required Quality Data

Code	Description	FY2021 Payment Rates	Wage Index Standardization Factor	FINAL FY2022 Hospice Payment Update of 2.0% minus 2 percentage points = +0.0%	FINAL FY 2022 Payment Rates
651	**Routine Home Care (days 1-60)**	$199.25	X 1.001	X 1.00	$199.41
651	**Routine Home Care (days 61+)**	$157.49	X 1.0009	X 1.00	$157.58
652	**Continuous Home Care Full rate = 24 hours of care**	$1,432.41	X 1.0004	X 1.00	$1,433.84 ($59.74 per hr.)
655	**Inpatient Respite Care**	$461.09	X 1.0014	X 1.00	$464.46
656	**General Inpatient Care**	$1,045.66	X1.0019	X 1.00	$1,047.33

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Rebasing And Recalculating Labor Component For Hospice Rates

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Rebasing and Revising Labor Component of Hospice Rates

- CMS has finalized that they are rebasing and revising the labor component of the rates for all levels of hospice care **using cost report data for freestanding hospices from 2018.**
  - CMS includes a detailed discussion of their proposed methodology in the proposed rule and provided the table below.
- **Proposed and Current Labor Shares by Level of Care**

	Final FY 2022 Labor Share	Proposed FY 2022 Labor Share	FY 2021 (Current Year) Labor Share
Routine Home Care	66.0%	64.7%	68.71%
Continuous Home Care	75.2%	74.6%	68.71%
Inpatient Respite Care	61.0%	60.1%	54.13%
General Inpatient Care	63.5%	62.8%	64.01%

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Frequency of Labor Component of Rates Adjustments

- **Frequency of updating labor shares in the future:** CMS states that they tentatively plan to rebase the hospice labor shares on a schedule of every 4-5 years, similar to other Medicare provider types.
- In light of the COVID–19 PHE, we plan to monitor the upcoming MCR data to see if a more frequent revision to the hospice labor shares is necessary in order to reflect the most recent cost structures of hospice providers.

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Accurate Completion Of Hospice Cost Report

- Many providers were not reporting salaries on the detailed level of care worksheets (A-1, A-2, A3, A-4, column 1), but rather reporting total costs (reflecting salary and non-salary costs) for these services for each level of care on Worksheets A-1, A-2, A-3, A-4, column 7
- Providers must meet the **new Level I edit conditions** that required freestanding hospices to fill out certain parts of their cost reports effective for freestanding hospice cost reports with a reporting period that ended on or after December 31, 2017.
- **The rates for every hospice in the country depend on it!**

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Hospice Data Trends

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Hospice Length of Stay FY 2016 - 2019

- Patients with neurological and organ-based failure conditions (with the exception of kidney disease/kidney failure) tend to have much longer lengths of stay compared to patients with cancer diagnoses.

	FY 2016	FY 2017	FY 2018	FY 2019
Average Length of Election	74 Days	74 Days	75 Days	77 Days
Median Lifetime Length of Stay	19 Days	19 Days	19 Days	20 Days
Average Lifetime Length of Stay	95 Days	95 Days	96 Days	99 Days

Source: Hospice claims data accessed from CCW on January 15, 2021.

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Average Length Of Stay by Disease in FY 2019

Category	Number of Hospice Users Discharged at the End of FY 2019	Average Length of Election	Median Lifetime Length of Stay	Average Lifetime Length of Stay
Alzheimer's, Dementia, and Parkinson's	210,944	126.9	52	169.0
CVA/Stroke	57,100	114.7	34	148.3
Cancers	290,868	45.7	17	53.5
Chronic Kidney Disease/Kidney Failure	28,130	35.6	8	44.3
Heart (CHF and Other Heart Disease)	210,087	85.4	24	107.6
Lung (COPD and Pneumonias)	112,852	82.2	20	108.0
Other	351,977	64.2	14	82.1
All Diagnoses	1,261,958	77.3	20	98.8

Source: Hospice claims data accessed from CCW on January 15, 2021

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Live Discharges By Reason

Reason for Discharge	Percentage in 2019
Revocation	37.5%
No longer terminally ill	37.2%
Moved out of service area without transferring hospices	10.7%
Transferred to another hospice	12.9%
Discharged for cause	1.6%

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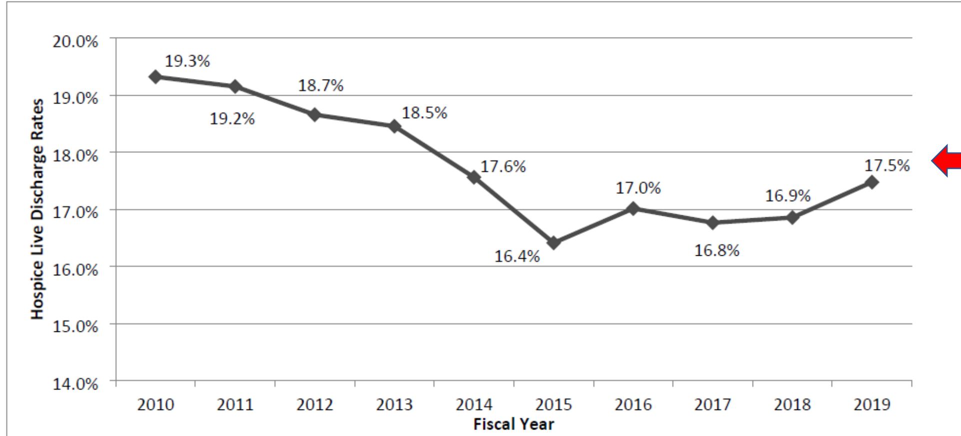
Annual Live Discharge Rates for FYs 2010 - FY 2019



Source: Analysis of data for FY 2010 through FY 2019 accessed from the CCW on January 15, 2021.

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Skilled Visits in Last Days of Life

- Percentage of Decedents Not Receiving Skilled Visits at the End of Life (on Routine Home Care Days), Calendar Years (CYs) 2015-2019

	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
No skilled visits on last day (and last day was RHC)	22.7%	20.4%	19.4%	19.5%	19.6%
No skilled visits on last two days (and last two days were RHC)	11.0%	9.3%	8.3%	7.8%	7.5%
No skilled visits on last three days (and last three days were RHC)	6.8%	5.7%	5.0%	4.6%	4.4%
No skilled visits on last four days (and last four days were RHC)	4.6%	3.8%	3.2%	2.9%	2.8%

Source: Analysis of Medicare hospice claims and administrative data (CY 2015-2019) accessed from the CCW on January 15, 2021.

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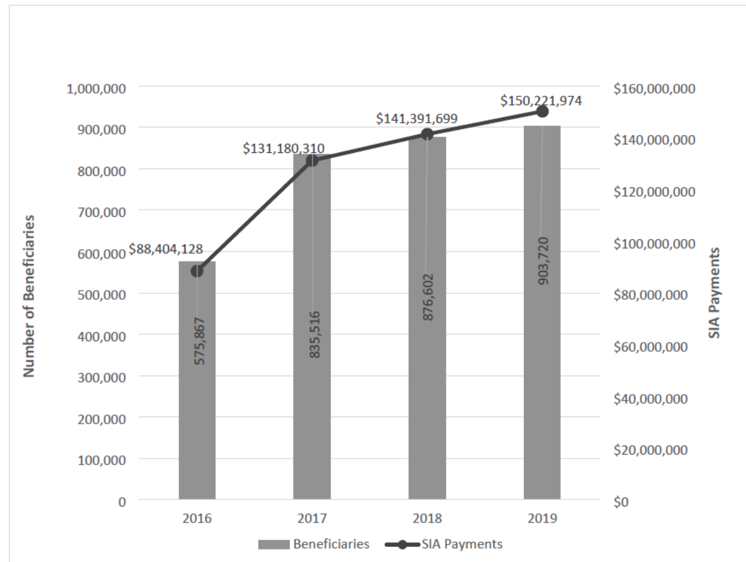
Number of Beneficiaries with Visits that Qualified for SIA Payments FY 2016 – FY 2019



Source: Analysis of data for FY 2016 through FY 2019 accessed from the CCW on January 15, 2021.

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Visits in Minutes

- Average Number of Minutes Provided in the Last Seven Days of Life on Routine Home Care days by Skilled Nurse and Medical Social Workers, CY 2015-2019

Year	Skilled Nurse Minutes	Social Worker Minutes	Total Minutes
2015	48.1	6.0	54.1
2016	49.5	6.5	56.0
2017	50.0	6.6	56.6
2018	50.3	6.6	56.9
2019	50.2	6.7	56.9

Source: Analysis of Medicare hospice claims and administrative data (CY 2015-2019) accessed from the CCW on January 15, 2021.

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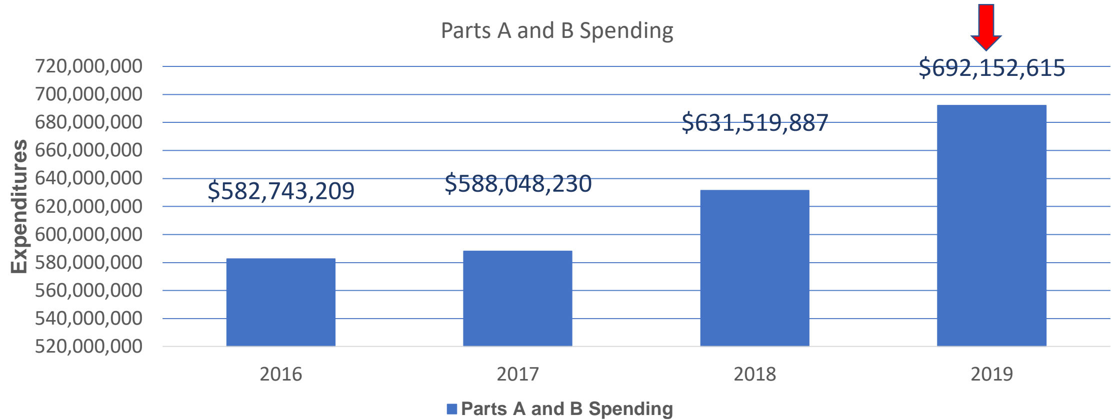
Non-Hospice Spending During a Hospice Election



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Spending Outside the Hospice Benefit by Claim Type

Claim Type	FY 2016	FY 2017	FY 2018	FY 2019
Durable Medical Equipment	$38,702,631	$40,740,569	$46,385,066	$54,465,708
Home Health Agency	$19,860,890	$17,491,197	$16,181,405	$16,274,141
Inpatient	$136,926,412	$132,750,947	$139,348,335	$141,717,834
Outpatient	$104,866,171	$109,554,523	$120,840,000	$135,302,250
Physician Billing	$261,085,794	$272,239,518	$296,053,914	$335,142,715
Skilled Nursing Facility	$21,301,311	$15,271,476	$12,711,167	$9,249,967

Source: Analysis of 100% Medicare Part A and B claims analytic files, FY 2016 – 2019 from the CCW, accessed January 15, 2021.

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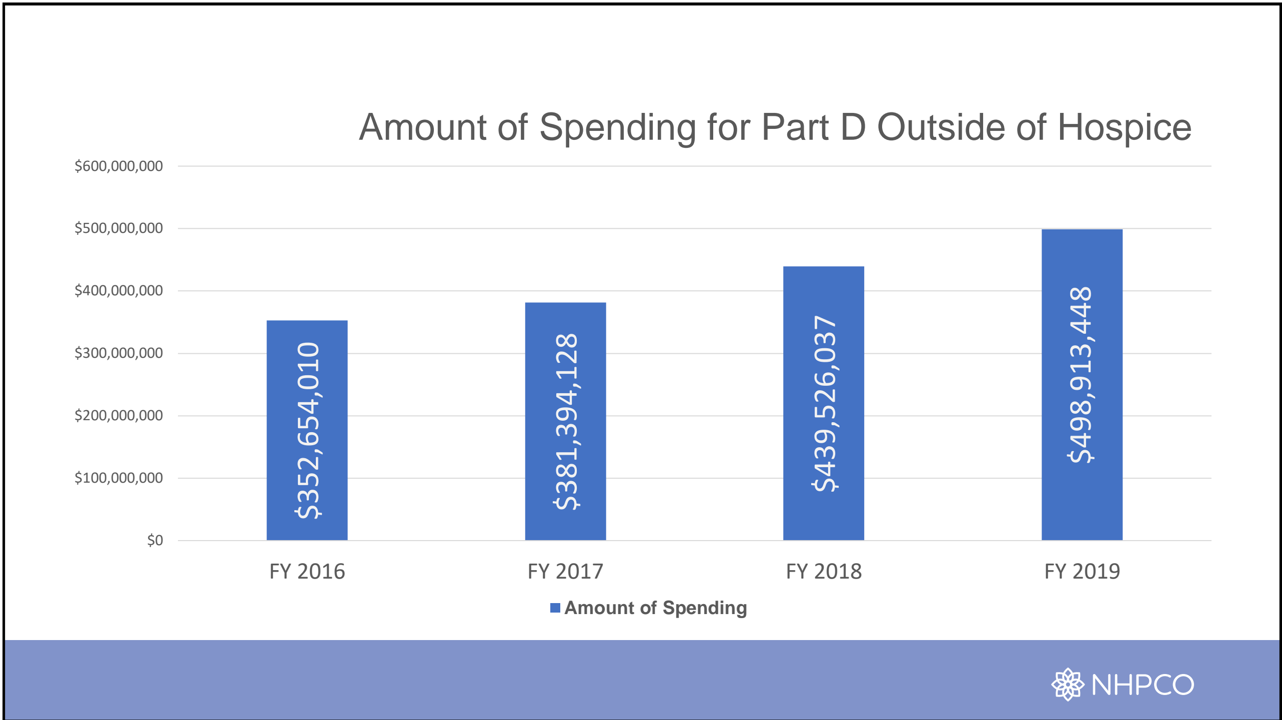

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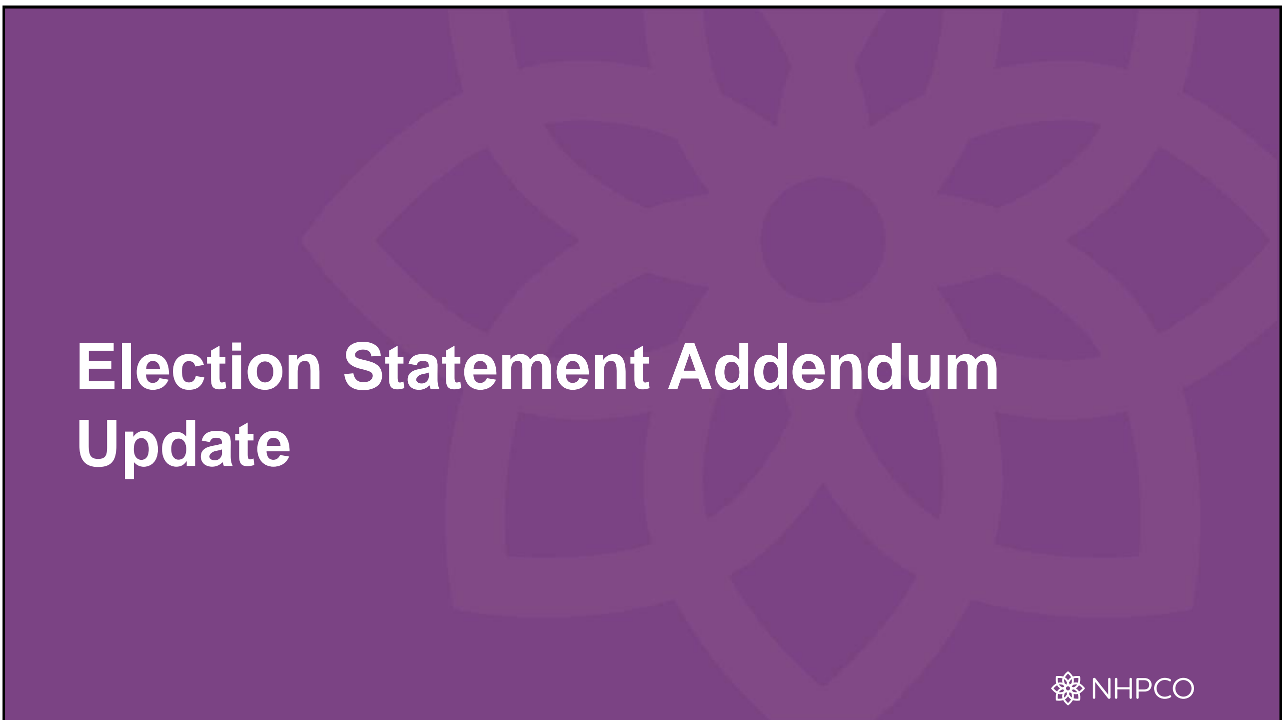

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Election Statement Addendum Clarifications

- **5 days**
  - Furnish the addendum within 5 days from the date a beneficiary or their representative requests it
  - If the request is within 5 days from the date of a hospice election.
- **If the patient dies or revokes within 5 days**
  - If beneficiary/representative requests the election statement addendum at the time of hospice election but dies within 5 days
  - The hospice would not be required to furnish the addendum as the requirement would be deemed as being met in this circumstance.
  - If the patient is furnished an addendum but dies before signing it, hospices should note that in the patient record.

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Election Statement Addendum Clarifications

- **Mailing the addendum**
  - CMS: There is nothing precluding hospices from furnishing an addendum through the mail.
  - CMS expects that hospices would take steps in working with patients and their representatives to better understand which methods (that is, in person, mail, etc.) of delivery would work best in furnishing the addendum
- **Updated model election statement addendum**
  - CMS has posted an updated model election statement addendum on the Hospice Webpage
  - This is an illustrative example for hospices to modify and develop their own forms that meet the content requirements at § 418.24.

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Election Statement Addendum Clarifications

- **3 days rather than 72 hours**
  - When a patient/representative requests
  - During the course of the hospice election
- **Date clarification**
  - Date the hospice furnishes the addendum must be within the required time frame (*e.g.*, 3 days or 5 days), rather than the signature date.
  - **The hospice would include the "date furnished" in the patient record and on the addendum.**
  - If the patient/representative refuses to sign the addendum, hospices must document the reason it's not signed.

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Election Statement Addendum Clarifications

- **Non-hospice provider requests addendum**
  - If a non-hospice provider requests an addendum, CMS does not expect a signed copy in the patient medical record.
  - Hospices can develop processes to address this, and how to document it.
- **Effective date:** October 1, 2021

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PHE Waivers Made Permanent

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PHE Waivers Made Permanent – Hospice Aide Services

- **§ 418.76(c)(1) Competency evaluation**
  - Hospices may use either a patient or a pseudo-patient in the evaluation of hospice aide competency.
- **§ 418.76(h)(1)(iii) Area of competency concern**
  - If an area of concern is verified by a hospice during an on-site visit, the hospice has to conduct, and the aide must complete, an evaluation of the **deficient skill and all related skills**, instead of completing another full competency evaluation.

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Hospice Quality Reporting

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Change to APU Reduction

- Beginning in FY 2024, a **4% reduction** will be applied to the coordinating APU year for failure to report HQRP data.
  - Data collection year: Calendar year 2022
- 2% reduction to the APU will remain through FY 2023
  - Data collection year: Calendar year 2021
- Impact on payments:
  - Annual market basket update could be less than the payment reduction
  - Payment rates could be less than payment rates for the preceding FY

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APU UPDATE

Compliance for no APU penalty
- Achievement of 90% HIS submission in a calendar year
- Timely submission of 4 quarters of CAHPS data

Reporting Year for HIS and Data Collection Year for CAHPS data (Calendar year)	Annual Payment Update Impacts Payments for the FY	Reference Year for CAHPS Size Exemption (CAHPS only)
CY 2020	FY 2022 APU	CY 2019
CY 2021	FY 2023 APU	CY 2020
CY 2022	FY 2024 APU*	CY 2021
CY 2023	FY 2025 APU	CY 2022

* Beginning in FY 2024 and all subsequent years, the payment penalty is 4 percent. Prior to FY 2024, the payment penalty is 2 percent.

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New Hospice Measures

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Hospice Care Index (HCI) Measure

Why this new measure?

- Solicitation of feedback from hospice stakeholders such as:
  - providers and family caregivers;
  - hospice and quality experts through a Technical Expert Panel (TEP);
  - interviews with hospice quality experts;
  - Consideration of public comments received in response to previous solicitations on claims-based hospice quality initiatives; and
  - a review of quality measurement recommendations offered by the HHS Office of Inspector General (OIG), MedPAC, and the peer-reviewed literature.

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Hospice Care Index (HCI) Measure

- The HCI will provide more information to better reflect several processes of care during a hospice stay, and better empower patients and family caregivers to make informed health care decisions.
- **Key characteristics**
  - Composite measure with 10 indicators
  - Claims based measure – data is taken from Medicare claims for calculation
  - Represents different aspects of hospice services
  - Designed to help identify whether hospices have aggregate performance trends that indicate higher or lower quality of care relative to other hospices

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HCI Score

- Each indicator is equal with a score of 1
- The sum of the points earned from meeting the criterion of each indictor results in the hospice's aggregated single HCI score
- Goal is to get the highest score possible -- a score of 10 is the highest hospice score
- As a claims-based measure, the HCI measure would not impose any data collection/submission requirements for the provider
- CMS has produced a You Tube video on the background of the HCI: https://youtu.be/by68E9E2cZc

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HCI #1: No CHC or GIP care

$$\frac{\text{Total number of CHC or GIP services days provided by the hospice within a reporting period}}{\text{Total number of hospice service days provided by the hospice at any level of care within a reporting period.}}$$

Index Earned Point Criterion

1 point = Hospices earn a point towards the HCI if they provided **at least one CHC or GIP service day** within a reporting period.

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HCI #2: Gaps in nursing visits greater than 7 days

Number of elections with the hospice where the patient experienced at least one gap between nursing visits exceeding 7 days (**more than 8 consecutive days**), excluding hospice elections where the patient elected hospice for less than 30 days within a reporting period.

Total number of elections with the hospice, excluding hospice elections where the patient elected hospice for less than 30 days within a reporting period

Index Earned Point Criterion
1 point = Hospices earn a point towards the HCI if their individual hospice score for gaps in skilled nursing visits greater than 7 days falls **below the 90th percentile** ranking among hospices nationally.

Nursing visit = includes both RN and LPN visits to recognize the frequency of skilled nursing visits and to maintain consistency in HCI when using revenue center code 055X.

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HCI #3: Early Live Discharges

Total number of live discharges from the hospice occurring within the first 7 days of hospice within a reporting period.

The total number of all live discharge from the hospice within a reporting period.

Index Earned Point Criterion
1 point = Hospices earn a point towards the HCI if their individual percentage of live discharges on or before the seventh day of hospice falls **below the 90th percentile** ranking among hospices nationally.

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HCI #4: Late Live Discharges

Total number of live discharges from the hospice occurring **on or after 180 days of enrollment** in hospice within a reporting period.

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The total number of all live discharge from the hospice within a reporting period.

Index Earned Point Criterion:
1 point = Hospices earn a point towards the HCI if their individual hospice score for live discharges on or after the 180th day of hospice falls below the 90th percentile ranking among hospices nationally

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HCI #5: Burdensome Transitions (Type 1) - Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission

Total number of live discharges from the hospice followed by hospital admission within 2 days, **then hospice readmission within 2 days of hospital discharge** within a reporting period.

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The total number of all live discharge from the hospice within a **reporting period.**

Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for Type 1 burdensome transitions **falls below the 90th percentile** ranking among hospices nationally.

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HCI #6: Burdensome Transitions (Type 2) - Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital

Total number of live discharges from the hospice followed by a hospitalization within 2 days of live discharge with death in the hospital within a reporting year.

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Total number of all live discharge from the hospice within a reporting year.

Index Earned Point Criterion
1 point = Hospices earn a point towards the HCI if their individual hospice score for Type 2 burdensome transitions falls below the 90th percentile ranking among hospices nationally.

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HCI #7: Per-beneficiary Medicare Spending

Total Medicare hospice payments received by a hospice within a reporting period.

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Total number of beneficiaries electing hospice with the hospice within a reporting period.

Index Earned Point Criterion

1 point = Hospices earn a point towards the HCI if their average Medicare spending per beneficiary falls below the 90th percentile ranking among hospices nationally.

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HCI #8: Skilled Nursing Care Minutes per Routine Home Care (RHC) Day

$$\frac{\text{Total skilled nursing minutes provided by a hospice on all RHC service days within a reporting period.}}{\text{The total number of RHC days provided by a hospice within a reporting period.}}$$

Index Earned Point Criterion

1 point = Hospices earn a point towards the HCI if their individual hospice score for Skilled Nursing Minutes per RHC day falls **above the 10th percentile** ranking among hospices nationally.

Nursing visit = includes both RN and LPN visits to recognize the frequency of skilled nursing visits and to maintain consistency in HCI when using revenue center code 055X.

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HCI #9: Skilled Nursing Minutes on Weekends

$$\frac{\text{Total sum of minutes provided by the hospice during skilled nursing visits during RHC services days occurring on Saturdays or Sunday within a reporting period.}}{\text{Total skilled nursing minutes provided by the hospice during RHC service days within a reporting period.}}$$

Index Earned Point Criterion

1 point = Hospices earn a point towards the HCI if their individual hospice score for percentage of skilled nursing minutes provided during the weekend is **above the 10th percentile** ranking among hospices nationally.

Nursing visit = includes both RN and LPN visits to recognize the frequency of skilled nursing visits and to maintain consistency in HCI when using revenue center code 055X.

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HCI #10: Visits Near Death

The number of decedent beneficiaries receiving a visit
by a skilled nurse or social worker for the hospice
in the last 3 days of the beneficiary's life within a reporting period.

The number of beneficiaries with at least 1 day of hospice
during the last 3 days of life within a reporting period.

Index Earned Point Criterion
1 point = Hospices earn a point towards the HCI if their individual hospice score for percentage of decedents receiving a visit by a skilled nurse or social worker in the last 3 days of life falls above the 10th percentile ranking among hospices nationally.

Visits by registered nurses, licensed vocational nurses and nurse practitioners (unless the nurse practitioner is acting as the beneficiary's attending physician) are reported under revenue code 055x

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HCI Reports

- CMS will furnish preview reports to providers via the CASPER system in QIES.
- The QM report will also include results of the individual indicators used to calculate the single HCI score and provide details on the indicators and HCI overall score to support hospices in interpreting the information.
- The HCI indicators will be available by visiting the Provider Data Catalog at https://data.cms.gov/provider-data/topics/hospice-care.
- **Add to HQRP: CMS will add the HCI composite measure to the HQRP starting in FY 2022**
- **Public Reporting: HCI will be added to the program for public reporting beginning no earlier than May 2022**

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Hospice Visits in the Last Days of Life (HVLDL) and Hospice Item Set V3.00

- The "Hospice Visits in the Last Days of Life" (HVLDL) measure is the respecified Hospice Visits When Death is Imminent" measure pair.
- Claims-based measure
  - Does not require the provider to collect/submit measure data
  - Data is collected from Medicare claims
- CMS will start publicly reporting the HVLDL measure beginning no earlier than **May 2022.**
- **FY2021** Medicare hospice claims data will be used and included in the Preview Reports no sooner than the May 2022 refresh.
- HVWDII Measure 1 data from the November 2020 refresh, covering HIS admissions during Q1 through Q4 2019, will be publicly displayed for all calendar year 2021 refreshes.

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Hospice Outcomes & Patient Evaluation (HOPE) Update

- This tool is intended to help hospices better understand care needs throughout the patient's dying process and contribute to the patient's plan of care.
- It will assess patients in real-time, based on interactions with the patient. HOPE will support quality improvement activities and calculate outcome and other types of quality measures in a way that mitigates burden on hospice providers and patients.
- CMS's two primary objectives for HOPE are:
  - to provide quality data for the HQRP requirements through standardized data collection, and
  - to provide additional clinical data that could inform future payment refinements.

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Hospice Outcomes & Patient Evaluation (HOPE) Update

- The draft HOPE has undergone cognitive and pilot testing, Alpha testing and will undergo a Beta field test in 2021 to establish reliability, validity and feasibility of the assessment instrument.
- CMS anticipates proposing the HOPE in future rulemaking after all testing is complete.
- CMS will:
  - Use field test results to create a final version of the HOPE -- for future rulemaking for national implementation
  - Continue to engage with stakeholders through sub-regulatory channels.
  - Continue to host HQRP Forums to allow hospices and other interested parties to engage on the latest updates and ask questions on the development of the HOPE and related quality measures.
  - Have a HOPE dedicated email: HospiceAssessment@cms.hhs.gov

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Quality Measure Development for Future Years

- Potential outcome measures from the HOPE assessment and their specifications:
  - Timely Reduction of Pain
  - Impact, Reduction in Pain Severity
  - Timely Reduction of Symptoms
  - The HOPE items for all three measures are collected at multiple time points across a patient's stay, including at Admission, Symptom Reassessment, Level of Care Change, and Recertification.
- CMS continues to develop all three candidate quality measures.
- CMS continues to solicit comments on current HOPE-based quality measure development and recommendations for future process and outcome measure constructs.

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Additional Claims Based Measures

- HVLDL and HCI claims-based measures support the Meaningful Measures initiative and address gaps in HQRP
- Claims-based measure concepts CMS is considering for development include:
  - Hospice services on weekends
  - Transitions after hospice live discharge
  - Medicare expenditures per beneficiary (including the share of non-hospice spending during hospice election
  - The share for hospice care prior to the last year of life
  - Post-mortem visits as measures of hospice quality
- CMS intends to submit additional claims-based measures for future consideration and solicit public comment.

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Hybrid Quality Measures

- CMS is considering developing hybrid quality measures that would be calculated using claims, assessment (HOPE), or other data sources to allow for more comprehensive set of information about care processes and outcomes (Assessment data can be used to support risk-adjustment).
- CMS seeks public comment on quality measure concepts and considerations for developing hybrid measures based on a combination of data sources.

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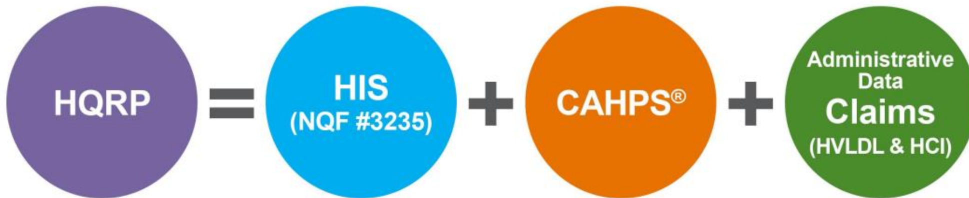
The Update HQRP



The New HQRP combines sources of data from the HIS, and CAHPS®, with administrative data (e.g., Medicare claims)

Source: The FY 2022 Hospice Final Rule: What Hospices Need to Know!
https://www.cms.gov/files/document/2021aug31hospice-final-rule-webinar.pdf

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Public Reporting

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HIS Comprehensive Assessment Measure

The Hospice and Palliative Care Composite Process Measure—HIS-Comprehensive Assessment at Admission measure:

Captures whether multiple key care processes were delivered upon patients' admissions to hospice (7 HIS measures)

CMS will remove the seven individual HIS process measures from public reporting as individual measures on Care Compare no earlier than **May 2022**.

Data on individual measures will be available in CMS's Provider Data Catalog.

There are no changes to the requirement to submit the HIS admission assessment to meet the HQRP reporting requirements for compliance.

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Calculating "Claims-based Measures" for Public Reporting

- CMS is will publicly report the HCI and HVLDL using 2 years of claims data which is 8 quarters of Medicare claims data
- The HCI and HVLDL measures will be reported beginning no earlier than **May 2022**,
- They will be included in the Preview Reports no sooner than the **May 2022 refresh**.
- The publicly-reported version of HCI on Care Compare will only include the final HCI score, and not the component indicators.
- Data on individual indicators will be available in CMS's Provider Data Catalog.

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Calculating "Claims-based Measures" for Public Reporting

CMS will calculate and report claims-based measures:

- Extract claims data to calculate claims-based measures at least 90 days after the last discharge date in the applicable period, which will used for quality measure calculations and public reporting on Care Compare.
- Refresh claims-based measure scores on Care Compare, in preview reports, and in the confidential CASPER QM preview reports annually. This cycle of updates aligns with most claims-based measures across Post Acute Care (PAC) settings.

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Hospice CAHPS – Star Ratings on Care Compare

Star Ratings to begin no sooner than FY 2022: CMS will introduce Star Ratings for public reporting of CAHPS Hospice Survey results on the Care Compare or successor websites no sooner than FY 2022

Star Ratings range: The stars would range from one star (worst) to five stars (best) similar to other post acute provider types

Overall rating: Only the overall Star Rating be publicly reported

Minimum: Hospices must have a minimum of 75 completed surveys to be assigned a Star Rating.

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Hospice CAHPS - Calculation

- The calculation and display of the CAHPS Hospice Survey Star Ratings be like that of other CAHPS Star Ratings programs.
- **Top box score**: Ratings will be calculated based on "top-box" scores for each of the eight CAHPS Hospice Survey measures.
- **Hospice level score**: A hospice-level score for a given survey item would then be calculated as the average of the individual-level responses, with adjustment for differences in case mix and mode of survey administration.
- **Methodology**: Star Ratings methodology will be published on the CAHPS Hospice Survey website, www.hospicecahpssurvey.org

Measure name	Scoring weight
Communication with family	1
Getting timely help	1
Treating patient with respect	1
Emotional and spiritual support	1
Help for pain and symptoms	1
Training family to care for patient	1
Rating of this hospice	1/2
Willing to recommend this hospice	1/2

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Public Reporting of HIS-based Measures Due to PHE Exemption

- CMS will publicly report the most recent available 8 quarters of CAHPS data starting with the February 2022 refresh through the **May 2023** refresh on Care Compare.

  No public reporting of Q1 2020 and Q2 2020 data due to the COVID-19 PHE.

- CMS will use 3 quarters of HIS data for the **February 2022** public reporting refresh of Care Compare for hospice.
- In each refresh **after February 2022**, CMS will report one more post-exemption quarter of data and one fewer pre-exemption quarter of data until they reach eight quarters of post-exemption data in May of 2023.

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Original, Revised, and Proposed Schedule for Care Compare Refreshes Affected by COVID-19 PHE Exemptions

Quarter Refresh	HIS Quarters in Original Schedule for Care Compare (number of quarters)	HIS Quarters in revised/proposed Schedule for Care Compare (number of quarters)
November 2020	Q1 2019- Q4 2019 (4)	Q1 2019- Q4 2019 (4)
February 2021	Q2 2019- Q1 2020 (4)	Q1 2019- Q4 2019 (4)
May 2021	Q3 2019-Q2 2020 (4)	Q1 2019- Q4 2019 (4)
August 2021	Q4 2019- Q3 2020 (4)	Q1 2019- Q4 2019 (4)
November 2021	Q1 2020- Q4 2020 (4)	Q1 2019- Q4 2019 (4)
February 2022	Q2 2020-Q1 2021 (4)	Q3 2020-Q1 2021 (3)

Note: The shaded cells represent data frozen due to COVID-19 PHE.

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Consolidated Appropriations Act, 2021
Hospice Program Integrity

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Pathway to Regulatory Action

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Office Of Inspector General Hospice Report #1 - Hospice Deficiencies Pose Risks To Medicare Beneficiaries

- Hospice Deficiencies Pose Risks to Medicare Beneficiaries Report (OEI-02-17-00020)
- July 2019

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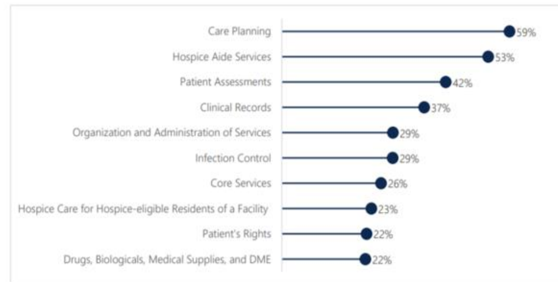
Study Findings

- Most common deficiencies from 2012 through 2016
- Care planning
- Hospice aide services
- Patient assessments



Note: The percentage is based on the number of hospices surveyed from 2012 through 2016 (N=4,563). These categories are based on the CoPs. For the full name of each of the CoPs, see CMS, SOM, Appendix M.

Source: OIG analysis of CMS data, 2018.

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Characteristics of Poor Performers

- 313 hospice providers identified as poor performers
- 88% had a history of other violations
- 67% were for-profit, similar to hospices nation-wide
- 40 hospices had a history of serious deficiencies
- NHPCO clarification with the OIG…
  - At least one condition level deficiency **or** one substantiated severe complaint in 2016
  - Both state-surveyed and accrediting organizations
  - Accrediting organization survey results are not public

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Recommendations from Prior OIG Work

CMS should:

- Analyze claims data to inform the survey process
- Analyze the deficiency data to inform the survey process
- Seek statutory authority to establish additional, intermediate remedies for poor hospice performance
- Include on Hospice Compare deficiency data from surveys, including information about complaints filed and resulting deficiencies

OIG Recommendations Specific to This Report

- Expand the deficiency data that accrediting organizations report to CMS and use these data to strengthen its oversight of hospices.
- Take the steps necessary to seek statutory authority to include information from accrediting organizations on Hospice Compare.
- Include on Hospice Compare the survey reports from State agencies.
- Include on Hospice Compare the survey reports from accrediting organizations, once authority is obtained.
- Educate hospices about common deficiencies and those that pose particular risks to beneficiaries.
- Increase oversight of hospices with a history of serious deficiencies.

OIG Report #2 - Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm

- Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm (OEI-02-17-00021)
- July 2019

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Report Content

- This report features 12 cases of harm to beneficiaries receiving hospice care.
- The OIG examined each case to identify vulnerabilities that could have led to the harm and to determine how such harm could be prevented in the future.
- Some instances of harm resulted from hospices providing poor care to beneficiaries and some resulted from abuse by caregivers or others and the hospice failing to take action.

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Ensuring Program Integrity in Hospice

Jennifer Kennedy, EdD, BSN, RN, CHC, National Hospice and Palliative Care Organization

The Connecticut Association for Healthcare at Home
September 2021

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Example Case

Case 1: The hospice did not treat a beneficiary's wounds, which became gangrenous

- A beneficiary with Alzheimer's disease developed pressure ulcers to both heels 2 weeks after starting hospice care. The ulcers rapidly worsened over the next several days and the beneficiary was admitted to the hospital for a high level of hospice care called general inpatient care. The beneficiary developed gangrene—the death of tissue—and subsequently needed the lower left leg amputated. This beneficiary revoked hospice

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Case 6: The hospice did not take action when a beneficiary was abused by her daughter

Case 6: The hospice did not take action when a beneficiary was abused by her daughter

- A beneficiary was consistently abused by her daughter, who was acting as her caregiver. The daughter would use a chain and elastic seatbelt to keep the beneficiary from getting out of bed. The daughter would also leave her mother in a wheelchair in the bathroom with the lights off and would spray her with water when she called out for help. Further, the daughter refused changes to her mother's drug regimen that left the beneficiary lethargic and weak because the daughter preferred to keep her mother sedated. The hospice's social worker did not visit the beneficiary until several weeks after being notified of the signs of abuse and did not assess the beneficiary's safety during his visit.

QIG Prior Recommendations

Existing recommendation from prior OIG work that addresses these findings:

- CMS should seek statutory authority to establish additional, intermediate remedies for poor hospice performance

QIG Recommendations to Strengthen Safeguards

- Strengthen requirements for hospices to report abuse, neglect, and other harm.
- Ensure that hospices are educating their staff to recognize signs of abuse, neglect, and other harm.
- Strengthen guidance for surveyors to report crimes to local law enforcement.
- Monitor surveyors' use of immediate jeopardy citations.
- Improve and make user-friendly the process for beneficiaries and caregivers to make complaints.

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Congressional Action Consolidated Appropriations Act, 2021

- Hospice Program Integrity Provisions

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Consolidated Appropriations Act, 2021

- Legislation was introduced in the 116th Congress to modify the hospice survey process including the Helping our Senior Population in Comfort Environments, or HOSPICE Act (Hospice Program Integrity)
- **Section 407** of Consolidated Appropriations Act (CAA), 2021
  - Surveyor education and reporting
  - Accrediting organizations to submit survey findings
  - Intermediate sanctions/remedies
  - Special Focus Program
  - Quality withhold increase

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Regulations

Consolidated Appropriations Act, 2021 Implementation

Leading Person-Centered Care

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The Proposed Rule

Link to rule

- CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; Inpatient Rehabilitation Facility Quality Reporting Program Requirements; and Long-term Care Hospital Quality Reporting Program Requirements

Link to NHPCO regulatory Alert

- CY 2022 Home Health Proposed Rule (CMS-1747-P)

CMS Goals

- CMS is proposing a "comprehensive strategy to enhance the hospice program survey process, increase accountability for hospice programs, and provide increased transparency to the public. CMS goals include:
- (1) maintaining the public trust through addressing conflicts of interest and improving survey transparency;
- (2) addressing inconsistency within the survey process through training and survey team composition and use of common hospice program deficiency reporting mechanisms; and
- (3) ensuring hospice programs are held accountable for addressing identified health and safety issues. The statutory requirements outlined in the CAA 2021 will address CMS' goals and are in the best interest of patients who receive care in Medicare-participating hospice programs."

Effective Dates

Provision	Effective Date
Requirement to use multidisciplinary survey teams	October 1, 2021
Prohibition of conflicts of interest	October 1, 2021
Expanding CMS-based surveyor training to Accrediting Organizations (AOs)	October 1, 2021
Requirement for AOs with CMS-approved accreditation programs to begin use of the Form CMS-2567 (or a successor form)	October 1, 2021
New hospice program hotline	1 year after the CAA 2021 enactment – December 27, 2021
Public disclosure of survey information	October 1, 2022
Requirement to implement a range of enforcement strategies	October 1, 2022
All other provisions	Effective upon enactment of the CAA 2021

Hospice Accreditation Organizations

- As of March 2021, there are three Accreditation Organizations (AOs) with CMS-approved hospice accreditation programs:
  - Accreditation Commission for Health Care, Inc. (ACHC)
  - Community Health Accreditation Partner (CHAP)
  - The Joint Commission (TJC)
- These three AOs survey approximately half of the over 5,000 Medicare-certified hospice programs, while the State Agencies (SAs) survey the remaining half.

Changes for Accreditation Organizations

Implementation of the statutory requirement for AOs to use the Form CMS-2567 when reporting survey deficiencies.

- CMS is proposing to require the AOs, as part of a hospice program AO's application and reapplication process, to submit a statement acknowledging that the AO will include a statement of deficiencies to document findings of the hospice program Medicare CoPs and will submit such in a manner specified by CMS.
- CMS proposes to add a new § 488.7(c), which would require the posting of the Form CMS-2567 in a manner that is prominent, easily accessible, readily understandable, and searchable for the general public and allows for timely updates.
- CMS states that "as directed by Congress, we are removing the prohibition that previously allowed AO hospice program survey reports to be considered confidential and proprietary. They propose to **require** that AOs **release deficiency reports** for hospice program surveys conducted under their respective deeming authority to increase transparency among the hospice beneficiary community."

Hospice Program Surveys and Hospice Program Hotline (§ 488.1110)

CMS Proposals:

- A standard survey would have to be conducted not later than 36 months after the date of the previous standard survey.
- A survey could be conducted more frequently than 36 months to assure that the delivery of quality hospice services complies with the CoPs and confirm that the hospice program corrected deficiencies that were previously cited.
- A standard or abbreviated standard survey would have to be conducted when complaint allegations against the hospice program were reported to CMS, the State, or local agency.

Hospice Program Surveys and Hospice Program Hotline (§ 488.1110)

CMS Proposals:

- As specified in the CAA 2021, the law now requires that a hotline must be maintained to:

1. to collect, maintain, and continually update information on HHAs and hospice programs located in the State or locality that are certified to participate in the program; and
2. to receive complaints (and answer questions) with respect to HHAs and hospice programs in the State or locality

The State or local agency must maintain a unit for investigating such complaints that possesses enforcement authority and has access to survey and certification reports, information gathered by any private accreditation agency utilized by the Secretary under section 1865 of the Act, and consumer medical records (but only with the consent of the consumer or his or her legal representative).

Surveyor Qualifications and Prohibition of Conflicts of Interest (§ 488.1115)

Disparities in Overall Survey Performance:

- Currently, AOs are required to provide training to their surveyors.
- As AO requirements allow for standards and processes that exceed those of CMS, the AO's training may differ from what CMS provides to SA surveyors, thereby creating a potential disparity in overall survey performance.
- CMS is proposing that all SA and AO hospice program surveyors would be required to take CMS-provided surveyor basic training currently available, and additional training as specified by CMS.

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Training modules are available free of charge through the Quality, Safety & Education Portal (QSEP), at https://qsep.cms.gov which contains the CMS training. QSEP training is accessible on an individual, self-paced basis.

Focus of Surveys and Emphasis on Assessment of Quality of Care

CMS is updating the hospice program basic training and including enhanced guidance for surveyors. The updated training will emphasize assessment of quality of care. CMS is emphasizing four **"core"** hospice program CoPs to emphasize the assessment of quality of care:

- §418.52 Condition of Participation: Patient's rights
- §418.54 Condition of Participation: Initial and comprehensive assessment of the patient
- §418.56 Condition of Participation: Interdisciplinary group, care planning and coordination of care
- §418.58 Condition of Participation: Quality assessment and performance improvement.

Conflict of Interest

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- In Section 4008 of the SOM, scenarios are described that would be conflicts of interest for SA surveyors, including surveyors who have an outside relationship with a facility surveyed by the SA.
- CMS is proposing to codify that the conflict of interest provision applies to both SA and AO surveyors to "ensure that there is no conflict of interest between the organization and the surveyor."

Criteria for Exclusion as a Surveyor

- CMS proposes that a "surveyor would be prohibited from surveying a hospice program if the surveyor currently serves, or within the previous 2 years has served, on the staff of or as a consultant to the hospice program undergoing the survey.
  - the surveyor could not have been a direct employee, employment agency staff at the hospice program, or an officer, consultant, or agent for the surveyed hospice program regarding compliance with the CoPs."
  - a "surveyor would be prohibited from surveying a hospice program if he or she has a financial interest or an ownership interest in that hospice.
  - the surveyor would also be disqualified if he or she has an immediate family member who has a financial interest or ownership interest with the hospice program to be surveyed or has an immediate family member who is a patient of the hospice program to be surveyed."

Multidisciplinary Survey Teams

- CMS proposes that the survey team must include at least one RN, and if the team is more than one surveyor, the additional surveyors should include "other disciplines with the expertise to assess hospice program compliance with the conditions of participation."
- This proposal would require all survey entities (SAs or AOs) to include "diverse professional backgrounds among their surveyors to reflect the professional disciplines responsible for providing care to persons who have elected hospice care."
- The disciplines in the multidisciplinary team may include physicians, nurses, medical social workers, pastoral or other counselors—bereavement, nutritional, and spiritual.

Baseline Knowledge of Survey Teams

CMS is proposing to establish baseline knowledge about the teams conducting surveys by asking all survey entities:

1. the extent to which their surveys are conducted by one professional, who by regulation must be a registered nurse;
2. the professional makeup of their current workforce; and
3. estimate a timeframe in which they could effectuate multidisciplinary teams if not already in place.

Specialty Surveyors

CMS suggests that they may use as a model, current guidance for long-term care facilities which uses specialty surveyors with expertise not typically included in a survey team (pharmacist, physician, registered dietitian, for example) which may not be needed for the entire survey but may be onsite during the survey.

Measuring and Reducing Survey Inconsistencies

- CCA 2021 requires that each State and the Secretary implement programs to **measure and reduce** inconsistencies in hospice survey results.
- CMS also believes that this applies to "reducing discrepancies between SA and AO surveys of hospice providers."
- CMS is proposing to enhance the requirements of the State Performance Standards System (SPSS) to direct States to implement processes to measure the degree or extent to which surveyors' findings and determinations are aligned with federal regulatory compliance and with an SA supervisor's determinations.

Measuring and Reducing Survey Inconsistencies

- CMS proposes to analyze trends in the disparity rate among States, as well as among AOs and states that they "believe that the disparate deficiency citations between AO surveyors and SA surveyors may, in part, be attributed to differences in surveyor training and education.
- Uniform Surveyor Training Provided by CMS - CMS believes that "uniform surveyor training would increase the consistency between the results of the surveys performed by SAs and AOs." If surveying entities (SAs and AOs) do not meet performance standards, they must develop and implement a corrective action plan.

Special Focus Program

- CMS proposes specific criteria that would be used to determine whether a hospice program participates in the SFP as follows:
  - a history of condition-level deficiencies on two consecutive standard surveys,
  - two consecutive substantiated complaint surveys, or
  - two or more condition-level deficiencies on a single validation survey (the validation survey with condition-level deficiencies would be in addition to a previous recertification or complaint survey with condition-level deficiencies).
- Selection for SFP: A subset of hospice programs that meet the proposed criteria would be selected to be in the SFP, and those hospice programs would be surveyed every 6 months.

Special Focus Program

- These additional enforcement remedies may be used to encourage poor-performing hospice programs to come into substantial compliance with CMS requirements before CMS is forced to terminate the hospice program's provider agreement.
- Once an SFP hospice program has completed 2 consecutive 6-month SFP surveys with no condition-level deficiencies cited, the facility would graduate from the SFP. If the hospice program did not meet the requirements to graduate, it would be placed on a termination track.

Enforcement Remedies for Hospice Programs with Deficiencies

- **Non-compliance with the Medicare hospice programs CoPs**
  - If deficiencies involved may immediately jeopardize the health and safety of the individual(s) to whom the hospice program furnishes items and services, then CMS "may terminate the hospice program's provider agreement, impose the one or more enforcement remedies or both."
- **Decision to impose remedies:** CMS states that imposition of remedies will be "based on the degree of noncompliance with the hospice program Federal requirements. CMS would be able to "impose one or more remedies for each discrete condition-level deficiency constituting noncompliance."
- **Immediate Jeopardy**
  - "if a hospice program's deficiencies involve IJ to the health and safety of the individuals to whom the program furnishes items and services, it shall take immediate action to ensure the removal of the IJ and to correct the deficiencies or terminate the certification of the program."

Available Remedies

1. Civil monetary penalties (CMPs) in an amount not to exceed $10,000 for each day of noncompliance by a hospice program with the requirements specified in section 1861(dd) of the Act;
2. Suspension of all or part of the payments to which a hospice program would otherwise be entitled under this title for items and services furnished by a hospice program, on or after the date on which the secretary determines that remedies should be imposed; and
3. Appointment of temporary management to oversee the operation of the hospice program and to protect and assure the health and safety of the individuals under the care of the program while improvements are made to bring the program into compliance with all such requirements.

- In addition to the above remedies, CMS is proposing to add two additional enforcement remedies:

4. a directed POC
5. directed in-service training

Directed Plan of Correction

- CMS may impose a directed POC on a hospice program that is out of compliance with the CoPs. A directed POC remedy would require the hospice program to take specific actions to bring the hospice program back into compliance and correct the deficient practice(s). A hospice program's directed POC would be developed by CMS or by the temporary manager, with CMS approval. The directed POC would set forth the outcomes to be achieved, the corrective action necessary to achieve these outcomes and the specific date the hospice program would be expected to achieve such outcomes. The hospice program would be responsible for achieving compliance.
- **Failure to achieve compliance**: If the hospice program failed to achieve compliance within the timeframes specified in the directed POC, CMS could impose one or more additional enforcement remedies until the hospice program achieved compliance or was terminated from the Medicare program.

Directed In-service Training

- CMS has outlined the requirements for conducting directed in-service training for hospice programs with condition-level deficiencies.
  - Directed in-service training would be required where staff performance resulted in noncompliance and it was determined that a directed in-service training program would correct this deficient practice through retraining the staff in the use of clinically and professionally sound methods to produce quality outcomes.
- CMS proposes that hospice programs use in-service programs conducted by instructors with an in-depth knowledge of the area(s) that would require specific training, so that positive changes would be achieved and maintained.
  - Hospice programs would be required to participate in programs developed by well-established education and training services. These programs would include, but not be limited to, schools of medicine or nursing, area health education centers, and centers for aging.

Directed In-service Training

- CMS will only recommend possible training locations to a hospice program and not require that the hospice program utilize a specific school/center/provider. The hospice program would be responsible for payment for the directed in-service training for its staff.

NHPCO's Comments To CMS

- NHPCO Regulatory Alert
- NHPCO Comments on CY 2022 Home Health...Proposed Rule: Hospice Survey Reform and Enforcement Remedies Provisions

NHPCO “Hills to Die On”

NHPCO identified five areas which we called “hills to die on” because of their serious implications for hospice providers or because the input needed to design and implement provisions in the proposed rule was so important.

- Suspension of all payments
- TEP for Special Focus Program before design and implementation. Consider TEP for other components of rule, such as surveyor consistency, before implementation.
- Design of “user-friendly, understandable” CMS-2567 for public and consumer audience
- Improving surveyor competency and consistency
  - Between states
  - Between states and accreditation organizations
- Consistent application of deficiency findings and enforcement remedies

National Accrediting Organizations

- NHPCO supported the proposed rule that requires accrediting organizations to file the 2567 and to participate in CMS surveyor training.
- NHPCO expressed concern about the “see one cite one” practice among surveyors and asked for clarification and consideration for how this practice will impact on survey deficiency reports.
- NHPCO questioned how the survey deficiency findings would be posted on Care Compare and the Accreditation Workgroup provided suggested data elements that would be important to consider in a public-facing survey deficiency report.

Survey and Certification of Hospice Programs

- Conflicting interpretations of regulations
  - Reason for citation not clearly specified in regulations
  - Multiple conflicting interpretations of certain regulations
  - Surveyors kept citing home health regulations, asking why 485s weren't in the hospice charts
  - Surveyor had many questions regarding Hospice CoPs as she was used to surveying LTC.
  - Confusion about difference between initial and comprehensive assessment
  - The interpretation of the regulations seems to change each year. We get sign off one year; the next year they say we didn't complete the requirement in its entirety.

Survey and Certification of Hospice Programs

- Overly prescriptive expectations/excessive documentation requirements
  - Cited for medication instructions that had never been corrected or called out previously
  - Surveyor's intense care plan scrutiny (ex. Noting areas that weren't indicative of patient concerns)
  - Wound care deficiency (extensive treatment to heal wound beyond what would be typically needed for a hospice patient)
  - Cited for not having physician orders for every frequency change. Hospice appealed and won.
- Review of employee records
  - Staff licensure not obtained from primary licensure source
  - Request to produce all employee files

Additional Comments

- **Hospice special focus program on Care Compare**: NHPCO expressed serious concern about how the hospice SFP designation would be displayed on Care Compare and encouraged CMS to learn from the experience with the Special Focus Facility program in nursing homes.
- **Enforcement Remedies for Hospice Programs with Deficiencies**: Five remedies in proposed rule – NHPCO suggested that they be imposed in this order:
  - Directed POC
  - Directed in-service education
  - Temporary management
  - Civil Monetary Penalties (CMPs)
  - Suspension of all or part of payments

Additional Comments

- Civil Monetary Penalties (CMPs)
- Assessed by the day or by the incident
- Comparable to other Medicare provider types, but $$ range is different. NHPCO commented that the dollar range for CMPs should be comparable to other provider types.

Range	Reason	$$ Range
Upper range	Deficiency that poses IJ to patient health and safety	$8,500 to $10,000 per day
Middle range	Repeat and/or a condition-level deficiency that did not pose IJ, but is directly related to poor quality patient care outcomes	$1,500 up to $8,500 per day
Lower range	Repeated and/or condition-level deficiencies that did not constitute IJ and were deficiencies in structures or processes that did not directly relate to poor quality patient care	$500 to $4,000 per day

Suspension of Payment for All or Part of the Payments

- CMS states that one enforcement remedy is to suspend all or part of the hospice's payments until they are in compliance.
- NHPCO strongly opposes this provision as it is more stringent than the home health regulation, which is suspension of payments for all new admissions.
- We also stated that if all payments were suspended, the hospice would be out of business very quickly and that suspension of payments should be limited to new admissions AND only in the case of immediate jeopardy.

NHPCO Comments on CY 2022 Home Health...Proposed Rule: Hospice Survey Reform and Enforcement Remedies Provisions

Now We Wait for a Final Rule

- After considering public comments that it receives by the close of the comment period, CMS may develop and publish a final regulation.
- At the time CMS forwards the rule for publication, it also forwards the regulation to the Government Accountability Office (GAO) and both houses of the Congress for review.
- The Final Rule is published in the Federal Register (FR) and made publicly available in print and on-line at http://www.federalregister.gov.

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