HOSPICE PROVISIONS
CY2024 HOME HEALTH PROPOSED RULE
COMMENT OUTLINE

I. **Hospice Special Focus Program (SFP)**
   - **a.** NAHC strongly supports the SFP's goal to "identify hospices as poor performers, based on defined quality indicators, in which CMS selects hospices for increased oversight to ensure that they meet Medicare requirements."
   - **b.** NAHC concerns
     - **i.** Algorithm needs to be improved prior to implementation. See points below and this letter to CMS.
       1. Condition-level deficiencies (CLDs) and substantiated complaints are not scaled.
          - **a.** The SFP Technical Expert Panel (TEP) was provided with a model SFP algorithm that scaled the CLDs and substantiated complaints per 100 beneficiaries (except for hospices in the smallest size quartile (less than 57 beneficiaries, in this instance) for which the raw number was used. As stated in the TEP Report this was to ensure that larger hospices were not at a disadvantage compared to smaller hospices. This was not included in the proposed algorithm and it's unclear why.
          - **b.** Scaling should be part of the algorithm for the reasons stated above.
       2. Some CLDs and complaints may be counted twice.
          - **a.** Hospices with deemed status through an accrediting organization (AO) may have a complaint survey from both the AO and the state agency (SA) if a complainant lodged a complaint with both entities. This could result in a substantiated complaint being counted twice.
          - **b.** If the AO and the SA cite the same CLDs related to a complaint, the CLD will also be doubly counted.
       3. CLDs that are being disputed should not be counted in the SFP algorithm until after the Informal Dispute Resolution (IDR) process is complete. (See IDR section below for recommendation that a timeframe should be associated with this process.)

4. If implemented as proposed, the SFP in 2024 will include CLDs cited for which due process was not available since the IDR process will not be implemented until 2024. This is especially concerning since it was just the beginning of 2023 that CMS implemented improvements to surveyor training guidelines to increase surveyor standardization between SAs and AOs. Moreover, not all SA survey teams participated in this training at the time it was deployed, and it is unknown if all surveyors have completed it at this time.
5. CAHPS Hospice Survey (CAHPS)
    a. Concerns about data
        i. Only 49.3% of hospices have reported on the four CAHPS measures and only 33% of hospices have a CAHPS star rating.
        ii. Greater variability of data - CMS stated in the proposed rule that the CAHPS Hospice Survey Index does not exhibit the same high concentration around the average value as the other measures indicating that hospice performance varies widely.
    b. Concern about heavily weighted CAHPS results
        i. CMS proposes to have the CAHPS scores be weighted at two times the other factors, even though the TEP was presented with an algorithm using a weight of 0.25.
        ii. It is unclear why there would be such an overweighting of data that is only available for half of hospice providers and where the results vary greatly.
        iii. Weighting to this degree creates an unfair bias in the algorithm to hospice providers that report this data and could incentivize hospices to not participate in the CAHPS Hospice Survey.
    c. The algorithm favors hospices that do not participate in CAHPS which creates a perverse incentive against participation. The algorithm should penalize those hospices that do not qualify for a CAHPS exemption yet choose to not participate. While these hospices would already be subject to the 4% annual payment update penalty, adding the increased chance of inclusion in the SFP could weigh heavily and may be a greater motivator for participation.
    d. NAHC is recommending that CMS identify those hospices that do not hold one of the allowable CAHPS exemptions yet choose to not participate in the CAHPS and weight this non-participation in the SFP algorithm.
    e. NAHC is recommending that CMS improve the algorithm so that these biases and incentives are eliminated.
6. Lack of transparency around how hospices are chosen for the SFP

a. In the proposed rule, CMS stated, "5,943 hospices would be eligible for participation in the SFP" and "[t]he hospices selected for the SFP from the 10 percent would be determined by CMS." To ensure transparency, CMS must provide additional information as to how it will decide which of the bottom 10% of hospices will be selected for the SFP. The SFP should not be used as punishment but rather as an educational tool for struggling hospices. We have concerns CMS provided no guidance on how it would utilize its discretion in selecting SFP candidates from the bottom 10% of performers.

b. Due to this lack of transparency hospices are not able to provide informed comment on the full impact of the SFP.

7. CMS did not comment on why it deviated so significantly in the proposed algorithm from the model algorithm presented to the TEP. It would be helpful to understand the reasons for this.

ii. Hospices should receive preview performance reports.

1. Given that hospices have not previously been subject to the SFP program, they should be provided with a preview of their performance on the algorithm data and their standing among other hospices across the country prior to implementation of the SFP. Much of the data inputs are not publicly available so hospice providers are not able to determine their performance relative to others, and providers should be aware of how they compare to other hospices.

2. This will allow hospices the opportunity to see in which indicators improvement is needed and begin working towards that.

iii. Technical Assistance (TA) should be part of the SFP

1. According to the CY 2022 HH PPS Final Rule, the hospice SFP is meant to address issues that place hospice beneficiaries at risk for poor quality of care by increasing hospice oversight and/or technical assistance.

2. TEP members strongly suggested that TA be mandatory for hospices that are part of the SFP for the duration of their time in the program. The TEP also suggested a list of approved TA providers, on which state and national hospice associations should be included, should be utilized due to the additional burden and conflict of interest present if completed by the survey entity. TEP members noted that national standards should be developed and shared with the SFP TA entities to ensure consistency in application of the TA.

II. Informal Dispute Resolution (IDR) Process

a. NAHC appreciates that CMS proposed this process that would provide hospices with the opportunity to informally dispute condition-level survey deficiencies with the survey entity. (Same process as that available to home health agencies currently.)

b. Hospices should comment on whether they plan to use this process if it is finalized, and if not, why not.

c. Some states offer hospices the ability to take advantage of the IDR process even though not required by CMS. Hospices that have used this option should comment on their experience.

d. NAHC supports the addition, overall; however, it is important to note that the risk associated with a condition level deficiency for hospice is greater than it is for home health agencies since home health does not have a Special Focus Program (SFP). Therefore, CMS should collect data on hospice utilization of the IDR process and the results.

e. There is not a set timeframe during which the survey entity must process the IDR request. Considering that state agencies are struggling to conduct surveys on open complaints, and revisits to ensure corrective action has occurred[1], it is likely that IDR requests will not be a priority for SA and will remain open for a significant period of time. This makes it possible that CLDs will be included in the count for the SFP algorithm and later be removed under the IDR. NAHC is recommending that CMS only utilize CLDs in the algorithm after the statement of deficiencies has been completed without any outstanding IDR requests.

III. Categorical Risk Screening

NAHC supports the proposal to revise § 424.518 to move initially enrolling hospices and those submitting applications to report any new owner (as described in § 424.518's opening paragraph) into the ''high'' level of categorical screening; revalidating hospices would be subject to moderate risk-level screening.

IV. 36-Month Rule

NAHC supports the proposal to expand Section 424.550(b)(1) to require that when a hospice undergoes a change in majority ownership (CIMO) (more than 50 percent) by sale within 36 months after the effective date of its initial enrollment or within 36 months following the hospice's most recent CIMO, the provider agreement and Medicare billing privileges will not convey. (Same language, including exceptions, that is applicable to home health.)

V. Definition of Managing Employee

NAHC supports the proposal to revise the managing employee definition in § 424.502 by adding the following language immediately after (and in the same paragraph as) the current definition: For purposes of this definition, this includes, but is not limited to, a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director.

[1] CMS, Fiscal Year 2022 (FY22) State Performance Standards System (SPSS) Findings