Kenneth Albert, R.N., Esq.
Chairman of the Board

HOMECARE & HOSPICE
National Association for Home Care & Hospice
228 Seventh Street, SE, Washington, DC 20003 • Ph: 202/547-7424 • 202/547-3540 fax

William A. Dombi, Esq.
President

August 29, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, The Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20101

RE: CMS-1780-P. *Comments relating to Medicare Program; 2024 Home Health Prospective Payment System Proposed Rule*

The National Association for Home Care & Hospice (NAHC) respectfully submits these comments regarding the *hospice-specific* proposals contained within the NPRM. NAHC is the largest trade association representing the interests of Medicare hospices and home health agencies (HHAs) nationwide including nonprofit, proprietary, urban, and rural based, hospital affiliated, public and private corporate entities, and government run providers since 1982. NAHC members provide most Medicare home care services throughout the U.S.

NAHC is also an original provider-member of the Leadership Council of Aging Organizations (LCAO) as it has put patients first in its health policy and advocacy positions since its inception. Each year, NAHC members serve millions of patients of all ages, infirmities, and disabilities, providing an opportunity for individuals to be cared for in their own homes, the care setting preferred by virtually all people.

Many members of our Forum of State Associations also support these comments. We are specifically joined on this letter by numerous state associations listed on the final page. Many others are filing their own comments too. State associations are an important voice in understanding the impact of the proposed rules in their local settings. Their "on the ground" perspective deserves special attention.

Special Focus Program

NAHC appreciates the time and effort expended by the Centers for Medicare & Medicaid Services (CMS) and the Technical Expert Panel (TEP) in development of the proposed Hospice Special Focus Program (SFP). We strongly support 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" and believe the appropriate quality indicators are essential in identifying hospice providers that would most benefit from the program. However, we have concerns that the SFP algorithm

identified in the proposed CY 2024 Home Health rule will not accurately identify the poorest performing hospices.

We, along with other national associations representing hospices, outlined some concerns in a letter submitted to the Administrator on August 16, 2023. For the reasons identified in that letter and those highlighted below, we **ask that CMS work with the existing SFP Technical Expert Panel (TEP) to**

- **improve the SFP algorithm methodology prior to its planned implementation on January 1, 2024,**
- **implement a nationwide pilot of the updated algorithm with all hospices, during which SFP results will not be publicly posted, and hospices will be provided interim reports of their performance ranking under the updated SFP algorithm metrics.**

This may require a delay in implementation and that CMS issue a new proposed rule with the modified algorithm to give stakeholders the opportunity to comment.

The consequences of being selected for the SFP are severe, which is why the selection criteria must be designed to identify the subset of hospices that are truly the poorest performers and *most* in need of remediation to address quality concerns. An interim performance period (or preview period) would help providers understand the algorithm, learn how their performance compares to others nationally, and identify where they need to target improvements to ensure high-quality care.

As currently constructed, we are concerned that the SFP algorithm would not only miss the opportunity to improve truly poor-performing hospices, but also could unfairly identify higher-performing hospice programs based on factors that are not as germane to patient and family care quality and satisfaction (e.g.., size of the hospice). The ramifications of a poorly targeted selection process could inadvertently lead to access issues for beneficiaries and their families. Some of our specific concerns with various aspects of the proposed algorithm inputs are as follows:

CONDITION-LEVEL DEFICIENCIES AND SUBSTANTIATED COMPLAINTS

- **Condition-level deficiencies (CLDs) and substantiated complaints are not scaled to account for the number of beneficiaries a hospice serves.**
  The SFP Technical Expert Panel (TEP) was provided with a model SFP algorithm that did scale 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 scaling was not included in CMS' proposed algorithm and it is unclear why CMS chose not to follow the TEP's lead.

  Scaling the data is essential to ensure programs are comparable. For example, a large provider who has received two substantiated complaints for an average daily census (ADC) of 500 does not raise the same level of concern as a provider who has two substantiated complaints but an ADC of 50. If the goal is to ensure beneficiaries are receiving patient-centered, quality hospice care, it is necessary to review these data as ratios rather than raw numbers in both the algorithm for SFP eligibility, as well as for the criteria for graduation or termination.

  Disputed CLDs and CLDs without due process are part of the SFP. If implemented as proposed, the SFP in 2024 will include CLDs cited for which due process was not available. The Informal Dispute Resolution (IDR) process is not yet implemented, and it is not fair to utilize

condition-level deficiency data that was cited at a time when hospices did not have due process available for recourse on incorrect citations. This is especially concerning since it was only at 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. **Utilizing results of 2023 surveys under these circumstances is inequitable and contributes to the possibility that a hospice that should be part of the SFP is not and vice versa.**

Going forward, CLDs that are being disputed but for which the dispute process is not complete could be counted in the SFP algorithm depending on when the survey agency completes the IDR request, as there is not a timeframe proposed for this process. **It should only be after the Informal Dispute Resolution (IDR) process is complete that the final Statement of Deficiencies is submitted and recorded in iQIES and any CDLs counted in the SFP algorithm.**

- **Past due surveys.**
  NAHC is receiving reports that SA surveyors are woefully behind in completing standard Medicare recertification surveys as well as complaint surveys. These anecdotal reports appear consistent with the survey data currently available. CMS' own Quality and Certification Oversight Reports (QCOR) data website indicates that in 2022, 35% of hospices did not have a survey in the prior 36 months. CMS indicates in the proposed rule that only 5.7% of hospices are not represented in the survey data from 2019-2021. This could be because the hospice has not had a survey as part of the 36-month cycle, the completed Statement of Deficiencies is not in the CASPER system, or there was not a recorded substantiated complaint. We understand data in QCor is not current, as indicated by the QCor statement "Due to systems migrations, hospice provider and survey information will be accurate and complete through September 29, 2022." However, if the data is accurate, it is an indication that the number of past due surveys is growing.

  CMS acknowledges in its Fiscal Year 2022 (FY22) State Performance Standards System (SPSS) Findings (Admin Info: 23-10-ALL) that *"The COVID-19 Public Health Emergency (PHE) has resulted in many lingering and difficult-to-solve challenges for SAs such as ongoing staffing shortages, ongoing resource challenges, unprecedented numbers of retirements among experienced surveyors, and significantly fewer than normal applicants applying for open positions due to constrained availability of health care workers. These staffing and resource challenges have occurred in conjunction with a marked increase in the number of health care provider complaints received during the PHE, resulting in numerous SAs struggling to conduct surveys on open complaints, and revisits to ensure corrective action has occurred."* These challenges have, according to the QCor data, expanded significantly after the years utilized in the SFP algorithm model that the TEP reviewed.

  Additionally, per information shared by hospices that have experienced a recertification survey since the implementation of the revised hospice survey process at the beginning of 2023, the survey is taking longer. Based on these reports, there is at least an additional day required for the surveys, which also impacts the workforce and resources available for surveys. **NAHC is concerned about whether the existing survey workforce can absorb the additional surveys that are needed under the SFP.**

CMS assumes that the absence of data in iQIES on complaint surveys is likely because the hospice program has no substantiated complaints. Considering the staffing and resource challenges identified by CMS in the SPSS report and recent information shared with NAHC by providers, it seems likely that there are complaints that have not been investigated. Data available in QCor shows ten states with no complaint investigations in 2022. While some of these states have a smaller number of hospices, and those hospices do not serve many beneficiaries compared to others in the nation, it is still difficult to believe that such many states have no substantiated complaints. QCor does not track complaint surveys that are past due, so there is no public data with this information, and we are not aware that CMS tracks this data elsewhere.

CLDs and substantiated complaints are critical factors in identifying poor performers, and CMS should ensure the recertification survey completion rate is at an acceptable level. CMS has identified that a reduction in past due surveys is necessary, requiring in its Fiscal Year (FY) 2023 State Per (SPSS) Guidance (Admin Info: 23-12-ALL) that state survey agencies reduce past due surveys by at least 50%. The 2022 QCor data shows that 40% of the CMS Location Offices have not completed 50% or more of the hospice recertification surveys. The range of past due surveys across these offices is 20% to 60%.

- **Some CLDs and complaints may be counted twice.**
  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. Additionally, if the AO and the SA cite the same CLDs related to a complaint, the CLD will also be doubly counted. **CMS should implement a mechanism that ensures that substantiated complaints for the same incident are only counted once.**

CAHPS HOSPICE SURVEY (CAHPS)

We agree that the caregiver voice should be included in any algorithm for the SFP; however, there are major limitations with the existing CAHPS Hospice Survey data that need to be addressed. CMS states that it proposes to use multiple data sources to provide a comprehensive view of the quality of care provided at the identified hospices. However, the CAHPS data source in the algorithm does not provide a comprehensive view of the quality of care. Only 49.3% of eligible hospices (2,929 of the 5,943 SFP-eligible hospices) report the four CAHPS Hospice Survey measures that are part of the proposed algorithm, and only 33% of hospices have enough data to have a CAHPS Hospice Survey Star Rating. 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.

NAHC strongly agrees with the members of the TEP regarding their concern about the limited availability of CAHPS data. CMS' SFP TEP contractor, Abt Associates, gave CAHPS a weight of only 0.25 in the algorithm presented to the TEP "…because approximately two-thirds of hospices do not have a CAHPS® score reported."[1] Despite this, CMS is proposing to veer substantially from the algorithm

[1] 2022 Technical Expert Panel and Stakeholder Listening Sessions: Hospice Special Focus Program Summary Report, Abt Associates, April 2023.

presented to the TEP by double weighting the CAHPS scores, effectively giving the input with the greatest data limitations the most influence in determining SFP candidates.

If we are understanding the algorithm correctly, those hospices not reporting CAHPS data get a kind of "pass," as the algorithm disregards this factor for these hospices. This structure creates a perverse incentive to not participate in the CAHPS Hospice Survey. Based upon an analysis utilizing publicly available data on QCor and in the data sheets at data.Medicare.gov to approximate CMS' proposed SFP algorithm, those hospices without a CAHPS score have more CLDs per beneficiary and more complaint survey deficiencies than those with a CAHPS score. This highlights the proposed structure's bias towards hospices that report CAHPS, and away from hospices that might need the SFP's increased oversight and education more (as evidenced by their higher number of CLDs and complaints).

NAHC strongly urges CMS to consider alternatives to this treatment of the CAHPS in the algorithm. Specifically, CMS should consider identifying CAHPS-exempt hospices that choose to not participate in the CAHPS and weigh this non-participation in the SFP algorithm. 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, positively impacting the percentage of hospices with CAHPS data and public information about more hospices' performance on this important quality element. Another alternative is to do this and weigh another factor in the algorithm more heavily, such as the Hospice Care Index (HCI). The HCI is the most objective of all the factors since it is claims-based.

Again, the purpose of the SFP is to identify the poorest performing hospices, but the proposed algorithm does not guarantee these are the providers that will end up in the program. Utilizing a data point, the CAHPS Hospice Survey, which encompasses slightly less than half of the hospice provider population and weighing it at two times the other algorithm factors is puzzling. **NAHC strongly urges CMS to improve the algorithm so that these biases and incentives are eliminated and to do so with the input of the SFP TEP.**

TECHNICAL ASSISTANCE

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 (TA). 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, which we believe should include state and national hospice associations. We have concerns about the survey entity itself being the organization tasked with providing the TA, given the additional burden and conflict of interest inherent in an entity responsible for citing deficiencies also being responsible for teaching hospices how to improve them. TEP members noted that national standards should be developed and shared with the SFP TA entities to ensure consistency in application of the TA. CMS did not provide any insight into the CY 2024 HH PPS proposed rule as to why this crucial component was not included in the SFP. **NAHC agrees with the TEP and strongly recommends that TA be incorporated into the SFP as suggested by the TEP.**

LACK OF TRANSPARENCY

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. Due to this lack of transparency, hospices are not able to ascertain and provide fully informed comments on the full impact of the SFP.

Also preventing fully informed comments is the fact that CMS did not explain why it deviated so significantly in the proposed algorithm from the model algorithm presented to the TEP, particularly as it relates to scaling CLDs and complaints by hospice size, and the weighting of the CAHPS input. The reason(s) for the deviation should be shared.

As stated above, the data necessary for a hospice to estimate its overall quality of care performance compared to other hospices across the nation is not publicly available. Hospices 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. This will allow hospices to identify which indicators need improvement and begin working to address those areas. **Therefore, NAHC is strongly recommending that CMS provide interim performance reports or preview reports to hospices prior to the implementation of the SFP.**

We understand there are data migration issues impacting QCor and the data that is publicly available. **We recommend that these issues be resolved before the implementation of the hospice SFP so that providers and others can depend on the accuracy and timely posting of the CLD and substantiated complaint data. Further, since the subset of quality-of-care CLDs are central to the SFP algorithm score, we request that CMS develop a separate "*Quality of Care Condition Level Deficiencies Report.*" This would provide much needed detail on the frequency of quality-of-care CLDs by CMS location and by state.**

NAHC also has concerns that CMS may be utilizing the SFP as a method for identifying and dealing with fraudulent behavior in the Medicare hospice program instead of its intended purpose of improving quality of care amongst poor performing hospices. We were surprised to see in an August 2023 CMS blog, CMS is Taking Action to Address Benefit Integrity Issues Related to Hospice Care, that the proposed SFP was included as one of the regulatory changes CMS is proposing this year to better tackle hospice fraud. CMS states in the proposed rule that the SFP would "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." Development of the SFP is required by the HOSPICE Act, an Act initiated in response to quality-of-care issues identified by CMS and the HHS Office of the Inspector General (OIG) in reports published in 2019. CMS would select some hospices from the bottom 10% of quality performance to be part of the SFP. Hospices selected will be under additional oversight to enable continuous improvement.

There are factors other than quality indicators that are far better at identifying fraudulent behavior and could do so early in a hospice's existence, allowing CMS to terminate the activity and the provider from the Medicare program quickly. These factors are related to provider enrollment and billing, are intended to catch all fraudsters instead of a subset and are not part of the SFP. Also, the SFP allows providers to remain in the program while working on improvement. Fraudsters have no place in the hospice program and should be dealt with swiftly. We believe CMS is expanding its tools under the Center for Program Integrity (CPI) to ferret out fraudulent behavior while also expanding its tools under the Center for

Clinical Standards and Quality (CCSQ) to improve the quality of hospice care. These important parallel initiatives should not be conflated.

CMS proposes to periodically review the effectiveness of the methodology and the algorithm and adjust through rulemaking, as necessary. As explained above, there are significant concerns about the proposed algorithm, and we worry that without changes prior to implementation, it will not achieve its goal of identifying the truly poorest performers and those *most* in need of remediation to address quality concerns. Implementing the SFP as proposed and attempting to adjust it while it is in full motion is not only an ineffective use of resources but also could have unintended access-to-care consequences, as patients and families are steered away from hospices that may not actually be good SFP candidates.

As stated above, we strongly support the purpose of the SFP and appreciate the time and effort expended by CMS and the TEP on the development of this program. It is essential that the SFP be carefully thought out and that the human and financial resources necessary for its success be allocated.

Informal Dispute Resolution (IDR) Process

NAHC appreciates that CMS proposes a process that would provide hospices with the opportunity to informally dispute condition-level survey deficiencies with the survey entity. (This is the same process as that available to home health agencies currently.) NAHC supports the addition, overall. However, we have some concerns about the inherent conflict of interest with the survey entity responsible for citing the CLD also being responsible for reviewing the dispute. We have heard from some providers that they would not file a dispute, even if they were certain the condition should not have been cited, due to this inherent conflict of interest. The risk associated with a condition level deficiency for hospice is greater than it is for home health agencies due to CLD inclusion in the SFP algorithm and the severe consequences to a hospice of inclusion in the SFP. **Therefore, CMS should collect data on hospice utilization of the IDR process and results to determine its effectiveness. This information could also be helpful to CMS in its oversight of survey entities.**

CMS has not established 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[2], it is likely that IDR requests will not be a priority for SAs and will remain open for a significant period. **NAHC is recommending that CMS institute a timeline for survey entities to complete the IDR process and recommends 30 calendar days from the date the dispute is filed.**

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.

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

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

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, which is applicable to home health.)

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.

Sincerely,

William A. Dombi
President

Katie Wehri
Director, Home Health & Hospice Regulatory Affairs

These comments are also submitted on behalf of the following State Association Co-signers

Arizona Association for Home Care
HomeCare Association of Arkansas
California Association for Health Services at Home
California Hospice and Palliative Care Association
Home Care Association of Colorado
Connecticut Association for Healthcare at Home
Home Care Association of Florida
Healthcare Association of Hawaii
Idaho Health Care Association
Illinois Homecare & Hospice Council
Indiana Association for Home and Hospice Care
Iowa Center for Home Care
Kansas Home Care & Hospice Association
Kentucky Home Care Association
Home Care Association of Louisianna
Home Care & Hospice Alliance of Maine
Maryland-National Capital Homecare Association.
Home Care Alliance of Massachusetts
Michigan HomeCare and Hospice Association
Minnesota Home Care Association
Mississippi Association for Home Care
Missouri Alliance for Home Care
Nebraska Association for Home Healthcare and Hospice
Home Care & Hospice Association of New Jersey
New Mexico Association for Home & Hospice Care
Home Care Association of New York State

Association for Home & Hospice Care of North Carolina
Granite State Home Health & Hospice Association (NH)
Ohio Health Care Association
Oregon Association for Home Care
Pennsylvania Homecare Association
Rhode Island Partnership for Home Care
South Carolina Home Care & Hospice Association
Tennessee Association for Home Care
Texas Association for Home Care and Hospice
Homecare and Hospice Association of Utah
VNAs of Vermont
Virginia Association for Home Care and Hospice
Wisconsin Association for Home Health Care