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Eli's Hospice Insider

Quality: Hospices' Concerns Brushed Aside As Medicare Implements 3 Unpopular New Quality Measures

Quality is a major focus of the recent final rule.

Major changes are ahead for hospice quality measures in the coming year.

In its hospice final rule for 2022, the Centers for Medicare & Medicaid Services cements its plans to launch a CAHPS Star Rating measure and a claims-based Hospice Care Index measure composed of 10 claims data points, and to display results for the Hospice Visits in Last Days of Life Measure. They will join the existing Hospice and Palliative Care Composite Process Measure - HIS-Comprehensive Assessment Measure at Admission to make up the four measures of the Hospice Quality Reporting Program.

CMS plans to debut the new measures on Medicare's Care Compare website by next May, indicates the rule published in the Aug. 4 Federal Register.

If that seems like a lot, you're right. CMS turned down numerous calls to slow down the changes. "We hoped our comments would have impacted the timing on some of HQRP content, we were not surprised that CMS stayed their course from the proposed rule," notes **Judi Lund Person** with the National Hospice and Palliative Care Organization.

Read on for the scoop on each new quality measure:

1. CAHPS Star Ratings. "Star ratings benefit the public in that they can be easier for some to understand than absolute measure scores, and they make comparisons between hospices more straightforward," CMS claims in a fact sheet about the rule.

The star rating measure includes Consumer Assessment of Healthcare Providers and Systems survey data for eight areas: communication with family; getting timely help; treating patient with respect; emotional and spiritual support; help for pain and symptoms; training family to care for the patient; rating of this hospice; and willing to recommend this hospice.

The star ratings will be "based on top box scores of the eight current CAHPS measures," Lund Person explains.

Criticism: "Many commenters questioned the weighting of the components of the star ratings, particularly the decision to weigh the two global questions (Overall Rating and Willingness to Recommend) at 50 percent of the weight for each composite measure," acknowledges CMS in the rule.

Those two measures "are highly correlated with one another, as both provide global assessments of hospice care," CMS explains in the final rule. "Given this, weighting each of the two measures at 100 percent would over-emphasize global assessments of care relative to the other aspects of care assessed by CAHPS Hospice Survey measures," the agency maintains. CMS does the same thing for hospital ratings, it adds.

Another criticism: "Some commenters raised questions about using 75 completed surveys as the threshold for public reporting of stars," CMS admits in the final rule. "This was a concern for many commenters because it would mean that star ratings would be available only for large hospices."

CMS can't go lower with the threshold, it insists. "If a hospice does not have enough survey completes to reliably

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measure performance, the star ratings would be picking up more noise than true performance," the rule says. "CMS seeks to balance the goal of reporting star ratings for as many hospices as possible with the need to ensure that the star ratings can be stably estimated and distinguish between hospices' performance."

Yet, "the public might misinterpret the lack of star ratings for smaller hospices as being evidence of poor quality care," commenters told CMS. The agency promises to "explore alternatives for presenting additional information about star ratings on the Care Compare website so that consumers may be informed about why smaller hospices may not have stars."

Stay tuned: CMS is testing an updated version of the CAHPS survey, including an online modality and fewer questions, it confirms in the rule. Any changes could also mean eventual changes to the CAHPS star rating system.

2. HCI. The brand-new Hospice Care Index will be comprised of claims-based data on 10 points (see box p. 2). "Collectively, the indicators represent different aspects of hospice care and provide a comprehensive characterization of the quality of care furnished by a hospice throughout the stay," CMS says in its fact sheet about the rule.

The HCI is the second claims-based measure CMS is implementing, after the HVLDL measure, Lund Person says.

Because the HCI is based on claims data, no new data collection will be required for it, CMS cheers. "Claims-based measures ... do not increase burden to providers," the agency maintains in the rule.

Criticism: Hospices lodged a number of concerns about the new measure in the comment process. Among those was that the items based on visit utilization fail to take into account all disciplines. "Claims do not fully capture patients' clinical conditions, patient and caregiver preferences, or hospice activities such as telehealth, chaplain visits, and specialized services such as massage or music therapy," commenters told CMS.

CMS is not swayed. "After much consideration of the input received, we believe the benefits of adopting the HCI outweigh its limitations," the rule says. "The HCI is not intended to account for all potentially valuable aspects of hospice care, nor is it expected to entirely close the information gaps presently found in the HQRP. Rather, the HCI will serve as a useful measure to add value to the HQRP by providing more information to patients and family caregivers and better empowering them to make informed health care decisions."

Plus, "RN services correlate well with CAHPS data and therefore are important services to reflect hospice quality of care," CMS adds.

CMS did have some good news about the indicators that count nurse visits with revenue code 055X. Because 055X includes both RN and LPN visits, they will be counted for those indicators, the final rule reveals.

CMS shoots down requests to update HCI data quarterly instead of annually, as well as HVLDL data. "Claims measures reflect business practices that are slow to change," CMS insists in the rule. For example, data show "a hospice's HCI scores would not normally fluctuate a great deal from one year to the next, and that they will fluctuate even less from quarter to quarter. Thus, quarterly updates would not necessarily provide meaningful support to hospices seeking to improve their quality of care. Instead, progress on HCI will occur over longer time frames, and annual updates are sufficient to support hospices' efforts to improve," the agency believes.

Do this: Hospices should "assess internal processes that will impact the data collected in [the] Hospice Care Index measure for process improvement," Lund Person advises. Plus they should "educate their staff about HQRP changes that will occur in 2022," she tells AAPC.

3. HVLDL. As proposed, CMS is moving ahead to display on Hospice Compare data from the claims-based Hospice Visits in the Last Days of Life (HVLDL) measure, which is replacing the Hospice Item Set data-based Hospice Visits When Death Is Imminent.

Criticism: Based on comments, hospices still protest that the measure includes only RN or medical social worker visits,

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failing to include LPN, chaplain, or other spiritual services.

"While CMS agrees that all patient visits are meaningful, based on our analyses, we found that RN and medical social worker visits correlate well with the CAHPS quality measures for 'would recommend' the hospice," the rule explains. Care Compare will list which disciplines are assessed in the measure, CMS adds elsewhere in the rule.

The included disciplines may not be set in stone, however. "If claims data are revised to include other disciplines, we may consider whether to include them in this measure," CMS allows.

Another criticism: The measure assesses whether patients received RN and MSW visits on two of the last three days of life. Commenters argued that two visits on one of the last three days of life should also count, and that visits during Continuous Home Care (CHC) and General Inpatient (GIP) care and telehealth visits should count as well.

CMS stands firm on its measure criteria. Data analysis shows that "when visits by RNs or medical social workers occurred in at least two of the last three days of life, family and caregivers agree or positively correlate that they would recommend the hospice more often," the rule notes. And CHC and GIP already require the visits, so they aren't included in this measure, CMS said.

As for telehealth visits, they "are not full substitutes for care provided in person, particularly in the case of the visits measured in the HVLDL and HCI measures," CMS claims. "We acknowledge that there may have been an increase in refusals during the COVID-19 [Public Health Emergency]. However, this increase would likely impact hospices in a region similarly, and thus will not impact a hospice's score relative to local competitors," CMS tells hospices in the rule.

Multiple commenters asked CMS for more time to get used to the two new claims-based measures. "While we are committed to provide time for understanding and preparation, we are not committed to ensuring that all hospices achieve high scores on the new measures before publicly reporting them," CMS says. "For these reasons, we believe that no additional dry run period is warranted."

4. COVID-19 PHE. CMS finalizes with no changes its proposal for how to avoid publicly reporting data from the first two quarters of the COVID-19 PHE after the Care Compare freeze ends.

For HIS quality measures, CMS will resume public reporting in February 2022 using data from only three quarters - Q3 and Q4 of 2020 and Q1 of 2021. For CAHPS quality measures, CMS will use the most recently available eight quarters of data starting with the February 2022 refresh and going through the May 2023 refresh on Care Compare, skipping over Q1 2020 and Q2 2020 data due to the PHE.

Note: The 79-page final rule is at www.govinfo.gov/content/pkg/FR-2021-08-04/pdf/2021-16311.pdf.

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