CMS Releases Hospice Quality Reporting Program Report

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The Centers for Medicare & Medicaid (CMS) has been developing a new Hospice Quality Reporting Program (HQRP) data collection tool – HOPE (Hospice Outcomes & Patient Evaluation). The HOPE is a standardized assessment instrument that hospices would use as part of the comprehensive assessment process to collect clinical and demographic patient data that is submitted to CMS and upon which future quality measures will be developed. CMS completed beta testing for the HOPE in fall 2022 and has been analyzing the results with the intent to propose HOPE implementation in the HQRP in future rulemaking.

CMS has utilized a Technical Expert Panel (TEP) to inform the development of the HOPE and provide input on future quality measures. For 2022 and 2023, the TEP focused primarily on discussions about the importance and usability of measure concepts and potential measures, specifications of potential measures, and the potential risk adjustment of future publicly reported HOPE-based quality measures. In a recently released report provides a broad summary of the TEP's work with a focus on the discussions on HOPE-based outcome measures and risk adjustment factors for these measures.

PROCESS MEASURES

The HOPE-based process measures under development focus on timely reassessment of pain and non-pain impact, based on the percentage of patients assessed with moderate or severe symptom impact who received a follow-up reassessment within two days.

	Timely Reassessment of Pain Impact	Timely Reassessment of Non-Pain Impact
Numerator	Assessments where pain impact is reassessed within 2 days of the triggering assessment date	Assessments where non-pain[11] symptoms impact is reassessed within 2 days of the triggering assessment date.
Denominator	Total assessments where pain impact is moderate or severe at admission.	Total assessments where non-pain impact is moderate or severe at admission.

Abt asked the TEP members to rate the face validity of both process measures. Face validity is the extent to which a measure is subjectively viewed as covering the concept it aims to measure. In other words, a high face validity

means a measure “looks like” it will measure what it is supposed to measure. The TEP rated both Timely Reassessment of Pain Impact and Timely Reassessment of Non-Pain Impact measures as having high face validity.

Abt also sought feedback from the TEP on whether CMS should exclude patients from process quality measure calculations based on their desired tolerance levels for symptoms, preferences for symptom management, presence of neuropathic pain, and whether they are actively dying at admission. The TEP supported several exclusions for the measures. The members also felt that:

- hospices should not be penalized if a patient died between admission and reassessment, thus preventing the hospice from completing a symptom reassessment
- process measures should include patients of all ages
- process measures should exclude patients for whom the hospice is unable to reassess symptom impacts as scheduled for certain reasons
- hospices should be penalized if reassessment is missing or delayed due to hospice staffing or scheduling issues.

Abt Associates, the contractor working for CMS on the HOPE, sought the TEP’s input regarding the future development of HOPE-based quality measures. Abt presented several potential future process measure concepts, including:

- Education for Medication Management
- Wound Management Addressed in Plan of Care
- Transfer of Health Information to Subsequent Provider
- Transfer of Health Information to Patient/Family Caregiver

Abt also requested TEP input on developing future HOPE-based outcome measures, such as:

- Patient Preferences Followed throughout Hospice Stay
- Hospitalization of Persons with Do-Not-Hospitalize Order Discussion

The TEP identified the three highest priorities for future HOPE quality measure development. They are:

- Education for Medication Management
- Wound Management Addressed in Plan of Care
- Hospitalization of Persons with Do-Not-Hospitalize Order

RISK ADJUSTMENT

The goal of risk adjustment is to ensure that quality measure outcomes are unaffected by external factors beyond the hospice’s control and that may differ between providers. This includes items such as diagnoses, functional status, age, living situations, etc.   Abt Associates presented the TEP with potential risk adjustment factors Overall, the TEP’s discussion on risk adjustment focused on

high-level concepts. The TEP broadly agreed that risk adjustment is very important The TEP discussed and ranked those options by relative importance. The table below summarizes the TEP's recommendations.

Must include	Important	Caution Advised	Do not include
• Age • Diagnoses	• Living situations • Site of service • Length of stay	• Payment source • Treatment • Risk of hospitalization	• Gender[9] • Clinical symptoms • Functional status • Management of care needs

The report includes some of the TEP's reasons for these recommendations and discussions around them.

The TEP felt that the external factors that warrant risk adjustment depend on the purpose of the public reporting. They suggested using different sets of risk adjustment factors for public reporting purposes than for hospice quality improvement work providing more detailed risk adjustment for hospices to use internally. For publicly reported data used to select a hospice, the TEP suggested using demographic factors (including age but excluding gender), socioeconomic factors, living situation, and diagnoses.

NEXT STEPS

Relative to HQRP measures, CMS submitted the two HOPE-based process measures, Timely Reassessment of Pain Impact and Timely Reassessment of Non-Pain Symptom Impact to the consensus-based entity (CBE) as part of the 2023 Measures Under Consideration (MUC). Based on the results of CBE review, CMS may finalize these measures in future rulemaking for the HQRP. For more information, see the Quality Measure Development page on the HQRP website.

Relative to implementation of the HOPE in the HQRP, as stated above, CMS has indicated it will propose this in future rulemaking. A timeline for this has not been shared by CMS, but NAHC believes it is possible that it is included in next year's hospice proposed rule. CMS could also incorporate it into another proposed rule.

NAHC is watching this closely and will share information as it becomes available in NAHC Report and on NAHC Communities.