



DATA LIMITATIONS WITH THE HOSPICE SPECIAL FOCUS PROGRAM



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EXECUTIVE SUMMARY

The Consolidated Appropriations Act of 2021 mandated the creation of the Hospice Special Focus Program (SFP) to monitor hospices identified as poor performers that fail to meet certain requirements.¹ As part of the program, CMS intends to make public a list of the lowest performing 10% of providers that their analysis has identified. This program is designed to be a helpful tool for patients and families looking to choose a hospice provider. If implemented correctly, the additional oversight may help poor-performing providers improve their quality of care. Otherwise, providers selected for the Hospice SFP that fail to address their performance deficiencies will be terminated from the Medicare program.

If the Hospice SFP is unable to correctly identify the worst hospice performers, however, various risks may arise:

- Reputational harm to providers incorrectly identified as delivering poor quality care.
- Diversion of patients away from providers incorrectly identified as poor quality.
- Referral of patients to poor quality providers that are not identified as such.
- Inappropriate allocation of resources for purposes of surveying and monitoring poor performing hospices.
- These risks highlight the importance of ensuring that the Hospice SFP correctly assesses performance and accurately identifies poor performers.

The National Hospice & Palliative Care Organization and the National Association for Home Care & Hospice commissioned McDermott+ to replicate the Centers for Medicare & Medicaid Services (CMS) methodology for identifying the bottom 10% of providers for the Hospice SFP. M+ used the most current data publicly available from CMS but, because of fundamental data limitations, was not able to fully replicate and evaluate the CMS methodology used for the Hospice SFP.

¹ 42 USC § 1395i-6(b).

SUMMARY OF KEY FINDINGS

Inadequate access to the data and incomplete data from survey backlogs prevented M+ from fully evaluating whether CMS methodology will correctly identify the absolute worst performers in the hospice industry. A key limitation is that the three years of survey and substantiated complaints data used by CMS in their original analysis are not publicly available. Table 1 below shows the data sources used by CMS compared to the data used by M+ for this report.

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TABLE 1: NON-ALIGNMENT OF MOST DATASETS FOR THE HOSPICE SFP

CMS DATA SOURCE (FROM SFP USER GUIDE BY ABT ASSOCIATES SUBMITTED TO CMS, DECEMBER 2023)	M+ DATA SOURCES AS OF JULY 24, 2024
Hospice Survey Data – Quality-of-Care Condition-Level Deficiencies (CLDs) May 1, 2020 – April 30, 2023 <i>Source: Quality, Certification & Oversight Reports</i>	Hospice Survey Data – Quality-of-Care CLDs Oct. 2021 – Aug. 2023 <i>Source: Quality, Certification & Oversight Reports</i>
Substantiated complaints May 1, 2020 – April 30, 2023 <i>Source: Quality, Certification & Oversight Reports</i>	Substantiated complaints Oct. 2019 – Sept. 2022 <i>Source: Quality, Certification & Oversight Reports</i>
Hospice Care Index (HCI) Overall Score Jan. 2021 – Dec. 2022 <i>Source: Hospice Provider Data Catalog</i>	HCI Overall Score Jan. 2021 – Dec. 2022 <i>Source: Hospice Provider Data Catalog</i>
Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Hospice Survey Data Jan. 2021 – Dec. 2022 <i>Source: Hospice Provider Data Catalog</i>	CAHPS Hospice Survey Data Historical data available Jan. 2021 – Dec. 2022. More current data are available July 2021 – June 2023 ² <i>Source: Hospice Provider Data Catalog</i>

Data limitations include:

- **Key Data Not Publicly Available:** The HCI and CAHPS data that CMS used in the original analysis for the 2024 Home Health Prospective Payment System Rate Update and SFP Requirements final rule, which finalized the parameters of the Hospice SFP algorithm, are the only data from January 2021 through

² The M+ analysis used CAHPS data from June 2021-June 2023 as it is the most current available as of the writing of this report. M+ has confirmed that none of the key findings in this report are impacted by the choice of using CAHPS Jan 2021 – Dec 2022 data versus July 2021 – June 2023 data.

December 2022 that are publicly available. CMS did not make public the data on the other key variables used in the original analysis, including the substantiated complaints and survey data from May 2020 through April 2023. CMS confirmed via email to M+ that it will not make this data available for the time periods used in the original analysis.

- **Publicly Available Data Doesn't Line Up:** The datasets that are publicly available for substantiated complaints, survey data, CAHPS data and HCI data are measured during different time periods and only share the same 12-month period between October 2021 and September 2022.
- **Data Missing Key Identifiers:** The survey data made available by CMS does not contain any identifiers to accurately determine which CLDs belong to the same survey cycle. This makes it difficult to accurately count unique deficiencies only once per survey cycle, which we understand is the criteria that CMS implemented but cannot be replicated through external analysis.
- **Data Includes Errors:** The survey data includes CLDs that are inappropriately tagged as “standard” deficiencies. CMS clarified via email to M+ that CMS will correct this issue in its next data release, but this correction has not yet been implemented at the time of this writing.

These data deficiencies make it very difficult for hospices to perform their own analysis to assess whether the algorithm will correctly identify the absolute worst performers. Because CMS envisions making this bottom 10% list public, data deficiencies could lead to significant reputational and financial harm to hospices that are incorrectly identified, even if later analysis reveals that they should not have been selected. Inaccurate selection could also have negative implications for beneficiaries if they are unwittingly steered toward poor performing providers.

In addition to data limitations, survey backlogs impose significant limitations on the ability of CMS to accurately assess provider performance. These surveys are a key component of the data analyzed for the Hospice SFP.

- The US Government Accountability Office (GAO) has documented that, as of May 2023, 10% of hospices participating in Medicare for 36 months or more are overdue for a survey. The GAO also found that 15% of hospices that were surveyed at least once in a three-year reporting cycle between 2017 and 2022 were cited for serious quality deficiencies.³
- M+ identified 5,979 hospices with data for at least one of the inputs (HCI, CAHPS, complaints or CLDs). Among these hospices, 1,548 (26%) have not been surveyed and therefore have missing data for CLDs. This high rate of not surveyed hospices may stem from the fact that the public file only includes surveys from two

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³ GAO-24-106442, Medicare Hospice: CMS Needs to Fully Implement Statutory Provisions and Prioritize Certain Overdue Surveys. <https://www.gao.gov/assets/gao-24-106442.pdf>

years of data (October 2021 – August 2023). CMS will need to release a public file that includes surveys over three years of data to allow the public to better evaluate the Hospice SFP.

- Hospices that have not been surveyed will be imputed the national “average” number of deficiencies for purposes of CMS’s Hospice SFP algorithm. For hospices that would have deficiencies uncovered if they were surveyed, this approach reduces their chances of being selected for the bottom 10%.

As previously noted, CMS plans to publicly identify the 10% worst performers based on its Hospice SFP algorithm, which is derived from data for substantiated complaints, CLDs, CAHPS and HCI. The high rate of hospice providers that are not being timely surveyed in accordance with federal law⁴ reduces confidence that the Hospice SFP will accurately identify the lowest 10% of performers, because not all hospice providers will have sufficient data to be accurately evaluated.

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BACKGROUND

In the 2024 Home Health Prospective Payment System Rate Update; and Special Focus Program Requirements final rule, CMS published its methodology for identifying the lower performing 10% of hospice providers for the Hospice SFP. The agency published additional details in the Hospice SFP user guide⁵ and the CMS hospice forum.⁶

Once CMS establishes a list of the bottom 10% of hospice providers using its algorithm, CMS will manually remove from that list hospices that are currently under enhanced oversight and/or on a termination track. Among the remaining hospices on the list, CMS will identify a subset of the worst performers for additional oversight and monitoring through increased surveys. It is our understanding that hospices identified in the bottom 10% list, as well as hospices selected for the SFP, will be publicly reported on the SFP website, and that those selected for the SFP that fail to improve their quality will be removed from the Medicare program.

The Hospice SFP is intended to identify hospices that fail to meet program requirements. Additional oversight of poor performers via increased surveys may help these hospices improve their performance. Both the hospice community and the Hospice SFP technical expert panel⁷ have advised CMS to further strengthen the program by providing technical assistance to hospices selected for the SFP. Such assistance is not currently a component of the program, however.

⁴ 42 CFR 488.1110(a). [https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-488/subpart-M#p-488.1110\(a\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-488/subpart-M#p-488.1110(a))

⁵ Abt Associates, *Special Focus Program User’s Guide: Algorithm and Public Reporting*, December 2023.

⁶ CMS Hospice Forum: Hospice IDR and SFP Updates, November 14 2023. <https://www.cms.gov/files/document/special-focus-program-users-guide-algorithm-and-public-reporting.pdf>

⁷ Abt Associates, *2022 Technical Expert Panel and Stakeholder Listening Sessions: Hospice Special Focus Program Summary Report*, April 28, 2023. <https://www.cms.gov/files/document/2022-technical-expert-panel-tep-and-stakeholder-listening-sessions-hospice-special-focus-program.pdf>

If implemented correctly, the Hospice SFP may help to strengthen the quality of care provided to hospice patients. But if CMS fails to correctly identify the worst performers in the hospice industry, it may lead to:

- Reputational harm to providers incorrectly identified as delivering poor quality care.
- Diversion of patients away from providers incorrectly identified as poor quality.
- Referral of patients to poor quality providers that are not identified as such.
- Inappropriate allocation of resources for purposes of surveying and monitoring poor performing hospices.

If the Hospice SFP is successful in identifying the worst hospice providers, it may help improve public trust in hospice care and improve the industry's trust in government oversight of hospice providers. Improved trust and better information for families may also lead to earlier adoption of hospice for terminally ill beneficiaries who, along with their families, may benefit from receiving these services sooner. As an example, in 2022 more than a quarter of hospice patients were enrolled in hospice for five days or less,⁸ and evidence suggests earlier enrollment in hospice can reduce Medicare spending and benefit patients, family members and caregivers.⁹

There is no statutory deadline for CMS to launch the Hospice SFP. CMS is authorized to take the time necessary to work with stakeholders to ensure that the Hospice SFP correctly identifies the worst hospice performers.

ANALYSIS

The substantiated complaints and survey data used by CMS for building the Hospice SFP algorithm in the 2024 Home Health Prospective Payment System Rate Update; and Special Focus Program Requirements final rule are not publicly available. To attempt to replicate and evaluate the CMS algorithm, M+ used the most current data publicly available as of July 24, 2024, which cover a different time period than the data CMS used for its original analysis. Specifically, M+ used the following data sources:

- Substantiated complaints from October 1, 2019, through September 30, 2022.
- Hospice survey data from October 1, 2021, through August 31, 2023.
- HCI data derived from claims for January 1, 2021, through December 31, 2022.
- Hospice CAHPS data from July 1, 2021, through June 30, 2023.¹⁰

These substantiated complaints and survey data do not fully align with the time periods covered in CMS's analysis of the Hospice SFP algorithm, which prevents M+ from evaluating the SFP algorithm with high confidence (see table 1 above). In comparison, Abt Associates' analysis for CMS, as described in the SFP user

⁸ MedPAC March 2024 Report to Congress, Chapter 9: Hospice Services, page 305. https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf

⁹ NORC at the University of Chicago, National Association for Homecare & Hospice, National Hospice and Palliative Care Organization. "Value of Hospice in Medicare." March 2023. <https://www.nhpco.org/hospiceworks/>

¹⁰ CMS used CAHPS data from January 2021 – December 2022 which are publicly available. M+ used CAHPS data from July 2021 – June 2023 to ensure that the most current data publicly available are used but have confirmed that the choice of CAHPS data (January 2021 – December 2022 versus July 2021 – June 2023) does not change any of the key findings from this analysis.

guide, used substantiated complaints and survey data from May 1, 2020, through April 30, 2023, and CAHPS and HCI data from January 1, 2021, through December 31, 2022. As a result, the original Hospice SFP analysis fully covers the 2021 and 2022 calendar years for all four data sets. The HCI and CAHPS data used in the original analysis share the same 24-month window, and the substantiated complaints and surveys share the same 36-month window.

The other key issues with trying to replicate the algorithm are:

- Each data input measures a different window of time for hospice performance.
- Many hospices have missing survey and/or CAHPS data which are important metrics to evaluate provider performance.

There are 5,979 hospices with data for at least one of the four data sets.¹¹ Of those hospices:

- 4,431 (74%) have been surveyed and/or have a substantiated complaint.
- 4,930 (82%) have an overall HCI score.
- 3,022 (51%) have a CAHPS score.

To minimize the risk of hospices being unfairly evaluated because of missing data related to the incomplete time periods covered, M+ limited its analysis to hospices that were active with the Medicare program as of Q2 2024 and had at least one claim in the Medicare standard analytic files limited data set for hospice for 2022. This limited review reduced the number of hospices analyzed from 5,979 to 5,052. Of those hospices:

- 3,593 (71%) have been surveyed and/or have a substantiated complaint.
- 4,730 (94%) have an overall HCI score.
- 2,962 (59%) have a CAHPS score.

According to the GAO, 10% of hospices participating in Medicare for 36 months or more are overdue for a survey. The GAO also found that approximately 15% of hospices that were surveyed at least once in a three-year reporting cycle between 2017 and 2022 were cited for serious quality deficiencies.¹² M+ found that over a quarter of hospices did not have survey data. The difference between the M+ and GAO estimates of hospices with missing survey data, may be due to M+ using the publicly available survey data which only captures two years of survey data, whereas the GAO had access to the most recent three years of survey data.

The Hospice SFP focuses on hospice providers in the bottom 10% based on performance, but this high rate of missing survey data could allow the poorest performing hospice providers to avoid being (correctly) assigned to the bottom 10% – and therefore render them ineligible for the Hospice SFP.

Additionally, of the 32,098 survey records listed in the publicly available hospice survey data from October 2021 through August 2023, 1,380 (4%) have their provider CMS certification number (CCN) listed as “PENDING.” A

¹¹ Hospices with “Pending” CCN in the hospice survey data were excluded.

¹² GAO-24-106442, [Medicare Hospice: CMS Needs to Fully Implement Statutory Provisions and Prioritize Certain Overdue Surveys.](https://www.gao.gov/assets/gao-24-106442.pdf)

“PENDING” CCN would generally be indicative of a new provider being surveyed for initial certification. Without an assigned CCN, a hospice’s survey data does not count toward the SFP. This could prevent newer hospices from being fairly evaluated and included in the analysis for the Hospice SFP.

Another key concern is that the publicly available survey data do not contain unique identifiers to ensure that CLDs are counted appropriately per survey cycle.¹³ It is an open question whether a CLD should be counted toward the Hospice SFP only once per survey cycle, or if every documented instance of the same deficiency should be counted, including follow-up surveys. It is not possible to evaluate the impacts of either approach because of limitations on linking the same CLDs together in the same survey cycle. CMS has stated via email to M+ that it plans to count CLDs only once per survey cycle; however, in the absence of unique identifiers for individual survey cycles, it is not possible to do so. As a proxy for that approach, M+ counted CLDs only once per hospice per condition, to remove the risk of double-counting deficiencies per survey cycle. However, this approach could result in undercounting condition level deficiencies for hospices.

The M+ analysis also evaluated the correlation between the four datasets included in the Hospice SFP algorithm. We found a correlation between overall HCI scores and CLDs:

- Hospices with zero or one CLDs have the highest average HCI score.
- HCI scores decrease for hospices with two or more CLDs.
- Hospices with missing survey data generally have an HCI score consistent with hospices that have two or more CLDs. It is likely that if these hospices were surveyed, their actual average number of CLDs would be higher than the average number of CLDs (0.29) that will be assigned to them in lieu of complete survey data.

For the Hospice SFP algorithm, hospices with missing survey data are assigned the average number of CLDs for the 11 conditions of participation (CoPs) selected by CMS. This methodological decision by CMS:

- Reduces the standard deviation used for standardizing scores, leading to slightly higher absolute values for standardized scores than would have occurred without imputation.

Relationship between HCI score and count of CLDs

Total CLDs for 11 CoPs	Total Hospices	Total Hospices with HCI Score	Average HCI Score When Populated
Missing	1510	1508	8.76
0	2940	2666	8.92
1	341	320	9.02
2	162	151	8.74
3	58	50	8.48
4	25	22	8.32
5+	16	13	7.62

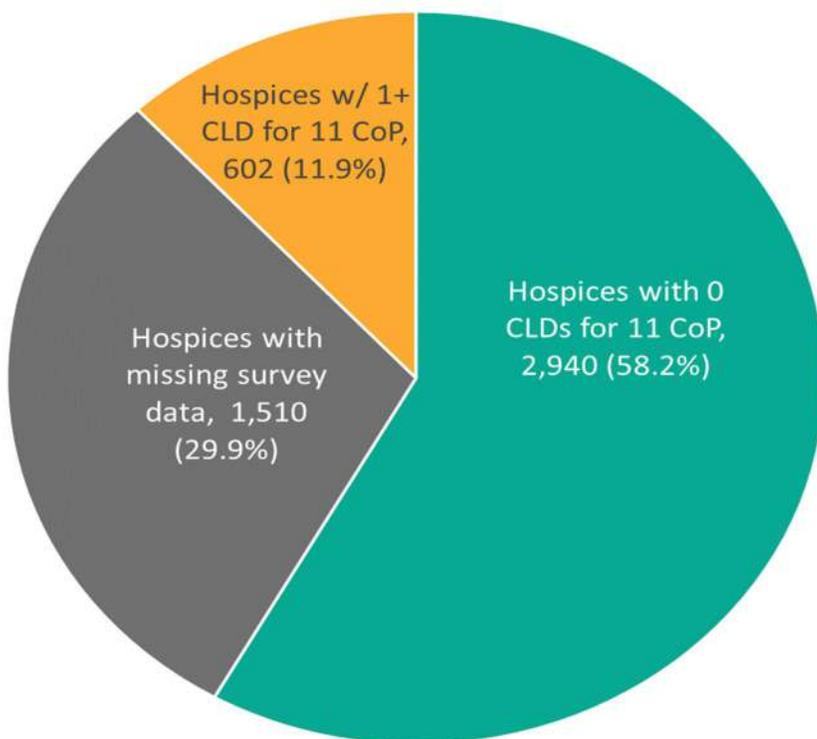
Source: M+ analysis of Hospice survey data for condition level deficiencies from October 1 2021 – August 31 2023 and Hospice Care Index (HCI) derived from claims for January 1 2021 – December 31 2022, after limiting to hospices that were actively enrolled with Medicare as of 2024 Q2 and had at least one Medicare claim in 2022.

¹³ The survey data do include a “Survey Event ID” and “Visit Number,” but they are not always populated and do not appear to accurately identify CLDs cited in the same survey cycle.

- May slightly reduce the chance that poor performing hospices with missing survey data will be selected for the bottom 10%.
- May make some hospices with missing survey data achieve a better score for the Hospice SFP than if they had actually been surveyed.

As an example, in the table above, we observe that higher numbers of CLDs are generally associated with lower HCI scores. Hospices with missing survey data have an average overall HCI score of 8.76, which is consistent with the typical HCI score for hospices with two CLDs. However, by assigning the average number of CLDs (0.29) to hospices with missing survey data, the Hospice SFP algorithm benefits hospices that likely would have had more deficiencies had they been surveyed.

Distribution of Hospices by Survey Data Results



As shown in the chart at left, 30% of the hospices analyzed by M+ have missing survey data. As noted, many of these hospices with missing survey data would likely have had one or more CLDs if they were surveyed. The M+ analysis shows that failing to survey all hospices within 36 months as required under current law prevents 30% of the hospices in our sample from being accurately evaluated on their performance.

Slight changes in performance can also cause a hospice to place in the bottom 10% for CLDs and substantiated complaints. As an example, the median hospice has zero CLDs for the 11 CoPs and zero substantiated complaints. Any hospice that finds itself with just one CLD or one substantiated complaint will find itself in the bottom 10th percentile for those metrics, respectively, increasing the hospice's odds of being in the bottom 10% overall.

In the M+ analysis only 4% of all hospices with zero CLDs were in the bottom 10% compared to 14% of hospices with one CLD. This reveals a concern that small changes in performance as recorded via survey data or substantiated complaints may impact selection for the SFP.

Metric	National Average	Standard Deviation	Median	Bottom 10th Percentile	Bottom 1st Percentile
HCI	8.86	1.21	9.00	7.00	5.00
CAHPS Bottom Box	25.29	9.38	24.00	37.00	54.50
CLDs for 11 CoPs	0.29	0.65	-	1.00	3.00
Substantiated Complaints	0.43	2.00	-	0.42	7.00

Source: M+ analysis of Hospice survey data for condition level deficiencies from October 1 2021 – August 31 2023, substantiated complaints from October 1 2019 – September 30 2022, HCI data for Jan 2021 - December 2022, and CAHPS data from July 2021 – June 2023 after limiting to hospices that were actively enrolled with Medicare as of 2024 Q2, had at least one Medicare claim in 2022, and at least one populated input. Standard deviations calculated after imputing the national average for each input where the hospice had missing data.

POLICY DISCUSSION

HOW TO ADDRESS MISSING DATA

M+ believes that it is not methodologically sound to “predict” the number of CLDs in a program designed to identify the worst *performing* providers. Nor is it methodologically sound to impute the average number of CLDs for hospices that have not been surveyed in the last 36 months.

A more sound methodological choice would be to evaluate hospices based only on the data available, rather than imputing averages for missing data. As an example, after calculating standardized scores for each data input, CMS uses two formulas for calculating the overall provider score. The first formula is for hospices with reported CAHPS data:

$$\text{Overall Score} = \frac{\text{CLDs for 11 CoPs} + \text{Complaints} - \text{HCI} + 2 * \text{CAHPS}}{5}$$

The second formula is for hospices without reported CAHPS data:

$$\text{Overall Score} = \frac{\text{CLDs for 11 CoPs} + \text{Complaints} - \text{HCI}}{3}$$

CMS could create additional, similar formulas to evaluate hospices with missing data for other inputs. As an example, a better formula to evaluate hospices with missing survey and CAHPS data, but populated substantiated complaints and HCI data, would be:

$$\text{Overall Score} = \frac{\text{Complaints over 3 years} - \text{HCI}}{2}$$

Dropping data inputs from counting toward the denominator for hospices with missing data would ensure that each hospice’s performance is evaluated solely on the data directly available without adding bias that may result from imputing national averages for missing data. CMS could accomplish this by continuing to give hospices a standardized value of zero for inputs where they have missing data, but no longer counting that data input toward the denominator. The general formula necessary to implement this approach then would be:

A = Count of total data inputs where the hospice has populated data for surveys, substantiated complaints, and HCI

B = Flag for one if the hospice has populated CAHPS data, zero otherwise

$$\text{Overall Score} = \frac{(\text{CLDs for 11 CoP} + \text{Complaints} - \text{HCI} + 2 * \text{CAHPS})}{A + 2 * B}$$

IMPROVING THE FORMULA

The formulas used by CMS may be further improved by reducing the weight for CAHPS. The Hospice SFP currently weights the CAHPS metric double relative to all other data inputs. However, a technical expert panel, established by Abt Associates and CMS to further inform the development of the SFP, assigned the lowest weight to CAHPS.¹⁴ The panel weighted HCI data at 1, survey data at 0.5, substantiated complaints at 0.5 and CAHPS data at 0.25.

Many hospices do not have populated CAHPS data because they are new or were unable to meet the minimum CAHPS cutoff of 50 survey responses (indicating they are a small hospice with a low patient count). Hospices with populated CAHPS data generally have a higher overall HCI score and are less likely to have CLDs for one of the 11 CoPs, but are more likely to have at least one substantiated complaint. Generally, hospices with populated CAHPS data are less likely to be in the bottom 10% for the SFP because of their typically higher HCI scores and lower likelihood of having a CLD for one of the 11 CoPs.

Hospices & CAHPS Availability	Hospices with Populated CAHPS Data	Hospices with Missing CAHPS Data
Total Hospices	2,962	2,090
Average Number of Medicare Patients	549	61
% of Hospices with Missing HCI Score	0.2%	15%
Average HCI Score (among those not missing HCI)	9.30	8.12
% of Hospices with Missing Survey Data	29%	31%
% with 1+ CLD for 11 CoPs (among those not missing survey data)	10%	14%
% with 1+ Substantiated Complaint (among those not missing survey data)	10%	3%
Substantiated Complaints Per 100 Beneficiaries (among those not missing survey data)	0.07	0.27

¹⁴ Abt Associates. 2022 Technical Expert Panel and Stakeholder Listening Sessions: Hospice Special Focus Program Summary Report. <https://www.cms.gov/files/document/2022-technical-expert-panel-tep-and-stakeholder-listening-sessions-hospice-special-focus-program.pdf>

As a sensitivity analysis, M+ identified the bottom 10% of hospice providers when the CAHPS measure is weighted equally with the other data inputs. Among the 505 hospices identified as part of the bottom 10% when CAHPS is weighted double, 463 (92%) remain in the bottom 10% when CAHPS is weighted equally with all other inputs, and 42 (8%) find themselves in the top 90%. The 42 providers that moved to the top 90% are replaced by 42 hospices that newly enter the bottom 10% list, of those 36 had populated CAHPS data and 6 did not. The hospices that newly enter the bottom 10% list have a worse score on one of the other three inputs (HCI, CLD or substantiated complaints) compared to the hospices that leave the bottom 10% when the CAHPS score is weighted equally with all other inputs. Removing CAHPS completely from the Hospice SFP algorithm continues to change the bottom 10% and further reduces the chances that hospices with populated CAHPS data will be selected for the bottom 10%.

	Hospices with CAHPS Data	
	Populated	Missing
Total Hospices	2962	2090
In bottom 10% in baseline when weighting CAHPS double	184	321
In bottom 10% after setting CAHPS weight equal to all other inputs	178	327
In bottom 10% after removing CAHPS from SFP	164	341
Percent of all hospices		
In bottom 10% in baseline when weighting CAHPS double	6.2%	15.4%
In bottom 10% after reducing CAHPS weight	6.0%	15.6%
In bottom 10% after removing CAHPS from SFP	5.5%	16.3%

CAHPS data are an important measure of the family and caregiver experience. But hospices with CAHPS data generally perform better along key quality of care metrics compared to hospices without CAHPS data.

It is important to note that CAHPS excludes hospices that:

- Were unable to generate the required minimum of 30 completed surveys to participate in CAHPS;
- Are low-volume hospices that had fewer than 50 surveyor-eligible patient/caregiver pairs in a year;
- Are new hospices with less than the minimum of eight reported quarters of data¹⁵ to be included in the publicly available file; or
- Refuse to submit CAHPS data and accept a 4% reduction in their annual Medicare payment rates.¹⁶

In other words, hospices with CAHPS data have higher patient volumes and have been around longer. Hospices with CAHPS data also generally perform better on claims-based metrics such as HCI scores relative to hospices without CAHPS data. There has also been an increase in newer hospices (which likely will not have CAHPS data

¹⁵ CMS, [CAHPS Hospice Survey](https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems/cahps-hospice). Accessed July 12, 2024. <https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems/cahps-hospice>

¹⁶ According to the CMS Hospice Forum on November 14, 2023, 98% of hospice providers that did not report CAHPS were either new or sufficiently small volume. This suggests that 2% of these hospice providers may have otherwise met the required criteria but chose not to report data. If these numbers are still current, this suggests that slightly more than 40 of the 2,090 hospices missing survey data in our analysis actively chose not to report CAHPS. [CMS Hospice Forum Transcript](https://www.cms.gov/files/document/cms-hospice-forum-transcript-november-2023.pdf), November 14, 2023, page 21. <https://www.cms.gov/files/document/cms-hospice-forum-transcript-november-2023.pdf>.

because of minimum reporting requirements) engaging in fraudulent activities.¹⁷ For these reasons, it may be reasonable to expect hospices reporting CAHPS data to have a relatively lower likelihood of being selected for the Hospice SFP. The formula that the technical expert panel developed for the SFP reduced the weight of CAHPS to be less than the weight assigned to all other inputs, which would reduce the impact of key limitations related to this metric.

CMS's current methodology of doubling the weight for CAHPS relative to all other metrics, even though CAHPS is missing for more than two-fifths of providers, will likely lead to some hospices being unfairly placed on the bottom 10% list instead of more deserving providers without CAHPS data.

CONCLUSION

Using the most current publicly available data from CMS, M+ attempted to replicate the CMS methodology for identifying the bottom 10% of providers for the Hospice SFP. However, because of the data limitations outlined in this report, M+ was not able to evaluate whether the methodology used by CMS to develop the bottom 10% list will accurately identify the absolute worst performing hospice providers in Medicare. The high rate of missing survey data and CAHPS data is a source of concern and could render some newer hospices with the poorest outcomes from being selected for the bottom 10% list.

CMS's current methodology of doubling the weight for CAHPS relative to all other metrics, even though CAHPS is missing for more than two-fifths of providers, will likely lead to some hospices being unfairly placed on the bottom 10% list instead of more deserving providers without CAHPS data.

The high rate of missing survey data and CAHPS data is a source of concern and could render some newer hospices with the poorest outcomes from being selected for the bottom 10% list.

¹⁷ CMS, [CMS is Taking Action to Address Benefit Integrity Issues Related to Hospice Care](https://www.cms.gov/blog/cms-taking-action-address-benefit-integrity-issues-related-hospice-care), August 22, 2023. <https://www.cms.gov/blog/cms-taking-action-address-benefit-integrity-issues-related-hospice-care>

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