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Public Comment
2023 Measures Under Consideration
Partnership for Quality Measurement
Pre-Rulemaking Measure Review - Post-Acute Care/Long-Term Care
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Since 1982, the National Association for Home Care & Hospice (NAHC) has been the leading association representing the interests of hospice, home health, and home care providers across the nation. Our members are providers of all sizes and types -- from small rural agencies to large national companies -- and including government-based providers, nonprofit voluntary hospices, privately-owned companies and public corporations. As such, we welcome the opportunity to comment on the CMS List of Measures Under Consideration. We are commenting on the following measures:

- MUC2023-163 Timely Reassessment of Pain Impact
- MUC2023-166 Timely Reassessment of Non-Pain Symptom Impact Measure Evaluation
- MUC2023-183 CAHPS Hospice Survey-Care Preferences
- MUC2023-191 CAHPS Hospice Survey Hospice Team Communication
- MUC2023-192 CAHPS Hospice Survey Getting Hospice Care Training

MUC2023-163 Timely Reassessment of Pain Impact and MUC2023-166 Timely Reassessment of Non-Pain Symptom Impact Measure Evaluation

These measures are based on a standardized comprehensive assessment instrument, the Hospice Outcome & Patient Evaluation (HOPE). While beta testing of the HOPE and analysis has been completed, the HOPE is not available to hospices and members of the PRMR PAC-LTC Committee. For the HOPE to be utilized as a requirement of the HQRP, it needs to go through the rulemaking process. Without the HOPE tool, it is not possible to provide informed review of these measures. Specifically, the ratings of “moderate” and “severe” are crucial to the measure but undefined without the HOPE. Additionally, “assessment” and “reassessment” are not defined nor is “IDG meeting”. According to the PQM PRMR PAC/LTC Committee Preliminary Analysis Report (Report), symptom impact assessments are administered at fixed timepoints during a hospice election – at admission (ADM) and in conjunction with the first and second interdisciplinary group (IDG) meetings. Hospices are not required to hold IDG meetings. The overwhelming majority of hospices do so, however, for the purpose of completing some of the required work of the IDG. These meetings are usually held every 7 or 14 days as some of the required work (update to the comprehensive assessment and review and revision, as necessary, of the plan of care) must be completed at least once every 15 days or as often as the patient’s condition requires. Regardless of how frequently these meetings occur, they continue throughout the patient’s time in hospice. It is unclear why symptom impact assessments, as described for these measures, are limited to timepoints of admission, and in conjunction with the first and second IDG meetings only. Further, it is unclear why the measures would look only at timely reassessments of pain and non-pain symptoms for these timepoints which are at the beginning of a patient’s episode of hospice care.

Most hospices conduct follow-up for symptoms (pain and non-pain) within hours of identifying symptom impact above a patient's preference/goal. This follow-up is completed via in-person visit, phone call or telehealth (two-way audio and video). Depending on the symptom and impact, initial follow-up often does not require an in-person visit. For instance, a pain or non-pain symptom that is addressed with a change in medication dosage may only require a conversation with the patient to determine effectiveness of the change to reduce the pain/non-pain symptom to an acceptable level. Patients experience pain and symptoms on the physical, emotional, social, and spiritual levels. CMS requires hospices to utilize an interdisciplinary group (IDG) consisting of professionals and individuals specializing in these areas in order to adequately address these levels. Symptoms that a non-RN member of the IDG may address could include, but are not limited to depression, anxiety, mood swings, confusion, sleep disturbances, etc. In situations where a patient's pain/non-pain symptoms are above their desired tolerance level, CMS should recognize reassessment by any of the appropriate IDG members. It is not clear, without the HOPE, if reassessments for these measures will be accepted by the appropriate IDG member for the non-pain symptom or the RN only.

We understand that when HOPE is implemented hospice-wide there will be more data from which measures can be developed. In the interim, we read with interest the 2021 and 2023 Technical Expert Panel (TEP) Hospice Quality Reporting Program Summary Report. Consistent with feedback shared from the TEP on the two process measures CMS is considering for the HQRP, NAHC believes that reassessment of pain and non-pain symptom impact is an important process supporting the delivery of quality hospice care. Overall, NAHC supports future HQRP process measures that build the framework for future outcome measures as we strongly believe that outcome measures are necessary in the HQRP. In both process and outcome measures it is imperative that patient preferences be incorporated. The exclusion for these measures, "*Hospice was unable to visit for the SRA – patient refused visits*", is a good beginning for this. Hospices work with patients to develop goals and interventions for the plan of care based on the assessment of the patient's needs and desires. It is not uncommon for patients to have a goal to maintain pain at a moderate or severe level for reasons related to their cultural and/or religious beliefs. They may also wish to maintain a moderate to severe impact level for pain/non-pain symptoms due to not wanting to experience some of the trade-offs (increased hours of sleep/drowsiness; inability to carry on a conversation with family, etc.) that come with the treatments necessary to reduce the impact level. Therefore, conducting a follow-up reassessment in these instances may not be necessary and could be an annoyance and burden to the patient. The Timely Reassessment of Pain Impact and the Timely Reassessment of Non-Pain Symptom Impact measure calculations should exclude those situations where the patient's pain/non-pain symptoms are at or below the patient's self-determined desired level.

Reliability was not analyzed for these measures according to the Report provided. The overall mean, percentiles, and overall standard deviation of the performance score are not provided. Without these details, the performance score and reliability cannot be simulated or assessed for these measures. Possible gaps by social risk factors were not assessed for these measures. For these reasons, and those outlined above, these measures should not be endorsed at this time.

MUC2023-183 CAHPS Hospice Survey-Care Preferences

In both process and outcome measures it is imperative that patient preferences be incorporated, so we are pleased to see that measures including this domain are being considered. However, the Criteria/Assertions summary in the PQM PRMR PAC/LTC Committee Preliminary Analysis Report (Report) for this measure raises concerns, as follows:

- The Report states "*Possibly limited room for improvement in the Care Preferences domain. Developers expect that a national sample will have greater variance than the mode experience sample, and reliability results will be higher*." There is limited articulation of the way an entity may improve performance on the measure focus within the program population.
- The overall survey response rate of ~30% is identified as a potential threat to validity. Based on analysis of previous response rates, by state, we find decreasing caregiver response rates for the CAHPS tool. For instance, in comparing the April 1, 2021 – March 31, 2023 response rates to the July 1, 2020 – June 30, 2022 response rates, there are 17 states with a drop in CAHPS response rate. To our knowledge, these drops have not been researched.

The Centers for Medicare & Medicaid Services (CMS) has indicated that it may revise the CAHPS Hospice Survey in the future by shortening it and incorporating a web-based mode option. In an experiment of the web-based mode, there was a slightly higher response rate than for the mail and telephone modes. However, it is not clear how this impacts the overall response rate for all states.

With possible limited room for improvement and limited articulation of the way an entity may improve performance on this measure combined with drops in response rates, this measure should not be approved for implementation at this time.

MUC2023-191 CAHPS Hospice Survey Hospice Team Communication
The measure has been in the HQRP since 2017. The substantive updates of the measure include the removal of one question from the composite ("*While your family member was in hospice care, how often did anyone from the hospice team give you confusing or contradictory information about your family member's condition or care*?"). This item was removed because of the complexity of its wording, low intraclass correlation coefficient (ICC) and low correlation with overall rating, and ceiling effects (that is, very high scores across hospices).

As with the other CAHPS Hospice Survey measures, the overall survey response rate of ~30% is identified as a potential threat to validity. Based on analysis of previous response rates, by state, we find decreasing CAHPS response rates. For instance, in comparing the April 1, 2021 – March 31, 2023 response rates to the July 1, 2020 – June 30, 2022 response rates, there are 17 states with a drop in CAHPS response rate. To our knowledge, these drops have not been researched. The Centers for Medicare & Medicaid Services (CMS) has indicated that it may revise the CAHPS Hospice Survey in the future by shortening it and incorporating a web-based mode option. In an experiment of the web-based mode, there was a slightly higher response rate than for the mail and telephone modes. However, it is not clear how this impacts the overall response rate for all states.

While we support the update of the measure with the removal of one of the questions, we are concerned about the drops in CAHPS response rates and the impact to the meaningfulness of this measure.

MUC2023-192 CAHPS Hospice Survey Getting Hospice Care Training
The measure has been in the HQRP since 2017. The substantive updates of the measure include replacing five separate questions with one new item ("*Hospice teams may teach you how to care for family members who need pain medicine, have trouble breathing, are restless or agitated, or have other care needs. Did the hospice team teach you how to care for your family member?*") This update was made to address stakeholders' requests for a shorter instrument to reduce burden on survey respondents. We support the intent of the updates to this measure, however, we are concerned by the slightly lower ICC of this version. The difference was not specified so it is unclear of the potential impact.

As with the other CAHPS Hospice Survey measures, the overall survey response rate of ~30% is identified as a potential threat to validity. Based on analysis of previous response rates, by state, we find decreasing CAHPS response rates. For instance, in comparing the April 1, 2021 – March 31, 2023 response rates to the July 1, 2020 – June 30, 2022 response rates, there are 17 states with a drop in CAHPS response rate. To our knowledge, these drops have not been researched. The Centers for Medicare & Medicaid Services (CMS) has indicated that it may revise the CAHPS Hospice Survey in the future by shortening it and incorporating a web-based mode option. In an experiment of the web-based mode, there was a slightly higher response rate than for the mail and telephone modes. However, it is not clear how this impacts the overall response rate for all states.

While we support the update of the measure with replacing five separate questions with one new item, we are concerned about the drops in CAHPS response rates and the impact to the meaningfulness of this measure.

Sincerely,

Katie Wehri

Katie Wehri
Director of Home Health & Hospice Regulatory Affairs