Hospice Workgroup Meeting 2

Meeting Notes 7/21/25

Meeting Introduction and Roll Call Stacy Howes welcomed attendees to the second hospice workgroup meeting, which focused on quality. Jeanne Marie Gawel conducted a roll call for workgroup members.

Meeting Reminders and House Rules Stacy Howes reminded participants that all meeting materials, including the slide deck, were available on the website. Attendees were also encouraged to submit questions for Meeting #4, which would involve discussions with community members about hospice utilization. House rules included avoiding substantive comments in the chat, introducing oneself before speaking, and muting phones when not speaking (00:07:51). Stacy Howes outlined the meeting's focus on quality, beginning with a review of the current state health plan quality standards and state and federal quality measures, including upcoming changes.

Current Quality Standard in the State Health Plan. Jeanne Marie Gawel reviewed a portion of the current State Health Plan standard noting that an existing Maryland-licensed general hospice provider, and those not yet licensed in Maryland but licensed elsewhere, must adhere to federal and state quality of care standards. Furthermore, any applicant not currently licensed in any state must also demonstrate compliance with these standards. All applicants are required to have a quality assurance and improvement program as per COMAR 10.07.21.09 and show how they will comply with federal and state hospice quality measures adopted by the Commission. Finally, an applicant must demonstrate a history of licensure good standing. A suggestion was made to add language requiring applicants to demonstrate acumen in healthcare operations if they are not already a hospice provider (00:08:52).

Maryland State-Level Quality Measure Stacy Howes explained that the only state-level quality measure currently available is the Maryland Health Care Commission Healthcare Worker Flu Vaccination Survey. This annual survey collects data on employee and volunteer flu vaccination rates, including the number of "gold star hospices" with 95% or more vaccinated staff. The survey also gathers information on mandatory flu shot policies, infection control coordinators, their training, and weekly hours spent on infection control activities (00:09:59). Oksana Likhova raised a question regarding the approval of infection control training courses, stating that OHCQ is not typically involved in such approvals unless specified in regulations, and had not received inquiries from hospices (00:11:35). Stacy Howes acknowledged this, stating it was likely in existing regulations and might need

updating. Leah Chambers inquired about non-compliance, to which Stacy Howes responded that fines would be instituted, though compliance has not been an issue (00:12:53).

Federal Hospice Quality Reporting Program (HQRP) Stacy Howes detailed the federal Hospice Quality Reporting Program (HQRP), mandated by the Affordable Care Act and managed by CMS, which aims to ensure high-quality care from Medicare-certified hospices. HQRP data is reported on the CMS Care Compare website and the Maryland quality reporting page. Key measures include the Hospice Care Index, Hospice Visits in the Last Days of Life, Hospice Item Set (HIS), and the Consumer Assessment of Healthcare Providers and Systems Hospice Survey (CAHPS) (00:13:42). The Hospice Care Index is a composite measure derived from Medicare claims, assessing care quality over the entire stay. Hospice Visits in the Last Days of Life measures in-person visits by RNs or MSWs during critical periods (00:15:07). The Hospice Item Set (HIS) captures the proportion of patients receiving seven applicable care processes at admission, but will be replaced by the Hospice Outcomes and Patient Evaluation (HOPE) tool on October 1st, 2025, with public reporting delayed until late 2027 (00:16:35). The Hospice CAHPS survey captures patient experience through caregiver and family feedback after a patient's passing, assessing communication, care quality, and emotional support across eight domains (00:18:01). Heather Guerieri questioned how MHCC intends to use the HIS data going forward with the change to HOPE reporting.

Discussion on Star Ratings and Quality Metrics Jeanne Marie Gawel initiated a discussion on how hospices define "three-star" or "five-star" ratings, noting that Care Compare stars relate only to CAHPS (00:21:50). Heather Guerieri confirmed that the star rating is solely based on the satisfaction survey. Cordt Kassner explained that only about 27% of hospices nationally have a calculated star rating due to the requirement of 75 completed CAHPS surveys, though Maryland has more star ratings due to the Certificate of Need requirement, which tends to create larger hospices (00:23:34). Cordt Kassner also highlighted that larger hospices tend to have lower quality ratings, and expressed that while they support using star ratings, they are a "softer measure" and not all hospices have them (00:24:42). Sara McKay agreed, noting that smaller organizations like theirs might not have star ratings despite performing well on HIS and CAHPS (00:25:58). Becky Miller emphasized that quality extends beyond claims-based and CAHPS scores, suggesting other indicators such as in-person visits over telehealth, responsiveness from referral to admission, and differing quality metrics for varying lengths of service (00:27:10).

Data Transparency and Accountability Brandan Rose stressed the importance of data transparency for benchmarking and identifying gaps in quality, citing the nursing home environment in Maryland as an example where public reporting drives quality (00:29:35). Carlos Graveran raised concerns about relying on self-reported data due to potential incentives for inflated reporting, advocating for more objective data in quality assessment (00:30:45). Monica Escalante noted that LPN visits at the end of life are excluded from visit counts, which inaccurately reflects care provided (00:32:20). Cordt Kassner shared that his national hospice locator website ranks hospices using seven metrics, excluding stars due to

their limited availability. He emphasized the importance of hospices "showing up," staffing ratios, and the "definitely recommend this hospice" question from the CAHPS survey (00:33:42). Cordt Kassner also suggested examining levels of care provided by hospices, particularly general inpatient and continuous care, as a potential quality indicator (00:36:12).

Challenges to Quality and Consideration of Penalties Sara McKay highlighted that short lengths of stay can impact quality due to gaps in regulations and expectations across different care settings, leading to issues with patient transfers and family understanding (00:37:40). Cordt Kassner proposed considering "sticks" or negative consequences alongside positive quality metrics, such as deductions for OIG investigations, immediate jeopardy findings from surveys, or negative media coverage, drawing a parallel to nursing home regulations. Stacy Howes found this reasonable, noting similarities with nursing home practices. Brandan Rose supported this concept, viewing it as an opportunity to raise the bar for quality and promote accountability (00:40:56). Brandon Rose pointed out the abuse icon and special focus facility icon displayed on CMS Care Compare for skilled nursing facilities. Cordt Kassner would like to see these displayed on the hospice pages. Oksana Likhova informed the group that CMS was working on implementing special focus programs and civil money penalties for hospices, though the special focus program was suspended, the mechanism for enforcement exists (00:45:26). Oksana Likhova sent a link to participants for the operations manual/Chapter 10 – Guidance. Cordt Kassner acknowledged past attempts to remove "bad apples" but recognized the challenges, including lawsuits over methodology, suggesting that Maryland should proactively define appropriate definitions and thresholds for such penalties rather than waiting for CMS (00:47:51).

Flexible Language for State Health Plan Stacy Howes sought feedback on adopting flexible language in the state health plan to avoid specifying exact measures, allowing adaptation to changing industry needs and quality measures (00:49:12). Steve Farrow and Brandan Rose supported this approach, noting it avoids cumbersome regulation revisions and allows for consistent measurement of care continuity across different care settings. Cordt Kassner agreed, advocating for flexibility in regulations paired with specific and timely notification of the measures to be used (00:51:05). Del. Ken Kerr inquired about the approval process for selected measures and the rationale behind their selection. Jeanne Marie Gawel explained that the process involves public notice and comment, followed by a Commission vote where the rationale for selected measures is presented, as was recently done for home health review (00:52:21). Leah Chambers sought clarity on the criteria for selecting the "best" quality measures, asking if the focus would be on high or low performers. Stacy Howes clarified that quality is one of several criteria for Certificate of Need (CON) review, and typically they would aim for the highest performers (00:55:57). Amanda Wright asked when facilities would know the selected quality measures to prepare for CON discussions. Jeanne Marie Gawel explained that once selected, measures are published on the website and in the Maryland Register, allowing agencies and the community 30 days to review and raise questions (00:57:22).

Recommended Hospice Question Monica Escalante suggested including the question "Do you recommend this hospice?" as a standardized quality measure for all facility types, which Stacy Howes found to be a good, standardized option (00:59:37).

Hospice Utilization and External Factors Cordt Kassner discussed the low hospice utilization rate in New York and suggested exploring external factors impacting hospice quality and use in Maryland, such as referral rates from hospitals and nursing facilities (01:01:12). Sara McKay and Brandan Rose agreed, emphasizing that delayed referrals and regulatory confusion in nursing homes significantly impact hospices' ability to provide optimal patient care, particularly for short lengths of stay (01:02:50). Brandan Rose would like to see more education for skilled nursing staff to encourage hospice utilization.

Financial and Quality Impact of Short Stays Monica Escalante highlighted that patients with very short lengths of stay are financially burdensome for hospices and can negatively affect their quality scores, leading some hospices to decline such patients (01:05:29). They also noted that these rushed admissions can be detrimental to the patient and caregiver experience, advocating for quality measures that incentivize collaboration with other healthcare partners to address drastically shorter lengths of stay, especially post-COVID (01:06:45).

Disparity Metrics in Hospice Care Stacy Howes inquired about potential metrics to address disparities in hospice care (01:08:01). Brandan Rose suggested capturing disparity data by documenting reasons for patient denials or lack of qualification, as denial reasons are already substantially documented (01:09:31). Carlos Graveran, however, expressed concern that such metrics might falsely imply hospices are turning away minority patients, when in fact, challenges often stem from patients' and families' reluctance to accept hospice care (01:10:43).

Approaches to Addressing Disparities Theressa Lee suggested looking into outreach efforts to minority populations, as Commissioners had previously emphasized this when approving hospice providers in areas with low hospice use (01:10:43). Cordt Kassner broadened the discussion of disparities beyond racial markers to include communication and language barriers (e.g., lack of Spanish interpreters), economic factors and social determinants of health, suggesting exploring how hospices serve diverse population groups (01:11:48). Theressa Lee proposed incentivizing hospices rather than penalizing them to encourage greater engagement with diverse populations, considering cultural issues that may prevent participation (01:13:14).

Challenges in Serving Diverse Populations Sara McKay highlighted the difficulty of using interpreters due to the many dialects within languages, which can hinder patients' connection with caregivers (01:13:14). Cordt Kassner also brought up the challenges of providing care in rural areas, suggesting that rural-urban disparities should be considered alongside other forms of disparity (01:14:44). Sara McKay further noted the challenge of caring for undocumented

individuals who may fear engaging with healthcare due to concerns about personal information (01:16:05).

Live Discharge Rates and Disparity Becky Miller introduced the live discharge rate as a key objective metric that could shed light on disparities, particularly in other states where patients might be discharged if their care needs are perceived as too high or for reimbursement reasons (01:17:03). Monica Escalante also suggested considering the utilization of Medicaid patients and potentially charity care, though Becky Miller noted the lack of a common definition for charity care (01:18:02).

***Meeting notes were taken using Gemini AI and supplemented by and reviewed for accuracy by Stacy Howes, Jeanne Marie Gawel, and Julie Beard.*