UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

TEXAS ASSOCIATION FOR HOME CARE & HOSPICE; INDIANA ASSOCIATION FOR HOME & HOSPICE CARE; ASSOCIATION FOR HOME & HOSPICE CARE OF NORTH CAROLINA; SOUTH CAROLINA HOME CARE & HOSPICE ASSOCIATION; and HOUSTON HOSPICE, Plaintiffs, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	Case No.:

COMPLAINT AND APPLICATION FOR A PRELIMINARY INJUNCTION OR STAY OF AGENCY ACTION

Plaintiffs, by and through undersigned counsel, bring this action against Defendant Xavier Becerra in his official capacity as the Secretary of the United States Department of Health and Human Services ("HHS") and against Defendant HHS, and state as follows:

INTRODUCTION

1. Plaintiffs bring this action to request that the Court preliminarily and permanently declare unlawful and set aside Defendants' promulgation of (1) the Hospice

Special Focus Program Final Rule and (2) the Hospice Special Focus Program List, along with its accompanying data.

2. Plaintiffs represent high-quality hospice programs that each have a mission of promoting the well-being of terminally ill patients and their families at a most fragile phase of their lives. Plaintiffs actively support efforts to improve oversight of hospice providers, especially ones that provide poor care or operate fraudulently. But Defendants' publication of a list of "poor performing" hospices is so arbitrary and flawed that it will make it harder for patients and families to find trustworthy providers. Defendants' actions convey a false narrative that "Special Focus Program" providers may be unsafe or dangerous, sowing fear among their current patients and "survivor's guilt" among family members whose loved ones passed away in the care of a listed provider. Just as troubling, Defendants' arbitrary list sends an implicit approval of truly low-quality or unethical providers who are not listed. This Court's intervention is essential.

3. Plaintiffs represent reputable hospice programs throughout Texas, Indiana, North Carolina, and South Carolina who are committed to providing compassionate, ethical, and quality care to patients and families. Plaintiffs include Houston Hospice, the city's oldest and largest non-profit hospice provider, which has earned the trust of countless patients and families. Last year, Houston Hospice served an average of 190 patients per day and has a strong record of quality and compliance. That is true even as Houston Hospice cares not only for patients at home but also for patients in an in-patient facility staffed with well-trained medical professionals. Incredibly, however, Defendants selected Houston Hospice for inclusion on the Special Focus Program List of 50 "poor performing" hospices from around the entire country.

4. To be sure, there is a real problem with a subset of hospice programs that provide poor care or operate unethically. For example, a recent *Hospice News* article reported that "[f]raudulent hospices in California [ ] have been targeting homeless people and methadone patients, promising them a steady supply of opioids in exchange for enrolling in hospice."[1]

5. In recent years, certain States (Arizona, California, Nevada, and Texas) have seen rapid growth in new hospice providers, far outstripping demand.[2] A 2022 California State Auditor Report found widespread indications of fraudulent hospice providers in Los Angeles County, such as a single building that reportedly had over 150 licensed hospice and home health agencies—more than the building's physical capacity.[3] According to the Report, hospice agencies in the County had an average of *fewer than five patients per day,* compared to the state average of 56 patients per day. Further, California's initial licensing process did not require adequate screening to ensure new hospice providers were qualified to provide services.[4] And then California failed to adequately investigate complaints of patient neglect or abuse.[5] In response to these findings, California state officials imposed a moratorium on

[1] Jim Parker, *Fraudulent Hospice Reportedly Target Homeless People, Methadone Patients to Pad Census*, HOSPICE NEWS (Aug, 23. 2024), available at https://hospicenews.com/2024/08/23/fraudulent-hospices-reportedly-target-homeless-people-methadone-patients-to-pad-census/ (last visited Jan. 15, 2025).

[2] *See* Ava Kofman, *Hospices in Four States to Receive Extra Scrutiny Over Concerns of Fraud, Waste and Abuse*, PROPUBLICA (July 21, 2023), available at https://www.propublica.org/article/hospices-arizona-california-nevada-texas-cms-medicaid-medicare (last visited Jan. 15, 2025).

[3] *See* Cal. State Auditor Rep. 2021-123, *California Hospice Licensure and Oversight: The State's Weak Oversight of Hospice Agencies Has Created Opportunities for Large-Scale Fraud and Abuse*, at 1 (Mar. 2022), available at https://www.documentcloud.org/documents/23318778-2022_ca_audit_report/ (last visited Jan. 15, 2025).

[4] *See id.* at 2.

[5] *See id.* at 2.

new hospice licenses. Still, against that backdrop, Defendants' selection of providers like Houston Hospice for the Special Focus Program List is galling.

6. Defendants' actions also badly stray from Congress's directives. To strengthen oversight of hospices, in 2020, Congress instructed HHS to establish a "special focus program" (SFP) to enhance enforcement for a subset of hospices that "the Secretary has identified as having substantially failed to meet" Medicare requirements. 42 U.S.C. § 1395i-6(b).[6]

7. Despite that clear statutory mandate, HHS promulgated the Hospice Special Focus Program Final Rule that adopted an algorithm to select hospices for the SFP that includes not only findings of noncompliance with Medicare requirements but also indicators *other than* noncompliance. *See* CMS, *Calendar Year 2024 Home Health Prospective Payment System Final Rule*, 88 Fed. Reg. 77,676, 77,879 (Nov. 13, 2023) (promulgating 42 C.F.R. § 488.1135). Those other indicators—(1) the Consumer Assessment of Healthcare Providers and Systems ("CAHPS") survey, and (2) the Hospice Care Index ("HCI")—do not measure whether a hospice provider is in violation of a Medicare requirement. Moreover, the Final Rule's use of them skews the results towards larger, established providers and away from smaller or new providers.

8. In addition, the algorithm makes no adjustments for size of hospice provider in counting the number of substantiated complaints a provider had, meaning that larger providers who had a relatively smaller percentage of complaints per patients served are treated the same as a small provider who had a larger percentage of complaints per patients it served.

[6] *See* Consolidated Appropriations Act of 2021, Pub. L. 116-260, § 407, 134 Stat. 1182, 3003 (Dec. 27, 2020).

9. After Defendants first proposed what became the Final Rule in July 2023, numerous voices from the hospice community submitted comments to CMS pointing out multiple flaws with CMS's algorithm and data inputs. Nonetheless, in November 2023, CMS proceeded to adopt the flawed Final Rule and algorithm as proposed. The problems with CMS's approach were so apparent that members of Congress and leaders of the hospice community called on CMS to delay proceeding with the Special Focus Program List selections to give more time for flaws to be addressed.[7]

10. Although Congress placed no deadline on CMS to issue the Special Focus Program List, *see* 42 U.S.C. § 1395i-6(b), CMS pressed forward to publicize the List nonetheless. On or about December 18, 2020, Defendants notified some fifty (50) hospice providers that they would be selected for the Special Focus Program. CMS offered no procedure for these providers to correct errors in CMS's data leading to their selection or to appeal their selection for the Program. And on December 20, 2024, Defendants posted on the CMS website the Hospice Special Focus Program List, publicizing to the world the 50 hospices selected from across the country as "poor performers."[8] Together with this Hospice Special Focus Program List, CMS released its "underlying data" that was used to create the list and that would be used to identify "future SFP candidates."[9]

11. The arbitrariness of Defendants' approach is compounded by the fact that CMS's "underlying data" is rife with errors. For example, CMS's data list certain hospices as having substantiated complaints involving violations of Medicare requirements when, in

[7] *See infra*, Legal and Factual Background, Part F.
[8] See Hospice Special Focus List, available at https://www.cms.gov/medicare/health-safety-standards/certification-compliance/hospice-special-focus-program (last visited Jan. 15, 2025).
[9] See Hospice Special Focus List, available at https://www.cms.gov/medicare/health-safety-standards/certification-compliance/hospice-special-focus-program (last visited Jan. 15, 2025).

fact, the complaints involved only State licensure issues or were not substantiated at all. Indeed, in less than three weeks since first publishing the Special Focus Program List, Defendants have changed the List twice, removing four initially listed programs and adding four others.

12. Defendants' actions violate the Administrative Procedure Act ("APA"): the Final Rule and List are contrary to law and were promulgated in excess of the Secretary's statutory authority, violating 5 U.S.C. § 706(2)(C); are arbitrary and capricious, violating 5 U.S.C. § 706(2)(A); and were promulgated without observance of procedure required by law, violating 5 U.S.C. § 706(2)(D).

13. Plaintiffs seek preliminary and permanent declaratory and injunctive relief, including setting aside the Hospice Special Focus Program Final Rule and List, enjoining the Special Focus Program, and ordering Defendants to withdraw the List and underlying data immediately.

PARTIES

14. Plaintiff Texas Association for Home Care & Hospice is a non-profit corporation organized under the laws of the State of Texas with its principal place of business located at 9390 Research Blvd, Bldg. I, Suite 300, Austin, TX 78759.

15. Plaintiff Indiana Association for Home & Hospice Care is a non-profit corporation organized under the laws of the State of Indiana with its principal place of business located at 6320-G Rucker Road, Indianapolis, IN 46220.

16. Plaintiff Association for Home & Hospice Care of North Carolina is a non-profit corporation organized under the laws of the State of North Carolina with its principal place of business located at 1511 Sunday Drive, Suite 318, Raleigh, NC 27607.

17. Plaintiff South Carolina Home Care & Hospice Association is a non-profit corporation organized under the laws of the State of South Carolina with its principal place of business located at 1511 Sunday Drive, Suite 318, Raleigh, NC 27607.

18. Texas Association for Home Care & Hospice, Indiana Association for Home & Hospice Care, Association for Home & Hospice Care of North Carolina have members who have been included in the Hospice Special Focus Program.[10] The Association Plaintiffs—Texas Association for Home Care & Hospice, Indiana Association for Home & Hospice Care, Association for Home & Hospice Care of North Carolina, and South Carolina Home Care & Hospice Association—each advocate on behalf of their members with state and federal regulators.[11] This advocacy is a central part of their organizational missions and an important benefit to their members.[12]

19. Plaintiff Houston Hospice is a non-profit organization organized under the laws of the State of Texas with its principal place of business located at 1905 Holcombe Blvd, Houston, TX 77030.

20. Defendant Xavier Becerra is the Secretary of the United States Department of Health and Human Services ("HHS"). He is sued in his official capacity. The Secretary administers the Medicare program through the Centers for Medicare and Medicaid Services ("CMS"), which is an agency within HHS.

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[10] Ex. 3, Declaration of Rachel Hammon, ¶ 8 (hereinafter "Hammon Decl."); Ex. 4, Declaration of Evan Reinhardt, ¶ 11 (hereinafter "Reinhardt Decl."); Ex. 5, Declaration of Timothy R. Rogers, ¶ 9 (hereinafter "AHHC Decl.").

[11] Ex. 3, Hammon Decl., ¶¶ 3, 4; Ex. 4, Reinhardt Decl., ¶ 7; Ex. 5, AHHC Decl., ¶ 3; Ex. 6, Declaration of Timothy R. Rogers, ¶ 5 (hereinafter "SCHCHA Decl.").

[12] Ex. 3, Hammon Decl., ¶ 4; Ex. 4, Reinhardt Decl., ¶¶ 6-7; Ex. 5, AHHC Decl., ¶¶ 3, 5; Ex. 6, SCHCHA Decl., ¶¶ 3, 5.

21. Defendant United States Department of Health and Human Services is the department of the federal government ultimately responsible for the federal Medicare and Medicaid programs.

JURISDICTION AND VENUE

22. This Court has jurisdiction over this action under 28 U.S.C. § 1331 because this action arises under the APA, 5 U.S.C. §§ 701 *et seq.*

23. Venue is proper pursuant to 28 U.S.C. § 1391(e)(2)-(3) because this is an action against officers and agencies of the United States, a substantial part of the events giving rise to certain Plaintiffs' claims occurred in this District, and Plaintiff Houston Hospice resides in this District.

24. The Complaint is timely under 28 U.S.C. § 2401(a).

LEGAL AND FACTUAL BACKGROUND

A. The Medicare Certification and Survey Process

25. The Medicare program, authorized under Title XVIII of the Social Security Act, is a federal program that provides health insurance benefits for Americans aged 65 years and older and certain disabled persons. *See* 42 U.S.C. §§ 1395 *et seq.*

26. The Medicare program includes a hospice benefit that covers an interdisciplinary set of services for patients who are terminally ill, *i.e.* those who have been certified by a physician to have a medical prognosis of six months or less if their illness runs its normal course. *See* 42 U.S.C. § 1395x(dd)(3)(A).

27. Medicare covers only those hospice services that are provided by Medicare-certified hospice programs. *See* 42 U.S.C. §§ 1395d, 1395x(dd).

28. To become Medicare-certified, a hospice must undergo a survey by a state survey agency to demonstrate that it satisfies the requirements to participate as a hospice in the Medicare program. *See* 42 C.F.R. §§ 418.1, 424.510, 488.3.

29. In lieu of having a survey performed by a state survey agency, a hospice may seek "deemed status" from a national accrediting organization. *See* 42 U.S.C. § 1395bb. When a hospice opts for the accreditation route, the accrediting organization, rather than state survey agency, performs the survey and determines that the hospice program satisfies the requisite conditions of participation for Medicare.

30. The statutory requirements to be certified as a hospice program are located at 42 U.S.C. § 1395x(dd). These include providing certain types of care on a 24-hour basis, 42 U.S.C. § 1395x(dd)(2)(A), having a hospice interdisciplinary group, *id.* § 1395x(dd)(2)(B), maintaining clinical records, § 1395x(dd)(2)(C), not discontinuing care due to an inability to pay, § 1395x(dd)(2)(D), using volunteers appropriately, § 1395x(dd)(2)(E), maintaining specified licenses, § 1395x(dd)(2)(F), and complying with the requirements that CMS determines necessary for patients' health and safety, § 1395x(dd)(2)(G).

31. Pursuant to its statutory authority, CMS has prescribed additional requirements for Medicare certification at 42 C.F.R., part 418, subparts B, C and D (§§ 418.20-.114). These regulatory requirements are often referred to as conditions of participation.

32. After the initial survey and certification process, hospices are subject to ongoing surveys to ensure that they continue to meet Medicare's statutory and regulatory requirements. 42 C.F.R. § 488.1110(a).

33. While surveys must be conducted at least once every three years, they may be conducted as frequently as necessary to "[a]ssure the delivery of quality hospice program services by determining whether a hospice program complies with the Act and conditions of participation" and to "[c]onfirm that the hospice program has corrected deficiencies that were previously cited." *Id.*

34. Surveys are also conducted anytime that a complaint against the hospice is reported to CMS or a state or local survey agency. 42 C.F.R. § 488.1110(b).

35. During a survey, the surveyor will determine whether the hospice has any deficiencies, which are defined as violations of Medicare statutory requirements or the conditions of participation located at 42 C.F.R. § 418, Parts C and D. *See* 42 C.F.R. § 488.1105 (defining "deficiency").

36. Depending on their severity, deficiencies may be either condition-level or standard-level. *Id.*

37. A condition-level deficiency means that the deficiency is "of such character as to substantially limit the provider's or supplier's capacity to furnish adequate care or which adversely affect the health and safety of patients." *See* 42 C.F.R. §§ 488.1005, 488.24.

38. A standard-level deficiency means "noncompliance with one or more of the standards that make up each condition of participation for hospice programs." 42 C.F.R. § 488.1105 (defining "Standard-level deficiency").

39. Hospices may be subject to enforcement action depending on the nature, degree, frequency, and impact of the deficiency. *See* 42 C.F.R. § 488.1215.

40. Available enforcement actions against hospices with deficiencies include payment suspensions, civil money penalties, and termination of the hospice's provider agreement, among other things. *See* 42 C.F.R. § 488.1220.

B. Congress Strengthens Medicare's Survey-and-Enforcement Scheme for Hospices.

41. In 2019, the HHS Office of Inspector General ("OIG") issued a report titled *Hospice Deficiencies Pose Risks to Medicare Beneficiaries.*[13] The report reviewed results from survey agencies and accrediting organizations, and found over 80 percent of hospices had at least one deficiency, meaning they failed to substantially comply with a requirement for participating in the Medicare program.[14] The report found that over 300 hospices (18%) had surveys showing at least one serious deficiency or at least one substantiated severe complaint, which the report deemed to be the "poor performers."[15] As a result, HHS OIG recommended that CMS strengthen the survey process, provide more information to beneficiaries, and increase oversight of hospices with a history of serious deficiencies.[16]

42. The 2019 OIG Report prompted Congress to develop legislation to implement OIG's recommendations. *See Helping Our Senior Population in Comfort Environments (HOPSICE) Act*, H.R. Rep. No. 116-660, at 5 (Dec. 17, 2020) (citing the HHS OIG report "that identified significant deficiencies in the quality of care delivered to Medicare hospice enrollees").

43. Consequently, in 2020, Congress added Section 1822 to the Social Security Act to establish a scheme of hospice surveys and enforcement remedies to ensure providers were

[13] *See* HHS OIG, *Hospice Deficiencies Pose Risks to Medicare Beneficiarie*s, OEI-02-17-00020 (July 2019), available at https://oig.hhs.gov/documents/evaluation/2677/OEI-02-17-00020-Complete%20Report.pdf (last visited Jan. 15, 2025).
[14] *See id.*, at 2, 4, 15.
[15] *See id.*, at 15.
[16] *See id.* at 17-20.

complying with the requirements of the Medicare program. *See* Consolidated Appropriations Act of 2021, Pub. L. 116-260, § 407, 134 Stat. 1182, 3003 (Dec. 27, 2020).

44. In Section 1822(a), Congress directed that "[a]ny entity that is certified as a hospice program (as defined in section 1395x(dd)(2) of this title) shall be subject to a standard survey by an appropriate State or local survey agency, or an approved accreditation agency, as determined by the Secretary, not less frequently than once every 36 months." 42 U.S.C. § 1395i-6(a)(1).

45. In Section 1822(b), Congress sought to implement an enhanced enforcement program for hospices that were not in compliance with Medicare requirements—the Hospice Special Focus Program. *See* 42 U.S.C. § 1395i-6(b). To that end, Congress directed CMS to "conduct a special focus program for enforcement of requirements for hospice programs that the Secretary has identified as having ***substantially failed to meet applicable requirements*** of [Title 42, Chapter 7 of the U.S. Code]." 42 U.S.C. § 1395i-6(b)(1) (emphasis added). Congress also directed that, "[u]nder such special focus program, the Secretary shall conduct surveys of each hospice program in the special focus program not less than once every 6 months." *Id.* § 1395i-6(b)(2).

46. Thus, by plain statutory text, CMS must identify hospices for the Hospice Special Focus Program based on their record of compliance with the statutory Medicare requirements, which include the regulatory conditions of participation, and then subject those hospices to increased oversight.

47. The legislative history of the Special Focus Program provisions confirms that Congress intended that the Special Focus Program would select hospices based on their records of deficiencies in complying with Medicare requirements. The relevant House

Committee Report describes the Special Focus Program as targeting "hospice agencies that the Secretary identifies as having *substantially failed to meet certification requirements*." *See* H.R. Rep. 116-660, at 9 (emphasis added).

48. Consistent with Congress' focus on Medicare requirements, Section 1822(c) directs CMS to take enforcement action against a hospice "if the Secretary determines on the basis of a standard survey or otherwise that a hospice program that is certified for participation under this subchapter is no longer in compliance with the requirements specified in section 1395x(dd) of this title." 42 U.S.C. § 1395i-6(c). Section 1395i-6(c) authorizes, among other remedies, "penalties in an amount not to exceed $10,000 for each day of noncompliance by a hospice program with the requirements specified in section 1395x(dd) of this title." 42 U.S.C. § 1395i-6(c)(5)(B)(i).

49. In short, Congress enacted Section 1822 of the Social Security Act in response to a report of widespread non-compliance with Medicare requirements among participating hospice programs. Compliance with Medicare requirements is the touchstone for Section 1822's survey-and-enforcement scheme, including the Hospice Special Focus Program.

C. CMS's Initial Proposed Rule for the Hospice Special Focus Program.

50. In July 2021, CMS issued a proposed rule implementing the Special Focus Program. *See* CMS, *Calendar Year 2022 Home Health Prospective Payment System Proposed Rule*, 86 Fed. Reg. 35,874, 35,974 (July 7, 2021). CMS explained that "Section 1822(b) of the Act requires the Secretary to conduct a Special Focus Program for hospice programs that the Secretary has identified as having substantially failed to meet applicable requirements of the Act." *Id.* at 35,974.

51. The July 2021 proposed rule also recognized that "Sections 1812, 1814, 1822, 1861, 1864, and 1865 of the Act establish requirements for Hospice programs and [] authorize surveys to determine whether they meet the Medicare conditions of participation." *Id.* at 36,009. It further stated that "[t]he Secretary must conduct a special focus program for the enforcement of conditions of participation for hospice programs that the Secretary has identified as having substantially failed to meet applicable requirements for Medicare participation." *Id.* at 36,010.

52. Correspondingly, CMS's proposed rule included criteria for the SFP that were based solely on findings of condition-level deficiencies in surveys. *See id.* at 35,974. The proposed inclusion criteria were "(i) [t]he hospice program is found to be deficient with condition-level findings during two consecutive standard surveys," "(ii) [t]he hospice program is found to be deficient with condition-level findings during two consecutive complaint surveys," or "(iii) [t]he hospice program is found to be deficient with two or more condition level findings during a validation survey." *Id.* at 36,010.

53. In November 2021, CMS declined to finalize the proposed rule. Rather, CMS explained that it intended "to review the public comments received and collaborate with hospice stakeholders to further develop the SFP that was initially proposed." CMS, *Calendar Year 2022 Home Health Prospective Payment System Final Rule*, 86 Fed. Reg. 62,240, 62,372 (Nov. 9, 2021).

D. CMS Hires an Outside Consultant and Convenes a Technical Expert Panel.

54. After declining to finalize its proposed rule, "CMS contracted with Abt Associates, Inc. (Abt), an independent research company, to support the development of the hospice SFP." Abt Associates, *2022 Technical Expert Panel and Stakeholder Listening Sessions:*

Hospice Special Focus Program Summary Report at 3 (April 28, 2023) (hereinafter "Technical Expert Report"), https://shorturl.at/OlIPX (last visited Jan. 15, 2025).

55. "Abt and CMS developed a revised preliminary methodology to identify poor performing hospices" for the Hospice Special Focus Program. *Id.* The revised preliminary methodology is an algorithm by which CMS would select hospices for the Hospice Special Focus Program.

56. Unlike the July 2021 proposed rule, the revised preliminary methodology no longer focused on condition-level deficiencies to select hospices. The revised preliminary methodology instead incorporated "a variety of hospice data sources, including hospice survey data," "Medicare claims data," and "consumer evaluations." *Id.* "[T]he Medicare claims data" (HCI scores) and "consumer evaluations" (CAHPS scores) do not measure a hospice provider's compliance with Medicare requirements. *Id.* Thus, CMS's work with Abt started the agency down the path of breaking with Congress' directive to identify hospices that "substantially fail[] to meet" Medicare requirements for the Hospice Special Focus Program. 42 U.S.C. § 1395i-6(b)(1).

57. Abt convened a Technical Expert Panel to provide feedback on the Hospice Special Focus Program, including the revised preliminary methodology. Technical Expert Report, *supra* at 3, 8. The Technical Expert Panel—composed as it was of nine industry experts—met in October and November 2022. Abt then held additional listening sessions "with groups of stakeholders including industry representatives, accrediting organizations, federal experts, and patient advocates." *Id.* at 3. In April 2023, Apt issued a report to CMS describing its work with the Technical Expert Panel and stakeholders.

E. CMS Proposes the Hospice Special Focus Program Rule and Selection Algorithm.

58. In July 2023, CMS issued a new proposed rule to implement the Special Focus Program. *See* CMS, *Calendar Year 2024 Home Health Prospective Payment System Proposed Rule*, 88 Fed. Reg. 43,654 (Jul. 10, 2023).

59. The July 2023 proposed rule states that "[s]election of hospices for the SFP is made based on the highest aggregate scores based on the algorithm used by CMS." *Id.* at 43,817. CMS proposed an algorithm that takes into account four potential criteria for selecting hospices: (i) condition-level deficiencies over a three-year period, (ii) substantiated complaints over a three-year period, (iii) HCI score, and, when available, (iv) CAHPS index score. *See id.* at 43,758-43,761. CMS would later adopt this algorithm verbatim in the Hospice Special Focus Program Final Rule.

60. Notwithstanding Congress' command to identify hospice providers that substantially fail to meet Medicare requirements, only two of CMS's four criteria relate to Medicare compliance—condition level deficiencies and substantiated complaints. The remaining two criteria—CAHPS and HCI scores—do not measure Medicare compliance at all.

1. Condition-Level Deficiencies and Substantiated Complaints

61. CMS's algorithm counts a hospice program's condition level deficiencies "from the previous 3 consecutive years of data." 88 Fed. Reg. at 43,760. "Hospices are surveyed for compliance with hospice program requirements prior to becoming certified . . . and then at least once every 36 months . . . for recertification." *Id.* at 43,759. A condition-level deficiency "is cited on a survey when a hospice is found to be noncompliant with all or part of a condition of participation (CoP), which is one of the health and safety requirements all

hospices are required to meet to participate in Medicare." *Id.* CMS's condition-level deficiency criterion thus helps measure a hospice program's Medicare compliance.

62. CMS's algorithm counts a hospice provider's "total number of substantiated complaints received against a hospice in the last 3 consecutive years of data before the release of the SFP selection list." *Id.* at 43,760. A patient, caregiver, or hospice staff member may file a complaint at any time, *id.* at 43,760, and hospices also regularly self-report complaints. A complaint triggers an investigation into whether the allegations are true and whether they amount to a deficiency in compliance with Medicare requirements. "If the allegation is found to be substantiated or confirmed, the [state agency] informs the hospice and submits the findings." *Id.* Substantiated complaints, too, relate to a hospice's compliance with Medicare requirements.

63. Although condition-level deficiencies and substantiated complaints measure Medicare compliance, CMS implemented these criteria in an unreasonable way. The revised preliminary methodology that CMS developed with Abt scaled these criteria, with limited exceptions, "per 100 beneficiaries served." Technical Expert Report, *supra* at 14. CMS's consultant explained that the scaling "was to ensure that larger hospices were not at a disadvantage compared to smaller hospices." *Id.*

64. Rather than scale these criteria, CMS elected to count hospice providers' *absolute* number of condition level deficiencies and substantiated complaints. As a result, a hospice provider serving 2,000 beneficiaries per year with 4 substantiated complaints would score worse in CMS's algorithm than a hospice provider serving 100 beneficiaries per year with 3 substantiated complaints.

65. Finally, during the rulemaking process, CMS failed to provide hospice providers and other stakeholders with an opportunity to assess the accuracy of its data related to condition-level deficiencies and substantiated complaints. CMS did not publish Excel files with its identification of condition-level deficiencies and substantiated complaints until after the comment period for the Hospice Special Focus Program Final Rule closed.[17] Hospices therefore had no meaningful opportunity to comment on CMS's data collection methods related to condition-level deficiencies and substantiated complaints during the rulemaking process.

66. Moreover, the data related to condition-level deficiencies and substantiated complaint records available to hospice providers and other stakeholders on a CMS website during the rulemaking process was, and continues to be, inaccurate.

2. Hospice Patient Experience Indicator (CAHPS Survey)

67. CMS's CAHPS survey program is used by CMS to calculate quality and patient experience measures. The CAHPS survey program asks hospice patients and caregivers to rate their experiences with certain aspects of their care.[18] Using the survey responses, CMS calculates certain measures, such as "Willing to recommend this hospice," "Getting timely help," and "Training family to care for patient."[19]

68. The CAHPS consumer evaluations do not track compliance with Medicare requirements. They measure "aspects of quality that are *not* found in the [Medicare] survey."

[17] Ex. 2, Declaration of Judith Lund Person, ¶¶ 43-44 (hereinafter "Lund Person Decl.").
[18] *See* CMS, CAHPS Hospice Survey, https://www.cms.gov/data-research/research/consumer-assessment-healthcare-providers-systems/cahps-hospice (last modified Sept. 10, 2024) (last visited Jan. 15, 2025).
[19] *See* CMS, CAHPS Hospice Survey, https://www.cms.gov/medicare/quality/hospice/cahpsr-hospice-survey (last modified Sept. 10, 2024) (last visited Jan. 15, 2025).

88 Fed. Reg. at 77,805 (emphasis added). A hospice need not obtain a certain score on the CAHPS measures as a Medicare requirement. *See* 42 C.F.R. § 418.312.

69. About half of hospices do not report CAHPS scores. 88 Fed. Reg. at 43,761. CMS does require hospices with 50 or more patients to submit CAHPS data, but not as a condition of participation. Hospices with less than 50 patients are exempt from this requirement, *see* 42 C.F.R. § 418.312(e), as are certain newly enrolled hospices.[20] Failure to report CAHPS data has no impact on a hospice's Medicare certification and results only in a minor payment reduction.[21]

70. CMS's algorithm for the Special Focus Program nonetheless includes the following CAHPS measures in a CAHPS index score: (1) Help for Pain and Symptoms, (2) Getting Timely Help, (3) Willingness to Recommend this Hospice, and (4) Overall Rating of this Hospice. *Id.* at 43,760-61.

71. For the approximately 50% of hospices that report CAHPS measures, those measures are weighted *two times* more than the other indicators in the Special Focus Program algorithm, despite being unrelated to the Medicare certification requirements that Congress instructed CMS to enforce. *Id.* at 43,763. For hospices that are exempt from CAHPS requirements or simply failed to report CAHPS measures, the algorithm calculates the hospice's score based only on condition-level deficiencies, substantiated complaints, and HCI score.

[20] *See* CMS, CAHPS Hospice Survey, https://www.cms.gov/medicare/quality/hospice/cahpsr-hospice-survey (last modified Sept. 10, 2024) (last visited Jan. 15, 2025).
[21] *See* CMS, Hospice Quality Reporting Program, https://www.cms.gov/medicare/quality/hospice (last modified Sept. 10, 2024) (last visited Jan. 15, 2025) (providing a 4% payment reduction).

72. Setting aside that using CAHPS scores at all was unlawful because such consumer-evaluation scores do not measure Medicare compliance, this is another area where CMS broke from the revised preliminary methodology that it developed with Abt. The revised preliminary methodology weighted CAHPS scores *half as much* as condition level deficiencies and substantiated complaints, and *a fourth as much* as HCI scores. Technical Expert Report, *supra* at 14. The revised preliminary methodology gave less weight to CAHPS scores because of the large number of hospice providers that do not report CAHPS information. *Id.*

73. Likewise, the Technical Expert Panel expressed "mixed opinions" about increasing the weighting for CAHPS scores due to the lack of availability of CAHPS data. *See id*. at 15-16.

74. Since hospices with less than 50 patients are exempt from reporting CAHPS scores, the algorithm skews arbitrarily toward larger agencies, despite there being no reasonable basis to find that larger agencies are more likely than smaller agencies to fail CMS requirements. CAHPS scores are known to often be lower among providers serving underserved communities, with the result that including CAHPS scores in the SFP algorithm disproportionately targets those providers. *See* 88 Fed. Reg. at 77,805 (Nov. 13, 2023).

75. Finally, in the July 2023 proposed rule, CMS referenced its "analysis of CYs . . . 2019 to 2021 CAHPS Hospice Survey data" and discussed how that analysis impacted its decision about how to treat the CAHPS score in the Special Focus Program algorithm, with a particular focus on how to treat hospices that did not report a CAHPS score. 88 Fed. Reg. at 43,761. CMS failed to provide commenters with access to these above-referenced analyses—omitting critical material used to develop the Special Focus Program algorithm—

thereby denying them a meaningful opportunity to comment on the Special Focus Program Proposed Rule.

3. Hospice Care Index ("HCI")

76. CMS's algorithm also uses a second quality measure that has no grounding in Medicare requirements: the Hospice Care Index ("HCI").[22]

77. HCI is a single number calculated using data from the claims for payment that a hospice has submitted to Medicare taking into account these ten aspects:

a. Continuous Home Care (CHC) or General Inpatient (GIP) Provided

b. Gaps in Skilled Nursing Visits

c. Early Live Discharges

d. Late Live Discharges

e. Burdensome Transitions (Type 1) – Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission

f. Burdensome Transitions (Type 2) – Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital

g. Per-beneficiary Medicare Spending

h. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day

i. Skilled Nursing Minutes on Weekends

j. Visits Near Death

78. Like the CAHPS score, the HCI score does not measure a hospice's compliance with Medicare's statutory requirements or the regulatory conditions of participation. *Cf.* 42

[22] *See* CMS.gov, Current Measures, https://www.cms.gov/medicare/quality/hospice/current-measures (last modified Sept. 10, 2024) (last visited Jan. 15, 2025).

U.S.C. § 1395x(dd); 42 C.F.R. §§ 418.20-.116. A hospice need not obtain a certain score on the HCI measure to remain Medicare compliant.

79. In fact, HCI scores are not available for over 20% of hospices, especially those that are smaller or new.[23] Despite that enormous gap in data, CMS persisted in using HCI as an input and arbitrarily assigned the average HCI score to hospices that did not have a publicly reported HCI score. *See* 88 Fed. Reg. at 43,762. As a result, a hospice that has a record of serious deficiencies in complying with Medicare requirements—*i.e.*, a true "poor performer"—but that lacks an HCI score receives an artificial and arbitrary bump up to the average HCI score in CMS's algorithm.

F. Commenters Raise Serious Concerns about CMS's Algorithm for Selecting Hospices.

80. CMS received numerous comments on the proposed rule, including from national trade associations. Commenters raised serious concerns about CMS's algorithm for selecting hospice programs, among them CMS's failure to scale condition-level deficiencies and substantiated complaints by beneficiaries served, CMS's assignment of average HCI scores to hospices with missing HCI data, and CMS's double weighting of CAHPS scores.

81. For example, on August 16, 2023, the National Hospice and Palliative Care Organization, the National Association for Home Care and Hospice, the National Partnership for Healthcare and Hospice Innovation, and Leading Age submitted comments on CMS's July 2023 proposed rule.[24] These national associations explained that the Technical

[23] *See* 88 Fed. Reg. at 77,807 (Nov. 13, 2023) ("[A]pproximately 21 percent of hospices did not have a publicly reported HCI score. Hospice providers that do not have HCI scores are likely to be small . . . [or] new . . . or both.").

[24] Comments of the National Association for Home Care and Hospice, and the National Partnership for Healthcare, Hospice Innovation, and Leading Age, Docket ID CMS-2023-0113-0180 (Aug. 16, 2023).

Expert Panel scaling of condition-level deficiencies and substantiated complaints "was to ensure that larger hospices were not at a disadvantage compared to smaller hospices," and "scaling the data is essential to ensure programs are comparable."[25] "If the goal is to ensure beneficiaries are receiving patient-centered, quality hospice care," the national associations concluded, "it is necessary to review these data as ratios rather than raw numbers."[26]

82. The national associations also raised concerns about the missingness of HCI data for 21.7% of hospices. Based on their analysis, the national associations "found providers without HCI scores were less likely to be included in the 10th percentile and, therefore, less likely to be included in the SFP," and "hospices that did not have an HCI score *had dramatically more CLDs per beneficiary* yet were less likely to fall into the bottom 10% of hospices."[27] "Thus, hospices more deserving of the SFP were less likely to be included."[28]

83. The national associations identified that "there are major limitations with the existing CAHPS® Hospice Survey data that . . . need to be addressed before CAHPS is incorporated into the algorithm."[29] Given that CMS had double weighted CAHPS scores and 49% of hospices do not report CAHPS data, the national associations raised concerns that CMS's proposed CAHPS selection criteria "will distort SFP selection."[30]

84. On October 4, 2023, a bipartisan group of Congress members raised similar concerns with CMS by letter.[31] The letter identified the lack of scaling condition-level

[25] *Id.* at 1-2.
[26] *Id.* at 2.
[27] *Id.* at 2 (emphasis added).
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] Letter from Beth Van Duyne, Member, United States House of Representatives, et al. to Shalanda Young, Director, Office of Management and Budget, and Chiquita Brooks-LaSure, Administrator, CMS (Oct. 4, 2023).

deficiencies and substantiated complaints as problematic. The Congress members stated that "accounting for relative size is critical to ensuring CMS is accurately comparing like hospices to best identify hospices in most need of focused education and oversight."[32]

85. The letter continued that "we are concerned that the proposal relies too heavily on the Hospice Care Index (HCI) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data – both of which have a large proportion of missing publicly reported data."[33] As for double weighting of CAHPS data, the Congress members "request[ed] CMS provide more transparency into why its proposed methodology for CAHPS data differed so drastically from that which the [Technical Expert Panel] recommended."[34]

86. The Congress members closed the letter by requesting that CMS engage in additional analysis before finalizing the July 2023 proposed rule. The letter states, "We request that CMS, in consultation with the [Technical Expert Panel], address the aforementioned limitations, and provide opportunity for stakeholder input on the changes prior to finalizing the SFP."[35]

G. CMS Finalizes the Hospice Special Focus Program Rule.

87. In November 2023, CMS finalized the proposed rule—the Hospice Special Focus Program Final Rule. *See* 88 Fed. Reg. at 77,676 (Nov. 13, 2023). The Hospice Special Focus Program Final Rule went into effect on January 1, 2024.

88. In the Final Rule, CMS defined the Hospice Special Focus Program as "a program conducted by CMS to identify hospices as poor performers, based on defined quality

[32] *Id.* at 1.
[33] *Id.* at 2.
[34] *Id.*
[35] *Id.*

indicators, in which CMS selects hospices for increased oversight to ensure that they meet Medicare requirements." 42 C.F.R. § 488.1105.

89. Hospices are selected for the Special Focus Program "based on the highest aggregate scores based on the algorithm used by CMS." 42 C.F.R. § 488.1135(b)(1).

90. The Final Rule calls for CMS to publicly post on its website (1) the 10 percent of hospice programs with the highest aggregate scores as determined by the CMS Special Focus Program algorithm and (2) the hospices that were selected from that 10 percent for participation in the Special Focus Program. 42 C.F.R. § 488.1135(f).

91. In the Final Rule, CMS adopted the same unlawful algorithm that had been proposed in the July 2023 proposed rule. 88 Fed. Reg. at 77,804. The Final Rule's algorithm thus calls for CMS to identify hospices for the Hospice Special Focus Program with condition-level deficiencies, substantiated complaints, CAHPS scores, and HCI scores. *Id.* And CMS considers only condition-level deficiencies, substantiated complaints, and HCI scores for the roughly half of hospices that do not report CAHPS information. *Id.* Thus, CMS finalized its unlawful approach of identifying hospices with CAHPS and HCI scores rather than based on Medicare program compliance.

92. In addition to disregarding CMS's statutory mandate, the algorithm continues to bear the same serious and arbitrary flaws as the July 2023 proposed rule. It does not scale condition-level deficiencies or substantiated complaints by beneficiaries served; it double weighs CAHPS scores when available; and it assigns average HCI scores for the approximately 21% of hospices that do not have HCI scores available. 88 Fed. Reg. at 77,804 (double weighting CAHPS), 77,808 (averaging missing HCI scores), 77,809 (refusing to scale).

93. Selection for the Special Focus Program carries serious legal consequences in addition to the irreparable harms attendant on being publicly deemed a "poor performer." If selected for the Special Focus Program, a hospice is surveyed not less than once every 6 months rather than on the standard 36-month cycle. *Compare* 42 C.F.R. § 488.1135(c)(1), *with* 42 C.F.R. § 488.1110(a).

94. If selected for the Special Focus Program, a hospice program whose Medicare certification is based upon accreditation immediately loses its deemed status and is placed under CMS or State survey agency jurisdiction until completion of the SFP (or termination). 42 C.F.R. § 488.1135(b)(2).

95. A hospice is deemed to have "completed" the Special Focus Program when it has either (a) completed two surveys within 18 months with no condition-level deficiencies and has no pending complaint surveys or (b) returned to substantial compliance with all requirements. 42 C.F.R. § 488.1135(d). A hospice that does not "complete" the Special Focus Program will be considered for termination from the Medicare program. 42 C.F.R. § 488.1135(e).

H. CMS Fails to Confront the Serious Flaws in the Hospice Special Focus Program Final Rule.

96. CMS's algorithm for identifying hospices is unlawful because it relies on criteria that do not measure Medicare compliance—CAHPS and HCI scores. This approach exceeds CMS's statutory authority. It is also arbitrary and capricious: An agency may not rely on factors that Congress did not intend for it to consider. The Hospice Special Focus Program is therefore fundamentally flawed and must be set aside.

97. CMS also failed to articulate reasonable explanations for the most serious flaws in the algorithm: (1) relying on CAHPS and HCI scores, (2) failing to scale condition-level

deficiencies and substantiated complaints, and (3) assigning average HCI scores to hospices with missing HCI data.[36]

1. Reliance on CAHPS and HCI Scores.

98. Section 1395i-6(b)(1) makes identifying hospice providers that have "substantially failed to meet applicable [Medicare] requirements" the touchstone of the Hospice Special Focus Program. CMS has provided no explanation for how CAHPS and HCI scores are consistent with Congress' directive, and indeed they are not. This was a major aspect of the problem that called for an explanation.

99. Indeed, before CMS published the July 2023 proposed rule, the Technical Expert Panel report commissioned by CMS had found that using CAHPS and HCI scores resulted in identifying hospices that "did not have a high number of substantiated complaints and Quality of Care CLDs," which "point[ed] to a *lack of correlation* across these dimensions." Technical Expert Report, *supra* at 15 (emphasis added). That is, the evidence submitted to CMS was that CAHPS and HCI scores are not proxies for hospices that fail to comply with Medicare requirements. Given the statutory text, comments, and evidence, CMS acted unreasonably when it failed to explain (and cannot explain) how CAHPS and HCI scores, by their nature or effect, identify a substantial failure to comply with Medicare requirements.

2. Refusal to Scale Condition-Level Deficiencies and Substantiated Complaints.

100. "Many commenters" raised concerns with CMS's decision to not scale condition-level deficiencies and substantiated complaints. 88 Fed. Reg at 77,808. In

[36] As for the double weighting of CAHPS scores, CMS claims that its initial analysis shows its "approach does not significantly help or hurt providers with or without CAHPS Hospice Survey data" in terms of overall algorithm scores. 88 Fed. Reg. at 77,805. CMS has not released its initial analysis; Plaintiffs reserve the right to amend once CMS files the administrative record.

response, CMS claimed that according to its undisclosed testing of the algorithm, "there was not a linear relationship between the number of CLDs identified in hospice surveys and the average number of beneficiaries that a CLD provider served each year," and that all providers have the same opportunity to receive condition-level deficiencies. *Id.* The lack of linear relationship would also occur if, as commenters have suggested, larger hospice providers generally have higher rates of compliance with Medicare requirements. CMS's conclusory response based on its undisclosed data was insufficient.

101. As for substantiated complaints, CMS acknowledged that "large hospices have more opportunities to receive complaints than small hospices." *Id.* But CMS rejected scaling because "this does not change the opportunity for substantiation (that is, a complaint cannot be substantiated if the surveyor does not find evidence that supports the complaint)." *Id.* This explanation is plainly inadequate; it is a truism that any given complaint can be substantiated or not. CMS left the fundamental issue unaddressed: Whether a hospice program's absolute number of substantiated complaints reflects a worse record of substantial compliance with Medicare requirements relative to other hospices.

102. CMS's failure to grapple with the relationship between absolute numbers and compliance leaves yet another major problem unaddressed. CMS's algorithm purports to identify the poorest performing hospices, and CMS purports to include the 50 poorest performing providers across the entire country in the Special Focus Program. 88 Fed. Reg. at 77,799, 77,809. Any serious flaw in the selection criteria comes at a cost. Because the selection is *relative*, based on overall algorithm scores, flaws in the selection criteria prevent CMS from identifying the worst performing hospices for the Special Focus Program, while misleading Medicare beneficiaries about which hospices are poor performers and wasting

resources on increased oversight for providers that do not need it. CMS has willingly tolerated bias in its algorithm, such as skewing toward large providers that serve many beneficiaries per year, but failed to offer a reasoned explanation for doing so, given it prevents CMS from identifying the worst performing hospices for the Special Focus Program.

3. Assigning Average HCI Scores to Hospices with Missing HCI Data.

103. In response to commenter concerns about missing HCI scores, CMS acknowledged that approximately 21% of hospices did not report HCI scores. 88 Fed. Reg. at 77,807. CMS also admitted that "hospice providers that did not have a publicly reported HCI score were significantly less likely to be identified in the candidate list of the SFP," and that "[t]his suggests that the algorithm may be limited in its ability to identify poor performing hospices with under 20 discharges over two years." *Id.* CMS nonetheless concluded that "the benefits of using the HCI score, including that it is based on claims data, that it captures care processes occurring at a hospice, and that it has no additional data reporting burden, outweigh the concerns." *Id.*

104. Here, again, CMS failed to offer a reasoned explanation for tolerating admitted bias in its algorithm. The cost is not error in the abstract as CMS portrays it. By its own admission, CMS's flawed HCI metric will likely leave poor performing small hospices out of the Special Focus Program and, as a corollary, put better performing larger hospice providers in the Program. This works unnecessary reputational harm, misinforms Medicare beneficiaries about provider quality, and wastes oversight resources. Yet CMS's explanation fails to account for these serious downsides.

I. The December 2024–January 2025 Hospice Special Focus Program List

105. On or about December 18, 2024, Defendants notified by letter some 50 hospice agencies that they would be included in the Special Focus Program. CMS offered no procedures for these agencies to correct errors in CMS's data related to their hospices or to challenge their designation. Indeed, the notification letters stated that their "selection for the SFP cannot be appealed."[37]

106. On December 20, 2024, Defendants published on the CMS website the first Hospice Special Focus Program List that included "the list of the initial cohort of 50 hospices selected for participation" in the SFP in 2025.[38] Together with this Hospice Special Focus Program List, CMS purported to release its "underlying data" that was used to create the list and that would be used to identify "future SFP candidates."[39]

107. The Hospice Special Focus Program List implements the unlawful algorithm from the Hospice Special Focus Program Final Rule. That is clear from, among other things, guidance that CMS published alongside the List.[40]

108. On or around January 2, 2025, CMS removed the Hospice Special Focus Program List from its website and replaced it with a new version.[41] CMS noted that it was making "technical corrections and changes" and would provide an update shortly.[42] The revised Hospice Special Focus Program List removed three hospice programs.[43]

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[37] Ex. 1, Declaration of Houston Hospice, ¶ 6 & Ex. A.
[38] See Hospice Special Focus List, available at https://www.cms.gov/medicare/health-safety-standards/certification-compliance/hospice-special-focus-program (last visited Jan. 15, 2025).
[39] See Hospice Special Focus List, available at https://www.cms.gov/medicare/health-safety-standards/certification-compliance/hospice-special-focus-program (last visited Jan. 15, 2025).
[40] *See generally* CMS, Hospice Special Focus Program User's Guide: *Algorithm and Public Reporting* (Dec. 2024), https://shorturl.at/T6v7p (last visited Jan. 15, 2025).
[41] Ex. 2, Lund Person Decl., ¶ 45.
[42] *Id.*
[43] *Id.*

109. On or around January 8, 2024, CMS posted another revised Hospice Special Focus Program List that identifies 50 hospice providers for the Hospice Special Focus Program.[44] The Hospice Special Focus Program List dated January 8, 2024 includes four hospice programs that were not originally included in the December 20, 2024 version, while removing four hospice programs that were originally included.[45]

110. The Hospice Special Focus Program List currently includes six hospice providers, including members of the Association Plaintiffs, with ***no*** condition level deficiencies or substantiated complaints in the last three years.[46] In other words, six hospice providers in the Special Focus Program remained substantially compliant with Medicare requirements throughout the period covered. The fact that 12% of the hospices in the Special Focus Program have track records of unbroken substantial compliance with Medicare, by CMS's chosen metrics, underscores the arbitrary nature of CMS's approach.

111. The Hospice Special Focus Program List does not include the top 50 scoring hospices according to CMS's algorithm.[47] The Final Rule states that "[s]election of hospices for the SFP is made based on the *highest aggregate scores* based on the algorithm used by CMS." 42 C.F.R. § 488.1135(b)(1) (emphasis added). When "[s]everal commenters questioned how CMS will use discretion to select hospice programs for the SFP from a list of 10 percent of highest scoring hospices," CMS responded that it would "select *the poorest performing hospices*, from the 10 percent selectee list based on the finalized SFP algorithm score, in *sequential value*." 88 Fed. Reg. at 77,809 (emphasis added)

[44] Ex. 2, Lund Person Decl., ¶ 46.
[45] *Id.*
[46] Ex. 2, Lund Person Decl., ¶ 23; Ex. 3, Hammon Decl., ¶ 8.
[47] Ex. 2, Lund Person Decl., ¶ 25.

112. Rather than include the top-50 scoring hospices, as the Final Rule requires, CMS has arbitrarily chosen a group of 50 hospices from a much larger range of scores, up to the top-121 scoring hospices.[48] In effect, CMS has selected 31 hospice providers in the Special Focus Program List that are not within the top 50 according to CMS's algorithm.[49] For example, Plaintiff Houston Hospice's algorithm score ranks 118th, yet CMS selected it for the Special Focus Program.[50] At the same time, CMS passed over 71 higher-scoring hospices and did not include them on the Special Focus List, despite their having higher algorithm scores than the List's lowest-scoring hospice on the List.[51]

113. CMS has not explained what criteria or methodology it actually used to select the hospices for the Special Focus List. CMS has either disregarded the Final Rule, which called for selection of the highest scoring providers, or CMS has erred in applying its algorithm. Either way, the Hospice Special Focus Program List is arbitrary and capricious.

114. The Hospice Special Focus Program List is also arbitrary and capricious because CMS made demonstrable errors in assigning complaints to hospice providers.[52] In connection with the Hospice Special Focus Program List, CMS published an Excel file with substantiated complaints used in its algorithm.[53] The Excel file includes, among other things, whether a state agency performed the survey leading to a substantiated complaint and identifying information such as "Complaint ID" and "Survey Event ID."

115. Certain state agencies, such as the California Department of Public Health and the Florida Agency for Health Care Administration, make their complaint files publicly

[48] Ex. 2, Lund Person Decl., ¶ 25.
[49] *Id.*
[50] *Id.*
[51] *Id.*
[52] Ex. 2, Lund Person Decl., ¶ 29, 33.
[53] *Id.*, ¶ 29.

available.[54] If CMS has accurately collected and analyzed data, CMS's Excel file of substantiated complaints should match the public records from the state agencies who performed the surveys.[55]

116. Based on a comparison of public records, however, CMS appears to have made errors in identifying substantiated complaints.[56] For example, CMS has listed Complaint ID No. 90822 alleged against provider Elizabeth Hospice as "substantiated."[57] The corresponding State survey from California for the complaint shows a finding that, "NO DEFICIENCIES WERE IDENTIFIED FROM THIS SURVEY."[58] The complaint was not, in other words, substantiated.

117. Similarly, CMS has listed Complaint ID Nos. 88846, 88848, and 88850 alleged against provider Sharp Hospicecare for which the State of California conducted surveys on May 19, 2022, November 22, 2021, and July 28, 2022, respectively, as "substantiated."[59] A review of the State surveys for these complaints shows a finding that "NO DEFICIENCIES WERE IDENTIFIED FROM THIS SURVEY."[60] These complaints, too, were not substantiated.

118. For another example, CMS has identified Complaint ID No. 83984 alleged against provider Lifepath Hospice for which the State of Florida conducted a survey on June 4, 2021 as "substantiated."[61] But a review of the State survey for that complaint shows

[54] Ex. 2, Lund Person Decl., ¶ 30.
[55] Ex. 2, Lund Person Decl., ¶¶ 30-32.
[56] Ex. 2, Lund Person Decl., ¶¶ 33.
[57] *Id.*, ¶ 34.
[58] *Id.*
[59] Ex. 2, Lund Person Decl., ¶¶ 35.
[60] *Id.*
[61] Ex. 2, Lund Person Decl., ¶ 36.

a finding that, "The agency was in compliance with Code of Federal Regulations (CFR) 42 Part 418, Condition of Participation for Hospice Care."[62]

119. There appear to be other errors in CMS's application of the substantiated complaint criteria. According to its guidance document, CMS claimed it would only count complaints as substantiated if the Complaint ID on CMS Form 2567 matches the Complaint ID in its Excel file of substantiated complaints.[63] CMS also claimed that complaints related to state licensure issues, whether substantiated or unsubstantiated, would not be counted for purposes of its algorithm.[64] On multiple occasions, though, CMS appears to have counted complaints as substantiated when the Complaint IDs did not match or when the underlying complaint related only to a state licensure issue.[65]

120. In implementing the Final Rule through the Hospice Special Focus Program List, CMS has provided no opportunity to challenge the substantiated complaints identified in its Excel file that factor into its algorithm, either before or after publishing the List. Had CMS provided an opportunity for hospices to be heard, CMS could have avoided errors in the List and spared hospices unnecessary harm.

121. Because CMS made clear errors in applying the algorithm, the Hospice Special Focus Program List lacks the support of substantial evidence, is arbitrary and capricious, and should be set aside.

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[62] *Id.*
[63] CMS, Hospice Special Focus Program User's Guide: *Algorithm and Public Reporting* at 8, https://shorturl.at/T6v7p (last visited Jan. 15, 2025).
[64] *Id.*
[65] Ex. 2, Lund Person Decl., ¶¶ 37-38.

J. Defendants' Unlawful Actions Have Caused and Will Continue to Cause Irreparable Harm to Houston Hospice.

122. Houston Hospice was one of the providers that received a letter from CMS on December 18, 2024.[66] The letter informed Houston Hospice that its "hospice program has been selected for the Special Focus Program (SFP) (42 C.F.R. § 488.1135) based on the SFP selection methodology," and that Houston Hospice "will be under enhanced oversight."[67] CMS made clear that "[y]our selection for the SFP cannot be appealed."[68]

123. On December 20, 2024, CMS published on its website the Special Focus Program List that included Houston Hospice. Houston Hospice had no opportunity to rebut or even discuss CMS's damaging claims before the agency posted Houston Hospice's name on the Special Focus Program list.[69]

124. Houston Hospice has suffered and will continue to suffer irreparable harm from its unlawful inclusion in the Hospice Special Focus Program.

1. <u>CMS Has Harmed Houston Hospice's Reputation.</u>

125. CMS defines the Special Focus Program as "a program conducted by CMS to identify hospices as poor performers, based on defined quality indicators, in which CMS selects hospices for increased oversight to ensure that they meet Medicare requirements." 42 C.F.R. § 488.1105. By including Houston Hospice in the Special Focus Program, CMS has publicly labelled Houston Hospice a "poor performer" among all hospice providers in the country and has implied that Houston Hospice does not "meet Medicare requirements."

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[66] Ex. 1, Houston Hospice Decl., ¶ 6 & Ex. A.
[67] Ex. A to Ex. 1, Houston Hospice Decl. Houston Hospice received the letter that is Exhibit A as a Microsoft Word file, with the "Formatted" comment in the margin.
[68] *Id.*
[69] Ex. 1, Houston Hospice Decl., ¶ 6.

126. That is simply not the case. Houston Hospice is the oldest and largest nonprofit hospice in Houston.[70] Since 1980, Houston Hospice has provided uncompromising, compassionate, end-of-life care to patients and families across Texas.[71] Houston Hospice is committed to providing the highest quality hospice care for patients of all ages, races, ethnicities, and places of origin—regardless of whether these individuals have insurance.[72]

127. The communities Houston Hospice serves believe it is accomplishing its mission.[73] According to the most current Consumer Assessment of Healthcare Providers and Systems survey data for January 2025, 100% of families responding to the survey would recommend Houston Hospice.[74] Houston Hospice is also accredited by the National Institute for Jewish Hospice and was named "Hospice of Choice" by Houston Jewish Funerals, Distinctive Life Cremation and Funeral Services.[75] The Mayor of Houston recognized Houston Hospice's "compassionate and respectful physical, social and spiritual support to [its] patients, loved ones and caregivers" in a proclamation declaring November 18, 2014 as "Houston Hospice Day."[76] Houston Hospice was awarded the 2017 Readers' Choice Award for Best Hospice (Houston Area).[77]

128. Houston Hospice has long been committed to compliance with all laws and regulations, including the Medicare conditions of participation.[78] Houston Hospice has a robust and exemplary compliance program.[79] It has been accredited by Community Health

[70] Ex. 1, Houston Hospice Decl., ¶ 9.
[71] *Id.*
[72] *Id.*
[73] Ex. 1, Houston Hospice Decl., ¶ 11.
[74] *Id.*, ¶ 12.
[75] *Id.*
[76] *Id.*, ¶ 11.
[77] *Id.*, ¶ 12.
[78] Ex. 1, Houston Hospice Decl., ¶ 10.
[79] *Id.*, ¶¶ 10, 13-14 (describing Houston Hospice's compliance program).

Accreditation Partner (CHAP) since 2008.[80] In February 2024, Houston Hospice underwent its reaccreditation survey and was found to be in substantial compliance with all Medicare conditions of participation.[81] Placing Houston Hospice on a list purporting to identify the nation's hospices with the poorest records of Medicare compliance is misleading and wrong.[82]

129. CMS's public criticism has caused and will continue to cause harm. Houston Hospice must attract Medicare beneficiaries to its hospice program.[83] Because Texas is not a certificate-of-need state, patients have a large number of hospice programs from which to choose.[84] In fact, there are 231 Medicare-certified hospice programs operating in Harris County alone, and 343 Medicare-certified hospice programs within Houston Hospice's 13-county geographic footprint.[85] CMS's public criticism will deter patients from selecting Houston Hospice.[86] Competitors will use the listing against Houston Hospice as a way to deter referral sources from offering Houston Hospice as a reputable option for care.[87]

130. CMS's public criticism will also likely do substantial damage to Houston Hospice's ability to obtain both the charitable contributions and the volunteer assistance that is critical to Houston Hospital's survival.[88] As a non-profit, Houston Hospice is highly dependent on the generosity of its community, generosity expressed through contributions of both finances and time.[89] The reimbursements that Houston Hospice receives from Medicare

[80] *Id.*, ¶ 13.
[81] *Id.*
[82] *Id.*
[83] Ex. 1, Houston Hospice Decl., ¶ 17.
[84] *Id.*
[85] *Id.*
[86] *Id.*
[87] *Id.*
[88] Ex. 1, Houston Hospice Decl., ¶ 18.
[89] *Id.*

and other payors is insufficient to cover its expenses to provide high quality care.[90] Houston Hospice would operate at a significant deficit but for the community's generous contributions, which accounted for 13% of its annual revenue in 2023.[91] The negative publicity and reputational harm associated with CMS's public criticism will likely harm Houston Hospice's ability to obtain the charitable contributions necessary for its success.[92]

131. Houston Hospice is also proud of the substantial volunteer commitment to its program.[93] Houston Hospice had 101 volunteers help support patients and their families in 2024, accounting for 5,215 total volunteer hours and over $150,000 of cost savings.[94] CMS's actions will make it harder to recruit and sustain volunteers, who may question whether they want to give their time to, and be associated with, Houston Hospice.[95]

132. CMS regulations require Houston Hospice to utilize volunteers in addition to its paid workforce. 42 C.F.R. § 418.78. In 2024, volunteer hours made up 7% of Houston Hospice's total hours, and 5.6% for Medicare-approved hours.[96] Houston Hospice has deep concerns that CMS's actions will serve as a barrier to attracting volunteers, as they may be misled by CMS's listing into believing that Houston Hospice is a poor performer.[97]

133. Houston Hospice also competes with other hospice programs and a significant number of other medical providers for healthcare professionals and staff.[98] The labor market for healthcare providers and other staff has proven challenging over the last several years and

[90] *Id.*
[91] *Id.*
[92] *Id.*
[93] Ex. 1, Houston Hospice Decl., ¶ 19.
[94] *Id.*
[95] *Id.*
[96] Ex. 1, Houston Hospice Decl., ¶ 19.
[97] *Id.*
[98] Ex. 1, Houston Hospice Decl., ¶ 20.

remains so today.[99] CMS's public criticism will make it more difficult for Houston Hospice to compete with other providers (among other potential employers) for healthcare professionals and other staff.[100]

2. CMS Has Imposed Increased Compliance Costs on Houston Hospice.

134. The Hospice Special Focus Program Final Rule requires that hospices in the Special Focus Program be surveyed at least every six months rather than Medicare's standard 36-month period. *Compare* 42 C.F.R. § 488.1110(a), *with id.*, § 488.1135(c)(1). Since becoming accredited by CHAP in 2008, Houston Hospice's reaccreditation surveys have taken place every three years.[101] Houston Hospice's unlawful inclusion in the Special Focus Program will greatly increase the frequency with which it will be surveyed.[102]

135. Houston Hospice incurs compliance costs from each survey.[103] Houston Hospice must comply with surveyors.[104] This involves employees sitting for interviews, providing records, and otherwise working with the surveyors.[105] In general, Houston Hospice devotes roughly 100 employee hours per survey at an average cost of $55 per hour.[106] Each survey therefore imposes approximately $5,500 in compliance costs on Houston Hospice.[107] Because Houston Hospice has been included in the Special Focus Program, Houston Hospice will necessarily incur those compliance costs at least every six months, as opposed to surveys

[99] *Id.*
[100] *Id.*
[101] Ex. 1, Houston Hospice Decl., ¶ 21.
[102] *Id.*
[103] Ex. 1, Houston Hospice Decl., ¶ 21.
[104] *Id.*
[105] *Id.*
[106] *Id.*
[107] *Id.*

every three years as in the past—a significant and unnecessary expenditure of the limited funds available to Houston Hospice.[108]

3. CMS Has Revoked Houston Hospice's Deemed Status.

136. Houston Hospice elected to become accredited by CHAP in 2008 to be held to a high standard of care with expert support.[109] Houston Hospice pays for the expertise of the accrediting agency to ensure high quality care, ongoing education, and compliance with federal and state conditions of participation.[110] Through this process, Houston Hospice also attained deemed status with Medicare accepting CHAP surveys in lieu of its own survey.[111]

137. Houston Hospice has maintained CHAP accreditation and deemed status for the past 16 years.[112] Houston Hospice has now lost the benefit of CHAP accreditation and its deemed status due to being placed in the Special Focus Program.[113] Thus, the value of CHAP accreditation, which cost Houston Hospice $19,600 for the most recent three-year period, has been substantially eroded.[114]

K. Defendants' Unlawful Actions Have Caused and Will Continue to Cause Irreparable Harm to Members of the Association Plaintiffs.

138. The Association Plaintiffs have members who have been included in the Hospice Special Focus Program. As with Houston Hospice, the members of the Association Plaintiffs received from CMS letters informing them of their inclusion in the Special Focus

[108] *Id.*
[109] Ex. 1, Houston Hospice Decl., ¶ 23.
[110] *Id.*
[111] *Id.*
[112] Ex. 1, Houston Hospice Decl., ¶ 23
[113] *Id.*
[114] *Id.*

Program. On December 20, 2024, CMS identified members of the Association Plaintiffs on the Hospice Special Focus Program List.[115]

139. Members of the Association Plaintiffs have suffered and will continue to suffer irreparable injury from the unlawful Hospice Special Focus Program Final Rule and Hospice Special Focus Program List.

140. By including members of the Association Plaintiffs in the Special Focus Program, CMS has publicly labelled those members "poor performers" and implied that they do not "meet Medicare requirements."[116] CMS's public criticism will make it more difficult for those members to attract patients for their Medicare programs, as well as to attract and retain employees.[117] At least some consumers review CMS lists and will not select hospice programs that are included on negative CMS listings when seeking hospice care for themselves or their loved ones.[118]

141. In addition, the reputational harm makes it more difficult for hospice programs to attract referrals from other facilities and makes it less likely other facilities will accept referrals from them, with the latter harming not only the hospice providers but also their patients.[119] At least some referral sources will not refer patients to hospices on CMS lists out of fear that patients will not receive adequate care and that working with a hospice labelled as a "bad actor" could lead to scrutiny of the referral source by state regulators.[120] Hospice providers sometimes transfer patients to nursing homes or hospitals for respite or other

[115] Ex. 3, Hammon Decl., ¶ 8; Ex. 4, Reinhardt Decl., ¶ 11; Ex. 5., AHHC Decl., ¶ 9.
[116] Ex. 3, Hammon Decl., ¶ 10; Ex. 4, Reinhardt Decl., ¶ 13; Ex. 5., AHHC Decl., ¶ 11; Ex. 6, SCHCHA Decl., ¶ 11.
[117] Ex. 3, Hammon Decl., ¶ 10; Reinhardt Decl., ¶ 14; Ex. 5., AHHC Decl., ¶ 11; Ex. 6, SCHCHA Decl., ¶ 11.
[118] Ex. 4, Reinhardt Decl., ¶ 15.
[119] *Id.*, ¶¶ 16-17.
[120] *Id.*, ¶ 16.

specialized care.[121] At least some nursing homes and hospitals will not accept patients from hospices that are included in CMS programs for fear that working with a "bad actor" could invite regulatory scrutiny.[122]

142. CMS's public criticism is misleading. For example, multiple TAHCH members that have been included in the Hospice Special Focus Program have zero condition level deficiencies and zero substantiated complaints over the past three years.[123] Thus, while CMS has told the public, including Medicare beneficiaries, that TAHCH's members are "poor performers" in complying with Medicare requirements and need additional oversight, these members remained fully compliant with Medicare throughout the relevant period according to CMS's own criteria for the Hospice Special Focus Program.

143. CMS has imposed increased compliance costs on members of the Association Plaintiffs through its unlawful actions. Surveys are burdensome for members of the Association Plaintiffs.[124] During a survey, a member must cooperate with the surveyor throughout the intrusive and disruptive survey process.[125] This often involves employees sitting for interviews, providing records, scheduling home visits, and providing any other information that the surveyor might request—all while taking these employees away from time dedicated to direct patient care.[126] Hospice providers also often hire consultants to facilitate and streamline the survey process.[127] Members spend thousands of dollars in

[121] *Id.*, ¶ 17.
[122] *Id.*, ¶ 17.
[123] Ex. 3, Hammon Decl., ¶ 8.
[124] Ex. 3, Hammon Decl., ¶ 12; Ex. 4, Reinhardt Decl., ¶ 20; Ex. 5, AHHC Decl., ¶ 13; Ex. 6, SCHCHA Decl., ¶ 13.
[125] Ex. 3, Hammon Decl., ¶ 12; Ex. 4, Reinhardt Decl., ¶ 20; Ex. 5, AHHC Decl., ¶ 13; Ex. 6, SCHCHA Decl., ¶ 13.
[126] Ex. 3, Hammon Decl., ¶ 12; Ex. 4, Reinhardt Decl., ¶ 20; Ex. 5, AHHC Decl., ¶ 13; Ex. 6, SCHCHA Decl., ¶ 13.
[127] Ex. 4, Reinhard Decl., ¶ 20.

employee time and resources complying with each survey.[128] By including members of the Association Plaintiffs in the Special Focus Program, CMS has increased their survey frequency and, consequently, increased their compliance costs.

144. CMS has also revoked deemed status for members of the Association Plaintiffs. Some members of the Association Plaintiffs previously held deemed status and were subject to surveys from accrediting agencies such as the Community Health Accreditation Partner (CHAP) and the Accreditation Commission for Health Care (ACHC).[129] Hospice programs select deemed status because, for among other reasons, deemed status is often tied to quality metrics used in contracting with insurance companies and other payer sources, allowing the hospice program to obtain favorable rates and referral status.[130] Members who have been placed in the Special Focus Program will lose the benefits of deemed status and will now be subject to surveys from state survey agencies.

145. Members will lose other benefits of deemed status. Deemed status through independent accreditation provides a reputational boost to hospice providers, as accreditation and deemed status are considered above and beyond minimum standards.[131] Accreditation agencies, including ACHC, provide best practices and recommendations to help hospices elevate standard of care.[132] Members that have been included in the unlawful Hospice Special Focus Program will lose these benefits of deemed status.

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[128] Ex. 3, Hammon Decl., ¶ 12; Ex. 4, Reinhardt Decl., ¶ 20; Ex. 5, AHHC Decl., ¶ 13; Ex. 6, SCHCHA Decl., ¶ 13.
[129] Ex. 3, Hammon Decl., ¶ 13; Ex. 4, Reinhardt Decl., ¶ 21; Ex. 5, AHHC Decl., ¶ 14. Additionally, the Joint Commission provides accreditation of many hospices.
[130] Ex. 3, Hammon Decl., ¶ 13; Ex. 5, AHHC Decl., ¶ 14.
[131] Ex. 4, Reinhardt Decl., ¶ 21.
[132] *Id.*, ¶ 21.

146. In addition, CMS has caused irreparable harm to Association Plaintiff members by posting erroneous data about substantiated complaints on its Special Focus List website. As noted, CMS's "underlying data" includes an Excel file titled "Hospice Special Focus Program Substantiated Complaints." CMS's Excel file includes various errors, including complaints that were not substantiated or that related only to state-licensing deficiencies, which are not supposed to count for the SFP algorithm.[133] CMS's public posting of data that purport to show a hospice had a deficiency in Medicare compliance when, in fact, the hospice did not causes inevitable reputational harm to that hospice.

COUNT ONE
Violation of 5 U.S.C. § 706(2)(A), (C) – Against All Defendants
(Contrary to Law and In Excess of Statutory Authority)

147. Plaintiffs restate and incorporate by reference the allegations above.

148. Congress provided Defendants with the authority to "conduct a special focus program for enforcement of requirements for hospice programs that the Secretary has identified as having substantially failed to meet applicable requirements of [chapter 7, Title 42, U.S. Code]," which provides the requirements for hospice participation in the Medicare program. 42 U.S.C. § 1395i-6(b)(1).

149. On its face, the authorizing statute permits Defendants to establish a Special Focus Program that identifies hospices for enforcement based only on their having "substantially failed" to meet the Medicare requirements. *See* 42 U.S.C. § 1395i-6(b)(1).

150. It is not a requirement of Medicare certification that hospices must achieve a certain score on those quality measures.

[133] Ex. 2, Lund Person Decl., ¶¶ 29-40.

151. Defendants acted contrary to 42 U.S.C. § 1395i-6(b)(1) and in excess of their statutory authority by promulgating the Hospice Special Focus Program Final Rule and List that targeted hospices based on CAHPS scores and HCI measures, rather than based solely (or at all) on findings of hospices to have been noncompliant with Medicare requirements.

152. The Hospice Special Focus Final Rule and List are contrary to law, were issued in excess of statutory authority, and are therefore unlawful.

COUNT TWO
Violation of 5 U.S.C. § 706(2)(A) – Against All Defendants
(Arbitrary and Capricious)

153. Plaintiffs restate and incorporate by reference the allegations above.

154. CMS's Final Rule, which establishes the Special Focus Program and the algorithm that relies on HCI and CAHPS scores, is a final agency action because it consummates the agency's rulemaking and has legal consequences for hospice programs.

155. The Hospice Special Focus Program List, along with the underlying data, is final agency action because it consummates the CMS's selection of hospices for the SFP in 2025 and creates legal consequences, including removing "deemed" status and imposing additional surveys on selected hospice providers.

156. Plaintiffs are adversely affected and aggrieved by the promulgation and enforcement of the Hospice Special Focus Final Rule and List.

157. "The APA's arbitrary-and-capricious standard requires that agency action be reasonable and reasonably explained." *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021). Agency action is "arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the

agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

158. The Hospice Special Focus Program Final Rule and Hospice Special Focus Program List are arbitrary and capricious for multiple reasons, including but not limited to the following.

159. *First*, in promulgating the Final Rule and implementing the Final Rule through the List, CMS has "relied on factors which Congress has not intended it to consider." *State Farm*, 463 U.S. at 43. CMS has identified hospice providers with CAHPS and HCI scores that do not measure compliance with Medicare requirements. Even if CAHPS and HCI scores were permissible factors (they are not), CMS has offered no explanation for how using CAHPS and HCI scores help it identify hospices with records of noncompliance, the "quality Congress deemed important in" § 1395i-6(b)(1). *Louisiana v. United States Dep't of Energy*, 90 F.4th 461, 475 (5th Cir. 2024).

160. CMS's arbitrary approach to Medicare requirements has manifested in other ways. CMS can *select* hospices for the Special Focus Program based on CAHPS and HCI scores, but the Final Rule's criteria for *completing* the Special Focus Program relate only to Medicare requirements. 42 C.F.R. § 488.1135(d). That is, a hospice is deemed to have "completed" the Special Focus Program when it has either (a) completed two surveys within 18 months with no condition-level deficiencies and has no pending complaint surveys or (b) returned to substantial compliance with all requirements, *id.*, even though some of the hospices selected for the Special Focus Program were never found to be out of substantial compliance in the first place. "Illogic and internal inconsistency"—such as selecting hospices

based on CAHPS and HCI scores but grading them on Medicare requirements—"are characteristic of arbitrary and unreasonable agency action." *Chamber of Com. of United States of Am. v. United States Dep't of Lab.*, 885 F.3d 360, 382 (5th Cir. 2018).

161. Indeed, the Hospice Special Focus Program list includes six hospice providers with no condition level deficiencies or substantiated complaints in the past three years. Given Congress' direction to identify hospices that substantially fail Medicare requirements, CMS's selection of six hospice programs with unbroken records of substantial compliance for the Special Focus Program is arbitrary and capricious.

162. *Second*, CMS failed to explain adequately why its algorithm uses absolute numbers of condition level deficiencies and substantiated complaints rather than scaling them by beneficiaries served. CMS overlooked fundamental aspects of the problem and failed to articulate a satisfactory explanation for its position. It did not explain why a hospice provider's absolute number of substantiated complaints measures its performance relative to other hospice providers. Nor did CMS confront the downside of not identifying the worst performing hospices. Because the selection is relative based on overall algorithm scores, flaws in the selection criteria prevent CMS from identifying the worst performing hospices for the Special Focus Program, while misleading Medicare beneficiaries and wasting resources on increased oversight for providers that do not need it.

163. *Third*, CMS has also failed to explain adequately its decision to assign average HCI scores to hospice programs that do not report HCI data. CMS acknowledged that approximately 21% of hospices did not report HCI scores and that "hospice providers that did not have a publicly reported HCI score were significantly less likely to be identified in the candidate list of the SFP," and that "[t]his suggests that the algorithm may be limited in its

ability to identify poor performing hospices with under 20 discharges over two years." 88 Fed. Reg. at 77,807. Using an admittedly flawed HCI metric will likely leave poor performing small hospices out of the Special Focus Program and, as a corollary, put better performing larger hospice providers in the Program. This works unnecessary reputational harm, misinforms Medicare beneficiaries about provider quality (overall and relatively), and does not focus enforcement resources on the right set of hospices. Because CMS did not confront the significant downsides to HCI scores, CMS has failed to "articulate a satisfactory explanation for its action." *State Farm*, 463 U.S. at 43.

164. *Fourth*, CMS's Hospice Special Focus Program List has disregarded the Final Rule, made errors in applying the algorithm for selecting hospices, or both. The Final Rule states that "[s]election of hospices for the SFP is made based on the *highest aggregate scores* based on the algorithm used by CMS." 42 C.F.R. § 488.1135(b)(1) (emphasis added). CMS has not included the top 50 scoring hospices. CMS also made demonstrable errors in identifying hospice providers' substantiated complaints. As a result, the Hospice Special Focus Program is either arbitrary and capricious for disregarding the Final Rule or for lacking the support of substantial evidence.

165. Plaintiffs have suffered and will continue to suffer irreparable harm as a result of Defendants' violations of 5 U.S.C. § 706(2)(A).

166. The Final Rule and List are arbitrary, capricious, an abuse of discretion and otherwise not in accordance with law and are therefore invalid under 5 U.S.C. § 706(2)(A).

167. Plaintiffs are entitled to injunctive and declaratory relief to remedy Defendants' unlawful conduct, as well as all other relief as set forth in its Prayer for Relief. *See* 5 U.S.C. § 705.

COUNT THREE
Violation of 5 U.S.C. § 706(2)(D) and 42 U.S.C. § 1395hh – Against All Defendants
(Promulgated Without Observance of Procedure Required by Law)

168. Plaintiffs restate and incorporate by reference the allegations above.

169. Under the APA, a court must set aside agency action that was implemented "without observance of procedure required by law." 5 U.S.C. § 706(2)(D).

170. The Medicare Act requires public notice and comment for any "rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under [Medicare]." 42 U.S.C. § 1395hh(a)(2).

171. As part of this requirement, the agency must provide notice of any proposed rulemaking, followed by an opportunity for the public to provide comments. 42 U.S.C. § 1395hh(b)(1).

172. When scientific studies or "critical factual material" provide the basis of a rule, an agency gives deficient notice by failing to make those sources available "in order to afford interested persons meaningful notice and an opportunity for comment." *See Texas v. U.S. Env't Prot. Agency*, 389 F. Supp. 3d 497, 505 (S.D. Tex. 2019) (quoting *Air Transp. Ass'n of Am. V. FAA*, 169 F.3d 1, 7 (D.C. Cir. 1999)).

173. CMS referenced in the Special Focus Program Proposed Rule its "analysis of CYs 2019 to 2021 CAHPS Hospice Survey data," and discussed how that analysis impacted its decision about how to treat the CAHPS score in the Special Focus Program algorithm, with a particular focus on how to treat hospices that did not report a CAHPS score.

174. CMS failed to provide commenters with access to these above-referenced analyses—critical material used to develop the Special Focus Program algorithm—thereby denying them a meaningful opportunity to comment on the Special Focus Program Proposed Rule.

175. CMS likewise failed to provide commenters with access to its data files on condition-level deficiencies and substantiated complaints. Commenters had no meaningful opportunity to comment on the CMS's collection of data on condition-level deficiencies and substantiated complaints, substantial components of the algorithm for selecting the Hospice Special Focus Program.

176. The Final Rule was promulgated without observance of procedure required by law and is therefore invalid.

APPLICATION FOR PRELIMINARY INJUNCTIVE RELIEF OR A STAY UNDER APA § 705[134]

177. Plaintiffs restate and reincorporate by reference the allegations stated above.

178. Plaintiffs have suffered and will continue to suffer at least three forms of irreparable injury from Defendants' unlawful actions—the Hospice Special Focus Program Final Rule and the Hospice Special Focus Program List. *First*, Defendants' unlawful actions have caused and will continue to cause reputational harm to Houston Hospice and the members of the Association Plaintiffs. *Second*, Defendants' unlawful actions will impose increased and unrecoverable compliance costs on Houston Hospice and members of the Association Plaintiffs, who must comply with increased surveys as a result of their unlawful inclusion in the Hospice Special Focus Program. *Third*, Defendants' unlawful actions deprive

[134] In accordance with Local Rule 7.1.D, undersigned counsel will confer with defendants' counsel regarding this application for a preliminary injunction once defendants' counsel are identified after service of this Complaint.

Houston Hospice and members of the Association Plaintiffs "deemed status" under Medicare—a statutory entitlement. In the above allegations and supporting declarations, Plaintiffs have established that each such harm is actual and imminent, as well as irreparable.

179. There is no adequate remedy at law for the unlawful Hospice Special Focus Program Final Rule and Hospice Special Focus Program List. A "plaintiff cannot recoup money damages from a federal agency on account of its sovereign immunity." *Mock v. Garland*, 697 F. Supp. 3d 564, 579 (N.D. Tex. 2023).

180. There is a substantial likelihood that Plaintiffs will prevail on the merits of their APA claims. The Hospice Special Focus Program Final Rule and Hospice Special Focus Program List are contrary to law, in excess of Defendants' statutory authority, arbitrary and capricious, and procedurally invalid. In the above allegations and supporting declarations, Plaintiffs have established that they are substantially likely to prevail on the merits of their APA claims.

181. "The balance-of-harms and public-interest factors merge when the government opposes an injunction." *Career Colleges & Sch. of Texas v. United States Dep't of Educ.*, 98 F.4th 220, 254 (5th Cir. 2024). While Plaintiffs will continue to suffer irreparable harm absent an injunction, Defendants have no interest in perpetuating unlawful agency action such as the Hospice Special Focus Program Final Rule and the Hospice Special Focus Program List. *Texas v. United States*, 40 F.4th 205, 229 (5th Cir. 2022). And the public interest favors government agencies abiding by federal law. *Id.* In the above allegations and supporting declarations, Plaintiffs have established that the balance of harms and public interest weigh in favor of injunctive relief.

182. Plaintiffs therefore request a preliminary and permanent injunction under Federal Rule of Civil Procedure 65 or a stay of agency action under APA § 705 that requires Defendants (i) to refrain from implementing the Final Rule and its algorithm; (ii) to rescind the selections for the Hospice Special Focus Program; (iii) to withdraw the Hospice Special Focus Program List and underlying data; (iv) to post in their place a notice that the Hospice Special Focus Program Final Rule and List have been stayed by a federal district court; and (v) to refrain from further selecting hospices for inclusion in the Hospice Special Focus Program or publishing the Hospice Special Focus Program List and underlying data.

183. Plaintiffs ask the Court to set their application for preliminary injunction for a hearing and, after the hearing, to issue a preliminary injunction against Defendants.

184. Plaintiffs ask the Court to include the application for permanent injunctive relief in the Court's final determination of the merits and, after such determination, to issue a permanent injunction, as well as to provide Plaintiffs with the other relief they have requested.

PRAYER FOR RELIEF

WHEREFORE, Provider respectfully requests that the Court:

A. Hold unlawful and set aside the Hospice Special Focus Program Final Rule under 5 U.S.C. § 706(2);

B. Hold unlawful and set aside the Hospice Special Focus Program List under 5 U.S.C. § 706(2);

C. Preliminarily and permanently enjoin Defendants from enforcing the Hospice Special Focus Program Final Rule;

D. Preliminarily and permanently order Defendants (i) to refrain from implementing the Final Rule and its algorithm; (ii) to rescind the selections for the Hospice

Special Focus Program; (iii) to withdraw the Hospice Special Focus Program List and underlying data; (iv) to post in their place a notice that the Hospice Special Focus Program Final Rule and List have been stayed by a federal district court; and (v) to refrain from further selecting hospices for inclusion in the Hospice Special Focus Program or publishing the Hospice Special Focus Program List and underlying data;

E. Award attorneys' fees and costs to Plaintiffs; and

F. Award any other relief as the Court deems just, equitable, and proper.

Dated: January 16, 2025

Respectfully submitted,

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Exhibit 1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

TEXAS ASSOCIATION FOR HOME CARE & HOSPICE, et al.,

Plaintiffs,

v.

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,

Defendants.

Case No.: _____

DECLARATION OF HOUSTON HOSPICE

Pursuant to 28 U.S.C. § 1746, I declare as follows:

1. My name is April Rose, BSN, RN, CHPN. I am Vice President of Patient Services for Houston Hospice. I respectfully submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction or a Stay under Administrative Procedure Act (APA) § 705. I am over twenty-one years old and have personal knowledge of the facts contained in this declaration.

2. I have been a nurse for 27 years and have spent the majority of my career in hospice care. I started working for a non-profit agency as a Registered Nurse Case Manager in 1997 providing direct patient care. Over the next 20 years I worked in almost every aspect of hospice, including direct patient care, team leadership, compliance and regulatory oversight, and overall business operations. I am a registered nurse with a certification in hospice and palliative care, degreed with my Associate and Bachelor of Science in Nursing

and am currently pursuing my Master's in Legal Studies with a Health Law Certification. I have been VP of Patient Services at Houston Hospice since December 2023.

3. Houston Hospice is a member of the Texas Association for Home Care & Hospice (TAHCH). TAHCH advocates for ethical practices, quality, and economic viability of licensed, Medicare-certified home care and hospice providers to enhance the well-being of individuals and their families throughout Texas.

4. TAHCH, through its regulatory team, advises its members like Houston Hospice and advocates for us with regard to state and federal regulatory issues. TAHCH facilitates meetings with regulators to address industry concerns and member issues, submits comments on state and federal regulations, and participates in workgroups and advisory committees. Houston Hospice relies on TAHCH to advance our interests with state and federal regulators, including the Centers for Medicare & Medicaid Services (CMS).

5. I am familiar with CMS' Final Rule that establishes, among other things, the Special Focus Program's selection criteria.[1]

6. On December 18, 2024, Houston Hospice received a letter from CMS stating that Houston Hospice would be included in the Special Focus Program. A true and correct copy of CMS' letter is attached to this Declaration.[2] Two days later, before Houston Hospice was able to evaluate the underlying allegations, CMS published on its website the Special Focus Program list that included Houston Hospice. We were offered no opportunity to rebut

[1] Calendar Year 2024 Home Health Prospective Payment System Final Rule, 88 Fed. Reg. 77676 (Nov. 13, 2023).

[2] *See* Ex. A (Dec. 18, 2024 CMS Notification of SFP Selection Letter to Houston Hospice).

or even discuss CMS' damaging claims before the Agency posted Houston Hospice's name on the Special Focus Program List.[3]

7. Houston Hospice has suffered and will continue to suffer significant and irreparable harm from CMS including Houston Hospice in the Special Focus Program.

8. CMS has harmed Houston Hospice's reputation by including Houston Hospice in the Special Focus Program. CMS defines the Special Focus Program as "a program conducted by CMS to identify hospices as poor performers, based on defined quality indicators, in which CMS selects hospices for increased oversight to ensure that they meet Medicare requirements."[4] By including Houston Hospice in the Special Focus Program, CMS has publicly labeled us a "poor performer" among all hospice providers in the whole country regarding our compliance with Medicare requirements.

9. That is simply not the case. Houston Hospice is the oldest and largest non-profit hospice in Houston. Since 1980, Houston Hospice has provided uncompromising and compassionate end-of-life care to patients and families across Texas. Houston Hospice is committed to providing the highest quality hospice care for patients of all ages, races, ethnicities, and places of origin—regardless of whether these individuals have insurance.

10. Houston Hospice has also long been committed to compliance with all laws and regulations, including the Medicare conditions of participation, as well as to the highest quality of care for patients. Kyllie Chang BSN, RN, CHPN is the compliance officer as well as quality and education manager for Houston Hospice. In collaboration with myself and our Quality Oversight Committee, Houston Hospice maintains a robust Quality Assessment

[3] *Id.*

[4] 42 C.F.R. § 488.1105.

Performance Improvement (QAPI) program. All employees are required to complete annual compliance trainings, including review and acknowledgement of the quality plan and code of conduct. All Houston Hospice staff are evaluated annually with performance evaluations, in addition to competency checks for all staff providing direct patient care. The QAPI plan mandates a monthly comprehensive audit for 10% of patients enrolled in hospice care at that point in time, 100% audit of all adverse events and complaints, tracking and trending of falls or infections, and performance-improvement projects to correct identified trends.

11. The communities we serve believe that we are accomplishing our mission. The Mayor of Houston recognized Houston Hospice's "compassionate and respectful physical, social and spiritual support to [its] patients, loved ones and caregivers" in a proclamation declaring November 18, 2014, as "Houston Hospice Day."

12. That level of care and compassion has continued to this day. According to the most-current Consumer Assessment of Healthcare Providers and Systems survey data for January 2025, 100% of families responding to the survey would recommend Houston Hospice. Houston Hospice is also accredited by the National Institute for Jewish Hospice and was named "Hospice of Choice" by Houston Jewish Funerals, Distinctive Life Cremation and Funeral Services. And Houston Hospice was awarded the 2017 Readers' Choice Award for Best Hospice (Houston Area). Houston Hospice also takes pride that its nurses are routinely awarded for excellence in nursing, and we promote the professional development of direct-care staff by, among other things, encouraging and supporting certifications in hospice and palliative care.

13. Further, the exceptional and compliant quality of Houston Hospice's care is well-documented. Houston Hospice has been accredited by Community Health

Accreditation Partner (CHAP) since 2008. Accreditation is viewed as a quality metric in the hospice-provider marketplace. In February 2024, Houston Hospice underwent our reaccreditation survey and was found to be in substantial compliance with Medicare's conditions of participation. The notion that Houston Hospice belongs on a nationwide list of "poor performers" for compliance with Medicare's requirements is misleading and wrong.

14. In that most-recent CHAP survey period, which spanned from June 12, 2021, to June 12, 2024, Houston Hospice had the honor to serve 5,364 patients, with an average daily census in 2024 of 190.

15. According to CMS' Special Focus Program list, Houston Hospice received four substantiated complaints in relevant time period of May 1, 2021, through April 30, 2024. At least one of these complaints appears to relate only to *state-licensure* issues, which are supposed to be excluded under CMS' algorithm.[5] And one of the four identified complaints was self-reported by Houston Hospice. In any event, the issues underlying the complaints were remedied promptly after complaints were made, bringing Houston Hospice back into substantial compliance.

16. Given the large volume of patients we served during this period, it is misleading to say those few complaints out of 5,364 patients make Houston Hospice a "poor performer." My understanding is that CMS' Special Focus Program algorithm did not scale or normalize substantiated complaints to reflect the volume of patients served. As a result, a smaller hospice that served only 100 patients in that period but had the same number of substantiated complaints would be treated by CMS' algorithm the same way it treats Houston Hospice,

[5] CMS, *Hospice Special Focus Program User's Guide: Algorithm and Public Reporting* at 8 (Dec. 2024), available at https://www.cms.gov/files/document/hospice-special-focus-program-users-guide-algorithm-and-public-reporting01082025.pdf.

even though the ratio of substantiated complaints in the smaller hospice would reflect a much worse compliance record.

17. In my experience, CMS' public criticism will cause immediate harm. Houston Hospice needs to attract Medicare beneficiaries to our hospice program. Because Texas is not a certificate-of-need state, patients have a large number of hospice programs from which to choose. In fact, there are 231 Medicare-certified hospice programs operating in Harris County alone, and 343 Medicare-certified hospice programs within Houston Hospice's 13-county geographic footprint. CMS' public criticism will likely deter patients from selecting Houston Hospice. Competitors will also likely use the listing against Houston Hospice as a way to deter referral sources from offering Houston Hospice as a reputable option for care. In my experience, adverse actions by regulators, including CMS, often result in a loss of patients for hospice programs.

18. CMS' public criticism will also likely do substantial damage to Houston Hospice's ability to obtain both the charitable contributions and the volunteer assistance that is critical to Houston Hospice's survival. As a non-profit, Houston Hospice is highly dependent on the generosity of our community, generosity expressed through contributions of both finances and time. The reimbursements that Houston Hospice receives from Medicare and other payors is not sufficient to cover our expenses to provide high quality care. Houston Hospice would operate at a significant deficit but for the community's generous contributions, which accounted for over 13% of Houston Hospice's annual revenue in 2023. The negative publicity and reputational harm associated with CMS' public criticism will likely harm Houston Hospice's ability to obtain the charitable contributions that are necessary for Houston Hospice's success.

19. Houston Hospice also is proud of the substantial volunteer commitment in our program. Houston Hospice had 101 volunteers help support patients and their families in 2024, accounting for 5,215 total volunteer hours and over $150,000 of cost savings. CMS' labeling Houston Hospice as a "poor performer" will likely make it harder to recruit and sustain volunteers who will likely question whether they want to give their time to, and be associated with, Houston Hospice. CMS Conditions of Participation require us to utilize volunteers in addition to our paid employee workforce.[6] In 2024, volunteer hours made up 7% of our total hours, and 5.6% for Medicare-approved hours. We are deeply concerned that CMS' actions will serve as a barrier to our ability to attract volunteers as they will likely be misled by CMS' listing that our nonprofit hospice is a poor performer.

20. Houston Hospice also competes with the other hospice programs and a significant number of other medical providers for healthcare professionals and staff. The labor market for healthcare providers and other staff has proven challenging over the last several years and remains so today. CMS' public criticism will make it more difficult for Houston Hospice to compete with other providers (among other potential employers) for healthcare professionals and other staff. Because Houston Hospice has been included in the Special Focus Program, CMS will consider Houston Hospice for termination from Medicare unless we satisfy the completion criteria for the Program.[7] While I am confident that Houston Hospice will complete the Special Focus Program, our inclusion in the Special Focus Program may cause some to question our ongoing participation in Medicare, which will likely harm our employee retention and recruitment efforts.

[6] 42 C.F.R. § 418.78.

[7] 42 C.F.R. § 488.1135(e).

21. CMS has also increased compliance costs for Houston Hospice by including Houston Hospice in the Special Focus Program. My understanding is that CMS will survey hospices within the Special Focus Program more frequently than hospices outside the Special Focus Program, at least every six months.[8] Since becoming accredited by CHAP in 2008, Houston Hospice's licensing surveys have generally taken place every three years—far less frequently than we will be surveyed during the Special Focus Program.

22. Houston Hospice incurs compliance costs from each survey. Houston Hospice must cooperate with surveyors. This involves employees sitting for interviews, providing records, and otherwise working with the surveyors. In general, Houston Hospice devotes roughly 100 employee hours per survey at an average cost of $55 per hour. Each survey therefore imposes approximately $5,500 in compliance costs on Houston Hospice. Because Houston Hospice has been included in the Special Focus Program, it will now incur those compliance costs at least every six months, as opposed to licensing surveys every three years as in the past—a significant and unnecessary expenditure of the limited funds available to Houston Hospice.

23. CMS has also revoked Houston Hospice's deemed status by including Houston Hospice in the Special Focus Program. Houston Hospice elected to become accredited by CHAP in 2008 to ensure the highest level of support in maintaining quality and regulatory compliance. Houston Hospice pays for the expertise of the accrediting agency to ensure high-quality care, ongoing education, and compliance with federal and state conditions of participation. Through this process, we also attained deemed status with Medicare accepting CHAP survey in lieu of their own survey. Houston Hospice voluntarily maintained CHAP

[8] 42 C.F.R. § 488.1110(a); 42 C.F.R. § 488.1135(c)(1).

accreditation and deemed status for the past 16 years. We have now lost the benefit of CHAP accreditation and our deemed status due to being placed in the Special Focus Program. Thus, the value of CHAP accreditation, which cost Houston Hospice $19,600 for the most-recent three-year period, has been substantially eroded by CMS' final rule. And now, an agency contracted with the state will conduct Houston's surveys rather than CHAP.

24. The revocation of deemed status imposes other significant and irreparable harms. One of the reasons we selected deemed status is because deemed status can be a required quality metric relied on by insurance companies and other payors in determining rates and referral status. The loss of deemed status means that we will likely lose those benefits.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 14, 2025.

April Rose, BSN, RN, CHPN

Exhibit A

IMPORTANT NOTICE – PLEASE READ CAREFULLY

You are receiving this letter because the CMS data systems identify you as an authorized official/administrator of the referenced organization. If you are not an authorized official/administrator of Houston Hospice, CCN 451530, please respond to the email transmittal to inform CMS immediately.

December 18, 2024

Houston Hospice
1905 HOLCOMBE
HOUSTON, TX 77030

RE: Notification of SFP Selection
CMS Certification Number (CCN): 451530

Via Email: CBLACKMON@HOUSTONHOSPICE.ORG

Dear Authorized Official/Administrator:

The purpose of this letter is to inform you that your hospice program has been selected for the Special Focus Program (SFP) (42 C.F.R. § 488.1135) based on the SFP selection methodology. Information on the selection process can be found at https://www.cms.gov/files/document/special-focus-program-users-guide-algorithm-and-public-reporting.pdf .

Hospice programs selected for the SFP will be under enhanced oversight; this means that the hospice will be subject to one standard survey every six months and revisits as needed. The list of SFP Participants will be posted on the CMS SFP Website at https://www.cms.gov/medicare/health-safety-standards/certification-compliance/hospice-special-focus-program. Your selection for the SFP cannot be appealed.

A hospice selected for the SFP completes the program consistent with the criteria set forth at 42 C.F.R. § 488.1135(d). Criteria include, but may not be limited to, that the hospice has two SFP surveys within 18 months with no condition-level deficiencies and has no pending complaint surveys triaged at an immediate jeopardy or condition level, or that the hospice has returned to substantial compliance with all requirements.

Any hospice that does not achieve substantial compliance may be considered for termination from the Medicare program. CMS will issue the termination letter to the hospice program in accordance with 42 C.F.R. §§ 489.53 and 488.1135(e)(1). Additionally, CMS may consider termination in accordance with 42 C.F.R. 488.1225 if any survey results in an immediate jeopardy citation while the hospice is in the SFP. *See* 42 C.F.R. 488.1135(e)(2).

CMS will impose enforcement remedies on an SFP hospice that fails to achieve and maintain significant improvement in correcting deficiencies consistent with 42 C.F.R. part 488, subpart N.

Hospices with an Accrediting Organization (AO) that are selected for the SFP will not retain deemed status and will be placed under CMS jurisdiction until completion of the SFP or termination. *See* 42 C.F.R. 488.1135(b). Questions regarding accreditation should be directed to your applicable AO.

After completing the SFP, the hospice will receive a survey within one-year post-SFP from the State Agency (SA) or AO (if applicable) and start a new standard 36-month survey cycle.

If you have any questions, please contact CMS_HospiceSFP@cms.hhs.gov.

Resources:
https://www.cms.gov/medicare/health-safety-standards/certification-compliance/hospice-special-focus-program

Sincerely,

CCSQ Hospice SFP Team

Copies sent via email: MARCUS.FOSTER@cms.hhs.gov

grace.minner@chapinc.org;jennifer.kennedy@chapinc.org;teresa.harbour@chapinc.org
acutecare855@vdh.virginia.gov

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Exhibit 2

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

TEXAS ASSOCIATION FOR HOME CARE & HOSPICE, et al., Plaintiffs, v. XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al., Defendants.	Case No.:

DECLARATION OF JUDITH LUND PERSON

Pursuant to 28 U.S.C. § 1746, I declare as follows:

1. My name is Judith Lund Person. I am the principal at LundPerson & Associates, LLC. I respectfully submit this declaration in support of Plaintiffs' Complaint and Application for a Preliminary Injunction or a Stay of Agency Action. I am over twenty-one years old and have personal knowledge of the facts contained in this declaration.

Background

2. In 1972, I received my B.A. in Sociology from the University of North Carolina at Greensboro. In 1990, I received an M.P.H. in Health Policy and Administration from the University of North Carolina at Chapel Hill.

3. Between 1980 and 2002, I was President and CEO of the Carolinas Center for Hospice and End-of-Life Care. The organization is a statewide, non-profit that provides assistance and educational programs to hospice programs in North and South Carolina,

collects data on hospice care, provides information to the general public on hospice care, and assists local communities who are interested in developing hospice programs.

4. I was a part of a small group of advocates that successfully advocated for the inclusion of hospice in Medicare in 1982, the National Hospice Education Project.

5. Between 2002 and 2023, I was Vice President, Regulatory and Compliance, for the National Hospice and Palliative Care Organization. In this role, I served as a key contact with the Centers for Medicare and Medicaid Services (CMS). I interfaced with CMS on hospice payment policy, Medicare Part D requirements, hospice surveys and certification, contractor management, and program integrity functions, among other things. I also worked with hospice providers and state hospice organizations on regulatory and compliance issues, quality and performance improvement, data collection, and strategic planning.

6. In July 2023, I became a principal at LundPerson & Associates, LLC. I serve as a consultant for hospice providers and state associations on hospice regulatory and policy issues, including regulatory issues, changes to the survey process, enforcement remedies, hospice fraud, and hospice special focus program implementation.

7. My life's work has evolved around supporting the hospice community, including through education, the sharing of experiences, and peer-to-peer communications, because I so believe in the importance of hospice services for patients and families.

CMS' Special Focus Program Final Rule and List

8. I am familiar with CMS' Final Rule that establishes, among other things, the Special Focus Program's selection criteria,[1] and served on the Technical Expert Panel (TEP)

[1] Calendar Year 2024 Home Health Prospective Payment System Final Rule, 88 Fed. Reg. 77676 (Nov. 13, 2023).

that provided feedback to CMS in 2022 to inform development of the SFP.[2]

9. The Final Rule provides that "[s]election of hospices for the SFP is made based on the highest aggregate scores based on the algorithm used by CMS." 42 C.F.R. § 488.1135(b)(1). I am familiar with the three versions of CMS' guidance document titled "Hospice Special Focus Program User's Guide: *Algorithm and Public Reporting*," posted on CMS' website in approximately December 2023, on December 20, 2024, and on January 8, 2025, which provide varying details on CMS' algorithm.[3] I will generally refer to the three versions of the guidance document titled "Hospice Special Focus Program User's Guide: *Algorithm and Public Reporting*," as the "Algorithm User Guide" and will refer to each version of the Algorithm User Guide specifically by the date on which it was published—December 2023, December 20, 2024, and January 8, 2025.

10. I am also familiar with CMS' recent actions selecting certain hospice programs for the Special Focus Program, including the listings on December 20, 2024, January 2, 2025, and January 8, 2025, on CMS' website of those hospices, as well as CMS' letters to individual hospices informing them of their inclusion in the Special Focus Program received by the initial set of hospices on approximately December 18, 2024.[4]

11. CMS has posted on its public website (i) three versions of an Excel file listing 50 hospice programs selected for the Special Focus Program, (ii) two versions of an Excel file

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[2] See Abt Associates, *2022 Technical Expert Panel and Stakeholder Listening Sessions: Hospice Special Focus Program Summary Report*, Deliverable 4-27 at 3, 8 (Apr. 28, 2023) (available at: https://www.cms.gov/files/document/2022-technical-expert-panel-tep-and-stakeholder-listening-sessions-hospice-special-focus-program.pdf) (last visited Jan. 13, 2025).

[3] See, e.g., CMS, Hospice Special Focus Program User's Guide: *Algorithm and Public Reporting* (Dec. 2024) (published Jan. 8, 2025), (available at https://www.cms.gov/files/document/hospice-special-focus-program-users-guide-algorithm-and-public-reporting01082025.pdf) (last visited Jan. 13, 2025).

[4] CMS, Hospice Special Focus Program (available at: https://www.cms.gov/medicare/health-safety-standards/certification-compliance/hospice-special-focus-program) (last visited Jan. 14, 2025).

providing the "Hospice Special Focus Program Condition Level Deficiencies," and (iii) an Excel file providing the "Hospice Special Focus Program Substantiated Complaints,"[5] as of the date of this declaration. I will generally refer to the Excel files listing hospice programs as the "SFP List," and, when referencing a specific version of the SFP List, will refer to the three versions of the SFP List published on CMS' website specifically by the dates on which they were published—December 20, 2024, January 2, 2025, and January 8, 2025 (e.g. "the December 20, 2024 SFP List").

CMS' Selection of Hospices for the SFP List

12. CMS' Final Rule states that "[s]election of hospices for the SFP is made based on the highest aggregate scores based on the algorithm used by CMS."[6]

13. To date, however, CMS had not publicly posted algorithm scores for all hospices that participate in Medicare. CMS has only publicly posted algorithm scores for the 50 hospices it selected for the SFP List.

14. I sought to verify whether CMS has, in fact, selected hospices with "the highest aggregate scores" for the SFP List. To do this, I worked in consultation with others to model all hospices' algorithm scores using the same indicators as CMS purported to use.

15. Those indicators are (1) substantiated complaints, (2) condition level deficiencies (CLDs), (3) Hospice Care Index (HCI) scores, and (4) Consumer Assessment of Healthcare Providers & Systems (CAHPS) scores.

16. As noted above, CMS has posted Excel files for (1) substantiated complaints and (2) condition level deficiencies on its Special Focus Program website.

[5] Id.
[6] 42 C.F.R. § 488.1135(f).

17. CMS posts HCI scores and CAHPS scores on its public website in the Hospice Provider Catalogue.

18. The SFP List includes a "final score" for each included hospice. The preamble to the Final Rule explains that, if a hospice has CAHPS data available, CMS scores the hospice based on the total number of condition level deficiencies over a three year period, from May 1, 2021, to April 30, 2024, total number of substantiated complaints over the same three-year period, its HCI score, and its CAHPS index score.[7] If a hospice lacks CAHPS data, CMS scores the hospice based on its condition level deficiencies over a three-year period, its substantiated complaints over a three-year period, and its HCI score.[8]

19. In attempting to verify whether CMS in fact, included hospices with "the highest aggregate scores" in the Special Focus Program, I, in consultation with others, first developed a spreadsheet that replicates CMS' approach to identifying the hospices with "the highest aggregate scores." We were able to replicate CMS' approach based on our familiarity with the January 8, 2025 Algorithm User Guide, and the CMS Final Rule. A true and correct copy of this spreadsheet with identifying information redacted for hospice programs not identified in the SFP List, is attached hereto at Exhibit A.

20. I, in consultation with others, then familiarized myself with the CLDs, substantiated complaints, CAHPS scores, and HCI scores that are publicly available on CMS' website in the Excel files providing the "Hospice Special Focus Program Condition Level Deficiencies," and "Hospice Special Focus Program Substantiated Complaints," as well as in the November 2024 refresh of the CMS Hospice Provider Catalogue, available at:

[7] 88 Fed. Reg. 77,676, 77,804 (Nov. 13, 2023).
[8] 88 Fed. Reg. 77,676, 77,804 (Nov. 13, 2023).

https://data.cms.gov/provider-data/topics/hospice-care (last visited January 13, 2025).

21. The spreadsheet underlying Exhibit A used those public data points and weighted the data points to calculate a "model score" for each active provider. The data points are weighted in the same way that CMS advised it weighted the data points in the Algorithm User Guide. The spreadsheet underlying Exhibit A also identifies CMS' algorithm score and rank for each hospice provider identified in the SFP List as published in the January 8, 2025 SFP List.

22. I verified that the spreadsheet underlying Exhibit A is accurate based on the fact that the model scores it calculates for the providers identified on the SFP List match the algorithm scores reported by CMS in the January 8, 2025 SFP List exactly.

23. In reviewing the January 8, 2025 SFP List, I observed that of the 50 hospices identified in the SFP List, 15 hospices did not have a single CLD, 23 hospices identified on the SFP List did not have a single substantiated complaint, and 6 hospices had no CLDs or substantiated complaints. This means that CMS selected those 6 hospices for inclusion on the SFP List based solely on their CAHPS scores and HCI scores, not based on any record of having not complied with Medicare requirements.

24. Additionally, I observed that the January 8, 2025 SFP List identifies 24 hospices that had CAHPS scores, while the other 26 hospices did not. This information is identified in the SFP List in the CLD, substantiated complaint, and CAHPS Index columns by the entry of "N/A" or "0". See excerpted columns from the January 8, 2025 SFP List, a true and correct copy of which are attached hereto at Exhibit B.

25. In comparing the spreadsheet underlying Exhibit A to the January 8, 2025 SFP List, I observed that, when ranking all hospice providers by model score, the 50 hospices

included in the CMS SFP List actually rank in the 121 highest scored hospices, not in the 50 highest scored hospices by model score. I observed that 31 of the hospices included in the SFP List are not in the 50 highest scored hospices by model score—62% of the hospices selected for the Special Focus Program. For example, Houston Hospice's algorithm score ranks 118, yet it was selected for inclusion in the Special Focus Program. At the same time, CMS passed over 71 higher-scoring hospices and did not include them on the Special Focus List, despite their having higher algorithm scores than the List's lowest-scoring hospice on the List.

26. Based on my analysis and in consultation with others, it appears to me that CMS stratified the algorithm scores it calculated for all providers to allocate hospices to the Special Focus Program by geographic CMS region, based on the percentage of total hospices in each CMS region compared to the total number of active hospices nationwide.

27. Based on my understanding of CMS' algorithm, two key inputs affecting the algorithm scores and CMS' hospice rankings are the count of CLDs and substantiated complaints.

28. I note that CMS' algorithm does not scale the substantiated complaints. This means that a facility that has an average daily census that includes a large number of patients is treated the same as a facility with a small census of patients, even though there is a much higher ratio of deficiencies for the smaller facility than the larger facility.

Errors in CMS' Substantiated Complaint Excel File

29. Because of this potential for skewed scores, in attempting to verify whether CMS has, in fact, included hospices with "the highest aggregate scores" in the Special Focus Program, I also reviewed the Excel file CMS posted on its public website purporting to

provide "Hospice Special Focus Program Substantiated Complaints" for accuracy. In doing so, I observed errors in CMS' identification of the count of substantiated complaints for certain hospice providers included in the SFP List.

30. In seeking to validate the "Hospice Special Focus Program Substantiated Complaints" Excel file publicly posted to CMS' website on December 20, 2024, I selected for review a sample of complaints from hospices that CMS identifies as "substantiated" in the "Hospice Special Focus Program Substantiated Complaints" Excel file. I included in this sample complaints alleged against hospices located in California and Florida because California and Florida make hospices' survey results available on the California Department of Public Health and Florida Agency for Health Care Administration public websites.

31. Based on a comparison of that Excel file and information about the underlying complaints provided to me from hospice providers and others, it appears that the "Hospice Special Focus Program Substantiated Complaints" Excel file inaccurately identifies substantiated complaints for various hospice providers.

32. To conduct this comparison for hospices in California and Florida, I reviewed various survey results (CMS Form CMS 2567) downloaded from the California Department of Public Health and Florida Agency for Health Care Administration public websites for the identified complaints. I then compared those survey results to the results identified by CMS in the "Hospice Special Focus Program Substantiated Complaints" Excel file.

33. As a result of that review, I was unable to validate CMS' assertions that complaints were substantiated for at least thirteen (13) of the sampled complaints, as the State published survey results found no deficiencies indicating that the States were unable to substantiate the complaints.

34. For example, the CMS "Hospice Special Focus Program Substantiated Complaints" Excel file lists Complaint ID No. 90822 alleged against provider Elizabeth Hospice (Provider No. 051528), for which the State of California conducted a survey on January 12, 2022 as "substantiated." However, a review of the State survey for that complaint shows a finding that, "NO DEFICIENCIES WERE IDENTIFIED FROM THIS SURVEY." See California CMS 2567 for Survey Event 2JJK11, dated January 12, 2022, a true and correct copy of which is attached hereto as Exhibit C.

35. Similarly, the CMS "Hospice Special Focus Program Substantiated Complaints" Excel file lists Complaint ID Nos. 88846, 88848, and 88850 alleged against provider Sharp Hospicecare (Provider No. 051598), for which the State of California conducted surveys on May 19, 2022, November 22, 2021, and July 28, 2022, respectively, as "substantiated." However, a review of the State surveys for these complaints all show findings that, "NO DEFICIENCIES WERE IDENTIFIED FROM THIS SURVEY." See California CMS 2567s for Survey Events IZBB11, Z6HU11, and 763N11, dated May 19, 2022, November 22, 2021, and July 28, 2022, respectively, true and correct copies of which are attached hereto as Exhibits D, E, and F.

36. Additionally, the CMS "Hospice Special Focus Program Substantiated Complaints" Excel file lists Complaint ID No. 83984 alleged against provider Lifepath Hospice (Provider No. 101507), for which the State of Florida conducted a survey on June 4, 2021 as "substantiated." However, a review of the State survey for that complaint shows a finding that, "The agency was in compliance with Code of Federal Regulations (CFR) 42 Part 418, Condition of Participation for Hospice Care." See Florida CMS 2567 for Survey Event LOY811, dated June 4, 2021, a true and correct copy of which is attached hereto as Exhibit

G.

37. Based on my understanding of the Algorithm User Guide, complaints should only be included in the CMS "Hospice Special Focus Program Substantiated Complaints" Excel file and used in CMS' algorithm if the Event ID number present on the CMS Form CMS 2567 matches the Event ID number on the "Hospice Special Focus Program Substantiated Complaints" Excel file, and if the complaint was substantiated in the state survey and relates to Medicare hospice requirements. However, based on my observations, CMS did not accurately consider substantiated complaint data in calculating "the highest aggregate scores" for hospice providers.

38. Notably, many of the complaints I reviewed in my sampling related to *state licensure issues*, not Medicare compliance obligations or deficiencies. Based on my understanding of the Algorithm User Guide, complaints related to state licensure issues, whether substantiated or unsubstantiated, should not be included in CMS' calculation of "the highest aggregate scores" for hospices.

39. Additionally, many of the complaints I reviewed in my sampling, including the complaints identified in paragraphs 34 and 35 of this declaration, were self-reported by hospice programs. Although self-reporting of complaints received by hospice programs is required by regulation and regularly included as part of hospices' compliance programs, I fear that CMS' inaccurate consideration of complaint data in calculating "the highest aggregate scores" amongst hospices will lead to a chilling effect on self-reports, increasing the risk that poor performing hospices will self-report fewer complaints while better performing hospices will continue to comply with their self-reporting obligations. This could further increase the risk that poor performing hospices will be excluded from the SFP List while better performing

hospices will be included in the SFP List instead because the number of reported complaints, and thus the number of potentially substantiated complaints, will be skewed toward self-reporting hospices.

40. Based on my review, I anticipate that there could be many more inaccuracies in the "Hospice Special Focus Program Substantiated Complaints" Excel file and other data used by CMS to calculate the algorithm scores for hospices.

CMS Has Modified the SFP List Multiple Times Since Its December 2024 Release

41. Based on my review of the CMS website, CMS published the first version of the Algorithm User Guide in approximately December 2023.

42. To my knowledge, based on conversations I have had with hospice providers included on the SFP List, CMS, by letter on December 18, 2024, notified the 50 hospices CMS intended to include on the SFP List that they had been selected for the Special Focus Program.

43. Based on my review of the CMS website and my conversations with hospice providers included on the SFP List, on December 20, 2024, CMS published to its public website: (i) the first version of the SFP List, (ii) the first version of the Excel file providing the "Hospice Special Focus Program Condition Level Deficiencies," (iii) the second version of the Algorithm User Guide and (iv) the Excel file providing the "Hospice Special Focus Program Substantiated Complaints." See excerpted columns from the December 20, 2024 SFP List, a true and correct copy of which are attached hereto as Exhibit H.

44. Notably, no data comparable to the data provided in the "Hospice Special Focus Program Condition Level Deficiencies" and the "Hospice Special Focus Program Substantiated Complaints" Excel files were publicly available in past years, including during

the rulemaking proceedings related to the Special Focus Program.

45. Subsequently, on January 2, 2025, to my knowledge, based on my review of the CMS website and my conversations with hospice providers included on the SFP List, CMS removed the December 20, 2024 SFP List from CMS' public website and replaced it with a new SFP List, noting that CMS was making "technical corrections and changes" and would provide an update shortly. See excerpted columns from the SFP List published by CMS to its public website on January 2, 2025, dated December 30, 2024, a true and correct copy of which are attached hereto at Exhibit I. I reviewed the January 2, 2025 SFP List and observed that CMS removed three hospices from this version of the SFP List. I did not observe the addition of three new hospices to replace the three removed hospices in the January 2, 2025 SFP List.

46. On January 8, 2025, to my knowledge, based on my review of CMS' public website, CMS then removed from its public website the January 2, 2025 SFP List and the December 20, 2024 version of the Algorithm User Guide replacing these files with a new SFP List, dated January 8, 2025, and a new Algorithm User Guide.[9] I reviewed these new files and observed that CMS removed an additional hospice provider from the SFP List and added four new providers to the SFP List.

47. Additionally, I observed that CMS again changed the number of active hospice providers it would use to calculate "the highest aggregate score" for hospice providers, using the number of active hospice providers as of December 30, 2024, without highlighting these changes for the public or otherwise expressly notifying the public that the January 8, 2025

[9] See CMS, Hospice Special Focus Program User's Guide: *Algorithm and Public Reporting* (Dec. 2024) (published Jan. 8, 2025), (available at https://www.cms.gov/files/document/hospice-special-focus-program-users-guide-algorithm-and-public-reporting01082025.pdf) (last visited Jan. 13, 2025); and see Exhibit B.

version of the Algorithm User Guide replaced the December 20, 2024 version of the same document.

48. To my knowledge, based on my review of CMS' public website, CMS also uploaded a new Excel file providing the "Hospice Special Focus Program Condition Level Deficiencies," on January 8, 2025. I reviewed the new Excel file providing the "Hospice Special Focus Program Condition Level Deficiencies," and observed the removal of a significant number of identified CLDs in comparison to the number of CLDs listed in the Excel file initially posted on December 20, 2024.

49. Based on my review of the changes to the SFP List, the Algorithm User Guide, and the changes to the Excel file providing the "Hospice Special Focus Program Condition Level Deficiencies," I observed, in consultation with others, that these changes resulted in changes to the standard deviation and average utilized in the CMS algorithm for calculating "the highest aggregate scores," affecting hospice providers included on the SFP List and selected for the Special Focus Program.

50. In sum, in the four weeks since CMS first selected a cohort of 50 hospices for the SFP List around December 18, 2024, CMS has already changed that SFP List twice, removing four hospices and adding four new ones.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 15th day of January, 2025 in Ashburn, Virginia

Judith Lund Person

Judith Lund Person

Exhibit A

CCN	STATE	HOSPICE	SFP SCORE CMS	SFP RANK CMS	SFP SCORE MODEL	SFP RANK MODEL
241557	MN	ECUMEN HOSPICE	5.349	1	5.349	1
		HOSPICE 2			4.975	2
		HOSPICE 3			4.318	3
		HOSPICE 4			4.108	4
751585	CA	VICTORIA HOSPICE SERVICES, INC	4.040	2	4.040	5
		HOSPICE 6			3.730	6
671715	TX	RICELAND HOSPICE	3.543	3	3.543	7
		HOSPICE 8			3.539	8
		HOSPICE 9			3.465	9
161612	IA	MOMENTS HOSPICE	3.402	4	3.402	10
		HOSPICE 11			3.292	11
		HOSPICE 12			3.289	12
481504	VI	TROPICAL HEALTH LLC A HEALTH AN	3.278	5	3.278	13
		HOSPICE 14			3.278	14
451780	TX	HOSPICE PLUS	3.248	6	3.248	15
		HOSPICE 16			3.229	16
		HOSPICE 17			3.215	17
921671	CA	ELITE HEALTH CARE SYSTEMS	3.201	7	3.201	18
311582	NJ	TRANSCEND HOSPICE AND PALLIATIV	2.980	8	2.980	19
751590	CA	SAINT MONTSERRAT HOSPICE CARE	2.937	9	2.937	20
		HOSPICE 21			2.937	21
		HOSPICE 22			2.931	22
51744	CA	ST LIZ HOSPICE, INC	2.926	10	2.926	23
		HOSPICE 24			2.905	24
151629	IN	COMFORT 1 HOSPICE, LLC	2.855	11	2.855	25
671786	TX	ELYSIAN HOSPICE	2.847	12	2.848	26
		HOSPICE 27			2.841	27
111754	GA	OPUSCARE OF GEORGIA	2.838	13	2.838	28
		HOSPICE 29			2.777	29
		HOSPICE 30			2.714	30
		HOSPICE 31			2.700	31
		HOSPICE 32			2.645	32
971505	TX	ROAD TO HAPPINESS HOME CARE SER	2.640	14	2.640	33
551546	CA	BRISTOL HOSPICE- NORTHERN LOS A	2.632	15	2.632	34
551507	CA	ADMIRAL HOSPICE CARE, INC	2.563	16	2.563	35
		HOSPICE 36			2.563	36
111707	GA	AMICASA HOSPICE HOME CARE	2.488	17	2.488	37
141697	IL	UNITED HOSPICE, INC	2.486	18	2.486	38
		HOSPICE 39			2.486	39
		HOSPICE 40			2.480	40
		HOSPICE 41			2.454	41
		HOSPICE 42			2.453	42
81508	DE	CHRISTIANACARE ACCENTCARE HOSP	2.429	19	2.429	43

CCN	STATE	HOSPICE	SFP SCORE CMS	SFP RANK CMS	SFP SCORE MODEL	SFP RANK MODEL
		HOSPICE 44			2.390	44
		HOSPICE 45			2.373	45
		HOSPICE 46			2.373	46
		HOSPICE 47			2.354	47
		HOSPICE 48			2.313	48
		HOSPICE 49			2.299	49
		HOSPICE 50			2.280	50
		HOSPICE 51			2.250	51
551744	CA	BAKERSFIELD COMMUNITY HOSPICE	2.249	20	2.249	52
551687	CA	SIERRA HOSPICE CARE, INC	2.236	21	2.236	53
231691	MI	AMBER HOSPICE CARE	2.236	22	2.236	54
		HOSPICE 55			2.236	55
		HOSPICE 56			2.226	56
		HOSPICE 57			2.213	57
		HOSPICE 58			2.211	58
61570	CO	NEW CENTURY HOSPICE OF DENVER	2.202	23	2.202	59
		HOSPICE 60			2.201	60
		HOSPICE 61			2.200	61
		HOSPICE 62			2.193	62
		HOSPICE 63			2.192	63
		HOSPICE 64			2.189	64
111762	GA	AFFINITY HOSPICE	2.159	24	2.159	65
111692	GA	AMITY CARE	2.143	25	2.143	66
		HOSPICE 67			2.134	67
		HOSPICE 68			2.112	68
		HOSPICE 69			2.112	69
		HOSPICE 70			2.112	70
141719	IL	ENTERA HOSPICE, INC	2.078	26	2.078	71
		HOSPICE 72			2.078	72
491581	VA	VITAS INNOVATIVE HOSPICE CARE	2.057	27	2.057	73
51794	CA	GRACE HOSPICE, INC	2.056	28	2.056	74
		HOSPICE 75			2.049	75
671634	TX	SELAH HOSPICE CARE, INC.	2.035	29	2.035	76
971612	TX	AMABLE HOME CARE LLC	2.035	30	2.035	77
		HOSPICE 78			2.035	78
		HOSPICE 79			2.035	79
		HOSPICE 80			2.035	80
91501	DC	CAPITAL HOSPICE	2.021	31	2.021	81
		HOSPICE 82			2.021	82
31687	AZ	AZ SUNSET HOSPICE	2.002	32	2.002	83
551755	CA	SUPPORTIVE HOSPICE CARE INC	1.985	33	1.985	84
		HOSPICE 85			1.985	85
151607	IN	HARMONYCARES HOSPICE	1.945	34	1.944	86

CCN	STATE	HOSPICE	SFP SCORE CMS	SFP RANK CMS	SFP SCORE MODEL	SFP RANK MODEL
111654	GA	TRADITIONS HEALTH	1.944	35	1.944	87
31700	AZ	AZ HOSPICE CARE INC	1.925	36	1.925	88
A01679	CA	QUEST HOSPICE, INC.	1.925	37	1.925	89
		HOSPICE 90			1.925	90
		HOSPICE 91			1.925	91
		HOSPICE 92			1.925	92
		HOSPICE 93			1.925	93
		HOSPICE 94			1.897	94
51597	CA	VITAS HEALTHCARE CORPORATION OF	1.888	38	1.888	95
		HOSPICE 96			1.862	96
		HOSPICE 97			1.862	97
		HOSPICE 98			1.848	98
		HOSPICE 99			1.848	99
		HOSPICE 100			1.848	100
		HOSPICE 101			1.848	101
261593	MO	HOSPICE COMPASSUS-JOPLIN	1.844	39	1.844	102
671562	TX	ALTUS HOSPICE	1.819	40	1.819	103
51716	CA	GENTIVA	1.811	41	1.811	104
751663	CA	GLOBAL HOSPICE CARE, INC	1.785	42	1.785	105
		HOSPICE 106			1.785	106
341587	NC	HEARTLAND HOSPICE (RALEIGH)	1.780	43	1.780	107
271521	MT	BEARTOOTH BILLINGS CLINIC HOSPI	1.771	44	1.771	108
111757	GA	HOSPICE360	1.771	45	1.771	109
		HOSPICE 110			1.769	110
971649	TX	UNICARE PALLIATIVE & HOSPICE CA	1.752	46	1.752	111
251644	MS	ALLIANCE HEALTHCARE HOSPICE, LL	1.738	47	1.738	112
		HOSPICE 113			1.738	113
		HOSPICE 114			1.738	114
		HOSPICE 115			1.738	115
		HOSPICE 116			1.738	116
		HOSPICE 117			1.721	117
451530	TX	HOUSTON HOSPICE	1.701	48	1.701	118
		HOSPICE 119			1.693	119
671613	TX	ELYSIAN HOSPICE LLC	1.683	49	1.683	120
331535	NY	VNS AND HOSPICE OF SUFFOLK, INC	1.683	50	1.683	121

SOURCE

CMS Hospice Special Focus Program (SFP), initial cohort of 50 hospices, revised posting as of January 8, 2025.
Hospice Special Focus Program Substantiated Complaints file and Condition Level Deficiencies file, revised posting January 8, 2025.
Hospice Provider Data Catalog, Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Data, 01/01/2022 - 12/31/2023
Hospice Provider Data Catalog, Hospice Care Index (HCI) Overall Score, 01/01/2022 - 12/31/2023
CMS, Provider of Services File (POS) - Internet Quality Improvement and Evaluation System (iQIES) - Hospice, October 1, 2024.
CMS, Quality, Certification and Oversight Reports (QCOR) data, accessed January 5, 2025.

Exhibit B

January 8, 2025
Hospice SFP 2025 Cohort- 50 Selectees (XLSX)
FILE: sfp-2025-cohort-50-selectees_2

COUNT	CCN	Facility Name	State	Subst. Complaint Count	QoC CLD Count	HCI	CAHPS Index	Final Score
1	241557	ECUMEN HOSPICE	MN	15	0	10.0	20	5.349
2	751585	VICTORIA HOSPICE SERVICES, INC	CA	1	8	9.0	#N/A	4.040
3	671715	RICELAND HOSPICE	TX	0	6	5.0	#N/A	3.543
4	161612	MOMENTS HOSPICE	IA	1	6	8.0	#N/A	3.402
5	481504	TROPICAL HEALTH LLC A HEALTH AN	VI	0	6	6.0	#N/A	3.278
6	451780	HOSPICE PLUS	TX	7	3	10.0	25	3.248
7	921671	ELITE HEALTH CARE SYSTEMS	CA	0	7	8.0	#N/A	3.201
8	311582	TRANSCEND HOSPICE AND PALLIATIV	NJ	0	7	#N/A	#N/A	2.980
9	751590	SAINT MONTSERRAT HOSPICE CARE,	CA	0	7	9.0	#N/A	2.937
10	051744	ST LIZ HOSPICE, INC	CA	1	7	8.0	39.5	2.926
11	151629	COMFORT 1 HOSPICE, LLC	IN	2	1	4.0	#N/A	2.855
12	671786	ELYSIAN HOSPICE	TX	0	0	7.0	87	2.847
13	111754	OPUSCARE OF GEORGIA	GA	4	1	9.0	#N/A	2.838
14	971505	ROAD TO HAPPINESS HOME CARE SER	TX	0	4	5.0	#N/A	2.640
15	551546	BRISTOL HOSPICE- NORTHERN LOS A	CA	0	0	7.0	82	2.632
16	551507	ADMIRAL HOSPICE CARE, INC	CA	0	5	7.0	#N/A	2.563
17	111707	AMICASA HOSPICE HOME CARE	GA	0	0	6.0	75	2.488
18	141697	UNITED HOSPICE, INC	IL	0	6	9.0	#N/A	2.486
19	081508	CHRISTIANACARE ACCENTCARE HOSP	DE	4	2	10.0	39.5	2.429
20	551744	BAKERSFIELD COMMUNITY HOSPICE,	CA	2	6	8.0	21	2.249
21	231691	AMBER HOSPICE CARE	MI	1	4	9.0	#N/A	2.236
22	551687	SIERRA HOSPICE CARE, INC	CA	1	4	9.0	#N/A	2.236
23	061570	NEW CENTURY HOSPICE OF DENVER	CO	4	1	10.0	40.5	2.202
24	111762	AFFINITY HOSPICE	GA	1	0	10.0	73	2.159
25	111692	AMITY CARE	GA	2	2	10.0	51	2.143
26	141719	ENTERA HOSPICE, INC	IL	0	5	#N/A	#N/A	2.078
27	491581	VITAS INNOVATIVE HOSPICE CARE	VA	3	0	10.0	52.5	2.057
28	051794	GRACE HOSPICE, INC	CA	0	0	9.0	76	2.056
29	671634	SELAH HOSPICE CARE, INC.	TX	0	5	9.0	#N/A	2.035
30	971612	AMABLE HOME CARE LLC	TX	0	5	9.0	#N/A	2.035
31	091501	CAPITAL HOSPICE	DC	1	1	7.0	52.5	2.021
32	031687	AZ SUNSET HOSPICE	AZ	0	2	4.0	#N/A	2.002
33	551755	SUPPORTIVE HOSPICE CARE INC	CA	2	2	9.0	#N/A	1.985
34	151607	HARMONYCARES HOSPICE	IN	2	4	8.0	26.5	1.945
35	111654	TRADITIONS HEALTH	GA	1	0	10.0	68	1.944
36	031700	AZ HOSPICE CARE INC	AZ	0	3	6.0	#N/A	1.925
37	A01679	QUEST HOSPICE, INC.	CA	0	3	6.0	#N/A	1.925
38	051597	VITAS HEALTHCARE CORPORATION OF	CA	4	0	10.0	39.5	1.888
39	261593	HOSPICE COMPASSUS-JOPLIN	MO	3	2	10.0	35	1.844
40	671562	ALTUS HOSPICE	TX	0	0	9.0	70.5	1.819
41	051716	GENTIVA	CA	2	0	8.0	48.5	1.811
42	751663	GLOBAL HOSPICE CARE, INC	CA	1	3	9.0	#N/A	1.785
43	341587	HEARTLAND HOSPICE (RALEIGH)	NC	4	0	10.0	37	1.780
44	111757	HOSPICE360	GA	0	5	10.0	#N/A	1.771
45	271521	BEARTOOTH BILLINGS CLINIC HOSPI	MT	0	5	10.0	#N/A	1.771
46	971649	UNICARE PALLIATIVE & HOSPICE CA	TX	1	0	4.0	#N/A	1.752
47	251644	ALLIANCE HEALTHCARE HOSPICE, LL	MS	0	2	5.0	#N/A	1.738
48	451530	HOUSTON HOSPICE	TX	4	0	9.0	31.5	1.701
49	671613	ELYSIAN HOSPICE LLC	TX	0	0	7.0	60	1.683
50	331535	VNS AND HOSPICE OF SUFFOLK, INC	NY	2	5	10.0	21.5	1.683

Exhibit C

PRINTED: 01/12/2025
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	051528	A. BUILDING: _____ B. WING: _____	01/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH HOSPICE	**800 W Valley Pkwy Escondido, CA 92025**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Entity Reported Incident (ERI) Number: CA 00761409 Category: Quality of Care/Treatment Sub-category: Resident Safety The investigation was limited to the specific ERI and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Health Facilities Evaluator Nurse 36471. NO DEFICIENCIES WERE IDENTIFIED FROM THIS SURVEY.	L000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Exhibit D

PRINTED: 01/06/2025
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	051598	A. BUILDING: _____ B. WING: _____	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARP HOSPICECARE	**8881 Fletcher Pkwy La Mesa, CA 91942**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Entity Reported Incident (ERI) Number: CA 00761778 Category: Quality of Care/Treatment, and Nursing Services The investigation was limited to the specific ERI and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Health Facilities Evaluator Nurse 36471. NO DEFICIENCIES WERE IDENTIFIED FROM THIS SURVEY.	L000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Exhibit E

PRINTED: 01/06/2025
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	051598	A. BUILDING: _____ B. WING: _____	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARP HOSPICECARE	**8881 Fletcher Pkwy La Mesa, CA 91942**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Entity Reported Incident (ERI) Number: CA 00751221 Category: Admission. Transfer & Discharge Rights The investigation was limited to the specific ERI and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Health Facilities Evaluator Nurse 36471. NO DEFICIENCIES WERE IDENTIFIED FROM THIS SURVEY.	L000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Exhibit F

PRINTED: 01/06/2025
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	051598	A. BUILDING: _____ B. WING: _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARP HOSPICECARE	**8881 Fletcher Pkwy La Mesa, CA 91942**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Entity Reported Incident (ERI) Number: CA 00793787 Category: Admission, transfer & Discharge Rights The investigation was limited to the specific ERI and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: Health Facilities Evaluator Nurse 39448. NO DEFICIENCIES WERE IDENTIFIED FROM THIS SURVEY.	L000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Exhibit G

PRINTED: 06/17/2021
FORM APPROVED

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HC22910023	A. BUILDING: _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFEPATH HOSPICE	4200 W CYPRESS ST TAMPA, FL 33607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	Initial Comments A complaint investigation 2021005777 was conducted at Lifepath Hospice on 6/04/2021. The agency had no deficiencies identified at the time of the survey.	T 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

PRINTED: 06/17/2021
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101507	A. BUILDING _____ B. WING _____	C 06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFEPATH HOSPICE	4200 W CYPRESS ST TAMPA, FL 33607

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS A complaint survey for complaint number FL00156328 / 2021005777, was conducted on 6/04/2021 at Lifepath Hospice specifically for review of the Conditions of Participation. The agency was in compliance with Code of Federal Regulations (CFR) 42 Part 418, Condition of Participation for Hospice Care.	L 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Exhibit H

December 20, 2024
Hospice SFP 2025 Cohort- 50 Selectees (XLSX)
File: sfp-2025-cohort-50-selectees

COUNT	CCN	Facility Name	State	Subst. Complaint count	QoC CLD count	HCI	CAHPS Index	Final Score
1	241557	ECUMEN HOSPICE	MN	15	0	10.0	20	5.341
2	751585	VICTORIA HOSPICE SERVICES, INC	CA	1	9	9.0	#N/A	4.149
3	671715	RICELAND HOSPICE	TX	0	6	5.0	#N/A	3.309
4	151629	COMFORT 1 HOSPICE, LLC	IN	2	2	4.0	#N/A	3.217
5	451780	HOSPICE PLUS	TX	7	3	10.0	25	3.174
6	161612	MOMENTS HOSPICE	IA	1	6	8.0	#N/A	3.169
7	311582	TRANSCEND HOSPICE AND PALLIATIV	NJ	0	8	#N/A	#N/A	3.126
8	481504	TROPICAL HEALTH LLC A HEALTH AN	VI	0	6	6.0	#N/A	3.045
9	921671	ELITE HEALTH CARE SYSTEMS	CA	0	7	8.0	#N/A	2.932
10	971505	ROAD TO HAPPINESS HOME CARE SER	TX	0	5	5.0	#N/A	2.894
11	671786	ELYSIAN HOSPICE	TX	0	0	7.0	87	2.837
12	111754	OPUSCARE OF GEORGIA	GA	4	1	9.0	#N/A	2.786
13	051744	ST LIZ HOSPICE, INC	CA	1	7	8.0	39.5	2.764
14	191686	NIGHTINGALE HOSPICE	LA	1	3	5.0	#N/A	2.716
15	751590	SAINT MONTSERRAT HOSPICE CARE,	CA	0	7	9.0	#N/A	2.667
16	551546	BRISTOL HOSPICE- NORTHERN LOS A	CA	0	0	7.0	82	2.621
17	111707	AMICASA HOSPICE HOME CARE	GA	0	0	6.0	75	2.478
18	081508	CHRISTIANACARE ACCENTCARE HOSP	DE	4	2	10.0	39.5	2.376
19	551507	ADMIRAL HOSPICE CARE, INC	CA	0	5	7.0	#N/A	2.366
20	551744	BAKERSFIELD COMMUNITY HOSPICE,	CA	2	7	8.0	21	2.358
21	111692	AMITY CARE	GA	2	3	10.0	51	2.339
22	141697	UNITED HOSPICE, INC	IL	0	6	9.0	#N/A	2.252
23	261581	CROSSROADS HOSPICE OF KANSAS CI	MO	3	5	10.0	28	2.236
24	061570	NEW CENTURY HOSPICE OF DENVER	CO	4	1	10.0	40.5	2.170
25	111762	AFFINITY HOSPICE	GA	1	0	10.0	73	2.149
26	231691	AMBER HOSPICE CARE	MI	1	4	9.0	#N/A	2.074
27	551687	SIERRA HOSPICE CARE, INC	CA	1	4	9.0	#N/A	2.074
28	551649	ROZE ROOM HOSPICE OF SOUTH BAY	CA	2	2	8.0	43	2.062
29	491581	VITAS INNOVATIVE HOSPICE CARE	VA	3	0	10.0	52.5	2.048
30	051794	GRACE HOSPICE, INC	CA	0	0	9.0	76	2.046
31	091501	CAPITAL HOSPICE	DC	1	1	7.0	52.5	1.990
32	111654	TRADITIONS HEALTH	GA	1	0	10.0	68	1.933
33	031687	AZ SUNSET HOSPICE	AZ	0	2	4.0	#N/A	1.913
34	551755	SUPPORTIVE HOSPICE CARE INC	CA	2	2	9.0	#N/A	1.897
35	141719	ENTERA HOSPICE, INC	IL	0	5	#N/A	#N/A	1.881
36	051597	VITAS HEALTHCARE CORPORATION OF	CA	4	0	10.0	39.5	1.878
37	151607	HARMONYCARES HOSPICE	IN	2	4	8.0	26.5	1.848
38	671634	SELAH HOSPICE CARE, INC.	TX	0	5	9.0	#N/A	1.837
39	971612	AMABLE HOME CARE LLC	TX	0	5	9.0	#N/A	1.837
40	671562	ALTUS HOSPICE	TX	0	0	9.0	70.5	1.809
41	051716	GENTIVA	CA	2	0	8.0	48.5	1.801
42	031700	AZ HOSPICE CARE INC	AZ	0	3	6.0	#N/A	1.800
43	A01679	QUEST HOSPICE, INC.	CA	0	3	6.0	#N/A	1.800
44	261593	HOSPICE COMPASSUS-JOPLIN	MO	3	2	10.0	35	1.791
45	341587	HEARTLAND HOSPICE (RALEIGH)	NC	4	0	10.0	37	1.770
46	671698	ICON HOSPICE	TX	0	1	3.0	#N/A	1.762
47	971649	UNICARE PALLIATIVE & HOSPICE CA	TX	1	0	4.0	#N/A	1.735
48	451530	HOUSTON HOSPICE	TX	4	0	9.0	31.5	1.692
49	671613	ELYSIAN HOSPICE LLC	TX	0	0	7.0	60	1.673
50	751663	GLOBAL HOSPICE CARE, INC	CA	1	3	9.0	#N/A	1.659

Exhibit I

January 2, 2025
Hospice SFP 2025 Cohort- 50 Selectees (XLSX)
FILE: sfp-2025-cohort-50-selectees_0

COUNT	CCN	Facility Name	State	Subst. Complaint count	QoC CLD count	HCI	CAHPS Index	Final Score
1	241557	ECUMEN HOSPICE	MN	15	*	10.0	20	5.341
2	751585	VICTORIA HOSPICE SERVICES, INC	CA	1	*	9.0	#N/A	4.149
3	671715	RICELAND HOSPICE	TX	0	*	5.0	#N/A	3.309
4	151629	COMFORT 1 HOSPICE, LLC	IN	2	*	4.0	#N/A	3.217
5	451780	HOSPICE PLUS	TX	7	*	10.0	25	3.174
6	161612	MOMENTS HOSPICE	IA	1	*	8.0	#N/A	3.169
7	311582	TRANSCEND HOSPICE AND PALLIATIV	NJ	0	*	#N/A	#N/A	3.126
8	481504	TROPICAL HEALTH LLC A HEALTH AN	VI	0	*	6.0	#N/A	3.045
9	921671	ELITE HEALTH CARE SYSTEMS	CA	0	*	8.0	#N/A	2.932
10	971505	ROAD TO HAPPINESS HOME CARE SER	TX	0	*	5.0	#N/A	2.894
11	671786	ELYSIAN HOSPICE	TX	0	*	7.0	87	2.837
12	111754	OPUSCARE OF GEORGIA	GA	4	*	9.0	#N/A	2.786
13	051744	ST LIZ HOSPICE, INC	CA	1	*	8.0	39.5	2.764
14	751590	SAINT MONTSERRAT HOSPICE CARE,	CA	0	*	9.0	#N/A	2.667
15	551546	BRISTOL HOSPICE- NORTHERN LOS A	CA	0	*	7.0	82	2.621
16	111707	AMICASA HOSPICE HOME CARE	GA	0	*	6.0	75	2.478
17	081508	CHRISTIANACARE ACCENTCARE HOSP	DE	4	*	10.0	39.5	2.376
18	551507	ADMIRAL HOSPICE CARE, INC	CA	0	*	7.0	#N/A	2.366
19	551744	BAKERSFIELD COMMUNITY HOSPICE,	CA	2	*	8.0	21	2.358
20	111692	AMITY CARE	GA	2	*	10.0	51	2.339
21	141697	UNITED HOSPICE, INC	IL	0	*	9.0	#N/A	2.252
22	261581	CROSSROADS HOSPICE OF KANSAS CI	MO	3	*	10.0	28	2.236
23	061570	NEW CENTURY HOSPICE OF DENVER	CO	4	*	10.0	40.5	2.170
24	111762	AFFINITY HOSPICE	GA	1	*	10.0	73	2.149
25	231691	AMBER HOSPICE CARE	MI	1	*	9.0	#N/A	2.074
26	551687	SIERRA HOSPICE CARE, INC	CA	1	*	9.0	#N/A	2.074
27	491581	VITAS INNOVATIVE HOSPICE CARE	VA	3	*	10.0	52.5	2.048
28	051794	GRACE HOSPICE, INC	CA	0	*	9.0	76	2.046
29	091501	CAPITAL HOSPICE	DC	1	*	7.0	52.5	1.990
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31	031687	AZ SUNSET HOSPICE	AZ	0	*	4.0	#N/A	1.913
32	551755	SUPPORTIVE HOSPICE CARE INC	CA	2	*	9.0	#N/A	1.897
33	141719	ENTERA HOSPICE, INC	IL	0	*	#N/A	#N/A	1.881
34	051597	VITAS HEALTHCARE CORPORATION OF	CA	4	*	10.0	39.5	1.878
35	151607	HARMONYCARES HOSPICE	IN	2	*	8.0	26.5	1.848
36	671634	SELAH HOSPICE CARE, INC.	TX	0	*	9.0	#N/A	1.837
37	971612	AMABLE HOME CARE LLC	TX	0	*	9.0	#N/A	1.837
38	671562	ALTUS HOSPICE	TX	0	*	9.0	70.5	1.809
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40	031700	AZ HOSPICE CARE INC	AZ	0	*	6.0	#N/A	1.800
41	A01679	QUEST HOSPICE, INC.	CA	0	*	6.0	#N/A	1.800
42	261593	HOSPICE COMPASSUS-JOPLIN	MO	3	*	10.0	35	1.791
43	341587	HEARTLAND HOSPICE (RALEIGH)	NC	4	*	10.0	37	1.770
44	971649	UNICARE PALLIATIVE & HOSPICE CA	TX	1	*	4.0	#N/A	1.735
45	451530	HOUSTON HOSPICE	TX	4	*	9.0	31.5	1.692
46	671613	ELYSIAN HOSPICE LLC	TX	0	*	7.0	60	1.673
47	751663	GLOBAL HOSPICE CARE, INC	CA	1	*	9.0	#N/A	1.659

Exhibit 3

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

TEXAS ASSOCIATION FOR HOME CARE & HOSPICE, et al.,

Plaintiffs,

v.

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.,

Defendants.

Case No.: _____

DECLARATION OF RACHEL HAMMON

Pursuant to 28 U.S.C. § 1746, I declare as follows:

1. My name is Rachel Hammon. I am the Executive Director of the Texas Association for Home Care & Hospice (TAHCH), one of the Plaintiffs in this action. I respectfully submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction or a Stay under Administrative Procedure Act (APA) § 705. I am over twenty-one years old and have personal knowledge of the facts contained in this declaration.

2. I received my Bachelor of Science degree in Nursing from the University of Texas in Austin and have over 31 years of experience in nursing with 28 years' experience in the home-health industry. Prior to my employment with TAHCH, and in my work with a home-health agency, I served in many roles (*i.e.*, Pediatric Case Manager, Medicare Case Manager, DON / Administrator and Corporate Director of Clinical Services), which gave me a diverse knowledge of the industry. At TAHCH, I have assisted

member agencies with compliance with state and federal laws (Medicare, Medicaid, OSHA, BON, etc.), served as a liaison with state and federal government officials, and served on the Nurse Practice Advisory Committee for the Board of Nurse Examiners.

3. TAHCH is an association of Texas Licensed home-care and hospice agencies, organizations, and individual professionals. TAHCH advocates for ethical practices, quality, and economic viability of licensed home-care and hospice providers to enhance the well-being of individuals and their families throughout Texas. TAHCH brings together organizations and individuals in a shared commitment to every Texas citizen in need of quality, affordable in-home services.

4. TAHCH, through its regulatory team, advocates for its members with state and federal regulators. This is a key purpose of TAHCH and an important benefit to our members. TAHCH facilitates meetings with regulators to address industry concerns and member issues, submits comments on state and federal regulations, and participates in workgroups and advisory committees. TAHCH devotes a substantial portion of its annual budget to its regulatory efforts. TAHCH's regulatory efforts include assisting members in education and training about compliance with state and federal regulations. TAHCH also coordinates with state and federal regulators regarding member concerns, compliance issues, and other matters important to its members. In my role as Executive Director, for example, I routinely work with legislators and state agency staff on legislation and policy that affects the home-care industry. Our members, many of whom are small businesses, rely on TAHCH to understand and interpret regulations, and to advance their interests with regulators, including the Centers for Medicare & Medicaid Services (CMS).

5. TAHCH represents over 1,200 licensed home- and community-support agencies. At least 142 are involved in hospice programs. Our hospice-program members range from small businesses with a single licensed and Medicare-certified facility in the State to large businesses with many licensed and Medicare-certified facilities across the State. Our members include both non-profit and for-profit organizations that provide hospice services throughout Texas, including in underserved communities, both rural and urban.

6. I am familiar with CMS' Final Rule that establishes, among other things, the Special Focus Program and its selection criteria.[1] TAHCH has submitted extensive comments to CMS regarding our concerns about, and the impact of the Final Rule—most notably that the algorithm could lead to inappropriate placement on the list and a lack of due process for providers.

7. I am also familiar with CMS' recent determinations making hospice programs part of the Special Focus Program, including the listing on CMS' website of hospices selected for the Special Focus Program,[2] as well as CMS' letters to individual hospices informing them of their inclusion in the Special Focus Program.

8. According to its public website as of January 14, 2025, CMS has placed 10 hospice facilities from Texas in the Special Focus Program. This includes multiple TAHCH members, such as Elysian Hospice (Stafford), Elysian Hospice (Addison), and Houston Hospice. Several of these listed hospice facilities from Texas, including TAHCH members Elysian Hospice (Stafford) and Elysian Hospice (Addison), were placed in the Special Focus

[1] Calendar Year 2024 Home Health Prospective Payment System Final Rule, 88 Fed. Reg. 77676 (Nov. 13, 2023).

[2] CMS, *Hospice Special Focus Program* (last visited Jan. 14, 2025), https://www.cms.gov/medicare/health-safety-standards/certification-compliance/hospice-special-focus-program

Program despite CMS' data showing they had *zero* substantiated complaints or condition-level deficiencies.

9. In my experience and based on my communications with members, TAHCH members have suffered and will continue to suffer harm from CMS' actions including them in the Special Focus Program.

10. Inclusion in the Special Focus Program harms the reputation of TAHCH and its members. CMS defines the Special Focus Program as "a program conducted by CMS to identify hospices as poor performers, based on defined quality indicators, in which CMS selects hospices for increased oversight to ensure that they meet Medicare requirements."[3] By including TAHCH members in the Special Focus Program, CMS has publicly labelled those members "poor performers" and implied that they do not "meet Medicare requirements." In my experience, CMS' public criticism will make it more difficult for TAHCH members who have been included in the Special Focus Program to attract patients for their Medicare programs, as well as to attract and retain employees.

11. Inclusion in the Special Focus Program will also lead to increased compliance costs for TAHCH members. According to the Final Rule, CMS (via State Survey Agencies) will survey hospices within the Special Focus Program more frequently than hospices outside the Special Focus Program.[4] In practice, TAHCH members are generally surveyed for continuing Medicare certification approximately every three years—less frequently than the every six months they will be surveyed during the Special Focus Program.

[3] 42 C.F.R. § 488.1105.

[4] 42 C.F.R. § 488.1110(a); 42 C.F.R. § 488.1135(c)(1).

12. In my experience, surveys are burdensome for TAHCH members. During a survey, a member must work with the surveyor throughout the intrusive and disruptive survey process. This often involves employees sitting for interviews, providing records, scheduling home visits, and providing any other information that the surveyor might request—all while taking these employees away from time dedicated to their normal day-to-day duties. In my experience, TAHCH members spend thousands of dollars in employee time and resources complying with each survey. By including TAHCH members in the Special Focus Program, CMS has increased their survey frequency and, consequently, increased compliance costs for those members.

13. Inclusion in the Special Focus Program has also revoked deemed status for certain TAHCH members.[5] As part of my job responsibilities, I regularly correspond with TAHCH's hospice members. From that correspondence, I am aware that some TAHCH members included in the Special Focus Program previously held deemed status and were subject to surveys from accrediting agencies such as Community Health Accreditation Partner (CHAP) and Accreditation Commission for Health Care (ACHC). In my experience, hospice programs select deemed status because deemed status is often tied to quality metrics used in contracting with insurance companies and other payer sources, allowing the hospice program to obtain favorable rates. TAHCH members who have been placed in the Special Focus Program will lose the benefits of deemed status.

14. Even some TAHCH members not included in the initial public listing on CMS' website of hospices selected for the Special Focus Program may suffer significant reputational harm. CMS' Final Rule requires CMS to post on its public website a "subset" of the bottom

[5] 42 C.F.R. § 488.1135(b)(2).

10% of what CMS determines to be poor performers.[6] Although CMS has not published this list yet, it may do so at any time under its Final Rule, which may harm additional TAHCH members.

15. In addition, CMS has caused irreparable harm to TAHCH members by posting erroneous data about substantiated complaints on its Special Focus List website. CMS' "underlying data" includes a Microsoft Excel file titled "Hospice Special Focus Program Substantiated Complaints."[7] My understanding from conferring with members and other hospice-community stakeholders is that CMS' data file includes various errors, including complaints that were not substantiated or that related only to state-licensing deficiencies, which are not supposed to count for the SFP algorithm.[8] CMS' public posting of data that purport to show a hospice had a deficiency in Medicare compliance when, in fact, the hospice did not causes inevitable reputational harm to that hospice.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 14, 2025.

Rachel Hammon

[6] 42 C.F.R. § 488.1135(f).

[7] CMS, *Hospice Special Focus Program Substantiated Complaints (XLSX)* (last visited Jan. 14, 2025), available for download at https://www.cms.gov/files/document/hospice-special-focus-program-substantiated-complaints.xlsx.

[8] CMS, *Hospice Special Focus Program User's Guide: Algorithm and Public Reporting* at 8 (Dec. 2024), available at https://www.cms.gov/files/document/hospice-special-focus-program-users-guide-algorithm-and-public-reporting01082025.pdf.

Exhibit 4

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

TEXAS ASSOCIATION FOR HOME CARE & HOSPICE, et al.,

Plaintiffs,

v.

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.

Defendants.

Case No.: _____

DECLARATION OF EVAN REINHARDT

Pursuant to 28 U.S.C. § 1746, I declare as follows:

1. My name is Evan Reinhardt. I am the Executive Director of the Indiana Association for Home and Hospice Care (IAHHC), one of the Plaintiffs in this action. I respectfully submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction or a Stay under Administrative Procedure Act ("APA") § 705. I am over twenty-one years old and have personal knowledge of the facts contained in this declaration.

2. I have served as the Executive Director of IAHHC since 2012. In that capacity, I have been directly involved in the standards of care for all of care in the home in Indiana, including Hospice, Home Health, and Personal Services, all of which overlap in their delivery to allow consumers to age in place or receive care at home. I am also the current Chairman of the Council of State Home Care and Hospice Associations, a national trade association representing trade associations around the country, and the Executive Director for the

Kentucky Home Care Association, as well as a member of the Forum of States Executive Committee for the National Alliance for Care at Home.

3. As the Chairman of the Council of State Home Care and Hospice Associations, a position I have held since 2021, I am responsible for the day-to-day management of the Council, including membership and events. Additionally, as the Chairman of the Council of State Home Care and Hospice Associations, I regularly travel to Washington, D.C., where I participate in meetings and other efforts related to care in the home including with regulators, such as the Centers for Medicare & Medicaid Services (CMS), and Medicare Administration Contractors, on behalf of our members.

4. Similar to my role as the Executive Director of IAHHC, as the Executive Director for the Kentucky Home Care Association since 2018, I have been directly involved in the standards of care for all of care in the home in Kentucky, including Hospice, Home Health, and Personal Services, all of which overlap in their delivery to allow consumers to age in place or receive care at home. I also travel to Frankfort, Kentucky regularly to lobby the administration, regulators, and the Kentucky General Assembly on issues related to care in the home. The Kentucky Home Care Association contracted with IAHHC to have IAHHC staff, including myself, provide the same or similar services to the Kentucky Home Care Association that we provide to IAHHC.

5. Prior to these roles, I worked as a Recruiter for a home care provider in Southern Indiana. In that role, I was responsible for coordinating with the clinical team to hire and manage a team of nurses and caregivers that delivered health care to our patients in their homes.

6. IAHHC is the voice of Indiana's home care and hospice providers. Our mission

is "to advance the cause of home care and hospice through leadership, collaboration, advocacy, and education." We represent all of home and hospice care: traditional home health nursing services, home-based and inpatient hospice care and non-medical services that allow Hoosiers to remain independent in their homes.

7. IAHHC, through its regulatory team, advocates for its members and patients and families served by our members to the Indiana Department of Health as well as to federal regulators at the Centers for Medicare & Medicaid Services (CMS). This is a key purpose of IAHHC and an important benefit to our members. Our members, many of whom are small businesses, rely on IAHHC to advance their interests with regulators, including CMS. IAHHC advances its members interests by, among other things, facilitating meetings with state and federal regulators to address industry concerns and member issues, submitting comments on state and federal regulations, and participating in workgroups and advisory committees. IAHHC devotes a substantial portion of its annual budget to its regulatory team for these efforts each year. As much as seventy percent of IAHHC's budget is devoted to the regulatory team's efforts, depending on the year.

8. IAHHC has approximately 540 members, including 47 hospice programs. Our hospice-program members range from small mom-and-pop shops to large national organizations. Our members provide hospice services across Indiana in both rural and urban areas. Our members include non-profit organizations that provide hospice services in underserved communities.

9. I am familiar with CMS' Final Rule that establishes, among other things, the

Special Focus Program's selection criteria.[1]

10. I am also familiar with CMS' recent determinations making hospice programs part of the Special Focus Program, including the listing on CMS' website of hospices selected for the Special Focus Program, as well as CMS' letters to individual hospices informing them of their inclusion in the Special Focus Program.[2]

11. According to its public website, CMS has placed Indiana hospices in the Special Focus Program, including a member of IAHHC.

12. In my experience and based on my communications with members, Indiana hospices have suffered and will continue to suffer harm from CMS' actions including them in the Special Focus Program.

13. Inclusion in the Special Focus Program harms the reputation of Indiana hospices. CMS defines the Special Focus Program as "a program conducted by CMS to identify hospices as poor performers, based on defined quality indicators, in which CMS selects hospices for increased oversight to ensure that they meet Medicare requirements."[3] By including Indiana hospices in the Special Focus Program, CMS has publicly labelled those hospices as "poor performers" and implied that have a record of not "meet[ing] Medicare requirements."

14. In my experience, CMS' public criticism will make it more difficult for Indiana hospices who have been included in the Special Focus Program, and other Indiana hospices

[1] Calendar Year 2024 Home Health Prospective Payment System Final Rule, 88 Fed. Reg. 77676 (Nov. 13, 2023).

[2] CMS, Hospice Special Focus Program (last visited Jan. 14, 2025), https://www.cms.gov/medicare/health-safety-standards/certification-compliance/hospice-special-focus-program

[3] 42 C.F.R. § 488.1105.

who may be included in the Special Focus Program in the future, to attract patients for their Medicare programs, as well as to attract and retain employees.

15. On a regular basis, IAHHC and its members discuss the reputational repercussions of CMS publications that reference hospices in a negative light. Many IAHHC members have relayed to me conversations with consumers and referral sources who have confirmed for our members that such CMS listings cause hospices harm in the public sphere. Consumers have confirmed to IAHHC members that consumers review the CMS lists and will not select hospice programs that are included on negative CMS listings when seeking hospice care for themselves or a loved one.

16. In my experience and based on my communications with IAHHC members, inclusion in the Special Focus Program will also make it more difficult for Indiana hospices to attract patients for their Medicare programs through referrals. Indiana hospices included in the Special Focus Program, and other IAHHC members, rely on referrals from nursing homes and hospitals as a source of new patients. Many IAHHC members have had conversations with referral sources, who have confirmed that a hospice's inclusion in CMS lists and programs that place hospices in a negative light, such as the Special Focus Program, will prevent or discourage nursing homes and hospices from referring patients to those hospice facilities. Referral sources will not refer patients to hospices on these CMS lists out of fear that patients will not be adequately cared for and that working with a hospice labeled a "bad actor" could lead to further scrutiny of the referring facility by the Indiana Department of Health or other government regulators, or otherwise harm their own certifications.

17. In my experience and based on my communications with IAHHC members, inclusion in the Special Focus Program will also inhibit Indiana hospices' ability to properly

care for their patients by reducing the pool of nursing home and hospital facilities that will accept patients from the hospice included in the Special Focus Program. At times, patients in hospice care are transferred to nursing homes and hospitals for respite care or other specialized care unrelated to the patient's hospice stay, such as wound and injury care. Hospices have contracts or other agreements with nursing home and hospital facilities to provide care for its patients in these scenarios. Nursing homes and hospitals have confirmed to IAHHC members; however, that they will not accept patients from hospices that are included in CMS programs and lists that paint the hospice in a negative light out of fear that working with a hospice labeled a "bad actor" could lead to further scrutiny of the accepting facility by the Indiana Department of Health or other regulators, or otherwise harm their own certifications.

18. In my experience, the vast majority of consumers and referral sources do not seek to independently assess CMS' basis for including a hospice on a list. Instead, consumers and referral sources tend to just accept CMS' designations, ratings, and listings at face value.

19. Inclusion in the Special Focus Program will also lead to increased compliance costs for Indiana hospices. According to the Final Rule, CMS or State Survey Agencies will survey hospices within the Special Focus Program more frequently than hospices outside the Special Focus Program.[4] In practice, IAHHC members are generally surveyed approximately every one to three years—less frequently than the every six months they will be surveyed during their participation in the Special Focus Program.

20. In my experience, surveys are very burdensome for IAHHC members and other Indiana hospices. The surveys by the Indiana Department of Health are intense and lengthy,

[4] 42 C.F.R. § 488.1110(a); 42 C.F.R. § 488.1135(c)(1).

and they typically go on for weeks at a time. During a survey, a member must cooperate with the surveyor. This often involves employees sitting for interviews, providing records, conducting tours, and coordinating interviews with patients and patients' family members, and it is generally very disruptive. In my experience, IAHHC members spend tens of thousands of dollars in employee time and resources complying with each survey, which often includes hiring consultants to facilitate and streamline the survey process. By including Indiana hospices in the Special Focus Program, CMS has increased their survey frequency and, consequently, increased compliance costs for those hospices.

21. Inclusion in the Special Focus Program has also revoked deemed status for Indiana hospices.[5] From publicly available information, I am aware that an IAHHC member that previously held deemed status and was subject to surveys from accrediting agency, Accreditation Commission for Health Care ("ACHC"), no longer has deemed status due to its inclusion in the Special Focus Program. In my experience, hospice programs opt to get deemed status for many reasons. A major driver is the reputational boost from having deemed status through independent accreditation, as accreditation and deemed status are considered by many as above and beyond minimum standards. Second, deemed status carries with it the benefit of not having to undergo the state survey process. Third, accreditation agencies, including ACHC, provide best practices and recommendations to help hospices elevate standard of care.

22. An IAHHC member who has been placed in the Special Focus Program has lost the above-described benefits of deemed status. This results not only in harm to the IAHHC member but also to patients, particularly if the member is required to divert resources

[5] 42 C.F.R. § 488.1135(b)(2).

away from ACHC in order to accommodate state surveys, given the IAHHC member is no longer able to achieve deemed status through ACHC accreditation. That would deprive the IAHHC member of the best practices and recommendations that ACHC distributes.

23. Even some IAHHC members and other Indiana hospices not included in the initial public listing on CMS' website of hospices selected for the Special Focus Program will suffer significant reputational harm. CMS' Final Rule requires CMS to post on its public website a "subset" of the bottom 10% of what CMS determines to be poor performers.[6] Though CMS has not published this list yet, it may do so at any time under its Final Rule.

24. In addition, CMS has caused irreparable harm to IACHH members by posting erroneous data about substantiated complaints on its Special Focus List website. CMS' "underlying data" includes an Excel files titled "Hospice Special Focus Program Substantiated Complaints." My understanding from conferring with members and other hospice community stakeholders is that CMS' data file includes various errors, including complaints that were not substantiated or that related only to state-licensing deficiencies, which are not supposed to count for the SFP algorithm. CMS' public posting of data that purport to show a hospice had a deficiency in Medicare compliance when, in fact, the hospice did not, causes inevitable reputational harm to that hospice.

[6] 42 C.F.R. § 488.1135(f).

I declare under penalty of perjury that the foregoing is true and correct. Executed this 14th day of January, 2025 in Indianapolis, Indiana.

Evan Reinhardt

Exhibit 5

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

TEXAS ASSOCIATION FOR HOME CARE & HOSPICE, et al.,

Plaintiffs,

v.

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.

Defendants.

Case No.: _____

DECLARATION OF TIMOTHY R. ROGERS

Pursuant to 28 U.S.C. § 1746, I declare as follows:

1. My name is Timothy R. Rogers. I am the President and CEO of the Association for Home & Hospice Care of North Carolina (AHHC), one of the Plaintiffs in this action. I respectfully submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction or a Stay under Administrative Procedure Act (APA) § 705. I am over twenty-one years old and have personal knowledge of the facts contained in this declaration.

2. I have over 32 years of experience working in the hospice, home care, and home health industry. Since 2001, I have served as the President & CEO of AHHC. Previously, I worked as the first Director of Government Relations and Chief Lobbyist AHHC, Vice President of Government Relations for Comprehensive Home Health Care and Hospice (now Liberty), and Director of Regulatory Affairs and Strategic Planning for Tar Heel Home Health (now Centerwell Home Health/Gentiva Hospice) and Hospice of Tar Heel.

3. AHHC is one of the oldest and largest nonprofit trade association representing providers of home health, hospice, palliative care, personal care, private duty nursing, companion/sitter services, providers of behavioral health care services that care for and support individuals with intellectual and developmental disabilities, and Program for All-Inclusive Care for the Elderly (PACE) provider members, in addition to other healthcare affiliates. AHHC was established in 1972 and currently has a membership of over 750 provider agencies and business partners, who provide products and services to providers. AHHC's mission is to provide Resources, Education, Advocacy and Leadership. AHHC strongly advocates for its members and the many patients they serve, and is recognized by colleagues, regulators, and legislators as one of the most active and effective home care & hospice associations in the United States.

4. Since its foundation, AHHC has steadily grown its hospice membership and not only became the largest and most comprehensive state hospice & palliative care association in the Carolinas in 2010, but also one of the largest in the country, and has proudly maintained this success since then. AHHC has over ninety-five (95) percent of North Carolina hospices as members, which is one of the highest market penetrations in the county.

5. AHHC, through its staff, contractors, and members, strongly advocates for their members and the many patients they serve, and is recognized by colleagues, regulators, and legislators as one of the most active and effective home care & hospice associations in the United States. This advocacy is central to the mission of AHHC and an important benefit to our members. AHHC facilitates meetings with policymakers and regulators to address industry concerns and member issues, submits comments on state and federal regulations, and participates in workgroups and advisory committees. AHHC devotes a substantial

portion of its annual budget to its regulatory efforts. Our members, many of whom are small businesses, rely on AHHC to advance their interests with regulators, including the Centers for Medicare & Medicaid Services (CMS).

6. AHHC has nearly 750 members, including 235 hospices. Our hospice members range from smaller, single-office hospices to larger organizations with multiple licensed offices. All of our hospices are certified by CMS. Our members collectively provide hospice services throughout North Carolina. Our members include components of national, for-profit companies and non-profit organizations.

7. I am familiar with CMS's final rule that establishes, among other things, the Special Focus Program's selection criteria.[1]

8. I am also familiar with CMS's recent determinations making hospice programs part of the Special Focus Program, including the listing on CMS's website of hospices selected for the Special Focus Program,[2] as well as CMS's letters to individual hospices informing them of their inclusion in the Special Focus Program.

9. According to its public website as of January 14, 2025, CMS has placed one hospice facility located in North Carolina in the Special Focus Program. At this time, CMS's list includes one AHHC member. This member acquired the hospice from another entity, and CMS relies upon data that predated the acquisition. This North Carolina hospice had no quality-of-care-related condition-level deficiencies. As the provider does not appear in the North Carolina Department of Health & Human Services' Provider Penalty Tracking

[1] Calendar Year 2024 Home Health Prospective Payment System Final Rule, 88 Fed. Reg. 77676 (Nov. 13, 2023).

[2] CMS, Hospice Special Focus Program (last visited Jan. 14, 2025), https://www.cms.gov/medicare/health-safety-standards/certification-compliance/hospice-special-focus-program

database, this provider has no "violations that have resulted in penalties or serious administrative actions against their license."

10. In my experience and based on my communications with members, AHHC members have suffered and will continue to suffer harm from CMS's actions including North Carolina hospices in the Special Focus Program. The Special Focus Program creates an impression that listed hospices are detrimental to the well-being of hospice patients and their families. The Special Focus Program is likely to decrease patients' access to hospice by creating an unreasonable fear about the hospice industry's overall commitment to compliance and quality of care.

11. Inclusion in the Special Focus Program harms the reputation of any AHHC member that has been or will be included in the Special Focus Program. CMS defines the Special Focus Program as "a program conducted by CMS to identify hospices as poor performers, based on defined quality indicators, in which CMS selects hospices for increased oversight to ensure that they meet Medicare requirements."[3] By including an AHHC member in the Special Focus Program, CMS has publicly labelled this member as a "poor performer" and implied that the hospice has a record of not "meet[ing] Medicare requirements." In my experience, CMS'S public criticism will make it more difficult for any AHHC member that has been or will be included in the Special Focus Program to attract patients for their hospice programs, as well as to attract and retain employees.

12. In my experience and based on my communications with AHHC members, inclusion in the Special Focus Program will also lead to increased compliance costs for AHHC members. According to the Final Rule, CMS or State Survey Agencies will survey

[3] 42 C.F.R. § 488.1105.

hospices within the Special Focus Program more frequently than hospices outside the Special Focus Program.[4] In practice, AHHC members are generally surveyed for continuing Medicare certification approximately every three years—less frequently than the every six months they will be surveyed during the Special Focus Program.

13. In my experience, surveys are burdensome for AHHC members. During a survey, a member must cooperate with the surveyor throughout the intrusive and disruptive survey process. This often involves employees sitting for interviews, providing records, scheduling home visits, and providing any other information that the surveyor might request—all while taking these employees away from time dedicated to direct patient care. In my experience, AHHC members spend thousands of dollars in employee time and resources complying with each survey. By including AHHC members in the Special Focus Program, CMS has increased their survey frequency and, consequently, increased compliance costs for those members.

14. Inclusion in the Special Focus Program also revokes deemed status for certain AHHC members.[5] As part of my job responsibilities, I regularly correspond with AHHC's hospice members. From that correspondence, I am aware that some AHHC members included in the Special Focus Program previously held deemed status and were subject to surveys from accrediting agencies. In my experience, hospice programs select deemed status because deemed status is often tied to quality metrics used in contracting with insurance companies and other payer sources, allowing the hospice program to obtain favorable rates and referral status. AHHC members who have been placed or will be placed in the Special

[4] 42 C.F.R. § 488.1110(a); 42 C.F.R. § 488.1135(c)(1).

[5] 42 C.F.R. § 488.1135(b)(2).

Focus Program will lose the benefits of deemed status. The AHHC member who has been placed in the Special Focus Program has lost the benefits of deemed status through its accreditation by the Accreditation Commission for Health Care.

15. Even some AHHC members not included in the initial public listing on CMS'S website of hospices selected for the Special Focus Program are poised to suffer significant reputational harm. CMS'S Final Rule requires CMS to post on its public website a "subset" of the bottom 10% of what CMS determines to be poor performers.[6] Though CMS has not yet published this list, it may do so at any time under its Final Rule, which would harm AHHC members.

16. In addition, CMS has caused irreparable harm to AHHC members by posting erroneous data about substantiated complaints on its Special Focus List website. CMS'S "underlying data" includes an Excel file titled "Hospice Special Focus Program Substantiated Complaints." My understanding from conferring with members and other hospice community stakeholders is that CMS'S data file includes various errors, including complaints that were not substantiated or that related only to state-licensing deficiencies, which are not supposed to count for the SFP algorithm. CMS'S public posting of data that purport to show a hospice had a deficiency in Medicare compliance when, in fact, the hospice did not, causes inevitable reputational harm to that hospice.

[6] 42 C.F.R. § 488.1135(f).

I declare under penalty of perjury that the foregoing is true and correct. Executed this 14th day of January, 2025 in Raleigh, North Carolina.

Timothy R. Rogers

Exhibit 6

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

TEXAS ASSOCIATION FOR HOME CARE & HOSPICE, et al.,

Plaintiffs,

v.

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services, et al.

Defendants.

Case No.: _____

DECLARATION OF TIMOTHY R. ROGERS

Pursuant to 28 U.S.C. § 1746, I declare as follows:

1. My name is Timothy R. Rogers. I am the President and CEO of the South Carolina Home Care & Hospice Association (SCHCHA), one of the Plaintiffs in this action. I respectfully submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction or a Stay under Administrative Procedure Act (APA) § 705. I am over twenty-one years old and have personal knowledge of the facts contained in this declaration.

2. I have over 32 years of experience working in the hospice, home care, and home health industry. Since 2001, I have served as the President & CEO of the Association for Home and Hospice Care of North Carolina (SCHCHA). In 2004, AHHC took over management of SCHCHA. Since then, I have also served as the President & CEO of SCHCHA. Previously, I worked as the first Director of Government Relations and Chief Lobbyist for AHHC, Vice President of Government Relations for Comprehensive Home

Health Care and Hospice (now Liberty), and Director of Regulatory Affairs and Strategic Planning for Tar Heel Home Health (now Centerwell/Gentiva) and Hospice of Tar Heel.

3. SCHCHA is a nonprofit trade association representing providers of home health, hospice, palliative care, personal care, private duty nursing, companion/sitter services, providers of behavioral health care services that care for and support individuals with intellectual and developmental disabilities, and Program for All-Inclusive Care for the Elderly (PACE) provider members, in addition to other healthcare affiliates. SCHCHA was established in 1979, and currently has a membership of over 250 provider agencies and business partners, who provide products and services to providers. SCHCHA's mission is to provide Resources, Education, Advocacy and Leadership. SCHCHA strongly advocates for its members and the many patients they serve, and is recognized by colleagues, regulators, and legislators as one of the most active and effective home care & hospice associations in the United States.

4. Since its foundation, SCHCHA has grown its hospice membership and became one of the largest and most comprehensive state hospice & palliative care association in the Carolinas in 2010, and has proudly maintained this success since then. SCHCHA has 80% percent of South Carolina hospices as members.

5. SCHCHA, through its staff, contractors, and members, strongly advocates for their members and the many patients they serve, and is recognized by colleagues, regulators, and legislators as one of the most active and effective home care & hospice associations in the United States. This advocacy is central to the mission of SCHCHA and an important benefit to our members. SCHCHA facilitates meetings with policymakers and regulators to address industry concerns and member issues, submits comments on state and federal regulations,

and participates in workgroups and advisory committees. SCHCHA devotes a substantial portion of its annual budget to its regulatory efforts. Our members, many of whom are small businesses, rely on SCHCHA to advance their interests with regulators, including the Centers for Medicare & Medicaid Services (CMS).

6. SCHCHA has over 250 members, including 75 hospices. Our hospice members range from smaller, single-office hospices to larger organizations with multiple licensed offices. Our members provide hospices services across South Carolina and in neighboring states. Our members include components of national, for-profit companies and non-profit organizations.

7. I am familiar with CMS's final rule that establishes, among other things, the Special Focus Program's selection criteria.[1]

8. I am also familiar with CMS's recent determinations making hospice programs part of the Special Focus Program, including the listing on CMS's website of hospices selected for the Special Focus Program,[2] as well as CMS's letters to individual hospices informing them of their inclusion in the Special Focus Program.

9. According to its public website as of January 14, 2025, CMS has not yet placed any hospice facilities located in South Carolina in the Special Focus Program.

10. The Special Focus Program creates an impression that listed hospices are detrimental to the well-being of hospice patients and their families. The Special Focus Program is likely to decrease patients' access to hospice by creating an unreasonable fear

[1] Calendar Year 2024 Home Health Prospective Payment System Final Rule, 88 Fed. Reg. 77676 (Nov. 13, 2023).

[2] CMS, Hospice Special Focus Program (last visited Jan. 14, 2025), https://www.cms.gov/medicare/health-safety-standards/certification-compliance/hospice-special-focus-program

about the hospice industry's overall commitment to compliance and quality of care.

11. Inclusion in the Special Focus Program harms the reputation of any SCHCHA member that would later be included in the Special Focus Program. CMS defines the Special Focus Program as "a program conducted by CMS to identify hospices as poor performers, based on defined quality indicators, in which CMS selects hospices for increased oversight to ensure that they meet Medicare requirements."[3] In my experience, CMS's public criticism will make it more difficult for any SCHCHA member that will be included in the Special Focus Program to attract patients for their hospice programs, as well as to attract and retain employees.

12. In my experience and based on my communications with SCHCHA members, inclusion in the Special Focus Program will also lead to increased compliance costs for SCHCHA members. According to the Final Rule, CMS or State Survey Agencies will survey hospices within the Special Focus Program more frequently than hospices outside the Special Focus Program.[4] In practice, SCHCHA members are generally surveyed for continuing Medicare certification approximately every three years—less frequently than the every six months they will be surveyed during the Special Focus Program.

13. In my experience, surveys are burdensome for SCHCHA members. During a survey, a member must cooperate with the surveyor throughout the intrusive and disruptive survey process. This often involves employees sitting for interviews, providing records, scheduling home visits, and providing any other information that the surveyor might request—all while taking these employees away from time dedicated to direct patient care. In

[3] 42 C.F.R. § 488.1105.

[4] 42 C.F.R. § 488.1110(a); 42 C.F.R. § 488.1135(c)(1).

my experience, SCHCHA members spend thousands of dollars in employee time and resources complying with each survey. By including SCHCHA members in the Special Focus Program, CMS has increased their survey frequency and, consequently, increased compliance costs for those members.

14. Even though SCHCHA members are not included in the initial public listing on CMS'S website of hospices selected for the Special Focus Program, South Carolina hospices are still poised to suffer significant reputational harm. CMS's Final Rule requires CMS to post on its public website a "subset" of the bottom 10% of what CMS determines to be poor performers.[5] Though CMS has not yet published this list, it may do so at any time under its Final Rule, which would harm SCHCHA members.

15. In addition, CMS has caused irreparable harm to SCHCHA members by posting erroneous data about substantiated complaints on its Special Focus List website. CMS's "underlying data" includes an Excel file titled "Hospice Special Focus Program Substantiated Complaints." My understanding from conferring with members and other hospice community stakeholders is that CMS's data file includes various errors, including complaints that were not substantiated or that related only to state-licensing deficiencies, which are not supposed to count for the SFP algorithm. CMS's public posting of data that purport to show a hospice had a deficiency in Medicare compliance when, in fact, the hospice did not, causes inevitable reputational harm to that hospice.

[5] 42 C.F.R. § 488.1135(f).

I declare under penalty of perjury that the foregoing is true and correct. Executed this 14th day of January, 2025 in Raleigh, North Carolina.

Timothy R. Rogers

JS 44 (Rev. 03/24)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

Texas Association for Home Care & Hospice, et al.

(b) County of Residence of First Listed Plaintiff Travis County, TX
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

See attached.

DEFENDANTS

Xavier Becerra, Secretary, United States Department of Health and Human Services, et al.

County of Residence of First Listed Defendant
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☒ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

INTELLECTUAL PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☒ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
5 U.S.C. § 706

Brief description of cause:
Judicial review of a Final Agency Action

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:

JURY DEMAND: ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
January 16, 2025

SIGNATURE OF ATTORNEY OF RECORD
/s/ James Munisteri

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) Plaintiffs-Defendants. Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) County of Residence. For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) Attorneys. Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. Jurisdiction. The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

III. Residence (citizenship) of Principal Parties. This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. Nature of Suit. Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. Origin. Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.

VI. Cause of Action. Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service.

VII. Requested in Complaint. Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. Related Cases. This section of the JS 44 is used to reference related cases, if any. If there are related cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

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**Pro Hac Vice* Applications Forthcoming