Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements
[CMS-1754-F]
Summary of Final Rule

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I. Introduction and Background

On July 29, 2021, the Centers for Medicare & Medicaid Services (CMS) placed on public display a final rule updating the Medicare hospice payment rates, wage index, the cap amount forfiscal year (FY) 2022 and the quality reporting requirements for FY 2022. Among other changes,this rule makes permanent selected regulatory blanket waivers that were issued to Medicare- participating hospice agencies during the COVID-19 public health emergency (PHE) and updates the hospice conditions of participation. This rule also updates the Hospice Quality Reporting Program and finalizes changes beginning with the January 2022 public reporting for the Home Health Quality Reporting Program to address exceptions related to the COVID-19 PHE. The final rule will be published in the August 4, 2021 issue of the *Federal Register.* **These regulations are effective on October 1, 2021.**

CMS estimates that the overall impact of the final rule will be an increase of $480 million in Medicare payments to hospices during FY 2022.

CMS notes that wage index addenda for FY 2022 (October 1, 2021 through September 30, 2022) will be available only through the internet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html

The final rule reviews the history of the Medicare hospice benefit, including hospice reform policies finalized in the FY 2016 hospice final rule (80 FR 47142); this rule, among other things, differentiated payments for routine home care (RHC) based on the beneficiary's length of stay and implemented a service intensity add-on (SIA) payment for services provided in the last 7

days of a beneficiary's life. CMS also reviews hospice policies it finalized in the FY 2020 hospice final rule (84 FR 38487). This includes rebasing the continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIP) payment rates. To offset these increases, CMS reduced RHC payment rates by 2.7 percent. CMS also finalized a policy to use the current year's pre-floor, pre-reclassification hospital inpatient wage index as the wage adjustment to the labor portion of the hospice rates. It also finalized modifications to the hospice election statement content requirements at §418.24(b) for implementation in FY 2021. CMS also notes that the Consolidated Appropriations Act (CAA) of 2021 extended the provision that currently mandates the hospice cap be updated by the hospice payment update percentage (hospital market basket update reduced by the multifactor productivity adjustment) rather than the CPI-U until October 1, 2030. The CAA of 2021 also revised section 1841(i)(5)(A)(i) of the Act to increase the payment reduction for hospices who fail to meet the hospice quality measure reporting requirements from two percent to four percent beginning with FY 2024.

II. Provisions of the Final Rule

A. Hospice Utilization and Spending Patterns

In the proposed rule, CMS described current trends in hospice utilization and provider behavior including lengths of stay, live discharge rates, skilled visits during the last days of life, and non-hospice spending. CMS also requested comments about factors influencing how services are furnished to hospice beneficiaries and whether the hospice election statement addendum has changed hospice decision making. These comments are summarized below.

Hospice Utilization and Spending Pattern. Many commenters stated that while the structure of the hospice benefit has remained unchanged, changes in patient characteristics, especially the shift from cancer patients to those with end-stage neurologic and other conditions, is the predominate factor for changes in utilization trends and hospice practices. Commenters suggested CMS provide more analysis of physician billing for non-hospice spending and Part D expenditures during a hospice election.

Skilled Visits in the Last Day of Life. Commenters recommended that CMS modify the service intensity add-on (SIA) payment to include any visit (e.g., spiritual care or hospice aid) counting toward the end-of-life care payment instead of limiting the payment to skilled visits.

Items, Services, and Drugs Related and Unrelated to the Terminal Illness and Related Conditions. Several commenters states that the determination of relatedness, as applied to whether a service is connected to the terminal prognosis, is a clinical decision specific to the unique circumstances of each patient.

Election Statement Addendum. Several commenters stated the addendum has not changed their practice for determining what is related or unrelated under the hospice benefit but has improved the communication with patients and their representatives during the admission process. One commenter stated that the burden of implementation of the addendum outweighs the benefits.

CMS plans to continue to monitor hospice trends and will consider these comments for ongoing monitoring analysis and potential future rulemaking.

B. FY 2022 Labor Shares

For FY 2022, CMS finalizes its proposal to rebase and revise the labor shares for CHC, RHC, IRC and GIP using Medicare Cost Report (MCR) data for freestanding hospices for 2018. The current labor shares for CHC and RHC were established with the FY 1984 Hospice benefit implementation based on the wage/nonwage proportions specified in Medicare's limit on home health agency costs (48 FR 38155 through 38156). The labor share for IRC and GIP were based on skilled nursing facility wage and nonwage cost limits and skilled nursing facility costs per day. CMS finalizes with a slight modification to its proposed methodology to continue to establish separate labor shares for CHC, RHC, IRC, and GIP and base them on the calculated compensation cost weights for each level of care from the 2018 MCR data. CMS explored the possibility of using facility-based hospice MCR data to calculate the compensation cost weights; however, it found that very few of these reports passed all the necessary edits and were usable.

Several commenters supported CMS' proposal to base the hospice labor shares on recent MCR data and they believe this will improve payment accuracy. CMS disagrees with commenters that the hospice MCR data does not provide adequate measures for labor expenses. CMS notes that the freestanding hospice MCR data was used to rebase the FY 2020 hospice payment rates. CMS acknowledges commenters' concerns about labor costs related to the PHE but believes that using 2018 labor shares based on 2018 data is a technical improvement over the data from the early 1980s used to calculate the current labor shares. In response to comments, CMS states it plans to rebase the hospice labor shares every four to five years; a schedule used for other PPS systems. As a result of the PHE, CMS plans to monitor upcoming MCR data to see if a more frequent revision to the hospice labor shares is necessary. Any revisions will be proposed in future rulemaking.

Methodology for Calculating Compensation Costs. CMS proposed to derive a compensation cost weight for each level of care that consists of five major components: (1) direct patient care salaries and contract labor costs, (2) direct patient care benefits costs, (3) other patient care salaries, (4) overhead salaries, and (5) overhead benefits costs. For each level of care, CMS proposed to use the same methodology to derive the components; however, for the (1) direct patient care salaries and (3) other patient care salaries, it proposed to use the MCR worksheet that is specific to that level of care (that is, Worksheet A-1 for CHC, Worksheet A-2 for RHC, Worksheet A-3 for IRC, and Worksheet A-4 for GIP). CMS finalizes this proposed methodology with a slight modification to include Physician Administrative Services and Nursing Administration as additional overhead costs. Technical details of the final methodology, including the specific line items used from the MCR for deriving the compensation cost weights for each level of care, and CMS' response to comments can be found in the final rule (see pages 25-38 of the display copy).

Table 1 (reproduced below) provides the final labor share for each level of care based on the compensation cost weights CMS derived using its finalized methodology. CMS finalizes that labor shares will be equal to three decimal places, consistent with the labor shares used in other Prospective Payment Systems (PPS) (such as the inpatient prospective payment system (IPPS)

and the Home Health Agency PPS). The final labor shares are significantly higher for CHC and IRC, and slightly lower for RHC and GIP.

Table 1: Final, Proposed, and Current Labor Shares by Level of Care for FY 2022			
	Final Labor Shares	**Proposed Labor Shares**	**Current Labor Shares**
Continuous Home Care	75.2%	74.6%	68.71%
Routine Home Care	66.0%	64.7%	68.71%
Inpatient Respite Care	61.0%	60.1%	54.13%
General Inpatient Care	63.5%	62.8%	64.01%

In response to comments requesting additional information about the labor share standardization factor, CMS explains that the labor share standardization factor is applied to the FY 2022 hospice payment rates, so the aggregate payments do not increase or decrease due to changes in the labor share values. Implementing hospice labor shares in a budget neutral fashion, is consistent with CMS' policy of implementing updates to the hospice wage index in a budget neutral manner as well as updates in other PPS. CMS calculates the labor share utilization factor by simulating total payments using FY 2020 hospice utilization claims data with the FY 2022 hospice wage index and the current labor shares and compares this with CMS' simulation of total payments using the FY 2022 hospice wage index with the final revised labor shares.

C. Routine FY 2022 Hospice Wage Index and Rates Update

A summary of key data for the final hospice payment rates for FY 2022 is presented below with additional details in the subsequent sections.

Summary of Key Data for FY 2022 Hospice Payment Rates			
Market basket update factor			
Market basket increase			+2.7%
Required multi-factor productivity (MFP) adjustment			-0.7%
Net MFP-adjusted update reporting quality data			**+2.0%**
Net MFP-adjusted update not reporting quality data			**+0.0%**
Hospice aggregate cap amount			$31,297.61
Hospice Payment Rate Care Categories	**Labor Share**	**FY 2021 Federal Rates Per Diem**	**FY 2022 Federal Rates Per Diem**
Routine Home Care (days 1-60)	66.0%	$199.25	$203.40
Routine Home Care (days 61+)	66.0%	$157.49	$160.74
Continuous Home Care, Full Rate = 24 hours of care, $60.94 hourly rate	75.2%	$1,432.41	$1462.52
Inpatient Respite Care	61.0%	$461.09	$473.75
General Inpatient Care	63.5%	$1,045.66	$1,068.28
Service Intensity Add-on (SIA) payment, up to 4 hours			$60.94 per hour
Note: RHC days account for most of hospice days—98.3 percent in FY 2019.			

1. FY 2022 Hospice Wage Index

In FY 2020, CMS finalized its proposal to use the current FY's hospital wage index data to calculate the hospice wage index values. For FY 2022, CMS finalizes its proposal to use the hospice wage index based on the FY 2022 hospital pre-floor, pre-reclassified wage index. This wage index uses hospital cost reporting periods beginning on or after October 1, 2017 and before October 1, 2018 (FY 2018 cost report data). The appropriate wage index value is applied to the labor portion of the hospital payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC and applied based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

For the hospice wage index CMS uses the Core Based Statistical Areas (CBSA) labor market area definitions, which are established by the Office of Management and Budget (OMB). They are generally subject to major revisions every 10 years to reflect information from the decennial census, but OMB also issues minor revisions in the intervening years through OMB Bulletins. CMS has previously adopted OMB changes to CBSA delineations for purposes of the hospice labor market areas. On March 6, 2020, OMB issued Bulletin No. 20-01, which provided updates to and superseded OMB Bulletin No. 18-04 that was issued on September 14, 2018.

After reviewing these changes in Bulletin 20-01, CMS has determined that these changes would not affect the Medicare wage index for FY 2022. CMS finalizes its proposal to adopt the updates set forth in OMB Bulletin No. 20-01, and notes that specific wage index updates are not necessary for FY 2022 as a result of adopting these updates.

CMS also finalizes its proposal to continue to apply current policies for handling geographic areas where there are no hospitals. For urban areas of this kind, all CBSAs within the state are used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value for use as a reasonable proxy for these areas. For FY 2022, there is one CBSAs without a hospital from which hospital wage data can be derived: 25980, Hinesville-Fort Stewart, Georgia. The FY 2022 wage index value for Hinesville-Fort Stewart, Georgia is 0.8649. For rural areas without hospital wage data, CMS has used the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. However, the only rural area currently without a hospital is on the island of Puerto Rico, which does not lend itself to this "contiguous" approach. Because CMS has not identified an alternative methodology, the agency finalizes its proposal to continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047.

In response to comments about the ability of hospices to seek geographic reclassification, or to utilize a rural floor provision, CMS notes these statutory provisions are specific to hospitals.[1] CMS continues to believe the use of the pre-floor and pre-reclassified hospital wage index results in the most appropriate adjustment to the labor portion of the hospice payment rates. CMS appreciates the concerns expressed by commenters about the impact of yearly wage index changes and acknowledges the concerns from providers impacted by the implementation of the New Brunswick-Lakewood, NJ CBSA designation. CMS notes that in the FY 2021 Hospice final

[1] Section 1866(d)(10) of the Act provides for a reclassification provision limited to hospitals. Section 4410(a) of the Balanced Budget Act of 1997 provides that the area wage index applicable to any hospital in an urban area of a state may not be less than the average wage index applicable to hospitals located in rural areas in that state.

rule (85 FR 47079), it finalized a 1-year transition for FY 2021, to mitigate short-term instability and negative impacts on certain providers and to provide time for providers to adjust to new labor market delineations.

2. Hospice Payment Update Percentage

For FY 2022, CMS finalizes a hospice payment update percentage of 2.0 percent. This is based on HIS Global, Inc's second quarter 2021 forecast of the inpatient hospital market basket update (2.7 percent) and the productivity adjustment (0.7 percent).

CMS notes that the labor portion of the hospice payment rates is currently as follows: for RHC, 68.71 percent; for CHC, 68.71 percent; for GIP, 64.01 percent; and for IRC, 54.13 percent. As discussed in section III.B of this rule, CMS finalizes its proposal to rebase and revise the labor share for RHC, CHC, GIP and IRC using MCR data for freestanding hospices. The final labor portion of the hospice payment rates is as follows: for RHC, 66.0 percent; for CHC, 75.2 percent; for GIP, 63.5 percent; and for IRC, 61.0 percent.

3. FY 2022 Hospice Payment Rates

In the hospice payment system, there are four payment categories that are distinguished by the location and intensity of the services provided: RHC or routine home care, IRC or short-term care to allow the usual caregiver to rest, CHC or care provided in a period of patient crisis to maintain the patient at home, and GIP or general inpatient care to treat symptoms that cannot be managed in another setting. The applicable base payment is then adjusted for geographic differences in wages by multiplying the labor share, which varies by category, of each base rate by the applicable hospice wage index.[2]

As discussed above, CMS made several modifications to the hospice payment methodology in FY 2016. CMS implemented two different RHC payment rates: one for the RHC rate for the first 60 days and a second RHC rate for days 61 and beyond and SIA payment when direct patient care is provided by an RN or social worker during the last 7 days of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provider (up to 4 hours total) that occurred on the day of the service. As required by statute, the new RHC rates were adjusted by a SIA budget neutrality factor—a separate factor for days 1-60 and for 61 days and beyond.

In the FY 2017 Hospice final rule, CMS initiated a policy to apply a wage index standardization factor to hospice payment rates to ensure overall budget neutrality when updating the hospice wage index with more recent hospital wage data.[3] CMS uses the same approach in other payment settings such as under Home Health Prospective Payment System (PPS), Inpatient Rehabilitation Facility PPS, and Skilled Nursing Facility PPS. To calculate the wage index standardization factor, CMS simulated total payments using the FY 2022 hospice wage index

[2] In FY 2014 and for subsequent fiscal years, CMS uses rulemaking as the means to update payment rates (prior to FY 2014, CMS had used a separate administrative instruction), consistent with the rate update process for other Medicare payment systems.

[3] CMS uses 2020 claims data to calculate the wage index standardization factor (the most recent available). Due the potential effects of COVID-19 PHE, CMS examined whether using 2019 claims data would result in any significant differences but found minimal difference between using 2019 and 2021 claims data.

and compared it to its simulation of total payments using the FY 2021 hospice wage index. By dividing payments for each level of care using the FY 2022 wage index by payments for each level of care using the FY 2021 wage index, CMS obtained a wage index standardization factor for each level of care (RHC days 1-60, RHC days 61+, CHC, IRC, and GIP). CMS also calculates a labor share standardization factor that uses the current labor shares in compared to the FY 2022 revised labor shares.[4] These factors are shown in the tables below.

Tables 2 and 3 (reproduced below) lists the FY 2022 hospice payment rates by care category and the wage index standardization factors.

Table 2: FY 2022 Hospice RHC Payment Rates

Code	Description	FY 2021 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standard-ization Factor	Labor Share Standard-ization Factor	FY 2022 Hospice Payment Update	FY 2022 Payment Rates
651	Routine Home Care (days 1-60)	$199.25	× 1.0004	× 1.0001	× 0.9995	× 1.02	$203.40
651	Routine Home Care (days 61+)	$157.49	× 1.0005	× 1.0009	× 0.9992	× 1.02	$160.74

Table 3: FY 2022 Hospice CHC, IRC, and GIP Payment Rates

Code	Description	FY 2021 Payment Rates	Wage Index Standardization Factor	Labor Share Standardization Factor	FY 2022 Hospice Payment Update	FY 2022 Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care	$1,432.41	× 1.0004	× 1.0006	× 1.02	$1,462.52 ($60.94 per hour)
655	Inpatient Respite Care	$461.09	× 1.0014	× 1.0059	× 1.02	$473.75
656	General Inpatient Care	$1,045.66	× 1.0019	× 0.9997	× 1.02	$1,068.28

Tables 4 and 5 of the rule list the comparable FY 2022 payment rates for hospices that do not submit the required quality data under the Hospice Quality Reporting Program as follows: Routine Home Care (days 1-60), $199.41; Routine Home Care (days 61+), $157.58; Continuous Home Care, $1,433.84; Inpatient Respite Care, 464.46; and General Inpatient Care, $1,047.33.

[4] This factor is included in the table calculations because of the difference between the current and finalized labor shares in this year's rule.

4. Hospice Cap Amount for FY 2022

By background, when the Medicare hospice benefit was implemented, Congress included two limits on payments to hospices: an aggregate cap and an inpatient cap. The intent of the hospice aggregate cap was to protect Medicare from spending more for hospice care than it would for conventional care at the end-of-life, and the intent of the inpatient cap was to ensure that hospice remained a home-based benefit.[5] The aggregate cap amount was set at $6,500 per beneficiary when first enacted in 1983, and since then this amount has been adjusted annually by the change in the medical care expenditure category of the consumer price index for urban consumers (CPI-U).

As required by the Impact Act, beginning with the 2016 cap year, the cap amount for the previous year will be updated by the hospice payment update percentage, rather than by the CPI-U for medical care. This provision was scheduled to sunset for cap years ending after September 30, 2025 and revert to the original methodology, but this sunset provision was extended by the CCA of 2021 until September 30, 2030.

The hospice cap amount for the FY 2022 cap year will be $31,297.61, which is equal to the FY 2021 cap amount ($30,683.93) updated by the FY 2022 hospice payment update percentage of 2.0 percent.

D. Clarifying Regulation Text Changes for the Hospice Election Statement Addendum

In the FY 2020 Hospice final rule, CMS finalized modifications to the hospice election statement content requirements at §418.24(b) to increase coverage transparency for patients under a hospice election. These changes that went into effect in FY 2021, included a new condition for payment requiring a hospice, upon request, to provide the beneficiary (or representative) an election statement addendum (referred to as the "addendum") outlining the items, services, and drugs that the hospice has determined are unrelated to the terminal illness and related conditions. Section 418.24 (c) sets forth the elements that must be included on the addendum such as the name of the hospice; beneficiary's name and hospital medical record identifier; a list of the beneficiary's current diagnoses/conditions present on hospital admission and the associated items, services, and drugs, not covered by the hospice; and name and signature of the Medicare hospice beneficiary (or representative) and date signed.

Since its implementation on October 1, 2020, CMS has received additional inquiries from stakeholders asking for clarification on certain aspects of the addendum. In the proposed rule, CMS provided clarification on, and proposed modifications to, certain signature and timing requirements and proposing clarifying regulations text changes. As discussed below, CMS finalizes the clarifications and addendum regulation text as proposed, except for requiring the reason that the addendum is not signed to be documented in the patient's medical record.

CMS finalizes its proposal to allow the hospice to furnish the addendum within 5 days from the date of a beneficiary or representative request if the request is within 5 days from the date of a

[5] If a hospice's inpatient days (GIP and respite) exceed 20 percent of all hospice days, then for inpatient care the hospice is paid: (1) the sum of the total reimbursement for inpatient care multiplied by the ratio of the maximum number of allowable inpatient days to actual number of all inpatient days; and (2) the sum of the actual number of inpatient days in excess of the limitation by the routine home care rate.

hospice election. For example, if the patient elect's hospice on December 1st and request the addendum on December 3rd, the hospice would have until December 8th to furnish the addendum. In response to requests for a different timeline to furnish the addendum to the beneficiary (or representative) when requested after the first 5 days of a hospice election, CMS states it continues to believe that 3 days is an adequate amount of time for the hospice to furnish the addendum.

CMS also finalizes its proposal to clarify in regulation that the "date furnished" must be within the required timeframe (that is, 3 or 5 days of the beneficiary or representative request, depending on when such request was made), rather than the signature date. Specifically, at §418.24(c), CMS finalizes that the hospice will include the "date furnished" in the patient's medical record and on the addendum itself. This change provides additional flexibility to the hospice as the date that the hospice furnished the addendum to the beneficiary (or representative) may differ from the date that the beneficiary or representative signs the addendum. In response to comments, CMS notes there is nothing precluding hospices from furnishing an addendum through the mail. Hospices would need to make sure the "date furnished" on the addendum is within the required timeframe.

CMS also finalizes, with modification, its guidance regarding a potential situation wherein the beneficiary or representative refuses to sign the addendum (85 FR 47088). CMS proposed that if a patient or representative refused to sign the addendum, the hospice must document clearly on both the addendum and in the medical record the reason the addendum is not signed to mitigate a claims denial for this condition for payment. In response to comments, CMS finalizes that the reason the addendum is not sign must be clearly noted on the addendum but is not required to also be included in the patient's medical record.

CMS clarifies that if a non-hospice provider requests the addendum, rather than the beneficiary or representative, the non-hospice provider is not required to sign the addendum.

CMS also clarifies in its regulations instances in which the beneficiary or representative requests the addendum and the beneficiary dies, revokes, or is discharged prior to signing the addendum. These regulation text changes are reflected at §418.24(c), §418.24(d)(4), and §418.24(d)(5). In response to comments, CMS is also amending the regulation text at §418.24 to state that if the beneficiary dies, revokes election, is discharged prior to signing the addendum, or refuses to sign the addendum, the addendum would not be required to be signed for the hospice to receive payment. The hospice must note on the addendum the reason the addendum was not signed, and the addendum would become part of the patient's medical record.

CMS also finalizes conforming regulation text changes at §418.24(c) in alignment with subregulatory guidance indicating that hospices have "3 days," rather than "72 hours" to meet the requirements when a patient requests the addendum during a hospice election. CMS' stated intent of this clarification is to better align the timing of "furnishing" an addendum to when the addendum is "requested".

CMS will post an updated model election statement addendum on the Hospice Webpage.[6]

[6] Hospice Webpage: https://www,cms.gov/Medicare/MEdicare-Fee-for-Service-Payment/Hospice/index

E. Hospice Waivers Made Permanent Conditions of Participation

Considering the COVID-19 PHE and need to support provider and supplier communities, CMS notes that it issued an unprecedented number of regulatory waivers under its statutory authority set forth at section 1135 of the Act. CMS states that the utilization and application of these waiver pushed it to consider whether permanent regulatory changes for selected waivers would be beneficial to patients, providers, and professionals.

CMS finalizes its proposals for the following revisions to the hospice Conditions of Participation (CoPs).

Hospice Aide Training and Evaluation – Using Pseudo-patients

CMS finalizes its proposal to revise it hospice regulations at §418.76(c)(1) to permit skill competencies to be assessed by observing an aide performing the skill with either a patient or a pseudo-patient as part of a simulation. The regulations currently require the aide to be evaluated by observing an aide's performance of the task with a patient. The final definitions for "Pseudo-patient" and "Simulation" are defined at §418.3. In brief, a pseudo-patient means a person trained to participate in a role-play situation, or a computer-based mannequin device. A simulation means a training and assessment technique that mimics the reality of the homecare environment.

Hospice Aide Training and Evaluation – Targeting Correction of Deficiencies

CMS finalizes its proposal to amend the requirement at §418.76(h)(1)(iii) that if an area of concern is verified by the hospice during the on-site visit, then then hospice must conduct, and the hospice aide must complete, a competency evaluation of the deficient skill and all related skills. Currently, the aide would have to complete another full competency evaluation. CMS states that these changes permit the hospice to focus on the hospice aide's specific deficient and related skill(s) instead of completing another full competency evaluation.

Commenters were overwhelming supportive of CMS' proposals. One commenter did not support the use of pseudo-patient or target competency testing and suggested that more research and data be obtained prior to making a policy decision. CMS believes, and other commenters noted, that the use of pseudo-patients and simulation is an accepted standard of practice for healthcare training. CMS notes these same requirements were implemented for home health aide supervision in 2019 and no adverse impacts have been noted in CMS survey data.

In response to commenters requesting clarification about the use of technology-based visits outside of a PHE, CMS states that the temporary changes to the hospice payment requirements to provide flexibilities to furnish services using telecommunications technology will expire at the end of the COVID-19 PHE.[7] The use of telehealth for conducting the required hospice face-to-face encounter is statutorily limited to the PHE.[8]

[7] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 PHE (85 FR 19230).
[8] Section 1814(a)(1)(7)(D)(i) of the Act as amended by section 3707 of the Coronavirus Aid, Relief, and Economic Security Act (Pub. L 116-136).

F. Proposals and Updates to the Hospice Quality Reporting Program (HQRP)

1. Background and Statutory Authority

The Hospice Quality Reporting Program (HQRP) includes the Hospice Item Set (HIS) and the Consumer Assessment of Healthcare Providers and System (CAHPS). Section 1814(i)(5)(A)(i) of the Act requires that beginning in FY 2014, hospices that fail to meet quality data submission requirements will receive a two percentage point reduction to the market basket update. The Consolidation Appropriations Act of 2021 (CAA 2021)[9] changed the payment reduction for failing to meet these reporting requirements from 2 to 4 percent. Specifically, the Act requires that beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and beginning with FY 2024 annual payment update (APU) and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.

The CAA 2021 also removes the prohibition on public disclosure of hospice surveys performed by a national accreditation[10] and adds new requirements to require each state and local survey agency to submit information about any survey or certification made with respect to a hospice program; the Secretary is now allowed to disclose accreditation surveys. The CAA 2021 also requires each national accreditation body with an approved hospice accreditation program, to submit information about any survey or certification made for a hospice program.[11] This information includes any inspection report, any enforcement actions taken as a result of a survey or certification, and any other information the Secretary deems appropriate. No later than October 1, 2022, this information will be published on a CMS website, such as Care Compare. In addition, national hospice accreditation programs are required to use the same survey form used by state and local survey agencies (Form CMS-2567) on or after October 1, 2021.

Any measure selected by the Secretary must have been endorsed by the consensus-based entity holding a contract for performance measures (currently held by the National Quality Forum (NQF)). However, the Secretary may specify measures that are not endorsed as long as a feasible and practical measure has not yet been endorsed by the consensus-based entity and consideration is given to measures that have been endorsed by the consensus-based organization.

In the FY 2014 Hospice final rule (78 FR 48256), CMS finalized the HIS as the data collection mechanism for reporting HQRP measures. CMS also finalized that hospice providers are required to provide regular and ongoing electronic submission of the HIS data for each patient admission to hospice on or after July 1, 2014, regardless of payer or patient age. The CAHPS Hospice Survey is also a component of the HQRP. The CAHPS® Hospice Survey collects data on the experiences of hospice patients and the primary caregivers listed in the hospice record. The survey is administered after the patient is deceased and queries the decedent's primary, informal caregiver about the patient and family experience of care.

[9] Pub. L. 116-260
[10] Section 1865(5) of the Act
[11] Newly added section 1822(a)(2) of the Act.

Table 6 (reproduced below) lists all the quality measures planned for the FY 2022 HQRP.

Table 6: Quality Measures Planned for FY 2022 HQRP	
NQF Number	**Short Measure Name**
3235	Hospice and Palliative Care Composite Measure – HIS Comprehensive Assessment at Admission 1. Patients Treated with an Opioid who are Given a Bowel Regimen (NQF #1617) 2. Pain Screening (NQF #1634) 3. Pain Assessment (NQF #1637) 4. Dyspnea Treatment (NQF #1638) 5. Dyspnea Screening (NQF #1639) 6. Treatment Preferences (NQF #1641) 7. Beliefs/Values Addressed (if desired by the patient) (NQF #16477)
Claims-based Measures	
Not Applicable	Hospice Visits in Last Days of Life (HVLDL)
Not Applicable	Hospice Care Index (HCI) 1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided 2. Gaps in Skilled Nursing Visits 3. Early Live Discharges 4. Late Live Discharges 5. Burdensome Transitions (Type 1 – Live Discharge from Hospice Followed by Hospitalization and Subsequent Hospice Readmission 6. Burdensome Transitions (Type 2 – Live Discharge from Hospice Followed by Hospitalization with the Patient Dying in the Hospital 7. Per-beneficiary Medicare Spending 8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day 9. Skilled Nursing Minutes on Weekends 10. Visits Near Death
CAHPS Hospice Survey	
2651	CAHPS Hospice Survey (single measure) • Communication with Family • Getting timely help • Treating patient with respect • Emotional and spiritual support • Help for pain and symptoms • Training family to care for the patient • Rating of this hospice • Willing to recommend this hospice

In the FY 2016 Hospice final rule (80 FR 47142), CMS finalized the process for removing previously adopted measures which included seven factors for removal of a measure. In the FY 2019 Hospice final rule (83 FR 38622) CMS adopted an eighth factor for removal of a measure. The finalized reasons for removing quality measures are:

1. Measure performance among hospices is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made;
2. Performance or improvement on a measure does not result in better patient outcomes;
3. A measure does not align with current clinical guidelines or practice;

4. A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available;
5. A measure that is more proximal in time to desired patient outcomes for the particular topic is available;
6. A measure that is more strongly associated with desired patient outcomes for the particular topic is available;
7. Collection or public reporting of a measure leads to negative unintended consequences; or
8. The costs associated with a measure outweighs the benefits of its continued use in the program.

In the FY 2019 Hospice final rule (83 FR 38622), CMS began the Meaningful Measures Initiative to identify high priority areas for quality measurement and improvement.[12] This initiative is designed to improve outcomes for patients, their families, their providers and also reduce reporting burden.

In the FY 2020 Hospice final rule (84 FR 38484), CMS discussed the development of quality measures using claims data to expand the sources for quality measure development. CMS also discussed the development of the Hospice Outcomes & Patient Evaluation (HOPE), a new patient assessment instrument to replace the HIS (discussed below in section F.6).

In response to a comment about the proposed updates and the significant resources required to implement them doing the PHE, CMS acknowledges the potential burden related to the updates and notes it made no updates in the FY 2021 final rule. For FY 2022, CMS states that two of the four finalized measures are claims-based measures which do not increase provider burden and it has reduced the HQRP from 10 down to 4 measures. In addition, the public reporting in FY 2022 is no sooner than May 2022.

2. Removal of the Seven "Hospice Item Set (HIS) Process Measures" from HQRP Beginning FY 2022

Consistent with its policy for measure removal, CMS reviewed the HIS measures (listed below) against the factors for removal. CMS' analysis determined that these measures meet factor 4: a more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available. CMS determined NQF #3235 HIS Comprehensive Assessment Measure (listed above in Table 6) is a more broadly applicable measure and provides, in a single measure meaningful differences between hospices regarding overall quality for both physical and psychosocial needs at admission. In addition, MedPAC noted that the HIS Comprehensive Assessment Measure differentiates the hospice's overall ability to address care processes better than the seven individual HIS process measures.[13]

[12] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInititativesGenInfo/MMF/General-info-Sub-PAge.html.
[13] MedPAC. (2020). *Chapter 12: Hospice Services*. http://medpac.gov/docs/default-source/reports/mar20-medpac-ch12-sec.pdf.

CMS finalized its proposal to remove the seven individual HIS process measures from the HQRP no earlier than FY 2022 and to no longer publicly report them as individual measures on Care Compare. CMS notes that it does not propose any changes to the requirement to submit the HIS admission assessment. CMS will continue to include the seven HIS process measures in the confidential quality measure (QM) Reports. Hospices which do not report HIS data used for the HIS Comprehensive Assessment Measure will not meet the requirements for compliance with the HQRP.

HIS Process Measures		
NQF Number	**Measure Name**	**Year Date Collection Began**
1617	Patients Treated with an Opioid Who Are Given a Bowel Regimen	October 1, 2014
1634	Pain Screening	October 1, 2014
1637	Pain Assessment	October 1, 2014
1638	Dyspnea Treatment	October 1, 2014
1639	Dyspnea Screening	October 1, 2014
1641	Treatment Preferences	October 1, 2014
1647	Beliefs/Values Addressed (if desired by the patient)	October 1, 2014

The majority of commenters supported the removal of the seven HIS process measures. In response to concerns raised by those opposing the removal of these measures, CMS emphasizes that all but one of the HIS measures are topped out individually and one measure is almost topped out and shows insignificant variability between hospices. In contrast, the HIS Comprehensive Assessment Measure measures whether a hospice assesses each patient on the seven HIS measures. CMS states this distinction explains why most hospice receive the maximum possible score on each of the individual measures but not for the HIS Comprehensive Assessment Measure. CMS acknowledges MedPAC's recommendation to remove the HIS Comprehensive Assessment Measure because the scores suggest the composite measure is limited in distinguishing provider quality. CMS continues to believe that the single measure currently shows sufficient variability to differentiate hospices and provides valuable information to patients and providers. In addition, removing this measure would result in the HQRP not having an admission quality of care measure.

3. Addition of a "Claims-based Index Measure", the Hospice Care Index

The HCI is a single measure comprising ten indicators from Medicare claims data. CMS notes that each indicator represents either a domain of hospice care recommended by leading hospice and quality experts[14] or a requirement included in the hospice CoPs. CMS believes the HCI will help identify whether hospices have aggregate performance trends that indicate higher or lower quality of care relative to other hospices.

CMS notes that since the HCI is a claims-based measure it would not impose any new collection of information requirements. Additional information about the background of the HCI is available at https://youtube/by68E92cZc.

[14] 2019: Vulnerabilities in Hospice Care (Office of the Inspector General)

a. Specifications for the HCI Indicators

The final rule discusses the data files used and analyses performed to specify the indicators and measures. CMS also provides the information required to calculate each indicator, including the numerator and denominator definition, different thresholds for receiving credit toward the overall HCI score, and explanations for those thresholds. Each indicator equally affects the single HCI score, reflecting the equal importance of each aspect of care delivered, and will be aggregated into a single HCI score. Highlight of this discussion are provided below, including a table at the end of this section.

Indicator One: Continuous Home Care (CHC) or General Inpatient (GIP) Provided. Medicare Hospice CoPs require hospices to be able to provide both CHC and GIP levels of care as needed to manage more intense symptoms.[15] This indicator identifies hospices that provided at least one day of hospice care under the CHC or the GIP levels of care during the period examined.

The specifications for this indicator are:

- Numerator: The total number of CHC or GIP services days provided by the hospice within a reporting period.
- Denominator: The total number of hospice service days provided by the hospice at any level of care within a reporting period
- Index Earned Point Criterion: Hospices earn a point towards the HCI if they provided at least one CHC or GIP service day within a reporting period.

Indicator Two: Gaps in Nursing Visits. Medicare Hospice CoPs require a member of the interdisciplinary team to ensure ongoing assessment of patient and caregiver needs and plan of care implementation.[16] This indicator identifies whether a hospice is below the 90th percentile in how often hospice stays of at least 30 days contain at least one gap of eight or more days without a nursing visit.

The specifications for this indicator are:

- Numerator: The number of elections with the hospice where the patient experienced at least one gap between nursing visits exceeding 7 days, excluding hospice elections where the patient elected hospice for less than 30 days within a reporting period.
- Denominator: The total number of elections with the hospice, excluding hospice elections where the patient elected hospice for less than 30 days within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice score for gaps in nursing visits greater than 7 days falls below the 90th percentile ranking among hospices nationally.

Indicator Three: Early Live Discharges. CMS discusses evidence that indicates high rates of live discharge suggest concerns in hospices' care processes, their advance care planning to prevent hospitalizations, or their discharge processes. MedPAC also examined the rate of live discharges

[15] Special coverage requirements, Title 42, Chapter IV, Subchapter B, Part 418, §§418.204 and 418.302.
[16] §§418.56 and 418.57

and concluded that an unusually high rate of live discharges could signal a potential concern with the quality of care provided by a hospice.[17] This indicator identifies whether a hospice is below the 90th percentile in the percentage of live discharges that occur within 7 days of hospice admission during the FY examined.

The specifications for this indicator are:

- Numerator: The total number of live discharges from the hospice occurring within the first 7 days of hospice within a reporting period.
- Denominator: The total number of all live discharges from the hospice occurring within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice percentage of live discharges on or before the seventh day of hospice falls below the 90th percentile ranking among hospices nationally.

Indicator Four: Late Live Discharges. CMS discusses that the rate of live discharges that occur 180 days or more after hospice enrollment is another potential concerning pattern of hospice care. This indicator identifies whether a hospice is below the 90th percentile in the percentage of live discharges that occur on or after the 180th day of hospice.

The specifications for this indicator are:

- Numerator: The total number of live discharges from the hospice occurring on or after 180 days of enrollment in hospice within a reporting period.
- Denominator: The total number of all live discharges from the hospice within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice percentage of live discharges on or after the 180th day of hospice falls below the 90th percentile ranking among hospices nationally.

Indicator Five: Burdensome Transitions (Type 1) – Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission. The Type 1 burdensome transitions reflect hospice live discharge with a hospital admission within 2 days of hospice discharge, and then hospice readmission within 2 days of hospital discharge. CMS discusses how this pattern of care transition may lead to fragmented care and may be associated with a deficiency in advance care planning. This indicator identifies whether a hospice is below the 90th percentile in the percentage of live discharges that are followed by a hospitalization (within 2 days of hospice discharge) and then followed by a hospice readmission (within 2 days of hospitalization).

The specifications for this indicator are:

- Numerator: The total number of live discharges from the hospice followed by a hospital admission within 2 days, then hospice readmission within 2 days of hospital discharge hospice within a reporting period.
- Denominator: The total number of all live discharges from the hospice within a reporting period.

[17] MedPAC. (2020). *Chapter 12: Hospice Services*. http://medpac.gov/docs/default-source/reports/mar20_medpac_ch12_sec.pdf.

- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice score for Type 1 burdensome transitions falls below the 90th percentile ranking among hospices nationally.

Indicator Six: Burdensome Transitions (Type 2) – Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital. CMS discusses how death in a hospital following live discharge is another concerning quality indicator because this pattern may be associated with a discharge process that is not properly assessing a patient's condition prior to discharge. This indicator identifies whether a hospice is below the 90th percentile in the percentage of live discharges that are followed by a hospitalization (within two days of hospice discharge) and then dies in the hospital.

The specifications for this indicator are:

- Numerator: The total number of live discharges from the hospice followed by a hospital admission within 2 days of live discharge with death in the hospital within a reporting year.
- Denominator: The total number of all live discharges from the hospice within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice score for Type 2 burdensome transitions falls below the 90th percentile ranking among hospices nationally.

Indicator Seven: Per-beneficiary Medicare Spending. CMS notes that estimates of per-beneficiary spending are endorsed by NQF (#2158) and reported by CMS for other care settings. CMS believes that because the Medicare hospice benefit pays a per diem rate, an important determinant of per-beneficiary spending is the length of election. This indicator identifies whether a hospice is below the 90th percentile in the average Medicare hospice payments per beneficiary.

The specifications for this indicator are:

- Numerator: Total Medicare hospice payments received by a hospice within a reporting period.
- Denominator: Total number of beneficiaries electing hospice with the hospice within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their average Medicare spending per beneficiary falls below the 90th percentile ranking among hospices nationally.

Indicator Eight: Nurse Care Minutes per Routine Home Care (RHC) Day. Medicare Hospice CoPs require a member of the interdisciplinary team to ensure ongoing assessment of patient and caregiver needs.[18] This indicator identifies whether a hospice is above the 10th percentile in average number of nursing minutes provided on RHC days during the reporting period.

The specifications for this indicator are:

[18] CoPs §§418.56 and 418.76

- Numerator: Total skilled nursing minutes provided by a hospice on all RHC service days within a reporting period.
- Denominator: The total number of RHC days provided by hospice within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice score for Nursing Minutes per RHC day falls above the 10th percentile ranking among hospices nationally.

Indicator Nine: Skilled Nursing Minutes on Weekends. CMS discusses its regulations at §418.100(c) that require nursing services, physician services, drugs and biologicals to be routinely available on a 24-hour basis seven days a week. To assess hospice service available, this indicator includes minutes of care provided by skilled nurses on weekend RHC days.

The specifications for this indicator are:

- Numerator: Total sum of minutes provided by the hospice during skilled nursing visits during RHC services occurring on Saturdays or Sundays within a reporting period.
- Denominator: Total skilled nursing minutes provided by the hospice during the RHC service days within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice score for percentage of skilled nursing minutes provided during the weekend is above the 10th percentile ranking among hospices nationally.

Indicator Ten: Visits Near Death. CMS discusses how the end of life is typically the period in the terminal illness with the highest symptom burden. This indicator identifies whether a hospice is above the 10th percentile in the percentage of beneficiaries with a nurse and/or medical services visit in the last 3 days of life.

The specifications for this indicator are:

- Numerator: The number of decedent beneficiaries receiving a visit by a skilled nurse or social worker staff for the hospice in the last 3 days of the beneficiary's life within a reporting period.
- Denominator: The number of decedent beneficiaries served by the hospice within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice score for percentage of decedents receiving a visit by a skilled nurse or social worker in the last 3 days of life falls below the 10th percentile ranking among hospices nationally.

Hospice Care Index Indicator Summary		
Name	**Hospice Score Units**	**Index Earned Point Criteria**
Provided Continuous Home Care (CHC) or General Inpatient (GIP) Provided	% days	Hospice Score Above 0%
Gaps in nursing care	% elections	Below 90 Percentile Rank
Early live discharges	% live discharges	Below 90 Percentile Rank
Late live discharges	% live discharges	Below 90 Percentile Rank
Burdensome transitions, Type 1	% live discharges	Below 90 Percentile Rank
Burdensome transitions, Type 2	% live discharges	Below 90 Percentile Rank

Hospice Care Index Indicator Summary		
Name	**Hospice Score Units**	**Index Earned Point Criteria**
Per-beneficiary Medicare spending	dollars	Below 90 Percentile Rank
Nurse care minutes per routine home care day	minutes	Above 10 Percentile Rank
Skilled nursing minutes on weekends	% minutes	Above 10 Percentile Rank
Visits near death	% decedents	Above 10 Percentile Rank

b. Hospice Care Index Scoring Example

Each indicator equally affects the single HCI score, reflecting the equal importance of each aspect of care delivered, and will be aggregated into a single HCI score. A hospice's HCI score is based on its collective performance on the ten performance indicators; all must be included to calculate the score. Table 8 in the final rule illustrates how a hypothetical hospice's score is determined across all ten indicators, and how the ten indicators' scores determine the overall HCI score.

c. Measure Reportability, Variability, and Validity

CMS discusses the testing it performed during the development of the HCI using claims data from FY 2019. Reportability analyses found that over 85 percent of hospices would yield reportable measure scores over 1 year. Variability analysis found that HCI demonstrates sufficient ability to differentiate hospices. During measure testing, CMS observed hospices achieved scores between three and ten (Figure 1 in the final rule). Validity analysis showed that HCI scores aligned with the family caregivers' perception of hospice quality, as measured by CAHPS Hospice survey (NQF #2651).

CMS conducted a stability analysis by comparing index scores calculated for the same hospice using claims form FYs 2017 and 2019. This analysis found that 82.8 percent of providers' scores changed by, at most, one point over 2 years.

d. Stakeholder Support

CMS discusses the various methods it used to obtain stakeholder support, including a Technical Expert Panel (TEP) convened by its measure development contractor and five listening sessions with national hospice provider organizations. CMS notes that stakeholders were generally supportive of a quality measure based on claims data for public reporting. Several stakeholders raised concerns that claims data may not adequately reflect the quality of care provided and may be a better indicator for program integrity issues. After consideration of this input, CMS believes the benefits of proposing adoption of the HCI outweighs its limitations.

In addition, the NQF Measures Application Partnership (MAP) met in January 2021 and conditionally supported the HCI for rulemaking contingent on NQF endorsement.[19]

[19] The MAP final recommendations can be found at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=94893.

e. Form, Manner and Timing of Data Collection and Submission

CMS finalizes its proposal to begin reporting the HCI using existing claims data items no earlier than May 2022. CMS will revise the confidential QM report to include claims-based measure scores, including agency and national rates through the Certification and Survey Provider Enhanced Reports (CASPER) or the replacement system. To help hospices interpret this information CMS will include results of the individual indicators of the HCI score, details on the indicators, and HCI overall scores.

Several commenters supported the incorporation of the HCI because it will provide important information to beneficiaries and their families and will identify aberrant practices when comparing hospices. Many commenters acknowledged CMS' need to identify hospices with aberrant policies but provided alternatives, including the development of different measures or provide information in PEPPER reports instead of the HCI. CMS believes the HCI reflects quality and aberrant practices; CMS discusses the support for the HCI by the TEP, MedPAC, and the Office of the Inspector General. CMS notes that PEPPER reports are issued to hospices to support their compliance efforts related to potential improper payments and the HCI information needs to be publicly available on Care Compare. CMS appreciates comments expressing concern about the impact these measures may have on small and/or rural hospices. CMS will monitor HCI score trends to identify whether any regional or size-based variations suggest a need for measure revision. In response to comments wanting more time and information to replicate the analysis for HCI, CMS reiterates the process used (discussed above) for the development of the HIS measures.

CMS also briefly discusses comments outside of the scope of the proposal related to other members of the interdisciplinary team. CMS acknowledges concerns that the HCI does not account for the full interdisciplinary team, including spiritual care members, providing hospice care. It states that changing the claims data to provide new and useful information is outside the scope of this measure and that using the current claims data still provides useful information.

4. Updates on the Hospice Visits in the Last Days of Life (HVLDL) and Hospice Item Set V3.00

CMS discusses the process it used, including obtaining public comment, for replacing the Hospice Visits When Death is Imminent II (HVWDII) measure pair (Section O of the HIS V2.01) with the HVLDL measure. OMB approved this replacement from the discharge assessment and HIS V3.00 became effective on Feb 16, 2021 (OMB control number 0938-1153).

In response to comments expressing concern that the measure should recognize the full spectrum of disciplines involved in hospice care, CMS reiterates the need to develop claims-based measures using available information. CMS states it found that RN and medical social visits correlate well with the CAHPS quality measure for "would recommend" the hospice. In addition, CMS believes the visit measure aligns with the SIA as patients' needs typically surge as the end-of-life approaches and more intensive services are needed.

5. Revision of §418.312(b) Submission of Hospice Quality Reporting Program Data

To address the inclusion of administrative data and correct technical errors, CMS finalizes its proposal to revise the regulations at §418.312(b) by adding paragraphs (b)(1) through (3). Specifically, paragraph (b)(1) includes the existing language on the standardized set of admission and discharge items; paragraph (b)(2) requires collection of administrative data, such as Medicare claims data, used for hospice quality measures to capture services throughout the hospice stay and automatically meet the HQRP requirements at §418.306(b)(2); and paragraph 3 is a technical correction and includes the eight measure removal factors for the HQRP.

6. Update Regarding the Hospice Outcomes & Patient Evaluation (HOPE) Development

The HOPE is intended to help hospices better understand a patient's care needs throughout the dying process and contribute this information to the patient's plan of care. CMS states the HOPE will provide quality data for the HQRP through standardized data collection and provide additional clinical data that could inform future payment refinements. CMS notes that although the standardization of measures required for adoption under the IMPACT Act of 2014 is not applicable to hospices, it intends to include applicable standardized elements to hospices.

CMS anticipates that the HOPE will replace the HIS. It will continue the development of the HOPE assessment in accordance with the Blueprint for the CMS Measures Management System. CMS will provide updates and engagement opportunities on its website.[20]

CMS will consider the comments it received as it continues the development of HOPE.

7. Update on Quality Measure Development for Future Years

CMS discusses its process to develop new measures, including convening TEP for information gathering and feedback.[21] CMS is interested in exploring patient preferences for symptom management, addressing patient spiritual and psychosocial needs, and medication management in the development of quality measures.

CMS intends to develop additional claims-based measures that may allow beneficiaries and their family caregivers to make more informed hospice choices and to hold hospices more accountable for the care they provide. CMS is considering measures that include hospice services on weekends, transitions after hospice live discharge, Medicare expenditures per beneficiary (including non-hospice spending during hospice election) and post-mortem visits. CMS is also considering developing hybrid quality measures that would be calculated using claims, assessment (HOPE), or other data sources.

[20] https://www.cms.gov/MEdicare/Quality-Initiatives-PAtient-Assessment-Instruments/Hospice-QualityQuality-Reporting/HOPE.html

[21] Information about the TEP and future measure concepts can be found at https://www.cms.gov/files/document/202-hqrp-tep-summary-report.pdf.

CMS received many comments on a wide range of topics related to the development of future quality measures. CMS will consider these comments for future development of quality measures and the Meaningful Measures System Blueprint.

8. CAHPS Hospice Survey Participation Requirements for the FY APU and Subsequent Years

The CAHPS® Hospice Survey collects data on the experiences of hospice patients and the primary caregivers listed in the hospice record. The survey is administered after the patient is deceased and queries the decedent's primary, informal caregiver about the patient and family experience of care. The CAHPS® Hospice Survey measures were re-endorsed by NQF (NQF #2651) on November 20, 2020. Measures include 6 composite measures and 2 global rating measures.

Public Reporting of CAHPS Hospice Survey. These 8 measures are reported on Hospice Compare.[22] Prior to the COVID-19 public health emergency (PHE), CMS reported the most recent 8 quarters of data on the basis of a rolling average, with the oldest quarter of data removed for each data refresh with the most recent quarter of data added. The data is refreshed 4 times a year in February, May, August, and November. Given COVID-19 PHE exemptions[23], public reporting continues to be the most recent 8 quarters of data, excluding the exempted quarters – Quarter 1 and Quarter 2 of CY 2020.

Volume-based Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements. CMS previously finalized a volume-based exemption for CAHPS Hospice Survey Data Collection Reporting requirement for FY 2021 and subsequent years (84 FR 38526). CMS finalized that hospices with fewer than 50 survey-eligible decedents/caregivers in the specified reporting period are exempted from the CAHPS® Hospice Survey data collection and reporting requirements for the corresponding payment determination (corresponds to the CY data collection period). To qualify for this exemption, hospices have to submit an annual exemption request form. The exception request form is available on the CAHPS® Hospice Survey web site at htpp://www.hospiceCAHPSurvey.org.

Hospices that have a total count of more than 50 unique decedents/caregivers in the year prior to the data collection are eligible to apply for the size exemption. Any exemption granted would be valid for only one year and an exemption request would need to be submitted annually.

The key dates for the volume-based exception for the CAHPS® Hospice Survey are summarized in Table 9 (reproduced below).

Table 9: Size Exemption Key Dates for FY 2022 through 2026

Fiscal Year	Data Collection Year	Reference Year (Count total number of unique patients in this year)	Size Exemption Form Submission Deadline
2022	2020	2019	December 31, 2020
2023	2021	2020	December 31, 2021

[22] Hospice compare is available at https://www.medicare.gov/care-compare/.
[23] https://www.cms.gov/files/document/guidance-memo-exemptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.

Table 9: Size Exemption Key Dates for FY 2022 through 2026			
Fiscal Year	**Data Collection Year**	**Reference Year (Count total number of unique patients in this year)**	**Size Exemption Form Submission Deadline**
2024	2022	2021	December 31, 2022
2025	2023	2022	December 31, 2023
2026	2024	2023	December 31, 2024

Newness Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements. CMS previously finalized a one-time newness exemption for hospices that meet the criteria (81 FR 52181). Specifically, hospices that are notified about their Medicare CCN after January 1, 2021 are exempted from the FY 2023 APU CAHPS® Hospice Survey requirement due to newness. CMS notes no action is required by the hospice to receive this exemption. The newness exemption is a one-time exemption from the survey. CMS encourages hospices to keep the letter providing them with their CCN.

Survey Participation Requirements. To meet participation requirements for a given year APU, Medicare certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from the corresponding FY reporting period. Table 10 (reproduced below) provides the deadlines for data submission for FYs 2023 through 2025. CMS notes there are no late submissions after the deadline, except for extraordinary circumstances beyond the control of the provider.

Table 10: CAHPS® Hospice Survey Data Submission Dates for the APUs in FYs FY 2023-2025	
Sample Month[1]	**Quarterly Data Submission Deadlines[2]**
FY 2023 APU	
January-March 2021 (Q1)	August 11, 2021
Monthly data collection April-June 2021 (Q2)	November 10, 2021
Monthly data collection July-September 2021 (Q3)	February 9, 2022
Monthly data collection October-December 2021(Q4)	May 11, 2022
FY 2024 APU	
January-March 2022 (Q1)	August 10, 2022
Monthly data collection April-June 2022 (Q2)	November 9 2022
Monthly data collection July-September 2022 (Q3)	February 8, 2023
Monthly data collection October-December 2022 (Q4)	May 130 2023
FY 2025 APU	
January-March 2023 (Q1)	August 9, 2023
Monthly data collection April-June 2023 (Q2)	November 8, 2023
Monthly data collection July-September 2023 (Q3)	February 14, 2024
Monthly data collection October-December 2023(Q4)	May 8, 2024
[1]Data collection for each sample month initiates two months following the month of patient death (for example, in April for deaths occurring in January). [2]Data submission deadlines are the second Wednesday of the submission month, which are August, November, February, and May.	

For direct question CMS encourages hospices to contact the CAHPS Hospice Survey Team at hospiceCAHPSsurvey@HCQIS.org or call 1-844-272-4621.

Proposal to Add CAHPS Hospice Survey Star Ratings to Public Reporting. CMS finalizes its proposal to introduce Star Ratings for public reporting of CAHPS Hospice Survey results on the Care Compare or successor website no sooner than FY 2022. The star ratings would be similar to that of other CAHPS Star Rating programs such as the Hospital CAHPS or Home Health CAHPS. The stars would range from one star (worst) to five stars (best).

CMS finalizes its proposal that the stars will be calculated based on "top-box" scores for each of the eight survey measures. Specifically, individual-level responses would be scored such that the most favorable response is scored 100 and all other responses are scored as 0. A hospice-level score for a given item would then be calculated as the average of the individual-level responses, with adjustment for differences in case mix and mode of survey administration. For a composite measure, the hospice-level measure score is the average of the hospice-level scores for each item within the measure. Similar to other programs, CMS finalizes that the cut-points used to determine the stars will be constructed using statistical clustering procedures that minimize the score differences within a star category and maximize the differences across star categories. CMS discusses the two-stage approach it will use to calculate these cut-points.

CMS also finalizes its proposal to calculate a summary of overall CAHPS Hospice Survey Star Rating by averaging the Star Ratings across the eight measures. CMS finalizes a weight of ½ for Rating of the Hospice, a weight of ½ for Willingness to Recommend the Hospice, and a weight of 1 for each of the other measures; the total would be rounded to a whole number. CMS finalizes that only the overall Star Rating would be publicly reported, and hospices must have a minimum of 75 completed surveys to be assigned a Star Rating. The details of the Star Ratings methodology will be published on the CAHPS Hospice Survey website (www.hospicecahpssurvey.org).

Many commenters suggested that the display of the star ratings be delayed to provide additional opportunities for providers to learn about and comment on the details of the methodology. CMS notes that it had not finalized a timeline and it will provide multiple opportunities to share information and receive comments from stakeholders. In response to specific comments about the methodology, CMS reviews the data analysis performed supporting its final methodology for the star ratings. CMS will also explore the feasibility of conducting a dry run of the star ratings with reporting to hospices via preview reports which would occur prior to the start of the public display of ratings.

9. Form, Manner, and Timing of Quality Data Submission

Section 1814(i)(5)(A)(i) of the Act requires that each hospice submit data to the Secretary in a form and manner specified by the Secretary.

Three timeframes for both HIS and CAHPS are important for HQRP Compliance: (1) the reporting year HIS and data collection year for CAHPS; (2) payment FY; and the reference Year. Table 11 (reproduced below) summarizes these three timeframes.

Table 11: HQRP Reporting Requirements and Corresponding Annual Payment Updates		
Reporting Year for HIS and Data Collection Year for CAHPS	**Annual Payment Update (APU) Impacts Payment for the FY**	**Reference Year for CAHPS Size Exception**
CY 2020	FY 2022 APU	CY 2019
CY 2021	FY 2023 APU	CY 2020
CY 2022	FY 2024 APU*	CY 2021
CY 2023	FY 2025 APU	CY 2022
*Beginning in FY 2024 and all subsequent years, the payment penalty is 4 percent. Prior to FY 2024, the payment penalty is 2 percent.		

Hospices must comply with CMS' submission data requirements. Table 12 (reproduced below) summarizes the HQRP compliance timeliness threshold requirements for a specific FY APU. CMS states that most hospices that fail to meet HQRP requirements miss the 90 percent threshold.

Table 12: HQRP Compliance Checklist		
Annual Payment Update	**HIS**	**CAHPS**
FY 2022	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admission/discharges occurring 1/1/20 – 12/3/2020	Ongoing monthly participation in the Hospice CAHPS survey 1/1/20 – 12/31/2020
FY 2023	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admission/discharges occurring 1/1/22– 12/3/2021	Ongoing monthly participation in the Hospice CAHPS survey 1/1/21 – 12/31/2021
FY2024	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admission/discharges occurring 1/1/22 – 12/3/2022	Ongoing monthly participation in the Hospice CAHPS survey 1/1/22 – 12/31/2022

In the FY 2020 Hospice final rule, CMS finalized its plans for migrating the systems used for submitting processing assessment data. HIS data is submitted using the Quality Improvement and Evaluation System (QIES) Assessment and the Submission Processing (ASAP) system. CMS continues to develop a new internet Quality Improvement and Evaluation System (iQIES) for data submission for the HQRP. CMS plans to provide updates about the system migration through subregulatory mechanisms such as web page postings, listserv messaging, and webinars.

10. Public Display of "Quality Measures and Other Hospice Data for the HQRP

Section 1814(i)(5)(E) of the Act requires the Secretary to establish any quality data submitted by hospices available to the public. To meet this requirement, CMS launched Hospice Compare in 2017. In September 2020, CMS transitioned Hospice Compare to the Care Compare website; Hospice Compare was discontinued in December 2020. In addition to the publicly reported quality data, in 2019, CMS added information about the hospices characteristics including diagnoses, location of care and levels of care provided by a hospice.

a. Proposal Regarding Data Collection and Reporting During a PHE

During the PHE, CMS granted an exemption to the HQRP reporting requirements for Quarter 4 (Q4) 2019 (October 1, 2019 through December 31, 2019), Quarter 1 (Q1) 2020 (January 1, 2020 through March 30, 2020) and Quarter 2 (Q2) 2020 (April 1, 2020 through June 30, 2020). This exemption impacted the public reporting schedule. HIS measures have been reported using four quarters of data and CAHPS measures are reported using eight rolling quarters of data. Table 13 (reproduced below) displays the original schedule for public reporting prior to the PHE.

Table 13: Original Public Reporting Schedule with Refreshes Affected by PHE Exceptions for the HQRP

Quarter Refresh	HIS Quarters in Original Schedule for Care Compare	CAHPS Quarters in Original Schedule for Care Compare
*November 2020	Q1 2019 – Q4 2019	Q1 2018 – Q4 2019
*February 2021	Q2 2019 – Q1 2020	Q2 2018 – Q1 2020
*May 2021	Q3 2019 – Q2 2020	Q3 2018 – Q2 2020
*August 2021	Q4 2019 – Q3 2020	Q4 2018 – Q3 2020
*November 2021	Q1 2020 – Q4 2020	Q1 2019 – Q4 2020
*February 2022	Q2 2020 – Q1 2021	Q2 2019 – Q1 2021
**May 2022	Q3 2020 – Q2 2021	Q3 2019 – Q2 2021
**August 2022	Q4 2020 – Q3 2021	Q4 2019 – Q3 2021
**November 2022	Q1 2021 – Q4 2021	Q1 2020 – Q4 2021
**February 2023	Q2 2021 – Q1 2022	Q2 2020 – Q1 2022
**May 2023	Q3 2021 – Q2 2022	Q3 2020 – Q2 2022
*Exception affects both HIS and CAHPS data for refresh. ** Exception affects only CAHPS data for refresh		

As discussed below, CMS conducted testing to inform decisions about publicly reporting data for those refreshes which include exempted data. CMS used this information to develop a plan for posting data as early as possible, for as many hospices as possible, and with scientific acceptability.

Update on Use of Q4 2019 Data and Data Freeze for Refreshes in 2021. CMS discusses the analysis it performed on data submitted for Q4 2019, which ended before the onset of the U.S. COVID-19 PHE. CMS observed that the HIS data submission rate for Q4 2019 was 1.8 percent higher than the previous CY (Q4 2018). For the CAHPS Hospice Survey, 2.1 percent more hospices submitted data in Q4 2019 than in Q4 2018. Based on these results, CMS proceeded with including these data in measure calculations for the November 2020 refresh.

CMS determined that it would not use HIS or CAHPS data from Q1 and Q2 2020 for public reporting because it did not have an adequate amount of data to reliably calculate and publicly display provider measure scores. CMS decided to freeze the data displayed – holding the data constant after the November 2020 refresh without subsequently updating the data through November 2021.[24]

Public Reporting of HIS-based Measures with Fewer than Standard Numbers of Quarters Due to PHE Exemption in February 2022. CMS is concerned that the November 2020 refresh data will

[24] See https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assesment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices.

become increasingly out-of-date and less useful. To provide updated information, CMS analyzed whether it could use fewer quarters of data for the last refresh affected by the exemption (February 2020) and more quickly resume public reporting of updated quality data. CMS discusses its analysis in the proposed rule and its findings that it could use fewer quarters of data for HIS data reporting.

CMS finalizes its proposal to resume public reporting of HIS quality measures in February 2022 using data from Q3 and Q4 of 2020 and Q1 of 2021 (Table 17, reproduced below).

Table 17: Original, Revised and Proposed Schedule for Refreshes Affected by PHE Exemptions		
Original Refresh	**HIS Quarters in Original Schedule for Care Compare (number of quarters)**	**HIS Quarters in Revised/Proposed Schedule for Care Compare (number of quarters)**
November 2020	Q1 2019 – Q4 2019 (4)	Q1 2019 – Q4 2019 (4)
February 2021	Q2 2019 – Q1 2020 (4)	Q1 2019 – Q4 2019 (4)*
May 2021	Q3 2019 – Q2 2020 (4)	Q1 2019 – Q4 2019 (4)
August 2021	Q4 2019 – Q3 2020 (4)	Q1 2019 – Q4 2019 (4)
November 2021	Q1 2020 – Q4 2020 (4)	Q1 2019 – Q4 2019 (4)
February 2022	Q2 2020 – Q1 2020 (4)	Q3 2020 – Q1 2021(3)
*The gray shading refers to the frozen quarters.		

CMS disagrees with suggestions that it posts a statement on Care Compare that the data displayed included care provided during the COVID-19 PHE. CMS states a notice will not help consumers distinguish care between hospices in their region and the posted information will help consumers understand relative performance at national and local levels during the PHE.

Public Reporting of "CAHPS Hospice Survey-based Measures" Due to the PHE Exemption. CMS finalizes its proposal that starting with the February 2022 refresh, CMS will display the most recent 8 quarters of CAHPS Hospice Survey data, excluding Q1 and Q2 2020. CMS will resume public reporting by displaying 3 quarters of post-exemption data, plus five quarters of pre-exemption data (Table 18, reproduced below).

CMS analyzed whether it could use fewer quarters of data for the last refresh affected by the exemption and more quickly resume public reporting of updated quality data. CMS found that using fewer than 8 quarters of data would reduce the proportion of hospices that would have the CAHPS Hospice Survey data displayed and that the overall reliability of the CAHPS scores declines with fewer quarters of data.

Table 18: CAHPS Hospice Survey Public Reporting Quarter During and After the Freeze	
Refresh	Publicly Reported Quarters
Freeze:	Q1 2018– Q4 2019
November 2020 – November 2021*	
February 2022	Q4 2018 – Q4 2019, Q3 2020 – Q1 2021
May 2022	Q1 2019 – Q4 2019, Q3 2020 – Q2 2021
August 2022	Q2 2019 – Q4 2019, Q3 2020 – Q3 2021
November 2022	Q3 2019 – Q4 2019, Q3 2020 – Q4 2021
February 2023	Q4 2019, Q3 2020 – Q1 2022
May 2023	Q3 2020 – Q2 2022
*The gray shading refers to the frozen quarters.	

CMS will take into consideration the suggestion that Care Compare provide information to users explaining that the published data included pre-COVID quarters.

b. Quality Measures to be Displayed on Care Compare in FY 2022 and Beyond

Removal of the seven "HIS process measures" from public reporting. As discussed above, CMS finalizes its proposal to remove the seven HIS process measures from the HQRP. CMS will remove the seven HIS process measures no earlier than the May 2022 refresh from public reporting on Care Compare and from the Preview Reports. CMS will continue to make the information available in the data catalogue.

CMS disagrees with comments suggesting it continue to provide information about the individual HIS measures on Care Compare. CMS does not believe this information will add value to consumers because the individual measures do not demonstrate whether the hospice provides high-quality care overall. It believes the HIS Comprehensive Assessment Measure differentiates hospices by holding them accountable for completing all seven process measures to ensure core hospice services are completed for all patients.

Calculating and publicly reporting "claims-based measure" as part of the HQRP. CMS discusses its methodology for calculating and reporting claims-based measures, with specific applications to HVLDL and HCI.

First, CMS finalizes its proposal to extract claims data to calculate claims-based measures at least 90 days after the last discharge date in the applicable period for quality measure calculations and public reporting on Care Compare. For example, if the last discharge date in the applicable period for a measure is December 31, 2022, for data collection January 1, 2022 through December 31, 2022, CMS will create the data extract on March 31, 2023, at the earliest. CMS will use this data to calculate and publicly report the claims-based measures for the 2022 reporting period. CMS notes this methodology is similar to those finalized in other PAC settings.

CMS notes that to implement this process, hospices will not be able to submit corrections to the underlying claims snapshot or add claims at the conclusion of the 90-day period following the last date of discharge used in the applicable period. Hospices will need to ensure the completeness and correctness of their claims prior to the claims "snapshot".

Second, CMS finalizes its proposal to update the claims-based measures annually. This update schedule aligns with most claims-based measures across PAC settings.

Third, CMS finalizes its proposal to calculate claims-based measure scores based on one or more years of data. CMS discusses the analysis it conducted to look at multiple years of reporting data. Based on this analysis, CMS proposed using 2 years of data to publicly report HCI and HVLDL in 2022 (Figures 2 in final rule). CMS plans to consider multiple years of data for other claims-based measures proposed in future years.

CMS agrees with comments that there is a lag time between the delivery of care and the calculation and reporting of the claims-based quality measures, but this time is needed to ensure accurate publication of the data. Some commenters supported CMS' proposal to use two years of data for reporting HVLDL and HCI; other commenters suggested using a 1-year time frame. CMS agrees that there are benefits to reporting just one year of data, but it needs to achieve a balance between reporting less time data with the need to be more inclusive of smaller hospices. In response to comments requesting CMS to consider quarterly updates instead of an annual update, CMS discusses its analysis that demonstrates that quarterly updates would not necessarily provide meaningful support to hospices seeking improvement in the quality of care.

Publicly Report the Hospice Care Index and "Hospice Visits in the Last Days of Life" Claims-based Measures. CMS finalizes its proposal to publicly report the HCI and HVLDV beginning no earlier than May 2022 using FY 2021 Medicare hospice claims data. It will also include this information in the Preview Reports no sooner than the May 2022 refresh. The publicly-reported HCI on Care Compare will only include the final HCI score and not the component indicators. The Preview Reports will reflect the HCI as publicly reported.

In response to comments requesting more time before measures are publicly reported, CMS believes there is sufficient time for hospice providers to understand and prepare for public reporting if it begins in May 2022. CMS states that it is committed to providing time for understanding and preparation, but it is not committed to ensuring all hospices achieve high scores on the new measures before publicly reporting them. CMS agrees with comments recommending simple language on Care Compare to ensure consumers can appropriately interpret quality information. CMS' measure development contractor has convened two small care giver workgroups to obtain feedback and it will continue to apply information provided by these groups as it refines plans for the public display of information.

Update on Publicly Reporting for the "Hospice Visits When Death is Imminent (HVWDII) Measure 1" and the Hospice Visits in the Last Days of Life (HVLDL) Measure". Because of the data freeze during the PHE, HVWDII Measure II data from the November 2020 refresh, covering HIS admissions during Q1 through Q4 2019, will be publicly displayed for all 2021 refreshes.

d. Update on Additional Information on Hospices for Public Reporting

CMS discusses the improvements to data tools to help Medicare beneficiaries compare costs. Beginning with 2017 data, the Medicare Provider Utilization and Payment Data: Hospice Public Use File (PUF) is public as part of the Post-Acute Care and Hospice Provide Utilization and Payment PUF (PAC PUF).

G. January 2022 Home Health (HH) Quality Reporting Program (QRP) Public Reporting Display Schedule with Fewer than Standard Number of Quarters Due to PHE Exemptions

To meet the January 2022 public reporting refresh cycle for home health facilities, CMS finalizes its proposal to use three quarters instead of four quarters for the January 2022 refresh affecting Outcome and Assessment Information Set (OASIS) based measures. For some claims-based

measures, CMS finalizes its proposal to use three quarters instead of four quarters for refreshes between January 2022 and July 2024. CMS will not make any changes for the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS). CMS will publicly report the most recently available four quarters of the HHCAHPS for these refresh cycles.

1. Proposal to Modify HH QRP Public Reporting to Address Data Exception During the PHE

During the PHE, CMS granted an exemption to the HH QRP reporting requirements for Quarter 4 (Q4) 2019 (October 1, 2019 through December 31, 2019), Quarter 1 (Q1) 2020 (January 1, 2020 through March 30, 2020) and Quarter 2 (Q2) 2020 (April 1, 2020 through June 30, 2020).[25] This exemption applied to the HH QRP OASIS-based measures, claims-based measures, and HHCAHPS survey.

Under the current HH QRP public display policy, Home Health Compares uses four quarters of data for OASIS-based measures and four or more quarters of data for claims-based measures. CMS uses four rolling quarters of data for HHCAHPS Survey measures on Care Compare. Table 20 in the final rule displays the original schedule for public reporting with refreshes of OASIS and HHCAHPS Survey measures prior to the Q1 and Q2 2020 data impacted by the PHE.

As discussed below, CMS conducted testing to inform decisions about publicly reporting data for those refreshes which include exempted data. CMS used this information to develop a plan for posting data as early as possible, for as many home health agencies as possible, and with scientific acceptability.

2. Update on Use of Q4 2019 HH QRP Data and Data Freeze for Refreshes in 2021

CMS discusses the analysis it performed on data submitted for Q4 2019, which ended before the onset of the U.S. COVID-19 PHE. CMS observed that the quality data submission rate for Q4 2019 was 0.4 percent higher than in Q4 2018. Based on these results, CMS proceeded with including these data in measure calculations for the October 2020 refresh.

Because CMS excepted HHAs from the reporting requirements for Q1 and Q2 2020, CMS did not use OASIS, claims or HHCAHPS data from these quarters. CMS did not have an adequate amount of data to reliably calculate and publicly display this information. CMS decided to freeze the data displayed – holding the data constant after the October 2020 refresh without subsequently updating the data through October 2021.[26]

3. Application of the COVID-19 PHE Affected Reporting (CAR) Scenario to Publicly Display Certain HH QRP Measures (Beginning in January 2022 through January 20214) Due to the PHE

[25] https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.
[26] https://www.cms.gov/files/document/hhqrp-pr-tip-sheet081320final-ex-508.pdf.

CMS finalizes its proposal to use the CAR scenario[27] for refreshes for January 2022 for OASIS and for refreshes from January 202 through July 2024 for some claims-based measures. CMS discusses its analysis and findings demonstrating it can use three quarters instead of four quarters of data for OASIS measures and for some claims-based measures for public reporting of data (Table 21).

The January 2022 refresh will allow CMS to begin displaying recent data in January 2022 instead of continuing to display October 2019 data (Q1 2019 through Q4 2019). Tables 22 and 23 (reproduced below) summarize the comparison between the original schedule for public reporting with the revised schedule for OASIS- and claims-based measures, respectively.

Table 22: Original, Revised and Proposed Schedule for Refreshes Affected by PHE Exceptions for the HH OASIS-based QMs

Quarter Refresh	OASIS Quarters in Original Schedule for Care Compare (number of quarters)	OASIS Quarters in Revised/Proposed Schedule for Care Compare (number of quarters)
October 2020	Q1 2019 – Q4 2019 (4)	Q1 2019– Q4 2019 (4)
January 2021	Q2 2019 – Q1 2020 (4)	Q1 2019 – Q4 2019 (4)
April 2021	Q3 2019 – Q2 2020 (4)	Q12019 – Q4 2020 (4)
July 2021	Q4 2019 – Q3 2020 (4)	Q1 2019 – Q4 2020 (4)
October 2021	Q1 2020 – Q4 2020 (4)	Q1 2019 – Q4 2020 (4)
January 2022*	Q2 2020 – Q1 2021 (4)	Q3 2020– Q1 2021 (3)

Note: The shaded cells represent data frozen due to the PHE.
*OASIS data with 3 versus 4 quarters of data.

Table 23: Original, Revised, and Example Schedule for Refreshes Affected by PHE Exceptions for HH Claims-based QMs

Quarter Refresh *Dates are for example only---Actual Dates will be provided sub-regulatory	Claims-based Quarters in Original Schedule for Care Compare (number of quarters)	Claims-based Quarters in revised/proposed Schedule for Care Compare (number of quarters) *Quarters are for example only---Actual Quarters will be provided sub-regulatory
October 2020	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)
January 2021	ACH, ED Use: Q2 2019- Q1 2020 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)
April 2021	ACH, ED Use: Q3 2019-Q2 2020 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)
July 2021	ACH, ED Use: Q4 2019- Q3 2020 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)

[27] For the CAR scenario, CMS calculated quality measures using Q2 2019, Q3 2019, Q4 2019 data to stimulate using only Q3 2020, Q4 2020, and Q1 2021 data for public reporting.

October 2021	ACH, ED Use: Q1 2020- Q4 2020 (4) DTC, MSPB: Q1 2019- Q4 2020 (8) PPR: Q1 2018- Q4 2020 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)
January 2022*	ACH, ED Use: Q2 2020-Q1 2021 (4) DTC, MSPB: Q1 2019- Q4 2020 (8) PPR: Q1 2018- Q4 2020 (12)	ACH, ED Use: Q3 2020-Q1 2021 (3) DTC, MSPB: Q1 2019- Q4 2019; Q3 2020 –Q4 2020 (6) PPR: Q1 2018-Q4 2019 Q3 2020 – Q4 2020 (10)
October 2022*	ACH, ED Use: Q1 2021-Q4 2021 (4) DTC, MSPB: Q1 2020- Q4 2021 (8) PPR: Q1 2019- Q4 2021 (12)	ACH, ED Use: Q1 2021-Q4 2021 (4) DTC, MSPB: Q3 2020 –Q4 2020 (6) PPR: Q1 2019-Q4 2019 Q3 2020 – Q4 2021 (10)
October 2023*	ACH, ED Use: Q1 2022-Q4 2022 (4) DTC, MSPB: Q1 2021- Q4 2022 (8) PPR: Q1 2020- Q4 2022 (12)	ACH, ED Use: Q1 2022-Q4 2022 (4) DTC, MSPB: Q1 2021- Q4 2022; (8) PPR: Q3 2020-Q4 2020 Q1 2021 – Q4 2022 (10)
October 2024†	ACH, ED Use: Q1 2023-Q4 2023 (4) DTC, MSPB: Q1 2022- Q4 2023 (8) PPR: Q1 2021- Q4 2023 (12)	ACH, ED Use: Q1 2023-Q4 2023 (4) DTC, MSPB: Q1 2022- Q4 2023 (8) PPR: Q1 2021- Q4 2023 (12)
Note: The shared cells represent data frozen due to PHE. DTC, MSPB and PPPR measures are updated annually in October. *Refreshes with few quarters of certain claims data. † Refreshes with the original public reporting schedule resuming for claims data.		

Commenters supported HH QRP resuming in January 2022. CMS does not agree with the suggestion that a statement is needed on Care Compare explaining the inclusion of data from the COVID-19 PHE. CMS does not believe this information will help consumers distinguish between HHAs in their region.

4. Update to the Public Display of the HHCAHPS Measures Due to the PHE Exception

The PHE exception for HHCCAHPS measures applied to Q1 and Q2 of 2020 and resulted in the freezing of the public display using Q1 2019 through Q4 2019 data for refreshes from October 2020 through October 2021. Beginning with January 2022, CMS will resume reporting four quarters of HHCAHPS data; the data for the January 2022 refresh are Q3 2020 through Q2 2021. These are the same quarters that would have been publicly displayed in the absence of the PHE. Table 24 (reproduced below) summarizes the display of the HHCAHPS measures.

Table 24: HHCAHPS Public Reporting Quarter During and After the Freeze

Refresh	**Publicly Reported Quarters**
Freeze:	Q1 2019 – Q4 2019
October 2020 – October 2021*	Q1 2019 – Q4 2019
January 2022**	Q3 2020 – Q2 2021
April 2022	Q4 2020 – Q3 2021
July 2022	Q1 2021 – Q4 2021
October 2022	Q2 2021 – Q1 2022
January 2023	Q3 2021 – Q2 2022
April 2023	Q4 2021 – Q3 2022
July 2023	Q1 2022 – Q4 2022
*The gray shading refers to the frozen quarters.	

**Resume rolling of most recent four rolling quarters of data. These are the same rolling quarters that would have been displayed in the absence of the PHE.

III. Requests for Information

A. Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement (dQM) in CMS Quality Programs

CMS requested input into the agency's planning for transformation to a fully digital quality enterprise, and specifically asked about the following:

- EHR/IT systems currently used by commenters and if they participate in a health information exchange (HIE);
- How commenters share information currently with other providers;
- Approaches by which CMS could incent or reward commenters who use health information technology (HIT) in innovative ways to reduce burden for post-acute settings, including but not limited to hospice providers;
- Resources and tools for use by hospices (and other post-acute care providers) and HIT vendors to facilitate interoperable, fully electronic health information sharing that incorporates FHIR standards and secure application programming interfaces (APIs); and
- Willingness of HIT vendors who work with hospices (and other post-acute care providers) to participate in pilots or models that align measure collection standards across care settings (e.g., sharing patient data via secure FHIR-based APIs for calculating and reporting digital measures).

CMS received many comments expressing support to the adoption of a standardized definition of dQM in the hospice setting and the use of FHIR to support quality measurements in the HQRP. Commenters noted that the variation among FHIR systems could impede the adoption of a standard system across hospices. Commenters also expressed concerns about the lack of interoperability capabilities of EHR vendor systems and encouraged adoption of FHIR APIs for health IT vendors. Many commenters emphasized that financial incentives would encourage adoption of new HIT systems. CMS will consider these comments as it considers FHIR in support of dQM.

B. Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs

CMS requested public comment on the possibility of expanding measure development and adding aspects of standardized patient assessment data elements (SPADEs) that could apply to hospice and address gaps in health equity in the HQRP.

- Recommendations for quality measures, or measurement domains that address health equity, for use in the HQRP.
- Suggested parts of social determinants of health SPADEs adoption that could apply to hospice in alignment with national data collection and interoperable exchange standards. CMS is seeking guidance on any additional items, including SPADEs that could be used to assess health equity in the care of hospice patients, for use in the HQRP.

- Ways CMS can promote health equity in outcomes among hospice patients. We are also interested in feedback regarding whether including facility-level quality measure results stratified by social risk factors and social determinants of health (for example, dual eligibility for Medicare and Medicaid, race) in confidential feedback reports could allow facilities to identify gaps in the quality of care they provide.
- Methods that commenters or their organizations use in employing data to reduce disparities and improve patient outcomes, including the source(s) of data used, as appropriate.
- Existing challenges providers' encounter for effective capture, use, and exchange of health information, such as data on race, ethnicity, and other social determinants of health, to support care delivery and decision making.

CMS received many comments about the use of standardized patient assessment data in the hospice setting to assess health equity and social determinants of health (SDOH). Commenters recommended CMS only utilize certain aspects of standardized data elements for patient assessment in collecting health equity data; other commenters were concerned that the standardized data elements for patient assessment do not capture SDOH. Commenters also provided additional factors that CMS should consider when collecting SDOH. CMS will consider these comments as it considers future development and expansion of its health equity quality measurement efforts.

IV. Waiver of Proposed Rulemaking

Normally, CMS publishes a notice of proposed rulemaking in the Federal Register and invite public comment on the proposed rule before the provisions of the rule are finalized, either as proposed or as amended in response to public comments, in accordance with the Administrative Procedures Act (APA) (5 U.S.C. 553), and where applicable, section 1871 of the Act. CMS can waive these procedures, if it finds good cause that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

CMS revises the provisions at §418.306(b)(2) to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. This policy will apply beginning with the FY 2024 annual payment update. CMS noted this revised statutory requirement in the proposed rule. Although it received comments, this update is statutorily required and self-implementing. Notice and comment are unnecessary because CMS is conforming the regulation to statute and there is no discretion on the part of the Secretary.

V. Regulatory Impact Analysis

CMS states that the overall impact of this final rule is an estimated net increase in Federal Medicare payments to hospices of $480 million for FY 2022. This aggregate increase is simply a result of the hospice payment update percentage of 2.0 percent, but results vary by facility type and area of country. Variation among facilities and region is a result of using the FY 2022 updated wage data and the finalized revised labor shares, which are implemented in a budget-neutral manner.

Table 25 in the rule (recreated below) shows the combined effects of the proposals and the variation by facility type and area of country. In brief, proprietary (for-profit) hospices (69 percent of all hospices) and non-profit hospices are expected to have a similar increase in hospice payments of 2.0 percent compared with overall payment increases of 2.2 percent for government hospices. Hospices located in rural areas would see an increase of 2.2 percent compared with 2.0 percent for hospices in urban areas. The projected overall impact on hospices also varies among regions of country – a direct result of the variation in the annual update to the wage index and hospices' mix of patients within each of the four payment categories given the final revised labor shares. Hospices providing services in the Outlying and South Atlantic regions would experience the largest estimated increase in payments of 2.9 and 2.5 percent, respectively in FY 2022 payments. In contrast, hospices serving patients in the New England and Middle Atlantic regions would experience, on average, the lowest estimated increase of 1.2 percent, respectively in FY 2022 payments.

Table 25: Projected Impact to Hospices for FY 2022

Hospice Subgroup	Hospices	FY 2022 Updated Wage Data	FY 2022 Labor Share	FY 2022 Hospice Payment Update (%)	Overall Total Impact for FY 2022
All Hospices	4,957	0.0%	0.0%	2.0%	2.0%
Hospice Type and Control					
Freestanding/Non-Profit	597	0.0%	0.0%	2.0%	2.0%
Freestanding/For-Profit	3,273	0.0%	0.0%	2.0%	2.0%
Freestanding/Government	39	0.2%	0.0%	2.0%	2.2%
Freestanding/Other	370	-0.3%	0.0%	2.0%	1.7%
Facility/HHA Based/Non-Profit	361	0.0%	0.0%	2.0%	2.0%
Facility/HHA Based/For-Profit	189	0.1%	0.1%	2.0%	2.2%
Facility/HHA Based/Government	88	0.0%	0.4%	2.0%	2.4%
Facility/HHA Based/Other	78	0.4%	-0.1%	2.0%	2.3%
Subtotal: Freestanding Facility Type	4,279	0.0%	0.0%	2.0%	2.0%
Subtotal: Facility/HHA Based Facility Type	716	0.1%	0.0%	2.0%	2.1%
Subtotal: Non-Profit	958	0.0%	0.0%	2.0%	2.0%
Subtotal: For Profit	3,462	0.0%	0.0%	2.0%	2.0%
Subtotal: Government	127	0.1%	0.1%	2.0%	2.2%
Subtotal: Other	448	-0.2%	0.0%	2.0%	1.8%
Hospice Type and Control: Rural					

Hospice Subgroup	Hospices	FY 2022 Updated Wage Data	FY 2022 Labor Share	FY 2022 Hospice Payment Update (%)	Overall Total Impact for FY 2022
Freestanding/Non-Profit	138	-0.1%	0.3%	2.0%	2.2%
Freestanding/For-Profit	355	-0.2%	0.4%	2.0%	2.2%
Freestanding/Government	19	0.2%	0.3%	2.0%	2.5%
Freestanding/Other	48	-0.4%	0.5%	2.0%	2.1%
Facility/HHA Based/Non-Profit	146	-0.3%	0.3%	2.0%	2.0%
Facility/HHA Based/For-Profit	44	0.3%	0.4%	2.0%	2.7%
Facility/HHA Based/Government	66	-0.1%	0.3%	2.0%	2.2%
Facility/HHA Based/Other	45	0.3%	0.3%	2.0%	2.6%
Facility Type and Control: Urban				2.0%	
Freestanding/Non-Profit	459	0.0%	-0.1%	2.0%	1.9%
Freestanding/For-Profit	2,918	0.1%	0.0%	2.0%	2.1%
Freestanding/Government	20	0.1%	-0.1%	2.0%	2.0%
Freestanding/Other	322	-0.3%	0.0%	2.0%	1.7%
Facility/HHA Based/Non-Profit	215	0.1%	-0.1%	2.0%	2.0%
Facility/HHA Based/For-Profit	145	0.1%	0.1%	2.0%	2.2%
Facility/HHA Based/Government	22	0.2%	0.4%	2.0%	2.6%
Facility/HHA Based/Other	33	0.5%	-0.2%	2.0%	2.3%
Hospice Location: Urban or Rural					
Rural	861	-0.2%	0.4%	2.0%	2.2%
Urban	4,134	0.0%	0.0%	2.0%	2.0%
Hospice Location: Region of the Country (Census Division)					
New England	156	-0.6%	-0.2%	2.0%	1.2%
Middle Atlantic	277	-0.7%	-0.1%	2.0%	1.2%
South Atlantic	582	0.3%	0.2%	2.0%	2.5%
East North Central	563	-0.2%	0.1%	2.0%	1.9%
East South Central	258	-0.2%	0.5%	2.0%	2.3%
West North Central	409	0.0%	0.2%	2.0%	2.2%

Hospice Subgroup	Hospices	FY 2022 Updated Wage Data	FY 2022 Labor Share	FY 2022 Hospice Payment Update (%)	Overall Total Impact for FY 2022
West South Central	981	-0.3%	0.3%	2.0%	2.0%
Mountain	506	0.2%	0.0%	2.0%	2.2%
Pacific	1,214	0.5%	-0.8%	2.0%	1.7%
Outlying	49	-1.4%	2.3%	2.0%	2.9%
Hospice Size					
0 - 3,499 RHC Days (Small)	1,120	0.1%	-0.2%	2.0%	1.9%
3,500-19,999 RHC Days (Medium)	2,232	0.0%	0.0%	2.0%	2.0%
20,000+ RHC Days (Large)	1,643	0.0%	0.0%	2.0%	2.0%

Source: FY 2020 hospice claims data from the CCW accessed on May11, 2021.

Region Key: New England=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic=Pennsylvania, New Jersey, New York;
South Atlantic=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East North Central=Illinois, Indiana, Michigan, Ohio, Wisconsin
East South Central=Alabama, Kentucky, Mississippi, Tennessee
West North Central=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
West South Central=Arkansas, Louisiana, Oklahoma, Texas
Mountain=Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific=Alaska, California, Hawaii, Oregon, Washington
Outlying=Guam, Puerto Rico, Virgin Islands