hfma healthcare financial management association

Medicare Program; FY 2021 Hospice Wage Index and Payment Rate Update [CMS-1733-F] Summary of Final Rule

TABLE OF CONTENTS

Issue	Page
I. Introduction and Background	1
II. Provisions of the Final Rule	2
A. Hospice Wage Index Changes	2
B. FY 2021 Hospice Wage Index and Rate Update	4
C. Election Statement Content Modifications and Addendum to Provide Greater Coverage Transparency and Safeguard Patient Rights	7
III. Regulatory Impact Analysis	11

I. Introduction and Background

On July 31, 2020, the Centers for Medicare & Medicaid Services (CMS) placed on public display a final rule updating the Medicare hospice payment rates, wage index, and cap amount for fiscal year (FY) 2021. The final rule will be published in the August 4, 2020 issue of the *Federal Register.*

CMS estimates that the overall impact of the final rule will be an increase of $540 million (2.4 percent) in Medicare payments to hospices during FY 2021.

This rule, as required by statute, finalizes annual updates to the hospice wage index, payment rates, and aggregate cap amount for FY 2021. This rule finalizes changes to the hospice wage index by adopting the Office of Management and Budget (OMB) statistical area delineations and applying a 5 percent cap on any wage index decreases in FY 2021. This rule also summarizes the changes to the hospice election statement finalized in last year's hospice rule and provides hospices with a model election statement and sample addendum. Of note, there were no proposals or updates to the Hospice Quality Reporting Program.

CMS notes that wage index addenda for FY 2021 (October 1, 2020 through September 30, 2021) are available only through the internet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index

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 include rebasing of 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.

II. Provisions of the Final Rule

A. Hospice Wage Index Changes

1. Implementation of New Labor Market Delineations

OMB generally issues major revisions to statistical areas every 10 years, based on the results of the decennial census. OMB, however, occasionally issues minor updates and revisions to statistical areas in the years between the decennial census. On September 14, 2018, OMB issued OMB Bulletin No. 18-04,[1] which established revisions to the delineations of Metropolitan Statistical Areas (MSA), Micropolitan Statistical Areas, and Combined Statistical Areas.[2] This bulletin contains a number of significant changes: new Core Based Statistical Areas (CBSAs), [3] urban counties that have become rural, rural counties that have become urban, and existing CBSAs that have been split apart. CMS states its belief that the hospice wage index should use the latest OMB delineations available as this will increase the integrity of the hospice wage index by creating a more accurate representation of geographic variation in wage levels.

CMS finalizes its proposal to implement the new OMB delineations as described in the September 14, 2018 OMB Bulletin No. 18-04 for the hospice wage index effective beginning in FY 2021. CMS notes that OMB published a new bulletin on March 6, 2020 (OMB Bulletin 20-01) that was not issued in time for development of the proposed rule.[4] CMS believes that these were minor updates, but notes that it would include, if needed, any updates from this bulletin in future rulemaking.

CMS discussed how it plans to treat Micropolitan Statistical Area definitions in the calculation of the wage index. OMB defines these areas as a "CBSA" associated with at least one urban cluster that has a population of at least 10,000 but less than 50,000. Consistent with its treatment of Micropolitan Areas under the IPPS, CMS will continue to treat Micropolitan Areas as "rural" and to include them in the calculation of each state's rural wage index.

CMS highlights the key changes related to implementation of the new OMB delineations:

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[1] This bulletin can be found at https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf
[2] A combined statistical area is a combination, for example, of two or more Metropolitan Statistical Areas, a Metropolitan Statistical Area and a Micropolitan Statistical Area, two or more Micropolitan Statistical Areas, or multiple Metropolitan and Micropolitan Statistical Areas that have social and economic ties as measured by commuting.
[3] CBSA is the OMB's collective term for Metropolitan and Micropolitan statistical areas.
[4] See https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf

- Thirty-four counties (and county equivalents) that are currently considered urban would be considered rural beginning in FY 2021 – wage index would decrease as a result, absent any other changes. Table 1 in the final rule list the counties affected.
- Forty-seven counties (and county equivalents) that are currently considered rural would be considered urban beginning in FY 2021 – wage index would increase as a result absent any other changes. Table 2 in the final rule lists the counties affected.
- Several urban counties would shift from one urban CBSA to another urban CBSA. In other cases, applying the new OMB delineations would involve a change only in CBSA name or number, while the CBSA continues to encompass the same constituent counties. Table 3 lists the counties that would change name or CBSA number.
- Nineteen urban counties would move from urban CBSA to a newly or modified CBSA. Table 4 in the final rule lists the counties affected.

2. Transition Period

CMS finalizes its proposed transition policy to help mitigate any significant negative impacts that hospices may experience due to its adoption of the revised OMB delineations. For FY 2021, as a transition, CMS will apply a 5 percent cap on any decrease in a geographic area's wage index value from the wage index value from the prior FY. This would allow the transition to be phased-in over two years; no cap would be applied to the reduction in the wage index for the second year (FY 2022). CMS believes that this approach is administratively simpler than a 1-year 50/50 blended wage index approach it has used as a transition policy in the past. CMS believes that 5 percent is a reasonable level for the cap to effectively mitigate any significant decreases in a geographic area's wage index value for FY 2021. These wage index updates and revisions would be implemented in a budget-neutral manner using the wage index standardization factor.

3. Comments

Commenters were almost all in favor of adoption of the revised OMB delineations from the September 14, 2018 Bulletin No. 18-04 and the transition methodology that would apply a 5 percent cap on any decrease in a geographic area's wage index value from the wage index value from the prior FY. A few commenters suggested alternatives to the 5-percent cap transition policy. MedPAC suggested, for example, that the 5 percent cap limit should apply to both increases and decreases in the wage index. Another commenter suggested a 3-percent cap instead of 5 percent. CMS reiterates in response that the purposes of the transition policy is to help mitigate the significant negative impacts of certain wage index changes. It also believes that 5 percent is a more reasonable level for the cap rather than 3 percent.

B. FY 2021 Hospice Wage Index and Rates Update

A summary of key data for the hospice payment rates for FY 2021 is presented below with additional details in the subsequent sections.

Summary of Key Data for Hospice Payment Rates for FY 2021			
Market basket update factor			
Market basket increase			+2.4%
Required multi-factor productivity (MFP) adjustment			0.0%
Net MFP-adjusted update reporting quality data			**+2.4%**
Net MFP-adjusted update not reporting quality data			**+0.4%**
Hospice aggregate cap amount			$30,683.93
Hospice Payment Rate Care Categories	**Labor Share**	**FY 2020 Federal Rates Per Diem**	**FY 2021 Federal Rates Per Diem**
Routine Home Care (days 1-60)	68.71%	$194.50	$199.25
Routine Home Care (days 61+)	68.71%	$153.72	$157.49
Continuous Home Care, Full Rate = 24 hours of care, $59.68 hourly rate	68.71%	$1,395.63	$1,432.41
Inpatient Respite Care	54.13%	$450.10	$461.09
General Inpatient Care	64.01%	$1,021.25	$1,045.66
Service Intensity Add-on (SIA) payment, up to 4 hours			$59.68 per hour
Note: RHC days account for the vast majority of all hospice days—98.2 percent in FY 2018.			

1. <u>FY 2021 Hospice Wage Index</u>

For FY 2021, CMS finalizes its proposal to use the hospice wage index based on the FY 2021 hospital pre-floor, pre-reclassified wage index with a 5 percent cap on the wage index decreases.[5] This would take into account the new OMB delineations but would not take into account any geographic reclassification of hospitals. 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.

CMS also continues to apply its current policies for handling geographic areas where there are no hospitals. For urban areas of this kind, all of the CBSAs within the state would be 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 2021, there is one CBSA without a hospital from which hospital wage data can be derived: 25980, Hinesville-Fort Stewart, Georgia. The FY 2021 wage index value for Hinesville-Fort Stewart, Georgia is 0.8527. For rural areas without hospital wage data, CMS has used the average pre-floor, pre-reclassified hospital wage index data from all <u>contiguous</u> 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

[5] CMS first began using the current FY's hospital wage index data in FY 2020.

will continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047.

Many commenters recommended more far-reaching revisions and reforms to the wage index methodology used under Medicare fee-for-service. MedPAC, for example, recommended that Congress repeal the existing hospital wage index and instead implement a wage index for use across other prospective payment systems. CMS states that while it appreciates the comments, these comments are outside of the scope of the proposed rule.

2. FY 2021 Hospice Payment Update Percentage

For FY 2021, the estimated inpatient hospital market basket update of 2.4 percent (the inpatient hospital market basket will be used in determining the hospice update factor) must be reduced by a productivity adjustment as mandated by the ACA. If CMS used the updated data from the IHS Global Inc's June 2020 macroeconomic forecast this would result in a 0.1 percentage point increase in the FY 2021 hospice payment update percentage. Under its statutory guidance,[6] CMS is required to reduce (not increase) the hospice market basket percentage point increase by changes in economy-wide productivity. Thus, CMS will apply a 0.0 percentage point productivity adjustment to the market basket percentage increase.

This results in a hospice payment update percentage for FY 2021 of 2.4 percent; this percentage is lower than the proposed rule in large part because that forecast was developed prior to the economic impact of the COVID-19 pandemic.

CMS notes that the labor portion of the hospice payment rates is currently as follows: for Routine Home Care, 68.71 percent; for Continuous Home Care, 68.71 percent; for General Inpatient Care, 64.01 percent; and for Respite Care, 54.13 percent.

3. FY 2021 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.[7]

In FY 2016 Hospice final rule, CMS made several modifications to the hospice payment methodology. 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. CMS also adopted a Service Intensity Add-on (SIA) payment when direct patient care is provided by an RN or social worker

[6] Sections 1886(b)(3)(B)(xi)(I) and 1814(i)(1)(C)(v) of the Act.

[7] 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.

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. CMS observed in the proposed rule that since FY 2016 there have been very minor adjustments needed as the utilization of the SIA from year-to-year remains relatively constant.

CMS proposed to remove the SIA budget neutrality factor to simplify the RHC payment rate updates. Thus, the RHC payment rates would only be updated by the wage index standardization factor and the hospice payment update percentage. Based on comments received, CMS did not finalize the removal of the SIA Budget Neutrality Factor for FY 2021. CMS agreed with commenters that given the increase to the CHC hourly rate in FY 2020, it was prudent to evaluate FY 2020 utilization data prior to eliminating this budget neutrality factor as utilization trends may differ from the past. CMS states that if very minor adjustments continue to be needed, it may propose to remove this factor in future rulemaking.

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. 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 2021 hospice wage index with a 5 percent cap on wage index decreases and compared it to its simulation of total payments using the FY 2020 hospice wage index. By dividing payments for each level of care using the FY 2021 wage index by payments for each level of care using the FY 2020 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). These factors are shown in the tables below.

Tables 6 and 7 of the final rule (reproduced below) lists the FY 2021 hospice payment rates by care category, the SIA budget neutrality factors, and the wage index standardization factors.

	Table 6: FY 2021 Hospice RHC Payment Rates					
Code	**Description**	**FY 2020 Payment Rates**	**SIA Budget Neutrality Factor**	**Wage Index Standardization Factor**	**FY 2021 Hospice Payment Update**	**FY 2021 Payment Rates**
651	Routine Home Care (days 1-60)	$194.50	× 1.0002	× 1.0002	× 1.024	$199.25
651	Routine Home Care (days 61+)	$153.72	× 1.0001	× 1.0004	× 1.024	$157.49

Table 7: FY 2021 Hospice Payment Rates for CHC, IRC, and GIP Payment Rates					
Code	**Description**	**FY 2020 Payment Rates**	**Wage Index Standardization Factor**	**FY 2021 Hospice Payment Update**	**FY 2021 Payment Rates**
652	Continuous Home Care Full Rate = 24 hours of care, $59.68 hourly rate	$1,395.63	× 1.0023	× 1.024	$1,432.41
655	Inpatient Respite Care	$450.10	× 1.0004	× 1.024	$461.09
656	General Inpatient Care	$1,021.25	× 0.9999	× 1.024	$1,045.66

Tables 8 and 9 of the final rule list the comparable FY 2021 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), $195.36; Routine Home Care (days 61+), $154.42; Continuous Home Care, $1,404.44; Inpatient Respite Care, $452.08; and General Inpatient Care, $1,025.23.

4. <u>Hospice Cap Amount for FY 2021</u>

By way of 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.[8] 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 FY 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 will sunset for cap years ending after September 30, 2025 and revert to the original methodology. CMS adds that the final hospice aggregate cap amount for the FY 2021 cap year will be $30,683.93 per beneficiary or the 2020 cap amount updated by the FY 2021 hospice payment update percentage ($29,964.78 * 1.024).

C. Election Statement Content Modifications and Addendum to Provide Greater Coverage Transparency and Safeguard Patient Rights

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. CMS also finalized the requirements as set forth at §418.24(c) for the hospice election statement addendum titled, "Patient Notification of Hospice Non-Covered Items, Services, and Drugs". CMS delayed the effective date of the election statement content

[8] 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.

modifications and the hospice election statement addendum until FY 2021 to allow hospices adequate time to make the necessary modifications to their current election statements, develop their own election statement addendum, and make any changes to their current software and business processes to accommodate the requirements.

CMS has posted a model hospice election statement and addendum on the Hospice Center webpage (https://www.cms.gov/files/document/model-hospice-election-statement-and-addendum.pdf) to assist hospices in understanding the content requirements. This election statement illustrates how hospices can incorporate the finalized modifications into their own election statements. The model addendum is intended to demonstrate how hospices can include all of the addendum requirements in a format that could assimilate their current processes. CMS solicited comments on these model examples to see if they were helpful in educating hospices in how to meet these requirements effective on October 1, 2020.

CMS received many suggested revisions for the modified election statement and the election statement addendum. These included formatting changes and reordering the required items for ease of use and readability as well as suggested language revisions to make some of the content requirements clearer, among other suggestions. CMS states its appreciation for the suggested modifications but notes that these examples are meant to be illustrative and are not required to be in the exact format as provided. Nevertheless, CMS accepted the majority of commenters' suggestions and incorporated them into the model examples, which CMS posted on its webpage.[9]

CMS reiterates that it did not propose any new policies as they relate to the modifications to the hospice election statement or the addendum requirements. CMS, however, still received comments on various aspects of the finalized policy and CMS summarizes those comments in the final rule. CMS, for example, clarifies the differences between the election statement addendum and the Advance Beneficiary Notice and provides additional guidance on when each document should be used. CMS also notes that hospices can develop their modified election statement and addendum in an electronic format if the content requirements are met.

Most commenters also recommended that CMS delay the October 1, 2020 effective date because of the public health emergency in response to the COVID-19 pandemic. CMS notes, however, that this policy already reflects a delayed effective date of 1 year and that there were no proposed changes this year. Thus, CMS reiterates that the hospice election statement modifications and the hospice election statement addendum requirements will be effective for elections beginning on and after October 1, 2020 as finalized in the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38520).

The changes CMS finalized in the FY 2020 final rule for the election statement content modifications and addendum for implementation in FY 2021 are described in detail in the final rule and summarized below.

Hospice Election Statement. In addition to the existing statement content requirements at §418.24(b) CMS finalized that hospices also would be required to include the following on the election statement:

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[9] See https://www.cms.gov/medicaremedicare-fee-service-paymenthospicehospice-regulations-and-notices/cms-1733-f

- Information about the holistic, comprehensive nature of the Medicare hospice benefit.
- A statement that, although it would be rare, there could be some necessary items, drugs, or services that will not be covered by the hospice because the hospice has determined that these items, drugs, or services are to treat a condition that is unrelated to the terminal illness and related conditions.
- Information about beneficiary cost-sharing for hospice services.
- Notification of the beneficiary’s (or representative’s) right to request an election statement addendum that includes a written list and a rationale for the conditions, items, drugs, or services that the hospice has determined to be unrelated to the terminal illness and related conditions and that immediate advocacy is available through the Beneficiary & Family Centered Care – Quality Improvement Organization (BFCC-QIO) if the beneficiary (or representative) disagrees with the hospice’s determination.

Election Statement Addendum. CMS finalized that hospices will be required, upon request, to provide to the beneficiary (or representative) an election statement addendum with a list and rationale for the conditions, items, services, and drugs that the hospice has determined are unrelated to the terminal illness and related conditions. Hospices will also be required to provide the election statement addendum upon request to other non-hospice providers that are treating such conditions, and Medicare contractors who request such information.

If the election statement addendum is requested at the time of hospice election, the hospice must provide this information, in writing within 5 days of the start of hospice care. Hospices are exempt from completing this addendum if the beneficiary dies within 5 days of the election date of hospice care. If the addendum is requested during the course of hospice care, the hospice must provide this information, in writing, immediately to the requesting beneficiary (or representative), non-hospice provider, or Medicare contractor. CMS believes this information should be readily available in the beneficiary’s hospice medical record. If there are changes to the hospice plan of care that determine a new illness or condition has arisen, hospices are required to issue an updated addendum to the patient (or representative) reflecting whether or not items, services, and supplies related to the new illness or condition will be provided by the hospice. This applies for both additions and removal of any unrelated conditions, items, services, and/or drugs.

The addendum called the “Patient Notification of Hospice Non-Covered Items, Services, and Drugs” is required to include the following information: finalized at §418.24:

1. Name of the hospice;
2. Beneficiary’s name and hospice medical record identifies;
3. Identification of the beneficiary’s terminal illness and related conditions;
4. A list of the beneficiary’s current diagnoses/conditions present on hospice admission (or upon plan of care update, as applicable) and the associated items, services and drugs, not covered by the hospice because the hospice has determined they are unrelated to the terminal illness and related conditions;
5. A written clinical explanation, in language the beneficiary and their representation can understand, why the identified conditions, items, services, and drugs are considered unrelated to the terminal illness and related conditions and not needed for pain or symptom management. This information would be accompanied by a general statement

that the decision as to whether or not conditions, items, services, and drugs are related is made for each patient and the beneficiary should share this clinical explanation with other health care providers they seek services that are unrelated to their terminal illness and related conditions;

6. References to any relevant clinical practice, policy or coverage guidelines;
7. Information on the following:
   - *Purpose of Addendum*. (i). The purpose of the addendum is to notify the beneficiary (or representative) of those conditions, items, services, and drugs the hospice will not cover because the hospice has determined they are unrelated to the beneficiary's terminal illness and related conditions. (ii). The addendum is subject to review and shall be updated, as needed, when the plan of care is updated in accordance with §418.56. The hospice will provide these updates in writing to the beneficiary (or representative).
   - *Right to Immediate Advocacy*. The addendum must include language that immediate advocacy is available through the BFCC-QIO if the beneficiary (or representative) disagrees with the hospice's determination. The language must include contact information for the BFCC-QIO and required language that encourages the beneficiary to contact the hospice provider to discuss the information on the form. In addition, required language will provide information about the BFCC-QIO and the ways the BFCC-QIO can assist you.
8. Name and signature of Medicare hospice beneficiary (or representative) and date signed, along with a statement that signing this addendum (or updates) is only acknowledgement of receipt and not necessarily the beneficiary's agreement with the hospice determinations.

CMS finalized that the signed addendum and updates become a new condition for payment. The addendum will not be required to be submitted with any hospice claims. Separate consent will not be needed to release this information to non-hospice providers furnishing services for unrelated condition (45 CFR 164.506). CMS notes that the CoPs already require that this information should be documented and communicated to beneficiaries but that making this a condition for payment will help ensure this information is provided.

The election statement addendum is only required for beneficiaries who request this information; hospices may choose to provide this information to all patients, regardless of payer source. Hospices can determine which member of the interdisciplinary group is responsible for completing the addendum; CMS expects this typically would be the hospice RN responsible for the plan of care.

CMS believes that the election statement addendum will provide greater transparency about coverage under the Medicare hospice benefit, inform the beneficiary about services they might need to obtain outside the hospice benefit, and allow a beneficiary to anticipate potential financial liabilities. CMS notes this addendum is not to be used for hospices to exercise unlimited ability to determine services as unrelated to the terminal illness and related conditions.

III. 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 $540 million or 2.4 percent, for FY 2021. This aggregate increase is simply a result of the hospice payment update percentage of 2.4 percent, but results vary by facility type and area of country. Variation among facilities and region is a result of using the FY 2021 updated wage data and the effect of moving from the old OMB delineations to the new OMB delineations with a 5 percent cap on wage index decreases. Changes to the wage index are implemented in a budget-neutral manner.

Table 10 in the final rule (recreated below) shows the combined effects of its policies and the variation by facility type and area of country. CMS notes that simulation payments are based on utilization in FY 2019 and only includes payments related to the level of care and not the service-intensity add-on.

In brief, proprietary (for-profit) hospices (67 percent of all hospices) and non-profit hospices are expected to have an increase in hospice payments of 2.4 percent – same as the hospice payment update percentage. Government hospices are expected to receive a 2.6 percent increase in hospice payments. Hospices located in rural areas would see an increase of 2.6 percent compared with 2.4% 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. Hospices providing services in the Middle Atlantic region would experience the largest estimated increase in payments of 2.9 percent. In contrast, hospices serving patients in the New England and Outlying regions would experience, on average, the lowest estimated increase of 1.7 and 1.6 percent, respectively in FY 2021 payments.

Table 10: Impact to Hospices for FY 2021					
	Hospices	**FY 2021 Updated Wage Data**	**New OMB Delineations (5% Cap)**	**Market Basket**	**Overall Total Impact**
All Hospices	4,760	0.0%	0.0%	2.4%	2.4%
Hospice Type and Control					
Freestanding/Non-Profit	594	0.0%	0.1%	2.4%	2.5%
Freestanding/For-Profit	3,002	0.0%	0.0%	2.4%	2.4%
Freestanding/Government	39	0.3%	0.0%	2.4%	2.7%
Freestanding/Other	362	0.1%	-0.1%	2.4%	2.4%
Facility/HHA-Based/Non-Profit	381	-0.1%	0.0%	2.4%	2.3%
Facility/HHA-Based/For-Profit	204	0.1%	0.0%	2.4%	2.5%
Facility/HHA-Based/Government	94	0.0%	0.1%	2.4%	2.5%
Facility/HHA-Based/Other	84	0.3%	0.2%	2.4%	2.9%
Subtotal: Freestanding Facility Type	3,997	0.0%	0.0%	2.4%	2.4%
Subtotal: Facility/HHA Based Facility Type	763	0.0%	0.0%	2.4%	2.4%
Subtotal: Non-Profit	975	0.0%	0.0%	2.4%	2.4%

Table 10: Impact to Hospices for FY 2021					
	Hospices	**FY 2021 Updated Wage Data**	**New OMB Delineations (5% Cap)**	**Market Basket**	**Overall Total Impact**
Subtotal: For Profit	3,206	0.0%	0.0%	2.4%	2.4%
Subtotal: Government	133	0.2%	0.0%	2.4%	2.6%
Subtotal: Other	446	0.1%	-0.1%	2.4%	2.4%
Hospice Type and Control: Rural					
Freestanding/Non-Profit	147	0.3%	0.0%	2.4%	2.7%
Freestanding/For-Profit	335	0.2%	0.0%	2.4%	2.6%
Freestanding/Government	21	0.3%	0.0%	2.4%	2.7%
Freestanding/Other	48	0.2%	0.0%	2.4%	2.6%
Facility/HHA-Based/Non-Profit	151	0.2%	0.0%	2.4%	2.6%
Facility/HHA-Based/For-Profit	47	0.5%	0.0%	2.4%	2.9%
Facility/HHA-Based/Government	68	0.1%	0.0%	2.4%	2.5%
Facility/HHA-Based/Other	51	0.1%	0.0%	2.4%	2.5%
Hospice Type and Control: Urban					
Freestanding/Non-Profit	447	0.0%	0.1%	2.4%	2.5%
Freestanding/For-Profit	2,667	0.0%	0.0%	2.4%	2.4%
Freestanding/Government	18	0.3%	0.0%	2.4%	2.7%
Freestanding/Other	314	0.1%	-0.1%	2.4%	2.4%
Facility/HHA-Based/Non-Profit	230	-0.2%	0.0%	2.4%	2.2%
Facility/HHA-Based/For-Profit	157	0.0%	0.0%	2.4%	2.4%
Facility/HHA-Based/Government	26	0.0%	0.1%	2.4%	2.5%
Facility/HHA-Based/Other	33	0.3%	0.3%	2.4%	3.0%
Hospice Location: Urban or Rural					
Rural	868	0.2%	0.0%	2.4%	2.6%
Urban	3,892	0.0%	0.0%	2.4%	2.4%
Hospice Location: Region of the Country (Census Division)					
New England	155	-0.7%	0.0%	2.4%	1.7%
Middle Atlantic	279	0.5%	0.0%	2.4%	2.9%
South Atlantic	562	0.0%	0.0%	2.4%	2.4%
East North Central	548	0.3%	0.0%	2.4%	2.7%
East South Central	261	0.1%	0.0%	2.4%	2.5%
West North Central	407	-0.6%	0.0%	2.4%	1.8%
West South Central	924	0.2%	0.0%	2.4%	2.6%
Mountain	484	-0.5%	0.0%	2.4%	1.9%
Pacific	1,094	0.0%	0.1%	2.4%	2.5%
Outlying	46	-0.7%	-0.1%	2.4%	1.6%

Table 10: Impact to Hospices for FY 2021					
	Hospices	**FY 2021 Updated Wage Data**	**New OMB Delineations (5% Cap)**	**Market Basket**	**Overall Total Impact**
Hospice Size					
0 - 3,499 RHC Days (Small)	1,066	0.0%	0.0%	2.4%	2.4%
3,500-19,999 RHC Days (Medium)	2,142	0.0%	0.0%	2.4%	2.4%
20,000+ RHC Days (Large)	1,552	0.0%	0.0%	2.4%	2.4%

Source: FY 2019 hospice claims data from the CCW accessed on May 12, 2020.

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