Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements
[CMS-1787-P]

Summary of Proposed Rule

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I. Introduction and Background

On April 4, 2023, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (88 FR 20022) a proposed rule updating the Medicare hospice payment rates, wage index, the cap amount and the quality reporting requirements for federal fiscal year (FY) 2024. It also includes information on hospice utilization trends and solicits comments on several issues, including the provision of higher levels of hospice care, spending patterns for non-hospice services provided during the election of the hospice benefit, and ways to examine health equity, among other topics. This rule also proposes to codify the Hospice Quality Reporting Program (HQRP) data submission threshold, discusses the Hospice Outcomes and Patient Evaluation tool (HOPE), and provides an update on future quality measures development and health equity efforts. In addition, this rule proposes that physicians who order or certify hospice services for Medicare beneficiaries must be enrolled in Medicare or validly opted-out as a prerequisite for payment for the specific hospice period of care. **Comments on the proposed rule are due by May 30, 2023.**

CMS estimates that the overall impact of the proposed rule will be an increase of $720 million (2.8 percent) in Medicare payments to hospices during FY 2024.

The proposed 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. In the FY 2020 hospice final rule (84 FR 38487) CMS rebased 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. In the FY 2022

hospice final rule (86 FR 42532), CMS finalized a policy to rebase and revise the labor shared for CHC, RHC, IRC, and GIP using cost report data for freestanding hospices.

CMS notes that wage index addenda for FY 2024 (October 1, 2023 through September 30, 2024) will be available only through the internet at https://www.cms.gov/files/zip/fy-2024-proposed-hospice-wage-index.zip

II. Provisions of the Proposed Rule

A summary of key data for the proposed hospice payment rates for FY 2024 is presented below with additional details in the subsequent sections.

Summary of Key Data for Proposed Hospice Payment Rates for FY 2024			
Market basket update factor			
Market basket increase			+3.0%
Required total factor productivity (TFP)			-0.2%
Net MFP-adjusted update reporting quality data			**+2.8%**
Net MFP-adjusted update not reporting quality data			**-1.2%**
Hospice aggregate cap amount			$33,396.55
Hospice Payment Rate Care Categories	**Labor Share**	**FY 2023 Federal Rates Per Diem**	**Proposed FY 2024 Federal Rates Per Diem**
Routine Home Care (days 1-60)	66.0%	$211.34	$217.74
Routine Home Care (days 61+)	66.0%	$167.00	$171.86
Continuous Home Care, Full Rate = 24 hours of care, $65.06 hourly rate	75.2%	$1,522.04	$1,561.53
Inpatient Respite Care	61.0%	$492.10	$506.38
General Inpatient Care	63.5%	$1,110.76	$1,142.20
Proposed Service Intensity Add-on (SIA) payment, up to 4 hours			$65.06 per hour
Notes: RHC days account for most of hospice days—98.8 percent in FY 2022. The Consolidation Appropriations Act of 2021 changed the payment reduction for failing to meet quality reporting requirements from 2 to 4 percent beginning in FY 2024.			

A. Hospice Utilization and Spending Patterns

This section of the proposed rule describes 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. It also solicits comments on hospice utilization, non-hospice spending, ownership transparency, hospice election decision-making, and ways to examine health equity.

In examining trends, CMS notes that there has been substantial growth in Medicare hospice utilization. The number of Medicare beneficiaries receiving hospice services has grown from 715,349 in FY 2003 to over 1.7 million in FY 2022. Similarly, Medicare hospice expenditures have risen from $5.0 billion in FY 2003 to an estimated $23 billion in FY 2022. Similar to the increase in the number of beneficiaries using the benefit, the total number of organizations offering hospice services also continues to grow with for-profit providers entering the market at higher rates than not-for-profit providers. CMS states, based on a MedPAC findings, that this is

because long stays in hospice have been very profitable and attracted new provider entrants with revenue-generating strategies specifically targeting these patients.[1] Growth in share of for-profit hospitals had increased from 65 percent in FY 2016 to 74 percent by 2022.

CMS ongoing analyses continue to show that that there has been a significant increase in the reporting of neurological-based diagnoses, including Alzheimer's disease and other related dementias. Beneficiaries with these terminal conditions tend to have longer hospice stays, which have historically been more profitable than shorter stays.[2]

CMS analyses show that there have only been slight changes over time in how hospices have been utilizing the different levels of care. RHC consistently represent the highest percentage of total hospice days and payments. In 2022, RHC accounts for 98.8 percent of all hospice days and 93.7 percent of payments.

2. Trends in Hospice Length of Stay and Live Discharges

Hospital Length of Stay

The number of days that a hospice beneficiary receives care under a hospice election is referred to as the hospice length of stay. The hospice length of stay is variable and depends on a multitude of factors including disease course, timing of referral, decision to resume curative treatment, and/or stabilization or improvement where the individual is no longer certified as terminally ill. CMS examined length of stay during a single hospice election and total lifetime length of stay – the sum of all days of hospice care across all hospice elections.

In FY 2022, the average length of stay in hospice was 80 days and average lifetime length of stay in hospice was 102 days, about a 2 percent growth from prior year. The median (50th percentile) length of stay was 19 days. CMS also examined average lifetime length of stays associated with hospice principal diagnosis in FY 2022. See Table 5 in the proposed rule (88 FR 20030). Hospice beneficiaries with a primary diagnosis of Alzheimer's, Dementia, and Parkinson's had the longest average lifetime length of stay at 170 days and Chronic Kidney Disease had the shortest average length of stay at 41 days.

Hospice Live Discharges

CMS notes that federal regulations limit the circumstances in which a Medicare hospice provider may discharge a patient from its care; it is permissible (under §418.26) when a patient moves out of the provider's service area, is determined to be no longer terminally ill, or for cause. The hospice cannot discharge the patient at their discretion, even if the care may be costly or inconvenient. To better understand the characteristics of hospices with high live discharge rates, CMS examined hospice live discharge rates over time and by length of stay.[3] Overall, CMS found that between 2013 and 2022, the overall rate of live discharges has decreased from 18.5 percent in 2013 to 17.2 percent in 2022. CMS also indicates that the proportion of live discharges

[1] Report to Congress, Medicare Payment Policy. Hospice Services, Chapter 10. MedPAC. March 2023.
[2] MedPAC 2023 March Report, Chapter 10
[3] CMS does not expect the rate of live discharges to be zero, given the uncertainties of prognostication and the ability of beneficiaries and their families to revoke the hospice election at any time.

occurring between length of stay intervals has remained relatively constant from FY 2019 to FY 2022.

3. Non-Hospice Spending During a Hospice Election

CMS also analyzed data on non-hospice spending for hospice beneficiaries during an election using FY 2022 data. CMS emphasizes that hospice services are intended to be comprehensive and inclusive and that since the creation of this benefit, it has reiterated that "virtually all" care needed by the terminally ill individual should be provided by the hospice and that it would be unusual and exceptional for services to be provided outside of the hospice for these individuals.

In FY 2022, the agency found that Medicare paid $1.4 billion for Part A and Part B items or services while a beneficiary was receiving hospice care. Notably, non-hospice spending has increased by 28.9 percent from FY 2019. In addition, total drug spending by Medicare, states, beneficiaries, and other payers in FY 2022 under Part D was $787 million for hospice beneficiaries during a hospice election (of which $554 million was paid by Medicare). For a prescription drug to be covered under Part D for an individual enrolled in hospice, the drug must be for treatment of an illness or condition completely unrelated to the terminal illness or related conditions. CMS states that the use of prior authorization by Part D sponsors has reduced certain drug categories typically used to treat common symptoms during the end of life, but the use of maintenance drugs (for which Part D sponsors do not use prior authorization based on current policy) has increased.[4]

Thus, in total, non-hospice Medicare expenditures occurring during a hospice election was $883 million for Parts A and B spending, plus $554 million for Part D spending, or about $1.4 billion in FY 2022. Further, hospice beneficiaries had $197 million in cost-sharing for items and services that were billed to Medicare Parts A and B, and $69 million in cost-sharing for drugs that were billed to Medicare Part D, while they were in a hospice election.

4. Hospice and End-Stage Renal Disease (ESRD)

CMS analyzed data to better understand how ESRD patients use hospice. It found that ESRD patients utilized hospice for less than half as often compared to the rate of hospice use among all Medicare beneficiaries in its sample. Results were similar when looking at hospice and ESRD service claims in the 14 days, 60 days, and 90 days before death.

5. Request for Information (RFI) on Hospice Utilization, Non-Hospice Spending; Ownership Transparency; and Hospice Election Decision-Making

CMS notes that although hospice use has grown considerably since the 1983 inception of the Medicare hospice benefit, there are still barriers that terminally ill and hospice benefit eligible beneficiaries may face when trying to access hospice care. It is particularly concerned that beneficiary populations with complex palliative needs and potentially high-cost medical care needs may underuse the hospice benefit. Despite substantial payment increase for higher levels of hospice care as result of rebased payment rates beginning in FY 2020, CMS has observed no

[4] Examples of maintenance drugs include those used to treat high blood pressure, heart disease, asthma, and diabetes.

significant change in the utilization of higher levels of care, including CHC, GIP, and IRC. It also notes that most beneficiaries that use dialysis shortly before death typically do not use hospice.

Given these observations, CMS is concerned that beneficiary populations with complex palliative needs face barriers in receiving hospice care. It notes that these findings serve as a call to action for CMS to address issues related to quality of care and access when striving to improve health equity. As it continues to focus on these issues, CMS solicits public comment on the following questions:

- Are there any enrollment policies for hospices that may be perceived as restrictive to those beneficiaries that may require higher cost end of life palliative care, such as blood transfusions, chemotherapy, radiation, or dialysis?
- Are there any enrollment policies for hospices that may be perceived as restrictive to those beneficiaries that may require higher intensity levels of hospice care?
- What continued education efforts do hospices take to understand the distinction between curative treatment and complex palliative treatment for services such as chemotherapy, radiation, dialysis, and blood transfusions as it relates to beneficiary eligibility under the hospice benefit? How is that information shared with patients at the time of election and throughout hospice service?
- Although the previously referenced analysis did not identify the cause for lower utilization of complex palliative treatments and/or higher intensity levels of hospice care, do the costs incurred with providing these services correlate to financial risks associated with enrolling such hospice patients?
- What are the overall barriers to providing higher intensity levels of hospice care and/or complex palliative treatments for eligible Medicare beneficiaries (for example, are there issues related to established formal partnerships with general inpatient/inpatient respite care facilities)? What steps, if any, can hospice providers or CMS take to address these barriers?
- What are reasons why non-hospice spending is growing for beneficiaries who elect hospice? What are ways to ensure that hospice is appropriately covering services under the benefit?
- What additional information should CMS or the hospice be required to provide the family/patient about what is and is not covered under the hospice benefit and how should that information be communicated?
- Are patients requesting the Patient Notification of Hospice Non-Covered Items, Services, and Drugs? Should this information be provided to all prospective patients at the time of hospice election or as part of the care plan?
- Should information about hospice staffing levels, frequency of hospice staff encounters, or utilization of higher LOC be provided to help patients and their caregivers make informed decisions about hospice selection? Through what mechanisms?
- The analysis included in this proposed rule shows increased overall non-hospice spending for Part D drugs for beneficiaries under a hospice election. What are tools to ensure that hospice is appropriately covering prescription drugs related to terminal illnesses and related conditions, besides prior authorization and the hospice election statement addendum?

- Given some of the differences between for-profit and not-for-profit utilization and spending patterns highlighted in this proposed rule, how can CMS improve transparency around ownership trends? For example, what and how should CMS publicly provide information around hospice ownership? Would this information be helpful for beneficiaries seeking to select a hospice for end of life care?

CMS believes information gathered from this RFI will help inform future rulemaking and believes that it could help improve the continuum of care under the hospice benefit by: (1) heightened patient and family satisfaction; (2) improvement in quality indicators; (3) lower rates of hospitalization (to include decreased intensive care unit admission and invasive procedures at the end of life); and (4) significantly lower health care expenditures at the end of life.

6. Request for Information on Health Equity under the Hospice Benefit

In line with the executive order on advancing racial equity,[5] CMS is working to advance health equity in its policies and programs. It notes that health inequities persist in hospice and overall palliative care, where Black and Hispanic populations are less likely to utilize care and over 80 percent of patients are White.[6] There is also some evidence that minorities experience disparities in quality of care with some evidence of higher rates of disenrollment and concerns about care coordination amongst hospices. CMS believes that an important first step in addressing these disparities is improving data collection to allow for better measurement and reporting on equity across its programs and policies. It is interested in receiving input regarding the potential collection of additional indices and data elements that can provide insight regarding underlying health status and non-medical factors, access to care, and experience in medical care.

CMS notes its appreciations for hospice agencies and industry associations sharing their support and commitment to addressing health disparities. It solicits public comment on the following questions:

- What efforts do hospices employ to measure impact on health equity?
- What factors do hospices observe that influence beneficiaries in electing and accessing hospice care?
- What geographical area indices, beyond urban/rural, can CMS use to assess disparities in hospice?
- What information can CMS collect and share to help hospices serve vulnerable and underserved populations and address barriers to access?
- What sociodemographic and SDOH data should be collected and used to effectively evaluate health equity in hospice settings?

[5] Executive Order 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (2021-01753.pdf (govinfo.gov))

[6] See Addressing Disparities in Hospice & Palliative Care. Nalley, Catlin. Oncology Times: March 20, 2021-Volume 43-Issue 6-p 1,10doi: 10.1097/01.COT.0000741732.73529.bb.; and Disparities in Palliative and Hospice Care and Completion of Advance Care Planning and Directives Among Non- Hispanic Blacks: A Scoping Review of Recent Literature (nih.gov).

- What are feasible and best practice approaches for the capture and analysis of data related to health equity?
- What barriers do hospices face in collecting information on SDOH and race and ethnicity? What is needed to overcome those barriers?

B. Proposed FY 2024 Hospice Wage Index and Rate Update

1. FY 2024 Hospice Wage Index

For FY 2024, CMS proposes to continue its policy to use the current FY's hospital wage index data to calculate the hospice wage index values. For FY 2024, the proposed hospice wage index would be based on the FY 2024 hospital pre-floor, pre-reclassified wage index using hospital cost reporting periods beginning on or after October 1, 2019 and before October 1, 2020 (FY 2020 cost report data). The hospice wage index does not take into account any geographic reclassification of hospitals, but would include a 5-percent cap on wage index decreases. 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 proposes to continue to apply current policies for geographic areas where there are no hospitals. For urban areas of this kind, all 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 2024, there is one CBSAs without a hospital from which hospital wage data can be derived: 25980, Hinesville-Fort Stewart, Georgia. The FY 2024 wage index value for Hinesville-Fort Stewart, Georgia is 0.8711. 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 proposes to continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047.

CMS notes that the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit; these values are subject to application of the hospice floor. The pre-floor and pre-reclassified hospital wage index below 0.8 will be further adjusted by a 15 percent increase subject to a maximum wage index value of 0.8.[7]

2. FY 2024 Hospice Payment Update Percentage

For FY 2024, the estimated inpatient hospital market basket update of 3.0 percent (the inpatient hospital market basket is used in determining the hospice update factor) must be reduced by a productivity adjustment as mandated by the ACA (currently estimated to be 0.2 percentage points). This results in a proposed hospice payment update percentage for FY 2024 of 2.8 percent; CMS proposes to revise this amount in the final rule if more recent data become

[7] For example, if County A has a pre-floor, pre-reclassified hospital wage index value of 0.3994, CMS would multiply 0.3994 by 1.15, which equals 0.4593.

available. Hospices that do not submit the required quality data under the Hospice Quality Reporting Program would receive a payment update percentage for FY 2024 of -1.2 percent.

CMS notes that in the 2022 final rule it rebased and revised the labor shares for the RHC, CHC, GIP, and IRC using cost report data for freestanding hospices. The labor portion of the hospice payment rates is currently 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 2024 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.[8]

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. CMS observes (as show in Table 8 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.

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.[9] To calculate the wage index standardization factor, CMS simulated total payments using FY 2022 hospice utilization claims data with the FY 2023 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor and the 5-percent cap on wage index decreases) and compared it to its simulation of total payment using the FY 2024 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, with the 5-percent cap on wage index decreases) and FY 2023 payment rates. By dividing payments for each level of care using the FY 2023 wage index by payments for each level of care using the FY 2022 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).

Tables 8 and 9 of the proposed rule (reproduced below) lists the proposed FY 2024 hospice payment rates by care category and the proposed wage index standardization factors.

[8] 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.
[9] CMS uses 2022 claims data to calculate the wage index standardization factor (the most recent available).

Table 8: Proposed FY 2024 Hospice RHC Payments						
Code	**Description**	**FY 2023 Payment Rates**	**SIA Budget Neutrality Factor**	**Wage Index Standardization Factor**	**Proposed FY 2024 Hospice Payment Update**	**Proposed FY 2024 Payment Rates**
651	Routine Home Care (days 1-60)	$211.34	× 1.0010	× 1.0012	× 1.028	$217.74
651	Routine Home Care (days 61+)	$167.00	× 1.0000	× 1.0011	× 1.028	$171.86

Table 9: Proposed FY 2024 Hospice CHC, IRC, and GIP Payment Rates					
Code	**Description**	**FY 2023 Payment Rates**	**Wage Index Standardization Factor**	**Proposed FY 2024 Hospice Payment Update**	**Proposed FY 2024 Payment Rates**
652	Continuous Home Care Full Rate = 24 hours of care	$1,522.04 ($63.42 per hour)	× 0.9980	× 1.028	$1,561.53 ($65.06 per hour)
655	Inpatient Respite Care	$492.10	× 1.0010	× 1.028	$506.38
656	General Inpatient Care	$1,110.76	× 1.0003	× 1.028	$1,142.20

Tables 10 and 11 of the proposed rule lists the comparable FY 2024 proposed 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), $209.26; Routine Home Care (days 61+), $165.18; Continuous Home Care, $1,500.77; Inpatient Respite Care, $486.68; and General Inpatient Care, $1,097.76.

4. Hospice Cap Amount for FY 2024

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.[10] 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

[10] 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.

30, 2025 and revert to the original methodology, but this sunset provision has been extended, most recently by the CAA, 2023 until September 30, 2032. CMS adds that the proposed hospice aggregate cap amount for the 2024 cap year will be $33,396.55 per beneficiary or the 2023 cap amount updated by the proposed FY 2024 hospice payment update percentage ($32,486.92 * 1.028).

C. Proposed Updates to the Hospice Quality Reporting Program

1. Background and Statutory Authority

The Hospice Quality Reporting Program (HQRP) includes the Hospice Item Set (HIS), administrative data, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey. 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)[11] 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 FY 2024 APU is based on CY 2022 quality data.

As finalized in the FY 2022 Hospice final rule (86 FR 42552), CMS began public reporting of the two new claims-based quality measures (QMs), the Hospice Visits in Last Days of Life (HVLDL) and the Hospice Care Index (HCI) in the August 2022 refresh of the Care Compare/Provider Data Catalogue (PDC). CMS did not propose any new quality measures for FY 2023. Table 12 (reproduced below) lists all the quality measures finalized in the FY 2022 Hospice final rule and in effect for the FY 2023 HQRP.[12]

Table 12: Quality Measures in Effect for the HQRP
Hospice Quality Reporting Program
Hospice Item Set
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)
Administrative Data, including Claims-based Measures
Hospice Visits in Last Days of Life (HVLDL)
Hospice Care Index (HCI) 1. Continuous Home Care (CHC) or General Inpatient Provided (GIP)

[11] Pub. L. 116-260

[12] Information on the current HQRP quality measures can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.

Table 12: Quality Measures in Effect for the HQRP
Hospice Quality Reporting Program
2. Gaps in Skilled Nursing Visits 3. Early Live Discharges 4. Late Live Discharges 5. Burdensome Transitions (Type 1)- Live Discharges form Hospice Followed by Hospitalization and Subsequent Hospice Readmission 6. Burdensome Transitions (Type 2) - Live Discharges form 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
CAHPS Hospice Survey (single measure) 1. Communication with Family 2. Getting timely help 3. Treating patient with respect 4. Emotional and spiritual support 5. Help for pain and symptoms 6. Training family to care for the patient 7. Rating of this hospice 8. Willing to recommend this hospice

2. Hospice Outcomes & Patient Evaluation (HOPE) Update

The HOPE is intended to help hospices better understand patient and family care needs throughout the hospice process and contribute this information to the patient's plan of care. HOPE will include key items from the HIS and demographics such as gender and race. HOPE is a multidisciplinary instrument to be completed by nursing, social work, and spiritual care staff. 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 discusses the development of HOPE and alpha testing. Alpha testing was completed at the end of January 2021 and CMS incorporated findings from alpha testing for the next draft of the HOPE assessment. Beta testing began in late fall 2021 and was completed in October 2022. CMS is using the input obtained from field testing to refine the HOPE and will propose a final version of HOPE in future rulemaking.

CMS will continue the development of the HOPE assessment in accordance with the Blueprint for the CMS Measures Management System. CMS will provide updates[13] and engagement opportunities on its website.[14] Comments about HOPE can be sent to

[13] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE.
[14] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.

HospiceAssessment@cms.hhs.gov. CMS intends to provide additional information about HOPE testing results on the HQRP website in late Spring 2023.

3. Update on Future Quality Measure (QM) Development

CMS plans to develop at least two HOPE-based process and outcome quality measures: (1) Timely Reassessment of Pain Impact; and (2) Timely Reassessment of Non-Pain Symptom Impact. Additional information about the development of these measures is available in the 2021 Technical Expert Panel (TEP) Summary Reports and the 2021 Information Gathering Report.[15]

4. Health Equity Updates Related to HQRP

CMS defines a health equity measure as a measure (or group of measures) that has the capability to identify, quantify, characterize, and/or link drivers of health and related needs to disparities in health access, processes, outcomes, or patient experiences. The measure(s) can be used to inform the design, implementation, and evaluation of interventions to advance equitable opportunity for optimal health and well-being for all individuals and populations.

In the FY 2023 Hospice final rule (87 FR 45669), CMS summarized public comments and suggestions received in response to a hospice health equity RFI. After considering these comments, in Fall 2022, CMS convened a health equity technical panel, the Home Health and Hospice Health Equity TEP (Home Health & Hospice HE TEP). The TEP is comprised of health equity experts from hospice and home health settings with expertise in quality assurance, patient advocacy, clinical work, and measure development. The TEP is charged with providing input on a potential cross-setting health equity structural composite measure. CMS notes that a summary of the TEP meeting and final recommendations will be available in 2023.

As part of its commitment to incorporate health equity into the HQRP, CMS is considering measure stratification to calculate quality measure outcomes separately for different beneficiary populations. CMS is also considering adding social determinants of health (SDOH) data items used in the post-acute care setting and hospital inpatient setting into HQRP. Adding SDOH to the HQRP would support the Agency's National Quality Strategy to streamline quality measures across CMS quality programs and support measure alignment across programs (referred to as the "Universal Foundation" of quality measure).[16]

CMS will consider input from hospice stakeholders as it develops health equity policies across CMS and other HHS initiatives. CMS also identified two current opportunities to provide public comments: (1) the Initial Proposals for Updating OMB's Race and Ethnicity Statistical Standards (88 FR 5375) and (2) future versions of the United States Core Data for Interoperability (USCDI).[17]

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[15] Both reports are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.

[16] Jacobs DB, Schreiber M, Seshamani M, Tsai D, Fowler E, Fleisher LA. Aligning Quality Measures across CMS – The Universal Foundation. N Engl J Med 2023;388;776-779.

[17] https://www.healthit.gov/sites/isa/files/2023-01/Draft-USCDI-Version-4-January-2023-Final.pdf.

4. CAHPS Hospice Survey Updates

The CAHPS Hospice Survey measures were re-endorsed by NQF in 2020. The eight survey-based measures are publicly reported on the CMS website, Care Compare, https://www.medicare.gov/care-compare. To meet the CAHPS Hospice Survey requirements for the HQRP, hospices must contract with a CMS-approved vendor to collect survey data for eligible patients on a monthly basis and the vendor must report the data to CMS by the quarterly deadlines. CMS does not propose any changes in this rule.

*CAHPS Hospice Survey Mode Experimen*t. CMS conducted a CAHPS Hospice Survey Mode Experiment in 2021. Fifty-six large hospices participated in the mode experiment and a total of 15,515 decedents/caregivers were randomly sampled from these hospices and randomly assigned to one of the modes of administration. The response rates to the revised survey were 35.1 percent in mail only mode, 31.5 percent in telephone only mode, 45.3 percent in mail-telephone combination, and 39.7 percent in web-mail mode. Additional results are discussed in the rule.

CMS plans to use these results to make potential changes to the administration protocols and survey instrument content. Potential measure changes will be submitted to the Measures Under Consideration (MUC) process in 2023 and may be proposed in future rulemaking.

5. 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 13 (reproduced below) summarizes these three timeframes.

Table 13: 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 2022	FY 2024 APU*	CY 2021
CY 2023	FY 2025 APU	CY 2022
CY 2024	FY 2026 APU	CY 2023
CY 2025	FY 2027 APU	CY 2024

*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 14 (reproduced below) summarizes the HQRP compliance timeliness threshold requirements for a specific FY APU. CMS requires that hospices submit 90 percent of all required HIS records within 30 days of the event (patient's admission or discharge). CMS states that most hospices that fail to meet HQRP requirements miss the 90 percent threshold.

Table 9: HQRP Compliance Checklist		
Annual Payment Update	**HIS**	**CAHPS**
FY 2024	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 1/1/2022– 12/31/2022	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2022 – 12/31/2022
FY 2025	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 1/1/2023 – 12/31/2023	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2023 – 12/31/2023
FY 2026	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 1/1/2024 – 12/31/2024	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2024 – 12/31/2024
FY 2027	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 1/1/2025 – 12/31/2025	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2025 – 12/31/2025

Proposal to Codify HQRP Data Completion Thresholds. CMS proposes to codify at §418.312(j)(1) the requirement that hospices must meet or exceed the data submission threshold set at 90 percent of all required HIS or successor instrument records within 30 days of the event (patient's admission or discharge) and submit the data through the CMS designated data submission systems. This threshold would apply to all HIS or successor instrument-based measures and data elements adopted into HQRP. CMS also proposes to codify at §418.312(j)(2) that a hospice must meet or exceed this threshold to avoid receiving a 4-percentage point reduction to its annual payment update for a given FY as codified at §418.306(b)(2).

Establishing Hospice Program Survey and Enforcement Procedures Under the Medicare Program; Provisions Update (CAA 2021, Section 407. The CAA directs the Secretary to create a Special Focus Program (SFP) for poor-performing hospice programs, sets out authority for imposing enforcement remedies for noncompliant hospice programs, requires the development and implementation of a range of remedies, and procedures for appealing determinations regarding these remedies. These remedies can be imposed instead of, or in addition to, termination of the hospice programs' participation in the Medicare program. In the 2022 Home Health final rule CMS finalizes all of the CAA provisions except for the SFP.[18]

Except for the SFP provision, CMS finalized CAA provisions in the CY 2022 Home Health PPS final rule.[19] To obtain input on the structure and methodology of the SFP, CMS convened a TEP; the final TEP feedback will be publicly available on the CMS website in April 2023. CMS plans to include a proposal implementing the SFP in the 2024 Home Health proposed rule.

[18] https://www.gov/info.gov/content/pkg/FR-2021-11-09/pdf/2021-23993.pdf.
[19] CY 2022 HH PPS final rule: https://www.govinfo.gov/content/pkg/FR-2021-11-09/pdf/2021-23993.pdf.

D. Proposals Regarding Hospice Ordering/Certifying Physician Enrollment

1. Background

CMS discusses its statutory authorities to establish a process for the enrollment of providers and suppliers into the Medicare program. The primary purpose of the enrollment process to confirm that providers and suppliers furnishing services or items to Medicare beneficiaries meet all applicable Federal and state requirements and prevent unqualified and potentially fraudulent individuals and entities from inappropriately billing Medicare.

The Affordable Care Act authorized the Secretary to require a physician ordering durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) be enrolled in Medicare for payment for the DMEPOS item to be made (section 6405(a)) and a similar provision regarding the certification of a physician (or certain eligible professionals) for Part A and B home health services (section 6405(b)). Section 6405(c) authorizes the Secretary to extend the requirements of sections 6405(a) and (b) to all categories of items or services under title XVIII of the Act (including covered Part D drugs) that are ordered, prescribed, or referred by a physician or eligible professional enrolled in Medicare under section 1866(j) of the Act. In 2016, consistent with section 6405(c), CMS proposed to extend the requirements that a physician or eligible professional must be either enrolled in Medicare in an approved status or have a valid opt-out affidavit to any Part A and Part B service, item, or drug. Commenters expressed concern about the burden of having to enroll in Medicare and CMS did not finalize this proposal.[20]

CMS discusses recent OIG and GAO reports that highlight program integrity concerns in the hospice program. A 2018 OIG study described schemes involving physicians falsely certifying beneficiaries as terminally ill when they were not.[21] The OIG expressed concerns that beneficiaries were inappropriately enrolled in hospice care and might be unwittingly forgoing needed treatment. A 2019 GAO report expressed concern that CMS's oversight of the quality of Medicare hospice care must keep pace with the increasing number of Medicare hospice beneficiaries and hospice providers.[22]

2. Proposed Provisions

CMS is concerned about increasing vulnerabilities in the hospice program and plans to examine options to decrease fraud, waste, and abuse in this program. As an initial step, CMS proposes that physicians who order or certify hospice services for Medicare beneficiaries must be enrolled in Medicare or validly opted-out as a prerequisite for payment for hospice period of care.

Using its authority under section 6405(c) of the Affordable Care Act, CMS proposes the following revisions to §424.507:

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[20] Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process' (84 FR 47794).
[21] "Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity" https://oig.hhs.gov/oei/reports/oei-02-16-00570/pdf.
[22] "Medicare Hospice Care: Opportunities Exist to Strengthen CMS Oversight of Hospice Providers" https://www.gao.gov/assets/gao-20-10.pdf.

- Add hospice to the current heading of §424.507(b) and the introductory text of §424.507(b).
- Revise the beginning of §424.507 (b)(1) to clarify that only a physician can order/certify hospice services.
- Revise §424.507(b)(3) to require that both the initial and subsequent hospice periods must be certified by an enrolled or validly opted-out physician.

CMS believes this proposal is less burdensome that the 2016 proposal because it impacts only one provider/supplier type. CMS also states that many hospice certifying physicians are already enrolled in Medicare or have validly opted-out.

Additional Information. CMS discusses additional steps it is taking to obtain additional information about provider and supplier ownership, including hospices. Specifically, CMS notes that it has proposed revisions in the Form CMS-855A Medicare provider enrollment application to collect additional information to understand indirect ownership relationships and the types of entities that own the provider/supplier/hospice.[23] CMS is considering additional provider enrollment measures related to hospice ownership as a means to strengthen protections against hospice fraud schemes.

III. Regulatory Impact Analysis

CMS states that the overall impact of this proposed rule is an estimated net increase in Federal Medicare payments to hospices of $720 million or 2.8 percent, for FY 2024. This aggregate increase is simply a result of the hospice payment update percentage of 2.8 percent, because other policy changes are implemented in a budget-neutral manner. There are distributional effects among facilities and region as a result of the updated wage index data.

Table 16 in the proposed 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 (almost three-quarters of all hospices) are expected to have an increase in hospice payments of 2.8 percent compared with 2.7 percent for non-profit and government hospices, respectively. Hospices located in rural areas would see an increase of 2.5 percent compared with 2.8 percent for hospices in urban areas. The projected overall impact on hospices varies more 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 and South Atlantic would experience the largest estimated increase in payments of 3.3 and 3.1 percent, respectively in FY 2024 payments. In contrast, hospices serving patients in the Outlying and New England regions would experience, on average, the lowest estimated increase of 1.2 and 2.1 percent, respectively in FY 2024 payments.

[23] 87 FR 76626

Table 16: Projected Impact to Hospices for FY 2024				
Hospice Subgroup	**Hospices**	**FY 2024 Updated Wage Data**	**FY 2024 Proposed Hospice Payment Update (%)**	**Overall Total Impact for FY 2024**
All Hospices	5,640	0.0%	2.8%	2.8%
Hospice Type and Control				
Freestanding/Non-Profit	567	-0.1%	2.8%	2.7%
Freestanding/For-Profit	4,007	0.0	2.8%	2.8%
Freestanding/Government	41	-0.2%	2.8%	2.6%
Freestanding/Other	353	0.3%	2.8%	3.1%
Facility/HHA Based/Non-Profit	329	-0.1%	2.8%	2.7%
Facility/HHA Based/For-Profit	188	-0.4%	2.8%	2.4%
Facility/HHA Based/Government	73	0.1%	2.8%	2.9%
Facility/HHA Based/Other	82	0.0%	2.8%	2.8%
Subtotal: Freestanding Facility	4,968	0.0%	2.8%	2.8%
Subtotal: Facility/HHA Based Facility Type	672	-0.1%	2.8%	2.7%
Subtotal: Non-Profit	896	-0.1%	2.8%	2.7%
Subtotal: For Profit	4,195	0.0%	2.8%	2.8%
Subtotal: Government	114	-0.1%	2.8%	2.7%
Subtotal: Other	435	0.2%	2.8%	3.0%
Hospice Type and Control: Rural				
Freestanding/Non-Profit	127	-0.3%	2.8%	2.5%
Freestanding/For-Profit	358	-0.3%	2.8%	2.5%
Freestanding/Government	23	-0.7%	2.8%	2.1%
Freestanding/Other	50	-0.2%	2.8%	2.6%
Facility/HHA Based/Non-Profit	128	-0.4%	2.8%	2.4%
Facility/HHA Based/For-Profit	51	-0.1%	2.8%	2.7%
Facility/HHA Based/Government	57	-0.2%	2.8%	2.6%
Facility/HHA Based/Other	44	-0.3%	2.8%	2.5%
Facility Type and Control: Urban				
Freestanding/Non-Profit	440	-0.1%	2.8%	2.7%
Freestanding/For-Profit	3,649	0.1%	2.8%	2.9%
Freestanding/Government	18	-0.1%	2.8%	2.7%
Freestanding/Other	303	0.3%	2.8%	3.1%

Table 16: Projected Impact to Hospices for FY 2024				
Hospice Subgroup	**Hospices**	**FY 2024 Updated Wage Data**	**FY 2024 Proposed Hospice Payment Update (%)**	**Overall Total Impact for FY 2024**
Facility/HHA Based/Non-Profit	201	0.0%	2.8%	2.8%
Facility/HHA Based/For-Profit	137	-0.5%	2.8%	2.3%
Facility/HHA Based/Government	16	0.3%	2.8%	3.1%
Facility/HHA Based/Other	38	0.1%	2.8%	2.9%
Hospice Location: Urban or Rural				
Rural	838	-0.3%	2.8%	2.5%
Urban	4,802	0.0%	2.8%	2.8%
Hospice Location: Census Division				
New England	151	-0.7%	2.8%	2.1%
Middle Atlantic	284	0.5%	2.8%	3.3%
South Atlantic	607	0.3%	2.8%	3.1%
East North Central	587	-0.5%	2.8%	2.3%
East South Central	255	-0.1%	2.8%	2.7%
West North Central	420	-0.3%	2.8%	2.5%
West South Central	1,101	0.2%	2.8%	3.0%
Mountain	589	-0.3%	2.8%	2.5%
Pacific	1,597	0.2%	2.8%	3.0%
Outlying	49	-1.6%	2.8%	1.2%
Hospice Size			2.8%	
0 - 3,499 RHC Days (Small)	1,414	0.1%	2.8%	2.9%
3,500-19,999 RHC Days (Medium)	2,551	0.0%	2.8%	2.8%
20,000+ RHC Days (Large)	1,675	0.0%	2.8%	2.8%

Source: FY 2022 hospice claims data from the CCW accessed on January 22, 2023.

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