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Medicare Program; FY 2025 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, and Hospice Quality Reporting Program Requirements [CMS-1810-P] Proposed Rule Summary

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I. Introduction and Background

On March 28, 2024, the Centers for Medicare & Medicaid Services (CMS) placed on public display a proposed rule updating the Medicare hospice payment rates, wage index and Hospital Quality Reporting Program (HQRP) for FY 2025. The proposed rule is scheduled to be published in the April 4, 2024 issue of the *Federal Register*. **Comments on the proposed rule are due by May 28, 2024.**

For FY 2025, CMS proposes to adopt the most recent Office of Management and Budget (OMB) statistical area delineations, which revises the existing care-based statistical areas, and would change the hospice wage index. Hospices affected by the change to their geographic wage index will be eligible for applying a 5-percent cap on any decrease to the wage index from the prior year. The rule also proposes that HQRP measures will be collected through a new collection instrument, the Hospice Outcomes and Patient Evaluation (HOPE) and proposes two HOPE-based measures. This rule also proposes changes to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey. CMS requests information regarding payment mechanisms for high intensity palliative care services and social determinants of health (SDOH) elements for inclusion as potential future measures in the HQRP.

CMS estimates that the overall impact of the proposed rule will be an increase of $705 million (2.6 percent) in Medicare payments to hospices during FY 2025.

CMS notes that wage index addenda for FY 2025 (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

In prior rules, CMS included data about hospice utilization trends. CMS will now include this information only on the CMS hospice center webpage at https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice.

II. Provisions of the Proposed Rule

A summary of key data for the proposed hospice payment rates for FY 2025 is presented below with additional details in the subsequent sections.

Summary of Key Data for Proposed Hospice Payment Rates for FY 2025			
Market basket update factor			
Market basket increase			+3.0%
Required total factor productivity (TFP)			-0.4%
Net TFP-adjusted update reporting quality data			**+2.6%**
Net TFP-adjusted update not reporting quality data			**-1.4%**
Hospice aggregate cap amount			$34,364.85
Hospice Payment Rate Care Categories	**Labor Share**	**FY 2024 Federal Rates Per Diem**	**Proposed FY 2025 Federal Rates Per Diem**
Routine Home Care (days 1-60)	66.0%	$218.33	$223.83
Routine Home Care (days 61+)	66.0%	$172.35	$176.39
Continuous Home Care, Full Rate = 24 hours of care, $67.10 hourly rate	75.2%	$1,565.45	$1,610.34
Inpatient Respite Care	61.0%	$507.71	$518.15
General Inpatient Care	63.5%	$1,145.31	$1,166.98
Proposed Service Intensity Add-on (SIA) payment, up to 4 hours			$67.10 per hour
Notes: 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. FY 2025 Hospice Wage Index and Rate Update

As discussed below in section 2, CMS proposes to adopt the most recent Office of Management and Budget (OMB) statistical area delineations, which revises the existing care-based statistical areas. Hospices affected by the change to their geographic wage index will be eligible for applying a 5-percent cap on any decrease to the wage index from the prior year.

1. FY 2025 Hospice Wage Index

The hospice wage index is used to adjust payment rates to reflect local differences in area wage levels, based on the location where services are furnished. CMS requires each labor market to be established using the most current hospital wage data available, including any changes made by OMB to the Metropolitan Statistical Area (MSA) definitions (§418.306(c)). CMS discusses its prior adjustments to the delineations of the labor markets based on OMB MSA definitions. In 2020, OMB issued Bulletin No. 20-01 which provided updates to and superseded OMB Bulletin No. 18-04.[1] In the FY 2021 Hospice final rule (85 FR 47070), CMS stated that if appropriate it would propose any updates from OMB Bulletin No. 20-01 in future rulemaking. As discussed in section 2, CMS proposes to adopt the updates from OMB Bulletin No. 23-01 (issued on July 21, 2023) which update and supersede OMB Bulletin No. 20-01.

[1] OMB Bulletin No. 20-01 is available at https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf.

For FY 2025, CMS proposes the proposed hospice wage index will be based on the FY 2025 hospital pre-floor, pre-reclassified wage index using hospital cost reporting periods beginning on or after October 1, 2020 and before October 1, 2021 (FY 2021 cost report data). The hospice wage index does not take into account any geographic reclassification of hospitals, but includes a 5-percent cap on wage index decreases. The appropriate wage index value is applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving routine home care (RHC) or continuous home care (CHC) and applied based on the geographic location of the facility for beneficiaries receiving general inpatient care (GIP) or inpatient respite care (IRC). 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.[2]

CMS also proposes to continue to apply current policies for geographic areas where there are no hospitals. For urban areas of this kind, all core-based statistical areas (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 2025, there is one CBSAs without a hospital from which hospital wage data can be derived: 25980, Hinesville-Fort Stewart, Georgia. The FY 2025 wage index value for Hinesville-Fort Stewart, Georgia is 0.8726.

For rural areas without hospital wage data, CMS uses the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. For FY 2025, as part of the proposal to adopt the revised OMB delineations, CMS proposes that rural North Dakota would become a rural area without a hospital from which hospital data can be devised. To calculate the wage index for rural area 99935, North Dakota, CMS proposes to use as a proxy the average pre-floor, pre-reclassified hospital wage data (update by the hospice floor) from the contiguous CBSA: CBSA 13900-Bismark, ND; CBSA 22020-Fargo, ND-MN; CNSA 24220-Grand Forks, ND-MH; and CBSA 33500, Minot, ND (Table 1). CMS proposes a FY 2025 hospice wage index of 0.8446 for rural North Dakota.

Previously, the only rural area without a hospital from which hospital wage data could be derived was Puerto Rico. For FY 2025, based on the proposal to use the revised OMB delineations, there would be a hospital in rural Puerto Rico from which hospital wage data could be derived. CMS proposes that the wage index for rural Puerto Rico would be based on this hospital data for the area instead of the previously available pre-hospice floor wage index of 0.4047 or an adjusted wage index value of 0.4654. Specifically, the proposed pre-hospice floor unadjusted wage index for rural Puerto Rico would be 0.2520 with an adjusted wage index by the hospice floor of 0.2898. Because 0.2808 is more than a 5-percent decline in the FY 2024 wage index, the 5-percent cap would apply and the proposed FY 2025 wage index will be 0.4421.

In addition, if the adoption of the revised OMB delineations is finalized, CMS proposes that Delaware, which was previously an all-urban State, would have one rural area with a hospital from which hospital wage data can be derived. The proposed FY 2025 wage index for rural area 99908 Delaware would be 1.0429.

[2] 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.

2. Proposed Implementation of New Labor Market Delineations

On July 1, 2023, OMB issued Bulletin No. 23-01, which updates and supersedes OMB Bulletin No. 20-01 (referred to as OMB "2020 Standards". OMB Bulletin No. 23-01 establishes revised delineations for the MSAs, Micropolitan Statistical Areas, Combined Statistical Areas, and Metropolitan Divisions, collectively referred to as Core Based Statistical Areas (CBSA).[3] CMS believes that using the most current OMB delineations would increase the integrity of the hospice wage index by creating a more accurate representation of geographic variation in wage levels. For FY 2025, CMS proposes to implement the new OMB delineations as described in OMB Bulletin No. 23-01 for the hospice wage index.

a. Micropolitan Statistical Areas. The OMB "2020 Standards" continue to define a Micropolitan Statistical Area" as a CBSA with at least one Urban Area that has a population of at least 10,000 but less than 50,000; CMS refers to these as Micropolitan Areas. CMS treats Micropolitan areas as rural and to include these areas in the calculation of each State's rural wage index.[4]

Overall, there are the same number of Micropolitan Areas (542) under the new OMB delineations based on the 2020 Census. CMS notes, however, there are a number of urban counties that have switched status and have joined or become Micropolitan Areas, and some counties that were previously part of a Micropolitan Area, and thus treated as rural, have become urban. Consistent with its current policy, in conjunction with its proposal to implement the new OMB labor market delineations, CMS proposes to continue to treat Micropolitan areas as rural and to include Micropolitan Areas in the calculation of each State's rural wage index.

b. Changes to Country-Equivalents in the State of Connecticut. In June 2022, the Census Bureau announced it was implementing Connecticut's request to replace the eight counties in the State with nine new "Planning Regions".[5] OMB Bulletin No, 23-01 includes planning regions as county-equivalents within the CBSA system. CMS is proposing to adopt the planning regions as county equivalents for wage index purposes. Table 2 in the proposed rule provides a crosswalk for counties located in Connecticut.

c. Urban Counties That Would Become Rural. Based on the revised OMB statistical area delineations, 53 counties and county equivalents that are currently considered urban would be considered rural beginning in FY 2025 (see Table 3, reproduced below).

Table 3: Urban Countries That Would Change to Rural Status

FIPS County Codes	County Number	State	Current CBSA	Current CBSA Name
01129	WASHINGTON	AL	33660	Mobile, AL
05025	CLEVELAND	AR	38220	Pine Bluff, AR
05047	FRANKLIN	AR	22900	Fort Smith, AR-OK
05069	JEFFERSON	AR	38220	Pine Bluff, AR

[3] OMB Bulletin No. 2021 is available at https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf.
[4] 70 FR 22397, 70 FR 45132, and 85 FR 47074,47080)
[5] 87 FR 34235-34240

Table 3: Urban Countries That Would Change to Rural Status				
FIPS County Codes	County Number	State	Current CBSA	Current CBSA Name
05079	LINCOLN	AR	38220	Pine Bluff, AR
10005	SUSSEX	DE	41540	Salisbury, MD-DE
13171	LAMAR	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA
16077	POWER	ID	38540	Pocatello, ID
17057	FULTON	IL	37900	Peoria, IL
17077	JACKSON	IL	16060	Carbondale-Marion, IL
17087	JOHNSON	IL	16060	Carbondale-Marion, IL
17183	VERMILION	IL	19180	Danville, IL
17199	WILLIAMSON	IL	16060	Carbondale-Marion, IL
18121	PARKE	IN	45460	Terre Haute, IN
18133	PUTNAM	IN	26900	Indianapolis-Carmel-Anderson, IN
18161	UNION	IN	17140	Cincinnati, OH-KY-IN
21091	HANCOCK	KY	36980	Owensboro, KY
21101	HENDERSON	KY	21780	Evansville, IN-KY
22045	IBERIA	LA	29180	Lafayette, LA
24001	ALLEGANY	MD	19060	Cumberland, MD-WV
24047	WORCESTER	MD	41540	Salisbury, MD-DE
25011	FRANKLIN	MA	44140	Springfield, MA
26155	SHIAWASSEE	MI	29620	Lansing-East Lansing, MI
27075	LAKE	MN	20260	Duluth, MN-WI
28031	COVINGTON	MS	25620	Hattiesburg, MS
31051	DIXON	NE	43580	Sioux City, IA-NE-SD
36123	YATES	NY	40380	Rochester, NY
37049	CRAVEN	NC	35100	New Bern, NC
37077	GRANVILLE	NC	20500	Durham-Chapel Hill, NC
37085	HARNETT	NC	22180	Fayetteville, NC
37087	HAYWOOD	NC	11700	Asheville, NC
37103	JONES	NC	35100	New Bern, NC
37137	PAMLICO	NC	35100	New Bern, NC
42037	COLUMBIA	PA	14100	Bloomsburg-Berwick, PA
42085	MERCER	PA	49660	Youngstown-Warren-Boardman, OH-PA
42089	MONROE	PA	20700	East Stroudsburg, PA
42093	MONTOUR	PA	14100	Bloomsburg-Berwick, PA
42103	PIKE	PA	35084	Newark, NJ-PA
45027	CLARENDON	SC	44940	Sumter, SC
48431	STERLING	TX	41660	San Angelo, TX
49003	BOX ELDER	UT	36260	Ogden-Clearfield, UT
51113	MADISON	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV
51175	SOUTHAMPTON	VA	47260	Virginia Beach-Norfolk-Newport News, VA- NC
51620	FRANKLIN CITY	VA	47260	Virginia Beach-Norfolk-Newport News, VA- NC

Table 3: Urban Countries That Would Change to Rural Status				
FIPS County Codes	County Number	State	Current CBSA	Current CBSA Name
54035	JACKSON	WV	16620	Charleston, WV
54043	LINCOLN	WV	16620	Charleston, WV
54057	MINERAL	WV	19060	Cumberland, MD-WV
55069	LINCOLN	WI	48140	Wausau-Weston, WI
72001	ADJUNTAS	PR	38660	Ponce, PR
72055	GUANICA	PR	49500	Yauco, PR
72081	LARES	PR	10380	Aguadilla-Isabela, PR
72083	LAS MARIAS	PR	32420	Mayagüez, PR
72141	UTUADO	PR	10380	Aguadilla-Isabela, PR

d. Rural Counties That Would Become Urban. Based on the revised OMB statistical area delineations, 54 counties and county equivalents that are currently considered rural would be considered urban beginning in FY 2025 (see Table 4, reproduced below).

Table 4: Rural Counties That Would Change to Urban Status				
FIPS County Code	**County Name**	**State**	**Proposed FY 2025 CBSA**	**Proposed FY 2025 CBSA Name**
01087	MACON	AL	12220	Auburn-Opelika, AL
01127	WALKER	AL	13820	Birmingham, AL
12133	WASHINGTON	FL	37460	Panama City-Panama City Beach, FL
13187	LUMPKIN	GA	12054	Atlanta-Sandy Springs-Roswell, GA
15005	KALAWAO	HI	27980	Kahului-Wailuku, HI
17053	FORD	IL	16580	Champaign-Urbana, IL
17127	MASSAC	IL	37140	Paducah, KY-IL
18159	TIPTON	IN	26900	Indianapolis-Carmel-Greenwood, IN
18179	WELLS	IN	23060	Fort Wayne, IN
20021	CHEROKEE	KS	27900	Joplin, MO-KS
21007	BALLARD	KY	37140	Paducah, KY-IL
21039	CARLISLE	KY	37140	Paducah, KY-IL
21127	LAWRENCE	KY	26580	Huntington-Ashland, WV-KY-OH
21139	LIVINGSTON	KY	37140	Paducah, KY-IL
21145	MC CRACKEN	KY	37140	Paducah, KY-IL
21179	NELSON	KY	31140	Louisville/Jefferson County, KY-IN
22053	JEFFRSON DAVIS	LA	29340	Lake Charles, LA
22083	RICHLAND	LA	33740	Monroe, LA
26015	BARRY	MI	24340	Grand Rapids-Wyoming-Kentwood, MI
26019	BENZIE	MI	45900	Traverse City, MI
26055	GRAND TRAVERSE	MI	45900	Traverse City, MI
26079	KALKASKA	MI	45900	Traverse City, MI

Table 4: Rural Counties That Would Change to Urban Status				
FIPS County Code	**County Name**	**State**	**Proposed FY 2025 CBSA**	**Proposed FY 2025 CBSA Name**
26089	LEELANAU	MI	45900	Traverse City, MI
27133	ROCK	MN	43620	Sioux Falls, SD-MN
28009	BENTON	MS	32820	Memphis, TN-MS-AR
28123	SCOTT	MS	27140	Jackson, MS
30007	BROADWATER	MT	25740	Helena, MT
30031	GALLATIN	MT	14580	Bozeman, MT
30043	JEFFERSON	MT	25740	Helena, MT
30049	LEWIS AND CLARK	MT	25740	Helena, MT
30061	MINERAL	MT	33540	Missoula, MT
32019	LYON	NV	39900	Reno, NV
37125	MOORE	NC	38240	Pinehurst-Southern Pines, NC
38049	MCHENRY	ND	33500	Minot, ND
38075	RENVILLE	ND	33500	Minot, ND
38101	WARD	ND	33500	Minot, ND
39007	ASHTABULA	OH	17410	Cleveland, OH
39043	ERIE	OH	41780	Sandusky, OH
41013	CROOK	OR	13460	Bend, OR
41031	JEFFERSON	OR	13460	Bend, OR
42073	LAWRENCE	PA	38300	Pittsburgh, PA
45087	UNION	SC	43900	Spartanburg, SC
46033	CUSTER	SD	39660	Rapid City, SD
47081	HICKMAN	TN	34980	Nashville-Davidson--Murfreesboro-- Franklin, TN
48007	ARANSAS	TX	18580	Corpus Christi, TX
48035	BOSQUE	TX	47380	Waco, TX
48079	COCHRAN	TX	31180	Lubbock, TX
48169	GARZA	TX	31180	Lubbock, TX
48219	HOCKLEY	TX	31180	Lubbock, TX
48323	MAVERICK	TX	20580	Eagle Pass, TX
48407	SAN JACINTO	TX	26420	Houston-Pasadena-The Woodlands, TX
51063	FLOYD	VA	13980	Blacksburg-Christiansburg-Radford, VA
51181	SURRY	VA	47260	Virginia Beach-Chesapeake-Norfolk, VA-NC
55123	VERNON	WI	29100	La Crosse-Onalaska, WI-MN

e. Urban Counties That Would Move to a Different Urban CBSA. Based on the revised OMB statistical area delineations, several counties shift from one urban CBSA to a new or existing urban CBSA. In some cases, there is only a change in the CBSA name or number while the CBSA would continue to encompass the same constituent counties. Table 5 in the proposed rule lists CBSAs that would change in name and/or CBSA numbers only – the constituent counties would not change (unless as discussed above an urban county becomes rural or vice versa).

In some cases, all the urban counties from a FY 2024 CBSA would be moved and subsumed by another CBSA in FY 2025 (see Table 6, reproduced below).

Table 6: Urban Areas Being Subsumed by Another CBSA			
Current CBSA Code	**Current CBSA Name**	**Proposed FY 2025 CBSA Code**	**Proposed FY 2025 CBSA Name**
31460	Madera, CA	23420	Fresno, CA
36140	Ocean City, NJ	12100	Atlantic City-Hammonton, NJ
41900	San Germán, PR	32420	Mayagüez, PR

In some cases, some counties would shift between existing and new CBSAs, changing the constituent makeup of the CBSAs. For example, the District of Columbia, DC, Charles County, MD and Prince Georges County, MD would move from CBSA 47894 (Washington-Arlington-Alexandria, DC-VA-MD-WV) into CBSA 47764 (Washington, DC-MD). Table 7, in the proposed rule, lists the 73 urban counties that would move from one urban CBSA to a new or modified urban CBSA.

f. Proposed Transition Period. CMS discusses how it has used prior transition periods when adapting changes with significant payment implications, especially large negative impacts, in order to mitigate the potential impacts of policy changes.

For the proposed changes related to the revised OMB delineations, CMS believes that the permanent 5-percent cap on wage index decreases would be sufficient to mitigate any potential negative impact on hospices and no transition is necessary. However, for FY 2025, to mitigate any potential negative impact, CMS proposes that in addition to the 5-percent cap being calculated for an entire CBSA or statewide rural area (the current policy), the cap could also be calculated at the county level, so that individual counties moving to a new delineation would not experience more than a 5 percent decrease in wage index from the previous FY. Specifically, **CMS proposes for FY 2025, the 5-percent cap would also be applied to counties that move from a CBSA or statewide rural area with a higher wage index value into a new CBSA or rural area with a lower wage index value**, so that the county's FY 2025 wage index would not be less than 95 percent of the county's FY 2024 wage index value.

CMS notes that because of the proposal to calculate the 5-percent cap for counties that experience an OMB designation change, some counties would have a wage index value that is different than the wage index value assigned to the other constituent counties that make up the CBSA or statewide rural area. This presents a challenge for claims processing because each CBSA or statewide rural area can have only one wage index value assigned to that CBSA or statewide rural area.

CMS proposes that beginning in FY 2025, counties that have a different wage index value than the CBSA or rural area into which they are designated after the application of the 5-percent cap would use a wage index transition code. The code would be five digits in length and begin with "50". CMS also proposes that the county would continue to use the assigned 50XXX transition

code until the county's wage index value calculated for that FY is not less than 95 percent of the county's capped wage index from the previous FY. Table 8, reproduced below, shows the counties that will use the transition code and the proposed code.

Table 8: Counties That Will Use a Wage Index Transition Code

FIPS Code	County Name	State	FY 2024 CBSA	FY 2024 CBSA Name	Proposed FY 2025 CBSA	Proposed FY 2025 CBSA Name	Proposed Code
01129	WASHINGTON	AL	33660	Mobile, AL	99901	ALABAMA	50001
13171	LAMAR	GA	12060	Atlanta-Sandy Springs-Alpharetta, GA	99911	GEORGIA	50002
15005	KALAWAO	HI	99912	HAWAII	27980	Kahului-Wailuku, HI	50003
16077	POWER	ID	38540	Pocatello, ID	99913	IDAHO	50004
17183	VERMILION	IL	19180	Danville, IL	99914	ILLINOIS	50005
18133	PUTNAM	IN	26900	Indianapolis-Carmel-Anderson, IN	99915	INDIANA	50006
21101	HENDERSON	KY	21780	Evansville, IN-KY	99918	KENTUCKY	50007
24009	CALVERT	MD	47894	Washington-Arlington-Alexandria, DC- VA-MD-WV	30500	Lexington Park, MD	50008
24047	WORCESTER	MD	41540	Salisbury, MD-DE	99921	MARYLAND	50009
25011	FRANKLIN	MA	44140	Springfield, MA	99922	MASSACHUSETTS	50010
26155	SHIAWASSEE	MI	29620	Lansing-East Lansing, MI	99923	MICHIGAN	50011
27075	LAKE	MN	20260	Duluth, MN-WI	99924	MINNESOTA	50012
27133	ROCK	MN	99924	MINNESOTA	43620	Sioux Falls, SD-MN	50013
32019	LYON	NV	99929	NEVADA	39900	Reno, NV	50014
36123	YATES	NY	40380	Rochester, NY	99933	NEW YORK	50015
37077	GRANVILLE	NC	20500	Durham-Chapel Hill, NC	99934	NC	50016
37087	HAYWOOD	NC	11700	Asheville, NC	99934	NC	50017
39123	OTTAWA	OH	45780	Toledo, OH	41780	Sandusky OH	50018
42103	PIKE	PA	35084	Newark, NJ-PA	99939	PA	50019
51113	MADISON	VA	47894	Washington-Arlington-	99949	VIRGINIA	50020

Table 8: Counties That Will Use a Wage Index Transition Code							
FIPS Code	**County Name**	**State**	**FY 2024 CBSA**	**FY 2024 CBSA Name**	**Proposed FY 2025 CBSA**	**Proposed FY 2025 CBSA Name**	**Proposed Code**
				Alexandria, DC-VA-MD-WV			
51175	SOUTHAMPTON	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC	99949	VIRGINIA	50021
51620	FRANKLIN CITY	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC	99949	VIRGINIA	50021
54057	MINERAL	WV	19060	Cumberland, MD- WV	99951	WV	50022
72001	ADJUNTAS	PR	38660	Ponce, PR	99940	PR	50023
72023	CABO ROJO	PR	41900	SanGermán, PR	32420	Mayagüez, PR	50024
72055	GUANICA	PR	49500	Yauco, PR	99940	PUERTO RICO	50025
72079	LAJAS	PR	41900	San Germán, PR	32420	Mayagüez, PR	50024
72081	LARES	PR	10380	Aguadilla-Isabela, PR	99940	PR	50026
72083	LAS MARIAS	PR	32420	Mayagüez, PR	99940	PR	50027
72121	SABANA GRANDE	PR	41900	San Germán, PR	32420	Mayaguez, PR	50024
72125	SAN GERMAN	PR	41900	San Germán, PR	32420	Mayagüez, PR	50024
72141	UTUADO	PR	10380	Aguadilla-Isabela, PR	99940	PR	50026

The FY 2025 proposed hospice wage index file provides a crosswalk between the FY 2025 wage index using the current and the proposed OMB wage delineations.[6]

3. FY 2025 Hospice Payment Update Percentage

CMS estimates the market basket percentage increase and the productivity adjustment based on HIS Global Inc.'s (IGI's) forecast using the fourth quarter 2023 forecast with historical data through the third quarter of 2023, the most recent available data. For FY 2025, 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 0.4 percentage points. This results in a proposed hospice payment update percentage for FY 2025 of 2.6 percent; CMS proposes to revise this amount in the final rule if more recent data become available. Hospices that do not submit the required quality data under the HQRP would receive a payment update percentage for FY 2025 of -1.4 percent.

[6] https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice/hospice-regulations-and-notices.

CMS proposes to update hospice payments by applying the 2018-based IPPS market basket percentage increase for FY 2025 of 3.0 percent, reduced by the statutorily required productivity adjustment of 0.4 percentage points along with the wage index budget neutrality adjustment to update the payment rates. For the FY 2025 hospice wage index, CMS proposes to use the FY 2025 pre-floor, pre-reclassified IPPS hospital wage index with the proposed revised 2023 OMB labor market delineations.

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; GIP, 63.5 percent; and for IRC, 61.0 percent.

4. FY 2025 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.

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.[7] To calculate the wage index standardization factor, CMS simulated total payments using FY 2023 hospice utilization claims data with the FY 2024 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, old OMB delineations, and the 5-percent cap on wage index decreases) and FY 2024 payment rates and compare it to its simulation of total payment using the FY 2023 hospice utilization claims data, the proposed FY 2025 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, the revised OMB delineations, and the 5-percent cap on wage index decreases) and FY 2024 payment rates. By dividing payments for each level of care using the FY 2024 wage index and FY 2024 payment rates for each level of care using the FY 2025 wage index and FY 2024 payment rates, CMS obtained a wage index standardization factor for each level of care (RHC days 1-60, RHC days 61+, CHC, IRC, and GIP).

Tables 9 and 10 (reproduced below) lists the proposed FY 2025 hospice payment rates by care category and the proposed wage index standardization factors.

[7] CMS uses FY 2023 claims data as of January 11, 2024 to calculate the wage index standardization factor (the most recent available).

Table 9: Proposed FY 2025 Hospice RHC Payments						
Code	**Description**	**FY 2024 Payment Rates**	**SIA Budget Neutrality Factor**	**Wage Index Standardization Factor**	**Proposed FY 2025 Hospice Payment Update**	**Proposed FY 2025 Payment Rates**
651	Routine Home Care (days 1-60)	$218.33	× 1.0009	× 0.9983	× 1.026	$223.83
651	Routine Home Care (days 61+)	$172.35	× 1.0000	× 0.9975	× 1.026	$176.39

Table 10: Proposed FY 2025 Hospice CHC, IRC, and GIP Payment Rates					
Code	**Description**	**FY 2024 Payment Rates**	**Wage Index Standardization Factor**	**Proposed FY 2025 Hospice Payment Update**	**Proposed FY 2025 Payment Rates**
652	Continuous Home Care Full Rate = 24 hours of care	$1,565.46 ($65.23 per hour)	× 1.0026	× 1.026	$1,610.34 ($67.10 per hour)
655	Inpatient Respite Care	$507.71	× 0.9947	× 1.026	$518.15
656	General Inpatient Care	$1,145.31	× 0.9931	× 1.026	$1,166.98

Tables 11 and 12 lists the comparable FY 2025 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), $215.10; Routine Home Care (days 61+), $169.51; Continuous Home Care, $1,547.56; Inpatient Respite Care, $497.95; and General Inpatient Care, $1,121.48.

In the FY 2016 Hospice final rule (80 FR 47172), CMS implemented a Service Intensity Add-on (SAI) payment for RHC when direct patient care is provided by a registered nurse (RN) or social worker during the last seven days of the beneficiary's life. The SAI payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided (up to four hours total) that occurred on the day of service. For FY 2025, the proposed SAI payment is $67.10 per hour, up to 4 hours. In addition, for FY 2025, the proposed SIA budget neutrality factor is 1.009 for RHC days and 1.000 for RHC days 61+.

5. Hospice Cap Amount for FY 2025

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.[8] The aggregate cap amount was set at $6,500 per beneficiary

[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.

when first enacted in 1983, and was 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 CAA, 2023 until September 30, 2032. The proposed hospice aggregate cap amount for the 2025 cap year will be $34,364.85 per beneficiary or the FY 2024 cap amount updated by the proposed FY 2025 hospice payment update percentage ($33,494.01 * 1.026).

B. Clarification of Regulation Text Changes

1. MD Director Condition of Participation (CoP)

CMS discusses discrepancies between the Medical Directors CoP at §418.102 and the payment requirements for the "certification of the terminal illness" and the "admission to hospice care" at §418.22 and §418.25, respectively. Although the CoP provisions at §§418.102(b) and (c) include requirements for the initial certification and recertification of the terminal illness, they do not include the physician member of the interdisciplinary group (IDG) as a type of practitioner who can provide these certifications, even though these physicians are able to certify terminal illness under the payment regulations (§418.22).

CMS proposes to align the medical director CoP and the hospice payment requirements. Specifically, CMS proposes the following:

a. Amend §418.102(b) by adding the physician member of the hospice interdisciplinary group as defined in §418.56(a)(1)(i), as an individual who may provide the initial certification of terminal illness.

b. Amend the medical director CoP (§418.102(c)) to include the medical director, physician designee (as defined at §418.3, if the medical director is not available), or physician member of the IDG among the specified physicians who may review the clinical information as part of the recertification of the terminal illness.

2. Certification of Terminal Illness and Admission to Hospice Care

CMS discusses additional discrepancies between the Medical Directors CoP at §418.102 and the payment requirements for the "certification of the terminal illness" and the "admission to hospice care" at §418.22 and §418.25, respectively. Although the CoP provisions at §418.102 state that "when the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director", the physician designee is not included as an individual who may certify terminal illness and determine admission to hospice care.

CMS proposes to align the medical director CoP and the hospice payment requirements by adding "physician designee (as defined in §418.3) to §418.22 and §418.25" to clarify that when the medical director is not available, a physician designated by the hospice, who is assuming the same responsibilities and obligations as the medical director, may certify terminal illness and determine admission to hospice care.

3. Election of Hospice Care

CMS discusses the distinctions between the "election statement" and the "notice of election" (NOE). A Medicare beneficiary (or their representative) must intentionally choose hospice care and must file an "election statement" with the hospice that includes an acknowledgement that they fully understand the palliative nature of hospice care as it relates to the individual's terminal illness and related conditions (§418.24). As part of "election statement" the individual waives all rights to Medicare payment for any care for the terminal illness and related conditions except for services provided by the designated hospice.

In the FY 2015 Hospice final rule, CMS finalized a requirement that a NOE must be filed with the hospice Medicare Administrative Contractor (MAC) within five calendar days after the effective date of hospice election. If the NOE is filed beyond this timeframe, hospice providers are liable for the services furnished during the days from the effective date of hospice election to the date of NOE filing (79 FR 50478). Late filing of the NOE raises program integrity concerns, including potential Medicare responsibility for paying non-hospice claims related to the terminal illness and related conditions and beneficiary responsibility for the associated cost-sharing for these services provided by non-hospice providers.

CMS proposes to reorganize the language in §418.24 to clarify that the election statement and NOE are two separate and distinct documents with separate purposes. Specifically, CMS proposes to title §418.24(b) as "Election Statement and to include NOE in the title for §418.24(e). CMS believes this reorganize will ensure that stakeholders understand that the election statement is required as acknowledgement of a beneficiary's understanding of the hospice benefit and is filed with the hospice, whereas the NOE is required for claims processing and filed with the hospice MAC.

CMS also reiterates that hospices must have a complete election statement containing all required elements (§418.24(b)) as a condition of payment. CMS encourages hospices to utilize the "Model Example of Hospice Election Statement" on the hospice webpage (https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice).

C. Request for Information (RFI) on Payment Mechanism for High Intensity Palliative Care Services

Under the hospice benefit, palliative care is defined as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering (§418.3). CMS discusses the data suggesting that hospice enrollment and services are underutilized for beneficiaries with complex palliative needs and potentially high-cost medical needs. In addition, feedback from beneficiaries and families suggests that upon election of the hospice benefit,

certain therapies such as dialysis, chemotherapy, radiation, and blood transfusions are not available, even if such therapies would provide palliation for symptoms.

In the FY 2024 hospice proposed rule (88 FR 20022), CMS solicited comments on several issues related to how CMS can assist hospices in better serving vulnerable and underserved populations and address barriers to access. In the FY 2024 hospice final rule (88 FR 51168), CMS noted that in response to this RFI, commenters stated that providing complex palliative treatments and higher intensity levels of hospice care may pose financial risks to hospices when enrolling patients that could receive these services. Commenters also stated that the current bundled per diem payment is not reflective of the increased expenses associated with higher cost.

As CMS continues to focus on improved access and value within the hospice benefit, it solicits public comment on the following questions:

- What could eliminate the financial risk commenters previously noted when providing complex palliative treatments and higher intensity levels of hospice care?
- What specific financial risks or costs are of particular concern that would prevent the provision of appropriate higher-cost palliative treatments? Are there individual cost barriers which may prevent a hospice from providing higher-cost palliative services? For example, is there a cost barrier to obtaining the appropriate equipment (e.g., dialysis machine) or a cost barrier related to the treatment itself (e.g., necessary drugs or specialized staff)?
- Should there be any parameters for when palliative treatment should qualify for a different type of payment?
    - CMS is interested in understanding from hospices who do provide these types of palliative treatments whether the patient is generally in a higher level of care (CHC, GIP) when the decision is made to furnish a higher-cost palliative treatment. Should an additional payment only be applicable when the patient is in RHC?
- Should CMS consider including high-cost treatments in the definition of palliative services (§418.3)?
- Should there be documentation that all other palliative measures have been exhausted prior to billing for payment for a higher-cost treatment? If so, would this continue to be a barrier for hospices?
- Should there be separate payments for different types of higher-cost palliative treatment or one standard payment for any higher-cost treatment that would exceed the per-diem rate?

D. 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)[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. CMS notes that about 18 percent of Medicare-certified hospices are non-compliant with the HQRP reporting requirements and are subject to the APU payment reduction for a given FY. The FY 2025 APU is based on CY 2023 quality data.

CMS did not propose any new quality measures for FY 2023 and FY 2024. Table 13 (reproduced below) lists all the quality measures finalized in the FY 2022 Hospice final rule and in effect for the FY 2025 HQRP.[10]

Table 13: Quality Measures in Effect for the HQRP
Hospice Quality Reporting Program
Hospice Item Set
Hospice and Palliative Care Composite Measure – HIS-Comprehensive Assessment Measure at Admission includes: 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) Provided 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 1. Communication with Family 2. Getting timely help

[9] Pub. L. 116-260

[10] 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 13: Quality Measures in Effect for the HQRP
Hospice Quality Reporting Program
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. Proposal to Implement Two Process Quality Measures Based on Proposed HOPE Data Collection

CMS proposes adding two process measures to the HQRP that would be calculated from data collected from HOPE:

1. Timely Reassessment of Pain Impact and
2. Timely Reassessment of Non-Pain Symptom Impact.

CMS proposes to use the data collected from HOPE (the proposed implementation of HOPE is discussed in the next section) that would collect data from a nurse's assessment of a patient's symptoms at multiple time points during an hospice stay. These two measures would determine whether a follow-up visit occurred within 48 hours of an initial assessment where there was an impact of moderate or severe symptoms with and without pain. CMS proposes these measures would be added to the HQRP no sooner than CY 2027.

CMS believes these two measures will add value to the HQRP by filling an identified informational gap in the current measure set. As compared to the single existing HQRP measure that includes pain symptom assessment, it believes the two proposed HOPE-based measures will better reflect hospices' efforts to alleviate a patient's symptoms on an ongoing basis.

Proposed Specifications. CMS proposes that the measures will be calculated using assessments collected at admission or at the HOPE Update Visit (HUV) timepoints. Pain symptom severity will be based on responses to the HOPE pain symptom impact data elements. Non-pain symptom severity and impact will be determined based on responses to the HOPE data elements related to shortness of breath, anxiety, nausea, vomiting, diarrhea, constipation, and agitation. Additional information can be found in the draft HOPE Guidance Manual on the HOPE webpage and the related Paperwork Reduction Act (PRA) that accompanied this proposed rule can also be accessed.[11]

CMS proposes that only in-person visits would count for the data collection – telehealth calls would not count for the reassessment. CMS also proposes that a follow-up visit cannot be the same visit as the initial assessment, but it can occur later in the same day as a separate visit. **CMS seeks comments on these proposals including whether only in-person visits are appropriate for data collection or if other types of visits, such as telehealth, should be considered as part of the data collection.**

[11] The draft guidance can be found at https://www.cms.gov/medicare/quality/hospice/hope and the PRA package. Can be accessed at https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing.

CMS proposes beneficiaries will be included in the denominator if they have a moderate or severe level of pain or non-pain symptom impact, respectively, at their initial assessment. CMS proposes the following exclusions: beneficiaries who die or are discharged alive before the two-day window; if the patient/caregiver refused the reassessment visit; the hospice was unable to contact the patient/caregiver to perform the reassessment; the patient traveled outside the service area; or the patient was in the ER/hospital during the two-day follow-up window. CMS believes that in these situations, a hospice would be unable to conduct a reassessment due to circumstances beyond their control. CMS proposes beneficiaries will be included in the numerator who receive a separate HOPE reassessment within two calendar days of the initial assessment.

Measure Reportability, Variability, and Validity. CMS used the results of the HOPE Beta Test to estimate HOPE data availability for a national population of hospice patients.[12] The reportability and variability analysis did not present concerns for these proposed measures and the validity analysis indicated that the proposed measures have a high face validity. CMS proposes future testing of these proposed measures using a full sample of hospices after HOPE has been implemented nationally.

Public Engagement and Support. CMS convened multiple technical expert panel (TEP) meetings to discuss the development of measures based on pain and non-pain symptoms. A TEP convened in 2023 reviewed the final measure specifications, HOPE Beta test results, and the face validity of the measures. The TEP gave strong support for the proposed measure specifications. In addition, CMS obtained hospice provider input during the HOPE Beta Test; registered nurses (RNs) reported that the two-day window of symptom reassessment aligned with their usual practice.

Future Quality Measure (QM) Development. CMS continues to consider developing hybrid quality measures that could be calculated from multiple data sources and to consider applying several risk adjustment factors, such as age and diagnosis, to ensure comparable, representative comparisons between hospices. In addition, the TEP also suggested using length of hospice stay but not functional status as a risk adjustment factor. Additional information about the development of measures can be found on the CMS website.[13]

3. Proposal to Implement the Hospice Outcomes & Patient Evaluation (HOPE) Assessment Instrument

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.

[12] Detailed information about reportability and validity testing is provided in the HOPE Beta Testing Report on the HOPE webpage at https://www.cms.gov/measure/quality/hospice/hope.
[13] The 2022-2023 HQRP TEP Summary Report is available at https://www.cms.gov/files/document/2023-hqrp-tep-summary-report.pdf and the 2023 Information Gathering Report is available at https://www.cms.gov/files/document/hospicequalityreportingprograminformationgatheringreport2023508.pdf.

HOPE data elements represent domains such as Administrative, Preferences for Customary Routine Activities, Active Diagnosis, Health Conditions, Medications, and Skin Conditions.

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 into the next draft of the HOPE assessment. Beta testing began in late fall 2021 and was completed in October 2022. CMS used the input obtained from field testing to refine the HOPE.

Beginning with FY 2025, CMS proposes to adopt and implement the HOPE patient-level data collection tool to replace the current Hospice Item Set (HIS). HOPE v1.0 contains demographic, record process, and patient-level standardized data elements that would be collected by all Medicare-certified hospices for all patients over the age of 18, regardless of payer source, to support HQRP quality measures. CMS proposes the following related to the data collection:

- HOPE data elements will be collected for hospice staff for each patient admission at three distinct time points: admission, HUV and discharge.
    - The timepoint for the HUV, which is dependent on the patient's length of stay, is limited to a subset of HOPE items addressing clinical issues important to the care of hospice patients as updates to the hospice plan of care.
- HOPE data will be collected during the hospice's routine clinical assessments, based on unique patient assessment visits and additional follow-up visits as needed.
- Not all HOPE items would be required to be completed at every timepoint.

CMS proposes that HOPE data collection would be effective beginning on or after October 1, 2025 and will support the proposed quality measures anticipated for public reporting on or after CY 2027. After HOPE implementation, hospices would no longer need to collect and submit the HIS. As authorized under section 1814(i)(5) of the Act, CMS would impose a 4 percent reduction on hospices who fail to submit HOPE collections timely with respect to the FY. CMS proposes to update §418.312(a)(b)(1) to require hospices to complete and submit a standardized set of items for each patient to capture patient-level data, regardless of payment or patient age.

CMS proposes to provide information about provider training on the CMS HQRP website and announced during Open Door Forums. In addition, the draft HOPE Guidance Manual v1.0 will be available after publication of the FY 2025 Hospice final rule.

Under section 1814(i)(5)(E) of the Act, the Secretary is required to establish procedures for making any data submitted by hospices available to the public. CMS states that to establish the reliability and validity of the quality measures, at least four quarters of data will need to be analyzed. CMS proposes that the data from the first quarter (anticipated to be Q4 CY 2024) will not be used for assessing validity and reliability of the quality measures. CMS proposes to assess the quality and completeness of the data near the end of Q4 2025.

Data collected by hospices during the fourth quarter of CY 2026 will be analyzed starting in CY 2027. This analysis will determine whether to report some or all of the quality measures publicly. CMS proposes that public reporting of the proposed quality measures will be implemented no earlier than FY 2027. Alternatively, CMS proposes public reporting may occur during the FY

2028 APU year, allowing ample time for data analysis, review of measures' appropriateness for public reporting, and allowing hospices to review their data before public reporting.

CMS proposes public reporting using fewer than four quarters of data for the initial reporting period. CMS proposes to use four quarters of data as the standard reporting period for future public reporting. CMS will propose the timeline for public reporting of data in future rulemaking.

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, 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 largely supported the potential health equity measure domains of Equity as a Key Organizational Priority, Trainings for Health Equity, and Organizational Culture of Equity. TEP members raised concerns about collecting hospice quality measure data from family or caregivers of hospice decedents rather than collecting data directly from patients receiving care. Additional information is available on the TEP report, available on the Hospice QRP Health Equity webpage.[14]

Request for Information (RFI) Regarding Future HQRP Social Determinants of Health (SDOH) Items. CMS defines SDOH as the socioeconomic, cultural, and environmental circumstances in which individuals live that impact their health. SDOH can be grouped into five broad domains: economic stability; education access and quality; health care access and quality; neighborhood and built environment; and social and community context. SDOH impact health-related social needs (HRSNs) which are individual-level, adverse social conditions that negatively impact a person's health or health care. HRSNs include lack of access to food, housing, or transportation.

CMS believes that measurement of SDOHs will provide information that would allow for better programs to target and mitigate disparities in health outcomes and would support ongoing HQRP initiatives by providing data to measure stratified resident risk and organizational performance. CMS requests stakeholder input on potential data collection items related to housing instability, food insecurity, utility, and transportation challenges that may be relevant to the hospice setting and how these SDOHs may need to be adapted to be better suited for the hospice setting.

CMS solicits public comment on the following questions:

- For each of the domains discussed below:

[14] https://www.cms.gov/medicare/quality/hospice/hospice-qrp-health-equity.

- Are these items relevant for hospice patients? Are these elements relevant for hospice caregivers?
- Which of these items are most suitable for hospice?
- How might these items need to be adapted to improve relevance for hospice patients and their caregivers? Would you recommend adjusting the listed timeframes for any items? Would you recommend revising any of the items' response options?

- Are there additional SDOH domains that would also be useful for identifying and addressing health equity issues in hospice?

(1) Housing Instability. Housing instability, which includes having trouble paying rent, overcrowding, or moving frequently may negatively affect physical health and make it harder to access health care. In addition to proposed HOPE item A1905 (Living Arrangements), CMS identified to following options as potential complimentary items to collect housing information. Exhibit I is reproduced from the proposed rule.

Exhibit I: Potential Items to Screen for Housing Instability in Hospice			
Tool	**Item**	**Response Options**	**Source**
Accountable Health Communities Health Related Social Needs (AHC HRSN)	Think about the place you live. Do you have problems with any of the following?	a. Pests such as bugs, ants, or mice b. Mold c. Lead paint or pipes d. Lack of heat e. Oven or stove not working f. Smoke detectors missing or not working g. Water leaks h. None of the above	https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf
Protocol for Responding to & Assessing Patients' Assets, Risks & Experience	Are you worried about losing your housing?	a. Yes b. No c. I choose not to answer this question	https://prapare.org/wp-content/uploads/2023/01/PRAPARE-English.pdf

(2) Food Insecurity. Adults who are food insecure may be at increased risk for a variety of negative health outcomes and health disparities. CMS identified to following options as potential complimentary items to collect information about food insecurity. Exhibit II is reproduced from the proposed rule.

Exhibit II. Potential Items to Screen for Food Insecurity in Hospice			
Tool	**Item**	**Response Options**	**Source**
Health Begins - Upstream Risk Screening Tool	Which of the following describes the amount of food your household has to eat: (Check one.)	a. Enough to eat b. Sometimes not enough to eat c. Often not enough to eat	https://www.aamc.org.media/25736/download
Hunger Vital Sign	1. Within the past 12 months we worried whether our food would run out before we got money to buy more.	a. Often true b. Sometimes true c. Never true	https://childrenshealthwatch.org/public- policy/hunger-vital-sign/
	2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more.	a. Often true b. Sometimes true c. Never true	
Children's HealthWatch	In the past year, have you ever used a Food Pantry/Soup Kitchen or received a food donation?	Yes No	http://childrenshealthwatch.org/public-policy/hunger-vital-sign/

(3) Utility Challenges. CMS discusses how the effects of a lack of utility security include vulnerability to environmental exposures such as dampness, mold, and thermal discomfort in the home, which have direct effect on residents' health. CMS identified to following options as potential complimentary items to collect information about utility challenges. Exhibit III is reproduced from the proposed rule.

Exhibit III. Potential Items to Screen for Utility Challenges in Hospice			
Tool	**Item**	**Response Options**	**Source**
North Carolina Medicaid Screening Tool	Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?	Yes No	https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions
WELL RX Toolkit	Do you have trouble paying for your utilities (gas, electricity, phone)?	Yes No	https://sirenetwork.ucsf.edu/ tools-resources/resources/wellrx- toolkit
Health Leads - Social Needs Screening Toolkit	In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?	Yes No	https://healthleadsusa.org/wp-content/uploads/2023/05/Screening_Toolkit_2018.pdf

(4) Transportation Challenges. Transportation barriers can impact access to medical appointments, getting medications, or from getting things a person needs daily. CMS identified

to following options as potential complimentary items to collect information about transportation challenges. Exhibit IV is reproduced from the proposed rule.

Exhibit IV. Potential Items to Screen for Transportation Challenges in Hospice			
Tool	**Item**	**Response Options**	**Source**
AHC HRSN	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	Yes No	https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf
Borders	Are you regularly able to get a friend or relative to take you to doctor's appointments?	Yes No	https://oaktrust.library.tamu.edu/bitstream/handle/1969.1/6016/etd-tamu-2006A-URSC-Borders.pdf

(5) All Domains. CMS identified to following options as potential complimentary items to collect information for all the domains. Exhibit V is reproduced from the proposed rule.

Exhibit V. Potential Items to Screen for All Domains			
Tool	**Item**	**Response Options**	**Source**
Kaiser Permanente's Your Current Life Situation Survey	In the past 3 months, did you have trouble paying for any of the following?	a. Food b. Housing c. Heat and electricity d. Medical needs e. Transportation f. Children g. Debts h. Other i. None of these	https://sirenetwork.ucsf.edu/sites/default/files/Your%20Current%20Life%20Situation%20Questionnaire%20v2-0%20%28Core%20and%20

5. Proposed CAHPS Hospice Survey and Measure Changes

In the FY 2024 Hospice final rule (88 FR 51164, CMS provided the results of the CAHPS Hospice Survey Mode Experiment conducted 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. Based on these results, CMS proposes changes to the administration protocols and survey instrument content.

CMS proposes to implement the revised Hospice Survey beginning with January 2025 decedents. Table 14 in the proposed rule provides a comparison of the current and proposed CAHPS Hospice Survey measures.

CMS proposes the following changes to the CAHPS Hospice Survey[15]:

- Removal of three nursing home items and an item about the family member that are not included in score measures.
- Removal of one survey item regarding confusing or contradictory information from the Hospice Team Communication measure.
- Replacement of the multi-item Getting Hospice Care Training measure with a new, one-item summary measure.
- Addition of two new items, which will be used to calculate a new Care Preferences measure.
- Simplified wording to component items in the Hospice Team Communication, Getting Timely Care, and Treating Family Members with Respect measures.

The revised CAHPS Hospice Survey received endorsement through the Consensus Standards Approval Committee (CSAC) Fall 2022 endorsement and maintenance cycle. The Care Preferences, Hospice Team Communication, and Getting Hospice Care Training measures are on the 2023 Measures Under Consideration list and are under evaluation by the Pre-Rulemaking Measure Review (PRMP) Post-Acute Care/Long-Term Care (PAC/LAC) Committee. The Consensus-Based Entity (CBE) did not reach consensus on the CAHPS Hospice Survey measures.

Impact to Public Reporting and Star Ratings. CMS discusses the impact the changes to the survey measures would have on public reporting. CMS will wait until it has eight quarters of data to include the new measure "Care Preferences" and the revised "Getting Hospice Care Training" in public reporting. CMS anticipates the first Care Compare refresh in which the publicly reported measure scores would be included would be November 2027, with scores calculated using Q1 2025 through Q4 2026. CMS notes these changes may be introduced in different quarters for measure scores and Star Ratings. Measured scores would be made available to hospices confidentially in Provider Preview reports once they met a threshold number of completed surveys.

CMS believes the proposed changes to the "Hospice Team Communication" measure are non-substantive and the measure could continue to be publicly reported and used in Star Ratings in the transition period between the current and new surveys. During the transition period, scores and Star Ratings would be calculated by combining scores from quarters using the current and new survey.

CMS proposes that the Family Caregiver Survey Rating Summary Star Rating will be based on seven measures instead of the current eight measures during the interim period until a full eight quarters of data are available for the "Getting Hospice Care Training' measure. The summary

[15] The current version of the CAHPS Hospice Survey is available at https://hospicecahpssurvey.org/en/survey-materials. The proposed items for removal from the survey are: Question 32 -34 (nursing home items); Question 30 (moving a family member); Questions 10 (regarding confusing or contradictory information); and Questions 17 -20, 23, 28, and 29 (Getting Hospice Care Training measure).

Star Rating would be based on nine measures once eight quarters of data are available for the new Care Preference and Getting Hospice Care Training measures.

Survey Administration Changes. CMS proposes adding a web-mail mode (email invitation to a web survey, with mail follow-up to non-responders); to add a pre-notification letter; and to extend the field period from 42 to 49 days, beginning with January 2025 decedents. The web-mail mode would be an alternative to the current modes (mail-only, telephone only, and mixed mode (mail with telephone follow-up) that hospices could select. CMS notes that extending the field period to 49 days is estimated to result in an increased response rate of 2.5 percentage points in the mail-only mode, the predominate mode for administration of the CAHPS Hospice Survey.

Case-mix and Mode Adjustments. Prior to public reporting, CAHPS Hospice Survey scores are adjusted for the effects of both mode of survey administration and case mix. Case mix refers to characteristics of the decedent and caregivers that are not under control of the hospice that may affect reports of hospice experiences such as education level, decedent's primary diagnosis, and length of final hospice episode.

With the introduction of a new mode of survey administration and survey items, CMS proposes updating the analytic adjustments that adjust responses for the effect of mode on survey responses. CMS currently uses the telephone-only mode as the reference mode. Given that most surveys are currently completed in mail-only mode, CMS proposes to change the reference mode to mail-only. CMS reviewed the variables included in the case-mix adjustment model and determined that no changes are needed.

6. 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.

HOPE Data Collection. CMS proposes that hospices will be required to begin collecting and submitting HOPE data as of October 1, 2025. After this effective date, hospices will no longer be required to collect or submit the HIS.

CMS proposes that the HOPE data will be submitted in the required format it designates (as set out in subregulatory guidance). At the time of implementation, all HOPE records will be submitted as an XML file, which is the required format for HIS. The format is subject to change in future years. CMS will provide the HOPE technical data specifications for software developers and vendors on the CMS website. CMS notes, that software developers and vendors should not wait for final data specifications but should review the draft technical data specifications when they are posted and provide feedback to CMS. CMS plans to conduct a call after the draft specifications are posted.

Retirement of the Hospice Abstraction Reporting Tool (HART). This free tool is used to collect HIS data. Since only a small percentage of hospices utilize the tool, CMS will no longer provide

a free tool for standardized data collection. Beginning October 1, 2025, hospices will need to select a private vendor to collect and submit HIS data and subsequent HOPE data to CMS.

Compliance. 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 15 (reproduced below) summarizes these three timeframes.

Table 15: HQRP Reporting Requirements and Corresponding Annual Payment Updates		
Reporting Year for HIS/HOPE and Data Collection Year for CAHPS	**Annual Payment Update (APU) Impacts Payment for the FY**	**Reference Year for CAHPS Size Exception**
CY 2023	FY 2025 APU*	CY 2022
CY 2024	FY 2026 APU	CY 2023
CY 2025	FY 2027 APU	CY 2024
CY 2026	FY 2028 APU	CY 2025

Submission of Data Requirements. Hospices must comply with CMS' submission data requirements. CMS proposes to apply the same submission requirements for the HOPE admission, discharge, and two HUV records. After HIS is phased out, hospices would continue to submit 90 percent of all required HOPE records within 30 days of the event or completion date (patient's admission, discharge, and based on the patient's length of stay up to two HUV timepoints).

To comply with CMS' quality reporting requirements for CAHPS, hospices are required to utilize a CMS-approved third-party vendor. A list of approved vendors is available on the CAHPS Hospice survey website.[16]

Table 16 (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 16: HQRP Compliance Checklist		
Annual Payment Update	**HIS**	**CAHPS**
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/HOPE records within 30 days of the event date (for example, patient's admission or discharge) for patient	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2025 – 12/31/2025

[16] www.hospicecahpsurvey.org

Table 16: HQRP Compliance Checklist		
Annual Payment Update	**HIS**	**CAHPS**
	admission/discharges occurring 1/1/2025 – 12/31/2025	
FY 2028	Submit at least 90 percent of all HIS/HOPE records within 30 days of the event date (for example, patient's admission date, HUV completion date or discharge) for patient admission/discharges occurring 1/1/2026 – 12/31/2026	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2026 – 12/31/2026

7. Burden and Costs

CMS proposes to update HQRP requirements by replacing HIS with HOPE. Hospices will be required to complete and submit an admission HOPE and a discharge HOPE for each patient, as well as the HUV assessment, when applicable, starting October 1, 2025 for FY 2027 APU.

The total number of Medicare-participating hospices is 5,640 and based on claims data, CMS determined there are approximately 490 admissions per hospice per year. The HOPE Admission is estimated to take 27 minutes for a nurse to complete relative to HIS, the new HOPE HIV is estimated to take 22 minutes for a nurse to complete, and HOPE Discharge is estimated to take 0 minutes to complete. Using the most recent hourly wage data for Registered Nurses and Medical Secretaries from the U.S. Bureau of Labor Statistics and accounting for fringe benefits (details provided in Table 18 in the proposed rule), CMS estimates an annual cost burden of approximately $185 million across all hospices starting in FY 2026 (Table 19).

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 $705 million or 2.6 percent, for FY 2025. The proposed hospice payment update percentage of 2.6 is based on the proposed 3.0 percent inpatient hospital market basket percentage increase reduced by a proposed 0.4 percentage point productivity adjustment.

The impact analysis represents the projected effects of the changes in hospice payments from FY 2024 to FY 2025. Using the most recent complete available data for this proposed rule (FY 2023 hospice claims data as of January 11, 2024), CMS simulated total payments using the FY 2024 wage index (using the old OMB delineations) and FY 2024 payment rates and compare it to its simulation of total payments using FY 2023 utilization claims data, the proposed FY 2025 wage index (using the revised OMB delineations) and FY 2024 payment rates.

Table 20 in the proposed rule (recreated below) shows the overall total FY 2025 impact to hospices 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 2.7 percent compared with 2.6 percent for non-profit and an increase of 2.4 percent for government hospices. Hospices located in rural areas would see an increase of 2.8 percent compared with 2.6 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 Mountain region would experience the largest estimated increase in payments of 4.2 percent in FY 2025 payments. In contrast, hospices serving patients in the Pacific, Outlying and New England regions would experience, on average, the lowest estimated increase of 0.8, 1.1, and 1.2, respectively in FY 2025 payments.

Table 20: Projected Impact to Hospices for FY 2025				
Hospice Subgroup	**Hospices**	**FY 2024 Updated Wage Data and Revised OMB Delineations**	**FY 2025 Proposed Hospice Payment Update (%)**	**Overall Total Impact for FY 2025**
All Hospices	6,044	0.0%	2.6%	2.6%
Hospice Type and Control				
Freestanding/Non-Profit	550	0.2%	2.6%	2.8%
Freestanding/For-Profit	4,012	0.0%	2.6%	2.6%
Freestanding/Government	37	-0.6%	2.6%	2.0%
Freestanding/Other	362	-0.1%	2.6%	2.5%
Facility/HHA Based/Non-Profit	316	-0.7%	2.6%	1.9%
Facility/HHA Based/For-Profit	189	0.1%	2.6%	2.7%
Facility/HHA Based/Government	71	0.2%	2.6%	2.8%
Facility/HHA Based/Other	84	-0.9%	2.6%	1.7%
Subtotal: Freestanding Facility	4,961	0.1%	2.6%	2.7%
Subtotal: Facility/HHA Based Facility Type	660	-0.5%	2.6%	2.1%
Subtotal: Non-Profit	866	0.0%	2.6%	2.6%
Subtotal: For Profit	4,204	0.1%	2.6%	2.7%
Subtotal: Government	108	-0.2%	2.6%	2.4%
Subtotal: Other	446	-0.2%	2.6%	2.4%
Hospice Type and Control: Rural				
Freestanding/Non-Profit	123	-0.1%	2.6%	2.5%
Freestanding/For-Profit	350	0.3%	2.6%	2.9%
Freestanding/Government	22	-0.1%	2.6%	2.5%
Freestanding/Other	55	0.5%	2.6%	3.1%
Facility/HHA Based/Non-Profit	117	0.2%	2.6%	2.8%
Facility/HHA Based/For-Profit	52	0.5%	2.6%	3.1%
Facility/HHA Based/Government	55	0.4%	2.6%	3.0%
Facility/HHA Based/Other	46	0.0%	2.6%	2.6%

Table 20: Projected Impact to Hospices for FY 2025				
Hospice Subgroup	**Hospices**	**FY 2024 Updated Wage Data and Revised OMB Delineations**	**FY 2025 Proposed Hospice Payment Update (%)**	**Overall Total Impact for FY 2025**
Facility Type and Control: Urban				
Freestanding/Non-Profit	427	0.2%	2.6%	2.8%
Freestanding/For-Profit	3,662	0.0%	2.6%	2.6%
Freestanding/Government	15	-0.8%	2.6%	1.8%
Freestanding/Other	307	-0.2%	2.6%	2.4%
Facility/HHA Based/Non-Profit	199	-0.9%	2.6%	1.7%
Facility/HHA Based/For-Profit	137	0.0%	2.6%	2.6%
Facility/HHA Based/Government	16	0.1%	2.6%	2.7%
Facility/HHA Based/Other	38	-1.1%	2.6%	1.5%
Hospice Location: Urban or Rural				
Rural	823	0.2%	2.6%	2.8%
Urban	5,221	0.0%	2.6%	2.6%
Hospice Location: Census Division				
New England	148	-1.4%	2.6%	1.2%
Middle Atlantic	280	-0.6%	2.6%	2.0%
South Atlantic	607	0.8%	2.6%	3.4%
East North Central	604	0.0%	2.6%	2.6%
East South Central	251	0.9%	2.6%	3.5%
West North Central	416	0.1%	2.6%	2.7%
West South Central	1,150	0.6%	2.6%	3.2%
Mountain	605	1.6%	2.6%	4.2%
Pacific	1,935	-1.8%	2.6%	0.8%
Outlying	48	-1.5%	2.6%	1.1%
Hospice Size			2.6%	
0 - 3,499 RHC Days (Small)	1,600	-0.9%	2.6%	1.7%
3,500-19,999 RHC Days (Medium)	2,718	-0.2%	2.6%	2.4%
20,000+ RHC Days (Large)	1,726	0.1%	2.6%	2.7%

Source: FY 2023 hospice claims data from the CCW accessed on January 11, 2024.

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