DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 418

[CMS–1773–P]

RIN 0938–AU83

Medicare Program; FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule proposes to establish a permanent mitigation policy to smooth the impact of year-to-year changes in hospice payments related to changes in the hospice wage index. This rule also proposes updates to the hospice wage index, payment rates, and aggregate cap amount for Fiscal Year (FY) 2023. In addition, this rule proposes updates to the Hospice Quality Reporting Program (HQRP) including the Hospice Outcomes and Patient Evaluation tool; an update on Quality Measures (QMs) that will be in effect in FY 2023 for the HQRP and future QMs; updates on the Consumer Assessment of Healthcare Providers and Systems, Hospice Survey Mode Experiment, discusses a request for information (RFI) on health equity.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, by May 31, 2022.

ADDRESSES: In commenting, please refer to file code CMS–1773–P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (choose *only one* of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1773–P, P.O. Box 8010, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1773–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: For general questions about hospice payment policy, send your inquiry via email to: *hospicepolicy@cms.hhs.gov.*

For questions regarding the CAHPS® Hospice Survey, contact Lori Teichman at (410) 786–6684 and Lauren Fuentes at (410) 786–2290.

For questions regarding the hospice quality reporting program, contact Cindy Massuda at (410) 786–0652.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Wage index addenda will be available only through the internet on our website at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html.*

I. Executive Summary

This proposed rule proposes to establish a permanent mitigation policy to smooth the impact of year-to-year changes in the hospice payments related to changes in the hospice wage index. This rule also proposes updates to the hospice wage index as well as updates to the hospice payment rates, and cap amount for FY 2023 as required under section 1814(i) of the Social Security Act (the Act). In addition, in this proposed rule CMS discusses updates to HQRP that include the Hospice Outcomes and Patient Evaluation (HOPE) tool with national beta testing; the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey with Star Ratings; developing a web-based survey; Public Reporting; a request for information that builds from last year's discussion on health equity, and update on advancing a health information exchange.

Lastly, the overall economic impact of this proposed rule is estimated to be $580 million in increased payments to hospices for FY 2023.

II. Background

A. Hospice Care

Hospice care is a comprehensive, holistic approach to treatment that recognizes the impending death of a terminally ill individual and warrants a change in the focus from curative care to palliative care for relief of pain and for symptom management. Medicare regulations define ''palliative care'' as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice (42 CFR 418.3). Palliative care is at the core of hospice philosophy and care practices, and is a critical component of the Medicare hospice benefit.

The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities while remaining primarily in the home environment. A hospice uses an interdisciplinary approach to deliver medical, nursing, social, psychological, emotional, and spiritual services through a collaboration of professionals and other caregivers, with the goal of making the beneficiary as physically and emotionally comfortable as possible. Hospice provides compassionate beneficiary and family/caregiver-centered care for those who are terminally ill.

As referenced in our regulations at § 418.22(b)(1), to be eligible for Medicare hospice services, the patient's attending physician (if any) and the hospice medical director must certify that the individual is ''terminally ill,'' as defined in section 1861(dd)(3)(A) of the Act and our regulations at § 418.3; that is, the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. The regulations at § 418.22(b)(2) require that clinical information and other documentation that support the medical prognosis accompany the certification and be filed in the medical record with it. Additionally, the regulations at § 418.22(b)(3) require that the

certification and recertification forms include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

Under the Medicare hospice benefit, once a terminally ill patient elects to receive hospice care, a hospice interdisciplinary group (IDG) is essential in ensuring the provision of primarily home-based services, keeping the choices of the patient and family first and foremost. The hospice IDG works with the beneficiary, family, and caregiver(s) to develop a coordinated, comprehensive care plan; reduce unnecessary diagnostics or ineffective therapies; and maintain ongoing communication with individuals and their families about changes in their condition and care. The beneficiary's care plan will shift over time to meet the changing needs of the individual, family, and caregiver(s) as the individual approaches the end of life.

If, in the judgment of the hospice IDG, which includes the hospice physician, the patient's symptoms cannot be effectively managed at home, then the patient is eligible for general inpatient care (GIP), a more medically intense level of care. GIP must be provided in a Medicare-certified hospice freestanding facility, skilled nursing facility, or hospital. GIP is provided to ensure that any new or worsening symptoms are intensively addressed so that the beneficiary can return to their home and continue to receive routine home care (RHC). Limited, short-term, intermittent, inpatient respite care (IRC) is also available to provide relief for the family or other caregivers, or when the family or other caregivers are absent. Additionally, an individual can receive continuous home care (CHC) during a period of crisis, in which an individual requires continuous care to achieve palliation or management of acute medical symptoms so that the individual can remain at home. CHC may be covered for as much as 24 hours a day, and these periods must be predominantly nursing care, in accordance with the regulations at § 418.204. A minimum of 8 hours of nursing care, or nursing and aide care, must be furnished on a particular day to qualify for the CHC rate (§ 418.302(e)(4)).

Hospices must comply with applicable civil rights laws,[1] including section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, under which covered entities must take appropriate steps to ensure effective communication with patients and patient care representatives with disabilities, including the provisions of auxiliary aids and services. In addition, they must take reasonable steps to ensure meaningful access for individuals with limited English proficiency, consistent with Title VI of the Civil Rights Act of 1964. Further information about these requirements may be found at: *http://www.hhs.gov/ocr/civilrights.*

B. Services Covered by the Medicare Hospice Benefit

Coverage under the Medicare hospice benefit requires that hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. Section 1861(dd)(1) of the Act establishes the services that are to be rendered by a Medicare-certified hospice program. These covered services include: Nursing care; physical therapy; occupational therapy; speech-language pathology therapy; medical social services; home health aide services (called hospice aide services); physician services; homemaker services; medical supplies (including drugs and biologicals); medical appliances; counseling services (including dietary counseling); short-term inpatient care in a hospital, nursing facility, or hospice inpatient facility (including both respite care and procedures necessary for pain control and acute or chronic symptom management); continuous home care during periods of crisis, and only as necessary to maintain the terminally ill individual at home; and any other item or service, which is specified in the plan of care and for which payment may otherwise be made under Medicare in accordance with Title XVIII of the Act.

Section 1814(a)(7)(B) of the Act requires that a written plan for providing hospice care to a beneficiary who is a hospice patient be established before care is provided by, or under arrangements made by, the hospice program; and that the written plan be periodically reviewed by the beneficiary's attending physician (if any), the hospice medical director, and an interdisciplinary group (section 1861(dd)(2)(B) of the Act). The services offered under the Medicare hospice benefit must be available to beneficiaries as needed, 24 hours a day, 7 days a week (section 1861(dd)(2)(A)(i) of the Act).

Upon the implementation of the hospice benefit, the Congress also expected hospices to continue to use volunteer services, though Medicare does not pay for these volunteer services (section 1861(dd)(2)(E) of the Act). As stated in the FY 1983 Hospice Wage Index and Rate Update proposed rule (48 FR 38149), the hospice must have an interdisciplinary group composed of paid hospice employees as well as hospice volunteers, and that ''the hospice benefit and the resulting Medicare reimbursement is not intended to diminish the voluntary spirit of hospices.'' This expectation supports the hospice philosophy of community based, holistic, comprehensive, and compassionate end of life care.

C. Medicare Payment and Quality for Hospice Care

Sections 1812(d), 1813(a)(4), 1814(a)(7), 1814(i), and 1861(dd) of the Act, and the regulations in 42 CFR part 418, establish eligibility requirements, payment standards and procedures; define covered services; and delineate the conditions a hospice must meet to be approved for participation in the Medicare program. Part 418, subpart G, provides for a per diem payment based on one of four prospectively-determined rate categories of hospice care (RHC, CHC, IRC, and GIP), based on each day a qualified Medicare beneficiary is under hospice care (once the individual has elected). This per diem payment is meant to cover all of the hospice services and items needed to manage the beneficiary's care, as required by section 1861(dd)(1) of the Act.

While recent news reports[2] have brought to light the potential role hospices could play in medical aid in dying (MAID) where such practices have been legalized in certain states, we wish to remind hospices that the Assisted Suicide Funding Restriction Act of 1997 (Pub. L. 105–12) prohibits the use of Federal funds to provide or pay for any health care item or service or health benefit coverage for the purpose of causing, or assisting to cause, the death of any individual including mercy killing, euthanasia, or assisted suicide. This means that while payments made to hospices are to cover all items, services, and drugs for the palliation and management of the terminal illness and related conditions, Federal funds cannot be used for the prohibited activities, even in the context of a per diem payment. However, the prohibition does not pertain to the provision of an item or service for the purpose of alleviating pain or discomfort, even if such use may

[1] Hospices are also subject to additional Federal civil rights laws, including the Age Discrimination Act, Section 1557 of the Affordable Care Act, and conscience and religious freedom laws.

[2] Nelson, R., Should Medical Aid in Dying Be Part of Hospice Care? Medscape Nurses. February 26, 2020. *https://www.medscape.com/viewarticle/925769#vp_1.*

increase the risk of death, so long as the item or service is not furnished for the specific purpose of causing or accelerating death.

1. Omnibus Budget Reconciliation Act of 1989

Section 6005(a) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239) amended section 1814(i)(1)(C) of the Act and provided changes in the methodology concerning updating the daily payment rates based on the hospital market basket percentage increase applied to the payment rates in effect during the previous Federal fiscal year.

2. Balanced Budget Act of 1997

Section 4441(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) established that updates to the hospice payment rates beginning FY 2002 and in subsequent FYs are to be the hospital market basket percentage increase for the current FY. Section 4442 of the BBA amended section 1814(i)(2) of the Act, effective for services furnished on or after October 1, 1997, to require that hospices submit claims for payment for hospice care furnished in an individual's home only on the basis of the geographic location at which the service is furnished. Previously, local wage index values were applied based on the geographic location of the hospice provider, regardless of where the hospice care was furnished. Section 4443 of the BBA amended sections 1812(a)(4) and 1812(d)(1) of the Act to provide for hospice benefit periods of two 90-day periods, followed by an unlimited number of 60-day periods.

3. FY 1998 Hospice Wage Index Final Rule

The FY 1998 Hospice Wage Index final rule (62 FR 42860) implemented a new methodology for calculating the hospice wage index and instituted an annual Budget Neutrality Adjustment Factor (BNAF) so aggregate Medicare payments to hospices would remain budget neutral to payments calculated using the 1983 wage index.

4. FY 2010 Hospice Wage Index Final Rule

The FY 2010 Hospice Wage Index and Rate Update final rule (74 FR 39384) instituted an incremental 7-year phase-out of the BNAF beginning in FY 2010 through FY 2016. The BNAF phase-out reduced the amount of the BNAF increase applied to the hospice wage index value, but was not a reduction in the hospice wage index value itself or in the hospice payment rates.

5. The Affordable Care Act

Starting with FY 2013 (and in subsequent FYs), the market basket percentage update under the hospice payment system referenced in sections 1814(i)(1)(C)(ii)(VII) and 1814(i)(1)(C)(iii) of the Act are subject to annual reductions related to changes in economy-wide productivity, as specified in section 1814(i)(1)(C)(iv) of the Act.

In addition, sections 1814(i)(5)(A) through (C) of the Act, as added by section 3132(a) of the Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111–148), required hospices to begin submitting quality data, based on measures specified by the Secretary of the Department of Health and Human Services (the Secretary) for FY 2014 and subsequent FYs. Since FY 2014, hospices that fail to report quality data have their market basket percentage increase reduced by 2 percentage points. Note that with the passage of the Consolidated Appropriations Act, 2021 (hereafter referred to as CAA 2021) (Pub. L. 116–260), the reduction changes to 4 percentage points beginning in FY 2024.

Section 1814(a)(7)(D)(i) of the Act, as added by section 3132(b)(2) of the PPACA, required, effective January 1, 2011, that a hospice physician or nurse practitioner have a face-to-face encounter with the beneficiary to determine continued eligibility of the beneficiary's hospice care prior to the 180th day recertification and each subsequent recertification, and to attest that such visit took place. When implementing this provision, the Centers for Medicare & Medicaid Services (CMS) finalized in the FY 2011 Hospice Wage Index final rule (75 FR 70435) that the 180th day recertification and subsequent recertifications would correspond to the beneficiary's third or subsequent benefit periods. Further, section 1814(i)(6) of the Act, as added by section 3132(a)(1)(B) of the PPACA, authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes. The types of data and information suggested in the PPACA could capture accurate resource utilization, which could be collected on claims, cost reports, and possibly other mechanisms, as the Secretary determined to be appropriate. The data collected could be used to revise the methodology for determining the payment rates for RHC and other services included in hospice care, no earlier than October 1, 2013, as described in section 1814(i)(6)(D) of the Act. In addition, CMS was required to consult with hospice programs and the Medicare Payment Advisory Commission (MedPAC) regarding additional data collection and payment revision options.

6. FY 2012 Hospice Wage Index Final Rule

In the FY 2012 Hospice Wage Index final rule (76 FR 47308 through 47314) it was announced that beginning in 2012, the hospice aggregate cap would be calculated using the patient-by-patient proportional methodology, within certain limits. Existing hospices had the option of having their cap calculated through the original streamlined methodology, also within certain limits. As of FY 2012, new hospices have their cap determinations calculated using the patient-by-patient proportional methodology. If a hospice's total Medicare payments for the cap year exceed the hospice aggregate cap, then the hospice must repay the excess back to Medicare.

7. IMPACT Act of 2014

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113–185) became law on October 6, 2014. Section 3(a) of the IMPACT Act mandated that all Medicare certified hospices be surveyed every 3 years beginning April 6, 2015 and ending September 30, 2025. In addition, section 3(c) of the IMPACT Act requires medical review of hospice cases involving beneficiaries receiving more than 180 days of care in select hospices that show a preponderance of such patients; section 3(d) of the IMPACT Act contains a new provision mandating that the cap amount for accounting years that end after September 30, 2016, and before October 1, 2025 be updated by the hospice payment percentage update rather than using the consumer price index for urban consumers (CPI–U) for medical care expenditures.

8. FY 2015 Hospice Wage Index and Payment Rate Update Final Rule

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50452) finalized a requirement that the Notice of Election (NOE) be filed within 5 calendar days after the effective date of hospice election. If the NOE is filed beyond this 5-day period, 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 50474). As with the NOE, the claims processing system must be notified of a beneficiary's discharge from hospice or hospice benefit revocation within 5

calendar days after the effective date of the discharge/revocation (unless the hospice has already filed a final claim) through the submission of a final claim or a Notice of Termination or Revocation (NOTR).

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50479) also finalized a requirement that the election form include the beneficiary's choice of attending physician and that the beneficiary provide the hospice with a signed document when he or she chooses to change attending physicians.

In addition, the FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50496) provided background, described eligibility criteria, identified survey respondents, and otherwise implemented the Hospice Experience of Care Survey for informal caregivers. Hospice providers were required to begin using this survey for hospice patients as of 2015.

Finally, the FY 2015 Hospice Wage Index and Rate Update final rule required providers to complete their aggregate cap determination not sooner than 3 months after the end of the cap year, and not later than 5 months after, and remit any overpayments. Those hospices that fail to submit their aggregate cap determinations on a timely basis will have their payments suspended until the determination is completed and received by the Medicare contractor (79 FR 50503).

9. FY 2016 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142), CMS finalized two different payment rates for RHC: A higher per diem base payment rate for the first 60 days of hospice care and a reduced per diem base payment rate for subsequent days of hospice care. CMS also finalized a service intensity add-on (SIA) payment payable for certain services during the last 7 days of the beneficiary's life. A service intensity add-on payment will be made for the social worker (SW) visits and nursing visits provided by a registered nurse (RN), when provided during routine home care in the last 7 days of life. The SIA payment is in addition to the routine home care rate. The SIA payment is provided for visits of a minimum of 15 minutes and a maximum of 4 hours per day (80 FR 47172).

In addition to the hospice payment reform changes discussed, the FY 2016 Hospice Wage Index and Rate Update final rule implemented changes mandated by the IMPACT Act, in which the cap amount for accounting years that end after September 30, 2016 and before October 1, 2025 would be updated by the hospice payment update percentage rather than using the CPI–U (80 FR 47186). In addition, we finalized a provision to align the cap accounting year for both the inpatient cap and the hospice aggregate cap with the FY for FY 2017 and thereafter. Finally, the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47144) clarified that hospices would have to report all diagnoses on the hospice claim as a part of the ongoing data collection efforts for possible future hospice payment refinements.

10. FY 2017 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52160), CMS finalized several new policies and requirements related to the HQRP. First, CMS codified the policy that if the National Quality Forum (NQF) made non-substantive changes to specifications for HQRP measures as part of the NQF's re-endorsement process, CMS would continue to utilize the measure in its new endorsed status, without going through new notice-and-comment rulemaking. CMS would continue to use rulemaking to adopt substantive updates made by the NQF to the endorsed measures adopted for the HQRP; determinations about what constitutes a substantive versus non-substantive change would be made on a measure-by-measure basis. Second, we finalized two new quality measures for the HQRP for the FY 2019 payment determination and subsequent years: (1) Hospice Visits when Death is Imminent Measure Pair; and (2) Hospice and Palliative Care Composite Process Measure-Comprehensive Assessment at Admission (81 FR 52173). The data collection mechanism for both of these measures is the Hospice Item Set (HIS), and the measures were effective April 1, 2017. Regarding the CAHPS® Hospice Survey, CMS finalized a policy that hospices that receive their CMS Certification Number (CCN) after January 1, 2017 for the FY 2019 Annual Payment Update (APU) and January 1, 2018 for the FY 2020 APU will be exempted from the Hospice CAHPS® requirements due to newness (81 FR 52182). The exemption is determined by CMS and is only for 1 year.

11. FY 2020 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38484), we finalized rebased payment rates for CHC and GIP and set those rates equal to their average estimated FY 2019 costs per day. We also rebased IRC per diem rates equal to the estimated FY 2019 average costs per day, with a reduction of 5 percent to the FY 2019 average cost per day to account for coinsurance. We finalized the FY 2020 proposal to reduce the RHC payment rates by 2.72 percent to offset the increases to CHC, IRC, and GIP payment rates to implement this policy in a budget-neutral manner in accordance with section 1814(i)(6) of the Act (84 FR 38496).

In addition, we finalized a policy to use the current year's pre-floor, pre-reclassified hospital inpatient wage index as the wage adjustment to the labor portion of the hospice rates. Finally, in the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38505), we finalized modifications to the hospice election statement content requirements at § 418.24(b), and added a requirement for hospices, upon request, to furnish an election statement addendum effective beginning in FY 2021. The addendum must list items, services, and drugs the hospice has determined to be unrelated to the terminal illness and related conditions, to increase coverage transparency for beneficiaries under a hospice election.

12. Consolidated Appropriations Act, 2021

Division CC, section 404 of the CAA 2021 amended section 1814(i)(2)(B) of the Act and extended the provision that currently mandates the hospice cap be updated by the hospice payment update percentage (hospital market basket update reduced by the productivity adjustment) rather than the CPI–U for accounting years that end after September 30, 2016 and before October 1, 2030. Prior to enactment of this provision, the hospice cap update was set to revert to the original methodology of updating the annual cap amount by the CPI–U beginning on October 1, 2025. Division CC, section 407(b) of CAA 2021 revised section 1814(i)(5)(A)(i) to increase the payment reduction for hospices who fail to meet hospice quality measure reporting requirements from 2 percentage points to 4 percentage points beginning with FY 2024.

13. FY 2022 Hospice Wage Index and Payment Rate Update Final Rule

In the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42532 through 42539), we finalized a policy to rebase and revise the labor shares for CHC, RHC, IRC and GIP using Medicare cost report (MCR) data for freestanding hospices (collected via CMS Form 1984–14, OMB NO. 0938–0758) for

2018. We established separate labor shares for CHC, RHC, IRC, and GIP based on the calculated compensation cost weights for each level of care from the 2018 MCR data. The revised labor shares were implemented in a budget neutral manner through the use of labor share standardization factors.

In the FY 2022 final rule, we removed the seven original Hospice Item Set (HIS) measures from the program because a more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available and already publicly reported. The Hospice Comprehensive Assessment Measure, NQF #3235, is one measure that is calculated and rolled up by completion of the seven individual measures. This measure helps to ensure all hospice patients receive a holistic comprehensive assessment. Also, in or after May 2022, we will start publicly reporting the two new claims-based measures. Specifically, this includes the: (1) Hospice Visits in the Last Days of Life (HVLDL) (which replaces the HIS Hospice Visits when Death is Imminent measure pair); and (2) Hospice Care Index (HCI) that includes 10 indicators that collectively represent different aspects of hospice care and aim to convey a comprehensive characterization of the quality of care furnished by a hospice throughout the hospice stay. Related to these changes, we finalized reporting eight quarters of claims data in order to display small providers. We finalized the public reporting of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey Star ratings on Care Compare to begin no sooner than FY 2022.

III. Provisions of the Proposed Rule

A. Proposed FY 2023 Hospice Wage Index and Rate Update

1. Proposed FY 2023 Hospice Wage Index

The hospice wage index is used to adjust payment rates for hospices under the Medicare program to reflect local differences in area wage levels, based on the location where services are furnished. The hospice wage index utilizes the wage adjustment factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act for hospital wage adjustments. Our regulations at § 418.306(c) require each labor market to be established using the most current hospital wage data available, including any changes made by the Office of Management and Budget (OMB) to the Metropolitan Statistical Areas (MSAs) definitions.

In general, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses. On March 6, 2020, OMB issued Bulletin No. 20–01, which provided updates to and superseded OMB Bulletin No. 18–04 that was issued on September 14, 2018. The attachments to OMB Bulletin No. 20–01 provided detailed information on the update to statistical areas since September 14, 2018, and were based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2017 and July 1, 2018. (For a copy of this bulletin, we refer readers to the following website: *https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf*.) In OMB Bulletin No. 20–01, OMB announced one new Micropolitan Statistical Area, one new component of an existing Combined Statistical Area (CSA), and changes to New England City and Town Area (NECTA) delineations. In the FY 2021 Hospice Wage Index final rule (85 FR 47070) we stated that if appropriate, we would propose any updates from OMB Bulletin No. 20–01 in future rulemaking. After reviewing OMB Bulletin No. 20–01, we determined that the changes in Bulletin 20–01 encompassed delineation changes that would not affect the Medicare wage index for FY 2022. Specifically, the updates consisted of changes to NECTA delineations and the redesignation of a single rural county into a newly created Micropolitan Statistical Area. The Medicare wage index does not utilize NECTA definitions, and, as most recently discussed in the FY 2021 Hospice Wage Index final rule (85 FR 47070), we include hospitals located in Micropolitan Statistical areas in each state's rural wage index. Therefore, in the FY 2022 Hospice Wage Index final rule (86 FR 42528) we adopted the updates set forth in OMB Bulletin No. 20–01 consistent with our longstanding policy of adopting OMB delineation updates.

In the FY 2020 Hospice Wage Index final rule (84 FR 38484), we finalized the proposal to use the current FY's hospital wage index data to calculate the hospice wage index values. In the FY 2021 Hospice Wage Index final rule (85 FR 47070), we adopted the revised OMB delineations with a 5-percent cap on wage index decreases, where the estimated reduction in a geographic area's wage index would be capped at 5-percent in FY 2021 and no cap would be applied to wage index decreases for the second year (FY 2022). For FY 2023, the proposed hospice wage index would be based on the FY 2023 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2018 and before October 1, 2019 (FY 2019 cost report data). The proposed FY 2023 hospice wage index would not take into account any geographic reclassification of hospitals, including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The proposed FY 2023 hospice wage index would include a 5-percent cap on wage index decreases as discussed later in this section. The appropriate wage index value would be applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

In the FY 2006 Hospice Wage Index final rule (70 FR 45135), we adopted the policy that, for urban labor markets without a hospital from which hospital wage index data could be derived, all of the CBSAs within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. For FY 2023, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville-Fort Stewart, Georgia. The FY 2023 wage index value for Hinesville-Fort Stewart, Georgia is 0.8620.

There exist some geographic areas where there were no hospitals, and thus, no hospital wage data on which to base the calculation of the hospice wage index. In the FY 2008 Hospice Wage Index final rule (72 FR 50217 through 50218), we implemented a methodology to update the hospice wage index for rural areas without hospital wage data. In cases where there was a rural area without rural hospital wage data, we use the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs, to represent a reasonable proxy for the rural area. The term ''contiguous'' means sharing a border (72 FR 50217). Currently, the only rural area without a hospital from which hospital wage data could be derived is Puerto Rico. However, for rural Puerto Rico, we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity of almost all of Puerto Rico's various

urban areas to non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we would continue to use the most recent wage index previously available for that area. For FY 2023, we propose to continue using the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047, subsequently adjusted by the hospice floor.

As described in the August 8, 1997 Hospice Wage Index final rule (62 FR 42860), the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit. These raw wage index values are subject to application of the hospice floor to compute the hospice wage index used to determine payments to hospices. As previously discussed, the pre-floor, pre-reclassified hospital wage index values below 0.8 will be further adjusted by a 15 percent increase subject to a maximum wage index value of 0.8. For example, if County A has a pre-floor, pre-reclassified hospital wage index value of 0.3994, we would multiply 0.3994 by 1.15, which equals 0.4593. Since 0.4593 is not greater than 0.8, then County A's hospice wage index would be 0.4593. In another example, if County B has a pre-floor, pre-reclassified hospital wage index value of 0.7440, we would multiply 0.7440 by 1.15, which equals 0.8556. Because 0.8556 is greater than 0.8, County B's hospice wage index would be 0.8.

The proposed hospice wage index applicable for FY 2023 (October 1, 2022 through September 30, 2023) is available on the CMS website at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html.*

2. Proposed Permanent Cap on Wage Index Decreases

As discussed in section III.A.1, we have proposed and finalized temporary transition policies in the past to mitigate significant changes to payments due to changes to the hospice wage index. Specifically, in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142) we implemented a 50/50 blend for all geographic areas consisting of the wage index values using the then-current OMB area delineations and the wage index values using OMB's new area delineations based on OMB Bulletin No. 13–01. In the FY 2021 Hospice Wage Index final rule (85 FR 47070), we adopted the revised OMB delineations with a 5-percent cap on wage index decreases, where the estimated reduction in a geographic area's wage index would be capped at 5-percent in FY 2021 and no cap would be applied to wage index decreases for the second year (FY 2022). As explained, we believed the 5-percent cap would provide greater transparency and be administratively less complex than the prior methodology of applying a 50/50 blended wage index. We noted that this transition approach struck an appropriate balance by providing a transition period to mitigate the resulting -short-term instability and negative impacts on providers and time for them to adjust to their new labor market area delineations and wage index values.

In the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42541), a few commenters stated that providers should be protected against substantial payment reductions due to dramatic reductions in wage index values from one year to the next. Because we did not propose to modify the transition policy that was finalized in the FY 2021 Hospice final rule, we did not extend the transition period for FY 2022. In the FY 2022 Hospice final rule, we stated that we continued to believe that applying the 5-percent cap transition policy in year one provided an adequate safeguard against any significant payment reductions associated with the adoption of the revised CBSA delineations in FY 2021, allowed for sufficient time to make operational changes for future FYs, and provided a reasonable balance between mitigating some short-term instability in hospice payments and improving the accuracy of the payment adjustment for differences in area wage levels. However, we acknowledged that certain changes to wage index policy may significantly affect Medicare payments. In addition, we reiterated that our policy principles with regard to the wage index include generally using the most current data and information available and providing that data and information, as well as any approaches to addressing any significant effects on Medicare payments resulting from these potential scenarios, in notice and comment rulemaking. With these policy principles in mind, we considered for this FY 2023 Hospice proposed rule how best to address the potential scenarios, which commenters raised concerns; that is, scenarios in which changes to wage index policy may significantly affect Medicare payments.

In the past, we have established transition policies of limited duration to phase in significant changes to labor market areas. In taking this approach in the past, we sought to mitigate short term instability and fluctuations that can negatively impact providers due to wage index changes. In accordance with the requirement of our regulations at § 418.306(c) each labor market is established using the most current hospital wage data available, including any changes made by the OMB to the Metropolitan Statistical Areas (MSAs) definitions. We have previously stated that, because the wage index is a relative measure of the value of labor in prescribed labor market areas, we believe it is important to implement new labor market area delineations with as minimal a transition as is reasonably possible. However, we recognize that changes to the wage index have the potential to create instability and significant negative impacts on certain providers even when labor market areas do not change. In addition, year-to-year fluctuations in an area's wage index can occur due to external factors beyond a provider's control, such as the COVID–19 PHE, and for an individual provider, these fluctuations can be difficult to predict. We also recognize that predictability in Medicare payments is important to enable providers to budget and plan their operations.

In light of these considerations, we are proposing a permanent approach to smooth year-to-year changes in providers' wage indexes. We are proposing a policy that increases the predictability of hospice payments for providers, and mitigates instability and significant negative impacts to providers resulting from changes to the wage index.

As previously discussed, we believed that applying a 5-percent cap on wage index decreases for FY 2021 provided greater transparency and was administratively less complex than prior transition methodologies. In addition, we believed this methodology mitigated short term instability and fluctuations that can negatively impact providers due to wage index changes. Lastly, we believed the 5-percent cap applied to all wage index decreases for FY 2021 provided an adequate safeguard against significant payment reductions related to the adoption of the revised CBSAs. However, as discussed earlier in this section of the proposed rule, we recognize there are circumstances that a one-year mitigation policy, like the one adopted for FY 2021, would not effectively address future years in which providers continue to be negatively affected by significant wage index decreases.

Typical year-to-year variation in the hospice wage index has historically been within 5-percent, and we expect

this will continue to be the case in future years. Therefore, we believe that applying a 5-percent cap on all wage index decreases in future years, regardless of the reason for the decrease, would effectively mitigate instability in hospice payments due to any significant wage index decreases that may affect providers in any year that commenters raised in the FY 2022 Hospice final rule. In addition, we believe that applying a 5-percent cap on all wage index decreases would increase the predictability of hospice payments for providers, enabling them to more effectively budget and plan their operations. Lastly, we believe that applying a 5-percent cap on all wage index decreases, from the prior year, would have a small overall impact on the labor market area wage index system. As discussed in further detail in section III.A.4. of this proposed rule, we estimate that applying a 5-percent cap on all wage index decreases, from the prior year, will have a very small effect on the wage index budget standardization factors for FY 2023. Because the wage index is a measure of the value of labor (wage and wage-related costs) in a prescribed labor market area relative to the national average, we anticipate that most providers will not experience year-to-year wage index declines greater than 5-percent in any given year. We believe that applying a 5-percent cap on all wage index decreases, from the prior year, would continue to maintain the accuracy of the overall labor market area wage index system.

Therefore, for FY 2023 and subsequent years, we are proposing to apply a permanent 5-percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. That is, we are proposing that a geographic area's wage index for FY 2023 would not be less than 95 percent of its final wage index for FY 2022, regardless of whether the geographic area is part of an updated CBSA, and that for subsequent years, a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY. We further propose that if a geographic area's prior FY wage index is calculated based on the 5-percent cap, then the following year's wage index would not be less than 95 percent of the geographic area's capped wage index in the prior FY. For example, if a geographic area's wage index for FY 2023 is calculated with the application of the 5-percent cap, then its wage index for FY 2024 would not be less than 95 percent of its capped wage index in FY 2023. Likewise, we are proposing to make the corresponding regulations text changes at § 418.306(c) as follows: Starting on October 1, 2022, CMS applies a cap on decreases to the hospice wage index such that the wage index applied to a geographic area is not less than 95 percent of the wage index applied to that geographic area in the prior FY. This 5-percent cap on negative wage index changes would be implemented in a budget neutral manner through the use of wage index standardization factors. Furthermore, the 5-percent cap would be applied after the application of the hospice wage index floor. Therefore, pre-floor, pre-reclassified hospital wage index values below 0.8 would be adjusted by the 15 percent increase, subject to a maximum wage index value of 0.8. If there is a 5 percent decrease from the previous FY's wage index value after the application of the hospice wage index floor, then the 5-percent cap on wage index decreases would also be applied.

In section III.A.4 of this proposed rule, we estimate the impact to payments for providers in FY 2023 based on this proposed policy. We also note that we would examine the effects of this policy on an ongoing basis in the future in order to assess its appropriateness.

3. Proposed FY 2023 Hospice Payment Update Percentage

Section 4441(a) of the BBA (Pub. L. 105–33) amended section 1814(i)(1)(C)(ii)(VI) of the Act to establish updates to hospice rates for FYs 1998 through 2002. Hospice rates were to be updated by a factor equal to the inpatient hospital market basket percentage increase set out under section 1886(b)(3)(B)(iii) of the Act, minus 1 percentage point. Payment rates for FYs since 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent FYs must be the inpatient market basket percentage increase for that FY. In the FY 2022 IPPS final rule CMS finalized the proposal to rebase and revise the IPPS market baskets to reflect a 2018 base year. We refer readers to the FY 2022 IPPS final rule for further information (86 FR 45194 through 45208).

Section 3401(g) of the Affordable Care Act mandated that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage would be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the ''productivity adjustment''). The United States Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the United States economy. We note that previously the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) was published by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021 release of productivity data, BLS replaced the term ''multifactor productivity'' with ''total factor productivity'' (TFP). BLS noted that this is a change in terminology only and will not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is now published by BLS as ''private nonfarm business total factor productivity''. However, as mentioned, the data and methods are unchanged. We refer readers to *http://www.bls.gov* for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch.* In addition, in the FY 2022 IPPS final rule (86 FR 45214), we noted that beginning with FY 2022, CMS changed the name of this adjustment to refer to it as the ''productivity adjustment'' rather than the ''MFP adjustment''.

The proposed hospice payment update percentage for FY 2023 is based on the proposed inpatient hospital market basket update of 3.1 percent (based on IHS Global Inc.'s fourth quarter 2021 forecast with historical data through the third quarter 2021). Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the proposed inpatient hospital market basket update for FY 2023 of 3.1 percent must be reduced by a productivity adjustment as mandated by the Affordable Care Act (currently estimated to be 0.4 percentage point for FY 2023). In effect, the proposed hospice payment update percentage for FY 2023 would be 2.7 percent. We also propose that if more recent data become available after the publication of this proposed rule and before the publication of the final rule (for

example, more recent estimates of the inpatient hospital market basket update and productivity adjustment), we would use such data, if appropriate, to determine the hospice payment update percentage for FY 2023 in the final rule. We continue to believe it is appropriate to routinely update the hospice payment system so that it reflects the best available data about differences in patient resource use and costs among hospices as required by the statute. Therefore, we are proposing to: (1) Update hospice payments using the methodology outlined and apply the 2018-based IPPS market basket update for FY 2023 of 3.1 percent, reduced by the statutorily required productivity adjustment of 0.4 percentage point along with the wage index budget neutrality adjustment to update the payment rates; and (2) use the FY 2023 hospice wage index which uses the FY 2023 pre-floor, pre-reclassified IPPS hospital wage index as its basis.

In the FY 2022 Hospice Wage Index final rule (86 FR 42532 through 42539), we rebased and revised the labor shares for RHC, CHC, GIP and IRC using MCR data for freestanding hospices (CMS Form 1984–14, OMB Control Number 0938–0758) from 2018. The current labor portion of the payment rates are: For RHC, 66.0 percent; for CHC, 75.2 percent; for GIP, 63.5 percent; and for IRC, 61.0 percent. The non-labor portion is equal to 100 percent minus the labor portion for each level of care. The non-labor portion of the payment rates are as follows: For RHC, 34.0 percent; for CHC, 24.8 percent; for GIP, 36.5 percent; and for IRC, 39.0 percent.

4. Proposed FY 2023 Hospice Payment Rates

There are four payment categories that are distinguished by the location and intensity of the hospice services provided. The base payments are 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. A hospice is paid the RHC rate for each day the beneficiary is enrolled in hospice, unless the hospice provides CHC, IRC, or GIP. CHC is provided during a period of patient crisis to maintain the patient at home; IRC is short-term care to allow the usual caregiver to rest and be relieved from caregiving; and GIP is to treat symptoms that cannot be managed in another setting.

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47172), we implemented two different RHC payment rates, one RHC rate for the first 60 days and a second RHC rate for days 61 and beyond. In addition, in that final rule, we implemented an SIA payment for RHC 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 provided (up to 4 hours total) that occurred on the day of service, if certain criteria are met. In order to maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, the new RHC rates were adjusted by a service intensity add-on budget neutrality factor (SBNF). The SBNF is used to reduce the overall RHC rate in order to ensure that SIA payments are budget-neutral. At the beginning of every FY, SIA utilization is compared to the prior year in order calculate a budget neutrality adjustment. In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52156), we initiated a policy of applying a wage index standardization factor to hospice payments in order to eliminate the aggregate effect of annual variations in hospital wage data. Typically, the wage index standardization factor is calculated using the most recent, complete hospice claims data available. However, due to the COVID–19 PHE, in the FY 2022 Hospice Wage Index and Payment Rate Update proposed rule we looked at using hospice claims data before the declaration of the COVID–19 PHE (FY 2019) to determine if there were significant differences between utilizing 2019 and 2020 claims data. The difference between using FY 2019 and FY 2020 hospice claims data was minimal. Therefore, in the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42543), we stated that we would continue our practice of using the most recent, complete hospice claims data available. For FY 2023 hospice rate setting, we saw minimal differences in using the updated data; therefore, we are continuing our longstanding policy of using the most recent data available. Specifically, we are using FY 2021 claims data with the FY 2023 payment rate updates. In order to calculate the wage index standardization factor, we simulate total payments using FY 2021 hospice utilization claims data with the FY 2022 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, without the 5-percent cap on wage index decreases) and FY 2022 payment rates and compare it to our simulation of total payments using the FY 2023 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, with the 5-percent cap on wage index decreases) and FY 2022 payment rates. By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2022 wage index and payment rates for each level of care by the FY 2023 wage index and FY 2022 payment rates, we obtain a wage index standardization factor for each level of care. The wage index standardization factors for each level of care are shown in the Tables 1 and 2.

The proposed FY 2023 RHC rates are shown in Table 1. The proposed FY 2023 payment rates for CHC, IRC, and GIP are shown in Table 2.

TABLE 1—PROPOSED FY 2023 HOSPICE RHC PAYMENT RATES

Code	Description	FY 2022 payment rates	SIA budget neutrality factor	Wage index standardization factor	Proposed FY 2023 hospice payment update	Proposed FY 2023 payment rates
651	Routine Home Care (days 1–60)	$203.40	1.0004	1.0008	1.027	$209.14
651	Routine Home Care (days 61+)	160.74	1.0003	1.0007	1.027	165.25

TABLE 2—PROPOSED FY 2023 HOSPICE CHC, IRC, AND GIP PAYMENT RATES

Code	Description	FY 2022 payment rates	Wage index standardization factor	Proposed FY 2023 hospice payment update	Proposed FY 2023 payment rates
652	Continuous Home Care Full Rate = 24 hours of care.	$1,462.52 ($60.94 per hour)	1.0024	1.027	$1,505.61
655	Inpatient Respite Care	473.75	1.0007	1.027	486.88
656	General Inpatient Care	1,068.28	1.0016	1.027	1,098.88

Sections 1814(i)(5)(A) through (C) of the Act require that hospices submit quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index and Rate Update final rule (76 FR 47320 through 47324), we implemented a HQRP as required by those sections. Hospices were required to begin collecting quality data in October 2012 and submit those quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. The proposed FY 2023 rates for hospices that do not submit the required quality data would be updated by the proposed FY 2023 hospice payment update percentage of 2.7 percent minus 2 percentage points. These rates are shown in Tables 3 and 4.

TABLE 3—PROPOSED FY 2023 HOSPICE RHC PAYMENT RATES FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Code	Description	FY 2022 payment rates	SIA budget neutrality factor	Wage index standardization factor	Proposed FY 2023 hospice payment update of 2.7% minus 2 percentage points = +0.7%	Proposed FY 2023 payment rates
651	Routine Home Care (days 1–60)	$203.40	1.0004	1.0008	1.007	$205.07
651	Routine Home Care (days 61+)	160.74	1.0003	1.0007	1.007	162.03

TABLE 4—PROPOSED FY 2023 HOSPICE CHC, IRC, AND GIP PAYMENT RATES FOR HOSPICES THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Code	Description	FY 2022 payment rates	Wage index standardization factor	Proposed FY 2023 hospice payment update of 2.7% minus 2 percentage points = +0.7%	Proposed FY 2023 payment rates
652	Continuous Home Care Full Rate= 24 hours of care	$1,462.52 ($60.94 per hour)	1.0024	1.007	$1,476.29
655	Inpatient Respite Care	$473.75	1.0007	1.007	$477.40
656	General Inpatient Care	1,068.28	1.0016	1.007	1,077.48

5. Proposed Hospice Cap Amount for FY 2023

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47183), we implemented changes mandated by the IMPACT Act of 2014 (Pub. L. 113–185). Specifically, we stated that for accounting years that end after September 30, 2016 and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the CPI–U. Division CC, section 404 of the CAA 2021 extended the accounting years impacted by the adjustment made to the hospice cap calculation until 2030. In the FY 2022 Hospice Wage Index final rule (86 FR 42539), we finalized conforming regulations text changes at § 418.309 to reflect the provisions of the CAA 2021. Therefore, for accounting years that end after September 30, 2016 and before October 1, 2030, the hospice cap amount is updated by the hospice payment update percentage rather than using the CPI–U.

The proposed hospice cap amount for the FY 2023 cap year is $32,142.65, which is equal to the FY 2022 cap amount ($31,297.61) updated by the proposed FY 2023 hospice payment update percentage of 2.7 percent.

B. Proposed Updates to the Hospice Quality Reporting Program

1. Background and Statutory Authority

The Hospice Quality Reporting Program (HQRP) specifies reporting requirements for the Hospice Item Set (HIS), administrative data, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey. Section 1814(i)(5) of the Act requires the Secretary to establish and maintain a quality

reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA 2021 (Pub. L. 116–260) to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. This policy will apply beginning with FY 2024 annual payment update (APU) that is based on CY 2022 quality data. 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 the FY 2024 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.

Depending on the amount of the annual update for a particular year, a reduction of 2 percentage points through FY 2023 or 4 percentage points beginning in FY 2024 could result in the annual market basket update being less than zero percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the specified year.

In the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), we finalized two new measures using claims data: (1) Hospice Visits in the Last Days of Life (HVLDL); and (2) Hospice Care Index (HCI). We also finalized a policy that claims-based measures will use 8 quarters of data in order to report on more hospices. In addition, we removed the seven Hospice Item Set (HIS) Process Measures from the program as individual measures and public reporting because the HIS Comprehensive Assessment Measure (NQF#3235) is sufficient for measuring care at admission without the seven individual process measures. For a detailed discussion of the historical use for measure selection and removal for the HQRP quality measures, we refer readers to the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142) and the FY 2019 Hospice Wage Index and Rate Update final rule (83 FR 38622). In the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42553), we finalized § 418.312(b)(2); this new provision requires hospices to provide administrative data, including claims-based measures, as part of the HQRP requirements for § 418.306(b). In that same final rule, we provided CAHPS Hospice Survey updates. We finalized temporary changes to our public reporting policies based on the March 27, 2020 memorandum [3] and provided another tip sheet, referred to as the Second Edition HRQP Public Reporting Tip Sheet (*https://www.cms.gov/files/document/second-edition-hqrp-public-reporting-tip-sheetpdf.pdf*) on the HQRP Requirements and Best Practices web page (*https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices*).

As finalized in the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), CMS is targeting the May 2022 refresh of Care Compare/Provider Data Catalogue (PDC) for the inaugural display of the two new claims-based quality measures (QMs), the Hospice Visits in Last Days of Life (HVLDL) and the Hospice Care Index (HCI). This rule proposes no new quality measures but proposes updates on already-adopted measures. Table 5 shows all quality measures finalized in the FY 2022 Hospice Wage Index and Payment Rate Update final rule and in effect for the FY 2023 HQRP.

TABLE 5—QUALITY MEASURES FINALIZED IN THE FY 2022 HOSPICE WAGE INDEX FINAL RULE AND IN EFFECT FOR FY 2023 FOR THE HOSPICE QUALITY REPORTING PROGRAM

Hospice quality reporting program	
NQF#	Hospice item set
3235	Hospice and Palliative Care Composite Process 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. 3. Pain Assessment. 4. Dyspnea Treatment. 5. Dyspnea Screening. 6. Treatment Preferences. 7. Beliefs/Values Addressed (if desired by the patient).
Administrative Data, including Claims-based Measures	
3645 Pending NQF endorsement	Hospice Visits in Last Days of Life (HVLDL). Hospice Care Index (HCI).

[3] Exceptions and Extensions for Quality Reporting Requirements for Acute Care Hospitals, PPS-Exempt Cancer Hospitals, Inpatient Psychiatric Facilities, Skilled Nursing Facilities, Home Health Agencies, Hospices, Inpatient Rehabilitation Facilities, Long-Term Care Hospitals, Ambulatory Surgical Centers, Renal Dialysis Facilities, and MIPS Eligible Clinicians Affected by COVID–19. Available at: *https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf*

TABLE 5—QUALITY MEASURES FINALIZED IN THE FY 2022 HOSPICE WAGE INDEX FINAL RULE AND IN EFFECT FOR FY 2023 FOR THE HOSPICE QUALITY REPORTING PROGRAM—Continued

Hospice quality reporting program	
NQF#	Hospice item set
	1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided. 2. Gaps in Skilled Nursing Visits. 3. Early Live Discharges. 4. Late Live Discharges. 5. Burdensome Transitions (Type 1)—Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission. 6. Burdensome Transitions (Type 2)—Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital. 7. Per-beneficiary Medicare Spending. 8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day. 9. Skilled Nursing Minutes on Weekends 10. Visits Near Death.
CAHPS Hospice Survey	
2651	CAHPS Hospice Survey. 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

As finalized in the FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule (84 FR 38484), we are developing a hospice patient assessment instrument identified as HOPE. HOPE contributes to the patient's plan of care through on-going patient assessments throughout the hospice stay. HOPE is designed to support the hospice conditions of participation (CoPs), including hospices' quality assessment and performance improvement (QAPI) and provide quality data to calculate outcome and other types of quality measures. Our primary objectives for HOPE are to provide quality data for the HQRP requirements through standardized data collection; support survey and certification processes; and provide additional clinical data that could inform future payment refinements.

HOPE is an on-going patient assessment instrument designed to capture patient and family care needs throughout the hospice stay. HOPE supports care planning, quality improvement efforts, and health and safety of patients enrolled in Medicare-certified hospices. HOPE will include key items from the HIS and demographics like gender and race. Some HIS items will be modified for inclusion in HOPE to increase specificity. This approach to include key demographic information reflects stakeholder feedback discussed in the FYs 2017 and 2018 Hospice Wage Index and Payment Rate Update final rules (81 FR 52171 and 82 FR 36669, respectively).

HOPE is multidisciplinary, with the assessment instrument to be completed by nursing, social work, and spiritual care staff. We are undergoing testing with three distinct disciplinary assessments in beta field testing described in this section. We stated in the FY 2022 Hospice Wage Index and Payment Update final rule (86 FR 42528) that while the standardized patient assessment data elements for certain post-acute care providers required under the IMPACT Act of 2014 are not applicable to hospices, it is reasonable to include some of those standardized elements that appropriately and feasibly apply to hospice. Some patients may move through the healthcare system to hospice. Therefore, tracking key demographic and social risk factor items that apply to hospice support our goals for continuity of care, overall patient care and well-being, interoperability, and health equity that is also discussed in this rule.

The draft of HOPE has undergone cognitive, pilot, and alpha testing, and is undergoing national beta field testing to establish reliability, validity, and feasibility of the assessment instrument. The purpose of the alpha test was to establish preliminary reliability and validity of the draft assessment items, and feasibility of the HOPE assessment. Specifically, the objectives were to:

- Establish inter-rater reliability (IRR) of the assessment items.
- Demonstrate validity of the assessment items.
- Demonstrate feasibility of the assessment and time points for data collection.

HOPE alpha testing completed at the end of January 2021. Based on the quantitative data analyses and feedback from assessors in alpha testing, the items generally support the feasibility of collecting the data items. Alpha testing also showed that HOPE exhibited acceptable inter-rater reliability ranging from moderate to very good with few exceptions and demonstrated evidence of convergent validity. We used findings of the alpha test to inform decisions about the next draft of the HOPE assessment, which are being tested in the national beta test that began in late fall 2021 and continuing through 2022.

National beta testing allows us to obtain input from participating hospice teams about the assessment instrument and field testing to refine and support the final draft items and assessment time points for HOPE. It also allows us to estimate the time to complete the HOPE data items. We anticipate proposing HOPE in future rulemaking after testing and analyses are complete.

We continue HOPE development in accordance with the Blueprint for the CMS Measures Management System. HOPE development is grounded in information gathering activities to identify and refine hospice assessment domains and candidate assessment items. We appreciate the industry's and national associations' engagement in providing input through information sharing activities, including listening sessions, expert interviews, key stakeholder interviews, and focus groups to support HOPE development. As CMS proceeds with field testing HOPE, we will continue to engage with stakeholders through sub-regulatory channels. In particular, we will continue to host HQRP Forums to allow hospices and other interested parties to engage with us on the latest updates and ask questions on the development of HOPE and related quality measures. We also have a dedicated email account, *HospiceAssessment@cms.hhs.gov,* for comments about HOPE.

We will use field test results to create a final version of HOPE to propose in future rulemaking for national implementation. We will continue to engage all stakeholders throughout this process that includes a variety of sub-regulatory channels and regular HQRP communication strategies, such as Open Door Forums, Medicare Learning Network (MLN), CMS.gov website announcements, listserv messaging, and other ad hoc publicly announced opportunities. We appreciate the support for HOPE and reiterate our commitment to providing updates and engaging stakeholders through sub-regulatory means. HOPE updates can be found at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE* and engagement opportunities, including those regarding HOPE are at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.*

3. Update on Future Quality Measure (QM) Development

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484), we provided updates related to CMS's process for identifying high priority areas of quality measurement and improvement and for developing quality measures that address those priorities. 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.* In this proposed rule, we provide contemplated updates for hospice quality measure concepts based on future use of HOPE and administrative data. In section III.B.6 of this proposed rule, we are seeking public comment from hospices on their health equity initiatives and a structural composite measure concept to inform future measure development.

To support new measure development, our contractor convened two technical expert panel (TEP) meetings in 2021. The TEP considered HOPE-based process measures that may be proposed with HOPE in future rulemaking. The TEP meetings in 2021 included HOPE-based process measures intended to (1) evaluate the rate at which hospices' use specific processes of care; (2) assist in reducing variation in care delivery; and (3) determine hospices' compliance with practices that are expected to improve outcomes. The TEP also considered potential areas for future quality measure development. We refer the public to the ''2021 Technical Expert Panel Meetings: Hospice Quality Reporting Program Summary Report'' available at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.*

As stated in the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42528), we continue to consider developing hybrid quality measures that could be calculated from multiple data sources: for example, claims, assessments (HOPE), or other data sources. Hybrid quality measures allow for a more comprehensive set of information about care processes and outcomes than can be calculated using claims data alone. As described in the ''2021 Technical Expert Panel Meetings: Hospice Quality Reporting Program Summary Report,'' the TEP discussed hybrid concepts such as hospitalizations during a hospice election and patterns of live discharge using claims data and HOPE data elements.

4. Updates to the CAHPS Hospice Survey Participation Requirements for the FY 2023 APU and Subsequent Years

a. Background and Description of the CAHPS Hospice Survey

The CAHPS Hospice Survey is a component of the CMS HQRP, which is used to collect data on the experiences of hospice patients and the primary caregivers listed in their hospice records. Readers who want more information about the development of the survey, originally called the Hospice Experience of Care Survey, may refer to 79 FR 50452 and 78 FR 48261.

b. Overview of the ''CAHPS Hospice Survey Measures''

The CAHPS Hospice Survey measures were re-endorsed by NQF on November 20, 2020. The re-endorsement can be found on the NQF website at: *https://www.qualityforum.org/Measures_Reports_Tools.aspx.* The survey received its initial NQF endorsement on October 26, 2016 (NQF #2651). We adopted 8 survey-based measures for the CY 2018 data collection period and for subsequent years. These eight measures are publicly reported on a designated CMS website, Care Compare, *https://www.medicare.gov/care-compare/.*

c. CAHPS Hospice Survey Mode Experiment

CMS recently conducted a mode experiment with the goal of testing the effects of adding a web-based mode to the CAHPS Hospice Survey. We are examining the impact of a web-based mode on survey response rates and scores. The survey currently has three approved modes without any web component (mail, telephone, and mail with telephone follow-up.). In addition, the test will allow for examination of the effects of a shortened survey (that is, removing existing survey items) on response rate and scores; assessment of the measure properties of a limited number of supplemental survey items suggested by stakeholders; and calculation of item-level mode adjustments for the shortened survey in the currently-approved modes of CAHPS Hospice Survey administration, as well as the proposed new web-based mode.

The mode experiment design applied all of the existing CAHPS Hospice Survey eligibility criteria, and sampled patients/caregivers across five arms. The first arm tested a new web-mail mode, in which invitations to the web survey were sent by email to those with email addresses. The email was personalized to the respondent and included a link to the web version of the survey, which can be completed on either a computer or a mobile device such as a smartphone or tablet. If the respondent did not complete the web survey after one week, or did not have a valid email address in which to send an email, up to two surveys were sent by mail. This arm used a shortened version of the CAHPS Hospice Survey.

In the next three arms, the shortened version of the CAHPS Hospice Survey instrument was administered in the three currently-approved modes: Mail only; telephone-only; and mixed mode

(mail with telephone follow up). The fifth arm, in which the current survey instrument was administered via mail only served as a comparison for all other arms. Across all arms, half of sampled caregivers received a pre-notification letter to examine the effects of such a letter on response rates.

Overall (across the five arms), CMS sampled 15,000 eligible caregivers from around 50 hospices over a six- to seven-month period. Caregivers were randomized within each hospice to one of the five arms.

We continue to analyze the results of the mode experiment and will keep stakeholders informed on any plans for changes to the survey content or administration options through our regular stakeholder communication channels. In this proposed rule, there are no changes to the administration procedures or content for the CAHPS Hospice Survey. Any changes to the CAHPS Hospice Survey will be proposed in future rulemaking.

d. Data Sources

In the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38484), we finalized the participation requirements for the CAHPS Hospice Survey. To meet the CAHPS Hospice Survey requirements for the HQRP, hospice facilities must contract with a CMS-approved vendor to collect survey data for eligible patients on a monthly basis and report that data to CMS on the hospice's behalf by the quarterly deadlines established for each data collection period.

e. Public Reporting of CAHPS Hospice Survey Results

We began public reporting of the results of the CAHPS Hospice Survey on Hospice Compare as of February 2018. Before the COVID–19 PHE, we reported the most recent 8 quarters of data on the basis of a rolling average, with the most recent quarter of data being added and the oldest quarter of data removed from the averages for each data refresh. As finalized in the FY 2022 Hospice Wage Index and Payment Rule Update (86 FR 42528), we are not reporting Q1 2020 and Q2 2020 data due to the COVID–19 PHE. Therefore, we have publicly reported the most recently available 8 quarters of CAHPS data that excluded Q1 2020 and Q2 2020 data. These data were publicly reported starting with the February 2022 refresh and will continue through the May 2023 refresh on Care Compare. The Second Edition HQRP Public Reporting Tip Sheet dated Dec. 2021 on the HQRP Requirements and Best Practices web page (*https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices*) summarizes CMS' approach to the HQRP as public reporting has resumed in February 2022. It also explains the HQRP public reporting changes associated with the FY 2022 Hospice Wage Index and Payment Rule Update final rule and provides a summary of the data refreshes.

f. Volume-Based Exemption for CAHPS Hospice Survey Data Collection and Reporting Requirements

In the FY 2020 Hospice Wage Index and Rate Update final rule (84 FR 38526), we finalized a policy making a volume-based exemption for CAHPS Hospice Survey Data Collection and Reporting requirements for FY 2021 and every year thereafter.

In this proposed rule, there would be no changes to this exemption. The exemption request form is available on the official CAHPS Hospice Survey website: *http://www.hospiceCAHPSsurvey.org.* Hospices that intend to claim the size exemption are required to submit to CMS their completed exemption request form by December 31, of the data collection year.

Hospices that served a total of fewer than 50 survey-eligible decedent/caregiver pairs in the year before the data collection year are eligible to apply for the size exemption. Hospices may apply for a size exemption by submitting the size exemption request form. The size exemption is only valid for the year on the size exemption request form. If the hospice remains eligible for the size exemption, the hospice must complete the size exemption request form for every applicable FY APU period, as shown in Table 6.

TABLE 6—SIZE EXEMPTION KEY DATES FY 2023 THROUGH FY 2026

Fiscal year	Data collection year	Reference year	Size exemption form submission deadline
FY 2023	CY 2021	CY 2020	December 31, 2021.
FY 2024	CY 2022	CY 2021	December 31, 2022.
FY 2025	CY 2023	CY 2022	December 31, 2023.
FY 2026	CY 2024	CY 2023	December 31, 2024.

g. Newness Exemption for CAHPS Hospice Survey Data Collection and Public Reporting Requirements

We previously finalized a one-time newness exemption for hospices that meet the criteria as stated in the FY 2017 Hospice Wage Index and Payment Rate Update final rule (81 FR 52181). In the FY 2019 Hospice Wage Index and Payment Rate Update final rule (83 FR 38642), we continued the newness exemption for FY 2023, and all subsequent years. We encourage hospices to keep the letter they receive providing them with their CMS Certification Number (CCN). The letter can be used to show when you received your number.

h. Survey Participation Requirements

We previously finalized survey participation requirements for FY 2022 through FY 2025 as stated in the FY 2018 and FY 2019 Hospice Wage Index and Payment Rate Update final rules (82 FR 36670 and 83 FR 38642 through 38643). We also continued those requirements in all subsequent years (84 FR 38526). Table 7 restates the data submission dates for FY 2023 through FY 2025.

TABLE 7—CAHPS HOSPICE SURVEY DATA SUBMISSION DATES FOR THE APU IN FY 2023, FY 2024, AND FY 2025

Sample months (month of death) *	CAHPS quarterly data submission deadlines **
FY 2023 APU	

TABLE 7—CAHPS HOSPICE SURVEY DATA SUBMISSION DATES FOR THE APU IN FY 2023, FY 2024, AND FY 2025—Continued

Sample months (month of death) *	CAHPS quarterly data submission deadlines **
CY January–March 2021 (Quarter 1)	August 11, 2021.
CY April–June 2021 (Quarter 2)	November 10, 2021.
CY July–September 2021 (Quarter 3)	February 9, 2022.
CY October–December 2021 (Quarter 4)	May 11, 2022.
FY 2024 APU	
CY January–March 2022 (Quarter 1)	August 10, 2022.
CY April–June 2022 (Quarter 2)	November 9, 2022.
CY July–September 2022 (Quarter 3)	February 8, 2023.
CY October–December 2022 (Quarter 4)	May 10, 2023.
FY 2025 APU	
CY January–March 2023 (Quarter 1)	August 9, 2023.
CY April–June 2023 (Quarter 2)	November 8, 2023.
CY July–September 2023 (Quarter 3)	February 14, 2024.
CY October–December 2023 (Quarter 4)	May 8, 2024.

* Data collection for each sample month initiates 2 months following the month of patient death (for example, in April for deaths occurring in January).

** Data submission deadlines are the second Wednesday of the submission months, which are the months August, November, February, and May.

For further information about the CAHPS Hospice Survey, we encourage hospices and other entities to visit: *https://www.hospiceCAHPSsurvey.org.* For direct questions, contact the CAHPS Hospice Survey Team at *hospiceCAHPSsurvey@HCQIS.org* or call 1–(844) 472–4621.

i. CAHPS Hospice Survey Star Ratings

We previously finalized a policy requiring us to display Hospice CAHPS Survey Star Ratings no sooner than FY 2022 as stated in the FY 2022 Hospice Wage Index and Payment Rule Update rule (86 FR 42528). Star Ratings will be publicly reported on Care Compare on Medicare.gov beginning with the August 2022 refresh. This start date allowed CMS to conduct a dry run of the Star Ratings with reporting to hospices via preview reports. Hospices first saw their Star Ratings in their preview reports during the November 2021 and March 2022 preview periods for the February 2022 and May 2022 updates of Care Compare on Medicare.gov. However, the CAHPS Hospice Survey Star Ratings will not be publicly reported in February or May 2022. The reporting period for the dry run covers data from Q4 2018 through Q4 2019 and Q3 2020 through Q1 2021. Detailed information about the calculation and display of Hospice CAHPS Survey Star Ratings can be found on the official CAHPS Hospice Survey website: *http://www.hospiceCAHPSsurvey.org.* There are no changes to the Hospice CAHPS Survey Star Ratings for FY 2023.

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

a. Statutory Penalty for Failure To Report

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. Such data must be submitted in a form and manner, and at a time specified by the Secretary. Section 1814(i)(5)(A)(i) of the Act was amended by the CAA 2021 and the payment reduction for failing to meet hospice quality reporting requirements is increased from 2 percent to 4 percent beginning with FY 2024. The Act requires that, beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and then beginning in FY 2024 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 fiscal year. Last year, we revised our rule at § 418.306(b)(2) in accordance with this statutory change (86 FR 42605).

b. Compliance

HQRP Compliance requires understanding three timeframes for both HIS and CAHPS; (1) The relevant Reporting Year, payment FY and the Reference Year. The ''Reporting Year'' (HIS)/''Data Collection Year'' (CAHPS). This timeframe is based on the calendar year. It is the same calendar year for both HIS and CAHPS. If the CAHPS Data Collection year is CY 2023, then the HIS reporting year is also CY 2023. (2) The APU is subsequently applied to FY payments based on compliance in the corresponding Reporting Year/Data Collection Year; and (3) For the CAHPS Hospice Survey, the Reference Year is the CY prior to the Data Collection Year. The Reference Year applies to hospices submitting a size exemption from the CAHPS survey (there is no similar exemption for HIS). For example, for the CY 2023 data collection year, the Reference Year, is CY 2022. This means providers seeking a size exemption for CAHPS in CY 2023 would base it on their hospice size in CY 2022. Submission requirements are codified in § 418.312.

For every CY all Medicare-certified hospices are required to submit HIS and CAHPS data according to the requirements in § 418.312. Table 8 summarizes the three timeframes. It illustrates how the CY interacts with the FY payments, covering the CY 2021 through CY 2024 data collection periods and the corresponding APU application from FY 2023 through FY 2026.

TABLE 8—HQRP REPORTING REQUIREMENTS AND CORRESPONDING ANNUAL PAYMENT UPDATES

Reporting year for HIS and data collection year for CAHPS data (calendar year)	Annual payment update impacts payments for the FY	Reference year for CAHPS size exemption (CAHPS only)
CY 2021	FY 2023 APU.	CY 2020.
CY 2022	FY 2024 APU*.	CY 2021.
CY 2023	FY 2025 APU.	CY 2022.

TABLE 8—HQRP REPORTING REQUIREMENTS AND CORRESPONDING ANNUAL PAYMENT UPDATES—Continued

Reporting year for HIS and data collection year for CAHPS data (calendar year)	Annual payment update impacts payments for the FY	Reference year for CAHPS size exemption (CAHPS only)
CY 2024	FY 2026 APU.	CY 2023.

*Beginning in FY 2024 and all subsequent years, the payment penalty is 4 percent. Prior to FY 2024, the payment penalty is 2 percent.

As illustrated in Table 8, CY 2021 data submissions compliance impacts the FY 2023 APU. CY 2022 data submissions compliance impacts the FY 2024 APU. CY 2023 data submissions compliance impacts FY 2025 APU. This CY data submission impacting FY APU pattern follows for subsequent years.

c. Submission Data and Requirements

As finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47192), hospices' compliance with HIS requirements beginning with the FY 2020 APU determination (that is, based on HIS-Admission and Discharge records submitted in CY 2018) are based on a timeliness threshold of 90 percent. This means CMS requires that hospices submit 90 percent of all required HIS records within 30-days of the event (that is, patient's admission or discharge). The 90-percent threshold is hereafter referred to as the timeliness compliance threshold. Ninety percent of all required HIS records must be submitted and accepted within the 30-day submission deadline to avoid the statutorily-mandated payment penalty. Hospice compliance with claims data requirements is based on administrative data collection. Since Medicare claims data are already collected from claims, hospices are considered 100 percent compliant with the submission of these data for the HQRP. There is no additional submission requirement for administrative data.

To comply with CMS' quality reporting requirements for CAHPS, hospices are required to collect data monthly using the CAHPS Hospice Survey. Hospices comply by utilizing a CMS-approved third-party vendor. Approved Hospice CAHPS vendors must successfully submit data on the hospice's behalf to the CAHPS Hospice Survey Data Center. A list of the approved vendors can be found on the CAHPS Hospice Survey website: *www.hospicecahpssurvey.org.* Table 9. HQRP Compliance Checklist illustrates the APU and timeliness threshold requirements.

TABLE 9—HQRP COMPLIANCE CHECKLIST

Annual payment update	HIS	CAHPS
FY 2023	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/21–12/31/21.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2021–12/31/2021.
FY 2024	Submit at least 90 percent of all HIS records or its successor instrument within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/22–12/31/22.	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 or its successor instrument within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/23–12/31/23.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2023–12/31/2023.

Note: The data source for the claims-based measures will be Medicare claims data that are already collected and submitted to CMS. There is no additional submission requirement for administrative data (Medicare claims), and hospices with claims data are 100-percent compliant with this requirement.

Most hospices that fail to meet HQRP requirements do so because they miss the 90 percent threshold. We offer many training and education opportunities through our website, which are available 24/7, 365 days per year, to enable hospice staff to learn at the pace and time of their choice. We want hospices to be successful with meeting the HQRP requirements. We encourage hospices to use this website at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Quality-Reporting-Training-Training-and-Education-Library.* For more information about HQRP Requirements, we refer readers to visit the frequently-updated HQRP website and especially the Best Practice, Education and Training Library, and Help Desk web pages at: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting.* We also encourage readers to visit the HQRP web page and sign-up for the Hospice Quality ListServ to stay informed about HQRP.

6. Request for Information Related to the HQRP Health Equity Initiative

CMS defines health equity as ''the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.'' CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive. CMS' goals are in line with Executive Order 13985, on the Advancement of Racial Equity and Support for the Underserved Communities, which can be found at: *https://www.whitehouse.gov/briefing-room/presidential-actions/2021/06/25/executive-order-on-diversity-equity-inclusion-and-accessibility-in-the-federal-workforce/.*

Belonging to an underserved community is often associated with worse health outcomes.[4] [5] [6] [7] [8] [9] [10] [11] Such

[4] Joynt KE, Orav E, Jha AK. Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care. JAMA. 2011; 305(7):675–681.

[5] Lindenauer PK, Lagu T, Rothberg MB, et al. Income Inequality and 30 Day Outcomes After

disparities in health outcomes are the result of multiple factors. Although not the sole determinants, poor access to care and provision of lower quality health care are important contributors to health disparities notable for CMS programs. Health inequities persist in hospice and palliative care, where Black and Hispanic populations are less likely to utilize care and over 80 percent of patients are White.[12] [13] [14] [15] After hospice admission, racial and ethnic disparities appear to impact quality of care and health outcomes.[16] Black patients may receive fewer supportive care medications despite higher symptom burdens, experience care less consistent with their expressed preferences, and encounter worse end-of-life communication.[17] [18] [19] [20] [21] In response to these disparities, 70 percent of home health organizations, including 22 percent that are hospices, indicated they would increase the resources dedicated to diversity, equity, and inclusion in 2021.[22] One important strategy for addressing these disparities is improving data collection to allow for better measurement and reporting on equity across our programs and policies.[23] [24]

We are committed to achieving equity in health care outcomes for our beneficiaries by supporting providers in quality improvement activities to reduce health inequities, enabling beneficiaries to make more informed decisions, and promoting provider accountability for health care disparities.[25] [26] CMS is committed to closing the equity gap in CMS quality programs. For more information on the portfolio of programs aimed at making information on the quality of health care providers and services, including disparities, more transparent, we refer readers to the FY 2022 Hospice Wage Index and Rate Update proposed rule (86 FR 19700).

In the FY 2022 Hospice Wage Index and Rate Update final rule, we received comments supportive of gathering standardized patient assessment data elements and additional SDOH data to improve health equity. In parallel, commenters advocated for education efforts for beneficiaries, providers, and stakeholders on the benefits of collecting and reporting demographic and social risk factor data. We received many comments about the use of standardized patient assessment data elements in the hospice setting to assess health equity and SDOH, some of which raised concerns there may be unintended consequences. Many commenters noted that hospice patients have different goals of care than non-hospice patients, which does not align with standardized data elements for patient assessment. Commenters encouraged CMS to only utilize certain aspects of standardized data elements for patient assessment (specifically, Z-codes 55–65) in collecting health equity data. We refer the readers to review the summary of public comments received in the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42528).

We will continue to take all comments and suggestions into account as we work to develop policies on this important topic. We appreciate hospices and national organizations sharing their support and commitment to addressing health disparities and offering meaningful comments for consideration in the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42528). Given the value of the comments thus far and the ongoing development of activities to improve health equity, we solicit public comment on the following questions:

- What efforts does your hospice employ to recruit staff, volunteers, and board members from diverse populations to represent and serve underserved populations? How does your hospice attempt to bridge any cultural gaps between your personnel and beneficiaries/clients? How does your hospice measure whether this has an impact on health equity?
- How does your hospice currently identify barriers to access in your community or service area? What are barriers to collecting data related to disparities, social determinants of health, and equity? What steps does your hospice take to address these barriers?
- How does your hospice collect self-reported data such as race/ethnicity, veteran status, socioeconomic status, housing, food security, access to interpreter services, caregiving status, and marital status used to inform its health equity initiatives?
- How is your hospice using qualitative data collection and analysis methods to measure the impact of its health equity initiatives?

In addition, we are considering a structural composite measure based on information already collected by hospices. Specifically, the structural composite measure could include organizational activities to address access to and quality of hospice care for underserved populations. The composite structural measure concept could include hospice reported data on hospice activities to address

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Acute Myocardial Infarction, Heart Failure, and Pneumonia: Retrospective Cohort Study. British Medical Journal. 2013; 346.

[6] Trivedi AN, Nsa W, Hausmann LRM, et al. Quality and Equity of Care in U.S. Hospitals. New England Journal of Medicine. 2014; 371(24):2298–2308.

[7] Polyakova, M., et al. Racial Disparities In Excess All-Cause Mortality During The Early COVID–19 Pandemic Varied Substantially Across States. Health Affairs. 2021; 40(2): 307–316.

[8] Rural Health Research Gateway. Rural Communities: Age, Income, and Health Status. Rural Health Research Recap. November 2018.

[9] *https://www.minorityhealth.hhs.gov/assets/PDF/Update_HHS_Disparities_Dept-FY2020.pdf.*

[10] *www.cdc.gov/mmwr/volumes/70/wr/mm7005a1.htm.*

[11] Poteat TC, Reisner SL, Miller M, Wirtz AL. COVID–19 Vulnerability of Transgender Women With and Without HIV Infection in the Eastern and Southern U.S. Preprint. medRxiv. 2020;2020.07.21.20159327. Published 2020 Jul 24. doi:10.1101/2020.07.21.20159327.

[12] 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.

[13] *https://journalofethics.ama-assn.org/article/racial-disparities-hospice-moving-analysis-intervention/2006-09.*

[14] Capital Caring, Seasons Execs: Improving Hospice Diversity Starts from the Inside Out. 11/17/21. Holly Vossel. Capital Caring, Seasons Execs: Improving Hospice Diversity Starts from the Inside Out—Hospice & Palliative Care Network of Maryland *https://hospicenews.com/2021/11/17/capital-caring-seasons-execs-improving-hospice-diversity-starts-from-the-inside-out/.*

[15] 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*).

[16] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3822363/.*

[17] Naming the Problem: A Structural Racism Framework to Examine Disparities in Palliative Care—ScienceDirect.

[18] Johnson KS. Racial and ethnic disparities in palliative care. J Palliat Med 2013;16:1329–1334.

[19] Elk R, Felder TM, Cayir E, Samuel CA. Social inequalities in palliative care for cancer patients in the United States: astructured review. Semin Oncol Nurs 2018;34:303–315.

[20] Elliott AM, Alexander SC, Mescher CA, Mohan D, Bar-nato AE. Differences in physicians' verbal and nonverbal communication with black and white patients at the end of life. J Pain Symptom Manage 2016;51:1–8.

[21] Johnson RL, Roter D, Powe NR, Cooper LA. Patient race/ethnicity and quality of patient-physician communication during medical visits. Am J Public Health 2004;94:2084–2090.

[22] Capital Caring, Seasons Execs: Improving Hospice Diversity Starts from the Inside Out. 11/17/21. Holly Vossel. Capital Caring, Seasons Execs: Improving Hospice Diversity Starts from the Inside Out—Hospice & Palliative Care Network of Maryland *https://hospicenews.com/2021/11/17/capital-caring-seasons-execs-improving-hospice-diversity-starts-from-the-inside-out/.*

[23] *https://hospicenews.com/2021/05/27/hospice-providers-leverage-data-to-reach-the-underserved/.*

[24] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3822363/.*

[25] *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf.*

[26] Report to Congress: Improving Medicare PostAcute Care Transformation (IMPACT) Act of 2014 Strategic Plan for Accessing Race and Ethnicity Data. January 5, 2017. Available at *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Research-Reports-2017-Report-to-Congress-IMPACT-ACT-of-2014.pdf.*

underserved populations' access to hospice care. For example, a hospice could receive a point for each domain where data are submitted to a CMS portal, regardless of the hospice's action in that domain (such as, reporting whether or not the hospice provided training for board members, leaders, staff and volunteers in culturally and linguistically appropriate services (CLAS), health equity, and implicit bias). The data could reflect the hospice's completed actions for each corresponding domain (for a total of three points) in a reporting year. A hospice could submit information such as documentation, examples, or narratives to qualify for the measure numerator. We are also seeking comment on how to score a domain for a hospice that submitted data reflecting no actions or partial actions in the given domain.

Examples of the domains we are considering are described in the following outline. We seek comment on each of these domains, including specific suggestions on items that should be added, removed, or revised.

Domain 1: Hospice commitment to reducing disparities is strengthened when equity is a key organizational priority. Candidate domain 1 could be satisfied when a hospice submits data on their actions regarding the role of health equity and community engagement in their strategic plan. Hospices could self-report data in the reporting year about their actions in each of the following areas, and submission of data for all elements could be required to qualify for the measure numerator.

- Hospice attests whether its strategic plan includes approaches to address health equity in the reporting year.
- Hospice reports community engagement and key stakeholder activities in the reporting year.
- Hospice reports on any attempts to measure input from patients and caregivers about care disparities they may experience and recommendations or suggestions.

Domain 2: Training board members, leaders, staff and volunteers in culturally and linguistically appropriate services (CLAS),[27] health equity, and implicit bias is an important step hospices take to provide quality care to diverse populations. Candidate domain 2 could focus on hospices' diversity, equity, inclusion and CLAS training for board members, employed staff, and volunteers by capturing the following self-reported actions in the reporting year. Submission of relevant data for all elements could be required to qualify for the measure numerator.

- Hospice attests whether employed staff were trained in CLAS and culturally sensitive care mindful of social determinants of health (SDOH) in the reporting year. Example data include specific training programs or training requirements for staff.
- Hospice attests whether it provided resources to staff and volunteers about health equity, SDOH, and equity initiatives in the reporting year. Examples include the materials provided, webinars, or learning opportunities.

Domain 3: Leaders and staff could improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. This candidate domain could capture activities related to organizational inclusion initiatives and capacity to promote health equity. Examples of equity-focused factors include proficiency in languages other than English, experience working with populations in the service area, experience working on health equity issues, and experience working with individuals with disabilities.

Submission of relevant data for all elements could be required to qualify for the measure numerator.

- Hospice attests whether equity-focused factors were included in the hiring of hospice senior leadership, including chief executives and board of trustees, in the previous reporting year.
- Hospice attests whether equity-focused factors were included in the hiring of hospice senior leadership, including chief executives and board of trustees, is more reflective of the services area patient than in the previous reporting year.
- Hospice attests whether equity-focused factors were included in the hiring of direct patient care staff (for example, RNs, medical social workers, aides, volunteers, chaplains, or therapists) in the previous reporting year.
- Hospice attests whether equity focused factors were included in the hiring of indirect care or support staff (for example. administrative, clerical, or human resources) in the previous reporting year.

We are interested in developing health equity measures based on information collected by hospices not currently available on claims, assessments, or other publicly available data sources to support development of future quality measures. We are soliciting public comment on the conceptual domains and quality measures described in this section. Furthermore, we are soliciting public comments on publicly reporting a composite structural health equity quality measure; displaying descriptive information on Care Compare from the data hospices provide to support health equity measures; and the impact of the domains and quality measure concepts on organizational culture change.

7. Advancing Health Information Exchange Update

The Department of Health and Human Services (HHS) has a number of initiatives designed to encourage and support the adoption of interoperable health information technology and to promote nationwide health information exchange to improve health care and patient access to their digital health information.

To further interoperability in post-acute care settings, CMS and the Office of the National Coordinator for Health Information Technology (ONC) participate in the Post-Acute Care Interoperability Workgroup (PACIO) to facilitate collaboration with industry stakeholders to develop Health Level Seven International® (HL7) Fast Healthcare Interoperability Resources® (FHIR) standards.[28] These standards could support the exchange and reuse of patient assessment data derived from the Minimum Data Set (MDS), Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF–PAI), LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS), Outcome and Assessment Information Set (OASIS), and other sources. The PACIO Project has focused on HL7 FHIR implementation guides for functional status, cognitive status and new use cases on advance directives, re-assessment timepoints, and Speech Language, Swallowing, Cognitive communication and Hearing (SPLASCH) pathology. We encourage PAC provider and health (IT) vendor participation as the efforts advance.

The CMS Data Element Library (DEL) continues to be updated and serves as a resource for PAC assessment data elements and their associated mappings to health IT standards, such as Logical Observation Identifiers Names and Codes (LOINC) and Systematized Nomenclature of Medicine Clinical Terms (SNOMED). The DEL furthers CMS' goal of data standardization and interoperability. Standards in the DEL (*https://del.cms.gov/DELWeb/pubHome*) can be referenced on the CMS website

[27] *https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf.*

[28] *http://pacioproject.org/.*

and in the ONC Interoperability Standards Advisory (ISA). The 2022 ISA is available at *https://www.healthit.gov/isa.*

The 21st Century Cures Act (Cures Act) (Pub. L. 114–255, enacted December 13, 2016) required HHS and ONC to take steps to further interoperability for providers and settings across the care continuum. Section 4003(b) of the Cures Act required ONC to take steps to advance interoperability through the development of a trusted exchange framework and common agreement aimed at establishing a universal floor of interoperability across the country. On January 18, 2022, ONC announced a significant milestone by releasing the Trusted Exchange Framework [29] and Common Agreement Version 1 [30]. The Trusted Exchange Framework is a set of non-binding principles for health information exchange, and the Common Agreement is a contract that advances those principles. The Common Agreement and the incorporated by reference Qualified Health Information Network Technical Framework Version 1 [31] establish the technical infrastructure model and governing approach for different health information networks and their users to securely share clinical information with each other—all under commonly agreed to terms. The technical and policy architecture of how exchange occurs under the Trusted Exchange Framework and the Common Agreement follows a network-of-networks structure, which allows for connections at different levels and is inclusive of many different types of entities at those different levels, such as health information networks, healthcare practices, hospitals, public health agencies, and Individual Access Services (IAS) For more information, we refer readers to *https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement.*

We invite readers to learn more about these important developments and how they are likely to affect hospices.

[29] The Trusted Exchange Framework (TEF): Principles for Trusted Exchange (Jan. 2022), *https://www.healthit.gov/sites/default/files/page/2022-01/Trusted_Exchange_Framework_0122.pdf.*

[30] Common Agreement for Nationwide Health Information Interoperability Version 1 (Jan. 2022), *https://www.healthit.gov/sites/default/files/page/2022-01/Common_Agreement_for_Nationwide_Health_Information_Interoperability_Version_1.pdf.*

[31] Qualified Health Information Network (QHIN) Technical Framework (QTF) Version 1.0 (Jan. 2022), *https://rce.sequoiaproject.org/wp-content/uploads/2022/01/QTF_0122.pdf.*

C. CAA 2021, Section 407. Establishing Hospice Program Survey and Enforcement Procedures Under the Medicare Program; Provisions Update

Division CC, section 407 of the CAA 2021, amended Part A of Title XVIII of the Act to add a new section 1822, and amended sections 1864(a) and 1865(b) of the Act, establishing new hospice program survey and enforcement requirements, required public reporting of survey information, and a new hospice hotline.

The law requires public reporting of hospice program surveys conducted by both State Agencies (SAs) and Accrediting Organizations (AOs), as well as enforcement actions taken as a result of these surveys, on the CMS website in a manner that is prominent, easily accessible, searchable, and presented in a readily understandable format. It removes the prohibition at section 1865(b) of the Act of public disclosure of hospice surveys performed by AOs, and requires that AOs use the same survey deficiency reports as SAs (Form CMS–2567, ''Statement of Deficiencies'' or a successor form) to report survey findings.

The law also requires hospice programs to measure and reduce inconsistency in the application of survey results among all surveyors, and requires the Secretary to provide comprehensive training and testing of SA and AO hospice program surveyors, including training with respect to review of written plans of care. The statute prohibits SA surveyors from surveying hospice programs for which they have worked in the last 2 years or in which they have a financial interest, requires hospice program SAs and AOs to use a multidisciplinary team of individuals for surveys conducted with more than one surveyor to include at least one registered nurse, and provides that each SA must establish a dedicated toll-free hotline to collect, maintain, and update information on hospice programs and to receive complaints.

The provisions in the CAA 2021 also direct 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, and requires the development and implementation of a range of remedies as well as 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. The remedies include civil money penalties (CMPs), suspension of all or part of payments, and appointment of temporary management to oversee operations.

In the CY 2022 Home Health Prospective Payment System (HH PPS) final rule (86 FR 62240), we addressed provisions related to the hospice survey enforcement and other activities described in this section. A summary of the finalized CAA provisions can be found in the CY 2022 HH PPS final rule: *https://www.govinfo.gov/content/pkg/FR-2021-11-09/pdf/2021-23993.pdf.* We finalized all the CAA provisions in CY 2022 rulemaking except for the special focus program (SFP). As outlined in the CY 2022 HH PPS final rule, we stated that we would take into account comments that we received and work on a revised proposal, seeking additional collaboration with stakeholders to further develop the methodology for the SFP Since the publication of the CY 2022 HH PPS final rule, we have decided to initiate a hospice Technical Expert Panel (TEP) in CY 2022. Accordingly, CMS plans to use the TEP findings to further develop a proposal on the methodology for establishing the hospice SFP, and we plan to include a proposal implementing a SFP in the FY 2024 Hospice rulemaking proposed rule.

IV. Response to Comments

Because of the large number of public comments, we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Collection of Information

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

VI. Regulatory Impact Analysis

A. Statement of Need

This proposed rule meets the requirements of our regulations at § 418.306(c) and (d), which require annual issuance, in the **Federal Register**, of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of CBSAs or previously used MSAs, as well as any

changes to the methodology for determining the per diem payment rates. This proposed rule would also update payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2023 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. The payment rate updates are subject to changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. Lastly, section 3004 of the Affordable Care Act amended the Act to authorize a quality reporting program for hospices, and this rule does not change the requirements for the HQRP in accordance with section 1814(i)(5) of the Act.

B. Overall Impacts

We estimate that the aggregate impact of the payment provisions in this proposed rule would result in an estimated increase of $580 million in payments to hospices, resulting from the hospice payment update percentage of 2.7 percent for FY 2023. The impact analysis of this proposed rule represents the projected effects of the changes in hospice payments from FY 2022 to FY 2023. Using the most recent complete data available at the time of rulemaking, in this case FY 2021 hospice claims data as of January 21, 2022, we apply the current FY 2022 wage index with the current labor shares. Using the same FY 2021 data, we apply the FY 2023 wage index and the current labor share values to simulate FY 2022 payments. We then apply a budget neutrality adjustment so that the aggregate simulated payments do not increase or decrease due to changes in the wage index.

Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) (Having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a RIA that, to the best of our ability presents the costs and benefits of the rulemaking.

C. Detailed Economic Analysis

1. Proposed Hospice Payment Update for FY 2023

The FY 2023 hospice payment impacts appear in Table 10. We tabulate the resulting payments according to the classifications (for example, provider type, geographic region, facility size), and compare the difference between current and future payments to determine the overall impact. The first column shows the breakdown of all hospices by provider type and control (non-profit, for-profit, government, other), facility location, facility size. The second column shows the number of hospices in each of the categories in the first column. The third column shows the effect of using the FY 2023 updated wage index data with a 5-percent cap on wage index decreases. This represents the effect of moving from the FY 2022 hospice wage index to the FY 2023 hospice wage index with a 5-percent cap on wage index decreases. The aggregate impact of the changes in column three is zero percent, due to the hospice wage index standardization factor. However, there are distributional effects of the FY 2023 hospice wage index. The fourth column shows the effect of the hospice payment update percentage as mandated by section 1814(i)(1)(C) of the Act, and is consistent for all providers. The proposed hospice payment update percentage of 2.7 percent is based on the proposed 3.1 percent inpatient hospital market basket update, reduced by a proposed 0.4 percentage point productivity adjustment. The fifth column shows the effect of all the proposed changes on FY 2023 hospice payments. It is projected aggregate payments would increase by 2.7 percent; assuming hospices do not change their billing practices. As illustrated in Table 10, the combined effects of all the proposals vary by specific types of providers and by location. We note that simulated payments are based on utilization in FY 2021 as seen on Medicare hospice claims (accessed from the CCW in January 21, 2022) and only include payments related to the level of care and do not include payments related to the service intensity add-on.

As illustrated in Table 10, the combined effects of all the proposals vary by specific types of providers and by location.

TABLE 10—PROJECTED IMPACT TO HOSPICES FOR FY 2023

Hospice subgroup	Hospices	FY 2023 updated wage data ≤with cap	FY 2023 proposed hospice payment update (%)	Overall total impact for FY 2023
All Hospices	5,186	0.0%	2.7%	2.7%
Hospice Type and Control:				
Freestanding/Non-Profit	581	−0.1	2.7	2.6
Freestanding/For-Profit	3,508	0.1	2.7	2.8
Freestanding/Government	42	0.1	2.7	2.8
Freestanding/Other	352	−0.1	2.7	2.6
Facility/HHA Based/Non-Profit	347	−0.2	2.7	2.5
Facility/HHA Based/For-Profit	200	−0.1	2.7	2.6
Facility/HHA Based/Government	79	−0.1	2.7	2.6
Facility/HHA Based/Other	77	−0.3	2.7	2.4
Subtotal: Freestanding Facility Type	4,483	0.0	2.7	2.7
Subtotal: Facility/HHA Based Facility Type	703	−0.2	2.7	2.5
Subtotal: Non-Profit	928	−0.1	2.7	2.6
Subtotal: For Profit	3,708	0.1	2.7	2.8
Subtotal: Government	121	0.0	2.7	2.7
Subtotal: Other	429	−0.1	2.7	2.6
Hospice Type and Control: Rural:				
Freestanding/Non-Profit	132	−0.1	2.7	2.6
Freestanding/For-Profit	351	0.0	2.7	2.7
Freestanding/Government	24	−0.6	2.7	2.1
Freestanding/Other	49	0.0	2.7	2.7
Facility/HHA Based/Non-Profit	135	−0.2	2.7	2.5
Facility/HHA Based/For-Profit	47	−0.7	2.7	2.0
Facility/HHA Based/Government	62	−0.2	2.7	2.5
Facility/HHA Based/Other	46	−0.1	2.7	2.6
Facility Type and Control: Urban:				
Freestanding/Non-Profit	449	−0.1	2.7	2.6
Freestanding/For-Profit	3,157	0.1	2.7	2.8
Freestanding/Government	18	0.3	2.7	3.0
Freestanding/Other	303	-0.1	2.7	2.6
Facility/HHA Based/Non-Profit	212	−0.2	2.7	2.5
Facility/HHA Based/For-Profit	153	-0.1	2.7	2.6
Facility/HHA Based/Government	17	−0.1	2.7	2.6
Facility/HHA Based/Other	31	−0.3	2.7	2.4
Hospice Location: Urban or Rural:				
Rural	846	−0.1	2.7	2.6
Urban	4,340	0.0	2.7	2.7
Hospice Location: Region of the Country (Census Division):				
New England	149	−0.5	2.7	2.2
Middle Atlantic	282	0.0	2.7	2.7
South Atlantic	588	−0.2	2.7	2.5
East North Central	559	−0.4	2.7	2.3
East South Central	256	−0.1	2.7	2.6
West North Central	410	−0.5	2.7	2.2
West South Central	1,015	0.3	2.7	3.0
Mountain	538	−0.2	2.7	2.5
Pacific	1,340	0.7	2.7	3.4
Outlying	49	−0.3	2.7	2.4
Hospice Size:				
0–3,499 RHC Days (Small)	1,076	0.3	2.7	3.0
3,500–19,999 RHC Days (Medium)	2,457	0.2	2.7	2.9
20,000+ RHC Days (Large)	1,653	0.0	2.7	2.7

Source: FY 2021 hospice claims data from CCW accessed on January 21, 2022.

Note: The overall total impact reflects the addition of the individual impacts, which includes the overall wage index impact of updating the wage data with a 5-percent cap on wage index decreases, as well as the proposed 2.7 percent hospice payment update percentage.

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.

2. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on last year's proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this proposed rule. It is possible that not all commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this proposed rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule. We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We are soliciting public comments on this assumption.

Using the occupational wage information from the BLS for medical and health service managers (Code 11–9111) from May 2020; we estimate that the cost of reviewing this rule is $114.24 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/current/oes_nat.htm*). This proposed rule consists of approximately 20,000 words. Assuming an average reading speed of 250 words per minute, it would take approximately 0.67 hours for the staff to review half of it. For each hospice that reviews the rule, the estimated cost is $76.16 (0.67 hours × $114.24). Therefore, we estimate that the total cost of reviewing this regulation is $4,036.48 ($76.16 × 53 reviewers).

D. Alternatives Considered

Since the hospice payment update percentage is determined based on statutory requirements, we only considered not updating hospice payment rates by the payment update percentage. Payment rates since FY 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent years must be the market basket percentage for that FY. Section 3401(g) of the Affordable Care Act also mandates that, starting with FY 2013 (and in subsequent years), the hospice payment update percentage will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. For FY 2023, since the hospice payment update percentage is determined based on statutory requirements at section 1814(i)(1)(C) of the Act, we cannot consider not updating the hospice payment rates by the hospice payment update percentage, nor can we consider updating the hospice payment rates by the hospice payment update percentage.

E. Accounting Statement

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A4/a-4.pdf*), in Table 11, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 11 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this proposed rule. This estimate is based on the data for 4,957 hospices in our impact analysis file, which was constructed using FY 2021 claims available in January 2022. All expenditures are classified as transfers to hospices.

TABLE 11—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS AND COSTS, FROM FY 2022 TO FY 2023

Category	Transfers
Annualized Monetized Transfers.	$ 580 million*.
From Whom to Whom?.	Federal Government to Medicare Hospices.

*The increase of $580 million in transfer payments is a result of the 2.7 percent hospice payment update compared to payments in FY 2022.

F. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities by meeting the Small Business Administration (SBA) definition of a small business (in the service sector, having revenues of less than $8.0 million to $41.5 million in any 1 year), or being nonprofit organizations.

For purposes of the RFA, we consider all hospices as small entities as that term is used in the RFA. The Department of Health and Human Services practice in interpreting the RFA is to consider effects economically ''significant'' only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The effect of the FY 2023 hospice payment update percentage results in an overall increase in estimated hospice payments of 2.7 percent, or $580 million. The distributional effects of the proposed FY 2023 hospice wage index do not result in a greater than 5 percent of hospices experiencing decreases in payments of 3 percent or more of total revenue. Therefore, the Secretary has determined that this rule will not create a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a MSA and has fewer than 100 beds. This rule will only affect hospices. Therefore, the Secretary has determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals (see Table 10).

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2022, that threshold is approximately $165 million. This rule is not anticipated to have an effect on state, local, or tribal governments, in the aggregate, or on the private sector of $165 million or more in any 1 year.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a

proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. We have reviewed this rule under these criteria of Executive Order 13132, and have determined that it will not impose substantial direct costs on state or local governments.

I. Conclusion

We estimate that aggregate payments to hospices in FY 2023 will increase by $580 million as a result of the market basket update, compared to payments in FY 2022. We estimate that in FY 2023, hospices in urban areas will experience, on average, a 2.7 percent increase in estimated payments compared to FY 2022; while hospices in rural areas will experience, on average, a 2.6 percent increase in estimated payments compared to FY 2022. Hospices providing services in the Pacific and West South Central regions would experience the largest estimated increases in payments of 3.4 percent and 3.0 percent, respectively. Hospices serving patients in areas in the New England and West North Central regions would experience, on average, the lowest estimated increase of 2.2 percent in FY 2023 payments.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on March 29, 2022.

List of Subjects in 42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR part 418 as set forth below.

PART 418—HOSPICE CARE

■ 1. The authority citation for part 418 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 2. Section § 418.306 is amended by revising paragraph (c) to read as follows:

§ 418.306 Annual update of the payment rates and adjustment for area wage differences.

* * * * *

(c) *Adjustment for wage differences.* (1) Each hospice's labor market is determined based on definitions of Metropolitan Statistical Areas (MSAs) issued by OMB. CMS will issue annually, in the **Federal Register**, a hospice wage index based on the most current available CMS hospital wage data, including changes to the definition of MSAs. The urban and rural area geographic classifications are defined in § 412.64(b)(1)(ii)(A) through (C) of this chapter. The payment rates established by CMS are adjusted by the Medicare contractor to reflect local differences in wages according to the revised wage data.

(2) Beginning on October 1, 2022, CMS applies a cap on decreases to the hospice wage index such that the wage index applied to a geographic area is not less than 95 percent of the wage index applied to that geographic area in the prior fiscal year.

* * * * *

Dated: March 29, 2022.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2022–07030 Filed 3–30–22; 4:15 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

[Docket No. FWS–HQ–ES–2020–0100; FF09E21000 FXES1111090FEDR 223]

RIN 1018–BE92

Endangered and Threatened Wildlife and Plants; Endangered Species Status for Amur Sturgeon

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed rule; reopening of public comment period and announcement of public hearing.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), are reopening the public comment period on our August 25, 2021, proposed rule to list the Amur sturgeon (*Acipenser schrenckii*), a fish species from the Amur River basin in Russia and China, as an endangered species under the Endangered Species Act of 1973, as amended (Act). We are taking this action to conduct a public hearing on the petition to list the Amur sturgeon. Comments previously submitted need not be resubmitted and will be fully considered in preparation of the final rule.

DATES:

Comment submission: The public comment period on the proposed rule that published on August 25, 2021, at 86 FR 47457 is reopened. We will accept comments received or postmarked on or before May 4, 2022. Comments submitted electronically using the Federal eRulemaking Portal (see **ADDRESSES**, below) must be received by 11:59 p.m. Eastern Time on the closing date, and comments submitted by U.S. mail must be postmarked by that date to ensure consideration.

Public hearing: On April 19, 2022, we will hold a public hearing on the proposed rule to list the Amur sturgeon under the Act from 6:00 to 7:30 p.m. Eastern Time, using the Zoom platform (for more information, see Public Hearing, below).

ADDRESSES: *Written comments:* You may submit comments by one of the following methods:

(1) *Electronically:* Go to the Federal eRulemaking Portal: *https://www.regulations.gov.* In the Search box, enter FWS–HQ–ES–2020–0100, which is the docket number for this rulemaking. Then, click on the Search button. On the resulting page, in the Search panel on the left side of the screen, under the Document Type heading, check the Proposed Rule box to locate this document. You may submit a comment by clicking on ''Comment.''

(2) *By hard copy:* Submit by U.S. mail to: Public Comments Processing, Attn: FWS–HQ–ES–2020–0100, U.S. Fish and Wildlife Service, MS: PRB/3W, 5275 Leesburg Pike, Falls Church, VA 22041–3803.

We request that you send comments only by the methods described above. We will post all comments on *https://www.regulations.gov.* This generally means that we will post any personal information you provide us (see Public Comments, below, for more information).

Document availability: The proposed rule and supporting documents, including the species status assessment report, are available at *https://www.regulations.gov* under Docket No. FWS–HQ–ES–2020–0100.

Public hearing: Interested parties may present verbal testimony (formal, oral comments) at a public hearing, which will be held virtually using the Zoom platform. See Public Hearing, below, for more information.

FOR FURTHER INFORMATION CONTACT: Elizabeth Maclin, Chief, Branch of Delisting and Foreign Species, Ecological Services, U.S. Fish and Wildlife Service, MS: ES, 5275 Leesburg Pike, Falls Church, VA 22041–3803; telephone, 703–358–2171. Individuals in the United States who are deaf, deafblind, hard of hearing, or have a speech disability may dial 711 (TTY, TDD, or TeleBraille) to access telecommunications relay services. Individuals outside the United States