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

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I. Introduction and Background

On July 28, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a final rule updating the Medicare hospice payment rates, wage index, the cap amount and the quality reporting requirements for federal fiscal year (FY) 2024.[1] It also summarizes comments CMS received on hospice utilization trends, the provision of higher levels of hospice care, spending patterns for non-hospice services provided during the election of the hospice benefit, and ways to examine health equity, among other topics. This rule also codifies the HQRP data submission threshold, discusses the Hospice Outcomes and Patient Evaluation tool (HOPE), and provides an update on future quality measures development and health equity efforts. In addition, this rule finalizes that physicians who order or certify hospice services for Medicare beneficiaries must be enrolled in Medicare or validly opted-out as a prerequisite for payment for the specific hospice period of care. In response to concerns raised by commenters. CMS will not implement or enforce this requirement until May 1, 2024, to give physicians more time.

CMS estimates that the overall impact of the final rule will be an increase of $780 million (3.1 percent) in Medicare payments to hospices during FY 2024.

The final rule reviews the history of the Medicare hospice benefit, including hospice reform policies finalized in the FY 2016 hospice final rule (80 FR 47142); this rule, among other things, differentiated payments for routine home care (RHC) based on the beneficiary's length of stay and implemented a service intensity add-on (SIA) payment for services provided in the last 7 days of a beneficiary's life. In the FY 2020 hospice final rule (84 FR 38487) CMS rebased the continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIP)

[1] It will be published in the Federal Register on August 2, 2023.

payment rates. To offset these increases, CMS reduced RHC payment rates by 2.7 percent. CMS also finalized a policy to use the current year's pre-floor, pre-reclassification hospital inpatient wage index as the wage adjustment to the labor portion of the hospice rates. In the FY 2022 hospice final rule (86 FR 42532), CMS finalized a policy to rebase and revise the labor shared for CHC, RHC, IRC, and GIP using cost report data for freestanding hospices.

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

II. Provisions of the Final Rule

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

Summary of Key Data for Hospice Payment Rates for FY 2024			
Market basket update factor			
Market basket increase			+3.3%
Required total factor productivity (TFP)			-0.2%
Net MFP-adjusted update reporting quality data			**+3.1%**
Net MFP-adjusted update not reporting quality data			**-0.9%**
Hospice aggregate cap amount			$33,494.01
Hospice Payment Rate Care Categories	**Labor Share**	**FY 2023 Federal Rates Per Diem**	**FY 2024 Federal Rates Per Diem**
Routine Home Care (days 1-60)	66.0%	$211.34	$218.33
Routine Home Care (days 61+)	66.0%	$167.00	$172.35
Continuous Home Care, Full Rate = 24 hours of care	75.2%	$1,522.04	$1,565.46
Inpatient Respite Care	61.0%	$492.10	$507.71
General Inpatient Care	63.5%	$1,110.76	$1,145.31
Service Intensity Add-on (SIA) payment, up to 4 hours			$65.23 per hour
Notes: RHC days account for most of hospice days—98.8 percent in FY 2022. The Consolidation Appropriations Act of 2021 changed the payment reduction for failing to meet quality reporting requirements from 2 to 4 percent beginning in FY 2024.			

A. Hospice Utilization and Spending Patterns

In the FY 2024 Hospice proposed rule (88 FR 20022) CMS provided data analysis on hospice utilization trends from FY 2013 through FY 2022. These analyses examined current trends in hospice utilization and provider behavior including lengths of stay, live discharge rates, skilled visits during the last days of life, and non-hospice spending. It also solicited comments on hospice utilization, non-hospice spending, ownership transparency, hospice election decision-making, and ways to examine health equity.

1. Correction to Figure 3 in the FY 2024 Hospice Proposed Rule

CMS notes that data in Figure 3 – Length of Stay Intervals Distribution for Live Discharges, FYs 2019 to 2022 was incorrect in the proposed rule and it provides the corrected figure in the final rule.

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

In the FY 2024 hospice proposed rule (88 FR 20022), CMS solicited comments on several issues related to how CMS can assist hospices in better serving vulnerable and underserved populations and address barriers to access. This included the following areas:

- Potentially restrictive admission policies for beneficiaries requiring higher-intensity end-of-life and/or palliative care, the frequency and modality in which hospices educate themselves on the distinction between curative and complex palliative treatments, and the way they communicate this information to patients throughout the hospice election.
- How hospices address financial risks associated with providing such services, overcome barriers to providing higher intensity levels of hospice care and complex palliative treatments, and provide necessary information to patients and families about coverage, staffing levels, staff encounters, and utilization of higher levels of care.
- Feedback on how CMS can work with hospice providers to ensure Medicare beneficiaries and their families are aware of the coverage under the hospice benefit and how it can enhance transparency in ownership trends for beneficiaries selecting hospice care.

In general, commenters expressed concerns about potential admission policies that could restrict access to higher cost end-of-life palliative care and discussed inconsistencies in beneficiary access to treatment that may be based on specific hospice policy or disease states. They believed that CMS needed to provide definitive instructions and clear expectations of hospice providers in determining curative versus palliative treatment coverage under the hospice benefit. In addition, commenters emphasized the need for CMS education towards patients and families about transitioning from curative interventions to palliative interventions at the time of hospice admission. A few commenters suggested that the Patient Notification of Hospice Non-Covered Items, Services, and Drugs should be provided to all prospective patients at the time of hospice election as part of the care plan. Other parties, in contrast, raised concerns about administrative burden regarding the provision of more information during a period in which beneficiaries and their families are overwhelmed and that such education may not service its intended purpose.

In response to CMS' inquiry on how to increase transparency to promote informed decision-making when choosing a hospice, respondents recommended providing public information about hospice staffing levels, frequency of hospice staff encounters, and utilization of higher levels of care. They suggested including this information on Medicare's Care Compare website or other accessible platforms to ensure transparency and facilitate informed decision-making. They also suggested CMS improve transparency around ownership trends and provide information about hospice ownership publicly, as ultimately, this information would be helpful for beneficiaries

seeking to select a hospice for end-of-life care. They also recommended differentiating between nonprofit and for-profit hospices and examining ownership trends.

CMS did not respond to the overall comments but stated the insights and suggestions provided by all respondents will help inform its hospice policy-making measures for future rulemaking to ensure better access and quality of care for Medicare beneficiaries.

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

In line with the executive order on advancing racial equity,[2] CMS is working to advance health equity in its policies and programs. In the FY 2024 hospice proposed rule CMS solicited comments from interested parties on health equity under the hospice benefit. It solicited comments from the public, hospice providers, patients, and advocates on the following areas:

- How hospices are measuring impact on health equity, barriers in electing and accessing hospice care, and challenges faced by hospices in collecting and analyzing information related to social determinants of health (SDOH).
- What data should be collected to evaluate health equity, geographical area indices that can be used to assess disparities in hospice.
- How CMS can collect and share information to help hospices serve vulnerable and underserved populations and address barriers to access.

Commenters described the various barriers and challenges in collecting information on SDOH and health equity data, such as patient resistance, difficulty in appropriately recording SDOH using electronic medical records (EMR), lack of specificity in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) questionnaires provided to patients' families, and limited resources for data collection. They also provided recommendations for CMS to consider, such as developing educational tools about cultural norms to facilitate discussions about hospice care, and implementing a nationally recognized, standardized, and required assessment tool with data elements collecting SDOH data. Commenters suggested examples of SDOH data that should be collected that included health literacy, race, ethnicity and language data, sexual orientation and gender identity data, housing security, air and water pollution, food security, living in heat islands, and access to health care. In addition, commenters also noted their efforts to employ and recruit diverse staff to better represent and serve underserved populations and its efforts to hold trainings for staff to address any barriers patients may experience.

CMS states that it plans to consider these comments and suggestions for future rulemaking as it seeks to improve how it can help hospices serve vulnerable and underserved populations.

B. FY 2024 Hospice Wage Index and Rate Update

1. FY 2024 Hospice Wage Index

For FY 2024, CMS continues its policy to use the current FY's hospital wage index data to

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

calculate the hospice wage index values. For FY 2024, the hospice wage index will be based on the FY 2024 hospital pre-floor, pre-reclassified wage index using hospital cost reporting periods beginning on or after October 1, 2019 and before October 1, 2020 (FY 2020 cost report data). The hospice wage index does not take into account any geographic reclassification of hospitals, but includes a 5-percent cap on wage index decreases. The appropriate wage index value is applied to the labor portion of the hospital payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC and applied based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

CMS also continues to apply current policies for geographic areas where there are no hospitals. For urban areas of this kind, all CBSAs within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value for use as a reasonable proxy for these areas. For FY 2024, there is one CBSAs without a hospital from which hospital wage data can be derived: 25980, Hinesville-Fort Stewart, Georgia. The FY 2024 wage index value for Hinesville-Fort Stewart, Georgia is 0.8732. For rural areas without hospital wage data, CMS has used the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. However, the only rural area currently without a hospital is on the island of Puerto Rico, which does not lend itself to this "contiguous" approach. Because CMS has not identified an alternative methodology, the agency proposes to continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047.

CMS notes that the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit; these values are subject to application of the hospice floor. The pre-floor and pre-reclassified hospital wage index below 0.8 will be further adjusted by a 15 percent increase subject to a maximum wage index value of 0.8.[3]

In response to comments about the ability of hospices to seek geographic reclassifications, or to utilize a rural floor provision, CMS notes these statutory provisions are specific to hospitals.[4] As it has consistently noted in the past, CMS continues to believe the use of the pre-floor and pre-reclassified hospital wage index results in the most appropriate adjustment to the labor portion of the hospice payment rates. In response to specific comments about the CBSA designation of Montgomery County, Maryland and Coeur d'Alene, ID, CMS notes that OMB's geographic area delineations are appropriate for determining hospice payments. It also notes that IPPS hospitals, home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and dialysis facilities all use CBSAs to define their labor market areas. However, CMS notes that if OMB redesignates Montgomery County, Maryland and Coeur d'Alene, ID, CMS would propose any changes in future rulemaking consistent with its longstanding approach of adopting OMB statistical area delineations.

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

[4] Section 1866(d)(10) of the Act provides for a reclassification provision limited to hospitals.

2. FY 2024 Hospice Payment Update Percentage

For FY 2024, CMS finalizes a hospice payment update percentage of 3.1 percent, compared to 2.8 percent, as proposed. CMS updated its data from the proposed rule based on IHS Global Inc.'s second quarter 2023 forecast of the inpatient hospital market basket update (3.3 percent) and the productivity adjustment (0.2 percent). Hospices that do not submit the required quality data under the Hospice Quality Reporting Program would receive a payment update percentage for FY 2024 of -0.9 percent.

CMS notes that in the 2022 final rule it rebased and revised the labor shares for the RHC, CHC, GIP, and IRC using cost report data for freestanding hospices. The labor portion of the hospice payment rates is currently as follows: for RHC, 66.0 percent; for CHC, 75.2 percent; for GIP, 63.5 percent; and for IRC, 61.0 percent.

Many commenters stated the unprecedented magnitude of the market basket forecast error over 2021 and 2022 warrants special consideration to avoid significant long-term underfunding of the hospice benefit and to help address current workforce challenges. They cite a 3.7 percent payment update error based on their calculations and requested that CMS use the special exceptions and adjustments authority to apply a one-time cumulative retrospective adjustment of 3.7 percent for FYs 2021 and 2022. In its response, CMS states that the inpatient hospital market basket percentage increases are required by law to be set prospectively and that there is currently no mechanism to adjust for market basket forecast error in the hospice payment update. It notes, however, that its analysis of the forecast error over a longer period of time shows that the forecast error has been both positive and negative and that overall, it has benefited providers. Specifically, CMS found that the 10-year cumulative forecast error showed a negative forecast error (that is, forecasted increases were greater than actual increases), of 0.9 percentage point (2013-2022).[5]

3. FY 2024 Hospice Payment Rates

In the hospice payment system, there are four payment categories that are distinguished by the location and intensity of the services provided: RHC or routine home care, IRC or short-term care to allow the usual caregiver to rest, CHC or care provided in a period of patient crisis to maintain the patient at home, and GIP or general inpatient care to treat symptoms that cannot be managed in another setting. The applicable base payment is then adjusted for geographic differences in wages by multiplying the labor share, which varies by category, of each base rate by the applicable hospice wage index.[6]

As discussed above, CMS made several modifications to the hospice payment methodology in FY 2016. CMS implemented two different RHC payment rates: one for the RHC rate for the first 60 days and a second RHC rate for days 61 and beyond and SIA payment when direct patient care is provided by an RN or social worker during the last 7 days of the beneficiary's life. The

[5] This analysis excludes FY 2018 when the hospice payment update was statutorily required to be 1.0 percent.
[6] In FY 2014 and for subsequent fiscal years, CMS uses rulemaking as the means to update payment rates (prior to FY 2014, CMS had used a separate administrative instruction), consistent with the rate update process for other Medicare payment systems.

SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provider (up to 4 hours total) that occurred on the day of the service. As required by statute, the new RHC rates were adjusted by a SIA budget neutrality factor—a separate factor for days 1-60 and for 61 days and beyond. Since FY 2016 there have been very minor adjustments needed as the utilization of the SIA from year-to-year remains relatively constant.

In the FY 2017 Hospice final rule, CMS initiated a policy to apply a wage index standardization factor to hospice payment rates to ensure overall budget neutrality when updating the hospice wage index with more recent hospital wage data.[7] To calculate the wage index standardization factor for FY 2024, CMS simulated total payments using FY 2022 hospice utilization claims data with the FY 2023 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor and the 5-percent cap on wage index decreases) and compared it to its simulation of total payment using the FY 2024 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, with the 5-percent cap on wage index decreases) and FY 2023 payment rates. By dividing payments for each level of care using the FY 2024 wage index by payments for each level of care using the FY 2023 wage index, CMS obtained a wage index standardization factor for each level of care (RHC days 1-60, RHC days 61+, CHC, IRC, and GIP).

Tables 1 and 2 of the final rule (reproduced below) lists the FY 2024 hospice payment rates by care category and the wage index standardization factors.

Table 1: FY 2024 Hospice RHC Payments

Code	Description	FY 2023 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2024 Hospice Payment Update	FY 2024 Payment Rates
651	Routine Home Care (days 1-60)	$211.34	× 1.0009	× 1.0011	× 1.031	$218.33
651	Routine Home Care (days 61+)	$167.00	× 1.0000	× 1.0010	× 1.031	$172.35

Table 2: FY 2024 Hospice CHC, IRC, and GIP Payment Rates

Code	Description	FY 2023 Payment Rates	Wage Index Standardization Factor	FY 2024 Hospice Payment Update	FY 2024 Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care	$1,522.04 ($63.42 per hour)	× 0.9976	× 1.031	$1,565.46 ($65.23 per hour)
655	Inpatient Respite Care	$492.10	× 1.0007	× 1.031	$507.71
656	General Inpatient Care	$1,110.76	× 1.0001	× 1.031	$1,145.31

Tables 3 and 4 of the final rule lists the comparable FY 2024 payment rates for hospices that do not submit the required quality data under the Hospice Quality Reporting Program as follows:

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

Routine Home Care (days 1-60), $209.86; Routine Home Care (days 61+), $165.66; Continuous Home Care, $1,504.72; Inpatient Respite Care, $488.01; and General Inpatient Care, $1,100.87.

4. Hospice Cap Amount for FY 2024

By background, when the Medicare hospice benefit was implemented, Congress included two limits on payments to hospices: an aggregate cap and an inpatient cap. The intent of the hospice aggregate cap was to protect Medicare from spending more for hospice care than it would for conventional care at the end-of-life, and the intent of the inpatient cap was to ensure that hospice remained a home-based benefit.[8] The aggregate cap amount was set at $6,500 per beneficiary when first enacted in 1983, and since then this amount has been adjusted annually by the change in the medical care expenditure category of the consumer price index for urban consumers (CPI-U).

As required by the Impact Act, beginning with the 2016 cap year, the cap amount for the previous year will be updated by the hospice payment update percentage, rather than by the CPI-U for medical care. This provision was scheduled to sunset for cap years ending after September 30, 2025 and revert to the original methodology, but this sunset provision has been extended, most recently by the CAA, 2023 until September 30, 2032. CMS adds that the hospice aggregate cap amount for the 2024 cap year will be $33,494.01 per beneficiary or the 2023 cap amount updated by the FY 2024 hospice payment update percentage ($32,486.92 * 1.031).

As in past years, CMS received comments recommending adjustments to the hospice cap calculation, including a recommendation from MedPAC. CMS reiterates that it does not have the statutory authority to reduce the aggregate cap amount nor wage-adjust the cap.

C. Proposed Updates to the Hospice Quality Reporting Program

1. Background and Statutory Authority

The Hospice Quality Reporting Program (HQRP) includes the Hospice Item Set (HIS), administrative data, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey. Section 1814(i)(5)(A)(i) of the Act requires that beginning in FY 2014, hospices failing to meet quality data submission requirements will receive a two percentage point reduction to the market basket update. The Consolidation Appropriations Act of 2021 (CAA 2021)[9] changed the payment reduction for failing to meet these reporting requirements from 2 to 4 percent. Specifically, the Act requires that beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and beginning with the FY 2024 annual payment update (APU) and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does

[8] If a hospice's inpatient days (GIP and respite) exceed 20 percent of all hospice days, then for inpatient care the hospice is paid: (1) the sum of the total reimbursement for inpatient care multiplied by the ratio of the maximum number of allowable inpatient days to actual number of all inpatient days; and (2) the sum of the actual number of inpatient days in excess of the limitation by the routine home care rate.
[9] Pub. L. 116-260

not comply with the quality data submission requirements for that FY. The FY 2024 APU is based on CY 2022 quality data.

As finalized in the FY 2022 Hospice final rule (86 FR 42552), CMS began public reporting of the two new claims-based quality measures (QMs), the Hospice Visits in Last Days of Life (HVLDL) and the Hospice Care Index (HCI) in the August 2022 refresh of the Care Compare/Provider Data Catalogue (PDC). Table 5 (reproduced below) lists all the current quality measures.[10]

Table 5: Quality Measures in Effect for the HQRP
Hospice Quality Reporting Program
Hospice Item Set
Hospice and Palliative Care Composite Measure – HIS-Comprehensive Assessment at Admission 1. Patients Treated with an Opioid who are Given a Bowel Regimen (NQF #1617) 2. Pain Screening (NQF #1634) 3. Pain Assessment (NQF #1637) 4. Dyspnea Treatment (NQF #1638) 5. Dyspnea Screening (NQF #1639) 6. Treatment Preferences (NQF #1641) 7. Beliefs/Values Addressed (if desired by the patient) (NQF #16477)
Administrative Data, including Claims-based Measures
Hospice Visits in Last Days of Life (HVLDL)
Hospice Care Index (HCI) 1. Continuous Home Care (CHC) or General Inpatient Provided (GIP) 2. Gaps in Skilled Nursing Visits 3. Early Live Discharges 4. Late Live Discharges 5. Burdensome Transitions (Type 1)- Live Discharges form Hospice Followed by Hospitalization and Subsequent Hospice Readmission 6. Burdensome Transitions (Type 2) - Live Discharges form Hospice Followed by Hospitalization with the Patient Dying in the Hospital 7. Per-beneficiary Medicare Spending 8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day 9. Skilled Nursing Minutes on Weekends 10. Visits Near Death
CAHPS Hospice Survey
CAHPS Hospice Survey (single measure) 1. Communication with Family 2. Getting timely help 3. Treating patient with respect 4. Emotional and spiritual support 5. Help for pain and symptoms 6. Training family to care for the patient 7. Rating of this hospice 8. Willing to recommend this hospice

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

2. Hospice Outcomes & Patient Evaluation (HOPE) Update

The HOPE is intended to help hospices better understand patient and family care needs throughout the hospice process and contribute this information to the patient's plan of care. HOPE will include key items from the HIS and demographics such as gender and race. HOPE is a multidisciplinary instrument to be completed by nursing, social work, and spiritual care staff. CMS notes that although the standardization of measures required for adoption under the IMPACT Act of 2014 is not applicable to hospices, it intends to include applicable standardized elements to hospices.

CMS discusses the development of HOPE and alpha testing. Alpha testing was completed at the end of January 2021 and CMS incorporated findings from alpha testing for the next draft of the HOPE assessment. Beta testing began in late fall 2021 and was completed in October 2022. CMS is using the input obtained from field testing to refine the HOPE and will propose a final version of HOPE in future rulemaking.

CMS will continue the development of the HOPE assessment in accordance with the Blueprint for the CMS Measures Management System. CMS will provide updates[11] and engagement opportunities on its website.[12] Comments about HOPE can be sent to HospiceAssessment@cms.hhs.gov. CMS intends to provide additional information about HOPE testing results on the HQRP website in fall of 2023.

Commenters were generally supportive of HOPE. Many commenters requested additional information on HOPE and a long lead time for implementation of HOPE. Some commenters supported collection of social risk data, including social determinants of health (SDOH). CMS appreciates all comments regarding the development of HOPE and states itis committed to implementing HOPE with a minimum burden to stakeholders.

3. Update on Future Quality Measure (QM) Development
CMS plans to develop at least two HOPE-based process and outcome quality measures: (1) Timely Reassessment of Pain Impact; and (2) Timely Reassessment of Non-Pain Symptom Impact. Additional information about the development of these measures is available in the 2021 Technical Expert Panel (TEP) Summary Reports and the 2021 Information Gathering Report.[13]

Commenters were generally supportive of the two HOPE-based measures in development but requested additional information about the measure specifications and also recommended more stakeholder engagement opportunities. Several commenters encouraged CMS to allow reassements to be completed telephonically or via remote patient monitoring and to allow any

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

members of the interdisciplinary care team to perform the assessment. CMS appreciates this input and will take these into consideration for future QM development.

4. Health Equity Updates Related to HQRP

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

In the FY 2023 Hospice final rule (87 FR 45669), CMS summarized public comments and suggestions received in response to a hospice health equity RFI. After considering these comments, in Fall 2022, CMS convened a health equity technical panel, the Home Health and Hospice Health Equity TEP (Home Health & Hospice HE TEP). The TEP is comprised of health equity experts from hospice and home health settings with expertise in quality assurance, patient advocacy, clinical work, and measure development. The TEP is charged with providing input on a potential cross-setting health equity structural composite measure. A detailed summary of the TEP and final TEP recommendations is available on the Hospice QRP Heath Equity webpage.[14]

As part of its commitment to incorporate health equity into the HQRP, CMS is considering measure stratification to calculate quality measure outcomes separately for different beneficiary populations. CMS is also considering adding social determinants of health (SDOH) data items used in the post-acute care setting and hospital inpatient setting into HQRP. Adding SDOH to the HQRP would support the Agency's National Quality Strategy to streamline quality measures across CMS quality programs and support measure alignment across programs (referred to as the "Universal Foundation" of quality measure).[15] CMS will consider input from hospice stakeholders as it develops health equity policies across CMS and other HHS initiatives.

Commenters generally supported CMS' initiative to expand health equity and SDOH measurements. Several commenters, however, recommended CMS wait until HOPE is implemented and to use HOPE as the instrument for collecting health equity measurements. CMS appreciates this input and will take these into consideration for future implementation of health equity and SDOH measurements.

5. CAHPS Hospice Survey Updates

The CAHPS Hospice Survey measures were re-endorsed by NQF in 2020. The eight survey-based measures are publicly reported on the CMS website, Care Compare, https://www.medicare.gov/care-compare. To meet the CAHPS Hospice Survey requirements for the HQRP, hospices must contract with a CMS-approved vendor to collect survey data for

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

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

eligible patients on a monthly basis and the vendor must report the data to CMS by the quarterly deadlines. CMS does not propose any changes in this rule.

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

CMS plans to use these results to make potential changes to the administration protocols and survey instrument content. Potential measure changes will be submitted to the Measures Under Consideration (MUC) process in 2023 and may be proposed in future rulemaking. CMS does not finalize any changes in this rule.

Commenters supported implementation of a web based survey. Several commenters made recommendations about ways to improve the survey including making the survey available in more languages, ensuring that survey questions are culturally sensitive, and shortening or simplifying the survey. CMS notes that when a web-based mode is available, the web-based mode will be included among all the approved survey modes a hospice could use. Before introducing the web-based survey mode, CMS will release detailed information about proposed changes to survey instrument content, survey administration protocols, and any data adjustment procedures needed to promote comparison between different modes of survey administration. CMS will consider commenters' suggestions as part of its ongoing efforts to improve health equity.

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

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

Three time limits for both HIS and CAHPS are important for HQRP Compliance: (1) the reporting year HIS and data collection year for CAHPS; (2) payment FY; and the reference Year. Table 6 (reproduced below) summarizes these three timeframes.

Table 6: HQRP Reporting Requirements and Corresponding Annual Payment Updates		
Reporting Year for HIS and Data Collection Year for CAHPS	**Annual Payment Update (APU) Impacts Payment for the FY**	**Reference Year for CAHPS Size Exception**
CY 2022	FY 2024 APU*	CY 2021
CY 2023	FY 2025 APU	CY 2022
CY 2024	FY 2026 APU	CY 2023
CY 2025	FY 2027 APU	CY 2024
*Beginning in FY 2024 and all subsequent years, the payment penalty is 4 percent. Prior to FY 2024, the payment penalty is 2 percent.		

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

Table 7: HQRP Compliance Checklist		
Annual Payment Update	**HIS**	**CAHPS**
FY 2024	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admission/discharges occurring 1/1/2022– 12/31/2022	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2022 – 12/31/2022
FY 2025	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admission/discharges occurring 1/1/2023 – 12/31/2023	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2023 – 12/31/2023
FY 2026	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admission/discharges occurring 1/1/2024 – 12/31/2024	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2024 – 12/31/2024
FY 2027	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admission/discharges occurring 1/1/2025 – 12/31/2025	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2025 – 12/31/2025

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

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

The CAA directs the Secretary to create a Special Focus Program (SFP) for poor-performing hospice programs, sets out authority for imposing enforcement remedies for noncompliant hospice programs, requires the development and implementation of a range of remedies, and procedures for appealing determinations regarding these remedies. These remedies can be imposed instead of, or in addition to, termination of the hospice programs' participation in the

Medicare program. In the 2022 Home Health final rule CMS finalizes all of the CAA provisions except for the SFP.[16]

Except for the SFP provision, CMS finalized CAA provisions in the CY 2022 Home Health PPS final rule.[17] To obtain input on the structure and methodology of the SFP, CMS convened a TEP; the final TEP feedback will be publicly available on the CMS website in April 2023. CMS included a proposal for implementation of the SFP in the 2024 Home Health proposed rule.[18]

E. Hospice Ordering/Certifying Physician Enrollment

1. Background

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

The Affordable Care Act authorized the Secretary to require a physician ordering durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) be enrolled in Medicare for payment for the DMEPOS item to be made (section 6405(a)) and a similar provision regarding the certification of a physician (or certain eligible professionals) for Part A and B home health services (section 6405(b)). Section 6405(c) authorizes the Secretary to extend the requirements of sections 6405(a) and (b) to all categories of items or services under title XVIII of the Act (including covered Part D drugs) that are ordered, prescribed, or referred by a physician or eligible professional enrolled in Medicare under section 1866(j) of the Act. In 2016, consistent with section 6405(c), CMS proposed to extend the requirements that a physician or eligible professional must be either enrolled in Medicare in an approved status or have a valid opt-out affidavit to any Part A and Part B service, item, or drug. Commenters expressed concern about the burden of having to enroll in Medicare and CMS did not finalize this proposal.[19]

CMS discusses recent OIG and GAO reports that highlight program integrity concerns in the hospice program. A 2018 OIG study described schemes involving physicians falsely certifying beneficiaries as terminally ill when they were not.[20] The OIG expressed concerns that beneficiaries were inappropriately enrolled in hospice care and might be unwittingly forgoing needed treatment. A 2019 GAO report expressed concern that CMS's oversight of the quality of

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[16] https://www.gov/info.gov/content/pkg/FR-2021-11-09/pdf/2021-23993.pdf.
[17] CY 2022 HH PPS final rule: https://www.govinfo.gov/content/pkg/FR-2021-11-09/pdf/2021-23993.pdf.
[18] 88 FR 43654
[19] Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process' (84 FR 47794).
[20] "Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity" https://oig.hhs.gov/oei/reports/oei-02-16-00570/pdf.

Medicare hospice care must keep pace with the increasing number of Medicare hospice beneficiaries and hospice providers.[21]

2. Proposed Provisions

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

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

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

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

Several commenters raised concerns about the impact of requiring the hospice physician to be enrolled. These concerns fell into three principal categories: (1) determining the physician's enrollment/opt-out status would be burdensome; (2) patient care would be postponed if the hospice needs to find another hospice physician who is enrolled/opted-out; and (3) hospices that employ physicians who are neither enrolled nor opted-out by choice would require time to hire replacement physicians. CMS disagrees with these concerns. CMS states that hospices can quickly certify physician status using the CMS ordering and referring data file (ORDF),[22] which lists all Medicare-enrolled and opted out physicians. CMS has not been notified of any burden from HHAs and other providers and suppliers that need to verify the status of a physician. CMS also believes that hospices will not have difficulties finding enrolled/opt-out physicians.

Commenters raised similar concerns about CMS' proposal to require the attending physician to be enrolled/opted-out. Some commenters also stated that requiring the hospice physician to be enrolled is a sufficient program integrity safeguard since both the hospice physician and the attending physician (only if the beneficiary has one) must certify the initial hospice episode. CMS does not agree with these concerns. CMS notes that the beneficiary retains the ability to select a new attending physician if their chosen one is neither enrolled nor opted-out but also

[21] "Medicare Hospice Care: Opportunities Exist to Strengthen CMS Oversight of Hospice Providers" https://www.gao.gov/assets/gao-20-10.pdf.
[22] https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/order-and-referring/data

does not need to have an attending physician. The proposal also does not prohibit the beneficiary's desired attending physician from treating the beneficiary in the hospice.

In response to comments, CMS clarifies there is no requirement for documenting the verification of the attending physician's enrollment/opt-out status but the hospice is ultimately responsible for confirming this status. CMS also notes that if the patient elects not to designate an attending physician, only the hospice certifying physician would certify the beneficiary's eligibility for the hospice benefit and they must be enrolled or opted-out. In addition, the hospice physician and attending physician need only be enrolled/opted-out at the time they make the certification or recertification.

In response to comments recommending alternative proposals, CMS states that it believes its efforts to address hospice program integrity issues requires a broad effort focused on many different issues. A focus on provider enrollment supports CMS' desire to avoid a "pay-and-chase" approach.

Several commenters recommended CMS delay implementation of its proposal to allow physicians time to enroll or opt-out and for allow time for CMS to make system changes and perform outreach. CMS agrees and believes an additional seven-months is ample time to ensure certifying hospice and attending physicians meet all Medicare requirements and address program integrity concerns. CMS believes a May 1, 2024 implementation data will allow hospice and attending physicians until April 30, 2024 to enroll or opt-out before the denial of hospice claims begins on May 1, 2024.

After consideration of comments, **CMS finalizes its hospice enrollment provisions as proposed, through the implementation date for these provisions will be May 1, 2024.**

III. Regulatory Impact Analysis

CMS states that the overall impact of this final rule is an estimated net increase in Federal Medicare payments to hospices of $780 million or 3.1 percent, for FY 2024. This aggregate increase is simply a result of the hospice payment update percentage of 3.1 percent, because other policy changes are implemented in a budget-neutral manner. There are distributional effects among facilities and region as a result of the updated wage index data.

Table 9 in the final rule (recreated below) shows the combined effects of the policies and the variation by facility type and area of country. In brief, proprietary (for-profit) hospices (almost three-quarters of all hospices) are expected to have an increase in hospice payments of 3.1 percent compared with 3.0 percent for non-profit and government hospices, respectively. Hospices located in rural areas would see an increase of 2.8 percent compared with 3.1 percent for hospices in urban areas. The projected overall impact on hospices varies more among regions of country – a direct result of the variation in the annual update to the wage index. Hospices providing services in the Middle Atlantic and South Atlantic would experience the largest estimated increase in payments of 3.6 and 3.4 percent, respectively in FY 2024 payments. In contrast, hospices serving patients in the Outlying and New England regions would experience,

on average, the lowest estimated increase of 1.5 and 2.4 percent, respectively in FY 2024 payments.

Table 9: Projected Impact to Hospices for FY 2024				
Hospice Subgroup	**Hospices**	**FY 2024 Updated Wage Data**	**FY 2024 Hospice Payment Update (%)**	**Overall Total Impact for FY 2024**
All Hospices	5,653	0.0%	3.1%	3.1%
Hospice Type and Control				
Freestanding/Non-Profit	559	-0.1%	3.1%	3.0%
Freestanding/For-Profit	4,013	0.0%	3.1%	3.1%
Freestanding/Government	38	-0.4%	3.1%	2.7%
Freestanding/Other	371	0.2%	3.1%	3.3%
Facility/HHA Based/Non-Profit	328	-0.1%	3.1%	3.0%
Facility/HHA Based/For-Profit	187	-0.4%	3.1%	2.7%
Facility/HHA Based/Government	72	0.2%	3.1%	3.3%
Facility/HHA Based/Other	85	0.0%	3.1%	3.1%
Subtotal: Freestanding Facility	4,981	0.0%	3.1%	3.1%
Subtotal: Facility/HHA Based Facility Type	672	-0.1%	3.1%	3.0%
Subtotal: Non-Profit	887	-0.1%	3.1%	3.0%
Subtotal: For Profit	4,200	0.0%	3.1%	3.1%
Subtotal: Government	110	-0.1%	3.1%	3.0%
Subtotal: Other	456	0.2%	3.1%	3.3%
Hospice Type and Control: Rural				
Freestanding/Non-Profit	127	-0.3%	3.1%	2.8%
Freestanding/For-Profit	354	-0.3%	3.1%	2.8%
Freestanding/Government	22	-0.8%	3.1%	2.3%
Freestanding/Other	55	-0.2%	3.1%	2.9%
Facility/HHA Based/Non-Profit	126	-0.4%	3.1%	2.7%
Facility/HHA Based/For-Profit	51	-0.1%	3.1%	3.0%
Facility/HHA Based/Government	56	-0.2%	3.1%	2.9%
Facility/HHA Based/Other	47	-0.3%	3.1%	2.8%
Facility Type and Control: Urban				
Freestanding/Non-Profit	432	-0.1%	3.1%	3.0%

Table 9: Projected Impact to Hospices for FY 2024				
Hospice Subgroup	**Hospices**	**FY 2024 Updated Wage Data**	**FY 2024 Hospice Payment Update (%)**	**Overall Total Impact for FY 2024**
Freestanding/For-Profit	3,659	0.0%	3.1%	3.1%
Freestanding/Government	16	-0.3%	3.1%	2.8%
Freestanding/Other	316	0.3%	3.1%	3.4%
Facility/HHA Based/Non-Profit	202	0.0%	3.1%	3.1%
Facility/HHA Based/For-Profit	136	-0.5%	3.1%	2.6%
Facility/HHA Based/Government	16	0.4%	3.1%	3.5%
Facility/HHA Based/Other	38	0.1%	3.1%	3.2%
Hospice Location: Urban or Rural				
Rural	838	-0.3%	3.1%	2.8%
Urban	4,815	0.0%	3.1%	3.1%
Hospice Location: Census Division				
New England	152	-0.7%	3.1%	2.4%
Middle Atlantic	284	0.5%	3.1%	3.6%
South Atlantic	608	0.3%	3.1%	3.4%
East North Central	592	-0.5%	3.1%	2.6%
East South Central	255	0.0%	3.1%	3.1%
West North Central	420	-0.1%	3.1%	3.0%
West South Central	1,104	0.2%	3.1%	3.3%
Mountain	591	-0.5%	3.1%	2.6%
Pacific	1,598	0.1%	3.1%	3.2%
Outlying	49	-1.6%	3.1%	1.5%
Hospice Size				
0 - 3,499 RHC Days (Small)	1,422	0.1%	3.1%	3.2%
3,500-19,999 RHC Days (Medium)	2,554	-0.1%	3.1%	3.0%
20,000+ RHC Days (Large)	1,677	0.0%	3.1%	3.1%

Source: FY 2022 hospice claims data from the CCW accessed on May 11, 2023.

Region Key: New England=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic=Pennsylvania, New Jersey, New York;
South Atlantic=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia

East North Central=Illinois, Indiana, Michigan, Ohio, Wisconsin
East South Central=Alabama, Kentucky, Mississippi, Tennessee
West North Central=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
West South Central=Arkansas, Louisiana, Oklahoma, Texas
Mountain=Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific=Alaska, California, Hawaii, Oregon, Washington
Outlying=Guam, Puerto Rico, Virgin Islands