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Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements Proposed Rule Summary

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I. Introduction and Background

On April 8, 2021, the Centers for Medicare & Medicaid Services (CMS) placed on public display a proposed rule updating the Medicare hospice payment rates, wage index, the cap amount for fiscal year (FY) 2022 and the quality reporting requirements for FY 2022. Among other changes, this rule proposes to make permanent selected regulatory blanket waivers that were issued to Medicare-participating hospice agencies during the COVID-19 public health emergency (PHE) and updates the hospice conditions of participation. This rule also includes a Home Health Quality Reporting Program proposal that proposes changes beginning with the January 2022 public reporting to address exceptions related to the COVID-19 PHE. The proposed rule will be published in the April 14, 2021 issue of the *Federal Register.* **Comments on the proposed rule are due by June 7, 2021.**

CMS estimates that the overall impact of the proposed rule will be an increase of $530 million (2.3 percent) in Medicare payments to hospices during FY 2022.

CMS notes that wage index addenda for FY 2022 (October 1, 2021 through September 30, 2022) will be available only through the internet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html

The proposed rule reviews the history of the Medicare hospice benefit, including hospice reform policies finalized in the FY 2016 hospice final rule (80 FR 47142); this rule, among other things, differentiated payments for routine home care (RHC) based on the beneficiary's length of stay and implemented a service intensity add-on (SIA) payment for services provided in the last 7

days of a beneficiary's life. CMS also reviews hospice policies it finalized in the FY 2020 hospice final rule (84 FR 38487). This includes rebasing the continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIP) payment rates. To offset these increases, CMS reduced RHC payment rates by 2.7 percent. CMS also finalized a policy to use the current year's pre-floor, pre-reclassification hospital inpatient wage index as the wage adjustment to the labor portion of the hospice rates. It also finalized modifications to the hospiceelection statement content requirements at §418.24(b) for implementation in FY 2021. CMS alsonotes that the Consolidated Appropriations Act (CAA) of 2021 extended the provision that currently mandates the hospice cap be updated by the hospice payment update percentage (hospital market basket update reduced by the multifactor productivity adjustment) rather than the CPI-U until October 1, 2030.

II. Provisions of the Proposed Rule

A. Hospice Utilization and Spending Patterns

This section of the proposed rule describes current trends in hospice utilization and provider behavior including lengths of stay, live discharge rates, skilled visits during the last days of life, and non-hospice spending. It also includes a comment solicitation on analysis of hospital utilization and spending trends.

1. General Hospice Utilization Trends

In examining trends, CMS notes that there has been substantial growth in Medicare hospice utilization. The number of Medicare beneficiaries receiving hospice services has grown from 584,438 in FY 2001 to over 1.6 million in FY 2019. Similarly, Medicare hospice expenditures have risen from $3.5 billion in FY 2001 to an estimated $20 billion in FY 2019. Similar to the increase in the number of beneficiaries using the benefit, the total number of organizations offering hospice services also continues to grow with for-profit providers entering the market at higher rates than not-for-profit providers. CMS states, based on a MedPAC findings, that this is because long stays in hospice have been very profitable and attracted new provider entrants with revenue-generating strategies specifically targeting these patients.[1] Growth in share of for-profit hospitals had increased from 61 percent in FY 2014 to 68 percent by 2019.

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

CMS analyses show that there have only been slight changes over time in how hospices have been utilizing the different levels of care. RHC consistently represent the highest percentage of total hospice days and payments. In 2019, RHC accounts for 98.3 percent of all hospice days and 93.8 percent of payments.

[1] Report to Congress, Medicare Payment Policy. Hospice Services, Chapter 12. MedPAC. March 2020. http://www.medpac.gov/docs/default-source/reports/mar20_medpac_ch12_sec.pdf.
[2] MedPAC 2020 March Report, Chapter 12

2. Trends in Hospice Length of Stay, Live Discharges and Skilled Visits in the Last Days of Life Analysis

Hospital Length of Stay

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

In FY 2019, the average length of stay in hospice was 77 days and average lifetime length of stay in hospice was 99 days, about a 3 percent growth from prior year. The median (50th percentile) length of stay was 20 days. CMS also examined average lifetime length of stays associated with hospice principal diagnosis in FY 2019. See Table 6 in the proposed rule (page 22 of the display copy). Hospice beneficiaries with a primary diagnosis of Alzheimer's, Dementia, and Parkinson's had the longest average lifetime length of stay at 169 days and Chronic Kidney Disease had the shortest average length of stay at 44 days.

Hospice Live Discharges

CMS notes that federal regulations limit the circumstances in which a Medicare hospice provider may discharge a patient from its care; it is permissible (under §418.26) when a patient moves out of the provider's service area, is determined to be no longer terminally ill, or for cause. The hospice cannot discharge the patient at their discretion, even if the care may be costly or inconvenient. To better understand the characteristics of hospices with high live discharge rates, CMS examined hospice live discharge rates over time and by length of stay.[3] Overall, CMS found that between 2010 and 2019, the overall rate of live discharges has decreased from 19.3 percent in 2010 to 17.5 percent in 2019. CMS also indicates that the proportion of live discharges occurring between length of stay intervals has remained relatively constant from FY 2016 to FY 2019.

Service Intensity Add-On (SIA) Payment

In the FY 2016 Hospice final rule (80 FR 47142), CMS established two different payment rates for RHC to reflect the cost of providing hospice care throughout the course of a hospice election: a higher base payment rate for the first 60 days and a reduced base payment rate for days 61 and later. CMS also implemented a SIA payment to reflect the higher costs associated with the last 7 days of life when direct patient care is provided by a RN or social worker. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided on that day of service (up to four hours).

CMS examined claims since the implementation of the SIA payment to determine if there was an increase in RN and social worker visits in the last seven days of life. The data show modest improvement in beneficiaries receiving more skilled nursing and social worker visits during the

[3] CMS does not expect the rate of live discharges to be zero, given the uncertainties of prognostication and the ability of beneficiaries and their families to revoke the hospice election at any time.

last days of life. In 2019, 80.4 percent of beneficiaries received a skilled visit on the last day of life compared with 77 percent in 2015 (the year preceding the SIA payment). SIA payments, on the other hand, have increased from $88 million to $150 million during this period. There were also only modest changes in the average number of minutes provided in the last seven days of life by skilled nursing and social workers on RHC days from CY 2015 to CY 2019. MedPAC reported similar trends in its March 2020 report to Congress.[4]

3. Non-Hospice Spending During a Hospice Election

CMS also analyzed data on non-hospice spending for hospice beneficiaries during an election using FY 2019 data. CMS emphasizes that hospice services are intended to be comprehensive and inclusive and that since the creation of this benefit, it has reiterated that "virtually all" care needed by the terminally ill individual should be provided by the hospice and that it would be unusual and exceptional for services to be provided outside of the hospice for these individuals.

In FY 2019, the agency found that Medicare paid $692 million for Part A and Part B items or services while a beneficiary was receiving hospice care. Notably, non-hospice spending has increased by 19 percent from FY 2016. In addition, total drug spending by Medicare, states, beneficiaries, and other payers in FY 2016 under Part D was $616 million for hospice beneficiaries during a hospice election (of which $499 million was paid by Medicare). For a prescription drug to be covered under Part D for an individual enrolled in hospice, the drug must be for treatment of an illness or condition completely unrelated to the terminal illness or related conditions. CMS states that the use of prior authorization by Part D sponsors has reduced certain drug categories typically used to treat common symptoms during the end of life, but the use of maintenance drugs (for which Part D sponsors do not use prior authorization based on current policy) has increased.[5]

Thus, in total, non-hospice Medicare expenditures occurring during a hospice election was $692 million for Parts A and B spending, plus $499 million for Part D spending, or about $1.2 billion in FY 2019. Further, hospice beneficiaries had $170 million in cost-sharing for items and services that were billed to Medicare Parts A and B, and $59 million in cost-sharing for drugs that were billed to Medicare Part D, while they were in a hospice election.

4. Comment Solicitation on Analysis of Hospice Utilization and Spending Patterns

CMS solicits comments on all aspects of the analysis presented in this proposed rule regarding hospice utilization and spending patterns. It is particularly interested in how this change in patient characteristics – from primarily patients with cancer to patients with neurological conditions and organ-based failure - may have influenced any changes in the provision of hospice services. CMS also solicits comments regarding skilled visits in the last week of life, particularly, what factors determine how and when visits are made as an individual approaches the end of life.

[4] MedPAC 2020 March Report, Chapter 12

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

CMS continues to be concerned about the potential "unbundling" of items, services, and drugs from the Medicare hospice benefit. That is, there may be items, services, and drugs that should be covered under the Medicare hospice benefit but are being paid under other Medicare benefits. It is soliciting comments as to how hospices make determinations as to what items, services and drugs are related versus unrelated to the terminal illness and related conditions. That is, how do hospices define what is unrelated to the terminal illness and related conditions when establishing a hospice plan of care. Likewise, CMS solicits comments on what other factors may influence whether or how certain services are furnished to hospice beneficiaries. Finally, CMS is interested in stakeholder feedback as to whether the hospice election statement addendum has changed the way hospices make care decisions and how the addendum is used to prompt discussions with beneficiaries and non-hospice providers to ensure that the care needs of beneficiaries who have elected the hospice benefit are met.

B. FY 2022 Labor Shares

For the FY 2022 proposed rule, CMS proposes to rebase and revise the labor shares for CHC, RHC, IRC and GIP using Medicare Cost Report (MCR) data for freestanding hospices for 2018. The current labor shares for CHC and RHC were established with the FY 1984 Hospice benefit implementation based on the wage/nonwage proportions specified in Medicare's limit on home health agency costs (48 FR 38155 through 38156). The labor share for IRC and GIP were based on skilled nursing facility wage and nonwage cost limits and skilled nursing facility costs per day. CMS proposes to continue to establish separate labor shares for CHC, RHC, IRC, and GIP and base them on the calculated compensation cost weights for each level of care from the 2018 MCR data. CMS states that it did explore the possibility of using facility-based hospice MCR data to calculate the compensation cost weights; however, it found that very few of these reports passed all the necessary edits and were usable.

CMS proposes to derive a compensation cost weight for each level of care that consists of five major components: (1) direct patient care salaries and contract labor costs, (2) direct patient care benefits costs, (3) other patient care salaries, (4) overhead salaries, and (5) overhead benefits costs. For each level of care, CMS proposes to use the same methodology to derive the components; however, for the (1) direct patient care salaries and (3) other patient care salaries, it proposes to use the MCR worksheet that is specific to that level of care (that is, Worksheet A-1 for CHC, Worksheet A-2 for RHC, Worksheet A-3 for IRC, and Worksheet A-4 for GIP). Technical details of the proposed methodology and the specific line items used from the MCR for deriving the compensation cost weights for each level of care can be found in the proposed rule (see pages 35-40 of the display copy).

Table 11 (reproduced below) provides the proposed labor share for each level of care based on the compensation cost weights CMS derived using its proposed methodology. CMS proposes that the labor shares be equal to three decimal places consistent with the labor shares used in other Prospective Payment Systems (PPS) (such as the inpatient prospective payment system (IPPS) and the Home Health Agency PPS). The proposed labor shares are significantly higher for CHC, RHC and IRC, and slightly lower for GIP.

CMS invites comments on its proposed methodology to derive the labor shares for each level of care.

Table 11: Proposed and Current Labor Shares by Level of Care		
	Proposed Labor Shares	Current Labor Shares
Continuous Home Care	74.6%	68.71%
Routine Home Care	64.7%	68.71%
Inpatient Respite Care	60.1%	54.13%
General Inpatient Care	62.8%	64.01%

C. Routine FY 2022 Hospice Wage Index and Rates Update

A summary of key data for the proposed hospice payment rates for FY 2022 is presented below with additional details in the subsequent sections.

Summary of Key Data for Proposed Hospice Payment Rates for FY 2022			
Market basket update factor			
Market basket increase			+2.5%
Required multi-factor productivity (MFP) adjustment			-0.2%
Net MFP-adjusted update reporting quality data			**+2.3%**
Net MFP-adjusted update not reporting quality data			**+0.3%**
Hospice aggregate cap amount			$31,389.66
Hospice Payment Rate Care Categories	**Labor Share**	**FY 2021 Federal Rates Per Diem**	**Proposed FY 2022 Federal Rates Per Diem**
Routine Home Care (days 1-60)	64.7%	$199.25	$203.81
Routine Home Care (days 61+)	64.7%	$157.49	$161.02
Continuous Home Care, Full Rate = 24 hours of care, $61.07 hourly rate	74.6%	$1,432.41	$1,465.79
Inpatient Respite Care	60.1%	$461.09	$474.43
General Inpatient Care	62.8%	$1,045.66	$1,070.35
Proposed Service Intensity Add-on (SIA) payment, up to 4 hours			$61.07 per hour
Note: RHC days account for most of hospice days—98.3 percent in FY 2019.			

1. FY 2022 Hospice Wage Index

In FY 2020, CMS finalized its proposal to use the current FY's hospital wage index data to calculate the hospice wage index values. For FY 2022, CMS proposes to use the hospice wage index based on the FY 2022 hospital pre-floor, pre-reclassified wage index. This wage index uses hospital cost reporting periods beginning on or after October 1, 2017 and before October 1, 2018 (FY 2018 cost report data). 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.

For the hospice wage index CMS uses the Core Based Statistical Areas (CBSA) labor market area definitions, which are established by the Office of Management and Budget (OMB). They are generally subject to major revisions every 10 years to reflect information from the decennial census, but OMB also issues minor revisions in the intervening years through OMB Bulletins. CMS has previously adopted OMB changes to CBSA delineations for purposes of the hospice labor market areas. 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.

After reviewing these changes in Bulletin 20-01, CMS has determined that these changes would not affect the Medicare wage index for FY 2022. It notes that while it is proposing to adopt the updates set forth in OMB Bulletin No. 20-01, specific wage index updates would not be necessary for FY 2022 as a result of adopting these updates.

CMS also proposes to continue to apply current policies for handling 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 2022, there is one CBSAs without a hospital from which hospital wage data can be derived: 25980, Hinesville-Fort Stewart, Georgia. The FY 2022 wage index value for Hinesville-Fort Stewart, Georgia is 0.8649. 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.

2. Hospice Payment Update Percentage

For FY 2022, the estimated inpatient hospital market basket update of 2.5 percent (the inpatient hospital market basket is used in determining the hospice update factor) must be reduced by a productivity adjustment as mandated by the ACA (currently estimated to be 0.2 percentage point). This results in a proposed hospice payment update percentage for FY 2021 of 2.3 percent; CMS proposes to revise this amount in the final rule if more recent data become available. It notes that CMS is proposing to rebase and revise the IPPS market basket in the 2022 IPPs proposed rule to reflect a 2018 base year.

CMS notes that the labor portion of the hospice payment rates is currently as follows: for RHC, 68.71 percent; for CHC, 68.71 percent; for GIP, 64.01 percent; and for IRC, 54.13 percent. As discussed in section III.B of this proposed rule, CMS proposes to rebase and revise the labor share for RHC, CHC, GIP and IRC using MCR data for freestanding hospices. The proposed labor portion of the hospice payment rates is as follows: for RHC, 64.7 percent; for CHC, 74.6 percent; for GIP, 62.8 percent; and for IRC, 60.1 percent.

3. FY 2022 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 SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provider (up to 4 hours total) that occurred on the day of the service. As required by statute, the new RHC rates were adjusted by a SIA budget neutrality factor—a separate factor for days 1-60 and for 61 days and beyond. CMS observes (as show in Table 5 in the proposed rule), that since FY 2016 there have been very minor adjustments needed as the utilization of the SIA from year-to-year remains relatively constant.

In the FY 2017 Hospice final rule, CMS initiated a policy to apply a wage index standardization factor to hospice payment rates to ensure overall budget neutrality when updating the hospice wage index with more recent hospital wage data.[7] CMS uses the same approach in other payment settings such as under Home Health Prospective Payment System (PPS), Inpatient Rehabilitation Facility PPS, and Skilled Nursing Facility PPS. To calculate the wage index standardization factor, CMS simulated total payments using the FY 2022 hospice wage index and compared it to its simulation of total payments using the FY 2021 hospice wage index. By dividing payments for each level of care using the FY 2022 wage index by payments for each level of care using the FY 2021 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). CMS also calculates a labor share standardization factor that uses the current labor shares in compared to the proposed revised labor shares.[8] These factors are shown in the tables below.

Tables 12 and 13 of the proposed rule (reproduced below) lists the proposed FY 2022 hospice payment rates by care category and the proposed wage index standardization factors.

[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.

[7] CMS uses 2020 claims data to calculate the wage index standardization factor (the most recent available). Due the potential effects of COVID-19 PHE, CMS examined whether using 2019 claims data would result in any significant differences but found minimal difference between using 2019 and 2021 claims data.

[8] This factor is included in the table calculations because of the difference between the current and proposed labor shares in this year's rule.

Table 12: Proposed FY 2022 Hospice RHC Payment Rates							
Code	**Description**	**FY 2021 Payment Rates**	**SIA Budget Neutrality Factor**	**Wage Index Standardization Factor**	**Labor Share Standardization Factor**	**Proposed FY 2022 Hospice Payment Update**	**Proposed FY 2022 Payment Rates**
651	Routine Home Care (days 1-60)	$199.25	× 1.0004	× 1.0002	× 0.9993	× 1.023	$203.81
651	Routine Home Care (days 61+)	$153.72	× 1.0005	× 0.9990	× 0.9988	× 1.023	$161.02

Table 13: Proposed FY 2022 Hospice CHC, IRC, and GIP Payment Rates						
Code	**Description**	**FY 2021 Payment Rates**	**Wage Index Standardization Factor**	**Labor Share Standardization Factor**	**Proposed FY 2022 Hospice Payment Update**	**Proposed FY 2022 Payment Rates**
652	Continuous Home Care Full Rate = 24 hours of care	$1,432.41	× 0.9998	× 1.0005	× 1.023	$1,465.79 ($61.07 per hour)
655	Inpatient Respite Care	$461.09	× 1.0007	× 1.0051	× 1.023	$474.43
656	General Inpatient Care	$1,045.66	× 1.0013	× 0.9993	× 1.023	$1,070.35

Tables 14 and 15 of the proposed rule list the comparable FY 2022 proposed payment rates for hospices that do not submit the required quality data under the Hospice Quality Reporting Program as follows: Routine Home Care (days 1-60), $199.83; Routine Home Care (days 61+), $157.87; Continuous Home Care, $1,437.14; Inpatient Respite Care, 465.16; and General Inpatient Care, $1,049.43.

4. Hospice Cap Amount for FY 2022

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.[9] 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).

[9] 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.

As required by the Impact Act, beginning with the 2016 cap year, the cap amount for the previous year will be updated by the hospice payment update percentage, rather than by the CPI-U for medical care. This provision was scheduled to sunset for cap years ending after September 30, 2025 and revert to the original methodology, but this sunset provision was extended by the CCA of 2021 until September 30, 2030. CMS adds that the proposed hospice aggregate cap amount for the 2022 cap year will be $31,389.66 per beneficiary or the 2021 cap amount updated by the FY 2022 hospice payment update percentage ($30,683.93 * 1.023).

D. Proposed Clarifying Regulation Text Changes for the Hospice Election Statement Addendum

In the FY 2020 Hospice final rule, CMS finalized modifications to the hospice election statement content requirements at §418.24(b) to increase coverage transparency for patients under a hospice election. These changes that went into effect in FY 2021, included a new condition for payment requiring a hospice, upon request, to provide the beneficiary (or representative) an election statement addendum (referred to as the "addendum") outlining the items, services, and drugs that the hospice has determined are unrelated to the terminal illness and related conditions. Section 418.24 (c) sets forth the elements that must be included on the addendum such as the name of the hospice; beneficiary's name and hospital medical record identifier; a list of the beneficiary's current diagnoses/conditions present on hospital admission and the associated items, services, and drugs, not covered by the hospice; and name and signature of the Medicare hospice beneficiary (or representative) and date signed.

Since its implementation on October 1, 2020, CMS has received additional inquiries from stakeholders asking for clarification on certain aspects of the addendum. In this proposed rule, CMS is providing clarification on, and proposing modifications to, certain signature and timing requirements and proposing clarifying regulations text changes.

CMS proposes to allow the hospice to furnish the addendum within 5 days from the date of a beneficiary or representative request, if the request is within 5 days from the date of a hospice election. For example, if the patient elects hospice on December 1st and request the addendum on December 3rd, the hospice would have until December 8th to furnish the addendum. Based on the current timing, hospices were reporting that in some instances they would have to furnish the addendum prior to completion of the comprehensive assessment, which is necessary to have a complete patient profile and fill-out the addendum accurately.

CMS also proposes to clarify in regulation that the "date furnished" must be within the required timeframe (that is, 3 or 5 days of the beneficiary or representative request, depending on when such request was made), rather than the signature date. Specifically, at §418.24(c), CMS proposes that the hospice would include the "date furnished" in the patient's medical record and on the addendum itself. This change provides additional flexibility to the hospice as the date that the hospice furnished the addendum to the beneficiary (or representative) may differ from the date that the beneficiary or representative signs the addendum.

CMS also clarifies its guidance regarding a potential situation wherein the beneficiary or representative refuses to sign the addendum (85 FR 47088). It clarifies that if a patient or representative refuses to sign the addendum, the hospice must document clearly in the medical record (and on the addendum itself) the reason the addendum is not signed to mitigate a claims

denial for this condition for payment. In such a case, although the beneficiary has refused to sign the addendum, the "date furnished" must still be within the required timeframe (that is, within 3 or 5 days of the beneficiary or representative request, depending on when such request was made), and noted in the chart and on the addendum itself. It also clarifies in regulation (§418.24(c)(9)) that if a non-hospice provider requests the addendum, rather than the beneficiary or representative, the non-hospice provider is not required to sign the addendum.

CMS also clarifies in its regulations instances in which the beneficiary or representative requests the addendum and the beneficiary dies, revokes, or is discharged prior to signing the addendum. These regulation text changes are reflected at §418.24(c), §418.24(d)(4), and §418.24(d)(5). CMS notes that it would continue to expect that the hospice would note the date furnished in the patient's medical record and on the addendum, if the hospice already completed the addendum, as well as an explanation in the patient's medical record noting that the patient died, revoked, or was discharged prior to the signing of the addendum.

CMS also proposes conforming regulation text changes at §418.24(c) in alignment with subregulatory guidance indicating that hospices have "3 days," rather than "72 hours" to meet the requirements when a patient requests the addendum during the course of a hospice election. CMS' stated intent of this clarification is to better align the timing of "furnishing" an addendum to when the addendum is "requested".

CMS solicits comments on these proposed clarifications and conforming regulation text changes.

E. Hospice Waivers Made Permanent Conditions of Participation

Considering the COVID-19 PHE and need to support provider and supplier communities, CMS notes that it issued an unprecedented number of regulatory waivers under its statutory authority set forth at section 1135 of the Act. CMS states that the utilization and application of these waiver pushed it to consider whether permanent regulatory changes for selected waivers would be beneficial to patients, providers, and professionals.

CMS proposes the following revisions to the hospice Conditions of Participation (CoPs).

<u>Hospice Aide Training and Evaluation – Using Pseudo-patients</u>

CMS proposes to revise it hospice regulations at §418.76(c)(1) to permit skill competencies to be assessed by observing an aide performing the skill with either a patient or a pseudo-patient as part of a simulation. The regulations currently require the aide to be evaluated by observing an aide's performance of the task with a patient. The proposed definitions for "Pseudo-patient" and "Simulation" are defined at §418.3. In brief, a pseudo-patient means a person trained to participate in a role-play situation, or a computer-based mannequin device. A simulation means a training and assessment technique that mimics the reality of the homecare environment. CMS believes that these changes could increase the speed of performing competency testing and would allow new aides to begin serving patients more quickly while still protecting patient health and safety.

Hospice Aide Training and Evaluation – Targeting Correction of Deficiencies

CMS proposes to amend the requirement at §418.76(h)(1)(iii) that if an area of concern is verified by the hospice during the on-site visit, then then hospice must conduct, and the hospice aide must complete, a competency evaluation of the deficient skill and all related skills. Currently, the aide would have to complete another full competency evaluation. CMS states that the proposed change would permit the hospice to focus on the hospice aide's specific deficient and related skill(s) instead of completing another full competency evaluation.

CMS requests public comment on its proposed changes to allow for the use of the pseudo patient for conducting hospice aide competency testing, and the proposed change to allow the hospice to focus on the hospice aides' specific deficient skill(s) instead of completing a full competency evaluation. It states that it particularly welcomes comments from hospices that implemented the use of pseudo-patients during the COVID-19 PHE and targeted correction of deficiencies by a hospice aide instead of conducting a full competency evaluation.

F. Proposals and Updates to the Hospice Quality Reporting Program (HQRP)

1. Background and Statutory Authority

The Hospice Quality Reporting Program (HQRP) includes the Hospice Item Set (HIS) and the Consumer Assessment of Healthcare Providers and System (CAHPS). Section 1814(i)(5)(A)(i) of the Act requires that beginning in FY 2014, hospices that fail to meet quality data submission requirements will receive a two percentage point reduction to the market basket update. The Consolidation Appropriations Act of 2021 (CAA 2021)[10] changed the payment reduction for failing to meet these reporting requirements from 2 to 4 percent. Specifically, the Act requires that beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and beginning with FY 2024 annual payment update (APU) and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.

The CAA 2021 also removes the prohibition on public disclosure of hospice surveys performed by a national accreditation[11] and adds new requirements to require each state and local survey agency to submit information about any survey or certification made with respect to a hospice program; the Secretary is now allowed to disclose accreditation surveys. The CAA 2021 also requires each national accreditation body with an approved hospice accreditation program, to submit information about any survey or certification made for a hospice program.[12] This information includes any inspection report, any enforcement actions taken as a result of a survey or certification, and any other information the Secretary deems appropriate. No later than October 1, 2022, this information will be published on a CMS website, such as Care Compare. In addition, national hospice accreditation programs are required to use the same survey form used by state and local survey agencies (Form CMS-2567) on or after October 1, 2021.

[10] Pub. L. 116-260
[11] Section 1865(5) of the Act
[12] Newly added section 1822(a)(2) of the Act.

Any measure selected by the Secretary must have been endorsed by the consensus-based entity holding a contract for performance measures (currently held by the National Quality Forum (NQF)). However, the Secretary may specify measures that are not endorsed as long as a feasible and practical measure has not yet been endorsed by the consensus-based entity and consideration is given to measures that have been endorsed by the consensus-based organization.

In the FY 2014 Hospice final rule (78 FR 48256), CMS finalized the HIS as the data collection mechanism for reporting HQRP measures. CMS also finalized that hospice providers are required to provide regular and ongoing electronic submission of the HIS data for each patient admission to hospice on or after July 1, 2014, regardless of payer or patient age. The CAHPS Hospice Survey is also a component of the HQRP. The CAHPS® Hospice Survey collects data on the experiences of hospice patients and the primary caregivers listed in the hospice record. The survey is administered after the patient is deceased and queries the decedent's primary, informal caregiver about the patient and family experience of care.

Table 16 (reproduced below) lists all the quality measures currently adopted for the HQRP.

Table 16: Quality Measures Adopted for the HQRP

NQF Number	Measure Name	Year Date Collection Began
1617*	Patients Treated with an Opioid Who Are Given a Bowel Regimen	October 1, 2014
1634*	Pain Screening	October 1, 2014
1637*	Pain Assessment	October 1, 2014
1638*	Dyspnea Treatment	October 1, 2014
1639*	Dyspnea Screening	October 1, 2014
1641*	Treatment Preferences	October 1, 2014
1647*	Beliefs/Values Addressed (if desired by the patient)	October 1, 2014
Not Applicable	Hospice Visits When Death is Imminent (HVWDII) *Measure 1*: Percent of patients receiving at least one visit from registered nurses, physicians, nurse practitioners, or physician assistants in the last three days of life. Me*asure 2*: Percent of patients receiving at least two visits from medical social workers, chaplains or spiritual counselors, licenses practical nurses or hospice aides in the last seven days of life.	April 1, 2017
3235	Hospice and Palliative Care Composite Measure – 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)	April 1, 2017
CAHPS Hospice Survey		
2651	CAHPS Hospice Survey (single measure) • Communication with Family • Getting timely help • Treating patient with respect	January 1, 2015

Table 16: Quality Measures Adopted for the HQRP		
NQF Number	**Measure Name**	**Year Date Collection Began**
	• Emotional and spiritual support • Help for pain and symptoms • Training family to care for the patient • Rating of this hospice • Willing to recommend this hospice	
*These measures are known as the Hospice Item Set (HIS) process measures.		

In the FY 2016 Hospice final rule (80 FR 47142), CMS finalized the process for removing previously adopted measures which included seven factors for removal of a measure. In the FY 2019 Hospice final rule (83 FR 38622) CMS adopted an eighth factor for removal of a measure. The finalized reasons for removing quality measures are:

1. Measure performance among hospices is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made;
2. Performance or improvement on a measure does not result in better patient outcomes;
3. A measure does not align with current clinical guidelines or practice;
4. A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available;
5. A measure that is more proximal in time to desired patient outcomes for the particular topic is available;
6. A measure that is more strongly associated with desired patient outcomes for the particular topic is available;
7. Collection or public reporting of a measure leads to negative unintended consequences; or
8. The costs associated with a measure outweighs the benefits of its continued use in the program.

In the FY 2019 Hospice final rule (83 FR 38622), CMS began the Meaningful Measures Initiative to identify high priority areas for quality measurement and improvement.[13] This initiative is designed to improve outcomes for patients, their families, their providers and also reduce reporting burden.

In the FY 2020 Hospice final rule (84 FR 38484), CMS discussed the development of quality measures using claims data to expand the sources for quality measure development. CMS also discussed the development of the Hospice Outcomes & Patient Evaluation (HOPE), a new patient assessment instrument to replace the HIS (discussed below in section F.6).

[13] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInititativesGenInfo/MMF/General-info-Sub-PAge.html.

2. Proposals to Remove the Seven "Hospice Item Set (HIS) Process Measures" from HQRP Beginning FY 2022

Consistent with its policy for measure removal, CMS reviewed the HIS measures (listed above in Table 16) against the factors for removal. CMS' analysis determined that these measures meet factor 4: a more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available. CMS determined NQF #3235 HIS Comprehensive Assessment Measure (listed above in Table 16) is a more broadly applicable measure and provides, in a single measure meaningful differences between hospices regarding overall quality for both physical and psychosocial needs at admission. In addition, MedPAC noted that the HIS Comprehensive Assessment Measure differentiates the hospice's overall ability to address care processes better than the seven individual HIS process measures.[14]

CMS proposes to remove the seven individual HIS process measures from the HQRP no earlier than FY 2022 and to no longer publicly report them as individual measures on Care Compare. CMS notes that it does not propose any changes to the requirement to submit the HIS admission assessment. CMS will continue to include the seven HIS process measures in the confidential quality measure (QM) Reports. Hospices which do not report HIS data used for the HIS Comprehensive Assessment Measure will not meet the requirements for compliance with the HQRP.

3. Proposal to Add a "Claims-based Index Measure", the Hospice Care Index

CMS proposes a new hospice quality measure, the Hospice Care Index (HCI) to provide more information about several processes of care during a hospice stay. The HCI is a single measure comprising ten indicators from Medicare claims data. CMS notes that each indicator represents either a domain of hospice care recommended by leading hospice and quality experts[15] or a requirement included in the hospice CoPs. CMS believes the HCI will help identify whether hospices have aggregate performance trends that indicate higher or lower quality of care relative to other hospices.

CMS notes that since the HCI is a claims-based measure it would not impose any new collection of information requirements. Additional information about the background of the HCI is available at https://youtube/by68E92cZc.

a. Specifications for the HCI Indicators

The proposed rule discusses the data files used and analyses performed to specify the indicators and measures. CMS also provides the information required to calculate each indicator, including the numerator and denominator definition, different thresholds for receiving credit toward the overall HCI score, and explanations for those thresholds. Each indicator equally affects the single HCI score, reflecting the equal importance of each aspect of care delivered, and will be

[14] MedPAC. (2020). *Chapter 12: Hospice Services*. http://medpac.gov/docs/default-source/reports/mar20-medpac-ch12-sec.pdf.
[15] 2019: Vulnerabilities in Hospice Care (Office of the Inspector General)

aggregated into a single HCI score. Highlight of this discussion are provided below, including a table at the end of this section.

Indicator One: Continuous Home Care (CHC) or General Inpatient (GIP) Provided. Medicare Hospice CoPs require hospices to be able to provide both CHC and GIP levels of care as needed to manage more intense symptoms.[16] This indicator identifies hospices that provided at least one day of hospice care under the CHC or the GIP levels of care during the period examined.

The specifications for this indicator are:

- Numerator: The total number of CHC or GIP services days provided by the hospice within a reporting period.
- Denominator: The total number of hospice service days provided by the hospice at any level of care within a reporting period
- Index Earned Point Criterion: Hospices earn a point towards the HCI if they provided at least one CHC or GIP service day within a reporting period.

Indicator Two: Gaps in Nursing Visits. Medicare Hospice CoPs require a member of the interdisciplinary team to ensure ongoing assessment of patient and caregiver needs and plan of care implementation.[17] This indicator identifies whether a hospice is below the 90th percentile in how often hospice stays of at least 30 days contain at least one gap of eight or more days without a nursing visit.

The specifications for this indicator are:

- Numerator: The number of elections with the hospice where the patient experienced at least one gap between nursing visits exceeding 7 days, excluding hospice elections where the patient elected hospice for less than 30 days within a reporting period.
- Denominator: The total number of elections with the hospice, excluding hospice elections where the patient elected hospice for less than 30 days within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice score for gaps in nursing visits greater than 7 days falls below the 90th percentile ranking among hospices nationally.

Indicator Three: Early Live Discharges. CMS discusses evidence that indicates high rates of live discharge suggest concerns in hospices' care processes, their advance care planning to prevent hospitalizations, or their discharge processes. MedPAC also examined the rate of live discharges and concluded that an unusually high rate of live discharges could signal a potential concern with the quality of care provided by a hospice.[18] This indicator identifies whether a hospice is below the 90th percentile in the percentage of live discharges that occur within 7 days of hospice admission during the FY examined.

[16] Special coverage requirements, Title 42, Chapter IV, Subchapter B, Part 418, §§418.204 and 418.302.
[17] §§418.56 and 418.57
[18] MedPAC. (2020). *Chapter 12: Hospice Services*. http://medpac.gov/docs/default-source/reports/mar20_medpac_ch12_sec.pdf.

The specifications for this indicator are:

- Numerator: The total number of live discharges from the hospice occurring within the first 7 days of hospice within a reporting period.
- Denominator: The total number of all live discharges from the hospice occurring within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice percentage of live discharges on or before the seventh day of hospice falls below the 90th percentile ranking among hospices nationally.

Indicator Four: Late Live Discharges. CMS discusses that the rate of live discharges that occur 180 days or more after hospice enrollment is another potential concerning pattern of hospice care. This indicator identifies whether a hospice is below the 90th percentile in the percentage of live discharges that occur on or after the 180th day of hospice.

The specifications for this indicator are:

- Numerator: The total number of live discharges from the hospice occurring on or after 180 days of enrollment in hospice within a reporting period.
- Denominator: The total number of all live discharges from the hospice within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice percentage of live discharges on or after the 180th day of hospice falls below the 90th percentile ranking among hospices nationally.

Indicator Five: Burdensome Transitions (Type 1) – Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission. The Type 1 burdensome transitions reflect hospice live discharge with a hospital admission within 2 days of hospice discharge, and then hospice readmission within 2 days of hospital discharge. CMS discusses how this pattern of care transition may lead to fragmented care and may be associated with a deficiency in advance care planning. This indicator identifies whether a hospice is below the 90th percentile in the percentage of live discharges that are followed by a hospitalization (within 2 days of hospice discharge) and then followed by a hospice readmission (within 2 days of hospitalization).

The specifications for this indicator are:

- Numerator: The total number of live discharges from the hospice followed by a hospital admission within 2 days, then hospice readmission within 2 days of hospital discharge hospice within a reporting period.
- Denominator: The total number of all live discharges from the hospice within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice score for Type 1 burdensome transitions falls below the 90th percentile ranking among hospices nationally.

Indicator Six: Burdensome Transitions (Type 2) – Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital. CMS discusses how death in a hospital following live discharge is another concerning quality indicator because this pattern may be associated with a discharge process that is not properly assessing a patient's condition prior to discharge. This indicator identifies whether a hospice is below the 90th percentile in the percentage of live discharges that are followed by a hospitalization (within two days of hospice discharge) and then dies in the hospital.

The specifications for this indicator are:

- Numerator: The total number of live discharges from the hospice followed by a hospital admission within 2 days of live discharge with death in the hospital within a reporting year.
- Denominator: The total number of all live discharges from the hospice within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice score for Type 2 burdensome transitions falls below the 90th percentile ranking among hospices nationally.

Indicator Seven: Per-beneficiary Medicare Spending. CMS notes that estimates of per-beneficiary spending are endorsed by NQF (#2158) and reported by CMS for other care settings. CMS believes that because the Medicare hospice benefit pays a per diem rate, an important determinant of per-beneficiary spending is the length of election. This indicator identifies whether a hospice is below the 90th percentile in the average Medicare hospice payments per beneficiary.

The specifications for this indicator are:

- Numerator: Total Medicare hospice payments received by a hospice within a reporting period.
- Denominator: Total number of beneficiaries electing hospice with the hospice within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their average Medicare spending per beneficiary falls below the 90th percentile ranking among hospices nationally.

Indicator Eight: Nurse Care Minutes per Routine Home Care (RHC) Day. Medicare Hospice CoPs require a member of the interdisciplinary team to ensure ongoing assessment of patient and caregiver needs.[19] This indicator identifies whether a hospice is above the 10th percentile in average number of nursing minutes provided on RHC days during the reporting period.

The specifications for this indicator are:

- Numerator: Total skilled nursing minutes provided by a hospice on all RHC service days within a reporting period.

[19] CoPs §§418.56 and 418.76

- Denominator: The total number of RHC days provided by hospice within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice score for Nursing Minutes per RHC day falls above the 10th percentile ranking among hospices nationally.

Indicator Nine: Skilled Nursing Minutes on Weekends. CMS discusses its regulations at §418.100(c) that require nursing services, physician services, drugs and biologicals to be routinely available on a 24-hour basis seven days a week. To assess hospice service available, this indicator includes minutes of care provided by skilled nurses on weekend RHC days.

The specifications for this indicator are:

- Numerator: Total sum of minutes provided by the hospice during skilled nursing visits during RHC services occurring on Saturdays or Sundays within a reporting period.
- Denominator: Total skilled nursing minutes provided by the hospice during the RHC service days within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice score for percentage of skilled nursing minutes provided during the weekend is above the 10th percentile ranking among hospices nationally.

Indicator Ten: Visits Near Death. CMS discusses how the end of life is typically the period in the terminal illness with the highest symptom burden. This indicator identifies whether a hospice is above the 10th percentile in the percentage of beneficiaries with a nurse and/or medical services visit in the last 3 days of life.

The specifications for this indicator are:

- Numerator: The number of decedent beneficiaries receiving a visit by a skilled nurse or social worker staff for the hospice in the last 3 days of the beneficiary's life within a reporting period.
- Denominator: The number of decedent beneficiaries served by the hospice within a reporting period.
- Index Earned Point Criterion: Hospices earn a point towards the HCI if their hospice score for percentage of decedents receiving a visit by a skilled nurse or social worker in the last 3 days of life falls below the 10th percentile ranking among hospices nationally.

Hospice Care Index Indicator Summary		
Name	**Hospice Score Units**	**Index Earned Point Criteria**
Provided Continuous Home Care (CHC) or General Inpatient (GIP) Provided	% days	Hospice Score Above 0%
Gaps in nursing care	% elections	Below 90 Percentile Rank
Early live discharges	% live discharges	Below 90 Percentile Rank
Late live discharges	% live discharges	Below 90 Percentile Rank
Burdensome transitions, Type 1	% live discharges	Below 90 Percentile Rank

Hospice Care Index Indicator Summary		
Name	**Hospice Score Units**	**Index Earned Point Criteria**
Burdensome transitions, Type 2	% live discharges	Below 90 Percentile Rank
Per-beneficiary Medicare spending	dollars	Below 90 Percentile Rank
Nurse care minutes per routine home care day	minutes	Above 10 Percentile Rank
Skilled nursing minutes on weekends	% minutes	Above 10 Percentile Rank
Visits near death	% decedents	Above 10 Percentile Rank

b. Hospice Care Index Scoring Example

Each indicator equally affects the single HCI score, reflecting the equal importance of each aspect of care delivered, and will be aggregated into a single HCI score. A hospice's HCI score is based on its collective performance on the ten performance indicators; all must be included to calculate the score. Table 18 in the proposed rule illustrates how a hypothetical hospice's score is determined across all ten indicators, and how the ten indicators' scores determine the overall HCI score.

c. Measure Reportability, Variability, and Validity

CMS discusses the testing it performed during the development of the HCI using claims data from FY 2019. Reportability analyses found that over 85 percent of hospices would yield reportable measure scores over 1 year. Variability analysis found that HCI demonstrates sufficient ability to differentiate hospices. During measure testing, CMS observed hospices achieved scores between three and ten (see Figure 6 in the proposed rule). Validity analysis showed that HCI scores aligned with the family caregivers' perception of hospice quality, as measured by CAHPS Hospice survey (NQF #2651).

CMS conducted a stability analysis by comparing index scores calculated for the same hospice using claims form FYs 2017 and 2019. This analysis found that 82.8 percent of providers' scores changed by, at most, one point over 2 years.

d. Stakeholder Support

CMS discusses the various methods it used to obtain stakeholder support, including a Technical Expert Panel (TEP) convened by its measure development contractor and five listening sessions with national hospice provider organizations. CMS notes that stakeholders were generally supportive of a quality measure based on claims data for public reporting. Several stakeholders raised concerns that claims data may not adequately reflect the quality of care provided and may be a better indicator for program integrity issues. After consideration of this input, CMS believes the benefits of proposing adoption of the HCI outweighs its limitations.

In addition, the NQF Measures Application Partnership (MAP) met in January 2021 and conditionally supported the HCI for rulemaking contingent on NQF endorsement.[20]

[20] The MAP final recommendations can be found at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=94893.

e. Form, Manner and Timing of Data Collection and Submission

CMS proposes to begin reporting the HCI using existing claims data items no earlier than May 2022 (additional details discussed below). CMS will revise the confidential QM report to include claims-based measure scores, including agency and national rates through the Certification and Survey Provider Enhanced Reports (CASPER) or the replacement system. To help hospices interpret this information CMS will include results of the individual indicators of the HCI score, details on the indicators, and HCI overall scores.

4. Updates on the Hospice Visits in the Last Days of Life (HVLDL) and Hospice Item Set V3.00

CMS discusses the process it used, including obtaining public comment, for replacing the Hospice Visits When Death is Imminent II (HVWDII) measure pair (Section O of the HIS V2.01) with the HVLDL measure. OMB approved this replacement from the discharge assessment and HIS V3.00 became effective on Feb 16, 2021 (OMB control number 0938-1153).

5. Proposal to Revise §418.312(b) Submission of Hospice Quality Reporting Program Data

To address the inclusion of administrative data and correct technical errors, CMS proposes to revise the regulations at §418.312(b) by adding paragraphs (b)(1) through (3). Specifically, paragraph (b)(1) would include the existing language on the standardized set of admission and discharge items; paragraph (b)(2) would require collection of administrative data, such as Medicare claims data, used for hospice quality measures to capture services throughout the hospice stay and automatically meet the HQRP requirements at §418.306(b)(2); and paragraph 3 would be technical corrections and include the eight measure removal factors for the HQRP.

6. Update Regarding the Hospice Outcomes & Patient Evaluation (HOPE) development

The HOPE is intended to help hospices better understand a patient's care needs throughout the dying process and contribute this information to the patient's plan of care. CMS states the HOPE will provide quality data for the HQRP through standardized data collection and provide additional clinical data that could inform future payment refinements. 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 anticipates that the HOPE will replace the HIS. It will continue the development of the HOPE assessment in accordance with the Blueprint for the CMS Measures Management System. CMS will provide updates and engagement opportunities on its website.[21]

[21] https://www.cms.gov/MEdicare/Quality-Initiatives-PAtient-Assessment-Instruments/Hospice-QualityQuality-Reporting/HOPE.html

7. Update on Quality Measure Development for Future Years

CMS discusses its process to develop new measures, including convening TEP for information gathering and feedback.[22] CMS is interested in exploring patient preferences for symptom management, addressing patient spiritual and psychosocial needs, and medication management in the development of quality measures.

CMS intends to develop additional claims-based measures that may allow beneficiaries and their family caregivers to make more informed hospice choices and to hold hospices more accountable for the care they provide. CMS is considering measures that include hospice services on weekends, transitions after hospice live discharge, Medicare expenditures per beneficiary (including non-hospice spending during hospice election) and post-mortem visits. CMS is also considering developing hybrid quality measures that would be calculated using claims, assessment (HOPE), or other data sources.

CMS seeks comment on the HOPE- and claims-based quality measures to distinguish between high-and low-quality hospices, support providers, and helps consumers select a hospice provider.

8. CAHPS Hospice Survey Participation Requirements for the FY APU and Subsequent Years

The CAHPS® Hospice Survey collects data on the experiences of hospice patients and the primary caregivers listed in the hospice record. The survey is administered after the patient is deceased and queries the decedent's primary, informal caregiver about the patient and family experience of care. The CAHPS® Hospice Survey measures were re-endorsed by NQF (NQF #2651) on November 20, 2020. Measures include 6 composite measures and 2 global rating measures.

Public Reporting of CAHPS Hospice Survey. These 8 measures are reported on Hospice Compare.[23] Prior to the COVID-19 public health emergency (PHE), CMS reported the most recent 8 quarters of data on the basis of a rolling average, with the oldest quarter of data removed for each data refresh with the most recent quarter of data added. The data is refreshed 4 times a year in February, May, August, and November. Given COVID-19 PHE exemptions[24], public reporting continues to be the most recent 8 quarters of data, excluding the exempted quarters – Quarter 1 and Quarter 2 of CY 2020.

Volume-based Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements. CMS previously finalized a volume-based exemption for CAHPS Hospice Survey Data Collection Reporting requirement for FY 2021 and subsequent years (84 FR 38526). CMS finalized that hospices with fewer than 50 survey-eligible decedents/caregivers in the specified reporting period are exempted from the CAHPS® Hospice Survey data collection and reporting requirements for the corresponding payment determination (corresponds to the CY

[22] Information about the TEP and future measure concepts can be found at https://www.cms.gov/files/document/202-hqrp-tep-summary-report.pdf.
[23] Hospice compare is available at https://www.medicare.gov/care-compare/.
[24] https://www.cms.gov/files/document/guidance-memo-exemptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.

data collection period). To qualify for this exemption, hospices have to submit an annual exemption request form. The exception request form is available on the CAHPS® Hospice Survey web site at htpp://www.hospiceCAHPSurvey.org.

Hospices that have a total count of more than 50 unique decedents/caregivers in the year prior to the data collection are eligible to apply for the size exemption. Any exemption granted would be valid for only one year and an exemption request would need to be submitted annually.

The key dates for the volume-based exception for the CAHPS® Hospice Survey are summarized in Table 19 (reproduced below).

Table 16: Size Exemption Key Dates for FY 2022 through 2026			
Fiscal Year	**Data Collection Year**	**Reference Year (Count total number of unique patients in this year)**	**Size Exemption Form Submission Deadline**
2022	2020	2019	December 31, 2020
2023	2021	2020	December 31, 2021
2024	2022	2021	December 31, 2022
2025	2023	2022	December 31, 2023
2025	2024	2023	December 31, 2024

Newness Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements. CMS previously finalized a one-time newness exemption for hospices that meet the criteria (81 FR 52181). Specifically, hospices that are notified about their Medicare CCN after January 1, 2021 are exempted from the FY 2023 APU CAHPS® Hospice Survey requirement due to newness. CMS notes no action is required by the hospice to receive this exemption. The newness exemption is a one-time exemption from the survey. CMS encourages hospices to keep the letter providing them with their CCN.

Survey Participation Requirements. To meet participation requirements for a given year APU, Medicare certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from the corresponding FY reporting period. Table 20 (reproduced below) provides the deadlines for data submission for FYs 2023 through 2025. CMS notes there are no late submissions after the deadline, except for extraordinary circumstances beyond the control of the provider.

Table 20: CAHPS® Hospice Survey Data Submission Dates for the APUs in FYs FY 2023-2025	
Sample Month[1]	**Quarterly Data Submission Deadlines[2]**
FY 2023 APU	
January-March 2021 (Q1)	August 11, 2021
Monthly data collection April-June 2021 (Q2)	November 10, 2021
Monthly data collection July-September 2021 (Q3)	February 9, 2022
Monthly data collection October-December 2021(Q4)	May 11, 2022
FY 2024 APU	
January-March 2022 (Q1)	August 10, 2022
Monthly data collection April-June 2022 (Q2)	November 9 2022
Monthly data collection July-September 2022 (Q3)	February 8, 2023
Monthly data collection October-December 2022 (Q4)	May 130 2023

FY 2025 APU	
January-March 2023 (Q1)	August 9, 2023
Monthly data collection April-June 2023 (Q2)	November 8, 2023
Monthly data collection July-September 2023 (Q3)	February 14, 2024
Monthly data collection October-December 2023(Q4)	May 8, 2024
[1]Data collection for each sample month initiates two months following the month of patient death (for example, in April for deaths occurring in January). [2]Data submission deadlines are the second Wednesday of the submission month, which are August, November, February, and May.	

For direct question CMS encourages hospices to contact the CAHPS Hospice Survey Team at hospiceCAHPSsurvey@HCQIS.org or call 1-844-272-4621.

Proposal to Add CAHPS Hospice Survey Star Ratings to Public Reporting. CMS proposes to introduce Star Ratings for public reporting of CAHPS Hospice Survey results on the Care Compare or successor website no sooner than FY 2022. The star ratings would be similar to that of other CAHPS Star Rating programs such as the Hospital CAHPS or Home Health CAHPS. The stars would range from one star (worst) to five stars (best).

CMS proposes that the stars will be calculated based on "top-box" scores for each of the eight survey measures. Specifically, individual-level responses would be scored such that the most favorable response is scored 100 and all other responses are scored as 0. A hospice-level score for a given item would then be calculated as the average of the individual-level responses, with adjustment for differences in case mix and mode of survey administration. For a composite measure, the hospice-level measure score is the average of the hospice-level scores for each item within the measure. Similar to other programs, CMS proposes that the cut-points used to determine the stars will be constructed using statistical clustering procedures that minimize the score differences within a star category and maximize the differences across star categories. CMS discusses the two-stage approach it will use to calculate these cut-points.

CMS also proposes to calculate a summary of overall CAHPS Hospice Survey Star Rating by averaging the Star Ratings across the eight measures. CMS proposes a weight of ½ for Rating of the Hospice, a weight of ½ for Willingness to Recommend the Hospice, and a weight of 1 for each of the other measures; the total would be rounded to a whole number. CMS proposes that only the overall Star Rating would be publicly reported and hospices must have a minimum of 75 completed surveys to be assigned a Star Rating. The details of the Star Ratings methodology will be published on the CAHPS Hospice Survey website (www.hospicecahpssurvey.org).

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

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

Three timeframes for both HIS and CAHPS are important for HQRP Compliance: (1) the reporting year HIS and data collection year for CAHPS; (2) payment FY; and the reference Year. Table 21 (reproduced below) summarizes these three timeframes.

Table 21: 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 2020	FY 2022 APU	CY 2019
CY 2021	FY 2023 APU	CY 2020
CY 2022	FY 2024 APU*	CY 2021
CY 2023	FY 2025 APU	CY 2022
*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 22 (reproduced below) summarizes the HQRP compliance timeliness threshold requirements for a specific FY APU. CMS states that most hospices that fail to meet HQRP requirements miss the 90 percent threshold.

Table 22: HQRP Compliance Checklist		
Annual Payment Update	**HIS**	**CAHPS**
FY 2022	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 1/1/20 – 12/3/2020	Ongoing monthly participation in the Hospice CAHPS survey 1/1/20 – 12/31/2020
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 admission/discharges occurring 1/1/22– 12/3/2021	Ongoing monthly participation in the Hospice CAHPS survey 1/1/21 – 12/31/2021
FY2024	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 1/1/22 – 12/3/2022	Ongoing monthly participation in the Hospice CAHPS survey 1/1/22 – 12/31/2022

In the FY 2020 Hospice final rule, CMS finalized its plans for migrating the systems used for submitting processing assessment data. HIS data is submitted using the Quality Improvement and Evaluation System (QIES) Assessment and the Submission Processing (ASAP) system. CMS continues to develop a new internet Quality Improvement and Evaluation System (iQIES) for data submission for the HQRP. CMS plans to provide updates about the system migration through subregulatory mechanisms such as web page postings, listserv messaging, and webinars.

10. Public Display of "Quality Measures and Other Hospice Data for the HQRP

Section 1814(i)(5)(E) of the Act requires the Secretary to establish any quality data submitted by hospices available to the public. To meet this requirement, CMS launched Hospice Compare in 2017. In September 2020, CMS transitioned Hospice Compare to the Care Compare website; Hospice Compare was discontinued in December 2020. In addition to the publicly reported quality data, in 2019, CMS added information about the hospices characteristics including diagnoses, location of care and levels of care provided by a hospice.

a. Proposal Regarding Data Collection and Reporting During a PHE

During the PHE, CMS granted an exemption to the HQRP reporting requirements for Quarter 4 (Q4) 2019 (October 1, 2019 through December 31, 2019), Quarter 1 (Q1) 2020 (January 1, 2020 through March 30, 2020) and Quarter 2 (Q2) 2020 (April 1, 2020 through June 30, 2020). This exemption impacted the public reporting schedule. HIS measures have been reported using four quarters of data and CAHPS measures are reported using eight rolling quarters of data. Table 23 (reproduced below) displays the original schedule for public reporting prior to the PHE.

Table 23: Original Public Reporting Schedule with Refreshes Affected by PHE Exceptions for the HQRP

Quarter Refresh	HIS Quarters in Original Schedule for Care Compare	CAHPS Quarters in Original Schedule for Care Compare
*November 2020	Q1 2019 – Q4 2019	Q1 2018 – Q4 2019
*February 2021	Q2 2019 – Q1 2020	Q2 2018 – Q1 2020
*May 2021	Q3 2019 – Q2 2020	Q3 2018 – Q2 2020
*August 2021	Q4 2019 – Q3 2020	Q4 2018 – Q3 2020
*November 2021	Q1 2020 – Q4 2020	Q1 2019 – Q4 2020
*February 2022	Q2 2020 – Q1 2021	Q2 2019 – Q1 2021
**May 2022	Q3 2020 – Q2 2021	Q3 2019 – Q2 2021
**August 2022	Q4 2020 – Q3 2021	Q4 2019 – Q3 2021
**November 2022	Q1 2021 – Q4 2021	Q1 2020 – Q4 2021
**February 2023	Q2 2021 – Q1 2022	Q2 2020 – Q1 2022
**May 2023	Q3 2021 – Q2 2022	Q3 2020 – Q2 2022
*Exception affects both HIS and CAHPS data for refresh. ** Exception affects only CAHPS data for refresh		

As discussed below, CMS conducted testing to inform decisions about publicly reporting data for those refreshes which include exempted data. CMS used this information to develop a plan for posting data as early as possible, for as many hospices as possible, and with scientific acceptability.

Update on Use of Q4 2019 Data and Data Freeze for Refreshes in 2021. CMS discusses the analysis it performed on data submitted for Q4 2019, which ended before the onset of the U.S. COVID-19 PHE. CMS observed that the HIS data submission rate for Q4 2019 was 1.8 percent higher than the previous CY (Q4 2018). For the CAHPS Hospice Survey, 2.1 percent more hospices submitted data in Q4 2019 than in Q4 2018. Based on these results, CMS proceeded with including these data in measure calculations for the November 2020 refresh.

CMS determined that it would not use HIS or CAHPS data from Q1 and Q2 2020 for public reporting because it did not have an adequate amount of data to reliably calculate and publicly display provider measure scores. CMS decided to freeze the data displayed – holding the data constant after the November 2020 refresh without subsequently updating the data through November 2021.[25]

[25] See https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assesment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices.

Proposal for Public Reporting of HIS-based Measures with Fewer than Standard Numbers of Quarters Due to PHE Exemption in February 2022. CMS is concerned that the November 2020 refresh data will become increasingly out-of-date and less useful. To provide updated information, CMS analyzed whether it could use fewer quarters of data for the last refresh affected by the exemption (February 2020) and more quickly resume public reporting of updated quality data. CMS discusses its analysis in the proposed rule and its findings that it could use fewer quarters of data for HIS data reporting.

CMS proposes that in the PHE it would use three quarters of HIS data for the final affected refresh, the February 2020 public reporting refresh of Care Compare. This will allow CMS to begin displaying Q3 2020, Q4 2020, and Q1 2021 data in February 2022. Table 28 (reproduced below) summarizes the comparison between the original schedule for public reporting with the revised schedule with using three quarters in the February 2022 refresh. Because it cannot report Q1 2020 and Q2 2020 CAHPS data, CMS proposes to publicly report the most-recently available eight quarters of CAHPS data starting with the February 2022 refresh and going through the May 2023 refresh on Care Compare.

Table 28: Proposed CAHPS Hospice Survey Public Reporting Quarter During and After the Freeze

Refresh	Publicly Reported Quarters
Freeze:	Q1 2019 – Q4 2019
November 2020 – November 2021*	Q1 2019 – Q4 2019
February 2022	Q4 2018 – Q4 2019, Q3 2020 – Q1 2021
May 2022	Q1 2019 – Q4 2019, Q3 2020 – Q2 2021
August 2022	Q2 2019 – Q4 2019, Q3 2020 – Q3 2021
November 2022	Q3 2019 – Q4 2019, Q3 2020 – Q4 2021
February 2023	Q3 2019, Q3 2020 – Q1 2022
May 2023	Q3 2020 – Q2 2022
*The gray shading refers to the frozen quarters.	

b. Quality Measures to be Displayed on Care Compare in FY 2022 and Beyond

Proposal to remove seven "HIS process measures" from public reporting. As discussed above, CMS is proposing to remove the seven HIS process measures from the HQRP. CMS proposes to remove the seven HIS process measures no earlier than the May 2022 refresh from public reporting on Care Compare and from the Preview Reports. CMS will continue to make the information available in the data catalogue.

Proposals for calculating and publicly reporting "claims-based measure" as part of the HQRP. CMS discusses four proposals related to calculating and reporting claims-based measures, with specific applications to HVLDL and HCI.

First, CMS proposes to extract claims data to calculate claims-based measures at least 90 days after the last discharge date in the applicable period for quality measure calculations and public reporting on Care Compare. For example, if the last discharge date in the applicable period for a measure is December 31, 2022, for data collection January 1, 2022 through December 31, 2022, CMS would create the data extract on March 31, 2023, at the earliest. CMS would use this data

to calculate and publicly report the claims-based measures for the 2022 reporting period. CMS notes this proposal is similar to those finalized in other PAC settings.

CMS notes that to implement this process, hospices would not be able to submit corrections to the underlying claims snapshot or add claims at the conclusion of the 90-day period following the last date of discharge used in the applicable period. Hospices would need to ensure the completeness and correctness of their claims prior to the claims "snapshot".

Second, CMS proposes that it will update the claims-based measures annually. This update schedule aligns with most claims-based measures across PAC settings.

Third, CMS proposes that it will calculate claims-based measure scores based on one or more years of data. CMS discusses the analysis it conducted to look at multiple years of reporting data. Based on this analysis, CMS proposes using 2 years of data to publicly report HCI and HVLDL in 2022. CMS plans to consider multiple years of data for other claims-based measures proposed in future years.

Proposal to Publicly Report the Hospice Care Index and "Hospice Visits in the Last Days of Life" Claims-based Measures. CMS proposes to publicly report the HCI and HVLDV beginning no earlier than May 2022 using FY 2021 Medicare hospice claims data. It will also include this information in the Preview Reports no sooner than the May 2022 refresh. The publicly-reported HCI on Care Compare will only include the final HCI score and not the component indicators. The Preview Reports will reflect the HCI as publicly reported.

Update on Publicly Reporting for the "Hospice Visits When Death is Imminent (HVWDII) Measure 1" and the Hospice Visits in the Last Days of Life (HVLDL) Measure". Because of the data freeze during the PHE, HVWDII Measure II data from the November 2020 refresh, covering HIS admissions during Q1 through Q4 2019, will be publicly displayed for all 2021 refreshes.

d. Update on Additional Information on Hospices for Public Reporting

CMS discusses the improvements to data tools to help Medicare beneficiaries compare costs. Beginning with 2017 data, the Medicare Provider Utilization and Payment Data: Hospice Public Use File (PUF) is public as part of the Post-Acute Care and Hospice Provide Utilization and Payment PUF (PAC PUF). Beginning May 2021, CMS will begin to display additional information from the PAC PUF on Care Compare. This additional information will include hospices' information about services provided to patients enrolled in Medicare Advantage.

G. Proposal for the January 2022 Home Health (HH) Quality Reporting Program (QRP) Public Reporting Display Schedule with Fewer than Standard Number of Quarters Due to PHE Exemptions

CMS includes proposals for the HH QRP in this proposed rule because it plans to resume public reporting for the HH QRP with the January 2022 refresh of Care Compare. To meet the January 2022 public reporting refresh cycle for home health facilities, CMS proposes using three quarters

instead of four quarters for the January 2022 refresh affecting Outcome and Assessment Information Set (OASIS) based measures. For some claims-based measures, CMS is also proposing to use three quarters instead of four quarters for refreshes between January 2022 and July 2024. CMS will not make any changes for the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS). CMS will publicly report the most recently available four quarters of the HHCAHPS for these refresh cycles.

1. Proposal to Modify HH QRP Public Reporting to Address Data Exception During the PHE

During the PHE, CMS granted an exemption to the HH QRP reporting requirements for Quarter 4 (Q4) 2019 (October 1, 2019 through December 31, 2019), Quarter 1 (Q1) 2020 (January 1, 2020 through March 30, 2020) and Quarter 2 (Q2) 2020 (April 1, 2020 through June 30, 2020).[26] This exemption applied to the HH QRP OASIS-based measures, claims-based measures, and HHCAHPS survey.

Under the current HH QRP public display policy, Home Health Compares uses four quarters of data for OASIS-based measures and four or more quarters of data for claims-based measures. CMS uses four rolling quarters of data for HHCAHPS Survey measures on Care Compare. Table 30 in the proposed rule displays the original schedule for public reporting of OASIS and HHCAHPS Survey measures prior to the Q1 and Q2 2020 data impacted by the PHE.

As discussed below, CMS conducted testing to inform decisions about publicly reporting data for those refreshes which include exempted data. CMS used this information to develop a plan for posting data as early as possible, for as many home health agencies as possible, and with scientific acceptability.

2. Update on Use of Q4 2019 HH QRP Data and Data Freeze for Refreshes in 2021

CMS discusses the analysis it performed on data submitted for Q4 2019, which ended before the onset of the U.S. COVID-19 PHE. CMS observed that the quality data submission rate for Q4 2019 was 0.4 percent higher than in Q4 2018. Based on these results, CMS proceeded with including these data in measure calculations for the October 2020 refresh.

Because CMS excepted HHAs from the reporting requirements for Q1 and Q2 2020, CMS did not use OASIS, claims or HHCAHPS data from these quarters. CMS did not have an adequate amount of data to reliably calculate and publicly display this information. CMS decided to freeze the data displayed – holding the data constant after the October 2020 refresh without subsequently updating the data through October 2021.[27]

[26] https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.
[27] https://www.cms.gov/files/document/hhqrp-pr-tip-sheet081320final-ex-508.pdf.

3. Proposal to Use the COVID-19 PHE Affected Reporting (CAR) Scenario to Publicly Display Certain HH QRP Measures (Beginning in January 2022 through January 20214) Due to the PHE

CMS proposes to use the CAR scenario[28] for refreshes for January 2022 for OASIS and for refreshes from January 202 through July 2024 for some claims-based measures. CMS discusses its analysis and findings that demonstrated it could use three quarters instead of four quarters of data for OASIS measures and for some claims-based measures for public reporting of data.

This proposal for the January 2022 refresh would allow CMS to begin displaying recent data in January 2022 instead of continuing to display October 2019 data (Q1 2019 through Q4 2019). Tables 32 and 33 (reproduced below) summarize the comparison between the original schedule for public reporting with the revised schedule for OASIS- and claims-based measures, respectively.

Table 32: Original Public Reporting Schedule with Refreshes Affected by PHE Exceptions for the HH OASIS-based QMs

Quarter Refresh	OASIS Quarters in Original Schedule for Care Compare	OASIS Quarters in Revised/Proposed Schedule for Care Compare
October 2020	Q1 2019 – Q4 2019	Q1 2019– Q4 2019
January 2021	Q2 2019 – Q1 2020	Q1 2019 – Q4 2019
April 2021	Q3 2019 – Q2 2020	Q12019 – Q4 2020
July 2021	Q4 2019 – Q3 2020	Q1 2019 – Q4 2020
October 2021	Q1 2020 – Q4 2020	Q1 2019 – Q4 2020
January 2022*	Q2 2020 – Q1 2021	Q3 2020– Q1 2021

Note: The shaded cells represent data frozen due to the PHE.
*Exception affects both HIS and CAHPS data for refresh. ** Exception affects only CAHPS data for refresh

Table 33: Original, Revised, and Proposed Schedule for Refreshes Affected by PHE Exceptions for HH Claims-based QMs

Quarter Refresh *Dates are for example only---Actual Dates will be provided sub-regulatory	Claims-based Quarters in Original Schedule for Care Compare (number of quarters)	Claims-based Quarters in revised/proposed Schedule for Care Compare (number of quarters) *Quarters are for example only---Actual Quarters will be provided sub-regulatory
October 2020	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)
January 2021	ACH, ED Use: Q2 2019- Q1 2020 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)
April 2021	ACH, ED Use: Q3 2019-Q2 2020 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)
July 2021	ACH, ED Use: Q4 2019- Q3 2020 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)

[28] For the CAR scenario, CMS calculated quality measures using Q2 2019, Q3 2019, Q4 2019 data to stimulate using only Q3 2020, Q4 2020, and Q1 2021 data for public reporting.

October 2021	ACH, ED Use: Q1 2020- Q4 2020 (4) DTC, MSPB: Q1 2019- Q4 2020 (8) PPR: Q1 2018- Q4 2020 (12)	ACH, ED Use: Q1 2019- Q4 2019 (4) DTC, MSPB: Q1 2018- Q4 2019 (8) PPR: Q1 2017- Q4 2019 (12)
January 2022*	ACH, ED Use: Q2 2020-Q1 2021 (4) DTC, MSPB: Q1 2019- Q4 2020 (8) PPR: Q1 2018- Q4 2020 (12)	ACH, ED Use: Q3 2020-Q1 2021 (3) DTC, MSPB: Q1 2019- Q4 2019; Q3 2020 –Q4 2020 (6) PPR: Q1 2018-Q4 2019 Q3 2020 – Q4 2020 (10)
October 2022*	ACH, ED Use: Q1 2021-Q4 2021 (4) DTC, MSPB: Q1 2020- Q4 2021 (8) PPR: Q1 2019- Q4 2021 (12)	ACH, ED Use: Q1 2021-Q4 2021 (4) DTC, MSPB: Q3 2020 –Q4 2020 (6) PPR: Q1 2019-Q4 2019 Q3 2020 – Q4 2021 (10)
October 2023*	ACH, ED Use: Q1 2022-Q4 2022 (4) DTC, MSPB: Q1 2021- Q4 2022 (8) PPR: Q1 2020- Q4 2022 (12)	ACH, ED Use: Q1 2022-Q4 2022 (4) DTC, MSPB: Q1 2021- Q4 2022; (8) PPR: Q3 2020-Q4 2020 Q1 2021 – Q4 2022 (10)
October 2024†	ACH, ED Use: Q1 2023-Q4 2023 (4) DTC, MSPB: Q1 2022- Q4 2023 (8) PPR: Q1 2021- Q4 2023 (12)	ACH, ED Use: Q1 2023-Q4 2023 (4) DTC, MSPB: Q1 2022- Q4 2023 (8) PPR: Q1 2021- Q4 2023 (12)
Note: The shared cells represent data frozen due to PHE. DTC, MSPB and PPPR measures are updated annually in October. *Refreshes with few quarters of certain claims data. † Refreshes with the original public reporting schedule resuming for claims data.		

4. Update to the Public Display of the HHCAHPS Measures Due to the PHE Exception

The PHE exception for HHCCAHPS measures applied to Q1 and Q2 of 2020 and resulted in the freezing of the public display using Q1 2019 through Q4 2019 data for refreshes from October 2020 through October 2021. Beginning with January 2022, CMS will resume reporting four quarters of HHCAHPS data; the data for the January 2022 refresh are Q3 2020 through Q2 2021. These are the same quarters that would have been publicly displayed in the absence of the PHE. Table 34 (reproduced below) summarizes the display of the HHCAHPS measures.

Table 34: HHCAHPS Public Reporting Quarter During and After the Freeze	
Refresh	Publicly Reported Quarters
Freeze:	Q1 2019 – Q4 2019
October 2020 – October 2021*	Q1 2019 – Q4 2019
January 2022**	Q3 2020 – Q2 2021
April 2022	Q4 2020 – Q3 2021
July 2022	Q1 2021 – Q4 2021
October 2022	Q2 2021 – Q1 2022
January 2023	Q3 2021 – Q2 2022
April 2023	Q4 2021 – Q3 2022
July 2023	Q1 2022 – Q4 2019
*The gray shading refers to the frozen quarters. **Resume rolling of most recent four rolling quarters of data. These are the same rolling quarters that would have been displayed in the absence of the PHE.	

III. Requests for Information

A. Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in CMS Quality Programs

CMS requests input into the agency's planning for transformation to a fully digital quality enterprise, and specifically asks about the following:

- EHR/IT systems currently used by commenters and if they participate in a health information exchange (HIE);
- How commenters share information currently with other providers;
- Approaches by which CMS could incent or reward commenters who use health information technology (HIT) in innovative ways to reduce burden for post-acute settings, including but not limited to hospice providers;
- Resources and tools for use by hospices (and other post-acute care providers) and HIT vendors to facilitate interoperable, fully electronic health information sharing that incorporates FHIR standards and secure application programming interfaces (APIs); and
- Willingness of HIT vendors who work with hospices (and other post-acute care providers) to participate in pilots or models that align measure collection standards across care settings (e.g., sharing patient data via secure FHIR-based APIs for calculating and reporting digital measures).

CMS indicates that it will not respond to comments received through the Hospice PPS final rule, but the input from commenters will be considered in future policy making.

In providing background for this RFI, CMS offers a definition for digital quality measures (dQMs): quality measures that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems. CMS notes that a dQM's score includes a calculation that processes digital data; the agency also lists multiple examples of dQM data sources (e.g., electronic health records - EHRs, wearable medical devices).

CMS discusses the potential role of FHIR-based standards for efficient exchange of clinical information across clinical settings by clinicians through APIs. Exploration is underway at the agency regarding the use of FHIR-based APIs to access quality data already being collected through its Quality Improvement and Evaluation System (QIES) and the Internet QIES (iQIES), with consideration also being given to using FHIR interfaces to access standardized assessment data from hospice EHRs.

CMS concludes the discussion of this RFI with a commitment to using policy levers and collaborating with stakeholders to transition to fully digital quality measurement across the agency, with staged implementation of a cohesive portfolio of dQMs and incorporation of principles from the HHS National Health Quality Roadmap.

B. Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs

CMS requests public comment on the possibility of expanding measure development and adding aspects of standardized patient assessment data elements (SPADEs) that could apply to hospice and address gaps in health equity in the HQRP.

- Recommendations for quality measures, or measurement domains that address health equity, for use in the HQRP.
- Suggested parts of social determinants of health SPADEs adoption that could apply to hospice in alignment with national data collection and interoperable exchange standards. CMS is seeking guidance on any additional items, including SPADEs that could be used to assess health equity in the care of hospice patients, for use in the HQRP.
- Ways CMS can promote health equity in outcomes among hospice patients. We are also interested in feedback regarding whether including facility-level quality measure results stratified by social risk factors and social determinants of health (for example, dual eligibility for Medicare and Medicaid, race) in confidential feedback reports could allow facilities to identify gaps in the quality of care they provide.
- Methods that commenters or their organizations use in employing data to reduce disparities and improve patient outcomes, including the source(s) of data used, as appropriate.
- Existing challenges providers' encounter for effective capture, use, and exchange of health information, such as data on race, ethnicity, and other social determinants of health, to support care delivery and decision making.

As background for this RFI, CMS provides multiple examples of poor health outcomes that could stem from disparate care across patient populations (e.g., higher COVID-19 complication rates for black, Latino, and Indigenous and Native Americans relative to whites). CMS also provides the following definition of equity for purposes of this RFI from Executive Order 13985 issued on January 21, 2021:

> the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.

Further, examples are provided of ongoing efforts by CMS to enhance the transparency of information about healthcare disparities, such as the addition of standardized patient assessment data elements to several post-acute care quality programs for required reporting of social determinants of health beginning with FY 2020.

IV. Advancing Health Information Exchange

CMS discusses in this section ongoing initiatives to advance health information exchange within the post-acute care settings and within the larger health care environment. It notes that the Department of Health and Human Services (HHS) has 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 health information. CMS invites providers to learn more about these developments and how they could affect hospices. It discussed the following efforts:

Post-Acute Care Interoperability Workgroup (PACIO)

The PACIO Project has focused on FHIR implementation guides for functional status, cognitive status and new use cases on advance directives and speech, and language pathology. CMS encourages PAC provider and health IT vendor participation to participate as these efforts advance. More information can be found at https://pacioproject.org/.

CMS Data Element Library (DEL)

The CMS DEL serves as the authoritative resource for PAC assessment data elements and their associated mappings to health IT standards such as Logical Observation Identifiers Names and Codes and Systematized Nomenclature of Medicine. The DEL furthers CMS' goal of data standardization and interoperability. Standards in the Data Element Library (https://del.cms.gov/DELWeb/pubHome) can be referenced on the CMS website and in the ONC Interoperability Standards Advisory (ISA). The 2021 ISA is available at https://www.healthit.gov/isa.

Trusted Exchange Framework and Common Agreement (TEFCA)

TEFCA was implemented as a provision of the 21st Century Cures Act (Cures Act) (Pub. L. 114-255, enacted December 13, 2016). This trusted exchange framework and common agreement is intended to enable the nationwide exchange of electronic health information across health information networks and provide a way to enable bi-directional health information exchange in the future. For more information on current developments related to TEFCA, CMS refers readers to https://www.healthit.gov/topic/interoperability/trusted-exchange-framework-and-common-agreement and https://rce.sequoiaproject.org/.

Interoperability, Information Blocking, and the ONC Health IT Certification Program

On May 1, 2020, the Office of the National Coordinator for Health Information Technology (ONC) published a final rule (85 FR 25642) that established policies related to information blocking as authorized under section 4004 of the 21st Century Cures Act. Information blocking is generally defined as a practice by a health IT developer of certified health IT, health information network, health information exchange, or health care provider that, except as required by law or specified by the Secretary of HHS as a reasonable and necessary activity, is likely to interfere with access, exchange, or use of electronic health information. Appropriate disincentives for health care providers are expected to be established by the Secretary through future rulemaking. Stakeholders can learn more about information blocking at https://www.healthit.gov/curesrule/final-rule-policy/information-blocking. ONC has posted

information resources including fact sheets (https://www.healthit.gov/curesrule/resources/fact-sheets), frequently asked questions (https://www.healthit.gov/curesrule/resources/information-blocking-faqs), and recorded webinars (https://www.healthit.gov/curesrule/resources/webinars).

V. Regulatory Impact Analysis

CMS states that the overall impact of this proposed rule is an estimated net increase in Federal Medicare payments to hospices of $530 million or 2.3 percent, for FY 2022. This aggregate increase is simply a result of the hospice payment update percentage of 2.3 percent, but results vary by facility type and area of country. Variation among facilities and region is a result of using the FY 2022 updated wage data and the proposed revised labor shares, which are implemented in a budget-neutral manner.

Table 35 in the proposed rule (recreated below) shows the combined effects of the proposals and the variation by facility type and area of country. In brief, proprietary (for-profit) hospices (69 percent of all hospices) are expected to have a similar increase in hospice payments of 2.3 percent compared with overall payment increases of 2.3 percent, compared with 2.2 percent for non-profit, and 2.7 percent for government hospices, respectively. Hospices located in rural areas would see an increase of 2.6 percent compared with 2.2 percent for hospices in urban areas. The projected overall impact on hospices also varies among regions of country – a direct result of the variation in the annual update to the wage index and hospices' mix of patients within each of the four payment categories given the proposed revised labor shares. Hospices providing services in the Outlying and South Atlantic regions would experience the largest estimated increase in payments of 4.4 and 2.9 percent, respectively in FY 2022 payments. In contrast, hospices serving patients in the New England and Middle Atlantic regions would experience, on average, the lowest estimated increase of 1.4 percent, respectively in FY 2022 payments.

Table 35: Projected Impact to Hospices for FY 2022

Hospice Subgroup	Hospices	FY 2022 Updated Wage Data	FY 2022 Labor Share	FY 2022 Hospice Payment Update (%)	Overall Total Impact for FY 2022
All Hospices	4,957	0.0%	0.0%	2.3%	2.3%
Hospice Type and Control					
Freestanding/Non-Profit	600	0.0%	-0.1%	2.3%	2.2%
Freestanding/For-Profit	3,224	0.0%	0.0%	2.3%	2.3%
Freestanding/Government	40	0.2%	-0.1%	2.3%	2.4%
Freestanding/Other	365	-0.3%	0.1%	2.3%	2.1%
Facility/HHA Based/Non-Profit	366	0.0%	0.0%	2.3%	2.3%
Facility/HHA Based/For-Profit	193	0.1%	0.2%	2.3%	2.6%
Facility/HHA Based/Government	90	0.2%	0.5%	2.3%	3.0%
Facility/HHA Based/Other	79	0.4%	-0.2%	2.3%	2.5%

Hospice Subgroup	Hospices	FY 2022 Updated Wage Data	FY 2022 Labor Share	FY 2022 Hospice Payment Update (%)	Overall Total Impact for FY 2022
Subtotal: Freestanding Facility Type	4,229	0.0%	0.0%	2.3%	2.3%
Subtotal: Facility/HHA Based Facility Type	728	0.1%	0.0%	2.3%	2.4%
Subtotal: Non-Profit	966	0.0%	-0.1%	2.3%	2.2%
Subtotal: For Profit	3,417	0.0%	0.0%	2.3%	2.3%
Subtotal: Government	130	0.2%	0.2%	2.3%	2.7%
Subtotal: Other	444	-0.3%	0.0%	2.3%	2.0%
Hospice Type and Control: Rural					
Freestanding/Non-Profit	141	-0.2%	0.5%	2.3%	2.6%
Freestanding/For-Profit	348	-0.2%	0.6%	2.3%	2.7%
Freestanding/Government	18	0.2%	0.5%	2.3%	3.0%
Freestanding/Other	48	-0.2%	0.7%	2.3%	2.8%
Facility/HHA Based/Non-Profit	148	-0.3%	0.4%	2.3%	2.4%
Facility/HHA Based/For-Profit	44	0.3%	0.5%	2.3%	3.1%
Facility/HHA Based/Government	68	0.0%	0.5%	2.3%	2.8%
Facility/HHA Based/Other	45	0.2%	0.4%	2.3%	2.9%
Facility Type and Control: Urban					
Freestanding/Non-Profit	459	0.0%	-0.1%	2.3%	2.2%
Freestanding/For-Profit	2,876	0.1%	-0.1%	2.3%	2.3%
Freestanding/Government	22	0.2%	-0.1%	2.3%	2.4%
Freestanding/Other	317	-0.4%	0.0%	2.3%	1.9%
Facility/HHA Based/Non-Profit	218	0.1%	-0.1%	2.3%	2.3%
Facility/HHA Based/For-Profit	149	0.1%	0.2%	2.3%	2.6%
Facility/HHA Based/Government	22	0.4%	0.5%	2.3%	3.2%
Facility/HHA Based/Other	34	0.5%	-0.3%	2.3%	2.5%
Hospice Location: Urban or Rural					
Rural	860	-0.2%	0.5%	2.3%	2.6%

Hospice Subgroup	Hospices	FY 2022 Updated Wage Data	FY 2022 Labor Share	FY 2022 Hospice Payment Update (%)	Overall Total Impact for FY 2022
Urban	4,097	0.0%	-0.1%	2.3%	2.2%
Hospice Location: Region of the Country (Census Division)					
New England	156	-0.6%	-0.3%	2.3%	1.4%
Middle Atlantic	277	-0.7%	-0.2%	2.3%	1.4%
South Atlantic	577	0.3%	0.3%	2.3%	2.9%
East North Central	561	-0.2%	0.2%	2.3%	2.3%
East South Central	258	-0.2%	0.7%	2.3%	2.8%
West North Central	408	0.0%	0.3%	2.3%	2.6%
West South Central	967	-0.3%	0.4%	2.3%	2.4%
Mountain	503	0.1%	0.1%	2.3%	2.5%
Pacific	1,201	0.5%	-1.2%	2.3%	1.6%
Outlying	49	-1.3%	3.4%	2.3%	4.4%
Hospice Size					
0 - 3,499 RHC Days (Small)	1,082	0.1%	-0.3%	2.3%	2.1%
3,500-19,999 RHC Days (Medium)	2,227	0.0%	0.0%	2.3%	2.3%
20,000+ RHC Days (Large)	1,648	0.0%	0.0%	2.3%	2.3%

Source: FY 2020 hospice claims data from the CCW accessed on January 15, 2021.

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

CMS also considered alternatives to its proposals. Due to the COVID-19 PHE, CMS examined whether there were significant differences between utilizing FY 2019 and FY 2020 claims data on the calculation of the wage index and labor share standardization factors. It found that the differences for rate setting were minimal and decided to continue using the most recent, complete hospice claims data at the time of rulemaking to set payment rates.