de: 4120-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 418 and 424

[CMS-1787-P]

RIN 0938-AV10

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

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the hospice wage index, payment rates, and aggregate cap amount for fiscal year (FY) 2024. This rule includes information on hospice utilization trends and solicits comments regarding information related to the provision of higher levels of hospice care; spending patterns for non-hospice services provided during the election of the hospice benefit; ownership transparency; equipping patients and caregivers with information to inform hospice selection; and ways to examine health equity under the hospice benefit. This rule also proposes conforming regulations text changes related to the anticipated expiration of the COVID-19 public health emergency (PHE). In addition, this rule proposes updates to the Hospice Quality Reporting Program; discusses the Hospice Outcomes and Patient Evaluation tool; provides an update on Health Equity and future quality measures; and provides updates on the Consumer Assessment of Healthcare Providers and Systems, Hospice Survey Mode Experiment. This rule also proposes to codify hospice data submission thresholds and discusses updates to hospice survey and enforcement procedures. Additionally, the rule proposes to require hospice certifying physicians to be Medicare-enrolled or to have validly opted-out.

DATES: To be assured consideration, comments must be received at one of the addresses provided below by May 30, 2023.

ADDRESSES: In commenting, refer to file code CMS-1787-P.

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

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

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1787-P,

P.O. Box 8010,

Baltimore, MD 21244-1850.

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

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-1787-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

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

FOR FURTHER INFORMATION CONTACT: For general questions about hospice payment

policy, send your inquiry via email to: hospicepolicy@cms.hhs.gov.

For questions regarding the CAHPS® Hospice Survey, contact Lauren Fuentes at (410) 786-2290.

For questions regarding the hospice conditions of participation (CoPs), contact Mary Rossi-Coajou at (410)786-6051.

For questions regarding the hospice public reporting, contact Charles Padgett at (410) 786-2811.

For questions regarding the hospice quality reporting program, contact Jermama Keys at (410) 786-7778.

For questions regarding hospice certifying physician provider enrollment, contact Frank Whelan at (410) 786-1302.

For information regarding the hospice special focus program, send your inquiry via email to QSOG_hospice@cms.hhs.gov.

SUPPLEMENTARY INFORMATION:

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

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

Index.html.

I. Executive Summary

A. Purpose

This rule proposes updates to the hospice wage index, payment rates, and cap amount for fiscal year (FY) 2024 as required under section 1814(i) of the Social Security Act (the Act). In addition, this rule includes information on hospice utilization and spending trends and solicits comments regarding those trends and ways to examine health equity under the hospice benefit. This rule also proposes text changes to regulations that align with the anticipated expiration of the COVID-19 PHE. This proposed rule discusses updates to the Hospice Quality Reporting Program (HQRP) and the further development of the Hospice Outcomes and Patient Evaluation (HOPE) tool with national beta test analyses; and discusses updates on Health Equity and future quality measures (QMs). It also provides updates on the Consumer Assessment of Healthcare Providers and Systems (CAHPS), Hospice Survey Mode Experiment. This rule includes a proposal to codify hospice data submission thresholds and discusses updates to hospice survey and enforcement procedures. In addition, this rule proposes provider enrollment requirements for ordering/certifying physicians for hospice services.

B. Summary of the Major Provisions

Section III.A of this proposed rule includes data analysis on historical hospice utilization trends. The analysis includes data on the number of beneficiaries using the hospice benefit, live discharges, reported diagnoses on hospice claims, Medicare hospice spending, and Medicare Parts A, B, and D non-hospice spending during a hospice election. In this section, we also solicit comments from the public, including hospice providers, beneficiaries, and patient advocates related to the following: increasing access to higher levels of hospice care; our analysis of non-hospice spending during a hospice election; ownership transparency; hospice election decision-making; and ways to examine health equity under the hospice benefit.

In section III.B of this proposed rule, we discuss the proposed FY 2024 hospice payment

update percentage of 2.8 percent, updates to the hospice payment rates, as well as the updates to the hospice cap amount for FY 2024 by the hospice payment update percentage of 2.8 percent. We also propose text changes to the regulations related to the anticipated expiration of the COVID-19 PHE.

In section III.C of this proposed rule, we discuss updates to the HQRP, including the HOPE tool; an update on Health Equity and future quality measures; updates on the CAHPS® Hospice Survey Mode Experiment; and a proposal to codify the hospice data submission threshold.

In section III.D of this proposed rule, we propose updates on hospice survey and enforcement procedures.

Finally, in section III. E of this proposed rule, we propose to require physicians who order or certify hospice services for Medicare beneficiaries to be enrolled in or validly opted-out of Medicare as a prerequisite for the payment of the hospice service in question.

The overall economic impact of this proposed rule is estimated to be $720 million in increased payments to hospices for FY 2024.

II. Background

A. Hospice Care

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

core of hospice philosophy and care practices, and is a critical component of the Medicare hospice benefit.

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

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

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

If, in the judgment of the hospice interdisciplinary team, which includes the hospice

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

Hospices covered by this rule must comply with applicable civil rights laws, including section 1557 of the Affordable Care Act, section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, which require covered programs to take appropriate steps to ensure effective communication with patients with disabilities and patient companions with disabilities, including the provisions of auxiliary aids and services when necessary for effective communication.[1] Further information may be found at: https://www.hhs.gov/ocr/civilrights.

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color or national origin in federally assisted programs or activities. Department Guidance indicates that the Department interprets Title VI to require covered entities to take reasonable steps to provide meaningful access to their programs or activities to individuals with limited

[1] Hospices receiving Medicare Part A funds or other Federal financial assistance from the Department are also subject to additional Federal civil rights laws, including the Age Discrimination Act, and are subject to conscience and religious freedom laws where applicable.

English proficiency (LEP). Regulations implementing section 1557 require reasonable steps to provide meaningful access to LEP individuals. Meaningful access may require the use of interpreters and translated materials.

B. Services Covered by the Medicare Hospice Benefit

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

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

Upon the implementation of the hospice benefit, the Congress also expected hospices to continue to use volunteer services, although Medicare does not pay for these volunteer services

(section 1861(dd)(2)(E) of the Act). As stated in the Health Care Financing Administration's (now Centers for Medicare & Medicaid Services (CMS)) proposed rule "Medicare Program; Hospice Care" (48 FR 38149), the hospice must have an interdisciplinary group composed of paid hospice employees as well as hospice volunteers, and that "the hospice benefit and the resulting Medicare reimbursement is not intended to diminish the voluntary spirit of hospices." This expectation supports the hospice philosophy of community based, holistic, comprehensive, and compassionate end of life care.

C. Medicare Payment for Hospice Care

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

While payment made to hospices is to cover all items, services, and drugs for the palliation and management of the terminal illness and related conditions, Federal funds cannot be used for prohibited activities, even in the context of a per diem payment. While a recent article in a policy journal[2] discussed the potential role hospices could play in medical aid in dying (MAID) where such practices have been legalized in certain states, the Assisted Suicide Funding Restriction Act of 1997 (Pub. L. 105-12, April 30, 1997) prohibits the use of Federal funds to

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

provide or pay for any health care item or service or health benefit coverage for the purpose of causing, or assisting to cause, the death of any individual including "mercy killing, euthanasia, or assisted suicide". However, the prohibition does not pertain to the provision of an item or service for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as the item or service is not furnished for the specific purpose of causing or accelerating death.

1. Omnibus Budget Reconciliation Act of 1989

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

2. Balanced Budget Act of 1997

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

3. FY 1998 Hospice Wage Index Final Rule

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

neutral to payments calculated using the 1983 wage index.

4. FY 2010 Hospice Wage Index Final Rule

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

5. The Affordable Care Act

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

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

Section 1814(a)(7)(D)(i) of the Act, as added by section 3132(b)(2) of the PPACA, required that effective January 1, 2011, a hospice physician or nurse practitioner have a face-to-face encounter with the beneficiary to determine continued eligibility of the beneficiary's hospice care prior to the 180th day recertification and each subsequent recertification and to attest that such visit took place. When implementing this provision, CMS finalized, in the FY 2011 Hospice Wage Index final rule (75 FR 70435), that the 180th day recertification and subsequent

recertifications would correspond to the beneficiary's third or subsequent benefit periods. Further, section 1814(i)(6) of the Act, as added by section 3132(a)(1)(B) of the PPACA, authorized the Secretary to collect additional data and information determined appropriate to revise payments for hospice care and other purposes. The types of data and information suggested in the PPACA could capture accurate resource utilization, which could be collected on claims, cost reports, and possibly other mechanisms, as the Secretary determined to be appropriate. The data collected could be used to revise the methodology for determining the payment rates for RHC and other services included in hospice care, no earlier than October 1, 2013, as described in section 1814(i)(6)(D) of the Act. In addition, CMS was required to consult with hospice programs and the Medicare Payment Advisory Commission (MedPAC) regarding additional data collection and payment revision options.

6. FY 2012 Hospice Wage Index Final Rule

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

7. IMPACT Act of 2014

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) (Pub. L. 113-185) became law on October 6, 2014. Section 3(a) of the IMPACT Act mandated that all Medicare certified hospices be surveyed every 3 years beginning April 6, 2015 and ending September 30, 2025. In addition, section 3(c) of the IMPACT Act requires medical review of hospice cases involving beneficiaries receiving more than 180 days of care in select hospices that show a preponderance of such patients; section 3(d) of the IMPACT Act mandates

that the cap amount for accounting years that end after September 30, 2016, and before October 1, 2025, be updated by the hospice payment percentage update rather than using the consumer price index for urban consumers (CPI-U) for medical care expenditures.

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

The FY 2015 Hospice Wage Index and Rate Update final rule (79 FR 50452) finalized a requirement that the Notice of Election (NOE) be filed within 5 calendar days after the effective date of hospice election. If the NOE is filed beyond this 5-day period, hospice providers are liable for the services furnished during the days from the effective date of hospice election to the date of NOE filing (79 FR 50474). As with the NOE, the claims processing system must be notified of a beneficiary's discharge from hospice or hospice benefit revocation within 5 calendar days after the effective date of the discharge/revocation (unless the hospice has already filed a final claim) through the submission of a final claim or a Notice of Termination or Revocation (NOTR).

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

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

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

the determination is completed and received by the Medicare contractor (79 FR 50503).

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

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

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

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

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52160), we finalized several new policies and requirements related to the HQRP. First, we codified the policy that if a Consensus-Based Entity (CBE), as noted in section 1890 of the Social Security

Act,[3] made non-substantive changes to specifications for HQRP measures as part of the measure re-endorsement process, we would continue to utilize the measure in its new endorsed status, without going through new notice-and-comment rulemaking. We would also continue to use rulemaking to adopt substantive updates made by the CBE to the endorsed measures adopted for the HQRP; determinations about what constitutes a substantive versus non-substantive change would be made on a measure-by-measure basis. Second, we finalized two new quality measures for the HQRP for the FY 2019 payment determination and subsequent years: Hospice Visits when Death is Imminent Measure Pair and Hospice and Palliative Care Composite Process Measure-Comprehensive Assessment at Admission (81 FR 52173). The data collection mechanism for both of these measures is the Hospice Item Set (HIS), and the measures were effective April 1, 2017. Regarding the CAHPS® Hospice Survey, we finalized a policy that hospices that receive their CMS Certification Number (CCN) after January 1, 2017 for the FY 2019 Annual Payment Update (APU) and January 1, 2018 for the FY 2020 APU will be exempted from the Hospice CAHPS® requirements due to newness (81 FR 52182). The exemption is determined by CMS and is only for 1 year.

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

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

[3] Section 1890 of the Social Security Act requires the Secretary of HHS to contract with a Consensus-based Entity (CBE) regarding performance measurement. The National Quality Forum (NQF) was the CBE from 2010 – 2023. Battelle Memorial Institute has been contracted as the CBE from March 2023—March 2028. In this rule and henceforth, references to NQF will be replaced with CBE.

this policy in a budget-neutral manner in accordance with section 1814(i)(6) of the Act (84 FR 38496).

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

12. Consolidated Appropriations Act, 2021 (CAA, 2021)

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

13. Consolidated Appropriations Act, 2022 (CAA, 2022)

Division P, section 312 of the CAA, 2022 (Pub. L. 117-103) amended section 1814(i)(2)(B) of the Act and extended the provision that currently mandates the hospice cap be updated by the hospice payment update percentage (hospital market basket percentage increase reduced by the productivity adjustment) rather than the CPI-U for accounting years that end after

September 30, 2016 and before October 1, 2031. Before the enactment of this provision, the hospice cap update was set to revert to the original methodology of updating the annual cap amount by the CPI-U beginning on October 1, 2030.

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

In the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42532 through 42539), we finalized a policy to rebase and revise the labor shares for CHC, RHC, IRC, and GIP using Medicare cost report (MCR) data for freestanding hospices (collected via CMS Form 1984–14, OMB NO. 0938–0758) for 2018. We established separate labor shares for CHC, RHC, IRC, and GIP based on the calculated compensation cost weights for each level of care from the 2018 MCR data. The revised labor shares were implemented in a budget neutral manner through the use of labor share standardization factors. In the FY 2022 Hospice Wage Index and Rate Update final rule, we removed the seven original Hospice Item Set (HIS) measures from the program because a more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available and already publicly reported. The Hospice Comprehensive Assessment Measure is one measure that is calculated and rolled-up by completion of the seven individual measures. This measure helps to ensure all hospice patients receive a holistic comprehensive assessment. In August 2022, we began publicly reporting the two new claims-based measures. Specifically, this includes the: (1) Hospice Visits in the Last Days of Life (HVLDL) (which replaces the HIS Hospice Visits when Death is Imminent measure pair); and (2) Hospice Care Index (HCI) that includes 10 indicators that collectively represent different aspects of hospice care and aim to convey a comprehensive characterization of the quality of care furnished by a hospice throughout the hospice stay. Related to these changes, we finalized reporting eight quarters of claims data in order to display small providers. We finalized the public reporting of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey Star ratings on Care Compare to begin no sooner than FY 2022.

15. Consolidated Appropriations Act, 2023 (CAA, 2023)

Division FF, section 4162 of the CAA, 2023 amended section 1814(i)(2)(B) of the Act and extended the provision that currently mandates the hospice cap be updated by the hospice payment update percentage (hospital market basket percentage increase reduced by the productivity adjustment), rather than the CPI-U for accounting years that end after September 30, 2016 and before October 1, 2032. Before the enactment of this provision, the hospice cap update was set to revert to the original methodology of updating the annual cap amount by the CPI-U beginning on October 1, 2031.

III. Provisions of the Proposed Rule

A. Hospice Utilization and Spending Patterns

CMS provides analyses of hospice utilization measures such as Medicare spending; level of care utilization; lengths of stay; live discharge rates; as well as services used outside of the hospice benefit while a patient is under a hospice election, using the most recent, complete claims data. Stakeholders report that such information can be used to educate hospices on Medicare policies to help ensure compliance. Moreover, in response to the Office of Inspector General (OIG) reports highlighting vulnerabilities in the Medicare hospice benefit (for example, hospices engaging in inappropriate billing, not providing needed services and crucial information to beneficiaries in order for them to make informed decisions about their care[4]), we continue to monitor both hospice and non-hospice spending under the hospice benefit.

1. General Hospice Utilization Trends

Since the implementation of the hospice benefit in 1983, there has been substantial growth in utilization of the hospice benefit. The number of Medicare beneficiaries receiving hospice services has grown from 715,349 in Federal FY 2003 to over 1.7 million in FY 2022. Medicare hospice expenditures have risen from $5 billion in FY 2003 to approximately $23

[4] "Hospice Inappropriately Billed Medicare Over $250 Million for General Inpatient Care'', OEI-02-10-00491, March, 2016. "Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio", OEI-02-16-00570, July, 2018.

billion in FY 2022.[5] CMS' Office of the Actuary expects aggregate hospice expenditures will continue to increase by approximately 9.1 percent annually.

The percentage of Medicare decedents who died while receiving services under the Medicare hospice benefit increased from FY 2013 to FY 2019, but then slowly declined from FY 2019 through FY 2022, as shown in Table 1.

TABLE 1: Deaths in Hospice by Fiscal Year

FY	Total Deaths of Medicare Beneficiaries	Deaths of Medicare Beneficiaries Using Hospice	Percentage of Deaths in Hospice
2013	2,137,210	1,008,696	47.2%
2014	2,123,163	1,019,681	48.0%
2015	2,223,276	1,073,414	48.3%
2016	2,206,351	1,090,208	49.4%
2017	2,277,722	1,142,726	50.2%
2018	2,328,210	1,183,284	50.8%
2019	2,326,932	1,208,997	52.0%
2020	2,578,741	1,290,390	50.0%
2021	2,807,442	1,339,339	47.7%
2022	2,695,584	1,314,765	48.8%

Source: Analysis of data for FYs 2013 through 2022 accessed from the CCW on January 20, 2023.
Note: Hospice deaths are counted as any hospice claim with a discharge status code of "40", "41", or "42".

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. In its March 2023 Report to the Congress,[6] MedPAC stated that for more than a decade, the increasing number of hospice providers is due almost entirely to the entry of for-profit providers. MedPAC also stated that long stays in hospice have been very profitable and this has attracted new provider entrants with revenue-generating strategies specifically targeting those patients expected to have longer lengths of stay. MedPAC has also stated that private equity involvement in the health care sector

[5] Analysis of data for FY 2003 through FY 2022 accessed from the Chronic Conditions Data Warehouse (CCW) on January 20, 2023.
[6] Report to Congress, Medicare Payment Policy. Hospice Services, Chapter 10. MedPAC. March 2023. https://www.medpac.gov/wp-content/uploads/2023/03/Ch10_Mar23_MedPAC_Report_To_Congress_SEC.pdf.

has been growing and that private equity funds have invested in home health and hospice.[7] In FY 2022, approximately 74 percent (4,204 out of 5,689) of hospices were for-profit and approximately 16 percent (897 out of 5,689) were non-profit, whereas in FY 2016, approximately 65 percent (2,842 out of 4,373) were for-profit and approximately 23 percent (991out of 4,373) of hospices were non-profit. In FY 2022, for-profit hospices provided approximately 64 percent of all hospice days while non-profit hospices provided approximately 27 percent of all hospice days.[8] Hospices that listed their ownership status as "Other", "Government", or had an unknown ownership status accounted for the remaining 9 percent of hospice days.

There have been notable changes in the pattern of diagnoses among Medicare hospice enrollees since the implementation of the Medicare hospice benefit from primarily cancer diagnoses to neurological diagnoses, including Alzheimer's disease and other related dementias (80 FR 25839). These patterns are consistent across all hospices regardless of ownership type. Our ongoing analysis of diagnosis reporting finds that neurological and organ-based failure conditions remain the top-reported principal diagnoses. Beneficiaries with these terminal conditions tend to have longer hospice stays, which have historically been more profitable than shorter stays.[9] Table 2 shows the top 20 most frequently reported principal diagnoses on FY 2022 hospice claims.

TABLE 2: Top Twenty Principal Hospice Diagnoses, FY 2022

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[7] Report to Congress, Medicare and the Healthcare Delivery System. Congressional Request: Private equity and Medicare. June 2021. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch3_medpac_report_to_congress_sec.pdf.

[8] FY 2016 - FY 2022 hospice claims data from CCW on January 20, 2023. Fourth quarter 2022 Provider of Service (POS) File (https://www.cms.gov/files/zip/posothercsvdec19.zip). Using the analytic file, we found there were 5,689 hospices that submitted at least one claim in FY 2022. Of those, we show the frequency of their ownership type as shown in the POS file. For-profit hospices include the "proprietary" categories. Non-profit includes the "voluntary non-profit" categories. Government includes the "Government" categories and the "Combination Government & Nonprofit" option. Other represents the "other" category. Thirty-nine hospices could not be linked to the POS file and are listed as unknown.

[9] Report to Congress, Medicare Payment Policy. Hospice Services, Chapter 10. MedPAC. March 2023. https://www.medpac.gov/wp-content/uploads/2023/03/Ch10_Mar23_MedPAC_Report_To_Congress_SEC.pdf.

Rank	International Classification of Diseases, Tenth Revision (ICD-10)/Reported Principal Diagnosis	Number of Beneficiaries	Percentage of all Reported Principal Diagnoses
1	G30.9-Alzheimer disease, unspecified	135,910	7.4%
2	G31.1-Senile degeneration of brain, not elsewhere classified	124,365	6.8%
3	J44.9-Chronic obstructive pulmonary disease, unspecified	78,630	4.3%
4	G30.1-Alzheimer disease with late onset	63,980	3.5%
5	I50.9-Heart failure, unspecified	52,375	2.8%
6	G20-Parkinson disease	52,155	2.8%
7	I25.10-Atherosclerotic heart disease of native coronary artery without angina pectoris	47,117	2.6%
8	C34.90-Malignant neoplasm of unspecified part of unspecified bronchus or lung	44,093	2.4%
9	U07.1-Emergency use of U07.1	43,505	2.4%
10	I67.2-Cerebral atherosclerosis	38,543	2.1%
11	I11.0-Hypertensive heart disease with (congestive) heart failure	36,860	2.0%
12	I67.9-Cerebrovascular disease, unspecified	35,120	1.9%
13	E43-Unspecified severe protein-energy malnutrition	33,111	1.8%
14	I63.9-Cerebral infarction, unspecified	29,291	1.6%
15	I13.0-Hypertensive heart and renal disease with (congestive) heart failure	27,455	1.5%
16	C61-Malignant neoplasm of prostate	24,806	1.3%
17	N18.6-End stage renal disease	24,565	1.3%
18	J96.01-Acute respiratory failure with hypoxia	23,329	1.3%
19	C25.9-Malignant neoplasm: Pancreas, unspecified	22,128	1.2%
20	J44.1-Chronic obstructive pulmonary disease with acute exacerbation, unspecified	20,928	1.1%

Source: Analysis of data for FY 2022 accessed from the CCW on January 20, 2023.
Notes: The frequencies shown represent beneficiaries that had a least one claim with the specific ICD–10 code reported as the principal diagnosis. Beneficiaries could be represented multiple times in the results if they had multiple claims during FY 2022 with different principal diagnoses. The percentage column represents the percentage of beneficiary/diagnosis pairs in a fiscal year with a specific ICD-10 code.

Hospice Utilization by Level of Care

Our analysis shows that there have only been slight changes over time in how hospices have utilized the different levels of care. RHC consistently represents the highest percentage of total hospice days as well as the highest percentage of total hospice payments as shown in Table 3.

TABLE 3: Percent of Hospice Days and Payments by Level of Care, FY 2013 and FY 2022

Level of Care	Percent of Hospice Days, FY 2013	Percent of Hospice Days, FY 2022	Percent of Payments, FY 2013	Percent of Payments, FY 2022

RHC	97.5%	98.8%	90.6%	93.7%
CHC	0.4%	0.1%	1.8%	0.6%
IRC	0.3%	0.3%	0.3%	0.7%
GIP	1.8%	0.9%	7.3%	5.0%

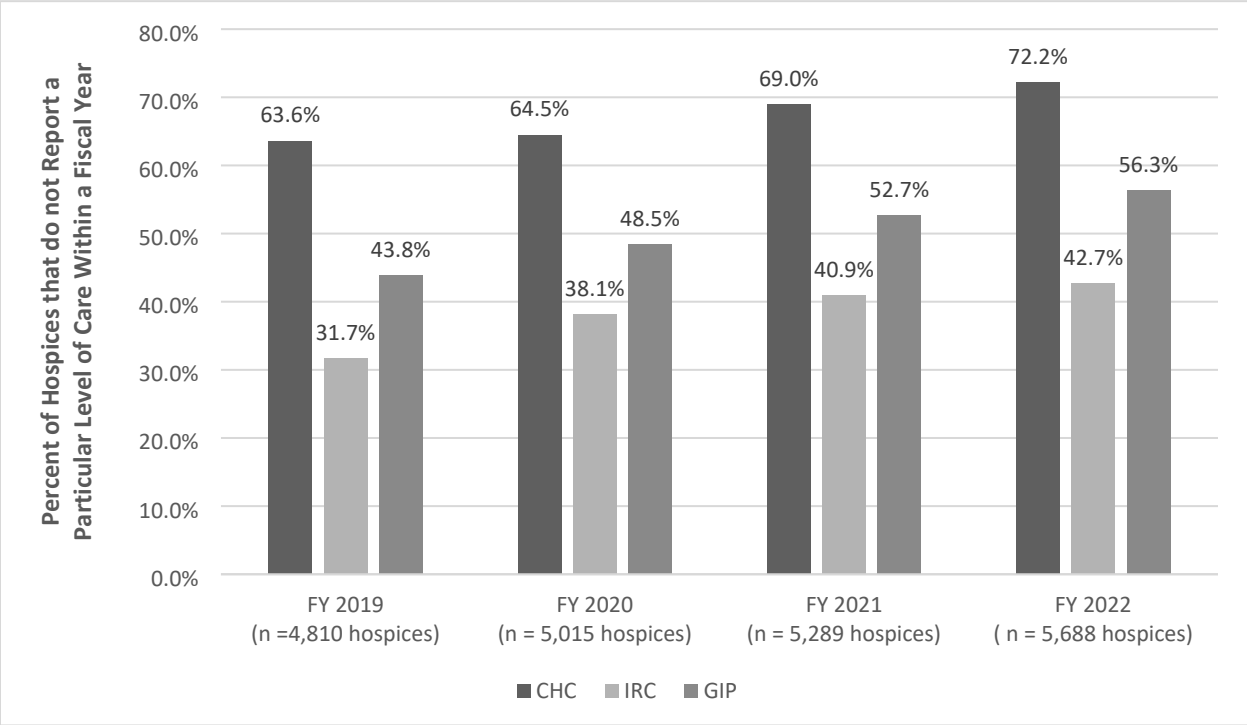
Source: Analysis of data for FY 2013 through FY 2022 accessed from the CCW on Jan 20, 2023.

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38496), we rebased the payment rates for the CHC, IRC, and GIP levels of care to better align hospice payment with the costs of providing care. It was our intent that rebasing these rates would adequately cover the costs of providing these higher intensity levels of care to ensure that hospices have access to the providers needed to comply with the hospice Conditions of Participation (CoPs), and promote patient access to all levels of care. Figure 1 shows that, despite rebasing payment rates for the higher levels of care, there still remains a high percentage of hospices that provide little to no CHC, IRC, or GIP.

We find that for-profit hospices make up 71.6 percent of hospices from FY 2019 through FY 2022, and that for-profit hospices make up 82.9 percent of the hospices that do not provide GIP in a given FY and 84.3 percent of the hospices that do not provide IRC in a given FY. Conversely, for-profit hospices make up 68.5 percent of the hospices that provide CHC in a given FY, indicating for-profit hospices are more likely to provide CHC compared to other ownership types. Hospices that are unable, or unwilling, to provide higher levels of care such as CHC and GIP may not adequately be able to care for patients who are in crisis or have symptoms that cannot be managed in the home, resulting in a worse outcome for the patient. Furthermore, not providing those levels of care, and also not providing IRC, places a greater burden on caregivers which may worsen the quality of care at the end of life. Also, most hospices that do not provide a particular level of care amongst CHC, IRC, and GIP are more likely to be in the bottom 25 percent of hospices across all FYs That is, the bottom 25 percent of hospices, which are the smallest from FY 2019 through FY 2022 make-up 40.6 percent of hospices that do not provide GIP in a given FY and make up 50.8 percent of the hospices that do not provide IRC in a given FY. The smallest hospices make up 27.7 percent of the hospices that do not provide CHC

in a given FY, meaning that group of small hospices has only a slightly higher rate of providing than would be expected otherwise.

Figure 1: Percent of Hospices Providing No Instances of CHC, IRC, GIP Care in FYs 2019-2022



Source: Analysis of data for FY 2019 through FY 2022 accessed from the CCW on January 20, 2023.

2. Trends in Hospice Length of Stay and Live Discharges

Eligibility under the Medicare hospice benefit is predicated on the individual being certified as terminally ill. Medicare regulations at § 418.3 define "terminally ill" to mean that the individual has a medical prognosis of life expectancy 6 months or less if the illness runs its normal course. However, we recognize that a beneficiary may be under a hospice election longer than 6 months, and the beneficiary is still eligible as long as there remains a reasonable expectation that the individual has a life expectancy of 6 months or less. It has always been our expectation that the certifying physicians would use their best clinical judgment, as described in our regulations at §§ 418.22 and 418.25, to determine if an individual has a life expectancy of 6 months or less with each certification and recertification.

<u>Hospice Length of Stay</u>

We examined hospice length of stay in three ways: (1) average length of election, meaning the number of hospice days during a single hospice election at the time of live discharge or death; (2) the median lifetime length of stay, which represents the 50th percentile, and (3) average lifetime length of stay, which includes the sum of all days of hospice care across all hospice elections. Extremely long lengths of stay influence both the average length of election and average lifetime length of stay. Table 4 shows the average length of election, the median and average lifetime lengths of stay from FYs 2019 through 2022.

TABLE 4: Hospice Length of Stay in Days FYs 2019 - 2022

	FY 2019	FY 2020	FY 2021	FY 2022
Average Length of Election	77	79	79	80
Median Lifetime Length of Stay	20	19	18	19
Average Lifetime Length of Stay	99	100	100	102

Source: Hospice claims data accessed from the CCW on January 20, 2023.

Length of stay estimates vary based on the reported principal diagnosis. Table 5 lists six of the most common clinical categories of principal diagnoses reported on hospice claims in FY 2022 along with the corresponding number of hospice discharges. Patients with neurological and organ-based failure conditions (with the exception of kidney disease/kidney failure) tend to have much longer lengths of stay compared to patients with cancer diagnoses.

TABLE 5: Average Length of Stay in Days for Hospice Users in FY 2022

Category	Number of Hospice Users Discharged at the End of FY 2022	Average Length of Election	Median Lifetime Length of Stay	Average Lifetime Length of Stay
Alzheimer's, Dementia, and Parkinson's	286,884	129.0	50	170.2
CVA/Stroke	135,336	97.4	21	125.3
Cancers	350,889	46.5	16	53.8
Chronic Kidney Disease	33,624	32.8	7	41.1
Heart (CHF and Other Heart Diseases)	241,166	90.7	25	115.3
Lung (COPD and Pneumonias)	142,517	72.2	11	95.1
Other	181,948	52.6	10	66.5
All Diagnoses	1,372,364	79.9	19	101.7

Source: Hospice claims data accessed from the CCW on January 20, 2023.
Notes: Only beneficiaries whose last day of hospice in FY 2022 was not associated with a discharge status code of ''30'' were counted (''30'' indicates they remained in hospice). We count the start of an election as when a patient begins hospice and is not already within a hospice election. We count elections as ending when we observe a discharge status code other than "30". Lifetime length of stay is determined using all hospice elections over the beneficiary's lifetime.

Hospice Live Discharges

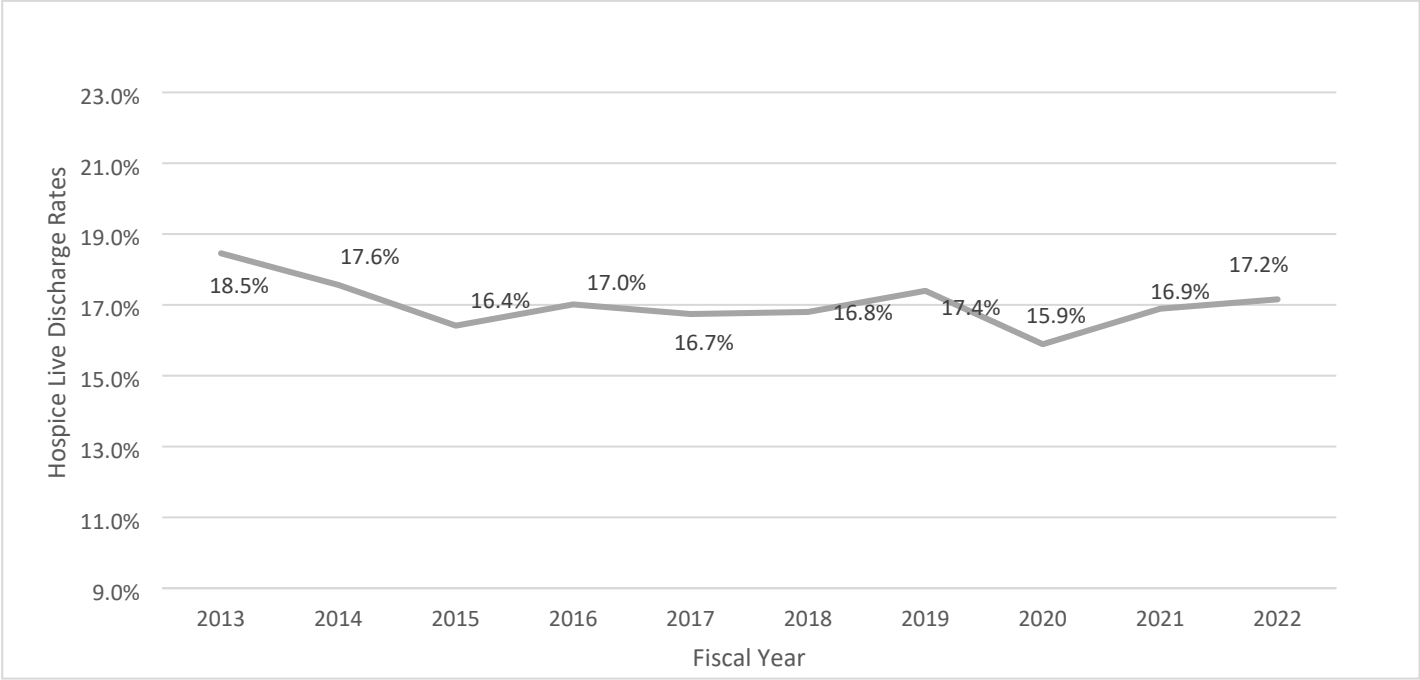
Federal regulations limit the circumstances in which a Medicare hospice provider may discharge a patient from its care. In accordance with § 418.26, discharge from hospice care is permissible when the patient moves out of the provider's service area, is determined to be no longer terminally ill, or for cause.[10] Hospices may not discharge the patient at their discretion, even if the care may be costly or inconvenient for the hospice. Additionally, an individual or representative may revoke the individual's election of hospice care at any time during an election period in accordance with the regulations at § 418.28. However, at any time thereafter, the beneficiary may re-elect hospice coverage at any other hospice election period that they are eligible to receive. Immediately upon hospice revocation, Medicare coverage resumes for those Medicare benefits previously waived with the hospice election. Only the beneficiary (or representative) can revoke the hospice election. A revocation must be in writing and must specify the effective date of the revocation. A hospice cannot revoke a beneficiary's hospice election, nor is it appropriate for hospices to encourage, request, or demand that the beneficiary or his or her representative revoke his or her hospice election.

From FY 2013 through FY 2022, the average live discharge rate has been approximately 17 percent per year. Of the live discharges in FY 2022, 35 percent were because of revocations, 36 percent were because the beneficiary was determined to no longer be terminally ill, 14.2 percent were because beneficiaries moved out of the service area without transferring hospices, and 12.9 percent were because beneficiaries transferred to another hospice. The remaining 1.9 percent were discharged for cause. The rate of live discharge varies by ownership status, where

[10] Live discharge "for cause" is defined in Chapter 9, Section 20.2.3 of the Hospice Benefit Policy Manual. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf.

non- profit hospices have live discharge rates of approximately 12 percent per year, for-profit hospices have approximately 21-22 percent of live discharges per year, and government/other types of hospices have live discharge rates of approximately 15 percent per year. Figure 2 shows the average annual rates of live discharge from FYs 2013 through 2022.

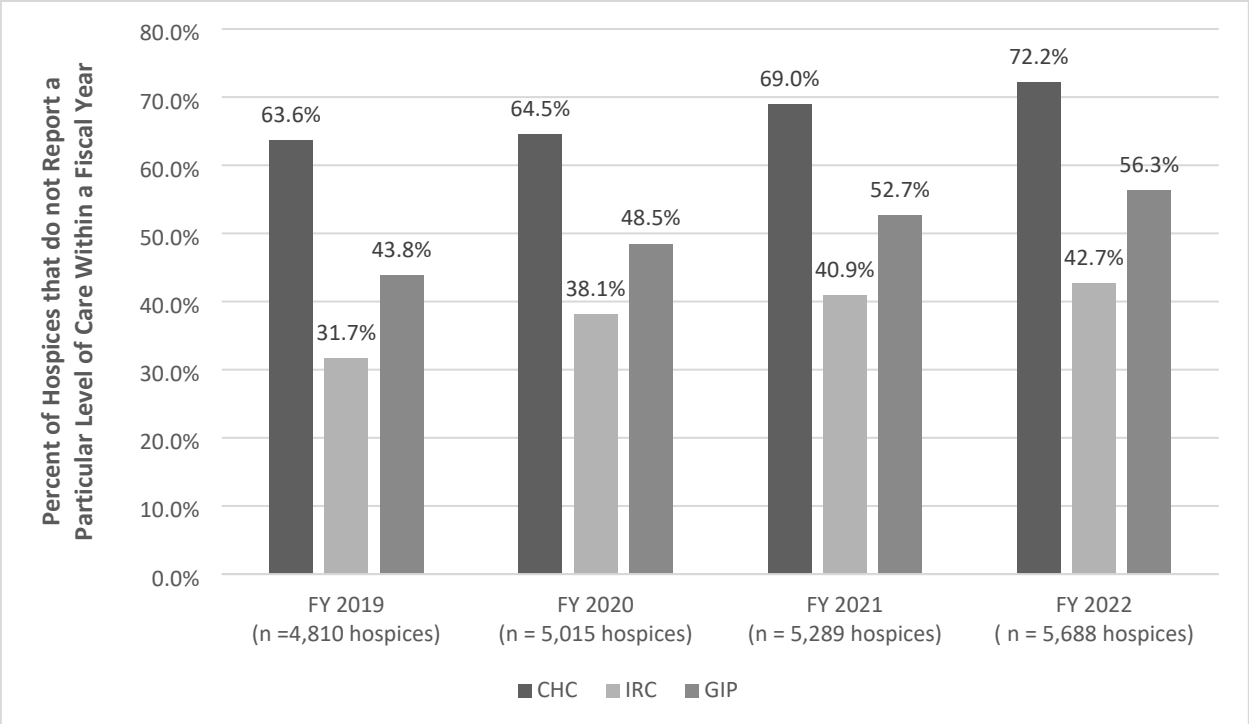
Figure 2: Annual Live Discharge Rates for FYs 2013 –2022



Source: Analysis of data for FY 2013 through FY 2022 accessed from the CCW on January 20, 2023.
Notes: All hospice claims examined list a discharge status code (meaning claims were excluded if they listed status code 30, indicating a continuing patient). Discharges ending in death had a discharge status code of 40, 41, or 42. Any claims not already excluded or that indicated a discharge resulting from death were considered live discharges.

Finally, we looked at the distribution of live discharges by length of stay intervals. Figure 3 shows the live discharge rates by length of stay intervals from FY 2019 through FY 2022. We found that the majority of live discharges occur in the first 30 days of hospice care and after 180 days of hospice care. The proportion of live discharges occurring between the lengths of stay intervals was relatively constant from FY 2019 to FY 2022 where approximately 25 percent of live discharges occurred within 30 days of the start of hospice care, and approximately 33 percent occurred after a length of stay over 180 days of hospice care.

Figure 3: Length of Stay Intervals Distribution for Live Discharges, FYs 2019 to 2022



Source: Analysis of data for FY 2019 through FY 2022 accessed from the CCW on January 20, 2023.
Notes: All hospice claims examined list a discharge status code (meaning claims were excluded if they listed status code 30, indicating they were a continuing patient). Discharges ending in death had a discharge status code of 40, 41, or 42. Any claims not already excluded or that indicated a discharge resulting from death were considered live discharges.

Non-Hospice Spending During a Hospice Election

The Medicare hospice per diem payment amounts were developed to cover all services needed for the palliation and management of the terminal illness and related conditions, as described in section 1861(dd)(1) of the Act. Hospice services provided under a written plan of care (POC) should reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. As referenced in our regulations at § 418.64 and section II.B of this proposed rule, a hospice must routinely provide all core services directly by hospice employees and they must be provided in a manner consistent with acceptable standards of practice. Under the current payment system, hospices are paid for each day that a beneficiary is enrolled in hospice care, regardless of whether services are rendered on any given day.

Additionally, when a beneficiary elects the Medicare hospice benefit, he or she waives the right to Medicare payment for services related to the treatment of the terminal illness and related conditions, except for services provided by the designated hospice and the attending

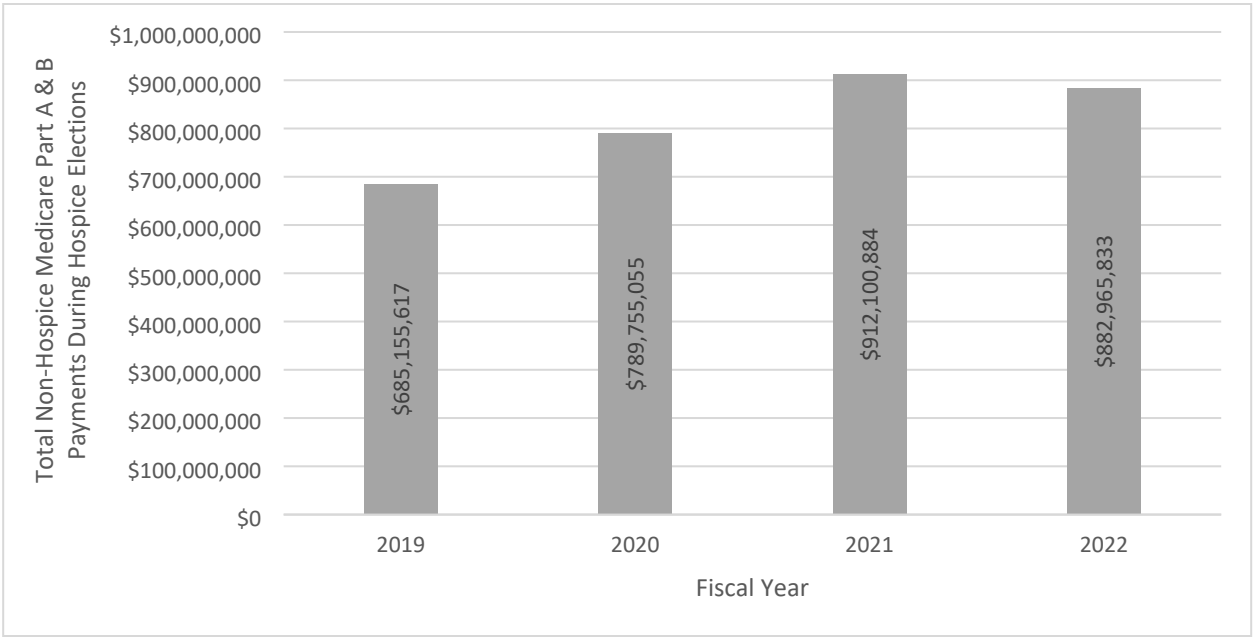
physician. The comprehensive nature of the services covered under the Medicare hospice benefit is structured so that hospice beneficiaries would not have to routinely seek items, services, and medications beyond those provided by hospice. We believe that it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life and we have reiterated since 1983 that "virtually all" care needed by the terminally ill individual would be provided by the hospice.

In examining overall non-hospice spending during a hospice election, Medicare paid over $1.4 billion in non-hospice spending during a hospice election in FY 2022 for items and services under Parts A, B, and D Medicare payments for non-hospice Part A and Part B items and services received by hospice beneficiaries during a hospice election increased from $685 million in FY 2019 to nearly $883 million in FY 2022 (see Figure 4). This represents an increase in non-hospice Medicare spending for Parts A and B of 28.9 percent. Whereas, there is minimal beneficiary cost sharing under the Medicare hospice benefit,[11] non-hospice services received outside of the Medicare hospice benefit are subject to beneficiary cost sharing. In FY 2022, the total beneficiary cost sharing amount for beneficiaries electing the hospice benefit was $197 million for Parts A and B.[12] In FY 2022, beneficiaries receiving hospice services from for-profit hospices had, on average, 60 percent higher non-hospice spending per day compared to beneficiaries under non-profit hospice care.

Figure 4: Medicare Payments for Non-Hospice Medicare Part A and Part B Items and Services During Hospice Elections, FYs 2019 –2022

[11] The amount of coinsurance for each prescription approximates five percent of the cost of the drug or biological to the hospice determined in accordance with the drug copayment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed $5. The amount of coinsurance for each respite care day is equal to five percent of the payment made by CMS for a respite care.

[12] Part A and B cost sharing is calculated by summing together the deductible and coinsurance amounts for each claim.



Source: Analysis of 100% Medicare Part A and B claims analytic files, FYs 2019 – 2022, from the CCW, accessed January 20, 2023.
Notes: Payments are based on estimated total non-hospice Medicare utilization ($) per hospice service day, excluding utilization on hospice admission or live discharge days. Only Medicare paid amounts are included. The Medicare paid amounts were equally apportioned across the length of each claim and only the days that overlapped a hospice election (not including hospice admission or live discharge days) were counted.

We also examined non-hospice spending during a hospice election by claim type for Parts A and B, as shown in Table 6. In percentage terms, we found a notable increase in billing related to skilled nursing facility claims in recent years. From FY 2019 to FY 2020, non-hospice spending related to skilled nursing facilities (SNFs) increase by 323 percent and then increased another 49 percent between FY 2020 and FY 2021. We found that roughly half of the SNF non-hospice spending that occurred in FY 2020 and FY 2021 was driven by SNF claims with a diagnosis of COVID-19. We also found that in FY 2022 SNF spending has declined, which may coincide with a reduction in COVID-19 cases.

TABLE 6: Total Medicare Spending Outside the Hospice Benefit during Days of Hospice Service (Excluding Admission/Live Discharge Days) By Claim Type [All Beneficiaries], FYs 2019 - 2022

Claim Type	FY 2019	FY 2020	FY 2021	FY 2022
Durable Medical Equipment	$54,366,410	$62,911,894	$53,089,457	$57,214,990
Home Health Agency	$16,274,533	$17,207,271	$16,600,988	$15,391,571

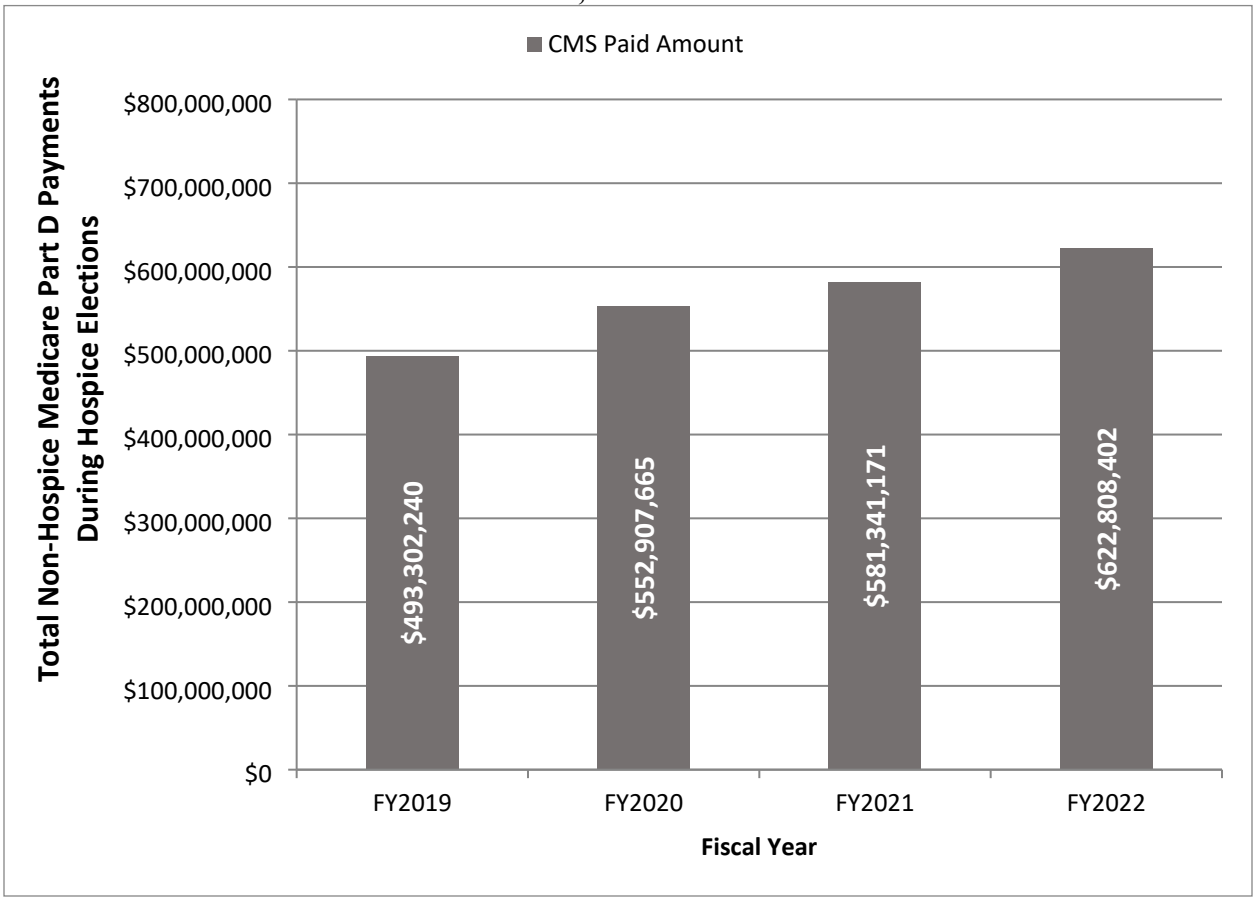
Inpatient	$135,556,881	$152,237,654	$164,126,999	$144,970,909
Outpatient	$134,890,458	$144,512,733	$161,433,749	$150,063,938
Physician Billing	$334,867,809	$374,275,518	$459,259,144	$471,598,388
Skilled Nursing Facility	$9,199,526	$38,609,985	$57,590,547	$43,726,037
Total	**$685,155,617**	**$789,755,055**	**$912,100,884**	**$882,965,833**

Source: Analysis of 100% Medicare Part A and B claims analytic files, FYs 2019 – 2022, from the CCW, accessed January 20, 2023.
Notes: Payments are based on estimated total non-hospice Medicare utilization ($) per hospice service day, excluding utilization on hospice admission or live discharge days. Only Medicare paid amounts are included. The Medicare paid amounts were equally apportioned across the length of each claim and only the days that overlapped a hospice election (not including hospice admission or live discharge days) were counted.

Hospices are responsible for covering drugs and biologicals related to the palliation and management of the terminal illness and related conditions while the patient is under hospice care. For a prescription drug to be covered under Part D for an individual enrolled in hospice, the drug must be for treatment completely unrelated to the terminal illness or related conditions. After a hospice election, many maintenance drugs or drugs used to treat or cure a condition are typically discontinued as the focus of care shifts to palliation and comfort measures. However, those same drugs may be appropriate to continue as they may offer symptom relief for the palliation and management of the terminal prognosis.[13] Similar to the increase in non-hospice spending during a hospice election for Medicare Parts A and B items and services, non-hospice spending for Part D drugs increased in from $493 million in FY 2019 to $623 million in FY 2022 (Figure 5).

[13] Update on Part D Payment Responsibility for Drugs for Beneficiaries Enrolled in Medicare Hospice. November 2016. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf.

Figure 5: Total Payments for Non-Hospice Medicare Part D Drugs During Hospice Elections, FYs 2019- 2022



Source: Analysis of 100% Part D prescription drug events (PDEs), FYs 2019 - 2022 from the CCW Virtual Research Data Center (VRDC) (January 20, 2023).
Notes: The Medicare paid amounts were assigned to hospice days based on the service date on the PDE. Only service dates that fell within a hospice election and were not hospice admission or live discharge days were counted. The Medicare paid amount includes the low-income cost-sharing subsidy and covered drug plan paid amount on Part D PDEs.

Analysis of Part D prescription drug events (PDEs) data suggests that the current use of prior authorization (PA) by Part D sponsors has reduced Part D program payments for drugs in four targeted categories (analgesics, anti-nauseants, anti-anxiety, and laxatives), which are typically used to treat common symptoms experienced during the end of life. However, under Medicare Part D there has been an increase in hospice beneficiaries filling prescriptions for a separate category of drugs we refer to as maintenance drugs.[14] Under CMS's current policy, Part D sponsors are not expected to place hospice PA requirements on categories of drugs (other than the four targeted categories listed above) or take special measures beyond their normal

[14] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2016-11-15-Part-D-Hospice-Guidance.pdf.

compliance and utilization review activities. Under this policy, sponsors are not expected to place PA requirements on maintenance drugs, for beneficiaries under a hospice election, though these drugs may still be subject to standard Part D formulary management practices. This policy was put in place in recognition of the operational challenges associated with requiring PA on all drugs for beneficiaries who have elected hospice and because of the potential barriers to access that could be created by requiring PA on all drugs.[15] Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma, and diabetes. These categories include beta blockers, calcium channel blockers, corticosteroids, and insulin.

Table 7 details the various components of Part D spending for patients receiving hospice care for FY 2022. The portion of the FY 2022 Part D spending that was paid by Medicare is the sum of the Low-Income Cost-Sharing Subsidy and the Covered Drug Plan Paid Amount, approximately $623 million. The beneficiary cost sharing amount was approximately $69 million.[16]

TABLE 7: Drug Cost Sources for Hospice Beneficiaries' FY 2022 Drugs Received Through Part D

Component	FY 2022 Expenditures
Patient Pay Amount	$67,633,318
Low-Income Cost-Sharing Subsidy	$169,197,953
Other True Out-of Pocket Amount	$1,547,055
Patient Liability Reduction Due to Other Payer Amount	$24,265,070
Covered Drug Plan Paid Amount	$453,610,449
Non-Covered Plan Paid Amount	$23,197,266
Six Payment Amount Totals	**$739,451,111**
Unknown/Unreconciled	$47,238,184
Gross Total Drug Costs, Reported	**$786,689,295**

Source: Analysis of 100% Part D PDEs, FY 2022, from the CCW, accessed January 20, 2023.
Notes: Payments and costs that occur on hospice admission or live discharge days are excluded from the analysis.

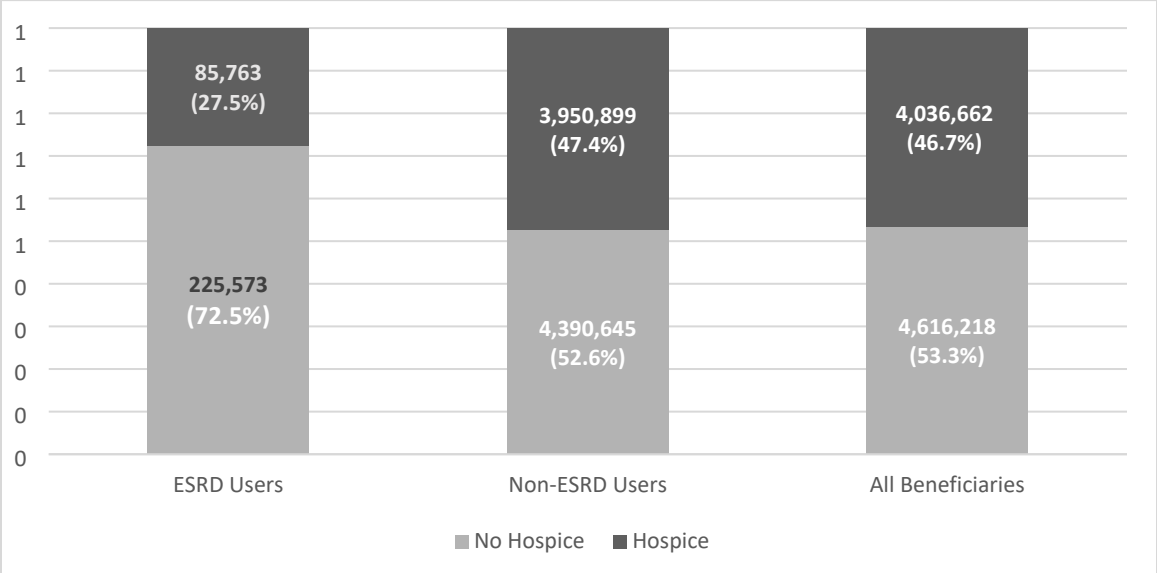
Hospice and End-Stage Renal Disease (ESRD)

[15] Part D Payment for Drugs for Beneficiaries Enrolled in Medicare Hospice. July 18, 2014. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/2014-PartD-Hospice-Guidance-Revised-Memo.pdf.
[16] Part D cost sharing is calculated by summing together the "the patient pay amount" and the "other true out of pocket" amount that are recorded on the Part D PDE.

Hospice enrollment for Medicare beneficiaries receiving maintenance dialysis for end-stage renal disease (ESRD) occurs less than half as often and much closer to the time of death, compared to the general Medicare population.

We analyzed fee for service (FFS) Medicare utilization from FYs 2017 through 2022 to better understand how ESRD patients use hospice. Our analysis included 8,991,619 beneficiaries with a date of death from FY 2017 through FY 2022. As shown in Figure 6, during this time period we found there were 85,763 beneficiaries with both hospice and ESRD service claims in the 30 days before death and they make up 27.5 percent of the 311,336 beneficiaries with ESRD services in the 30 days before death. That is a little over half of the rate of hospice use at the end of life compared to the overall rate of hospice use among all Medicare beneficiaries in our sample (46.7 percent). Results are similar when looking at hospice and ESRD service claims in the 14 days before death, 60 days before death, and 90 days before death.

Figure 6: Number and Percent of Beneficiaries Utilizing Hospice in the 30 Days Before Death by Receipt of ESRD Services in the 30 Days Before Death (FFS Medicare Decedents – FYs 2017 –2022)



Source: Analysis of 100% Part A and Part B claims and the Medicare Beneficiary Summary File from FY 2017 – FY 2018, from the CCW, accessed January 20, 2023

Separately, we looked at all FFS beneficiaries from FY 2017 through FY 2021 and identified 110,159 beneficiaries who had both ESRD service and hospice claims during that

time. For those beneficiaries with no overlap between their hospice and ESRD claims, we examined the number of days that passed from the last ESRD service claim and their day of death.[17] Looking at those beneficiaries who began hospice within 14 days of their last ESRD claim, we find that the average number of days between the last date of the ESRD service and their day of death is 15.2 days. The median is 11 days and 95 percent of beneficiaries have 31 or fewer days between their last date of ESRD service and their day of death.

Our expectation continues to be that hospices offer and provide comprehensive, virtually all-inclusive care. In order to preserve the Medicare hospice benefit and ensure that Medicare beneficiaries have access to comprehensive, high quality and appropriate end-of-life hospice care, we would continue to examine program vulnerabilities and implement safeguards in the Medicare hospice benefit, when appropriate.

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

We define hospice care as a set of comprehensive services, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care (§ 418.3). Hospice care changes the focus to comfort care (palliative care) for pain relief and symptom management instead of care to cure the patient's illness. Under the hospice benefit, palliative care is defined as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering (§ 418.3). Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual

[17] For the analysis, we begin with 110,159 beneficiaries. We first exclude beneficiaries with one or more days of overlap between a hospice claim and an ESRD service claim (n = 24,095). We then exclude beneficiaries whose first day of hospice is not after their last ESRD service date (n = 7,235). Next, we exclude beneficiaries whose last hospice date is recorded as occurring after their day of death (n = 122). Finally, we exclude beneficiaries if they started hospice 14 days or more after their last ESRD service claim (n = 24,420). After the exclusions, we are left with 54,287 beneficiaries. For this analysis we do not require a beneficiary to remain continuously enrolled in hospice until death, although for most beneficiaries that does occur.

needs and to facilitate patient autonomy, access to information, and choice. CMS continually works to ensure access to quality hospice care for all eligible Medicare beneficiaries by establishing, refining, readapting, and reinforcing policies to improve the value of care at the end of life for these beneficiaries. That is, we seek to strengthen the notion that in order to provide the highest level of care for hospice beneficiaries, we must provide ongoing focus to those services that enforce CMS' definitions of hospice and palliative care, and eliminate any barriers to accessing hospice care.

Adequate care under the hospice benefit has consistently been demonstrated to be associated with symptom reduction, less intensive care, decreased hospitalizations, improved outcomes from caregivers, lower overall costs and higher alignment with patient preferences and family satisfaction.[18] Although hospice use has grown considerably since the 1983 inception of the Medicare hospice benefit, there are still barriers that terminally ill and hospice benefit eligible beneficiaries may face when trying to access hospice care. Specifically, the national trends[19] that examine hospice enrollment and service utilization for those beneficiary populations with complex palliative needs and potentially high-cost medical care needs reveal that there may be an underuse of the hospice benefit, despite the demonstrated potential to both improve quality of care and lower costs.[20]

In particular, our analysis in Table 3 illustrates the decrease in the percentages of hospices billing for higher levels of care (LOC) (CHC, GIP, IRC), despite substantial payment rate increases as a result of rebasing beginning in FY 2020 (84 FR 38496). Additionally, as illustrated in Figure 1, the percentages of hospices providing no CHC, IRC, or GIP have also increased from FY 2019 to FY 2022. We received comments in the FY 2020 final rule (84 FR 38484), noting that the rebased payment rates would help ensure that hospices would

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[18] Obermeyer Z, Makar M, Abujaber S, Dominici F, Block S, Cutler DM. Association Between the Medicare Hospice Benefit and Health Care Utilization and Costs for Patients With Poor-Prognosis Cancer. JAMA. 2014;312(18):1888–1896. doi:10.1001/jama.2014.14950.

[19] Wachterman MW, Hailpern SM, Keating NL, Kurella Tamura M, O'Hare AM. Association Between Hospice Length of Stay, Health Care Utilization, and Medicare Costs at the End of Life Among Patients Who Received Maintenance Hemodialysis. JAMA Intern Med. 2018 Jun 1;178(6):792-799. doi: 10.1001/jamainternmed.2018.0256. PMID: 29710217; PMCID: PMC5988968.

[20] Meier DE. Increased access to palliative care and hospice services: opportunities to improve value in health care. Milbank Q. 2011 Sep;89(3):343-80. doi: 10.1111/j.1468-0009.2011.00632.x. PMID: 21933272; PMCID: PMC3214714.

have greater access to the contractors and facilities that provide these levels of care, which would ultimately benefit patients and their caregivers due to increased availability. As such, we anticipated that rebasing the payment rates for these three levels would result in an increase in utilization; however, as indicated in section III.A. of this proposed rule, this has not been the case.

It is longstanding that there is a subset of hospice eligible beneficiaries that would likely benefit from receiving palliative rather than curative chemotherapy, radiation, blood transfusions, and dialysis for treatment. The analysis shown in Figure 6 highlights that most beneficiaries that use dialysis shortly before death typically do not use hospice, while comparatively, a smaller subset of beneficiaries with diagnoses unrelated to kidney disease do use hospice and dialysis for several weeks on average. Similarly, anecdotally we have heard from beneficiaries and families their understanding that palliative therapies such as dialysis, chemotherapy, radiation, and blood transfusions are not options upon election of the hospice benefit. Generally, these patients report that they have been told by hospices that Medicare does not allow for the provision of these types of treatments upon hospice election. While these types of treatments are not intended to cure the patient's terminal illness, some practitioners, with input from the hospice interdisciplinary group (IDG), may determine for some patients these adjuvant treatment modalities would be beneficial for symptom control. In these instances, these palliative treatments would be covered under the hospice benefit.

These persistent decreases in the use of higher LOC (even after increased payments) and limited higher cost palliative treatments under the hospice benefit, suggest that there may be some barriers for those beneficiary populations with complex palliative needs to access higher LOC. These findings are contrary to the manner by which CMS strives to set the stage for eliminating barriers for eligible beneficiaries, and reduces access to hospice care that is wholly patient centered, uses a multidisciplinary care team in medical decision making, is coordinated across settings, reduces unnecessary hospitalizations, and saves health care dollars. As such, the

results of the aforementioned findings serve as a call to action for CMS to address issues related to quality care and access when striving to improve health equity. As we continue to focus on improved access and value within the hospice benefit, we are soliciting public comment on the following questions:

- Are there any enrollment policies for hospices that may be perceived as restrictive to those beneficiaries that may require higher cost end of life palliative care, such as blood transfusions, chemotherapy, radiation, or dialysis?
- Are there any enrollment policies for hospices that may be perceived as restrictive to those beneficiaries that may require higher intensity levels of hospice care?
- What continued education efforts do hospices take to understand the distinction between curative treatment and complex palliative treatment for services such as chemotherapy, radiation, dialysis, and blood transfusions as it relates to beneficiary eligibility under the hospice benefit? How is that information shared with patients at the time of election and throughout hospice service?
- Although the previously referenced analysis did not identify the cause for lower utilization of complex palliative treatments and/or higher intensity levels of hospice care, do the costs incurred with providing these services correlate to financial risks associated with enrolling such hospice patients?
- What are the overall barriers to providing higher intensity levels of hospice care and/or complex palliative treatments for eligible Medicare beneficiaries (for example, are there issues related to established formal partnerships with general inpatient/inpatient respite care facilities)? What steps, if any, can hospice providers or CMS take to address these barriers?
- What are reasons why non-hospice spending is growing for beneficiaries who elect hospice? What are ways to ensure that hospice is appropriately covering services under the benefit?

- What additional information should CMS or the hospice be required to provide the family/patient about what is and is not covered under the hospice benefit and how should that information be communicated?
- Are patients requesting the Patient Notification of Hospice Non-Covered Items, Services, and Drugs? Should this information be provided to all prospective patients at the time of hospice election or as part of the care plan?
- Should information about hospice staffing levels, frequency of hospice staff encounters, or utilization of higher LOC be provided to help patients and their caregivers make informed decisions about hospice selection? Through what mechanisms?
- The analysis included in this proposed rule shows increased overall non-hospice spending for Part D drugs for beneficiaries under a hospice election. What are tools to ensure that hospice is appropriately covering prescription drugs related to terminal illnesses and related conditions, besides prior authorization and the hospice election statement addendum?
- Given some of the differences between for-profit and not-for-profit utilization and spending patterns highlighted in this proposed rule, how can CMS improve transparency around ownership trends? For example, what and how should CMS publicly provide information around hospice ownership? Would this information be helpful for beneficiaries seeking to select a hospice for end of life care?

CMS is committed to improving the Medicare hospice benefit based, in part, on information collected by hospices not currently available on claims, assessments, or other publicly available data sources to support development of improved quality for end of life hospice care. We will continue to review our policies to support ownership transparency, patient education and transparency of hospice benefits, and to analyze the type of care that patients are receiving while in hospice to help to inform future rulemaking. We believe the information gathered under this RFI would help to improve the continuum of care under the hospice benefit

by: (1) heightened patient and family satisfaction; (2) improvement in quality indicators; (3) lower rates of hospitalization (to include decreased intensive care unit admission and invasive procedures at the end of life); and (4) significantly lower health care expenditures at the end of life.

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

CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."[21] CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are vulnerable or underserved, and providing the care and support that our beneficiaries need to thrive. CMS' goals are in line with Executive Order 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government."[22]

Health inequities persist overall in hospice and palliative care, where Black and Hispanic populations are less likely to utilize care and over 80 percent of patients are White.[23,24,25,26] After hospice admission, some studies have shown that minorities experience disparities in the quality of care, with some evidence of higher rates of hospice disenrollment and concerns about care coordination amongst hospices with a higher proportion of Black enrollees;

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[21] CMS Framework for Health Equity 2022–2032. https://www.cms.gov/files/document/cms-framework-health-equity.pdf.

[22] https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01753.pdf.

[23] Addressing Disparities in Hospice & Palliative Care. Nalley, Catlin. Oncology Times: March 20, 2021-Volume 43-Issue 6-p 1,10doi: 10.1097/01.COT.0000741732.73529.bb.

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

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

[26] Disparities in Palliative and Hospice Care and Completion of Advance Care Planning and Directives Among Non-Hispanic Blacks: A Scoping Review of Recent Literature (nih.gov).

however, data on minority hospice enrollees is limited.[27] An important first step in addressing these disparities is improving data collection to allow for better measurement and reporting on equity across our programs and policies.[28,29] We are interested in receiving input regarding the potential collection of additional indices and data elements that can provide insight regarding underlying health status and non-medical factors, access to care, and experience in medical care. Indices for measurements related to health-related social needs, social determinants of health, and social risk factors, have been developed and are currently being studied to better understand the policy implications.[30]

CMS defines health equity data as the combination of quantitative and qualitative elements that enable the examination of health differences between populations and their causes.[31] The Office of Disease Prevention and Health Promotion and Healthy People defines social determinants of health (SDOH) as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[32] Health-related social needs are defined as the individual-level manifestations of SDOH, such as housing instability and food insecurity.[33] Social risk factors are defined as adverse social conditions that are associated with poor health, and can be measures from the community or individual-level for characteristics such as socioeconomic position, cultural context, social relationships, and residential and community context.[34]

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[27] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3822363/.
[28] https://hospicenews.com/2021/05/27/hospice-providers-leverage-data-to-reach-the-underserved/.
[29] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3822363/.
[30] https://aspe.hhs.gov/sites/default/files/documents/474a62378abf941f20b3eaa74ca5721c/Area-level-Indices-ASPE-Reflections.pdf.
[31] https://www.cms.gov/files/document/path-forwardhe-data-paper.pdf.
[32] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health
[33] Centers for Medicare & Medicaid Services. (2021). A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights. June 2021. Available at: https://innovation.cms.gov/media/document/ahcm-screeningtool-companion. Accessed: November 23, 2021.
[34] Alderwick H, Gottlieb LM, 2019. Meanings and misunderstandings: a social determinants of health lexicon for health care systems. The Milbank Quarterly, 97(2), p.407. https://doi.org/10.1111%2F1468-0009.12390.

We appreciate hospice agencies and industry associations sharing their support and commitment to addressing health disparities and offering meaningful comments for consideration. Given the value of this engagement with CMS, and the ongoing development of activities to improve health equity, we solicit public comment on the following questions:

- What efforts do hospices employ to measure impact on health equity?
- What factors do hospices observe that influence beneficiaries in electing and accessing hospice care?
- What geographical area indices, beyond urban/rural, can CMS use to assess disparities in hospice?
- What information can CMS collect and share to help hospices serve vulnerable and underserved populations and address barriers to access?
- What sociodemographic and SDOH data should be collected and used to effectively evaluate health equity in hospice settings?
- What are feasible and best practice approaches for the capture and analysis of data related to health equity?
- What barriers do hospices face in collecting information on SDOH and race and ethnicity? What is needed to overcome those barriers?

B. Proposed Routine FY 2024 Hospice Wage Index and Rate Update

1. Proposed FY 2024 Hospice Wage Index

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

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

In the FY 2020 Hospice Wage Index final rule (84 FR 38484), we finalized the proposal to use the current FY's hospital wage index data to calculate the hospice wage index values. In the FY 2021 Hospice Wage Index final rule (85 FR 47070), we adopted the revised OMB delineations with a 5-percent cap on wage index decreases, where the estimated reduction in a geographic area's wage index would be capped at 5 percent in FY 2021 and no cap would be

applied to wage index decreases for the second year (FY 2022). In the FY 2023 Hospice Wage Index final rule (87 FR 45673), we finalized for FY 2023 and subsequent years the application of a permanent 5-percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline, so that a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY.

For FY 2024, the proposed hospice wage index would be based on the FY 2024 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2019 and before October 1, 2020 (FY 2020 cost report data). The proposed FY 2024 hospice wage index would not take into account any geographic reclassification of hospitals, including those in accordance with section 1886(d)(8)(B) or 1886(d)(10) of the Act. The proposed FY 2024 hospice wage index would include a 5-percent cap on wage index decreases. The appropriate wage index value would be applied to the labor portion of the hospice payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC. The appropriate wage index value is applied to the labor portion of the payment rate based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

In the FY 2006 Hospice Wage Index final rule (70 FR 45135), we adopted the policy that, for urban labor markets without a hospital from which hospital wage index data could be derived, all of the CBSAs within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value to use as a reasonable proxy for these areas. For FY 2023, the only CBSA without a hospital from which hospital wage data can be derived is 25980, Hinesville-Fort Stewart, Georgia. This remains the same for FY 2024 and the wage index value for Hinesville-Fort Stewart, Georgia is 0.8711.

To address rural areas where there were no hospitals, and thus no hospital wage data on which to base the calculation of the hospice wage index, in the FY 2008 Hospice Wage Index final rule (72 FR 50217 through 50218), we implemented a methodology to update the hospice wage index for rural areas without hospital wage data. In cases where there was a rural area

without rural hospital wage data, we use the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs, to represent a reasonable proxy for the rural area. The term "contiguous" means sharing a border (72 FR 50217). Currently, the only rural area without a hospital from which hospital wage data could be derived is Puerto Rico. However, for rural Puerto Rico, we would not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity of almost all of Puerto Rico's various urban areas to non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas); instead, we would continue to use the most recent wage index previously available for that area. For FY 2024, we propose to continue using the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047, subsequently adjusted by the hospice floor.

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

The proposed hospice wage index applicable for FY 2024 (October 1, 2023 through September 30, 2024) is available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Wage-Index.html.

2. Proposed FY 2024 Hospice Payment Update Percentage

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

Section 3401(g) of the Affordable Care Act mandated that, starting with FY 2013 (and in subsequent FYs), the hospice payment update percentage would be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP) as projected by the Secretary for the 10-year period ending with the applicable FY, year, cost reporting period, or other annual period) (the "productivity adjustment"). The United States Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the United States economy. We note that previously the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) was published by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021 release of productivity data, BLS replaced the term "multifactor productivity" with "total factor productivity" (TFP). BLS noted that this is a change in terminology only and would not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is now published by BLS as "private nonfarm business total factor productivity." However,

as mentioned, the data and methods are unchanged. We refer readers to https://www.bls.gov for the BLS historical published TFP data. A complete description of IHS Global Inc.'s (IGI's) TFP projection methodology is available on the CMS website at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch. In addition, in the FY 2022 IPPS final rule (86 FR 45214), we noted that beginning with FY 2022, CMS changed the name of this adjustment to refer to it as the "productivity adjustment" rather than the "MFP adjustment".

The proposed hospice payment update percentage for FY 2024 is based on the proposed inpatient hospital market basket update of 3.0 percent (based on IGI's fourth quarter 2022 forecast with historical data through the third quarter 2022). Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the proposed inpatient hospital market basket update for FY 2024 of 3.0 percent must be reduced by a productivity adjustment as mandated by the Affordable Care Act (currently estimated to be 0.2 percentage point for FY 2024). In effect, the proposed hospice payment update percentage for FY 2024 would be 2.8 percent. We also propose that if more recent data become available after the publication of this proposed rule and before the publication of the final rule (for example, a more recent estimate of the inpatient hospital market basket update and/or productivity adjustment), we would use such data, if appropriate, to determine the hospice payment update percentage for FY 2024 in the final rule. We continue to believe it is appropriate to routinely update the hospice payment system so that it reflects the best available data encompassing differences in patient resource use and costs among hospices as required by the statute. Therefore, we are proposing to: (1) update hospice payments using the methodology outlined and apply the 2018-based IPPS market basket update for FY 2024 of 3.0 percent, reduced by the statutorily required productivity adjustment of 0.2 percentage point along with the wage index budget neutrality adjustment to update the payment rates; and (2) use the FY 2024 hospice wage index which uses the FY 2024 pre-floor, pre-reclassified IPPS hospital wage index as its basis.

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

3. Proposed FY 2024 Hospice Payment Rates

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

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47172), we implemented two different RHC payment rates, one RHC rate for the first 60 days and a second RHC rate for days 61 and beyond. In addition, in that final rule, we implemented an SIA payment for RHC when direct patient care is provided by an RN or social worker during the last 7 days of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided (up to 4 hours total) that occurred on the day of service, if certain criteria are met. In order to maintain budget neutrality, as required under section 1814(i)(6)(D)(ii) of the Act, the new RHC rates were adjusted by a service intensity add-on budget neutrality factor (SBNF). The SBNF is used to reduce the overall RHC rate in order to ensure that SIA payments are budget-neutral. At the beginning of

every FY, SIA utilization is compared to the prior year in order calculate a budget neutrality adjustment.

In the FY 2017 Hospice Wage Index and Rate Update final rule (81 FR 52156), we initiated a policy of applying a wage index standardization factor to hospice payments in order to eliminate the aggregate effect of annual variations in hospital wage data. For FY 2024 hospice rate setting, we are continuing our longstanding policy of using the most recent data available. Specifically, we are using FY 2022 claims data with the FY 2024 payment rate updates. In order to calculate the wage index standardization factor, we simulate total payments using FY 2022 hospice utilization claims data with the FY 2023 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, and the 5 percent cap on wage index decreases) and FY 2023 payment rates and compare it to our simulation of total payments using FY 2022 utilization claims data, the FY 2024 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, and the 5 percent cap on wage index decreases) and FY 2023 payment rates. By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2023 wage index and payment rates for each level of care by the FY 2024 wage index and FY 2023 payment rates, we obtain a wage index standardization factor for each level of care. The wage index standardization factors for each level of care are shown in the Tables 8 and 9.

The proposed FY 2024 RHC rates are shown in Table 8. The proposed FY 2024 payment rates for CHC, IRC, and GIP are shown in Table 9.

TABLE 8: Proposed FY 2024 Hospice RHC Payment Rates

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

TABLE 9: Proposed FY 2024 Hospice CHC, IRC, and GIP Payment Rates

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

Sections 1814(i)(5)(A) through (C) of the Act require that hospices submit quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index and Rate Update final rule (76 FR 47320 through 47324), we implemented a HQRP as required by those sections. Hospices were required to begin collecting quality data in October 2012 and submit those quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA, 2021 to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. This policy would apply beginning with the FY 2024 annual payment update (APU) that is based on calendar year (CY) 2022 quality data. Specifically, the Act requires that, for FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and

beginning with the FY 2024 APU and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. The proposed FY 2024 rates for hospices that do not submit the required quality data would be updated by the proposed FY 2024 hospice payment update percentage of 2.8 percent minus 4 percentage points. These rates are shown in Tables 10 and 11.

TABLE 10: Proposed FY 2024 Hospice RHC Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2023 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2024 Hospice Payment Update of 2.8% minus 4 percentage points = -1.2%	Proposed FY 2024 Payment Rates
651	Routine Home Care (days 1-60)	$211.34	1.0010	1.0012	0.988	$209.26
651	Routine Home Care (days 61+)	$167.00	1.0000	1.0011	0.988	$165.18

TABLE 11: Proposed FY 2024 Hospice CHC, IRC, and GIP Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2023 Payment Rates	Wage Index Standardization Factor	FY 2024 Hospice Payment Update of 2.8% minus 4 percentage points = -1.2%	Proposed FY 2024 Payment Rates
652	Continuous Home Care Full Rate= 24 hours of care	$1,522.04	0.9980	0.988	$1,500.77 ($62.53 per hour)
655	Inpatient Respite Care	$492.10	1.0010	0.988	$486.68
656	General Inpatient Care	$1,110.76	1.0003	0.988	$1,097.76

4. Proposed Hospice Cap Amount for FY 2024

As discussed in the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47183), we implemented changes mandated by the IMPACT Act of 2014. Specifically, we stated that for accounting years that end after September 30, 2016, and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage rather than using the CPI–U. Division CC, section 404 of the CAA, 2021 extended the accounting

years impacted by the adjustment made to the hospice cap calculation until 2030. In the FY 2022 Hospice Wage Index final rule (86 FR 42539), we finalized conforming regulations text changes at § 418.309 to reflect the provisions of the CAA, 2021. Division P, section 312 of the CAA, 2022 amended section 1814(i)(2)(B) of the Act and extended the provision that mandates the hospice cap be updated by the hospice payment update percentage (hospital market basket update reduced by the productivity adjustment) rather than the CPI-U for accounting years that end after September 30, 2016, and before October 1, 2031. Division FF, section 4162 of the CAA, 2023 amended section 1814(i)(2)(B) of the Act and extended the provision that currently mandates the hospice cap be updated by the hospice payment update percentage (hospital market basket update reduced by the productivity adjustment) rather than the CPI-U for accounting years that end after September 30, 2016, and before October 1, 2032. Before the enactment of this provision, the hospice cap update was set to revert to the original methodology of updating the annual cap amount by the CPI-U beginning on October 1, 2031. Therefore, for accounting years that end after September 30, 2016, and before October 1, 2032, the hospice cap amount is updated by the hospice payment update percentage rather than the CPI-U. As a result of the changes mandated by the CAA 2023, we are proposing conforming regulation text changes at § 418.309 to reflect the new language added to section 1814(i)(2)(B) of the Act.

The proposed hospice cap amount for the FY 2024 cap year is $33,396.55, which is equal to the FY 2023 cap amount ($32,486.92) updated by the proposed FY 2024 hospice payment update percentage of 2.8 percent.

5. Conforming Regulations Text Revisions for Telehealth Services

We are proposing to revise the regulations text at § 418.22(a)(4)(ii) in accordance with Division FF, section 4113(f) of the CAA, 2023, effective January 1, 2024. Additionally, we are proposing to remove § 418.204(d), effective retroactively to May 12, 2023, to align with the anticipated end of the COVID-19 PHE. In the first COVID-19 interim final rule "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public

Health Emergency" (85 FR 19230, 19289) (April 6, 2020), we amended the hospice regulations at § 418.204 on an interim basis to specify that when a patient is receiving routine home care, hospices may provide services via a telecommunications system, if it is feasible and appropriate to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patients' terminal illness and related conditions without jeopardizing the patients' health or the health of those who are providing such services during the COVID-19 PHE. We stated that this change was effective for the duration of the COVID-19 PHE. Specifically, we propose to:

- Revise § 418.22(a)(4)(ii), which outlines the certification of terminal illness requirements. We propose to add "or through December 31, 2024, whichever is later" after "During a Public Health Emergency, as defined in § 400.200 of this chapter."
- Revise § 418.204, to remove paragraph (d) to eliminate the use of technology in furnishing services during a PHE.

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

1. Background and Statutory Authority

The Hospice Quality Reporting Program (HQRP) specifies reporting requirements for the Hospice Item Set (HIS), administrative data, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey. Section 1814(i)(5) of the Act requires the Secretary to establish and maintain a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA 2021 to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. Specifically, the Act requires that, beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and beginning with the FY 2024 APU and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. This payment penalty increase to 4 percent is statutorily

required; as discussed below, we are proposing to codify its application and set completeness thresholds at proposed §418.312(j).

Depending on the amount of the annual update for a particular year, a reduction of 4 percentage points beginning in FY 2024 could result in the annual market basket update being less than zero percent for a FY and may result in payment rates that are less than payment rates for the preceding FY. Any reduction based on failure to comply with the reporting requirements, as required by section 1814(i)(5)(B) of the Act, would apply only for the specified year. Typically, about 18 percent of Medicare-certified hospices are found non-compliant with the HQRP reporting requirements and subject to the APU payment reduction for a given FY.

In the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), we finalized two new measures using claims data: (1) Hospice Visits in the Last Days of Life (HVLDL); and (2) Hospice Care Index (HCI). We also finalized a policy that claims-based measures would use 8 quarters of data in order to publicly report on more hospices.

In addition, we removed the seven Hospice Item Set (HIS) Process Measures from the program as individual measures and public reporting because the HIS Comprehensive Assessment Measure is sufficient for measuring care at admission without the seven individual process measures. For a detailed discussion of the historical use for measure selection and removal for the HQRP quality measures, we refer readers to the FY 2016 Hospice Wage Index and Rate Update final rule (80 FR 47142) and the FY 2019 Hospice Wage Index and Rate Update final rule (83 FR 38622). In the FY 2022 Hospice Wage Index and Rate Update final rule (86 FR 42553), we finalized § 418.312(b)(2), which requires hospices to provide administrative data, including claims-based measures, as part of the HQRP requirements for § 418.306(b). In that same final rule, we provided CAHPS Hospice Survey updates. We finalized temporary changes to our public reporting policies based on the March 27, 2020

memorandum[35] and provided another tip sheet, referred to as the "Third Edition HQRP Public Reporting Tip Sheet" on the HQRP Requirements and Best Practices webpage.

As finalized in the FY 2022 Hospice Wage Index and Payment Rate Update final rule (86 FR 42552), public reporting of the two new claims-based quality measures (QMs), the Hospice Visits in Last Days of Life (HVLDL) and the Hospice Care Index (HCI) is available on the Care Compare/Provider Data Catalogue (PDC) webpages as of the August 2022 refresh. In the FY 2023 Hospice proposed rule (87 FR 19442), we did not propose any new quality measures. However, we provide updates on already-adopted measures. Table 12 shows current quality measures finalized since the FY 2022 Hospice Wage Index and Payment Rate Update final rule.

TABLE: 12 Quality Measures in Effect for the Hospice Quality Reporting Program

Hospice Quality Reporting Program
Hospice Item set
Hospice and Palliative Care Composite Process Measure—HIS-Comprehensive Assessment Measure at Admission includes: 1. Patients Treated with an Opioid who are Given a Bowel Regimen 2. Pain Screening 3. Pain Assessment 4. Dyspnea Treatment 5. Dyspnea Screening 6. Treatment Preferences 7. Beliefs/Values Addressed (if desired by the patient)
Administrative Data, including Claims-based Measures
Hospice Visits in Last Days of Life (HVLDL)

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

Hospice Care Index (HCI)
1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided
2. Gaps in Skilled Nursing Visits
3. Early Live Discharges
4. Late Live Discharges
5. Burdensome Transitions (Type 1)–Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission
6. Burdensome Transitions (Type 2)–Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital
7. Per-beneficiary Medicare Spending
8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day
9. Skilled Nursing Minutes on Weekends
10. Visits Near Death
CAHPS Hospice Survey
CAHPS Hospice Survey
1. Communication with Family
2. Getting timely help
3. Treating patient with respect
4. Emotional and spiritual support
5. Help for pain and symptoms
6. Training family to care for the patient
7. Rating of this hospice
8. Willing to recommend this hospice

2. Proposed Hospice Outcomes & Patient Evaluation (HOPE) Update

As finalized in the FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements final rule (84 FR 38484), we are developing a hospice instrument named Hospice Outcomes & Patient Evaluation (HOPE). Our primary objectives for HOPE are to provide quality data for the HQRP requirements through standardized data collection; and provide additional clinical data that could inform future payment refinements. To the extent that the instrument utilizes data already being collected for the Hospice QRP, our statutory authority for the HOPE instrument derives from section 1814(i)(5)(C) of the Act. In addition, statutory language at section 1861(aa)(2)(G) of the Act permits the Secretary to impose "such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services."

The HOPE tool would be a component of implementing high-quality and safe hospice

care for patients, both in Medicare and non-Medicare. HOPE would also contribute to the patient's plan of care through providing patient data ongoing throughout the hospice stay. By providing data from multiple time points across the hospice stay, HOPE would provide information to hospice providers to improve practice and care quality. HOPE is intended to provide quality data to calculate outcomes and develop additional quality measures.

We stated in the FY 2022 Hospice Wage Index and Payment Update final rule (86 FR 42528) that while the standardized patient assessment data elements for certain post-acute care providers required under the IMPACT Act of 2014 are not applicable to hospices, it would be reasonable to include some of those standardized elements that appropriately and feasibly apply to hospice to the extent permitted by our statutory authority. Many patients move through other providers within the healthcare system to hospice. Therefore, considering tracking key demographic and social risk factor items that apply to hospice could support our goals for continuity of care, overall patient care and well-being, development of infrastructure for the interoperability of electronic health information, and health equity which is also discussed in this rule.

In the FY 2023 Hospice final rule (87 FR 45669), we outlined the testing phases HOPE has undergone, including cognitive, pilot, alpha testing, and national beta field testing.

National beta testing, completed at the end of October 2022, allowed us to obtain input from participating hospice teams about the assessment instrument and field testing to refine and support the final draft items and time points for HOPE. It also allowed us to estimate the time to complete the HOPE data items and establish the interrater reliability of each item.

We continue HOPE development in accordance with the Blueprint for the CMS Measures Management System. The development of HOPE is grounded in information gathering activities to identify and refine hospice domains and candidate items. We appreciate the industry's and trade associations' engagement in providing input through information sharing activities, including listening sessions, expert interviews, key stakeholder interviews, and focus groups to

support HOPE development. As CMS proceeds with the refinement of HOPE, we will continue to engage with stakeholders through sub-regulatory channels. We intend to continue to host HQRP Forums to allow hospices and other interested parties to engage with us on the latest updates and ask questions on the development of HOPE and related quality measures as appropriate. We also have a dedicated email account, HospiceAssessment@cms.hhs.gov, for comments about HOPE. We will use field test results to create a final version of HOPE to propose in future rulemaking for national implementation. We will continue to inform all stakeholders throughout this process by using a variety of sub-regulatory channels and regular HQRP communication strategies, such as Open Door Forums (ODF), Medicare Learning Network (MLN), CMS.gov website announcements, listserv messaging, and other ad hoc publicly announced opportunities. We appreciate the support for HOPE and reiterate our commitment to providing updates and engaging stakeholders through sub-regulatory means. HOPE updates can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE and engagement opportunities, including those regarding HOPE are at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.

We plan to provide additional information regarding HOPE testing results on the HQRP website in late Spring of 2023.

3. Proposed Update on Future Quality Measure (QM) Development

In the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38484), we provided updates related to CMS's process for identifying high priority areas of quality measurement and improvement and for developing quality measures that address those priorities. Information on the current HQRP quality measures can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.

In this proposed rule, we provide updates on the status of current HQRP measures and the development of hospice quality measure concepts based on the future use of HOPE, administrative, and health equity data. On July 26, 2022, the CBE endorsed the claims-based Hospice Visits in the Last Days of Life measure (HVLDL). More information can be found on the HQRP Quality Measure Development webpage: https://www.cms.gov/medicare/hospice-quality-reporting-program/quality-measure-development. CMS intends to develop several quality measures based on information collected by HOPE when it is implemented. Currently, CMS intends to develop at least two HOPE-based process and outcome quality measures: (1) Timely Reassessment of Pain Impact; and (2) Timely Reassessment of Non-Pain Symptom Impact. Additional information about CMS's HOPE-based measure development efforts is available in the 2021 technical expert panel (TEP) Summary Reports and the 2021 Information Gathering Report, available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.

4. Proposed Health Equity Updates related to HQRP

a. Background

In the FY 2023 Hospice Payment Rate Update proposed rule (87 FR 19442), we included a Request for Information (RFI) on hospices' current health equity activities and a future approach to advancing health equity in hospice. We define health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. We are working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to

thrive. CMS' goals outlined in the *CMS Framework for Health Equity 2022–2023* are in line with Executive Order 13985, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government."[36] The goals included in the *CMS Framework for Health Equity* serve to further advance health equity, expand coverage, and improve health outcomes for the more than 170 million individuals supported by our programs, and sets a foundation and priorities for our work, including: strengthening our infrastructure for assessment, creating synergies across the health care system to drive structural change, and identifying and working to eliminate barriers to CMS-supported benefits, services, and coverage.

In addition to the *CMS Framework for Health Equity*, CMS seeks to "advance health equity" as one of eight goals comprising the CMS National Quality Strategy (NQS).[37] The NQS identifies a wide range of potential quality levers that can support our advancement of equity, including: establishing a standardized approach for patient-reported data and stratification; employing quality and value-based programs to publicly report and incentivize closing equity gaps; and developing equity-focused performance metrics, regulations, oversight strategies, and quality improvement initiatives.

A goal of this NQS is to address persistent disparities that underly our healthcare system. Racial disparities, in particular, are estimated to cost the U.S. $93B in excess medical costs and $42B in lost productivity per year, in addition to economic losses due to premature deaths.[38] At the same time, racial and ethnic diversity has increased in recent years with an increase in the percentage of people who identify as two or more races accounting for most of the change, rising

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[36] https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01753.pdf.

[37] Centers for Medicare & Medicaid Services. What is the CMS Quality Strategy? Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy.

[38] Ani Turner, The Business Case for Racial Equity, A Strategy for Growth, W.K. Kellogg Foundation and Altarum, April 2018.

from 2.9 percent to 10.2 percent between 2010 and 2020.[39] Therefore, we need to consider ways to reduce disparities, achieve equity, and support our diverse population through the way we measure quality and display of data.

We solicited public comments via the aforementioned RFI on a potential health equity structural composite measure in the Hospice Quality Reporting Program. CMS defines a health equity quality measure as a measure (or group of measures) that has the capability to identify, quantify, characterize, and/or link drivers of health and related needs to disparities in health access, processes, outcomes, or patient experiences; the measure(s) can be used to inform the design, implementation, and evaluation of interventions to advance equitable opportunity for optimal health and well-being for all individuals and populations. We refer readers to the FY 2023 Hospice Payment Rate Update final rule (87 FR 45669) for a summary of the public comments and suggestions received in response to the health equity RFI.

We took these comments into account, and we continue to work to develop policies, quality measures, and measurement strategies on this important topic. After considering public comments, CMS decided to convene a health equity technical expert panel to provide additional input to inform the development of health equity quality measures. The work of this technical expert panel is described in detail below.

Home Health and Hospice Health Equity Technical Expert Panel:

To support new health equity measure development, the Home Health and Hospice Health Equity Technical Expert Panel (Home Health & Hospice HE TEP) was convened by a CMS contractor in Fall 2022. The Home Health & Hospice HE TEP was comprised of health equity experts from hospice and home health settings, specializing in quality assurance, patient advocacy, clinical work, and measure development. The TEP was charged with providing input

[39] 2022 National Healthcare Quality and Disparities Report. Content last reviewed November 2022. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.

on a potential cross-setting health equity structural composite measure concept as set forth in the FY 2023 Hospice Payment Rate Update proposed rule (87 FR 19442) as part of an RFI related to the HQRP Health Equity Initiative. Specifically, the TEP assessed the face validity and feasibility of the potential structural measure. The TEP also provided input on possible confidential feedback report options to be used for monitoring health equity. TEP members also had the opportunity to provide ideas for additional health equity measure concepts or approaches to addressing health equity in hospice and home health settings. A summary of the Home Health & Hospice HE TEP meetings and final TEP recommendations would be available in 2023.

Universal Foundation

To further the goals of the CMS National Quality Strategy (NQS) , CMS leaders from across the Agency have come together to move towards a building-block approach to streamline quality measures across CMS quality programs for the adult and pediatric populations. This "Universal Foundation" of quality measure will focus provider attention, reduce burden, identify disparities in care, prioritize development of interoperable, digital quality measures, allow for cross-comparisons across programs, and help identify measurement gaps. The development and implementation of the Preliminary Adult and Pediatric Universal Foundation Measures will promote the best, safest, and most equitable care for individuals as we all come together on these critical quality areas. As CMS moves forward with the Universal Foundation, we will be working to identify foundational measures in other specific settings and populations to support further measure alignment across CMS programs as applicable.

To learn more regarding the impact and next steps of the Universal Foundation, read the recent publication of "Aligning Quality Measures Across CMS - the Universal Foundation" in the New England Journal of Medicine at https://www.nejm.org/doi/pdf/10.1056/NEJMp2215539.

b. Anticipated Future State

Possible Future Health Equity Efforts

We are committed to developing approaches to meaningfully incorporate the advancement of health equity into the HQRP. One consideration is including social determinants of health into our quality measures and data stratification. Social determinants of health—social, economic, environmental, and community conditions—may have a stronger influence on the population's health and well-being than services delivered by practitioners and healthcare delivery organizations.[40] Given these impacts, measure stratification is important. Measure stratification helps identify disparities by calculating quality measure outcomes separately for different beneficiary populations. By looking at measure results for different populations separately, CMS and providers can see how care outcomes may differ between certain patient populations in a way that would not be apparent from an overall score (i.e., a score averaged over all beneficiaries). This helps CMS to better fulfill our health equity goals. For example, when certain quality measures from the past two decades related to healthcare outcomes for children are stratified by race, ethnicity, and income, they show that important health disparities have been narrowed, because outcomes for children in the lowest income households and for Black and Hispanic children improved faster than outcomes for children in the highest income households or for White children.[41] This differential impact would not be apparent without stratification. This work supports our desire to understand with providers what can be learned from stratifying our quality measures by race, ethnicity, and income.

As part of our efforts to advance health equity in hospice, we are taking into consideration the health equity measures used in other health care provider settings. There are social determinants of health (SDOH) data items in the standardized patient assessment instruments used in the post-acute care (PAC) settings, and data items related to social drivers of

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[40] 2022 National Healthcare Quality and Disparities Report. Content last reviewed November 2022. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.

[41] 2022 National Healthcare Quality and Disparities Report. Content last reviewed November 2022. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.

health in acute care settings such as the hospital inpatient quality reporting program. We see value in aligning SDOH data items across all care settings and might consider adding SDOH data items used by other care settings into HQRP as we develop future health equity quality measures under our HQRP statutory authority.[42] This would further the NQS to align quality measures across our programs as part of the Universal Foundation.[43]

As we move this important work forward, we will continue to take input from hospice stakeholders into account and monitor the application of proposed health equity policies across CMS and other HHS initiatives. As of this publication, the Initial Proposals for Updating OMB's Race and Ethnicity Statistical Standards, 88 FR 5375, seeks public comment. Also, the Office of the National Coordinator for Health IT (ONC) welcomes input on data classes and data elements for future versions of the United States Core Data for Interoperability (USCDI) - a standardized set of health data classes and constituent data elements for nationwide, interoperable health information exchange.[44] In addition, while the anticipated health equity efforts that impact policy changes would proceed through the notice and comment rulemaking process, other activities would be completed through sub-regulatory channels and regular communication strategies, such as Open-Door Forums, Medicare Learning Network, CMS.gov website announcements, listserv messaging, and other opportunities.

5. Proposed CAHPS Hospice Survey Updates

CAHPS Hospice Survey Mode Experiment

In the FY 2023 Hospice Payment Rate Update final rule (87 FR 45669), we provided information on a mode experiment CMS conducted in 2021. The purpose of the experiment was to test:

[42] https://www.nejm.org/doi/full/10.1056/NEJMp2215539, February 1, 2023.
[43] https://www.nejm.org/doi/full/10.1056/NEJMp2215539, February 1, 2023.
[44] https://www.healthit.gov/sites/isa/files/2023-01/Draft-USCDI-Version-4-January-2023-Final.pdf.

- A web-mail mode (email invitation to a web survey, with mail follow-up to non-responders).
- A revised survey version, which is shorter and simpler than the current survey, and includes new questions on topics suggested by stakeholders.
- Modifications to survey administration protocols designed to improve overall response rates, such as a prenotification letter and extended field period.

Fifty-six large hospices participated in the mode experiment, representing a range of geographic regions, ownership, and past performance on the CAHPS Hospice Survey. A total of 15,515 decedents/caregivers were randomly sampled from these hospices. Sampled decedents/caregivers were randomly assigned to one of four modes of administration (mail only, telephone only, mail-telephone, web-mail); mail only cases were randomly assigned to be administered either the revised or the current survey.

The information received on the CAHPS Hospice Survey Mode Experiment CMS conducted in 2021, resulted in the following findings:

- Response rates to the revised survey were 35.1 percent in mail only mode, 31.5 percent in telephone only mode, 45.3 percent in mail-telephone, and 39.7 percent in web-mail mode;
- Response rates to web-mail mode were similar to mail only mode for those without email addresses (35.2 percent vs. 34.4 percent), but 13 percentage points higher for those with email addresses (49.6 percent vs. 36.7 percent);
- Response rates to mail-only administration of the revised and current survey were similar (35.1 percent vs. 34.2 percent);
- Mailing of a prenotification letter resulted in an increased response rate of 2.4 percentage points;
- Extending the field period to 49 days (from the current 42 days) resulted in an increased response rate of 2.5 percentage points in the mail only mode.

In addition, the following changes were tested as part of the revised CAHPS Hospice Survey:

- Removal of one survey item regarding confusing or contradictory information from the Hospice Team Communication measure;
- Replacement of the multi-item Getting Hospice Care Training measure with a new, one-item summary measure;
- Addition of a new, two-item Care Preferences measure;
- Simplified wording to component items in the Hospice Team Communication, Getting Timely Care, and Treating Family Member with Respect measures

CMS will use mode experiment results to inform decisions about potential changes to administration protocols and survey instrument content. Potential measure changes will be submitted to the Measures Under Consideration (MUC) process in 2023 and may be proposed in future rulemaking. We are not proposing any changes in this rule.

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

a. Statutory Penalty for Failure to Report

Section 1814(i)(5)(C) of the Act requires that each hospice submit data to the Secretary on quality measures specified by the Secretary. The data must be submitted in a form and manner, and at a time specified by the Secretary. Section 1814(i)(5)(A)(i) of the Act was amended by the CAA 2021 and the payment reduction for failing to meet hospice quality reporting requirements is increased from 2 percent to 4 percent beginning with FY 2024. The Act requires that, beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and then beginning in FY 2024 and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. In the FY 2023 Hospice Wage Index and Payment Rate Update proposed rule (87 FR 19442), we revised our regulations at § 418.306(b)(2) in accordance with this statutory change

(86 FR 42605). We are not proposing any new public reporting proposals in this rule.

b. Compliance

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

For every CY, all Medicare-certified hospices are required to submit HIS and CAHPS data according to the requirements in § 418.312. Table 13 summarizes the three timeframes. It illustrates how the CY interacts with the FY payments, covering the CY 2022 through CY 2025 data collection periods and the corresponding APU application from FY 2024 through FY 2027.

TABLE: 13 HQRP Reporting Requirements and Corresponding Annual Payment Updates

Reporting Year for HIS and Data Collection Year for CAHPS data	Annual Payment Update Impacts Payments for the FY	Reference Year for CAHPS Size Exemption (CAHPS only)
CY 2022	FY 2024 APU	CY 2021
CY 2023	FY 2025 APU	CY 2022
CY 2024	FY 2026 APU	CY 2023
CY 2025	FY 2027 APU	CY 2024

As illustrated in Table 13, CY 2022 data submissions compliance impacts the FY 2024 APU. CY 2023 data submissions compliance impacts the FY 2025 APU. CY 2024 data submissions compliance impacts FY 2026 APU. This CY data submission impacting FY APU

pattern follows for subsequent years.

c. Submission of Data Requirements

As finalized in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142, 47192), hospices' compliance with HIS requirements beginning with the FY 2020 APU determination (that is, based on HIS-Admission and Discharge records submitted in CY 2018) are based on a timeliness threshold of 90 percent. This means CMS requires that hospices submit 90 percent of all required HIS records within 30 days of the event (that is, patient's admission or discharge). The 90-percent threshold is hereafter referred to as the timeliness compliance threshold. Ninety percent of all required HIS records must be submitted and accepted within the 30-day submission deadline to avoid the statutorily-mandated payment penalty. Hospice compliance with claims data requirements is based on administrative data collection. Since Medicare claims data are already collected from claims, hospices are considered 100 percent compliant with the submission of these data for the HQRP. There is no additional submission requirement for administrative data.

To comply with CMS' quality reporting requirements for CAHPS, hospices are required to collect data monthly using the CAHPS Hospice Survey. Hospices comply by utilizing a CMS-approved third-party vendor. Approved Hospice CAHPS vendors must successfully submit data on the hospice's behalf to the CAHPS Hospice Survey Data Center. A list of the approved vendors can be found on the CAHPS Hospice Survey website: www.hospicecahpssurvey.org. Table 14, HQRP Compliance Checklist, illustrates the APU and timeliness threshold requirements.

TABLE:14 HQRP Compliance Checklist

Annual Payment Update	HIS	CAHPS

FY 2024	Submit at least 90 percent of all HIS records or its successor instrument within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/22 – 12/31/22.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2022 – 12/31/2022
FY 2025	Submit at least 90 percent of all HIS records or its successor instrument within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/23 – 12/31/23.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2023 – 12/31/2023
FY 2026	Submit at least 90 percent of all HIS records or its successor instrument within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/24 – 12/31/24.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2024 – 12/31/2024
FY 2027	Submit at least 90 percent of all HIS records or its successor instrument within 30 days of the event date (patient's admission or discharge) for patient admissions/discharges occurring 1/1/25 – 12/31/25.	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2025 – 12/31/2025

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

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

d. Proposal to Codify HQRP Data Completion Thresholds

As previously noted, we are proposing to add paragraph (j) to § 418.312 for data completion thresholds. In the FY 2016 Hospice Wage Index final rule (80 FR 47192 through

47193), we finalized HQRP thresholds for completeness of HQRP data submissions. To ensure that hospices are meeting an acceptable standard for completeness of submitted data, we finalized the policy that, beginning with the FY 2018 HQRP, hospices must meet or exceed one data submission threshold. Hospices must meet or exceed a data submission threshold set at 90 percent of all required HIS or successor instrument records within 30 days of the event (that is, patient's admission or discharge).

Under our finalized policy, some assessment data did not obtain a response and, in those circumstances, are not "missing" nor is the data incomplete. For example, in the case of a patient who does not have any of the medical conditions in a "check all that apply" listing, the absence of a response of a health condition indicates that the condition is not present, and it would be incorrect to consider the absence of such data as missing in a threshold determination.

In the FY 2017 Hospice Wage Index proposed rule (81 FR 25498), we received comments on our previously finalized policies for form, manner, and timing of data collection. These public comments were considered and summarized in the FY 2017 Hospice Wage Index final rule (81 FR 52143). In the FY 2022 Hospice Wage Index and Payment Rate Update final rule and the FY 2023 Hospice Wage Index and Payment Rate Update final rule (87 FR 45669), we provided an HQRP Compliance Checklist, which illustrated additional details about how the compliance thresholds applied to APUs by FY.

We propose to codify these data completeness thresholds at § 418.312(j)(1) for measures data collected using the HIS or a successor instrument. Under this section, we propose to codify our requirement that hospices must meet or exceed a data submission threshold set at 90 percent of all required HIS or successor instrument records within 30 days of the event (that is, patient's admission or discharge) and submit the data through the CMS designated data submission systems. This threshold would apply to all HIS or successor instrument-based measures and data elements adopted into HQRP. We also propose to codify § 418.312(j)(2) that a hospice must meet or exceed this threshold to avoid receiving a 4-percentage point reduction to its annual

payment update for a given FY as codified at § 418.306(b)(2).

We invite public comment on our proposal to codify in regulations text the HQRP data completion thresholds at § 418.312(j) for measures and standardized patient assessment elements collected using the HIS or successor instrument and compliance threshold to avoid receiving 4 percentage point reduction as described under § 412.306(b)(2).

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

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

This law (CAA 2021) requires public reporting of hospice program surveys conducted by both State Agencies (SAs) and Accrediting Organizations (AOs), as well as enforcement actions taken as a result of these surveys on the CMS website in a manner that is prominent, easily accessible, searchable, and presented in a readily understandable format. It removes the prohibition at section 1865(b) of the Act of public disclosure of hospice surveys performed by AOs, and requires that AOs use the same survey deficiency reports as SAs (Form CMS-2567, "Statement of Deficiencies," or a successor form) to report survey findings.

The CAA 2021 also requires hospice programs to measure and reduce inconsistency in the application of survey results among all hospice program surveyors, and requires the Secretary to provide comprehensive training and testing of SA and AO hospice program surveyors, including training with respect to review of written plans of care. The CAA 2021 prohibits SA surveyors from surveying hospice programs for which they have worked in the last 2 years or have a financial interest, requires hospice program SAs and AOs to use a multidisciplinary team of individuals for surveys conducted with more than one surveyor to include at least one RN and provides that each SA must establish a dedicated toll-free hotline to collect, maintain, and update

information on hospice programs and to receive complaints.

The provisions in the CAA 2021 also direct the Secretary to create a Special Focus Program (SFP) for poor-performing hospice programs, sets out authority for imposing enforcement remedies for noncompliant hospice programs, and requires the development and implementation of a range of remedies as well as procedures for appealing determinations regarding these remedies. These remedies can be imposed instead of, or in addition to, termination of a hospice programs' participation in the Medicare program. The remedies include civil money penalties (CMPs), suspension of all or part of payments, and appointment of temporary management to oversee operations.

In the CY 2022 Home Health Prospective Payment System (HH PPS) final rule (86 FR 62240), we addressed provisions related to the hospice survey enforcement and other activities described in this section. A summary of the finalized CAA provisions can be found in the CY 2022 HH PPS final rule: https://www.govinfo.gov/content/pkg/FR-2021-11-09/pdf/2021-23993.pdf. We finalized all the CAA provisions in CY 2022 rulemaking except for the special focus program (SFP). As outlined in the CY 2022 HH PPS final rule, we stated that we would take into account comments that we received and work on a revised proposal, seeking additional collaboration with stakeholders to further develop the methodology for the SFP since the publication of the CY 2022 HH PPS final rule.

In the FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (87 FR 45669) final rule, we affirmed our intention to initiate a hospice special focus program Technical Expert Panel (TEP) to provide input on the structure and methodology of the SFP. Public comments received in response to the FY 2023 Hospice Wage Index and Payment Rate Update proposed rule were generally supportive of CMS's efforts to establish an SFP and to convene a TEP to provide feedback on the development of the SFP. A TEP convened by a CMS contractor provided feedback and considerations on the preliminary SFP concepts, including the development of a methodology to identify hospice poor-performers,

as well as graduation and termination criteria, and public reporting. A 30-day call for nominations was held July 14 through August 14, 2022 and nine TEP members were selected, representing a diverse range of experience and expertise related to hospice care and quality. The final TEP feedback will be publicly available on the CMS website in April 2023.

Accordingly, CMS plans to include a proposal implementing an SFP in the CY 2024 Home Health Prospective Payment Update Rate proposed rule.

E. Proposals Regarding Hospice Ordering/Certifying Physician Enrollment

1. Medicare Provider Enrollment

Section 1866(j)(1)(A) of the Act requires the Secretary to establish a process for the enrollment of providers and suppliers into the Medicare program. The overarching purpose of the enrollment process is to help confirm that providers and suppliers furnishing services or items (or ordering/certifying the provision thereof) to Medicare beneficiaries meet all applicable Federal and state requirements. The process is, to an extent, a "gatekeeper" that prevents unqualified and potentially fraudulent individuals and entities from entering and inappropriately billing Medicare. Since 2006, we have undertaken rulemaking efforts to outline our enrollment procedures. These regulations are generally codified in 42 CFR part 424, subpart P (currently §§ 424.500 through 424.575 and hereafter occasionally referenced as subpart P). They address, among other things, requirements that providers and suppliers must meet to enroll in Medicare.

As outlined in § 424.510, one requirement is that the provider or supplier must complete, sign, and submit to its assigned Medicare Administrative Contractor (MAC) the appropriate enrollment form, typically the Form CMS-855 (OMB Control No. 0938-0685). The Form CMS-855, which can be submitted via paper or electronically through the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) process (System of Record Notice (SORN): 09-70-0532), collects important information about the provider or supplier. Such data includes, but is not limited to, general identifying information (for example, legal business name), licensure and/or certification data, and practice locations. After receiving the provider's or

supplier's initial enrollment application, CMS or the MAC reviews and confirms the information thereon and determines whether the provider or supplier meets all applicable Medicare requirements. We believe this screening process has greatly assisted CMS in executing its responsibility to prevent Medicare fraud, waste, and abuse.

As previously mentioned, over the years we have issued various final rules pertaining to provider enrollment. These rules were intended not only to clarify or strengthen certain components of the enrollment process but also to enable us to take further action against providers and suppliers: (1) engaging (or potentially engaging) in fraudulent or abusive behavior; (2) presenting a risk of harm to Medicare beneficiaries or the Medicare Trust Funds; or (3) that are otherwise unqualified to furnish Medicare services or items. Consistent with this, and for reasons explained in section III.E.2. of this proposed rule, we are proposing to require physicians who order or certify hospice services for Medicare beneficiaries (hereafter occasionally referenced as "hospice physicians") to be enrolled in or validly opted-out of Medicare as a prerequisite for the payment of the hospice service in question.

2. Statutory and Policy Background

Section 6405(a) of the Affordable Care Act (which amended section 1834(a)(11)(B) of the Act) states that the Secretary may require that a physician ordering durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) be enrolled in Medicare for payment for the DMEPOS item to be made. Section 6405(b) of the Affordable Care Act (which amended sections 1814(a)(2) and 1835(a)(2) of the Act) contains a similar provision regarding the certification of a physician (or certain eligible professionals) for Part A and B home health services. Section 6405(c) of the Affordable Care Act, meanwhile, authorizes the Secretary to extend the requirements of sections 6405(a) and (b) to all other categories of items or services under title XVIII of the Act (including covered Part D drugs) that are ordered, prescribed, or referred by a physician or eligible professional enrolled in Medicare under section 1866(j) of the Act.

Pursuant to this authority, we finalized 42 CFR 424.507(a) and (b) in an April 27, 2012 final rule titled "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements" (77 FR 25284). Section 424.507(a) and (b) collectively state that for payment to be made for ordered imaging services, clinical laboratory services, DMEPOS items, or home health services, the service or item must have been ordered or certified by a physician or, when permitted, an eligible professional who -- (1) is enrolled in Medicare in an approved status; or (2) has a valid opt-out affidavit on file with a Part A and B MAC. The purpose of § 424.507(a) and (b) is to confirm that the physicians and eligible professionals who order or certify the items and services referenced in those paragraphs are qualified.

In a proposed rule titled "Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process," which was published in the **Federal Register** on March 1, 2016 (81 FR 10720), we proposed to significantly expand the scope of § 424.507(a) and (b) to include physicians and eligible professionals furnishing, ordering, referring, certifying, or prescribing any Part A and Part B service, item, or drug. Section 424.507(a) and (b) would no longer have been restricted to the four services and items referenced therein. A number of commenters expressed concern about the burden of having to enroll in Medicare pursuant to our proposal. Largely for this reason, we did not finalize our proposal in the subsequent September 10, 2019 final rule with comment period.[45]

This non-finalization did not, however, negate our aforementioned and continued authority under section 6405(c) of the Affordable Care Act to apply the requirements of sections 6405(a) and (b) of the Affordable Care Act to other categories of Medicare covered items and services. We constantly review program integrity trends to determine whether certain provider and supplier types and services warrant closer scrutiny from a provider enrollment perspective.

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[45] "Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process" (84 FR 47794).

During this process, and notwithstanding the previously mentioned non-finalization, we have remained ready to propose expansions to § 424.507(a) and (b) should circumstances warrant. We believe that the latter situation currently exists with respect to hospices.

The OIG in July 2018 issued a study titled "Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity" (OEI-02-16-00570). This report noted that Medicare in 2016 spent about $16.7 billion for hospice care for 1.4 million beneficiaries, up from $9.2 billion for fewer than 1 million beneficiaries in 2006; with this growth, the OIG stated, "significant vulnerabilities have arisen, one of which involves improper activity."[46] The report described how some hospice fraud schemes involved paying recruiters to target beneficiaries who are not eligible for hospice care;, other schemes involved physicians falsely certifying beneficiaries as terminally ill when they were not.[47] (Pursuant to 42 CFR 418.20(b), a physician must certify the beneficiary as being terminally ill in order for the beneficiary to be eligible to elect hospice care.) The OIG cited several examples of this behavior, including the following:

- Two certifying physicians from a California hospice were convicted of health care fraud for falsely certifying beneficiaries as terminally ill. The false certifications were part of a wider fraud scheme that the hospice owner organized. The scheme involved illegal payments to patient recruiters for bringing in beneficiaries, establishing fraudulent diagnoses, and altering medical records.[48]

- A Mississippi hospice owner used patient recruiters to solicit beneficiaries who were not eligible for hospice care. These patients were unaware of their enrollment in hospice care. The owner submitted fraudulent charges and received more than $1 million from Medicare.[49]

- A Minnesota-based hospice chain agreed to pay $18 million to resolve allegations that it improperly billed Medicare for care provided to beneficiaries who were ineligible for

[46] https://oig.hhs.gov/oei/reports/oei-02-16-00570.pdf, p. 1.
[47] Ibid., 6.
[48] Ibid., p. 7.
[49] Ibid.

hospice because they were not terminally ill. The hospice chain also allegedly discouraged physicians from discharging ineligible beneficiaries.[50]

- A hospice physician improperly certified a beneficiary who a hospital determined to be in "good shape" only days before as terminally ill.[51]
- A hospice falsely informed a beneficiary that she could remain on a liver transplant list even if she chose hospice care. However, she was removed from the transplant list when she elected hospice care. When the beneficiary learned of this, she ceased hospice care so she could be reinstated on the transplant list.[52]
- A physician received kickbacks for recruiting beneficiaries, many of whom were not terminally ill but seeking opioids.[53]

More generally, the OIG expressed concern that: (1) beneficiaries are put at risk when they are inappropriately enrolled in hospice care because they might be unwittingly forgoing needed treatment;[54] (2) "some hospice physicians are not always meeting requirements when certifying beneficiaries for hospice care;"[55] and (3) hospice fraud schemes are growing.[56]

We note further that the Government Accountability Office (GAO) in October 2019 issued a report titled "Medicare Hospice Care: Opportunities Exist to Strengthen CMS Oversight of Hospice Providers" (GAO-20-10).[57] The GAO observed therein that the number of: (1) Medicare hospice beneficiaries had almost tripled to nearly 1.5 million by fiscal year 2017; and (2) Medicare hospice providers had doubled.[58] The GAO stated that in light of this growth: "It is imperative that CMS's oversight of the quality of Medicare hospice care keeps pace with

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[50] Ibid.
[51] Ibid., p. 6.
[52] Ibid.
[53] Ibid., p. 12.
[54] Ibid., p. 6.

[55] Ibid., p. 12.

[56] Ibid.

[57] https://www.gao.gov/assets/gao-20-10.pdf.
[58] Ibid., p. 25.

changes so that the agency can ensure the health and safety of these terminally ill beneficiaries."[59]

In light of the foregoing, we believe that expanding § 424.507(a) and (b) to include hospice services could strengthen the program integrity aspect of physician certifications. The careful screening that the enrollment process entails would help us determine whether the physician meets all Federal and state requirements (such as licensure) or presents any program integrity risks, such as past final adverse actions (as that term is defined in § 424.502). If an unenrolled physician certifies a Medicare beneficiary's need for hospice care, we have insufficient background on the physician to know whether he or she was qualified to do so or has an adverse history. We believe that some of the aforementioned examples of improper behavior the OIG found can be at least partially avoided through closer vetting of the physician. Moreover, the screening process could help foster beneficiary health and safety by ensuring the physician is appropriately licensed.

3. Proposed Provisions

Using our authority under section 6405(c) of the Affordable Care Act, we accordingly propose the following revisions to § 424.507.

First, the current heading of § 424.507(b) is "Conditions for payment of claims for covered home health services". We propose to add "and hospice" between "health" and "services" to account for our intended inclusion of hospice services within § 424.507(b).

Second, the introductory text of § 424.507(b) reads: "To receive payment for covered Part A or Part B home health services, a provider's home health services claim must meet all of the following requirements:". To accommodate hospice services, we would revise this to state: "To receive payment for covered Part A or Part B home health services or for covered hospice services, a provider's home health or hospice services claim must meet all of the following requirements:".

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[59] Ibid.

Third, the opening language of § 424.507(b)(1) states: "The ordering/certifying physician, or the ordering/certifying physician assistant, nurse practitioner, or clinical nurse specialist working in accordance with State law…..". Under 42 CFR 418.22(b), and as alluded to previously, only a physician (which can include the hospice's medical director) can certify that the beneficiary is terminally ill. We propose to revise the beginning of § 424.507(b)(1) to state: "The ordering/certifying physician for hospice or home health services, or, for home health services, the ordering/certifying physician assistant, nurse practitioner, or clinical nurse specialist working in accordance with State law…..". This would help clarify that § 424.507(b)(1) should not be read to imply that the eligible professionals listed therein can certify the beneficiary's terminal status.

Fourth, we note that § 418.22(c)(1)(i) and (ii) state that for the initial 90-day hospice period, the following physicians, respectively, must certify that the beneficiary is terminally ill: (1) the hospice's medical director or the physician member of the hospice interdisciplinary group; and (2) the individual's attending physician (who must meet the definition of physician in § 410.20) if the beneficiary has one. For subsequent hospice periods, § 418.22(c)(2) states that only one of the physicians in § 418.22(c)(1)(i) must provide the certification. Given the hospice program integrity concerns previously mentioned, we believe that each certification required under § 418.22(c) should be by an enrolled or validly opted-out physician. Therefore, we propose to add § 424.507(b)(3) to reflect this requirement and would refer therein to the requirements of § 418.22(c).

As already mentioned, we did not finalize our March 1, 2016 proposed revisions to § 424.507(b)(1) due partly to the burden involved. Our intended changes to § 424.507(b)(1) in this proposed rule would be significantly less burdensome on health care providers and suppliers than our March 1, 2016 proposal because they would only impact one additional provider/supplier type. Moreover, many hospice certifying physicians are already enrolled in Medicare or have validly opted-out, meaning that they need take no action should our proposal

be finalized, thus further reducing the burden on the hospice physician community. We seek comment on this proposal.

4. Additional Information

We note that CMS is taking steps in the area of provider enrollment to capture additional information about provider and supplier ownership, including for hospices. For instance, we proposed in a December 15, 2022 Paperwork Reduction Act submission (87 FR 76626) to revise the Form CMS-855A Medicare provider enrollment application (Medicare Enrollment Application - Institutional Providers; OMB Control No. 0938-0685) to collect from providers/suppliers that complete this form important data such as (but not limited to):

- Requiring the provider/supplier/hospice to specifically identify via a checkbox whether a reported organizational owner is itself owned by another organization or individual.
- Requiring the provider/supplier/hospice to explicitly identify whether a listed organizational owner/manager does or does not fall within the categories of entities listed on the application (e.g., holding company, investment firm, etc.), with "private-equity company" and "real estate investment trust" added to this list of types of organizations.

This information will help CMS better understand the provider/supplier/hospice's indirect ownership relationships and the types of entities that own it. Moreover, CMS is considering additional provider enrollment measures related to hospice ownership and management as a means of strengthening protections against hospice fraud schemes and to improve transparency.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section

3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this rule that contain information collection requirements.

A. Hospice Certifying Physician Enrollment

As proposed in section III E. of this proposed rule, physicians who order or certify hospice services for Medicare beneficiaries (hereafter occasionally referenced as "hospice physicians," as described in section III. E) must be enrolled in Medicare or validly opted-out as a prerequisite for payment of the hospice service in question. Most hospice certifying physicians are already Medicare-enrolled or validly opted-out. Nonetheless, CMS data indicates that approximately 2,173 physicians who have ordered or certified Medicare hospice services are not. These physicians, as already stated, would be required to enroll or opt-out under our proposal.

Strictly for purposes of establishing an estimate, we would project that the average hospice physician would complete a Form CMS-855O enrollment application (Medicare Enrollment Application-- Registration for Eligible Ordering and Referring Physicians and Non-Physician Practitioners - OMB Control No.: 0938-1135) rather than an opt-out affidavit to comply with our proposed requirements. Per previous estimates, it would take approximately 0.5 hours for a physician to complete the Form CMS-855O application.

According to the most recent wage data provided by the Bureau of Labor Statistics (BLS) for May 2021 (see https://www.bls.gov/oes/current/oes_nat.htm), the mean hourly wage

for the general category of "Physicians, All Other" is $111.30. With fringe benefits and overhead, the total per hour rate is $222.60. The foregoing wage figures are outlined in Table 15:

TABLE: 15 National Occupational Employment and Wage Estimates

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefits and overhead ($/hr)	Adjusted hourly wage ($/hr)
Physicians, All Other	29-1216	111.30	111.30	222.60

Our proposal would therefore result in a 1,087-hour burden at a cost of $241,966 (1,087 x $222.60). (Most of these physicians would enroll during the first year of our proposal in order to continue ordering or certifying hospice services.) Averaged over the 3-year OMB-approval period, this results in annual burdens of 362 hours and $80,655. This burden would be updated as part of a separate Paperwork Reduction Act submission.

B. Codification of HQRP Data Completeness Thresholds

The proposal to codify HQRP data completeness thresholds reflects the same thresholds which have been applied to the HQRP since the FY 2018 Hospice final rule (82 FR 36638). As such, this proposal would not impose any additional collection of information burden on hospices.

V. Response to Comments

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

VI. Regulatory Impact Analysis

A. Statement of Need

1. Hospice Payment

This proposed rule meets the requirements of our regulations at § 418.306(c) and (d), which require annual issuance, in the **Federal Register**, of the hospice wage index based on the most current available CMS hospital wage data, including any changes to the definitions of CBSAs or previously used Metropolitan Statistical Areas (MSAs), as well as any changes to the methodology for determining the per diem payment rates. This proposed rule would also update payment rates for each of the categories of hospice care, described in § 418.302(b), for FY 2024 as required under section 1814(i)(1)(C)(ii)(VII) of the Act. The payment rate updates are subject to changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act.

2. Hospice Quality Reporting Program

Sections 1814(i)(5)(A) through (C) of the Act authorizes the HQRP which requires that hospices submit quality data, based on measures to be specified by the Secretary. In the FY 2012 Hospice Wage Index and Rate Update final rule (76 FR 47320 through 47324), we implemented a HQRP as required by those sections. Hospices were required to begin collecting quality data in October 2012 and submit those quality data in 2013. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY. Section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA 2021 to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. This policy will apply beginning with the FY 2024 annual payment update (APU) that is based on CY 2022 quality data. Specifically, the Act requires that, for FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and beginning with the FY 2024 APU and for each subsequent year, the Secretary shall reduce the

market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY.

3. Impact of Hospice Ordering/Certifying Physician Enrollment

We believe that the only impact of this proposal would involve the burden estimated in section IV of this proposed rule regarding the completion of the Form CMS-855O, which we projected to be $241,966, over a 3-year period, or $80,655 per year.

B. Overall Impacts

1. Hospice Payment

We estimate that the aggregate impact of the payment provisions in this proposed rule would result in an estimated increase of $720 million in payments to hospices, resulting from the hospice payment update percentage of 2.8 percent for FY 2024. The impact analysis of this proposed rule represents the projected effects of the changes in hospice payments from FY 2023 to FY 2024. Using the most recent complete data available at the time of rulemaking, in this case FY 2022 hospice claims data as of January 22, 2023, we simulate total payments using the FY 2023 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, and the 5 percent cap on wage index decreases) and FY 2023 payment rates and compare it to our simulation of total payments using FY 2022 utilization claims data, the FY 2024 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, and the 5-percent cap on wage index decreases) and FY 2023 payment rates. By dividing payments for each level of care (RHC days 1 through 60, RHC days 61+, CHC, IRC, and GIP) using the FY 2023 wage index and payment rates for each level of care by the FY 2024 wage index and FY 2023 payment rates, we obtain a wage index standardization factor for each level of care. We apply the wage index standardization factors so that the aggregate simulated payments do not increase or decrease due to changes in the wage index.

Certain events may limit the scope or accuracy of our impact analysis, because such an analysis is susceptible to forecasting errors due to other changes in the forecasted impact time

period. The nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon hospices.

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

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

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

A regulatory impact analysis (RIA) must be prepared for rules that are significant under section 3(f)(1) as described above. We estimate that this rulemaking exceeds the $100 million threshold under section 3(f)(1). Accordingly, we have prepared a RIA, that to the best of our

ability, presents the costs and benefits of the rulemaking.

C. Detailed Economic Analysis

1. Proposed Hospice Payment Update for FY 2024

The FY 2024 hospice payment impacts appear in Table 16. We tabulate the resulting payments according to the classifications (for example, provider type, geographic region, facility size), and compare the difference between current and future payments to determine the overall impact. The first column shows the breakdown of all hospices by provider type and control (non-profit, for-profit, government, other), facility location, facility size. The second column shows the number of hospices in each of the categories in the first column. The third column shows the effect of using the FY 2024 updated wage index data with a 5-percent cap on wage index decreases. This represents the effect of moving from the FY 2023 hospice wage index to the FY 2024 hospice wage index with a 5-percent cap on wage index decreases. The aggregate impact of the changes in column three is zero percent, due to the hospice wage index standardization factor. However, there are distributional effects of the FY 2024 hospice wage index. The fourth column shows the effect of the hospice payment update percentage as mandated by section 1814(i)(1)(C) of the Act, and is consistent for all providers. The proposed hospice payment update percentage of 2.8 percent is based on the proposed 3.0 percent inpatient hospital market basket update, reduced by a proposed 0.2 percentage point productivity adjustment. The fifth column shows the total effect of the proposed updated wage data and the proposed hospice payment update percentage on FY 2024 hospice payments but does not include the effect of moving from the 2 percent reduction to the 4 percent reduction for failure to report quality. It is projected aggregate payments would increase by 2.8 percent; assuming hospices do not change their billing practices. As illustrated in Table 16, the combined effects of all the proposals vary by specific types of providers and by location. We note that simulated payments are based on utilization in FY 2022 as seen on Medicare hospice claims (accessed from the CCW in January 22, 2023) and only include payments related to the level of care and do not include

payments related to the service intensity add-on.

As illustrated in Table 16, the combined effects of all the proposals vary by specific types of providers and by location.

TABLE 16: Projected Impact to Hospices for FY 2024

Hospice Subgroup	Hospices	FY 2024 Updated Wage Data	FY 2024 Proposed Hospice Payment Update (%)	Overall Total Impact for FY 2024
All Hospices	5,640	0.0%	2.8%	2.8%
Hospice Type and Control				
Freestanding/Non-Profit	567	-0.1%	2.8%	2.7%
Freestanding/For-Profit	4,007	0.0%	2.8%	2.8%
Freestanding/Government	41	-0.2%	2.8%	2.6%
Freestanding/Other	353	0.3%	2.8%	3.1%
Facility/HHA Based/Non-Profit	329	-0.1%	2.8%	2.7%
Facility/HHA Based/For-Profit	188	-0.4%	2.8%	2.4%
Facility/HHA Based/Government	73	0.1%	2.8%	2.9%
Facility/HHA Based/Other	82	0.0%	2.8%	2.8%
Subtotal: Freestanding Facility Type	4,968	0.0%	2.8%	2.8%
Subtotal: Facility/HHA Based Facility Type	672	-0.1%	2.8%	2.7%
Subtotal: Non-Profit	896	-0.1%	2.8%	2.7%
Subtotal: For-Profit	4,195	0.0%	2.8%	2.8%
Subtotal: Government	114	-0.1%	2.8%	2.7%
Subtotal: Other	435	0.2%	2.8%	3.0%
Hospice Type and Control: Rural				
Freestanding/Non-Profit	127	-0.3%	2.8%	2.5%
Freestanding/For-Profit	358	-0.3%	2.8%	2.5%
Freestanding/Government	23	-0.7%	2.8%	2.1%
Freestanding/Other	50	-0.2%	2.8%	2.6%
Facility/HHA Based/Non-Profit	128	-0.4%	2.8%	2.4%
Facility/HHA Based/For-Profit	51	-0.1%	2.8%	2.7%
Facility/HHA Based/Government	57	-0.2%	2.8%	2.6%
Facility/HHA Based/Other	44	-0.3%	2.8%	2.5%
Hospice Type and Control: Urban				
Freestanding/Non-Profit	440	-0.1%	2.8%	2.7%
Freestanding/For-Profit	3,649	0.1%	2.8%	2.9%
Freestanding/Government	18	-0.1%	2.8%	2.7%
Freestanding/Other	303	0.3%	2.8%	3.1%
Facility/HHA Based/Non-Profit	201	0.0%	2.8%	2.8%
Facility/HHA Based/For-Profit	137	-0.5%	2.8%	2.3%
Facility/HHA Based/Government	16	0.3%	2.8%	3.1%

Facility/HHA Based/Other	38	0.1%	2.8%	2.9%
Hospice Location: Urban or Rural				
Rural	838	-0.3%	2.8%	2.5%
Urban	4,802	0.0%	2.8%	2.8%
Hospice Location: Region of the Country (Census Division)				
New England	151	-0.7%	2.8%	2.1%
Middle Atlantic	284	0.5%	2.8%	3.3%
South Atlantic	607	0.3%	2.8%	3.1%
East North Central	587	-0.5%	2.8%	2.3%
East South Central	255	-0.1%	2.8%	2.7%
West North Central	420	-0.3%	2.8%	2.5%
West South Central	1,101	0.2%	2.8%	3.0%
Mountain	589	-0.3%	2.8%	2.5%
Pacific	1,597	0.2%	2.8%	3.0%
Outlying	49	-1.6%	2.8%	1.2%
Hospice Size				
0 - 3,499 RHC Days (Small)	1,414	0.1%	2.8%	2.9%
3,500-19,999 RHC Days (Medium)	2,551	0.0%	2.8%	2.8%
20,000+ RHC Days (Large)	1,675	0.0%	2.8%	2.8%

Source: FY 2022 hospice claims data from CCW accessed on January 22, 2023.
Note: The overall total impact reflects the addition of the individual impacts, which includes the wage index impact as well as the proposed 2.8 percent market basket update. However, it does not include the effect of moving from the 2 percent reduction to the 4 percent reduction for failure to report quality data.

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

2. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review this rule, we assume that the total number of unique commenters on last year's proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this proposed rule. It is possible

that not all commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this proposed rule. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule. We also recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule, and therefore for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. We are soliciting public comments on this assumption.

Using the occupational wage information from the BLS for medical and health service managers (Code 11-9111) from May 2021; we estimate that the cost of reviewing this rule is $115.22 per hour, including overhead and fringe benefits (https://www.bls.gov/oes/current/oes_nat.htm). This proposed rule consists of approximately 30,000 words. Assuming an average reading speed of 250 words per minute, it would take approximately 1 hour for staff to review half of it. For each hospice that reviews the rule, the estimated cost is $115.22 (1 hour x $115.22). Therefore, we estimate that the total cost of reviewing this regulation is $8,526.28 ($115.22 x 74 reviewers).

3. Impacts for the Hospice Quality Reporting Program for FY 2024

The HQRP requires the active collection under OMB control number #0938-1153 (CMS 10390; expiration 02/29/2024) of the Hospice Items Set (HIS) and CAHPS® Hospice Survey (OMB control number 0938-1257) (CMS–10537; expiration 01/31/2023). Failure to submit data required under section 1814(i)(5) of the Act with respect to a CY will result in the reduction of the annual hospice market basket percentage increase otherwise applicable to a hospice for that calendar year. From FY 2014 through FY 2023, hospices that failed to report quality data had their market basket percentage increase reduced by 2 percentage points. As noted in section C.5. of this proposed rule, section 1814(i)(5)(A)(i) of the Act was amended by section 407(b) of Division CC, Title IV of the CAA 2021 (Pub. L. 116-260) to change the

payment reduction for failing to meet hospice quality reporting requirements to 4 percentage points, beginning with FY 2024. This section analyzes the estimated impact of the transition from 2 percentage points to 4 percentage points.

Based on historical performance trends, we estimate that roughly 18.4 percent of hospices (an estimated 1,049 out of approximately 5,700 active hospices) will fail to receive the full annual percentage increase in FY 2024, if active Medicare-certified hospices perform similarly in CY 2022 to hospice performance in previous years. We project that the 4 percentage point penalty for hospices will represent approximately $53 million in hospice payment dollars during the reporting period, out of an estimated total $23.8 billion paid to all hospices. The net impact of the policy change from 2 percent APU penalty to 4 percent APU penalty is estimated to be $26.5 million.

D. Alternatives Considered

1. Hospice Payment

Since the hospice payment update percentage is determined based on statutory requirements, we did not consider not updating the hospice payment rates by the payment update percentage. The proposed 2.8 percent hospice payment update percentage for FY 2024 is based on a proposed 3.0 percent inpatient hospital market basket update for FY 2024, reduced by a proposed 0.2 percentage point productivity adjustment. Payment rates since FY 2002 have been updated according to section 1814(i)(1)(C)(ii)(VII) of the Act, which states that the update to the payment rates for subsequent years must be the market basket percentage increase for that FY. Section 3401(g) of the Affordable Care Act also mandates that, starting with FY 2013 (and in subsequent years), the hospice payment update percentage will be annually reduced by changes in economy-wide productivity as specified in section 1886(b)(3)(B)(xi)(II) of the Act. For FY 2024, since the hospice payment update percentage is determined based on statutory requirements at section 1814(i)(1)(C) of the Act, we cannot consider not updating the hospice payment rates by the hospice payment update percentage.

2. Hospice Quality Reporting Program

We did not consider any alternatives in this proposed rule.

3. Hospice Physician Enrollment

We did not consider any alternatives to our proposal to require physicians who order or certify hospice services for Medicare beneficiaries to be enrolled in or validly opted-out of Medicare as a prerequisite for the payment of the hospice service in question. This is because the enrollment process is the only available, feasible means of ascertaining the physician's compliance with all applicable requirements and whether he or she has any adverse legal history.

E. Accounting Statement

As required by OMB Circular A-4 (available at https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf), in Table 11, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. Table 17 provides our best estimate of the possible changes in Medicare payments under the hospice benefit as a result of the policies in this proposed rule. This estimate is based on the data for 5,640 hospices in our impact analysis file, which was constructed using FY 2022 claims available in January 22, 2023. All expenditures are classified as transfers to hospices.

TABLE 17: Accounting Statement
Classification of Estimated Transfers and Costs, From FY 2023 to FY 2024

Category	**Transfers**
Annualized Monetized Transfers	$720 million*
From Whom to Whom?	Federal Government to Medicare Hospices
Category	**Costs**
Annualized Monetized Costs Associated with Changes in APU Reductions due to Data Submission Requirements	$26.5 million**

*The increase of $720 million in transfer payments is a result of the proposed 2.8 percent hospice payment update compared to payments in FY 2023.
**The $26.5 million is the amount CMS is projected to recoup based on the increased penalty for hospices that fail to meet HQRP data submission requirements, Compared to APU penalties in FY 2023.

F. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities if a

rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. We consider all hospices as small entities as that term is used in the RFA. The North American Industry Classification System (NAICS) was adopted in 1997 and is the current standard used by the Federal statistical agencies related to the U.S. business economy. There is no NAICS code specific to hospice services. Therefore, we utilized the NAICS U.S. industry title "Home Health Care Services" and corresponding NAICS code 621610 in determining impacts for small entities. The NAICS code 621610 has a size standard of $16.5 million.[60] Table 18 shows the number of firms, revenue, and estimated impact per home health care service category.

TABLE 18: NUMBER OF FIRMS, REVENUE, AND ESTIMATED IMPACT OF HOME HEALTH CARE SERVICES BY NAICS CODE 621610

NAICS Code	NAICS Description	Enterprise Size	Number of Firms	Receipts ($1,000)	Estimated Impact ($1,000) per Enterprise Size
621610	Home Health Care Services	<100	5,861	210,697	$35.95
621610	Home Health Care Services	100-499	5,687	1,504,668	$264.58
621610	Home Health Care Services	500-999	3,342	2,430,807	$727.35
621610	Home Health Care Services	1,000-2,499	4,434	7,040,174	$1,587.77
621610	Home Health Care Services	2,500-4,999	1,951	6,657,387	$3,412.29
621610	Home Health Care Services	5,000-7,499	672	3,912,082	$5,821.55
621610	Home Health Care Services	7,500-9,999	356	2,910,943	$8,176.81
621610	Home Health Care Services	10,000-14,999	346	3,767,710	$10,889.34
621610	Home Health Care Services	15,000-19,999	191	2,750,180	$14,398.85
621610	Home Health Care Services	≥20,000	961	51,776,636	$53,877.87
621610	Home Health Care Services	Total	23,801	82,961,284	$3,485.62

Source: Data obtained from United States Census Bureau table "us_6digitnaics_rcptsize_2017" (SOURCE: 2017 County Business Patterns and Economic Census) Release Date: 5/28/2021: https://www2.census.gov/programs-surveys/susb/tables/2017/.
Notes: Estimated impact is calculated as Receipts ($1,000)/Number of firms.

The Department of Health and Human Services practice in interpreting the RFA is to consider effects economically "significant" only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The majority of hospice visits are Medicare paid visits and therefore the majority of hospice's revenue consists of Medicare

[60] https://www.sba.gov/sites/default/files/2019-08/SBA%20Table%20of%20Size%20Standards_Effective%20Aug%2019%2C%202019_Rev.pdf.

payments. Based on our analysis, we conclude that the policies finalized in this rule would result in an estimated total impact of 3 to 5 percent or more on Medicare revenue for greater than 5 percent of hospices. Therefore, the Secretary has certified that this hospice proposed rule would have significant economic impact on a substantial number of small entities. We estimate that the net impact of the policies in this rule is a 2.8 percent or approximately $720 million in increased revenue to hospices in FY 2024. The 2.8 percent increase in expenditures when comparing FY 2023 payments to estimated FY 2024 payments is reflected in the last column of the first row in Table 18 and is driven solely by the impact of the hospice payment update percentage reflected in the fourth column of the impact table. In addition, small hospices would experience a greater estimated increase (4.1 percent), compared to large hospices (3.8 percent) due to the policy to cap wage index decreases at 5 percent. Further detail is presented in Table 18, by hospice type and location.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a MSA and has fewer than 100 beds. This rule will only affect hospices. Therefore, the Secretary has determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals (see Table 18).

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2023, that threshold is approximately $177 million. This rule is not anticipated to have an effect on state, local, or tribal governments, in the aggregate, or on the private sector of $177 million or more in any 1 year.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. We have reviewed this rule under these criteria of Executive Order 13132, and have determined that it will not impose substantial direct costs on state or local governments.

I. Conclusion

We estimate that aggregate payments to hospices in FY 2024 will increase by $720 million as a result of the market basket update, compared to payments in FY 2023. We estimate that in FY 2024, hospices in urban areas will experience, on average, a 2.8 percent increase in estimated payments compared to FY 2023; while hospices in rural areas will experience, on average, a 2.5 percent increase in estimated payments compared to FY 2023. Hospices providing services in the Middle and South Atlantic regions would experience the largest estimated increases in payments of 3.3 percent and 3.1 percent, respectively. Hospices serving patients in areas in the Outlying regions would experience, on average, the lowest estimated increase of 1.2 percent in FY 2024 payments.

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

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on March 28, 2023.

List of Subjects

42 CFR Part 418

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

42 CFR Part 424

Health facilities, Health professions, Medicare Reporting and recordkeeping requirements.

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

PART 418-HOSPICE CARE

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

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

2. Amend § 418.22 by revising paragraph (a)(4)(ii) to read as follows:

§ 418.22 Certification of terminal illness.

(a) * * *

(4) * * *

(ii) During a Public Health Emergency, as defined in § 400.200 of this chapter, or through December 31, 2024, whichever is later, if the face-to-face encounter conducted by a hospice physician or hospice nurse practitioner is for the sole purpose of hospice recertification, such encounter may occur via a telecommunications technology and is considered an administrative expense. *Telecommunications technology* means the use of interactive multimedia communications equipment that includes, at a minimum, the use of audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site hospice physician or hospice nurse practitioner.

* * * * *

§ 418.204 [Amended]

3. Amend § 418.204 by removing paragraph (d).

§ 418.309 [Amended]

4. Amend § 418.309 in paragraphs (a)(1) and (2) by removing "2030" and adding "2032" in its place.

5. Amend § 418.312 by adding paragraph (j) to read as follows:

§ 418.312 Data submission requirements under the hospice quality reporting program.

* * * * *

(j) *Data completion thresholds.* (1) Hospices must meet or exceed data submission threshold set at 90 percent of all required Hospice Item Set (HIS) or successor instrument records within 30-days of the beneficiary's admission or discharge and submitted through the CMS designated data submission systems.

(2) A hospice must meet or exceed the data submission compliance threshold in paragraph (j)(1) of this section to avoid receiving a 4-percentage point reduction to its annual payment update for a given fiscal year as describe under § 412.306(b)(2) of this chapter.

PART 424-CONDITIONS FOR MEDICARE PAYMENT

6. The authority for part 424 continues to read as follows:

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

7. Amend § 424.507 by revising paragraphs (b) introductory text and (b)(1) introductory text and adding paragraph (b)(3) to read as follows:

§ 424.507 Ordering covered items and services for Medicare beneficiaries.

* * * * *

(b) *Conditions for payment of claims for covered home health and hospice services.* To receive payment for covered Part A or Part B home health services or for covered hospice services, a provider's home health or hospice services claim must meet all of the following requirements:

(1) The ordering/certifying physician for hospice or home health services, or, for home health services, the ordering/certifying physician assistant, nurse practitioner, or clinical nurse specialist working in accordance with State law, must meet all of the following requirements:

* * * * *

(3) For claims for hospice services, the requirements of paragraph (b) of this section apply with respect to any physician described in § 418.22(c) of this chapter who made the applicable certification described in § 418.22(c).

* * * * *

Dated: March 28, 2023.

_____

Xavier Becerra,

Secretary,

Department of Health and Human Services.

[FR Doc. 2023-06769 Filed: 3/31/2023 4:15 pm; Publication Date: 4/4/2023]