Medicare Program; FY 2023 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements [CMS-1773-P]
Summary of Proposed Rule

I. Introduction and Background

On April 4, 2022, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (87 FR 19442) a proposed rule updating the Medicare hospice payment rates, wage index, the cap amount and the quality reporting requirements for federal fiscal year (FY) 2023. Among other changes, this rule proposes a permanent, budget neutral approach to smooth year-to-year changes in the hospice wage index by applying a permanent cap on negative wage index changes greater than a 5 percent decrease from the prior year. This rule also proposes updates to the Hospice Quality Reporting Program (HQRP) including an update on the development of a patient assessment instrument, titled the Hospice Outcomes and Patient Evaluation tool (HOPE). In addition, the proposed rule includes updates on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and a request for information on health equity. **Comments on the proposed rule are due by May 31, 2022.**

CMS estimates that the overall impact of the proposed rule will be an increase of $580 million (2.7 percent) in Medicare payments to hospices during FY 2023.

CMS notes that wage index addenda for FY 2023 (October 1, 2022 through September 30, 2023) will be available only through the internet at https://www.cms.gov/files/zip/fy-2023-proposed-hospice-wage-index.zip

The proposed rule reviews the history of the Medicare hospice benefit, including hospice reform policies finalized in the FY 2016 hospice final rule (80 FR 47142); this rule, among other things, differentiated payments for routine home care (RHC) based on the beneficiary's length of stay and implemented a service intensity add-on (SIA) payment for services provided in the last 7 days of a beneficiary's life. In the FY 2020 hospice final rule (84 FR 38487) CMS rebased the continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIP) payment rates. To offset these increases, CMS reduced RHC payment rates by 2.7 percent. CMS also finalized a policy to use the current year's pre-floor, pre-reclassification hospital inpatient wage index as the wage adjustment to the labor portion of the hospice rates. In the FY 2022 hospice final rule (86 FR 42532), CMS finalized a policy to rebase and revise the labor shared for CHC, RHC, IRC, and GIP using cost report data for freestanding hospices.

II. Provisions of the Proposed Rule

A summary of key data for the proposed hospice payment rates for FY 2023 is presented below with additional details in the subsequent sections.

Summary of Key Data for Proposed Hospice Payment Rates for FY 2023			
Market basket update factor			
Market basket increase			+3.1%
Required total factor productivity (TFP)			-0.4%
Net MFP-adjusted update reporting quality data			**+2.7%**
Net MFP-adjusted update not reporting quality data			**+0.7%**
Hospice aggregate cap amount			$32,142.65
Hospice Payment Rate Care Categories	**Labor Share**	**FY 2022 Federal Rates Per Diem**	**Proposed FY 2023 Federal Rates Per Diem**
Routine Home Care (days 1-60)	66.0%	$203.40	$209.14
Routine Home Care (days 61+)	66.0%	$160.74	$165.25
Continuous Home Care, Full Rate = 24 hours of care, $60.94 hourly rate	75.2%	$1,462.52	$1,505.61
Inpatient Respite Care	61.0%	$473.75	$486.88
General Inpatient Care	63.5%	$1,068.28	$1,098.88
Proposed Service Intensity Add-on (SIA) payment, up to 4 hours			$60.94 per hour
Note: RHC days account for most of hospice days—98.3 percent in FY 2019. Beginning with the November 18, 2021 release of productivity data, BLS replaced the term "multifactor productivity" with "total factor productivity" (TFP)"			

A. Proposed FY 2023 Hospice Wage Index and Rate Update

1. FY 2023 Hospice Wage Index

For FY 2023, CMS proposes to continue its policy to use the current FY's hospital wage index data to calculate the hospice wage index values. For FY 2023, the proposed hospice wage index would be based on the FY 2023 hospital pre-floor, pre-reclassified wage index using hospital cost reporting periods beginning on or after October 1, 2018 and before October 1, 2019 (FY 2019 cost report data). The hospice wage index does not take into account any geographic reclassification of hospitals, but CMS proposes to include a 5-percent cap on wage index decreases (as discussed later in this section). The appropriate wage index value is applied to the labor portion of the hospital payment rate based on the geographic area in which the beneficiary resides when receiving RHC or CHC and applied based on the geographic location of the facility for beneficiaries receiving GIP or IRC.

CMS also proposes to continue to apply current policies for geographic areas where there are no hospitals. For urban areas of this kind, all CBSAs within the state would be used to calculate a statewide urban average pre-floor, pre-reclassified hospital wage index value for use as a reasonable proxy for these areas. For FY 2022, there is one CBSAs without a hospital from which hospital wage data can be derived: 25980, Hinesville-Fort Stewart, Georgia. The FY 2023 wage index value for Hinesville-Fort Stewart, Georgia is 0.8620. For rural areas without hospital wage data,

CMS has used the average pre-floor, pre-reclassified hospital wage index data from all contiguous CBSAs to represent a reasonable proxy for the rural area. However, the only rural area currently without a hospital is on the island of Puerto Rico, which does not lend itself to this "contiguous" approach. Because CMS has not identified an alternative methodology, the agency proposes to continue to use the most recent pre-floor, pre-reclassified hospital wage index value available for Puerto Rico, which is 0.4047.

CMS notes that the pre-floor and pre-reclassified hospital wage index is used as the raw wage index for the hospice benefit; these values are subject to application of the hospice floor. The pre-floor and pre-reclassified hospital wage index below 0.8 will be further adjusted by a 15 percent increase subject to a maximum wage index value of 0.8.[1]

2. Permanent Cap on Wage Index Decreases

In the past, CMS notes that it had established transition policies of limited duration to phase in significant changes to labor market areas. It notes, however, that year-to-year fluctuations in an area's wage index can occur due to external factors beyond a provider's control, such as COVID-19 PHE, which are unrelated to changes in labor market areas. It states that predictability in Medicare payments is important to enable providers to budget and plan their operations.

CMS proposes to apply a permanent 5-percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. Specifically, CMS proposes that a geographic area's wage index for FY 2023 would not be less than 95 percent of its final wage index for FY 2022 and that for subsequent years, a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY. This policy would be implemented in a budget neutral manner through the use of wage index standardization factors. The 5-percent cap would also be applied after the application of the hospice wage index floor.

3. FY 2023 Hospice Payment Update Percentage

For FY 2023, the estimated inpatient hospital market basket update of 3.1 percent (the inpatient hospital market basket is used in determining the hospice update factor) must be reduced by a productivity adjustment as mandated by the ACA (currently estimated to be 0.4 percentage points). This results in a proposed hospice payment update percentage for FY 2023 of 2.7 percent; CMS proposes to revise this amount in the final rule if more recent data become available.

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

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

4. FY 2023 Hospice Payment Rates

In the hospice payment system, there are four payment categories that are distinguished by the location and intensity of the services provided: RHC or routine home care, IRC or short-term care to allow the usual caregiver to rest, CHC or care provided in a period of patient crisis to maintain the patient at home, and GIP or general inpatient care to treat symptoms that cannot be managed in another setting. The applicable base payment is then adjusted for geographic differences in wages by multiplying the labor share, which varies by category, of each base rate by the applicable hospice wage index.[2]

As discussed above, CMS made several modifications to the hospice payment methodology in FY 2016. CMS implemented two different RHC payment rates: one for the RHC rate for the first 60 days and a second RHC rate for days 61 and beyond and SIA payment when direct patient care is provided by an RN or social worker during the last 7 days of the beneficiary's life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provider (up to 4 hours total) that occurred on the day of the service. As required by statute, the new RHC rates were adjusted by a SIA budget neutrality factor—a separate factor for days 1-60 and for 61 days and beyond. CMS observes (as show in Table 2 in the proposed rule), that since FY 2016 there have been very minor adjustments needed as the utilization of the SIA from year-to-year remains relatively constant.

In the FY 2017 Hospice final rule, CMS initiated a policy to apply a wage index standardization factor to hospice payment rates to ensure overall budget neutrality when updating the hospice wage index with more recent hospital wage data.[3] To calculate the wage index standardization factor, CMS simulated total payments using FY 2021 hospice utilization claims data with the FY 2022 wage index (pre-floor, pre-reclassified hospital wage index with the hospice floor, without the 5-percent cap on wage index decreases) and compared it to its simulation of total payment using the FY 2023 hospice wage index (pre-floor, pre-reclassified hospital wage index with hospice floor, with the 5-percent cap on wage index decreases) and FY 2022 payment rates. By dividing payments for each level of care using the FY 2023 wage index by payments for each level of care using the FY 2022 wage index, CMS obtained a wage index standardization factor for each level of care (RHC days 1-60, RHC days 61+, CHC, IRC, and GIP).

Tables 1 and 2 of the proposed rule (reproduced below) lists the proposed FY 2023 hospice payment rates by care category and the proposed wage index standardization factors.

[2] In FY 2014 and for subsequent fiscal years, CMS uses rulemaking as the means to update payment rates (prior to FY 2014, CMS had used a separate administrative instruction), consistent with the rate update process for other Medicare payment systems.
[3] CMS uses 2021 claims data to calculate the wage index standardization factor (the most recent available).

Table 1: Proposed FY 2023 Hospice RHC Payments						
Code	**Description**	**FY 2022 Payment Rates**	**SIA Budget Neutrality Factor**	**Wage Index Standardization Factor**	**Proposed FY 2023 Hospice Payment Update**	**Proposed FY 2023 Payment Rates**
651	Routine Home Care (days 1-60)	$203.40	× 1.0004	× 1.0008	× 1.027	$209.14
651	Routine Home Care (days 61+)	$160.74	× 1.0003	× 1.0007	× 1.027	$162.25

Table 2: Proposed FY 2023 Hospice CHC, IRC, and GIP Payment Rates					
Code	**Description**	**FY 2022 Payment Rates**	**Wage Index Standardization Factor**	**Proposed FY 2023 Hospice Payment Update**	**Proposed FY 2023 Payment Rates**
652	Continuous Home Care Full Rate = 24 hours of care	$1,462.52 ($60.94 per hour)	× 1.0024	× 1.027	$1,505.61
655	Inpatient Respite Care	$473.75	× 1.0007	× 1.027	$486.88
656	General Inpatient Care	$1,068.28	× 1.0016	× 1.027	$1,098.88

Tables 3 and 4 of the proposed rule lists the comparable FY 2023 proposed payment rates for hospices that do not submit the required quality data under the Hospice Quality Reporting Program as follows: Routine Home Care (days 1-60), $205.07; Routine Home Care (days 61+), $162.03; Continuous Home Care, $1,476.29; Inpatient Respite Care, $477.40; and General Inpatient Care, $1,077.48.

5. Hospice Cap Amount for FY 2023

By background, when the Medicare hospice benefit was implemented, Congress included two limits on payments to hospices: an aggregate cap and an inpatient cap. The intent of the hospice aggregate cap was to protect Medicare from spending more for hospice care than it would for conventional care at the end-of-life, and the intent of the inpatient cap was to ensure that hospice remained a home-based benefit.[4] The aggregate cap amount was set at $6,500 per beneficiary when first enacted in 1983, and since then this amount has been adjusted annually by the change in the medical care expenditure category of the consumer price index for urban consumers (CPI-U).

As required by the Impact Act, beginning with the 2016 cap year, the cap amount for the previous year will be updated by the hospice payment update percentage, rather than by the CPI-U for medical care. This provision was scheduled to sunset for cap years ending after September

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

30, 2025 and revert to the original methodology, but this sunset provision was extended by the CCA of 2021 until September 30, 2030. CMS adds that the proposed hospice aggregate cap amount for the 2023 cap year will be $32,142.65 per beneficiary or the 2022 cap amount updated by the proposed FY 2023 hospice payment update percentage ($31,297.61 * 1.027).

B. Proposed Updates to the Hospice Quality Reporting Program

1. Background and Statutory Authority

The Hospice Quality Reporting Program (HQRP) includes the Hospice Item Set (HIS), administrative data, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey. Section 1814(i)(5)(A)(i) of the Act requires that beginning in FY 2014, hospices that fail to meet quality data submission requirements will receive a two percentage point reduction to the market basket update. The Consolidation Appropriations Act of 2021 (CAA 2021)[5] changed the payment reduction for failing to meet these reporting requirements from 2 to 4 percent. Specifically, the Act requires that beginning with FY 2014 through FY 2023, the Secretary shall reduce the market basket update by 2 percentage points and beginning with FY 2024 annual payment update (APU) and for each subsequent year, the Secretary shall reduce the market basket update by 4 percentage points for any hospice that does not comply with the quality data submission requirements for that FY. The FY 2024 APU is based on CY 2022 quality data.

As finalized in the FY 2022 Hospice final rule (86 FR 42552), CMS plans to display the two new claims-based quality measures (QMs), the Hospice Visits in Last Days of Life (HVLDL) and the Hospice Care Index (HCI) in the May 2022 refresh of the Care Compare/Provider Data Catalogue (PDC). Table 5 (reproduced below) lists all the quality measures finalized in the FY 2022 Hospice final rule and in effect for the FY 2023 HQRP.[6]

Table 5: Quality Measures for the FY 2023 HQRP	
Hospice Quality Reporting Program	
NQF Number	**Hospice Item Set**
3235	Hospice and Palliative Care Composite Measure – HIS-Comprehensive Assessment at Admission 1. Patients Treated with an Opioid who are Given a Bowel Regimen (NQF #1617) 2. Pain Screening (NQF #1634) 3. Pain Assessment (NQF #1637) 4. Dyspnea Treatment (NQF #1638) 5. Dyspnea Screening (NQF #1639) 6. Treatment Preferences (NQF #1641) 7. Beliefs/Values Addressed (if desired by the patient) (NQF #16477)
Administrative Data, including Claims-based Measures	
3645	Hospice Visits in Last Days of Life (HVLDL)
Pending NQF endorsement	Hospice Care Index (HCI) 1. Continuous Home Care (CHC) or General Inpatient Provided (GIP) 2. Gaps in Skilled Nursing Visits

[5] Pub. L. 116-260

[6] 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. n

Table 5: Quality Measures for the FY 2023 HQRP	
Hospice Quality Reporting Program	
	3. Early Live Discharges 4. Late Live Discharges 5. Burdensome Transitions (Type 1)- Live Discharges form Hospice Followed by Hospitalization and Subsequent Hospice Readmission 6. Burdensome Transitions (Type 2) - Live Discharges form Hospice Followed by Hospitalization with the Patient Dying in the Hospital 7. Per-beneficiary Medicare Spending 8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day 9. Skilled Nursing Minutes on Weekends 10. Visits Near Death
CAHPS Hospice Survey	
2651	CAHPS Hospice Survey (single measure) 1. Communication with Family 2. Getting timely help 3. Treating patient with respect 4. Emotional and spiritual support 5. Help for pain and symptoms 6. Training family to care for the patient 7. Rating of this hospice 8. Willing to recommend this hospice

2. Hospice Outcomes & Patient Evaluation (HOPE) Update

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

CMS discusses the development of HOPE and alpha testing. Alpha testing was completed at the end of January 2021. Alpha testing supported the feasibility of collecting the data items, generally demonstrated acceptable inter-rater reliability, and demonstrated evidence of convergent validity. CMS incorporated findings from alpha testing for the next draft of the HOPE assessment which is being beta testing nationally. Beta testing began in late fall 2021 and continuing through 2022. CMS anticipates proposing HOPE in future rulemaking after testing and analyses are complete. CMS will continue the development of the HOPE assessment in accordance with the Blueprint for the CMS Measures Management System.
CMS will provide updates[7] and engagement opportunities on its website.[8] Comments about HOPE can be sent to HospiceAssessment@cms.hhs.gov.

[7] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE.
[8] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.

3. Update on Future Quality Measure (QM) Development

Two technical expert panel (TEP) meetings in 2021 considered HOPE-based process measures intended to (1) evaluate the rate at which hospices' use specific processes of care; (2) assist in reducing variation in care delivery; and (3) determines hospices' compliance with practices that are expected to improve outcomes. The TEP also considered potential areas for future quality measure development.[9]

CMS continues to consider developing hybrid quality measures that could be calculated from multiple data sources including claims and HOPE. The TEP also discussed hybrid concepts such as hospitalizations during a hospice election and patterns of live discharge using claims data and HOPE data elements.

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

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

*CAHPS Hospice Survey Mode Experimen*t. The survey currently has three approved modes: mail, telephone, and mail with telephone follow-up. CMS discusses the design and testing protocol for evaluating a web-based mode on survey response rates and scores. CMS is also testing the effects of a shortened survey on response rate and scores; assessment of the measure properties of a limited number of supplemental survey items suggested by stakeholders; and calculation of item-level mode adjustments for the shortened survey in both the currently approved modes and the web-based mode.

CMS sampled 15,000 eligible caregivers from approximately 50 hospices over a six- to seven-month period. CMS is analyzing the results of the testing and will propose any changes to the CAHPS Hospice Survey in future rulemaking.

Public Reporting of CAHPS Hospice Survey. These 8 measures are reported on Hospice Compare.[10] Prior to the COVID-19 public health emergency (PHE), CMS reported the most recent 8 quarters of data on the basis of a rolling average, with the oldest quarter of data removed for each data refresh with the most recent quarter of data added. The data is refreshed 4 times a year in February, May, August, and November. Given COVID-19 PHE exemptions[11], public reporting continues to be the most recent 8 quarters of data, excluding the exempted quarters –

[9] The "2021 TEP Meetings: HQRP Summary Report" is available at https://www.cms.gov/Medicare/Quality-Reporting/Hospice-QRP-Provider-Engagement-Opportunities.
[10] Hospice compare is available at https://www.medicare.gov/care-compare/.
[11] https://www.cms.gov/files/document/guidance-memo-exemptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.

Quarter 1 and Quarter 2 of CY 2020. This data was publicly reported with the February 2022 refresh and will continue through the May 2023 refresh on Care Compare. The Second Edition HQRP Public Reporting Tip Sheet summarizes HQRP public reporting and is available on the HQRP Requirements and Best Practice webpage.[12]

Volume-based Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements. CMS previously finalized a volume-based exemption for CAHPS Hospice Survey Data Collection Reporting requirement for FY 2021 and subsequent years (84 FR 38526). CMS finalized that hospices with fewer than 50 survey-eligible decedents/caregivers in the specified reporting period are exempted from the CAHPS® Hospice Survey data collection and reporting requirements for the corresponding payment determination (corresponds to the CY data collection period). To qualify for this exemption, hospices have to submit an annual exemption request form. The exception request form is available on the CAHPS® Hospice Survey web site at htpp://www.hospiceCAHPSurvey.org.

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

The key dates for the volume-based exception for the CAHPS® Hospice Survey are summarized in Table 6 (reproduced below).

Table 6: Size Exemption Key Dates for FY 2023 through 2026

Fiscal Year	Data Collection Year	Reference Year (Count total number of unique patients in this year)	Size Exemption Form Submission Deadline
2023	2021	2020	December 31, 2021
2024	2022	2021	December 31, 2022
2025	2023	2022	December 31, 2023
2025	2024	2023	December 31, 2024

Newness Exemption for CAHPS® Hospice Survey Data Collection and Reporting Requirements. CMS previously finalized a one-time newness exemption for hospices that meet the criteria (81 FR 52181). Specifically, hospices that are notified about their Medicare CCN after January 1, 2022 are exempted from the FY 2024 APU CAHPS® Hospice Survey requirement due to newness. CMS notes no action is required by the hospice to receive this exemption. The newness exemption is a one-time exemption from the survey. CMS encourages hospices to keep the letter providing them with their CCN.

Survey Participation Requirements. To meet participation requirements for a given year APU, Medicare certified hospices must collect CAHPS® Hospice Survey data on an ongoing monthly basis from the corresponding FY reporting period. Table 7 (reproduced below) provides the deadlines for data submission for FYs 2023 through 2025. CMS notes there are no late submissions after the deadline, except for extraordinary circumstances beyond the control of the provider.

[12] This tip sheet, dated December 2021, is available at http://www.cms.gov/Medicare/Quality-Initiative-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HQRP-Requirements-and-Best-Practices.

Table 7: CAHPS® Hospice Survey Data Submission Dates for the APUs in FYs FY 2023-2025	
Sample Month[1]	**Quarterly Data Submission Deadlines[2]**
FY 2023 APU	
January-March 2021 (Q1)	August 11, 2021
Monthly data collection April-June 2021 (Q2)	November 10, 2021
Monthly data collection July-September 2021 (Q3)	February 9, 2022
Monthly data collection October-December 2021(Q4)	May 11, 2022
FY 2024 APU	
January-March 2022 (Q1)	August 10, 2022
Monthly data collection April-June 2022 (Q2)	November 9 2022
Monthly data collection July-September 2022 (Q3)	February 8, 2023
Monthly data collection October-December 2022 (Q4)	May 130 2023
FY 2025 APU	
January-March 2023 (Q1)	August 9, 2023
Monthly data collection April-June 2023 (Q2)	November 8, 2023
Monthly data collection July-September 2023 (Q3)	February 14, 2024
Monthly data collection October-December 2023(Q4)	May 8, 2024
[1]Data collection for each sample month initiates two months following the month of patient death (for example, in April for deaths occurring in January). [2]Data submission deadlines are the second Wednesday of the submission month, which are August, November, February, and May.	

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

CAHPS Hospice Survey Star Ratings to Public Reporting. In the FY 2022 Hospice final rule (86 FR 42528), CMS finalized a policy to display Hospice CAHPS Survey Star Ratings no sooner that FY 2022. CMS plans to publicly report Star Ratings on Care Compare beginning with the August 2022 refresh. Hospices saw their Star Ratings in their preview reports during the November 2021 and March 2022 preview periods for the February 2022 and May 2022 updates of Care Compare.

Detailed information about the calculation and display of the Hospice CAHPS Survey Star ratings is available on the CAHPS Hospice Survey website (www.hospicecahpssurvey.org). There are no changes in the Star Ratings for FY 2023.

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

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

Three timeframes for both HIS and CAHPS are important for HQRP Compliance: (1) the reporting year HIS and data collection year for CAHPS; (2) payment FY; and the reference Year. Table 8 (reproduced below) summarizes these three timeframes.

Table 8: HQRP Reporting Requirements and Corresponding Annual Payment Updates		
Reporting Year for HIS and Data Collection Year for CAHPS	**Annual Payment Update (APU) Impacts Payment for the FY**	**Reference Year for CAHPS Size Exception**
CY 2021	FY 2023 APU	CY 2020
CY 2022	FY 2024 APU*	CY 2021
CY 2023	FY 2025 APU	CY 2022
*Beginning in FY 2024 and all subsequent years, the payment penalty is 4 percent. Prior to FY 2024, the payment penalty is 2 percent.		

Hospices must comply with CMS' submission data requirements. Table 9 (reproduced below) summarizes the HQRP compliance timeliness threshold requirements for a specific FY APU. CMS states that most hospices that fail to meet HQRP requirements miss the 90 percent threshold.

Table 9: HQRP Compliance Checklist		
Annual Payment Update	**HIS**	**CAHPS**
FY 2023	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admission/discharges occurring 1/1/2022– 12/3/2021	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2021 – 12/31/2021
FY 2024	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admission/discharges occurring 1/1/2022 – 12/3/2022	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2022 – 12/31/2022
FY 2025	Submit at least 90 percent of all HIS records within 30 days of the event date (patient's admission or discharge) for patient admission/discharges occurring 1/1/20 23 – 12/3/2023	Ongoing monthly participation in the Hospice CAHPS survey 1/1/2023 – 12/31/2023

6. Request for Information (RFI) related to the HQRP Health Equity imitative

CMS notes that significant disparities in hospice and palliative care outcomes persist nationwide, such as reduced utilization of hospice services by Black and Hispanic beneficiaries. CMS states its ongoing commitment to closing the equity gap in the agency's quality programs, including the HQRP. In response to a predecessor RFI that addressed health equity in its quality programs (FY 2022 Hospice final rule), hospice stakeholders and other commenters supported the collection and reporting of standardized patient assessment data elements and additional social risk factor and demographic data as one approach to achieving equity (86 FR 42599-42600).

a. Organizational and Data Collection Approaches to Advancing Equity

In this proposed rule, CMS issues a new but related RFI, exploring current organizational and data collection practices by hospices of potential applicability to advancing equity in the HQRP. **Specifically, CMS asks the following:**

- What efforts does your hospice employ to recruit staff, volunteers, and board members from diverse populations to represent and serve underserved populations? How does your hospice attempt to bridge any cultural gaps between your personnel and

beneficiaries/clients? How does your hospice measure whether this has an impact on health equity?

- How does your hospice currently identify barriers to access in your community or service area? What are barriers to collecting data related to disparities, social determinants of health, and equity? What steps does your hospice take to address these barriers?
- How does your hospice collect self-reported data such as race/ethnicity, veteran status, socioeconomic status, housing, food security, access to interpreter services, caregiving status, and marital status used to inform its health equity initiatives?
- How is your hospice using qualitative data collection and analysis methods to measure the impact of its health equity initiatives?

b. Structural Composite Measure for Addition to the HQRP

CMS also requests comments on all aspects of a possible new HQRP measure intended to assess a hospice organization's commitment to activities that impact equity. The measure would be structural and use a composite format. A hospice would attest to the performance of multiple activities; the activities would be grouped into domains and a point would be awarded in each domain if all activities were performed. CMS asks if partial point scoring should be allowed when a hospice attests that some but not all activities within a domain had been performed. CMS describes three potential domains and their component activities.

Domain 1 Strategic plan for health equity and community engagement

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

Domain 2 Personnel training about diversity, equity, inclusion, and culturally and linguistically appropriate services (CLAS)

- Hospice attests whether employed staff were trained in CLAS and culturally sensitive care mindful of social determinants of health (SDOH) in the reporting year.
- Hospice attests whether it provided resources to staff and volunteers about health equity, social determinants of health, and equity initiatives in the reporting year.

Domain 3 Organizational inclusion activities and capacity to promote health equity

- Hospice attests whether equity-focused factors were included in the hiring of hospice senior leadership, including chief executives and board of trustees, in the previous reporting year.
- Hospice attests whether equity-focused factors included in the hiring of hospice senior leadership are more reflective of the hospice's service area patients than in the previous reporting year.
- Hospice attests whether equity-focused factors were included in the hiring of direct patient care staff in the previous reporting year (e.g., nurses, chaplains, volunteers).
- Hospice attests whether equity focused factors were included in the hiring of indirect care or support staff in the previous reporting year (e.g., administrators, clerks).

c. Other Areas for Comment

CMS invites comment as to whether the new structural composite measure results should be publicly reported along with descriptions of component activities from one or more domains. Feedback is also requested about the potential impact of the suggested domains on organizational culture change within a hospice.

CMS indicates that it will not respond specifically to comments received about this RFI through the FY 2023 Hospice final rule, but that the input from commenters will be considered in future policy making.

7. Advancing Health Information Exchange Update

In the FY 2022 Hospice PPS proposed rule, CMS discussed several ongoing HHS initiatives to advance health information exchange within the post-acute care (PAC) settings and within the larger health care environment. The agency now provides updates about selected activities.

Post-Acute Care Interoperability Workgroup (PACIO). The PACIO Project continues to develop Fast Healthcare Interoperability Resources (FHIR) implementation guides and new use cases. CMS again strongly encourages hospices and other PAC providers to participate in PACIO.

CMS Data Element Library (DEL). The CMS DEL serves as the authoritative resource for PAC assessment data elements and their associated mappings to health IT standards (e.g., SNOMED). CMS states that the latest DEL standards are now available in the 2022 ONC Interoperability Standards Advisory (see https://www.healthit.gov/isa).

Trusted Exchange Framework and Common Agreement (TEFCA). This trusted exchange framework and common agreement is intended to enable the nationwide exchange of electronic health information across health information networks and provide a way to enable bi-directional health information exchange in the future. CMS notes that TEFCA Version 1 was released January 18, 2022, and is available for download at https://www.healthit.gov/sites/default/files/page/2022-01/Common_Agreement_for_Nationwide_Health_Information_Interoperability_Version_1.pdf.

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

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

The CAA 2021 requires public reporting on the CMS website 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. The law removes the prohibition at section 1865(b) of the Act of public disclosure of hospice surveys performed by AOs. In

addition, the law requires that AOs use the same survey deficiency reports as SAs (Form CMS-2567, "Statement of Deficiencies" or a successor form).

The CAA 2021 also requires hospice programs to measure and reduce inconsistency in the application of survey results among all surveyors. The Secretary is required to provide comprehensive training and testing of SA and AO hospice program surveyors.

The CAA 2021 also prohibits SA surveyors from surveying hospice programs for which they have worked in the last 2 years or in which they have a financial interest. Hospice program SAs and AOs must use a multidisciplinary team of individuals for surveys conducted with more than one surveyor to include at least one registered nurse. In addition, each SA must establish a dedicated toll-free hotline to collect, maintain, and update information on hospice programs and receive complaints.

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

Except for the SFP provision, CMS finalized CAA provisions in the CY 2022 Home Health PPS final rule.[13] In the final rule, CMS stated it was going to work on a revised proposal for the SFP based on comments received and additional input from stakeholders. CMS now plans to initiate a hospice TEP in CY 2022 to develop a methodology for establishing the hospice SFP and plans to include a proposal for the SFP in the FY 2024 Hospice rulemaking proposed rule.

III. Regulatory Impact Analysis

CMS states that the overall impact of this proposed rule is an estimated net increase in Federal Medicare payments to hospices of $580 million or 2.7 percent, for FY 2023. This aggregate increase is simply a result of the hospice payment update percentage of 2.7 percent, because other policy changes are implemented in a budget-neutral manner. There are distributional effects among facilities and region as a result of the updated wage index data with a 5-percent cap on wage index decreases.

Table 10 in the proposed rule (recreated below) shows the combined effects of the proposals and the variation by facility type and area of country. In brief, proprietary (for-profit) hospices (two-thirds of all hospices) are expected to have an increase in hospice payments of 2.8 percent compared with overall payment increases of 2.7 percent, compared with 2.6 percent for non-profit, and 2.8 percent for government hospices, respectively. Hospices located in rural areas would see an increase of 2.6 percent compared with 2.7 percent for hospices in urban areas. The projected overall impact on hospices varies more among regions of country – a direct result of the variation in the annual update to the wage index. Hospices providing services in the Pacific and West South Central regions would experience the largest estimated increase in payments of

[13] CY 2022 HH PPS final rule: https://www.govinfo.gov/content/pkg/FR-2021-11-09/pdf/2021-23993.pdf.

3.4 and 3.0 percent, respectively in FY 2023 payments. In contrast, hospices serving patients in the New England and West North Central regions would experience, on average, the lowest estimated increase of 2.2 percent, respectively in FY 2023 payments.

Table 10: Projected Impact to Hospices for FY 2023

Hospice Subgroup	Hospices	FY 2023 Updated Wage Data with Cap	FY 2023 Proposed Hospice Payment Update (%)	Overall Total Impact for FY 2023
All Hospices	5,186	0.0%	2.7%	2.7%
Hospice Type and Control				
Freestanding/Non-Profit	581	-0.1%	2.7%	2.6%
Freestanding/For-Profit	3,508	0.1%	2.7%	2.8%
Freestanding/Government	42	0.1%	2.7%	2.8%
Freestanding/Other	352	-0.1%	2.7%	2.6%
Facility/HHA Based/Non-Profit	347	-0.2%	2.7%	2.5%
Facility/HHA Based/For-Profit	200	-0.1%	2.7%	2.6%
Facility/HHA Based/Government	79	-0.1%	2.7%	2.6%
Facility/HHA Based/Other	77	-0.3%	2.7%	2.4%
Subtotal: Freestanding Facility Type	4,483	0.0%	2.7%	2.7%
Subtotal: Facility/HHA Based Facility Type	703	-0.2%	2.7%	2.5%
Subtotal: Non-Profit	928	-0.1%	2.7%	2.6%
Subtotal: For Profit	3,708	0.1%	2.7%	2.8%
Subtotal: Government	121	0.0%	2.7%	2.7%
Subtotal: Other	429	-0.1%	2.7%	2.6%
Hospice Type and Control: Rural				
Freestanding/Non-Profit	132	-0.1%	2.7%	2.6%
Freestanding/For-Profit	351	0.0%	2.7%	2.7%
Freestanding/Government	24	-0.6%	2.7%	2.1%
Freestanding/Other	49	0.0%	2.7%	2.7%
Facility/HHA Based/Non-Profit	135	-0.2%	2.7%	2.5%
Facility/HHA Based/For-Profit	47	-0.7%	2.7%	2.0%

Table 10: Projected Impact to Hospices for FY 2023				
Hospice Subgroup	**Hospices**	**FY 2023 Updated Wage Data with Cap**	**FY 2023 Proposed Hospice Payment Update (%)**	**Overall Total Impact for FY 2023**
Facility/HHA Based/Government	62	-0.2%	2.7%	2.5%
Facility/HHA Based/Other	46	-0.1%	2.7%	2.6%
Facility Type and Control: Urban				
Freestanding/Non-Profit	449	-0.1%	2.7%	2.6%
Freestanding/For-Profit	3,157	0.1%	2.7%	2.8%
Freestanding/Government	18	0.3%	2.7%	3.0%
Freestanding/Other	303	-0.1%	2.7%	2.6%
Facility/HHA Based/Non-Profit	212	-0.2%	2.7%	2.5%
Facility/HHA Based/For-Profit	153	-0.1%	2.7%	2.6%
Facility/HHA Based/Government	17	-0.1%	2.7%	2.6%
Facility/HHA Based/Other	31	-0.3%	2.7%	2.4%
Hospice Location: Urban or Rural				
Rural	846	-0.1%	2.7%	2.6%
Urban	4,340	0.0%	2.7%	2.7%
Hospice Location: Region of the Country (Census Division)				
New England	149	-0.5%	2.7%	2.2%
Middle Atlantic	282	0.0%	2.7%	2.7%
South Atlantic	588	-0.2%	2.7%	2.5%
East North Central	559	-0.4%	2.7%	2.3%
East South Central	256	-0.1%	2.7%	2.6%
West North Central	410	-0.5%	2.7%	2.2%
West South Central	1,015	0.3%	2.7%	3.0%
Mountain	538	-0.2%	2.7%	2.5%
Pacific	1,340	0.7%	2.7%	3.4%
Outlying	49	-0.3%	2.7%	2.4%

Table 10: Projected Impact to Hospices for FY 2023				
Hospice Subgroup	**Hospices**	**FY 2023 Updated Wage Data with Cap**	**FY 2023 Proposed Hospice Payment Update (%)**	**Overall Total Impact for FY 2023**
Hospice Size				
0 - 3,499 RHC Days (Small)	1,076	0.3%	2.7%	3.0%
3,500-19,999 RHC Days (Medium)	2,457	0.2%	2.7%	2.9%
20,000+ RHC Days (Large)	1,653	0.0%	2.7%	2.7%

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

Region Key: New England=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic=Pennsylvania, New Jersey, New York;
South Atlantic=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East North Central=Illinois, Indiana, Michigan, Ohio, Wisconsin
East South Central=Alabama, Kentucky, Mississippi, Tennessee
West North Central=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
West South Central=Arkansas, Louisiana, Oklahoma, Texas
Mountain=Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific=Alaska, California, Hawaii, Oregon, Washington
Outlying=Guam, Puerto Rico, Virgin Islands