NHPCO Member Regulatory Alert
August 01, 2011

**Summary at a Glance:** On July 29, 2011, the Final FY2012 Wage Index rule was posted on the Federal Register Public Inspection page. The final rule will be published in the Federal Register on August 4, 2011. On August 1, 2011, the FY2012 hospice payment rates were announced. Rates and cap amount are also included in this Regulatory Alert. Key elements of this final rule include:

1. **FY2012 Hospice Payment Rates**
2. **Hospice Aggregate Cap**
3. **Wage Index and hospital market basket update of 3.0%**
   - Hospital market basket update of 3.0% does not take into account the BNAF reduction, figured into the wage index values and estimated by CMS to be a .5% reduction in rates
   - Net rate increase for FY2012 is 2.5%, with variation based on the wage index value.
   - State-by-state charts and wage index calculator posted soon.
4. **BNAF reductions – third year of the 7 year phase out of BNAF**
   - BNAF reduction is a calculation completed by CMS before the wage index values are published for FY2012.
   - A description of the BNAF reduction, how the reduction is applied to the wage index.
5. **Cap methodology calculation options**
   - A description of the two cap methodology calculations, a definition of each methodology, how to elect a methodology, and time limitations on cap determination reopening.
6. **Hospice face-to-face requirement**
   - Clarifications on the same physician, nurse practitioner as an employee of a larger health system, timeframes for completing the face-to-face, explanation of exceptional circumstances, clarifications on discharge when the face-to-face is not completed timely, and the manual references for the hospice.
7. **QIO decision on patient appeal of discharge**
   - CMS clarifies that the decision of the QIO is final when the QIO disagrees with the hospice when a patient is discharged and appeals the discharge.
8. **Hospice aide and homemaker clarifications**
   - Technical corrections to regulatory language.
9. **Quality reporting for hospices**
   - Required measures for FY2014
   - Mandatory and voluntary submission of data
   - Penalty for not submitting data
   - Other measures under consideration
   - NHPCO resources for quality measures
10. **Hospice value-based purchasing**
    - Description of value-based purchasing pilot for hospices
11. **Redesigned Provider Statistical & Reimbursement Report**
    - Description of PS&R report and its value for cap calculations

NHPCO’s Health Policy Team has created a copy of the [Medicare Hospice Regulations](#) (PDF), including the Conditions of Participation and the changes to regulations finalized with this rule.
A copy of the final rule can be found at http://www.ofr.gov/OFRUpload/OFRData/2011-19488.PI.pdf and will be published in the Federal Register on August 4, 2011.

1. FY2012 Hospice Payment Rates


NHPCO will release the state-by-state rate spreadsheets and the wage index calculator in the coming days.

Table 1: FY2012 Hospice Payment Rates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
<th>Wage Component Subject to Index</th>
<th>Non-Weighted Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care</td>
<td>$151.03</td>
<td>$103.77</td>
<td>$47.26</td>
</tr>
<tr>
<td>652</td>
<td>Continuous Home Care Full Rate = 24 hours of care Hourly rate = $36.73</td>
<td>$881.46</td>
<td>$605.65</td>
<td>$275.81</td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$156.22</td>
<td>$84.56</td>
<td>$71.66</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$671.84</td>
<td>$430.04</td>
<td>$241.80</td>
</tr>
</tbody>
</table>

2. Hospice Aggregate Cap

The aggregate cap amount for the cap year ending October 31, 2011 is $24,527.69.

3. Wage Index and Hospital Marketbasket Increase

The wage index for FY2012 is published in this final rule. Addendum A contains the wage index values for each CBSA or urban area. Addendum B contains the wage index values for rural areas. In this final rule, CMS announced that the hospital marketbasket increase for FY2012 is 3.0%. With the BNAF adjustment in the wage index value, the net rate increase is 2.5%. See below for more information on the BNAF.

4. BNAF Reductions

This rule implements the third year of a 7 year phase out of the budget neutrality adjustment factor (BNAF). This is a multiplier to the wage index and has, since the mid-1990’s, provided for a percentage increase in rates. The FY2009 final hospice wage index rule began the 7 year elimination of the BNAF, which will continue through FY2016. The BNAF reduction is applied to the wage index before publication in Addenda A and B each year in the annual wage index final rule, and as such, is not visible as a separate calculation. The effect of the BNAF reduction is a - .5% reduction in the rates that a hospice would otherwise receive.
5. **Aggregate Cap Calculation Methodology**

In recent years the number of hospices exceeding the annual aggregate cap on payment has increased, and over the past couple of years a number of hospices have gone to court challenging the methodology that CMS has used to calculate the hospice cap amount. These hospices have argued that the cap calculation regulatory provisions established in 42 C.F.R. §418.309 are inconsistent with the Medicare statutory provisions, and several courts have agreed and have ruled in favor of the hospices challenging the CMS methodology. In light of these developments, CMS issued a Ruling regarding the cap methodology, and in this final rule CMS has also finalized changes to the hospice cap regulation.

A. **Ruling on Hospice Cap Appeals**


In this ruling, CMS stated that all currently pending appeals that are challenging the validity of 42 CFR 418.309(b)(1) will be remanded to the applicable Medicare contractor for recalculation of the hospice’s cap using a patient-by-patient proportional methodology, as described in the Ruling. Each beneficiary who received care during a cap year will be allocated to that hospice on the basis of a fraction, based on days of care, to account for the portion of their overall hospice stay that occurred in that hospice during that cap year. CMS acknowledges that at the time of the calculation the beneficiary may still be receiving care and therefore the proper final allocation of the patient between multiple cap years and multiple hospices may not be completely accurate, but the contractors are instructed to use the best data available and not wait until all patients have died or otherwise left hospice care. The determinations will be subject to reopening, so if the hospice later wants to go back and have the cap recalculated using final data that wasn't available at the time of the initial calculation, they may do so.

B. **Changes in the Cap Calculation Methodology**

The FY 2012 hospice wage index final rule revises the cap calculation regulation to give providers the option to elect either having their cap calculated using the current methodology (streamlined methodology) or having it calculated using a patient-by-patient proportional methodology. More details on the cap methodologies are below.

1. **Cap determinations for cap years ending on or before October 31, 2011**

For cap years ending October 31, 2011 and for prior cap years, hospices will have their cap calculated under the current methodology (“streamlined methodology”), subject to the following: if, as of October 1, 2011 the hospice hasn’t yet received a cap determination for any year ending October 31, 2011 or earlier, the hospice may elect to have the calculation done using the patient-by-patient proportional methodology (described below).

Hospices who have filed challenges to the current cap calculation methodology are subject to the CMS Ruling addressed above. All hospices that have challenged the cap regulation will have their
cases remanded to their Medicare contractor for recalculation of their cap using a patient-by-patient proportional methodology.

2. **Cap determinations for cap years ending on or after October 31, 2012**

For cap years ending October 31, 2012 and all subsequent cap years, a hospice’s cap will be calculated using the patient-by-patient proportional methodology, subject to the following: if the hospice had not filed a challenge to the current cap regulation and did not opt to have the patient-by-patient proportional methodology applied for a cap year ending on or before October 31, 2011, the hospice is eligible to make a one-time election to have its cap calculated using the streamlined methodology. The election would remain in effect for subsequent years unless the hospice submits a written election change to the patient-by-patient proportional methodology or the hospice appeals the streamlined methodology. Once such a hospice elects the patient-by-patient proportional methodology or challenges the streamlined methodology, they cannot later opt to switch back to the streamlined methodology. In such cases, past cap year determinations may be adjusted to avoid over-counting of beneficiaries.

3. **Patient-by-Patient Proportional Methodology Defined**

Under the patient-by-patient proportional methodology, a hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient’s total days of care in all hospices and all years that was spent in that hospice in that cap year, using the best data available at the time of the calculation. The total number of beneficiaries for a hospice’s cap year is determined by adding the whole or fractional share of each Medicare beneficiary that receives hospice care from that hospice during that actual cap year. In this way, the cap “credit” for a single beneficiary may be divided up between more than one cap year in which the patient received hospice care and more than one hospice that provided care to the patient. When a hospice’s cap is calculated using the patient-by-patient proportional methodology and a beneficiary included in that calculation survives into another cap year, the contractor may need to make adjustments to prior cap determinations, subject to existing re-opening regulations.

4. **Streamlined Methodology Defined**

Under the “streamlined methodology”, a hospice’s cap is calculated by including in its cap calculation those beneficiaries who have elected to receive care from that hospice and who have not been previously been included in the calculation of any hospice cap. Under this methodology, a beneficiary is counted for cap purposes in only one cap year, even if their stay in hospice includes time in more than one cap year. In the case in which a beneficiary received care from more than one hospice, each hospice includes in its number of Medicare beneficiaries only that fraction that represents the portion of a patient’s total days of care in all hospices and all years that was spent in that hospice in that cap year, using the best data available at the time. The cap calculation may later be adjusted based on updated data.

Contractors will provide hospices with instructions regarding the cap determination methodology election process. Regardless of which methodology is used, the contractor will continue to demand any additional overpayment amounts due to CMS at the time of the hospice cap determination.
The contractor will continue to include the hospice cap determination in a letter which serves as a notice of program reimbursement ("NPR") under 42 CFR 405.1803(a)(3).

C. Election of methodology

1. For cap years on or before October 31, 2011: The hospice may elect to have their final cap determinations for such cap year(s), and all subsequent cap years, calculated using the patient-by-patient proportional methodology. The election must occur in the period beginning October 1, 2011 (the effective date of this final rule) but before receipt of the 2011 (or prior) cap year determination.

2. For cap years ending on or after October 31, 2011: Hospices would have their aggregate caps calculated using the patient-by-patient proportional methodology, unless a hospice exercises a one-time election to have its aggregate cap for cap years 2012 and beyond calculated using the streamlined methodology.

3. Timeframe for electing the streamlined methodology: The election must be made no later than 60 days after receipt of the 2012 cap determination. The hospice can elect to continue using the streamlined methodology any time between October 1, 2011 and up to 60 days after receipt of the 2012 cap determination.

4. New Hospices: All new hospices that are Medicare-certified after the effective date of this final rule (October 1, 2011) will have their cap determinations calculated using the patient-by-patient proportional methodology.

D. Instructions on selecting a cap methodology

A. MACs will provide hospices with instructions regarding the cap determination methodology election process. In addition, the contractor will continue to demand any additional overpayment amounts due to CMS at the time of the hospice cap determination. The MAC will include the hospice cap determination in a letter which serves as a notice of program reimbursement under 42 CFR §405.1803(a)(3). Cap determinations are subject to the existing CMS reopening regulations.

B. CMS will also ask MACs to include language on the 2012 cap determinations which explains that the provider has up to 60 days from the date of receipt of the determination letter to elect to continue using the streamlined methodology.

E. Timeframe for counting beneficiaries using the streamlined methodology
Beneficiaries and their associated days are counted from September 28th to September 27th. This timeframe for counting beneficiaries was implemented because it allows those beneficiaries who elected hospice near the end of the cap year to be counted in the year when most of the services were provided.
F. **Timeframe for counting beneficiaries using the patient-by-patient proportional methodology**

Beneficiaries and their associated days of care are counted from November 1st through October 31st, to match that of the cap year. This ensures that the proportional share of each beneficiary’s days in that hospice during the cap year is accurately computed.

G. **Reopening a cap determination letter**

In response to concerns expressed in the NHPCO comment letter, CMS clarified that the cap determination letter is limited to a 3-year timeframe for reopening, unless fraud is suspected, where the reopening is unlimited. The cap determination letter is a Notice of Program Reimbursement (NPR) and follows the NPR regulations found at 42 CFR §405.1885. The hospice regulatory text has been revised in the section on hospice caps at §418.309(d)(3) to reference the reopening requirements. Reopening regulations are also found in the Paper-Based Manual 15-1, chapter 29, entitled “Provider Payment Determination and Appeals,” available on the CMS website.

H. **For more information**

The final regulations concerning the cap calculation methodology will also be included in a revised cap section of the hospice claims processing manual (Internet-only manual (IOM) 100-04, chapter 11, section 80) to reflect the changes implemented in this final. CMS also states that there will be examples of the details of the calculations, a MedLearn Matters article, and information on the [CMS Hospice Center webpage](http://www.nhpco.org/regulatory). NHPCO will also provide additional information in the Regulatory and Compliance Center of the NHPCO website (www.nhpco.org/regulatory).

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6. **Hospice Face-to-Face Requirement**

A. **Same physician:** This final rule clarifies that any hospice physician can perform the face-to-face encounter regardless of whether the same physician recertifies the patient’s terminal illness and composes the recertification physician narrative.

B. **Definition of employee:** The complete definition of a hospice employee at 42 CFR §418.3 is as follows: “Employee means a person who:

1. Works for the hospice and for whom the hospice is required to issue a W–2 form on his or her behalf;
2. if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice; or
3. is a volunteer under the jurisdiction of the hospice.”

The complete definition of employee applies to the nurse practitioner who is completing face-to-face encounters for the hospice. If the hospice is a subdivision of an agency or organization, such as a
health system, where the nurse practitioner is assigned to the hospice, they would be considered a direct employee for purposes of face-to-face.

C. Timeframe for face-to-face encounters: The regulations were revised to ensure that the face-to-face encounter is required “prior to” the 3rd benefit period recertification and for each subsequent recertification.

D. Exceptional circumstances: Providers have had some confusion about whether the examples used in CR7337 allowing the exceptional circumstance were the only exceptional circumstances allowed or whether they were examples. CMS states that “the manual provides some examples, but these examples are not intended to be all-inclusive.”

E. Discharge when face-to-face is not completely timely: CMS states that “if the face-to-face encounter requirements are not met, the beneficiary is no longer certified as terminally ill, and consequently is not eligible for the Medicare hospice benefit. Therefore, the hospice must discharge the patient from the Medicare hospice benefit because he or she is not considered terminally ill for Medicare purposes. The hospice can readmit the patient to the Medicare hospice benefit once the required encounter occurs, provided the patient signs a new election form and all other new election criteria are met. If they choose to do so, hospices can provide care to these patients in the interim at the hospice’s own expense until eligibility is re-established, but that care must occur outside of the Medicare hospice benefit.”

F. Up-to-date information on face-to-face encounter policy: Providers can go to the Hospice Benefit Policy Manual (IOM 100-02, Chapter 9), Section 20.1 for comprehensive guidance on the hospice face-to-face encounter policy.

7. QIO decision on patient appeal of discharge

In response to a question from a commenter about discharge after a face-to-face encounter and the responsibility of the hospice when the patient appeals to the QIO, CMS writes: “If a patient appeals a pending discharge to the QIO, the QIO decision is binding; a hospice could not discharge a patient as ineligible if the QIO deems that patient to be eligible. The provider is required to continue to provide services for the patient. In the QIO response, the QIO should advise the provider as to why it disagrees with the hospice, which should help the provider to re-evaluate the discharge decision. If at another point in time the hospice feels that the patient is no longer hospice eligible, the provider should give timely notice to the patient of its decision to discharge. The patient could again appeal to the QIO, and the hospice and patient would await a new determination from the QIO based on the situation at that time” (75 FR 70448).
8. Hospice Aide and Homemaker Services

Regulatory text has been corrected to correct technical issues regarding hospice aide and homemaker and a correction to the CoP reference at 42 CFR §418.202(g).

9. Quality Reporting For Hospices

Introduction: The Patient Protection and Affordable Care Act (ACA) requires that each hospice submit data to the Secretary of HHS on quality measures specified by the Secretary (Section 1814(i)(5)(C)). Measures selected must have been endorsed by the consensus-based entity under contract to CMS, currently the National Quality Forum (NQF). A measure that has not received endorsement may be selected if it focuses on an important content area not covered by endorsed measures. The Secretary must publish selected measures no later than October 1, 2012 applicable to FY2014.

a. Measures for the first year of quality reporting (FY2014)

i. Outcome Measure: NQF #0209 (Comfortable Dying)
Hospices will report the NQF-endorsed measure that is related to pain management, NQF #0209: The percentage of patients who were uncomfortable because of pain on admission to hospice whose pain was brought to a comfortable level within 48 hours.

A primary goal of hospice care is to enable patients to be comfortable and free of pain, so that they may live each day as fully as possible. This patient-level data would be aggregated and submitted on a template prepared by CMS no later than April 1, 2013.

Measure specifications for this measure can be found at the National Quality Forum website (www.qualityforum.org). In preparation for implementing this quality measure, NHPCO has resources for your hospice. See the box below for links and additional information.

NOTE: NQF # 0209 is the NHPCO Comfortable Dying measure. Detailed information on implementation of this measure is available on the NHPCO web site: www.nhpco.org/outcomemeasures. Questions related to this measure can be sent to EROM@nhpco.org

ii. Structural Measure: Participation in a QAPI program that includes at least 3 quality indicators related to patient care
This structural measure requires the hospice to: 1) indicate if it as a QAPI program that includes at least three indicators related to patient care; and 2) submit a description of the quality indicators related to patient care. Submission of the description of the indicators is the requirement; the results of the indicators are not submitted. The descriptions of the patient-care focused quality indicators would be submitted on a template prepared by CMS and submitted no later than January 31, 2013.

b. Voluntary and Mandatory Submission of Data

**Mandatory Submission:** Hospices will begin mandatory reporting on quality indicators in 2012, for the FY2014 wage index year. The first year of reporting will be based on the time period October 1, 2012 through December 31, 2012. Both the QAPI measure and the pain measure will be reported. The details and reporting dates are indicated on the table below.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Requirement</th>
<th>Reporting Period</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. QAPI program with at least three patient care-related indicators</td>
<td>October 1, 2012 through December 31, 2012, with template for reporting ready by December 31, 2011</td>
<td></td>
<td>January 31, 2013</td>
</tr>
<tr>
<td>Name of Indicator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of numerator and denominator, if available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data source (EMR, paper medical record, adverse events log)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. NQF #0209: The percentage of patients who were uncomfortable because of pain on admission to hospice whose pain was brought to a comfortable level within 48 hours.</td>
<td>TBA</td>
<td>October 1, 2012 through December 31, 2012, with template ready by December 31, 2011</td>
<td>April 1, 2013</td>
</tr>
</tbody>
</table>
Voluntary Submission: Hospices who choose to participate in the voluntary submission process will submit information only on the structural measure for the time period October 1 – December 31, 2011, submitted by January 31, 2012. The description of each of the patient-care focused quality indicators would allow CMS to learn more about patient care quality issues in hospice and would provide useful information in the design and structure of the quality reporting program. The table below gives more detail on the voluntary reporting process.

Table 2: Voluntary Quality Reporting for FY2014

<table>
<thead>
<tr>
<th>Measure</th>
<th>Requirement</th>
<th>Reporting Period</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. QAPI program with at least three patient care-related indicators</td>
<td>October 1, 2011 through December 31, 2011 with template and data submission requirements by November 2011.</td>
<td>January 31, 2012</td>
<td></td>
</tr>
<tr>
<td>Name of Indicator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of numerator and denominator, if available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data source (EMR, paper medical record, adverse events log)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

c. Data submission

CMS will provide a spreadsheet template for hospices to submit quality reporting data. CMS is considering a web interface for data collection, to protect the security of data transmission, reduce data errors and streamline analysis. The spreadsheet will likely be a part of this web interface. Training in the use of this data submission tool will be provided, and a call-in helpline will be established and staff for hospices who have specific questions about the data submission process. For hospices that are unable to complete the web-based data entry, a downloadable data entry form will be available. More information will be available from CMS by December 31, 2011.

d. Penalty for not submitting data

Beginning in FY2014 and each following year, the Secretary is required to reduce the market basket increase of hospices who do not comply with the quality data submission requirements for that fiscal year. A reduction of 2 percentage points is required for non-participation. This could mean that the hospice’s annual marketbasket update is less than 0.0% for a fiscal year. The data collection timeframes will allow CMS to identify the hospices who do not comply with this requirement.
### e. Timelines

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Task</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2014</td>
<td>Data collection</td>
<td>October 1, 2012 – December 31, 2012</td>
</tr>
<tr>
<td></td>
<td>Reporting</td>
<td>QAPI indicators: January 31, 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pain measure: April 1, 2013</td>
</tr>
<tr>
<td>FY2015 and beyond</td>
<td>Data collection</td>
<td>January 1, 2013 through December 31, 2013</td>
</tr>
<tr>
<td></td>
<td>Reporting</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

### f. Operational details

Operational details for data submission methods and format for the hospice quality data reporting program can be found on the [CMS website](https://www.cms.gov). CMS expects information to be available no later than December 31, 2011.

### g. Additional measures under consideration.

**Family Evaluation of Hospice Care (FEHC):** CMS states that they are considering this measure for consideration in the FY2013 Hospice Wage Index proposed rule. Measurement of patient/family experience of hospice care is a high priority for CMS. The NQF website now contains updated information regarding the [endorsed FEHC measure #0208](https://www.qualityforum.org), which includes a composite score and a global score.

CMS states: “We recognize that many (approximately one-third) of all hospices do participate in the NHPCO sponsored data collection and analysis of the FEHC survey. We are also aware of limitations of the FEHC survey, some of which may be addressed in the near future through updates to the survey. Ensuring patient and family centered care continues to be a priority for CMS. Therefore, we are considering this measure for inclusion in next year’s rule for data collection beginning October 2012 for the FY 2014 program, or for data collection beginning in January 2013 for the FY 2015 program. We will also consider the comments received in making decisions about future measure development.”

**Other measures:** In the quality reporting process, CMS expects to explore and expand the list of measures in coming years. Future topics under consideration include patient safety, effective symptom management, patient and family experience of care, and alignment of care with patient preferences.

### h. Data available to the public:

No date has been set for public reporting of hospice data. In the final rule, CMS states that “we recognize that public reporting of quality data is a vital component of a
robust quality reporting program and are fully committed to developing the necessary systems for public reporting of hospice quality data.”

10. Hospice Value Based Purchasing

Beginning no later than FY2015, CMS has stated that they will “require hospices to report an expanded and comprehensive set of quality measures from which we can select for pilot testing a value-based purchasing program.” During the FY 2013, FY 2014 and FY2015 hospice rulemaking, CMS intends to expand and implement a more comprehensive set of measures and will solicit comments regarding the analysis and design for a hospice value-based purchasing pilot, with a goal of improving the quality of care while reducing spending.

Value-based purchasing is being used with many Medicare provider types and involves the assessment of performance of the provider based on selected quality measures, with incentive payment awards to those providers who perform the best or improve the most in terms of quality.

11. Redesigned Provider Statistical & Reimbursement Report

As CMS announced in the proposed FY2012 Hospice Wage Index rule, there will be a redesigned PS&R system available by the end of the year, which will provide more complete information on beneficiary utilization of hospice services, and will allow hospices easy access to national, beneficiary-specific, hospice utilization data. In the final rule, CMS states that they expect hospices to use the information to help manage their caps. They also state that they may require hospices to self-report their caps using PS&R data in the future.

Late-breaking Debt Ceiling Update: The publication of the final rule comes as the press is reporting that a deal has tentatively been reached to raise the federal debt ceiling and a plan has been set forth for long-term deficit reduction. NHPCO and the Hospice Action Network are reviewing the legislative text of the deal and, pending Congressional approval of any proposal, will be providing any relevant details on how the legislation could impact the hospice community.

Members should direct any inquiries to regulatory@nhpco.org. Thank you.