FY2020 Hospice Wage Index Final Rule

To: NHPCO Hospice Provider Members
From: NHPCO Regulatory and Quality Teams
Date: August 2, 2019

Summary at a Glance

On July 31, 2019, the Centers for Medicare and Medicaid Services (CMS) released the Final FY 2020 hospice payment rule. The final rule includes rebasing of and an increase in payment rates for Continuous Home Care (CHC), Inpatient Respite Care (IRC), and General Inpatient Care (GIP), a reduction in routine home care (RHC) rates, changes to the hospice election statement, a new requirement for an election statement addendum detailing the items, services or drugs the hospice will not cover, and changes to the hospice quality reporting program. In response to the proposed rule, NHPCO responded with a comment letter, developed with member feedback and robust discussion from the NHPCO Regulatory Committee and the NHPCO Quality and Standards Committee.

Resources for the final rule include:

1. FY2020 Hospice Wage Index Final Rule State/County Charts with Final Rates, see below.
2. NHPCO State/County FY2020 Hospice Wage Index Final Rule Rate Calculator, available in Reimbursement – Medicare page of nhpco.org.
3. Free webinar for NHPCO members on final rule, Tuesday, August 6, 2:00pm ET. Register online for the webinar.
4. Changes to Hospice Regulations at 42 CFR 418 (PDF).
5. Podcast on the FY2020 Hospice Wage Index final rule in two parts – part one to be released on Tuesday, August 6, check the NHPCO Podcast page.

Details of the final rule follow.

Hospice Payment Rates

The final rule announces a 2.6% increase in hospice rates. The increases are used solely to rebase the rates for Continuous Home Care (CHC), Inpatient Respite Care (IRC), and General Inpatient Care (GIP). The RHC rates are reduced by -2.72% to accommodate the rebasing for the other three levels of
The rates for Routine Home Care (RHC), at both the high and low tier, are a reduction of $1.75 per day from the original FY2019 RHC high tier rate, and a reduction of $0.49 from the original FY2019 RHC payment rates for the low tier rate.

**PAYMENT RATES WITH QUALITY REPORTING**

October 1, 2019 - September 30, 2020

**RHC Rates**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY2019 Original Payment Rates</th>
<th>FY2019 Rebased Payment Rates</th>
<th>SIA Budget Neutrality Factor</th>
<th>Wage Index Standardization Factor</th>
<th>FY2020 Hospice Payment Update</th>
<th>FY2020 Payment Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>RHC 1-60 days</td>
<td>$196.25</td>
<td>$190.91</td>
<td>X 0.9924</td>
<td>X 1.0006</td>
<td>X 1.026</td>
<td>$194.50</td>
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<tr>
<td>651</td>
<td>RHC 61+ days</td>
<td>$154.21</td>
<td>$150.02</td>
<td>X 0.9982</td>
<td>X 1.0005</td>
<td>X 1.026</td>
<td>$153.72</td>
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**PAYMENT RATES WITH NO QUALITY REPORTING**

October 1, 2019 – September 30, 2020

2% reduction in payment rates, with an increase of 0.6%
## Hospice Cap

For FY2020, the hospice cap will be $29,964.78, which is equal to the FY 2019 cap amount ($29,205.44) updated by the FY 2020 hospice payment update percentage of 2.6%.

## Hospital Wage Index Year

CMS finalized the proposal to use the current fiscal year pre-reclassified hospital wage index as the basis for the hospice wage index. The use of the current year IPPS hospital wage index is in place as a wage index methodology for Medicare’s skilled nursing facility (SNF), home health and inpatient hospital prospective payment system. The wage index values published by CMS reflect the elimination of the 1-year lag in wage index data.

## Changes to the Hospice Election Statement

CMS finalized the proposal to amend the hospice election statement. Effective October 1, 2020 (FY 2021), hospices will be required to include the following on the hospice election statement:

- Information about the holistic, comprehensive nature of the Medicare hospice benefit.

### Table

<table>
<thead>
<tr>
<th>Description</th>
<th>FY2019 Original Payment Rates</th>
<th>FY2019 Rebased Payment Rates</th>
<th>SIA Budget Neutrality Factor</th>
<th>Wage Index Standardization Factor</th>
<th>FY2020 Payment Update of 2.6% minus 2% = +0.6%</th>
<th>FINAL FY2020 Payment Rates</th>
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</thead>
<tbody>
<tr>
<td>RHC 1-60</td>
<td>$192.39</td>
<td>$190.91</td>
<td>X 0.9924</td>
<td>X 1.0006</td>
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<td>Service Intensity Add-on</td>
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<td>$56.80</td>
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<td>X 0.9978</td>
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<td>X 0.9978</td>
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<td>Inpatient Respite</td>
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<td></td>
<td>X 1.0024</td>
<td>X 1.0006</td>
<td>$1,001.35</td>
</tr>
</tbody>
</table>
• A statement that, although it would be rare, there could be some necessary items, drugs, or services that will not be covered by the hospice because the hospice has determined that these items, drugs, or services are to treat a condition that is unrelated to the terminal illness and related conditions.

• Information about beneficiary cost-sharing for hospice services.

• Notification of the beneficiary’s (or representative’s) right to request an election statement addendum that includes a written list and a rationale for the conditions, items, drugs, or services that the hospice has determined to be unrelated to the terminal illness and related conditions and that immediate advocacy is available through the BFCC-QIO if the beneficiary (or representative) disagrees with the hospice’s determination.

CMS is implementing these changes to the election statement because the “the incidence of anecdotal reports and the amount and nature of the non-hospice services being billed to Medicare outside of the hospice benefit suggests that hospice beneficiaries may not be fully informed, at the time of admission or throughout the hospice election, of the items, services, and drugs the hospice has determined to be unrelated to their terminal illness and related conditions. We believe this is necessary information for patients and their families to make informed care decisions.”

CMS reports that numerous anecdotal reports have been received from beneficiaries, families, the Medicare Ombudsman’s office, and non-hospice providers where hospice patients were obtaining needed items, services, and drugs outside of the hospice benefit because they had been told that hospice would not cover these items, services, and drugs, as the hospice had determined that they were unrelated to the terminal illness and related conditions. The beneficiaries and/or the families stated that they did not know they would have to seek care outside of the hospice benefit for these conditions because the hospice did not tell them these items, services, and drugs would not be furnished by the hospice until the patient needed them.

Services Unrelated to the Terminal Illness and Related Conditions

CMS reiterated their “long-standing position that services unrelated to the terminal illness and related conditions should be exceptional, unusual and rare given the comprehensive nature of the services covered under the Medicare hospice benefit as articulated upon the implementation of the benefit (48 FR 56008, 56010, December 16, 1983). To the extent that individuals receive services outside of the Medicare hospice benefit during a hospice election, Medicare coverage is determined by whether or not the services are for the treatment of a condition completely unrelated to the individual’s terminal illness and related conditions (48 FR 38146, 38148, August 22, 1983)”

CMS cited the NHPCO’s “Determining Relatedness to the Terminal Prognosis Process Flow” in the final rule as an example of a “national industry association engaged in activities with hospices to communicate a process for helping hospices make these relatedness determinations in the form of
clinical decision-making process workflows. The latest version of this document can be found here (PDF).

While not mentioned in the final rule, a companion process flow on “Determination of Hospice Medication Coverage,” (PDF) developed by the NHPCO Pharmacist Community in collaboration with the NHPCO Regulatory Committee may also be helpful.

New Requirement for Addendum to Patients

CMS is finalizing a requirement for hospices to include an addendum to patients, titled “Patient Notification of Hospice Non-Covered Items, Services, and Drugs.” Effective October 1, 2020 (FY 2021), hospices will be required to issue the addendum detailing non-covered items, services and drugs when the patient or representative requests it, either at admission or during the course of hospice care. This new signed addendum will also serve as a new condition for payment.

Title and Components of Addendum:

Title: “Patient Notification of Hospice Non-Covered Items, Services, and Drugs”

Required components:

1. Name of the hospice;
2. Beneficiary’s name and hospice medical record identifier;
3. Identification of the beneficiary’s terminal illness and related conditions;
4. A list of the beneficiary’s current diagnoses/conditions present on hospice admission (or upon plan of care update, as applicable) and the associated items, services, and drugs, not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions;
5. A written clinical explanation, in language the beneficiary and his or her representative can understand, as to why the identified conditions, items, services, and drugs are considered unrelated to the terminal illness and related conditions and not needed for pain or symptom management. This clinical explanation would be accompanied by a general statement that the decision as to whether or not conditions, items, services, and drugs is related is made for each patient and that the beneficiary should share this clinical explanation with other health care providers from which they seek services unrelated to their terminal illness and related conditions;
6. References to any relevant clinical practice, policy, or coverage guidelines.
7. Information on the following domains:
   a. Purpose of Addendum
   b. Right to Immediate Advocacy
8. Name and signature of Medicare hospice beneficiary (or representative) and date signed, along with a statement that signing this addendum (or its updates) is only acknowledgement of
receipt of the addendum (or its updates) and not necessarily the beneficiary’s agreement with the hospice’s determinations.

More detail on the addendum follows in Q&A format. Answers to the questions are CMS language from the final rule. All references to “we” refer to CMS.

**What is the purpose for the addendum?**

**A:** We [CMS] believes that the addendum should be clear in its purpose that these are items, services, and drugs the hospice has determined to be **unrelated to the terminal illness** and therefore not the hospice’s coverage responsibility but may be covered under other Medicare benefits.

**What will the addendum be used for?**

**A:** CMS states that “the addendum is used to communicate items, services, and drugs that would not be on the initial (or subsequent) hospice plan of care to ensure coverage transparency where the hospice has determined that certain items, services, or drugs would not be covered (that is, furnished and paid for by the hospice) because they are unrelated to the terminal illness and related conditions.”

**What is the effective date for the addendum?**

**A:** We [CMS] will finalize an effective date of FY 2021 (October 1, 2020) for the election statement modifications and the addendum. This delayed effective date will allow sufficient time for us to develop a model election statement addendum to provide the industry as they move forward making the changes to their own election statements and as they develop an addendum to communicate those items, services, and drugs they will not be covering because they have determined them to be unrelated to the terminal illness and related conditions. This additional year will allow hospices to make any current process and software changes to incorporate the addendum into their workflow.

This will also allow CMS more time to fully investigate the details brought up by commenters specifically regarding operational and auditing processes, training and education, and we will engage in rulemaking for FY 2021 as necessary to seek any additional comments on any operational or logistical proposals.

**Is the addendum required for all beneficiaries?**

**A:** CMS states that the “addendum would be provided only upon request as we [CMS] believe this would best achieve coverage transparency without imposing undue burden on hospices. Likewise, because we believe that hospices should already have processes in place to make determinations of unrelatedness, additional payment should not be made for completion of the addendum.

**Do we have to give the addendum to every beneficiary electing hospice?**
A: While hospices can choose to provide the addendum to every electing beneficiary, we are not requiring that it is mandatory, unless the patient (or representative) requests the addendum.

What if a hospice provides all items, services and drugs for hospice patients already?

A: For those providers who do furnish all items, services and drugs for hospice patients, this requirement would be met in that there would be no request for an addendum as the hospice would be furnishing all of the patient’s care needs.

What if the beneficiary or representative requests an addendum on admission?

A: If the beneficiary (or representative) requests the addendum at the time of the hospice election (that is, at the time of admission to hospice), hospices could include language on the addendum that those unrelated conditions, items, services, and drugs are those the hospice has identified as present on admission and that any changes to this list (due to new, changing, or inadvertently excluded conditions, items, services, and drugs) would be reflected in written updates to the addendum.

What is the timeframe if the addendum is requested at start of care?

A: If the beneficiary (or representative) requests an addendum at the time of hospice election, the hospice would have 5 days from the start of hospice care to furnish this information in writing. We are finalizing our proposal that if the beneficiary requests the election statement at the time of hospice election but dies within 5 days, the hospice would not be required to furnish the addendum as the requirement would be deemed as being met in this circumstance.

What is the timeframe if addendum is requested after the date of hospice election?

A: If the addendum is requested during the course of hospice care (that is, after the date of the hospice election), we are finalizing that the hospice would have 72 hours from the date of the request to provide the written addendum.

Should the hospice give information about the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) to all patients on admission?

A: Yes, For Hospice elections beginning on or after October 1, 2020, the Hospice must provide information on the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), including the right to immediate advocacy and BFCC-QIO contact information.

What is the right to immediate advocacy mentioned in the list of required elements for the addendum?
A: The addendum must include language that immediate advocacy is available through the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if the individual (or representative) disagrees with the hospice’s determination.

How would a hospice update the addendum?

A: Hospices have the option to make updates to the addendum, if necessary, to include such conditions, items, services and drugs they determine to be unrelated throughout the course of a hospice election. We believe that the requirements proposed and these suggestions would mitigate hospices’ concerns regarding any items, services, or drugs that may have been inadvertently excluded when completing the addendum.

Could the addendum be used as part of the update process for the plan of care and as a tool for patient/family discussions?

A: The IDG should be proactive in developing each patient’s plan of care by planning ahead for anticipated patient changes and needs. Decisions should reflect patient/family preferences and should not solely be a response to a crisis. We believe that the addendum is to be used as a tool to have these discussions both at the time of hospice election, when care planning begins, and throughout the course of a hospice election, as care planning changes to meet the needs of hospice patients and their families.

Can we use the addendum to communicate items, services and drugs that are related but that the hospice is not paying for?

A: While some commenters stated that addendum should also address those items, services, and drugs that may be related, but that the hospice is not covering, for example a brand name drug as opposed to a hospice formulary drug, or if a patient requests to continue using a specific drug that the hospice determines is no longer providing medical benefit to the patient, we [CMS] does not think the addendum is the appropriate mechanism to communicate this information.

What is the requirement for a signature on the addendum?

A: The addendum would include a statement that signing the addendum (and any updates) is only an acknowledgement of receipt of the addendum and not necessarily the beneficiary’s agreement with the hospice’s determinations (84 FR 17595).

How would a hospice implement this new requirement?
A: CMS encourages hospices to “review their current admission processes to see how the addendum could assimilate into their procedures to help ameliorate any issues upon implementation. We [CMS] believes that because hospices already should have processes in place to make determinations about those items, services, and drugs that they will not cover because they are unrelated to the terminal illness and related conditions, hospices will be able to adapt the addendum into their current processes.”

Is there a specific format for the addendum?

A: We [CMS] did not propose a specific format in which to document such conversations and hospices can develop their own processes to incorporate into their workflow. We [CMS] believes that careful documentation that the addendum was discussed and whether or not it was requested would be an essential step a hospice could take to protect themselves from claims denials related to any absence of an addendum (or addendum update) in the medical record.

Will an addendum form be developed by CMS?

A: CMS suggests that “each individual hospice develop and incorporate the addendum into their current admissions process in a way that best meets the hospices’ needs, as well as providing this information as quickly as possible considering the potential for beneficiary cost-sharing. Likewise, non-hospice providers should have timely access to this information in order to promote continuity of care and communication amongst all patient providers and to ensure appropriate claims submission.

Will CMS provide additional guidance on unrelatedness?

A: We [CMS] reminds commenters that since the implementation of the Medicare hospice benefit, it has been our position that virtually all of the care needed by terminally ill individuals should be provided by the hospice (48 FR 56010). As such, there should not be a voluminous list of unrelated items, services, and drugs given the comprehensive nature of hospice services under the Medicare hospice benefit and the requirement that the hospice provide care addressing the physical, medical, psychosocial, emotional, and spiritual needs of hospice patients and families facing terminal illness and bereavement.

When would we use an ABN?

A: If there is a situation in which the patient wants to continue with related items, services, and drugs that the hospice has previously been providing, but that the hospice determines are no longer reasonable and necessary, or the patient decides to switch to a brand name drug rather than the generic equivalent on the hospice formulary, and the hospice provides the item, service, or drug, the hospice would provide the beneficiary with an ABN to notify the beneficiary that he or she would be financially liable. If the hospice does not continue to provide the item, service, or drug, no ABN is required to be given to the beneficiary.
Should we use the addendum to communicate with non-hospice providers or suppliers?

A: CMS reminds providers that “the ongoing sharing of information with other non-hospice healthcare providers and suppliers furnishing services unrelated to the terminal illness and related conditions is necessary to ensure coordination of services and to meet the patient, family, and caregiver needs. [§ 418.56(e)(5)] The coordination requirements include that the hospice must develop and maintain a system of communication and integration amongst all providers furnishing care to the terminally ill patient. For non-hospice providers or suppliers billing Medicare for services received by hospice beneficiaries unrelated to their terminal illness and related conditions, this includes being able to provide documentation from the hospice listing the conditions (and thus items, drugs, and services) the hospice determined to be unrelated and documented as such on the hospice plan of care.”

How does the new addendum requirement interface with Part D?

A: We [CMS] intend to work with hospices and Part D plans to develop a process in which the addendum potentially could be used at the point-of-service when hospice beneficiaries are filling drug prescriptions to ensure timely access to needed drugs. Complete documentation on the part of the hospice, coupled with timely notification of Part D sponsors, mitigates the risk for possible double payment by the Medicare program for drugs, and is anticipated to prevent Part D enrollees in hospice from having a hospice related medication billed by a pharmacy to their Part D plan, potentially subjecting the beneficiary to out-of-pocket expenses.

Why is the addendum a Condition of Payment?

A: While we understand stakeholder concerns about including an addendum statement as a condition for payment, we believe this is necessary to ensure that hospices are diligent in providing this information to Medicare hospice beneficiaries on request. We regard this addendum as an important mechanism of accountability for hospices to provide coverage information to beneficiaries electing the hospice benefit. We also believe that the various reports by the OIG (for example; OIE-02-16-00570, July, 2018, “Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio,”’ 37 and A-06-10-00059, June 2012, “Medicare Could Be Paying Twice For Prescription Drugs For Beneficiaries In Hospice”’) highlight the issues with a patient’s lack of knowledge of hospices’ limitation on their coverage, and the possibility of hospices potentially not covering items, services, and drugs that should be hospices’ responsibility. We reiterate that the election statement addendum, as a condition for payment, would achieve the goal of increasing comprehensive patient education, awareness, empowerment, and coverage transparency.

We [CMS] continue to believe that as a condition for payment, this would ensure a more comprehensive and thoughtful approach by hospices in communicating important coverage information to beneficiaries.
Will CMS collaborate with the Medicare Administrative Contractors (MACs) on guidelines for the condition for payment?

A: We [CMS] will collaborate with the MACs to establish clear guidelines on the use of the addendum as a condition for payment and we will propose any requirements in future rulemaking, as necessary. We do not want hospices to perceive that the purpose of this addendum is punitive against hospices, nor that it is a mechanism to deny claims; rather we want hospices to understand that the intent of this addendum is to keep patients at the forefront of their decision-making equipped with adequate information to make care choices as they approach the end of life.

Changes to regulatory text are detailed in the final rule and are available here for convenience (PDF).

Request for Information Regarding the Role of Hospice and Coordination of Care at End-of-Life

CMS requested information on hospice and the relationships with managed care, ACOs and new payment models. NHPCO solicited comments from members and included a robust set of comments answering this RFI. CMS did not share information in the final rule about this RFI, but states “as we continue to review the comments received, we believe that the information gathered under this RFI will help inform: (1) Future CMS payment models; (2) the role of hospice with respect to ACOs; and (3) our general understanding of the traditional FFS hospice environment in relation to the increasing penetration of managed care through the MA program.”

Hospice Quality Reporting Program

Claims based measures:

CMS plans to explore the development of other claims-based and outcome measures for the HQRP. They state that claims-based measures would be only one type of quality measure in the HQRP and they will take comments received by providers and other stakeholders into consideration as they continue to address the high priority areas of identifying gaps in care and reducing regulatory burden as we explore the development of other claims-based and outcome measures for the HQRP.

Update on Current Claims-Based Measure Development

CMS identified two “high priority” areas that will be addressed by claims-based measure development: potentially avoidable hospice care transitions and access to levels of hospice care.

- The potentially avoidable hospice care transitions concept was developed as a measure under consideration called “Transitions from Hospice Care, Followed by Death or Acute Care.” The goal of this measure is to identify hospices that have notably higher rates of live discharges followed
shortly by death or acute care utilization, when compared to their peers. CMS is considering stakeholder and MAP feedback and is looking at multiple ways to measure this construct, including separating out the components to reduce the measure’s complexity.

- After further analyses, CMS determined that the access to levels of hospice care measure concept as currently specified could result in hospices providing higher levels of care when it is not required by the plan of care or expected by CMS.
- CMS appreciates the comments and the support for continuing to refine efforts to measure these two high priority concepts identified by the OIG in its 2018 report, entitled “Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity and will take these comments under advisement as they continue exploring options for measuring these constructs.

**Hospice Assessment Tool – new name Hospice Outcomes & Patient Evaluation (HOPE)**

- CMS’s goal for a hospice assessment tool is to be more comprehensive than the HIS by capturing care needs in real-time and throughout the end of life; not just at admission and discharge. In addition, a comprehensive assessment tool will provide standardized data as all Medicare-certified hospices will be collecting the same data in standardized manner. A new hospice assessment tool is intended to support quality measure development and care planning.
- CMS intends to offer training and other supports as the new tool is being prepared for implementation; the timeline and process for implementation of the final tested tool will be established through rulemaking.
- CMS continues the process of developing a new hospice assessment that meets the objectives of patient-centered care. This process includes additional information gathering, including review of feedback on the HEART tool, and stakeholder engagement to develop a draft instrument for alpha testing that will ultimately support a national beta test.
- After considering the comments received in response to the proposed rule and for the reasons discussed above, CMS will call the hospice assessment tool the Hospice Outcomes & Patient Evaluation (HOPE).

**Update on the CMS System for Reporting Quality Measures and Standardized Patient Assessment Data and Associated Procedural Issue**

- CMS will be migrating to the iQIES system as soon as FY 2020 and will provide further information regarding the migration and any future system of record changes via sub-regulatory mechanisms to make this transition as smooth as possible.

**CAHPS Survey**

- The CAHPS® Hospice Survey is a component of the CMS HQRP which is used to collect data on the experiences of hospice patients and the primary caregivers listed in their hospice records.
- CMS solicited comments in the proposed rule regarding suggested changes, additions or deletions to the instrument that would improve its value to hospices for quality improvement
and consumers for selecting a hospice. Highlights of impact of stakeholder comments includes the following:

- **Length and availability of survey:** CMS is currently exploring ways to simplify and shorten the survey and we are examining the feasibility of using web-based data collection in conjunction with traditional survey methods.
- **Health literacy:** CMS had a literacy-level review of the questionnaire and are reviewing what changes may be feasible to make.
- **Sending the survey sooner to caregivers:** CMS will think about sending the survey sooner as they consider potential changes to the survey.
- **Hospice staff v. facility staff for patient residing in a facility:** To help the respondent make these distinctions, CMS includes specific references to the hospice involved as part of the mail questionnaire and the telephone questionnaire script.
- **Wording changes to the questionnaire, response scales and hospice provider logos:** During survey development extensive cognitive interviews were conducted with potential respondents to see if they could understand the response scales. CMS does not allow hospice logos to be placed on the questionnaire for mail surveys.
- **CMS will take comments into consideration as they consider changes. Any potential changes will be proposed through future rulemaking.**

**Update to “Hospice Visits when Death is Imminent” Measure to Be Publicly Displayed in August 2019**

- Measure #1 in the measure pair will be reported in August 2019 on Hospice Compare.
- CMS is finalizing their proposal to continue collection of Measure #2 to complete additional testing and to make a determination about the public reporting of Measure 2 of the “Hospice Visits when Death is Imminent” measure pair.
- They expect to complete analysis by the end of FY 2020 and determine next steps for public reporting based on meeting established standards for reliability, validity, and reportability.
- CMS will continue to use a variety of sub-regulatory channels and regular HQRP communication strategies to provide ongoing updates of testing results and plans for modifying and reporting this measure.

**Posting Information from Government Data Sources as Information for Public Reporting**

- CMS stated that they will provide mock-ups of the data from government data sources for stakeholder feedback and show the relationship between the data from other U.S. government websites and hospice related data. The goal is for the information to help consumers in comparing providers.
- CMS is finalizing the proposal to post information from other publicly available U.S. government sources to publicly report in the future and as soon as FY 2020 on Hospice Compare or another CMS website.

Watch for more tools and resources from NHPCO to help implement these new regulatory requirements. Any questions can be sent to regulatory@nhpco.org or quality@nhpco.org