FY 2024 Hospice Wage Index and Quality Reporting Final Rule Analysis

To: *NHPCO Provider and State Members*
From: *NHPCO Regulatory Team*
Date: *August 1, 2023*

(A comprehensive analysis following NHPCO's Regulatory Alert from July 28, 2023)

Summary at a Glance

In the 4:15 posting of the Federal Register for July 28, 2023 the FY 2024 Hospice Wage Index and Quality Reporting final rule was posted to the public inspection part of the Federal Register. The rule for fiscal year 2024 includes the following:

- **Final FY 2024 rate increase: 3.1%** which is a 0.3 percentage point increase from the FY 2024 proposed rule. Rates for each level of care are available below.
- **Cap amount:** The hospice cap amount for the FY 2024 cap year is **$33,494.01**, which is equal to the FY 2023 cap amount ($32,486.92) updated by the FY 2024 hospice payment update percentage of 3.1 percent.
- **HOPE Tool:** CMS states it will provide additional information on the HOPE Tool test results on the HQRP website in fall 2023.
- **Update on Future Quality Measure (QM) Development:** CMS appreciated the comments on future QM development and will continue to engage stakeholders in the development of measures.
- **CAHPS Hospice Survey Experiment:** CMS provided an update on a survey-mode experiment and stated any new modes for completion of the survey would be released with detailed information.
- **Hospice Certifying Physician Medicare Enrollment or Valid Opt-Out:** On May 1, 2024, hospice certifying physicians, including hospice physicians and hospice attending physicians, will be required to be enrolled in Medicare or validly opted-out.

The CMS Fact Sheet on the final rule describes additional details of the rule. Final FY 2024 Hospice Wage Index values were also posted. The FY 2024 Final State/County Rate Charts are available and can now be used for FY 2024 budget purposes. CMS accepted and responded to many of the recommendations NHPCO advocated for in our comment letter.

NHPCO Analysis

1. **FY 2024 Hospice Payment Update Percentage**
   The hospice payment update percentage for FY 2024, based on more recent data, is **3.1 percent** for hospices that submit the required quality data and **-0.9 percent** (FY 2024 hospice payment update of 3.1 percent minus 4 percentage points) for hospices that do not submit the required quality data.

2. FY 2024 Hospice Payment Rates

Table 1: FY 2024 Hospice RHC Payment Rates for Hospices Participating in HQRP

Code	Description	FY 2023 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2024 Hospice Payment Update	FINAL FY 2024 Payment Rates
651	**Routine Home Care (Days 1-60)**	$211.34	1.0009	1.0011	1.031	$218.33
651	**Routine Home Care (days 61+)**	$167.00	1.0000	1.0010	1.031	$172.35

Table 2: FY 2024 Hospice CHC, IRC, and GIP Rates for Hospices Participating in HQRP

Code	Description	FY 2023 Payment Rates	Wage Index Standardization Factor	FY 2024 Hospice Payment Update	FY 2024 FINAL Payment Rates
652	**Continuous Home Care Full Rate = 24 hours of care**	$1,522.04 ($63.42 per hour)	0.9976	1.031	$1565.46 ($65.23 per hour)
655	**Inpatient Respite Care**	$492.10	1.0007	1.031	$507.71
656	**General Inpatient Care**	$1,110.76	1.0001	1.031	$1,145.31

For Hospices not Participating in the Hospice Quality Reporting Program

The Consolidated Appropriations Act (CAA), 2021 changed the payment reduction for hospices failing to meet quality reporting requirements. For FY 2024, the payment reduction is increased to 4 percent. This reduction applies with the FY 2024 Annual Payment Update (APU) based on CY 2022 quality data collection. The **FY 2024 rates for hospices that do not submit the required quality data would be updated by -0.9 percent**, which is the FY 2024 hospice payment update percentage of 3.1 percent minus 4 percentage points.

Table 3: FY 2024 Hospice RHC Payment Rates for Hospices that DO NOT Submit the Required Quality Data

Code	Description	FY 2023 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2024 Hospice Payment Update of 3.1% minus 4 percentage points = -0.9%	FY 2024 FINAL Hospice Payment Rates
651	**Routine Home Care (days 1-60)**	$211.34	1.0009	1.0011	0.991	$209.86
651	**Routine Home Care (days 61+)**	$167.00	1.0000	1.0010	0.991	$165.66

Table 4: FY 2024 Hospice CHC, IRC, and GIP Payment Rates for Hospices That DO NOT Submit the Required Quality Data

Code	Description	FY 2023 Payment Rates	Wage Index Standardization Factor	FY 2024 Hospice Payment Update of 3.1% minus 4 percentage points = -0.9%	FY 2024 FINAL Hospice Payment Rates
652	**Continuous Home Care Full Rate = 24 hours of care**	$1,522.04 ($63.42 per hour)	0.9976	0.991	$1,504.72 ($62.70 per hour)
655	**Inpatient Respite Care**	$492.10	1.0007	0.991	$488.01
656	**General Inpatient Care**	$1,110.76	1.0001	0.991	$1,100.87

3. Hospice Cap Amount for FY 2024

The hospice cap amount for the FY 2024 cap year is **$33,494.01**, which is equal to the FY 2023 cap amount ($32,486.92) updated by the FY 2024 hospice payment update percentage of 3.1 percent.

4. Hospice Wage Index Values

The final hospice wage index applicable for FY 2024 (October 1, 2023 through September 30, 2024) is available on the CMS website. The FY 2024 FINAL State/County Rate Charts is available on the Regulatory & Compliance Center Billing & Reimbursement page under Medicare and Medicaid Reimbursement Rates.

5. Clarification on wage index values

In response to a question submitted in the comments, CMS stated the "wage index value [is applied] to the labor portion of the hospice payment rate based on the geographic area in which the

beneficiary resides when receiving RHC or CHC and the geographic location of the facility for beneficiaries receiving GIP or IRC."

6. **Special Exceptions and Adjustments Authority**

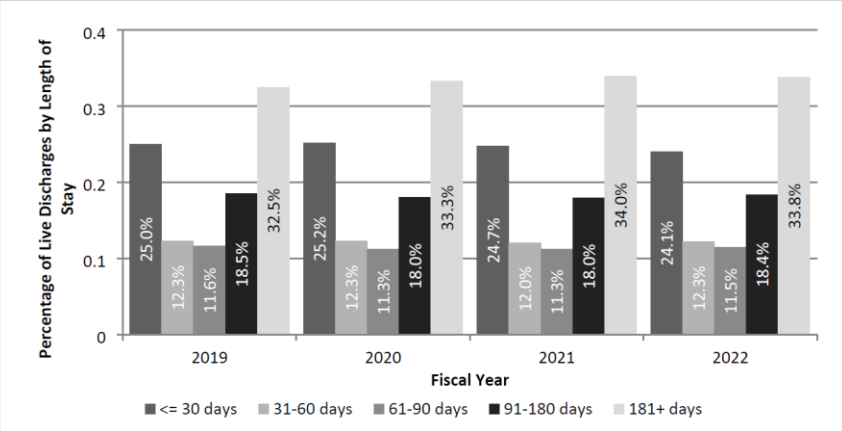
NHPCO requested CMS use its special exceptions and adjustments authority to apply a one-time cumulative retrospective adjustment of 3.7 percent for FYs 2021 and 2022 to ensure Medicare payments more accurately reflect the cost of providing hospice care. The NHPCO comment letter cited a large percentage (nearly 90 percent) of hospice revenue is from Medicare and insufficient payments from Medicare have a significant impact on hospice provider revenue.

CMS responded that the hospice percentage increases are based on the hospital market basket percentage increases and are required by law to be set prospectively. They stated, "there is currently no mechanism to adjust for market basket forecast error in the hospice payment update."

7. **Comments received regarding information related to the provision of higher levels of hospice care; spending patterns for nonhospice services provided during the election of the hospice benefit; ownership transparency; equipping patients and caregivers with information to inform hospice selection.**

Correction to Figure 3 in the FY 2024 Hospice Proposed Rule

In the FY 2024 Hospice Wage Index and Rate Update proposed rule (88 FR 20032), CMS inadvertently provided incorrect data for Figure 3. Figure 3— Length of Stay Intervals Distribution for Live Discharges, FYs 2019 to 2022 is corrected to read as follows:



Source: Analysis of data for FY 2019 through FY 2022 accessed from the CCW on May 11, 2023.
Notes: All hospice claims examined list a discharge status code (meaning claims were excluded if they listed status code 30, indicating they were a continuing patient). Discharges ending in death had a discharge status code of 40, 41, or 42. Any claims not already excluded or that indicated a discharge resulting from death were considered live discharges.

CMS comments on the use of continuous home care (CHC)

"Regarding the use of CHC during the active dying phase, as established in 1983 Hospice Care final rule (48 FR 56008) and amended in the FY 2010 Hospice Wage Index final rule (74 FR 39384), [CMS] would like to remind commenters that a period of crisis is a period in which a patient requires continuous care, which is predominantly nursing care, to achieve palliation or management of acute medical symptoms and thus CHC may be provided only during a period of crisis as necessary to maintain an individual at home. A patient who is actively dying may or may not require continuous home care and each patient must be evaluated to determine the intensity of care needs.

"If a patient is having a period of crisis, requires a minimum of 8 hours of nursing, hospice aide, and/or homemaker care during a 24-hour day, which begins and ends at midnight, and is actively dying, then continuous home care can be provided. We continue to encourage hospice visits when the patient is actively dying, and where the need for greater family and caregivers support is evident, by reminding readers of the service intensity add-on (SIA) payment in the last 7 days of life, as finalized in the FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (80 FR 47142)."

8. **Request for Information (RFI) on Health Equity under the Hospice Benefit**

CMS appreciated the comments and suggestions provided and plans to consider them in potential future rulemaking as all options are explored. CMS shared a fact sheet outlining their strategic vision for health equity.

9. **Conforming Text Revisions for Telehealth Services**

Hospice Face to Face Encounter: Revise § 418.22(a)(4)(ii), which outlines the certification of terminal illness requirements to add "or through December 31, 2024, whichever is later" after "During a Public Health Emergency, as defined in § 400.200 of this chapter." (*See specific regulatory change on page 9 of this alert.*)

> **CMS comments: "**We thank commenters for their consideration of the regulation changes regarding the use of telehealth under the Medicare hospice benefit and we agree that the use of telehealth benefits patients and their families, particularly in rural areas. We note that, at this time, the statute only authorized the Secretary to extend this flexibility through December 31, 2024.
>
> "Additionally, while we acknowledge the usefulness of telehealth, we continue to believe that hospice at its core is a benefit best provided in-person and stress the importance of in-person services. Currently, we do not have plans to make this provision permanent, nor do we believe that we have the statutory authority to do so."

Modifiers or codes for hospice telehealth services

NHPCO and other commenters encouraged CMS to develop modifiers or codes for telehealth services and require reporting on the hospice claim form, allowing the costs to be "allowable administrative costs on the hospice agency cost report."

CMS responded, "upon expiration of the face-to-face flexibility on December 31, 2024, we would expect telehealth services be summarily limited to follow-up contact with patients and would not expect to see the provision of hospice services furnished via telecommunications systems. As such, the value of claims reporting for this type of contact is not apparent at this time."

Remove subsection (d) from § 418.204

The final rule removes subsection (d) to eliminate the use of technology in furnishing services during a PHE, in keeping with the declaration of the end of the PHE in May 2023.

10. Updates to the Hospice Quality Reporting Program (HQRP)

CMS reports approximately 18 percent of Medicare-certified hospices are found non-compliant with the HQRP reporting requirements and subject to the APU payment reduction for a given FY.

Table 5: Quality Measures in Effect for the Hospice Quality Reporting Program

Hospice Quality Reporting Program
Hospice Item Set
Hospice and Palliative Care Composite Process Measure --- HIS-Comprehensive Assessment Measure at Admission includes: 1. Patients Treated with an Opioid who are Given a Bowel Regimen 2. Pain Screening 3. Pain Assessment 4. Dyspnea Treatment 5. Dyspnea Screening 6. Treatment Preferences 7. 7. Beliefs/Values Addressed (if desired by the patient
Administrative Data, Including Claims-based Measures
Hospice Visits in Last Days of Life (HVLDL)
Hospice Care Index (HCI) 1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided 2. Gaps in Skilled Nursing Visits 3. Early Live Discharges 4. Late Live Discharges 5. Burdensome Transitions (Type 1)—Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission 6. Burdensome Transitions (Type 2)—Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital 7. Per-beneficiary Medicare Spending 8. Skilled Nursing Minutes per Routine Home Care (RHC) Day 9. Skilled Nursing Minutes on Weekends 10. Visits Near Death
CAHPS Hospice Survey
CAHPS Hospice Survey 1. Communication with Family 2. Getting timely help 3. Treating patient with respect 4. Emotional and spiritual support 5. Help for pain and symptoms 6. Training family to care for the patent 7. Rating of this hospice 8. Willing to recommend this hospice

Hospice Outcomes and Patient Evaluation (HOPE) tool

HOPE is a patient assessment tool intended to "provide quality data for the HQRP requirements through standardized data collection; and provide additional clinical data that could inform future payment refinements." CMS is continuing development of the HOPE tool and will use field test results to create a final version of HOPE which will be proposed in future rulemaking for national

implementation. CMS plans to provide additional information regarding HOPE testing results on the HQRP website in fall of 2023.

In response to public comments on administrative burden and implementation lead time, CMS stated it is "committed to developing and implementing HOPE with a minimum burden to stakeholders."

CMS will continue to engage with stakeholders through sub-regulatory channels and additional opportunities for hospices to engage and ask questions. Comments and questions about HOPE should be directed to HospiceAssessment@cms.hhs.gov.

Update on Future Quality Measure (QM) Development
On July 26, 2022, the Consensus-Based Entity (CBE) endorsed the claims-based Hospice Visits in the Last Days of Life measure (HVLDL).

CMS intends to develop "several quality measures based on information collected by HOPE when it is implemented." Currently, CMS intends to develop at least two HOPE-based process and outcome quality measures:

- Timely Reassessment of Pain Impact
- Timely Reassessment of Non-Pain Symptom Impact.

CMS responded it appreciates all stakeholder input regarding quality measure development and "remain committed to building a robust, evidence-based set of HQRP measures that holistically and reliably reflect the quality of hospice care."

Health Equity Updates related to HQRP
CMS is seeking to advance health equity through the *CMS Framework for Health Equity* as well as through the CMS National Quality Strategy (NQS). "CMS leaders from across the Agency have come together to move towards a building-block approach to streamline quality measures across CMS quality programs for the adult and pediatric populations. This 'Universal Foundation' of quality measure will focus provider attention, reduce burden, identify disparities in care, prioritize development of interoperable, digital quality measures, allow for cross comparisons across programs, and help identify measurement gaps."

Through this work, CMS is working to develop and implement the Preliminary Adult and Pediatric Universal Foundation Measures. These measures would incorporate:

- health equity measures from other healthcare provider settings
- social determinants of health data items in the standardized patient assessment instruments used in the post-acute care (PAC) settings
- data items related to social drivers of health in acute care settings

CAHPS Hospice Survey Updates
CMS detailed the results of the mode experiment conducted in 2021. CMS states it will "use mode experiment results to inform decisions about potential changes to administration protocols and survey instrument content. Potential measure changes will be submitted to the Measures Under Consideration (MUC) process in 2023 and may be proposed in future rulemaking."

There are no changes to the CAHPS® Hospice survey in this rule. In response to public comments, CMS stated if and when a web-based mode is approved as a CAHPS® survey administration mode, it would not be required, and hospices would have the option to choose among all approved modes. In addition, CMS will also "consider opportunities to make the CAHPS® Hospice Survey easier for caregivers to understand and complete."

Form, Manner, and Timing of Quality Data Submission

TABLE 6: HQRP Reporting Requirements and Corresponding Annual Payment Updates

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

TABLE 7: HQRP Compliance Checklist

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

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

Codification of HQRP Data Completion Thresholds

CMS has added the data completion thresholds to the hospice regulations at § 418.312 (j). See specific regulatory language on page 12 of this alert.

11. Hospice Certifying Physician Enrollment

CMS has finalized the proposal that all hospice certifying physicians must be either enrolled or validly opted out of the Medicare program. The provider or supplier must complete, sign, and submit to its assigned Medicare Administrative Contractor (MAC) the appropriate enrollment form, typically the Form CMS-855. Form CMS-855, which can be submitted via paper or electronically through the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) process, collects important information about the provider or supplier. Such data includes, but is not limited to, general identifying information (for example, legal business name), licensure and/or certification data, and practice locations. After receiving the provider's or supplier's initial enrollment application, CMS or the MAC reviews and confirms the information thereon and determines whether the provider or supplier meets all applicable Medicare requirements. CMS believes this screening process has greatly assisted CMS in executing its responsibility to prevent Medicare fraud, waste, and abuse.

Adding hospice services to § 424.507(a) and (b)

Will determine whether the physician meets all Federal and state requirements (such as licensure) or presents any program integrity risks, such as past final adverse actions.
Could help foster beneficiary health and safety by ensuring the physician is appropriately licensed.

What physicians must be enrolled or validly opted-out?

CMS states "each certification required under § 418.22(c) should be conducted by an enrolled or validly opted-out physician." CMS believes the definition of attending physician in § 418.3 describes the attending physician as being "identified by the beneficiary, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care." It is important to include attending physicians as well as hospice physicians in the enrollment requirement. CMS has added language in § 424.507(b)(3) to reflect this requirement. See specific regulatory text on page 12 of this alert.

CMS Look Up Data File

Hospices can quickly verify status using the CMS ordering and referring data file (ORDF) which lists all Medicare-enrolled and opted-out physicians. CMS reports HHAs and DMEPOS providers use this tool to find the Medicare enrollment or opt-out status of physicians.

Implementation Date

CMS has announced a **May 1, 2024,** implementation date. Unenrolled and non-opted out hospice and attending physicians will have until April 30, 2024, to enroll or opt-out before the denial of hospice claims commences on May 1, 2024, per § 424.507(b).

12. Changes in Hospice Regulations (Changes marked in red)

§ 418.22 Certification of terminal illness.

* * * * *

(a) * * *

(4) ***Face-to-face encounter.***

(i) As of January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient whose total stay across all hospices is anticipated to reach the 3rd benefit period. The face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the 3rd benefit period recertification, and every

benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care.

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

§ 418.204 [Amended]
Amend § 418.204 by removing paragraph (d).

13. § 418.204 Special coverage requirements.

(a) ***Periods of crisis.*** Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide (also known as hospice aide) services or both may be covered on a 24-hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation and management of acute medical symptoms.

(b) ***Respite care.***

(1) Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual.
(2) Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time.

(c) ***Bereavement counseling.*** Bereavement counseling is a required hospice service, but it is not reimbursable.

~~(d) ***Use of technology in furnishing services during a Public Health Emergency.*** When a patient is receiving routine home care, during a Public Health Emergency as defined in § 400.200 of this chapter, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patients' terminal illness and related conditions. The use of such technology in furnishing services must be included on the plan of care, meet the requirements at § 418.56, and must be tied to the patient-specific needs as identified in the comprehensive assessment and the plan of care must include a description of how the use of such technology will help to achieve the goals outlined on the plan of care.~~

[48 FR 56026, Dec. 16, 1983, as amended at 55 FR 50835, Dec. 11, 1990; 74 FR 39413, Aug. 6, 2009; 85 FR 19289, Apr. 6, 2020]

§ 418.309 [Amended]
In § 418.309 amend paragraphs (a)(1) and (2) by removing the date "October 1, 2030"

and adding in its place the date “October 1, 2032”.

14. § 418.309 Hospice aggregate cap.

A hospice's aggregate cap is calculated by multiplying the adjusted cap amount (determined in paragraph (a) of this section) by the number of Medicare beneficiaries, as determined by one of two methodologies for determining the number of Medicare beneficiaries for a given cap year described in paragraphs (b) and (c) of this section.

(a) ***Cap Amount.*** The cap amount was set at $6,500 in 1983 and is updated using one of two methodologies described in paragraphs (a)(1) and (a)(2) of this section.

(1) For accounting years that end on or before September 30, 2016, and end on or after October 1, ~~2030~~ 2032, the cap amount is adjusted for inflation by using the percentage change in the medical care expenditure category of the Consumer Price Index (CPI) for urban consumers that is published by the Bureau of Labor Statistics. This adjustment is made using the change in the CPI from March 1984 to the fifth month of the cap year.

(2) For accounting years that end after September 30, 2016, and before October 1, ~~2030~~ 2032, the cap amount is the cap amount for the preceding accounting year updated by the percentage update to payment rates for hospice care for services furnished during the fiscal year beginning on the October 1 preceding the beginning of the accounting year as determined pursuant to section 1814(i)(1)(C) of the Act (including the application of any productivity or other adjustments to the hospice percentage update).

§ 418.312 Data submission requirements under the hospice quality reporting program

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(j) Data completion thresholds.

(1) Hospices must meet or exceed data submission threshold set at 90 percent of all required HIS or successor instrument records within 30-days of the beneficiary’s admission or discharge and submitted through the CMS designated data submission systems.

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

PART 424-CONDITIONS FOR MEDICARE PAYMENT

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

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

7. Amend § 424.507 by --

a. Revising paragraphs (b) introductory text and (b)(1) introductory text; and

b. Adding new paragraph (b)(3).

The revisions and addition read as follows:

§ 424.507 Ordering covered items and services for Medicare beneficiaries.

* * * * *

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

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

(i) Be identified by his or her legal name.
(ii) Be identified by his or her NPI.
(iii)
(A) Be enrolled in Medicare in an approved status; or
(B) Have validly opted-out of the Medicare program.

* * * * *

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

Next Steps

The CMS Fact Sheet on the final rule describes additional details of the rule. Final FY 2024 Hospice Wage Index values were also posted. The FY 2024 Final State/County Rate Charts are available and can now be used for FY 2024 budget purposes.

Any comments or questions can be directed to regulatory@nhpco.org with "FY 2024 Wage Index and Payment Update" in the subject line.

Questions or comments related to the quality sections of the proposed rule should be directed to quality@nhpco.org.

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