National Hospice and Palliative Care Organization

Regulatory Alerts

NHPCO
Leading Person-Centered Care

CY 2024 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements Finalized

To: *NHPCO Provider and State Members*
From: *NHPCO Regulatory & Quality Teams*
Date: *November 3, 2023*

Summary at a Glance

The calendar year (CY) 2024 Home Health Prospective Payment System Rate Update and Quality Reporting Program Requirements final rule was posted for public inspection at the Federal Register on November 1, 2023. This rule includes several hospice provisions, including the hospice special focus program, informal dispute resolution, and provider and supplier enrollment changes. The Centers for Medicare & Medicaid Services (CMS) has released a fact sheet accompanying the final rule.

Key sections of the final rule include:

- **Special Focus Program.** CMS is finalizing the implementation of the hospice special focus program (SFP) for 2024, including an algorithm for admission to the SFP, survey requirements, the process for graduating from the SFP, and termination from the Medicare program as proposed.
- **Hospice Informal Dispute Resolution (IDR).** CMS is finalizing its proposals without modification to permit hospices with condition-level deficiencies to have an informal opportunity to resolve disputes related to survey findings. CMS stated the agency will publish timeline guidance for the IDR.
- **Provider Enrollment.** CMS is finalizing Medicare provider and supplier enrollment changes as proposed, including:
    - Highest level of screening for newly enrolling hospice providers.
    - Fingerprinting requirements for all five percent or greater owners.
    - Deactivation for six months of Medicare non-billing.
- **Ownership Requirements.** CMS is finalizing hospice change in ownership proposals as proposed:
    - Adds hospices to change in majority ownership regulations currently in effect for home health agencies (HHAs).
    - Adds hospice to the HHA "36 month" rule, which means if a change in ownership occurs within 36 months after the effective date of the HHA's or hospice's initial enrollment in Medicare or within 36 months after the effective date of the HHA's or hospice's most recent change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the new owner, subject to certain exceptions.

NHPCO will also be hosting a webinar on these provisions and other end of year regulatory updates on **November 9** from **2-3:15 p.m. ET**. Any questions can be directed to regulatory@nhpco.org with 'CY 2024 Home Health final rule' in the subject line.

NHPCO Analysis

A. Hospice Special Focus Program

The Hospice Special Focus Program (SFP) was originally required as a part of the hospice program integrity measures in Division CC, section 407 of the Consolidated Appropriations Act of 2021 (CAA 2021). This final rule implements regulations for the hospice SFP for poor performing hospices and includes:

- the SFP algorithm (including data sources) to identify indicators of hospice poor performance,
- the criteria for selection and graduation from the SFP,
- survey requirements and enforcement remedies under the SFP, including potential termination from the Medicare program, and
- public reporting of SFP hospices and the bottom ten percent of hospices identified as poor performing under CMS's finalized SFP methodology.

Background

CMS initially proposed SFP policies in the CY 2022 Home Health Prospective Payment System Rate Update and Quality Reporting Program Requirements proposed rule. However, the agency did not finalize proposals in response to stakeholder feedback, and subsequently established a Technical Expert Panel (TEP) to further inform the implementation of the SFP. While both CMS and the TEP supported a methodology that incorporates certain survey Condition-Level Deficiencies (CLDs) and substantiated complaints in addition to Hospice Care Index and CAHPS® data, CMS' final SFP methodology deviates substantively from TEP recommendations in key areas.

Table 1. Key Differences Between the Final SFP Methodology and TEP Recommendations

	TEP Recommendation	2024 Home Health Final Rule
Scaling	To ensure that larger hospices are on a level playing field with smaller hospices, the TEP adopted a scaling methodology for Quality-of-Care CLDs and substantiated complaints per 100 beneficiaries.	CMS does not adopt a scaling methodology for CLDs and substantiated complaints, which means a single Quality-of-Care CLD or substantiated complaint will be scored the same regardless of hospice size.
Weighting	In consideration that approximately two-thirds of hospices have not reported Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores, the TEP adopted a lower weight of 0.25 for the SFP score calculation.[1]	CMS doubles the weight of the CAHPS® Index in the SFP algorithm, which means CAHPS® scores will be counted twice for those hospices with a CAHPS score, or 40 percent of the overall algorithm score for hospices with CAHPS® Hospice survey data. Hospices without a CAHPS score will only be scored based on other indicators for which data are available.

[1] Although some TEP participants recommended a higher weight for CAHPS Hospice Survey Star Rating scores in recognition of the family and caregiver perspective, other TEP participants raised concerns about this approach given the absence or limited CAHPS® data for certain hospice providers.

	TEP Recommendation	2024 Home Health Final Rule
Technical Assistance	The TEP unanimously agreed that technical assistance should be provided by a third party to SFP hospices.	CMS will not provide technical assistance to SFP hospices, nor will CMS arrange to have this assistance provided by a third party.[2]
Public Reporting	The TEP recommended that SFP hospices should be clearly identified by an icon and easy to understand language on the CMS Care Compare website. The TEP broadly agreed that SFP data should be included within a single spreadsheet easily accessible on the Provider Data Catalog website.	CMS will publish a list of both SFP hospices and a list containing the top ten percent of hospices with the worst scores under the final SFP algorithm.

CMS is finalizing the implementation of the SFP as proposed for 2024. This means CMS will make no changes to the proposed SFP methodology in the CY 2024 Home Health Prospective Payment System Rate Update and Quality Reporting Program Requirements proposed rule. In response to CMS' decision to move forward with the agency's proposed SFP methodology, NHPCO joined other national associations in issuing a statement condemning the agency's decision to move forward with the special focus program as proposed, noting that "*CMS' decision to progress using a flawed methodology for the SFP algorithm will threaten the ability of millions of older adults and other hospice beneficiaries to access quality hospice care*."

The following includes an overview of CMS' finalized SFP policies.

Special Focus Program Definitions

- ***Hospice Special Focus Program (SFP)*** means a program conducted by CMS to identify hospices as poor performers, based on defined quality indicators, in which CMS selects hospices for increased oversight to ensure that they meet Medicare requirements. Selected hospices either successfully complete the SFP program or are terminated from the Medicare program.

- ***SFP status*** means the status of a hospice provider in the SFP with respect to the provider's standing in the SFP, which is indicated by one of the following status levels: Level 1 – in progress; Level 2 – completed successfully; or Level 3 – terminated from the Medicare program.

- ***SFP survey*** refers to a standard survey as defined in § 488.1105 and is performed after a hospice is selected for the SFP and is conducted every six months, up to three occurrences.

[2] In response to stakeholder comments regarding the provision of technical assistance, CMS states in this final rule "[w]hile CMS is not providing direct technical assistance, [CMS] will ensure that SFP hospices are aware of the various resources and tools available to assist them in improving quality." See page 333 of the unpublished rule.

Effective Date and Implementation

CMS will implement the hospice SFP beginning January 1, 2024, as proposed. CMS will select hospices for inclusion in the SFP during the first quarter of 2024. CMS indicates that the agency will continue to make potential future refinement to SFP policies, as determined necessary.

Hospice Special Focus Program Eligibility

A hospice will be eligible for potential SFP enrollment if the hospice:

1. has hospice survey data or Medicare Hospice Quality Reporting Program (HQRP) data,
2. is an active provider that has billed a Medicare Fee-For-Service (FFS) claim in the past 12 months, and
3. operates in the United States, including the District of Columbia and United States territories.

Based on this criteria, 97.5 percent of active hospice providers (5,943 hospices out of 6,093 active hospice providers) would be eligible for participation in the SFP.

4. Final Hospice Special Focus Program Algorithm

CMS finalizes its proposal to identify hospices for inclusion in the special focus program from hospice surveys, including certain Quality-of-Care CLDs and substantiated complaints, the Hospice Care Index based on Hospice Medicare claims data, and certain Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey measures.

Table 2. Final Data Sources and Indicators in the Hospice Special Focus Program[3]

Source	Hospice Surveys	Hospice Quality Reporting Program (HQRP)	
Indicators		Claims Data	CAHPS® Hospice Survey Measures
	Quality-of-Care CLDs	Hospice Care Index (HCI)	• Help for Pain and Symptoms • Getting Timely Help • Willingness to Recommend this Hospice • Overall Rating of this Hospice
	Substantiated Complaints		

Data Sources

To identify the pool of hospices eligible for SFP participation, CMS will pull three consecutive years of the most recent Medicare hospice survey data. This means that to determine SFP eligibility in 2024, CMS would use 2020 - 2023 survey data. From this survey data, CMS will then count the total number of Quality-of-Care CLDs and substantiated complaints for each hospice in the data pool. CMS will standardize scores for SFP-eligible hospices with missing survey and HCI data, resulting in an assigned value of zero.

Quality-of-Care Condition-Level Deficiencies

CMS finalizes its proposal to include 11 Quality-of-Care CLDs as data indicators in the SFP algorithm. These 11 CLDs are identified in Table 3 below.

[3] See Table F1 on page 302 of the unpublished rule.

Table 3. SFP Quality of Care Condition-Level Deficiencies[4]

Tag	Condition of Participation (COP)
§418.52	COP: Patient's rights.
§418.54	COP: Initial and comprehensive assessment of the patient.
§418.56	COP: Interdisciplinary group, care planning, and coordination of services.
§418.58	COP: Quality assessment and performance improvement.
§418.60	COP: Infection control.
§418.64	COP: Core services.
§418.76	COP: Hospice aide and homemaker services.
§418.102	COP: Medical director.
§418.110	COP: Hospices that provide inpatient care directly.
§418.108	COP: Short-term inpatient care.
§418.112	COP: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID.

Substantiated Complaints

CMS finalizes its proposal to include a hospice's total number of substantiated complaints in the last three years of consecutive data, as noted above. This only includes complaints against a hospice that have been substantiated.

Complaints against a hospice may be filed with the State Agency (SA) or Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) at any time by a patient and/or caregiver(s) and hospice staff members.[5] Once a complaint is filed with the SA, the SA may conduct an unannounced complaint investigation survey to substantiate or refute the complaint. If the complaint is substantiated, the SA will inform the hospice and submit its findings to iQIES.

CMS' analysis of CY 2019-202 survey data found that 81.8 percent of hospices (4,860 out of 5,943 SFP-eligible hospices) received no substantiated complaints over the past three years.

Hospice Quality Reporting Program (HQRP) Data

A. Hospice Care Index (HCI) Overall Score

CMS will determine a hospice's overall HIC score from eight quarters of Medicare FFS claims data. Hospices with less than 20 Medicare claims over this period are excluded from reporting this measure. The HCI captures multiple aspects of care delivery across ten indicators comprising a composite HCI overall score, with hospices earning a point for each indicator met (range: 0 - 1). This means a lower score indicates a lower quality of care.

CMS' analysis of 2019-2021 HCI claims data (excluding January - June 2020) found that 78.3 percent of hospices (4,656 of the 4,943 SFP-eligible hospices) had a publicly reported HCI score. CMS found that most of these hospices (86.1 percent) had an HCI score of eight or more out of ten.

[4] See Table F2 on page 303 of the unpublished rule.
[5] See CMS. State Operations Manual, Chapter 5. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107c05pdf.pdf.

B. CAHPS® Hospice Survey

CMS finalizes its proposal to use four measures from the CAHPS® Hospice Survey:

- help for pain and symptoms,
- getting timely help,
- willingness to recommend the hospice, and
- overall rating of the hospice.

CMS will calculate CAHPS® Hospice Survey measure scores across eight rolling quarters for all hospices with at least 30 completed surveys. CMS' analysis of the CY 2019-2021 file found that only approximately 49 percent of all SFP-eligible hospices had CAHPS® Hospice Survey data.

CMS finalizes its proposal to adjust bottom-box scores of the four CAHPS® measures to create a CAHPS® Hospice Survey Index. To establish this index, CMS will calculate a single score for each hospice based on a weighted sum of the bottom-box scores for the four CAHPS® measures. CMS will calculate bottom-box scores for each respondent as "100" if the respondent selected the least positive response categories for the question and "0" if the respondent selected a different response category. Survey respondents who do not answer a question are not included in question scoring.

These measures are assigned individual weights to determine a final survey index score, as follows:

Overall Assessment of Hospice Care	**Weighting**
willingness to recommend this hospice	0.5
overall rating of this hospice	0.5
Distinct Aspects of hospice Care	
help for pain and symptoms	1.0
getting timely help	1.0

CMS finalizes its proposal to assign a weight of **2.0** to the final CAHPS® Hospice Survey Index, which means this score has double the weight of other SFP measures. To account for hospices with missing CAHPS® data, CMS finalizes its proposal to consider solely other SFP indicators which are available, including Quality-of-Care CLDs, substantiated complaints, and HCI scores. For additional details on CMS' steps in calculating a hospice's CAHPS® Hospice Survey score, refer to CMS' document, entitled '[Calculating CAHPS® Hospice Survey Top-, Middle-, and Bottom-Box Scores]'.

5. Survey and Enforcement Criteria

Under the SFP, a hospice will be surveyed "not less than once every 6 months," consistent with section 1822(b)(2) of the Social Security Act. SFP hospices may also be subject to one or more enforcement remedies, including civil money penalties, suspension of payment for all new patient admissions, temporary management of the hospice program, directed plan of correction, or directed in-service training, based on a SFP hospice's noncompliance with one or more COPs or failure to correct deficiencies, at CMS' discretion.[6] These enforcement remedies could be of increasing severity if subsequent surveys result in a citation of a CLD or CLDs for the SFP hospice.

[6] See 42 CFR 488.1220.

Accredited hospices who have been deemed to meet Medicare CoPs that are selected for the SFP will have their deemed status removed for the duration of the SFP and will be placed directly under CMS oversight. This means the SFP hospice would be subject to CMS or SA surveys regardless of their accreditation status until graduating from the SFP or termination from the Medicare program.

6. SFP Graduation

To graduate from the SFP program, CMS finalizes its proposal that a SFP hospice will graduate from the SFP if the hospice "has, in an 18-month timeframe, no CLDs cited or IJ's for any two 6-month SFP surveys, and has no pending complaint survey triaged at an immediate jeopardy or condition-level, or has returned to substantial compliance with all requirements."[7] If a SFP hospice receives complaint investigations or a 36-month recertification survey, CMS indicates the 18-month SFP timeline may be extended.

7. Termination from the Medicare Program

CMS finalizes conditions for an SFP hospice's termination from the Medicare as proposed. This means that a SFP hospice would be considered for termination if:

- The hospice fails any two SFP surveys by having any CLDs on the surveys in an 18-month period,
- The hospice has pending complaint investigations triaged at intermediate jeopardy (IJ) or condition-level, or
- The hospice is not able to achieve substantial compliance at any time during the 18 months.

In other words, hospice providers who are unable to resolve the deficiencies that brought them into the SFP and cannot meet the proposed completion criteria of having no CLDs cited for any two SFP surveys during an 18-month period would be placed on a termination track.

In cases of a SFP hospice's termination from the Medicare program, CMS will issue a termination notice to the hospice in accordance with 42 CFR § 489.53.

8. Public Reporting

CMS finalizes its proposal to publicly report, at least on an annual basis, hospices selected for the SFP. CMS will post this information on public-facing website at the Hospice Special Focus Program webpage or a successor website.

The webpage will include the following:

- general SPF information,
- program guidance,
- a subset consisting of 10 percent of hospice programs based on the highest aggregate scores determined by the SFP algorithm,
- SFP selections from the 10 percent subset as determined by CMS, and
- SFP status.

In this final rule, CMS indicates its belief that the agency has the authority to publicly post the 10 percent of hospices with worst scores under the agency's SFP methodology "because the statute states

[7] See page 336 of the unpublished rule.

that survey reports, enforcement actions, and any other information determined appropriate by the Secretary shall be published on a CMS public website in a manner that is prominent, easily accessible, readily understandable, and searchable."[8]

CMS will report the SFP list annually and may periodically update this list as hospices graduate from the SFP. CMS has indicated that the hospices selected to participate in the SFP would be determined in the first quarter of 2024 and each subsequent year.

B. Hospice Informal Dispute Resolution

CMS is finalizing the hospice Informal Dispute Resolution (IDR) process to address disputes related to survey CLD findings as proposed for 2024. Specifically, this IDR process would provide hospices with an informal opportunity to dispute or clarify survey findings for hospices seeking recertification or reaccreditation at an earlier stage, prior to engaging in a formal hearing. In other words, the IDR process is intended to help save time and resources expended by hospices as well as the SA and CMS. This process would be similar to the IDR process already in effect for home health agencies.

A hospice may initiate the IDR process following receipt of the official survey Statement of Deficiencies and plan of Correction, Form CMS-2567 to address condition-level survey findings. Hospices may not initiate the IDR process for standard-level findings, which do not trigger an enforcement action and do not have appeal or hearing rights.

The IDR process may also be initiated by hospices under SA monitoring (through a complaint investigation or validation survey) or those under the SFP. However, a hospice may not initiate the IDR process to dispute a hospice's selection into the SFP, or otherwise refute an enforcement action. In addition, the initiation of the IDR process will not delay the effective date of any enforcement action, particularly with IJ findings.

1. IDR Process

Upon receipt of a CMS-2567 'Statement of Deficiencies and Plan of Correction', a hospice will receive notification in writing about the opportunity to request an IDR. This request must be submitted in writing (either electronically or hard copy) and within the same ten calendar days permitted for submitting an acceptable plan of correction. This request should address specific survey findings that are in dispute.

For hospice programs deemed through a CMS-approved accrediting organization (AO), the hospice will submit the IDR request to the AO. The same process would be observed, and the AO will coordinate with CMS regarding any enforcement actions. If a deemed hospice fails to meet Medicare requirements or shows continued condition-level noncompliance, deemed status is generally removed and oversight is placed under the SA.

CMS will publish additional guidance on the IDR process following this rule's finalization.

[8] See page 339 of the unpublished rule.

2. Revised Survey Findings

If the SA or CMS revises or removes survey findings based on IDR results, the CMS-2567 would be revised, if CMS accepts the findings. This would also include an adjustment to any enforcement remedies imposed specifically in response to overturned deficiency findings.

C. Provider and Supplier Enrollment Changes

CMS is finalizing Medicare provider and supplier enrollment changes as proposed in the goal to increase program integrity protections and strengthen the provider enrollment process.

Hospice Screening

Under 42 CFR § 424.518, providers are subject to certain levels of screening which determine the extent of CMS and Medicare Administrative Contractor's (MAC) scrutiny of initial applications, revalidation applications, practice location additions, and new owner changes. There are three levels of screening:

- **Limiting categorical risk.** MACs will verify a provider or supplier's compliance with applicable Federal regulations and State requirements prior to making an enrollment determination. This includes license verifications and database checks on pre- and post-enrollment basis to ensure the continued satisfaction of provider and supplier enrollment criteria.[9]
- **Moderate categorical risk.** In addition to the above screening, MACs will also conduct an on-site visit of the provider or supplier.[10]
- **High categorical risk.** In addition to both limited and moderate screening, the MAC will require the submission of a set of fingerprints for national background check purposes from individuals who hold a five percent or greater direct or indirect ownership interest in a provider or supplier. This also includes a fingerprint-based criminal history record check with the Federal Bureau of Investigation's Integrated Automated Fingerprint Identification System.[11]

These levels are based on the degree of risk of fraud, waste, and abuse posted by a provider type. Hospices are currently subject to a moderate risk screening category for Medicare enrollment purposes. However, in the effort to better address fraud and abuse, CMS is finalizing changes for enhanced screening of hospices and hospice owners in certain situations.

Specifically, CMS finalizes the move of the following categories of hospices to the high level of screening category:

- newly enrolling hospice providers, and
- hospices submitting applications to report any new owner (as described in the opening paragraph of § 424.518).

[9] See 42 CFR 424.518(a)(2).
[10] See 42 CFR 424.518(b).
[11] See 42 CFR 424.518(c)(2).

This means that hospice owners with five percent or greater direct or indirect ownership will be required to submit fingerprints for a criminal background check. Revalidating hospices are subject only to moderate level screening.

36-Month Rule for Changes in Hospice Majority Ownership

CMS finalizes its proposal to limit the situations under which a hospice provider's agreement and billing privileges under Medicare would transfer to a new owner following a change in ownership, consistent with home health agencies. In other words, CMS will expand home health change in majority ownership rules to hospice providers. Specifically, the hospice provider's agreement and Medicare billing privileges would not transfer to the new owner within 36 months of the hospice's initial enrollment or most recent change in majority ownership, subject to certain exceptions. This means that the new hospice owner must instead enroll as a new hospice and obtain a state survey or an accreditation from an approved AO. CMS finalizes this change in response to quality-of-care concerns associated with an increase in changes in hospice ownership in recent years.

Consistent with home health agencies, CMS finalizes four exceptions to the 36-month rule for hospices:[12,13]

- The hospice has submitted two consecutive years of full cost reports since initial enrollment or the last change in majority ownership, whichever is later. This does not include low utilization or no utilization cost reports,
- The hospice's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation,
- The owners of an existing hospice are changing the hospice's existing business structure and the owners remain the same, or
- An individual owner of a hospice dies.

CMS is adopting confirming regulatory changes to § 424.550 to finalize these exceptions.

Hospice Ownership Category Revisions

CMS finalizes its proposal to revise the Form CMS-855A Medicare provider enrollment application (Medicare Enrollment Application--Institutional Providers; (OMB Control No. 0938-0685) to collect from providers and suppliers (including hospices) important data such as, but not limited to:

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

[12] See pages 447 – 448 of the unpublished rule.
[13] See 42 CFR 424.550(b)(2).

Deactivation of Medicare Billing Privileges after Six Months

CMS finalizes its proposal to deactivate a Medicare provider or supplier's billing privileges after six consecutive months of Medicare non-billing. Currently, the Medicare billing deactivation period is 12 consecutive months. Deactivation means the provider's or supplier's billing privileges are stopped but not revoked. This means that billing privileges can be restored or reactivated upon the submission of information required under 42 CFR § 424.540. Specifically, a deactivated provider or supplier must recertify that its Medicare enrollment application is correct, provide any appropriate missing information, and maintain compliance with all applicable Medicare enrollment requirements.

For hospices, this does not require a new certification by the SA or the establishment of a new provider agreement, unlike home health agencies.[14]

Definition of "Managing Employee"

CMS finalizes its proposal to add a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director to the definition of 'managing employee' in 42 CFR § 424.502 with one exception.[15] Consistent with sections 1124 and 1124A of the Social Security Act, providers and suppliers must report their managing employees in the appropriate Medicare enrollment application as a condition of Medicare enrollment.

Managing employee is currently defined as a "general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier."

The revised definition reads as follows:

> "Managing employee means a general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W–2 employee of the provider or supplier. <u>For purposes of this definition, this includes, but is not limited to, a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director.</u>" (new language underscored)

[14] 42 CFR 424.540(b)(3)(i) requires that home health agencies "whose Medicare billing privileges are deactivated under the provisions found at paragraph (a) of this section must obtain an initial State survey or accreditation by an approved accreditation organization before its Medicare billing privileges can be reactivated."

[15] In a February 15, 2023 proposed rule titled 'Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities', CMS separately proposed a definition specific and exclusive to a skilled nursing facility. The proposed definition in the 2024 Home Health proposed rule would have supplemented that definition; but as the February 15, 2023 rule has not been finalized, the additions of the hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director will be added to existing regulatory text in 42 CFR § 424.502.

This means that for hospices, the hospice administrator and medical director must be reported on the Form CMS-855A Medicare provider enrollment application, regardless of the amount of managing control that individual has.

Previously Waived Fingerprinting of High-Risk Providers and Suppliers

CMS previously waived the finger printing requirement for the COVID-19 public health emergency. CMS finalizes its proposal that this requirement may be waived in future emergencies for the high-risk category of providers (including hospices) in future waivers, at CMS' discretion.

However, revalidation applications are only screened at the moderate-risk level, which means owners of high-risk providers and suppliers would not undergo a fingerprint-based criminal background check (FBCBC). Therefore, CMS proposed to incorporate within the high-risk screening category revalidated certain providers and suppliers whose FBCBC requirement was waived when they initially enrolled in Medicare.

CMS finalizes its proposal which includes the moderate risk revalidation for hospices, DMEPOS suppliers, home health, opioid treatment programs, Medicare diabetes prevention program (MDPP) suppliers, and skilled nursing facilities that underwent FBCBCs:

- when they initially enrolled in Medicare, or
- upon revalidation after CMS waived the FBCBC requirement (under the circumstances described in paragraph (c)(1)(viii)) when the provider or supplier initially enrolled in Medicare.

The latter provision clarifies that providers and suppliers who had fingerprinting waived when initially enrolling in Medicare would not remain in the high-screening category in perpetuity. In other words, once the provider or supplier is fingerprinted upon revalidation, they would move to the moderate-risk category, unless some other basis exists under 42 CFR § 424.518(c) for staying in the high-risk category.[16]

Expansion of Reapplication Bar

CMS finalizes its proposal to expand the maximum length of reapplication to 10 years to account for severe provider or supplier conduct as proposed. Under existing regulations at § 424.530(f), CMS may prohibit a prospective provider or supplier from enrolling in the Medicare program if their enrollment application is denied due to the submission of false, omitted, or misleading information. The current maximum length of the reapplication bar is three years.

In addition, CMS finalizes its proposal that providers who are subject to a reapplication bar may not order, refer, certify, or prescribe Medicare-covered services, items, or drugs. To enforce this policy, Medicare will not pay for any such services, items, or drugs when ordered, referred, certified, or prescribed by a provider or supplier subject to a reapplication bar.

CMS also finalizes its proposal that a physician or other eligible professional who has had a felony conviction within the previous ten years may not order, refer, certify, or prescribe Medicare-covered

[16] Hospices must revalidate their Medicare enrollment in accordance with 42 CFR § 424.515 every five years.

services, items, or drugs, if CMS determines the conviction to be detrimental to the best interests of the Medicare program.

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NHPCO Special Focus Program Resources

Survey Readiness and Response Toolkit

This resource provides comprehensive support to hospices before, during, and after a hospice Medicare survey. The toolkit includes eighteen Condition of Participation (CoP) compliance guides along with nineteen supplemental resources to address every step of the survey. In addition, the toolkit is available as one comprehensive document or as separate standalone supplemental resources.

Hospice Survey Readiness and Response Webinar

The hospice survey process is changing. CMS has designated particular Conditions of Participation for surveyor focus and later this year, surveyors will begin recommending penalties for some deficiencies found on surveys. Now is the time to prepare, learn about the new survey process, hear from a hospice who has been preparing for their next survey, and hear more about the resources NHPCO has released to support providers in the survey readiness process.

NHPCO Hospice Quality Reporting Program Comprehensive Resource Guide

This guide provides a comprehensive overview of the Hospice Quality Reporting Program (HQRP), including the CAHPS® Hospice Survey, Hospice Item Set Comprehensive Assessment at Admission, Hospice Care Index, and Hospice Visits in Last Days of Life. The guide includes details of each measure, compliance and payment implications, public reporting requirements, and best practices.

NHPCO Hospice CAHPS Survey and Star Ratings Resource

This resource provides an overview of the CAHPS® Hospice Survey and associated Star Ratings, including details regarding survey administration, data collection, score calculation, and public reporting.

NHPCO Hospice Care Index Resource

This resource provides an overview of the Hospice Care Index (HCI) measure, including detailed descriptions of each HCI indicator, score calculation, and public reporting requirements.