NHPCO Analysis of the FY 2024 Hospice Wage Index and Quality Reporting Proposed Rule

Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements

To: *NHPCO Provider & State Members*
From: *NHPCO Policy Team*
Date: *April 4, 2023*

(A comprehensive analysis following our Regulatory Alert of March 31, 2023)

Summary at a Glance

The FY 2024 Hospice Wage Index and Quality Reporting proposed rule went on display for public inspection on the Federal Register website on Friday, March 31, 2023. The proposals for fiscal year 2024 include the following:

- Proposed rate increase of 2.8%. Rates for each level of care are available below.
- Cap amount: The proposed hospice cap amount for the FY 2024 cap year is **$33,396.55**
- 4% payment penalty will apply for FY 2024 rates based on CY 2022 data submission.
- The Hospice Outcomes & Patient Evaluation (HOPE) tool is still under review.
- The Hospice CAHPS® tool modes are still under consideration.
- The proposal to implement the Hospice Special Focus Program will be published in the CY 2024 Home Health Prospective Payment Update Rate proposed rule, which will be issued this summer.
- Proposed addition of hospice physicians to the Medicare enrollment process required for covered hospice services.
- CMS Fact Sheet: Fiscal Year (FY) 2024 Hospice Payment Rate Update Proposed Rule (CMS-1787-P) | CMS

Comments are due no later than **May 30, 2023**, with file code: **CMS-1787-P**

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Proposed FY 2024 Hospice Wage Index and Rate Update

On Friday, March 31, 2023, the FY 2024 Hospice Wage Index and Payment Update proposed rule went on display on the Federal Register website for public inspection.

- The proposed rate increase for FY 2024 is **2.8%.** The proposed hospice cap amount for FY 2024 is **$33,396.55**. **NOTE:** The percentage increase may change when the final rate update is issued in late July, based on the latest available data for the percentage increase calculation.
- NHPCO will prepare the **FY 2024 Proposed Wage Index State/County Rate Chart** when the CMS wage index file is available. Providers can find the state/county charts on the Regulatory Medicare Reimbursement page of the NHPCO website for members.
- The **CMS charts showing the current (FY 2023) and proposed (FY 2024) rates for each level of care**, both for hospices that do and do not submit quality data, are included below.

HOSPICES WHO SUBMIT THE REQUIRED QUALITY DATA

Proposed FY 2024 Hospice Payment Rates (with Quality Reporting)

Code	Description	FY 2023 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	Proposed FY 2024 Hospice Payment Update	Proposed FY 2024 Payment Rates
651	Routine Home Care (days 1-60)	$211.34	1.0010	1.0012	1.028	$217.74
651	Routine Home Care (days 61+)	$167.00	1.000	1.0011	1.028	$171.86

Code	Description	FY 2023 Payment Rates	Wage Index Standardization Factor	Proposed FY 2024 Hospice Payment Update	Proposed FY 2024 Payment Rates
652	Continuous Home Care Full rate = 24 hours of care	$1,522.04	0.9980	1.028	$1,561.53 ($65.06 per hour)
655	Inpatient Respite Care	$492.10	1.0010	1.028	$506.38
656	General Inpatient Care	$1,110.76	1.0003	1.028	$1,142.20

HOSPICES WHO DO NOT SUBMIT THE REQUIRED QUALITY DATA

Changes to the Payment Reduction Percentage for Failing to Meet Hospice Quality Reporting Requirements

The Consolidated Appropriates Act (CAA), 2021included a provision to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. This policy would apply beginning with the FY 2024 annual payment update (APU) that is based on calendar year (CY) 2022 quality data. The rate charts below reflect a 4% reduction in the hospice payment update.

Proposed FY2024 Hospice Payment Rates for Hospices that DO NOT Submit the Required Quality Data

Code	Description	FY 2023 Payment Rates	SIA Budget Neutrality Adjustment Factor	Wage Index Standardization Factor	Proposed FY 2024 Hospice Payment Update of 2.8% minus 4 percentage points = -1.2%	Proposed FY 2024 Payment Rates
651	Routine Home Care (days 1-60)	$211.34	1.0010	1.0012	0.988	$209.26
651	Routine Home Care (days 61+)	$167.00	1.0000	1.0011	0.988	$165.18

Code	Description	FY 2023 Payment Rates	Wage Index Standardization Factor	Proposed FY 2024 Hospice Payment Update of 2.8% minus 4 percentage points = -1.2%	Proposed FY 2024 Payment Rates
652	Continuous Home Care Full rate = 24 hours of care	$1,522.04	0.9980	0.988	$1,500.77 ($62.53 per hour)
655	Inpatient Respite Care	$492.10	1.0010	0.988	$486.68
656	General Inpatient Care	$1,110.76	1.0003	0.988	$1,097.76

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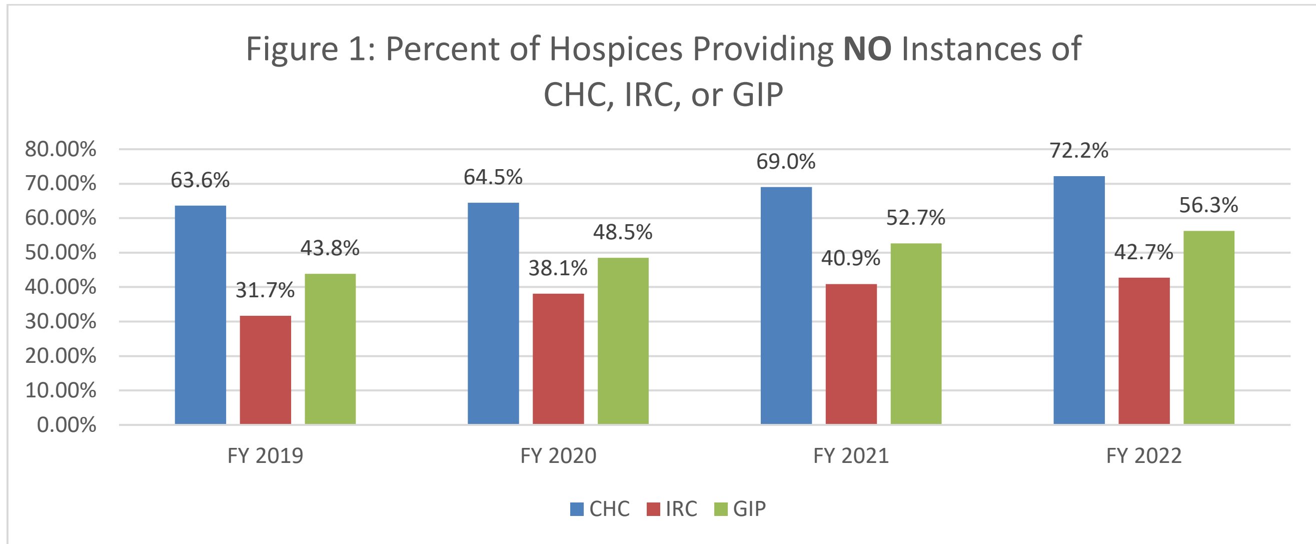
Data And Trends

Hospice Utilization and Spending Patterns

- Percentage of deaths in hospice continued its decline with 48.8% of Medicare Beneficiaries utilizing hospice in FY 2022 while the number of beneficiaries who died declined from the high in 2021.
- In FY2022, 74% of hospices were for-profit v. 16% were non-profit
    - 64% of all hospice days were provided by for-profit hospices v. 27% by non-profit
- The number of hospices not providing continuous home care (CHC), inpatient respite care (IRC), and general inpatient continues to grow in FY 2022. The below chart highlights the increase since FY 2019.



Trends in Hospice Length of Stay and Live Discharges

- Average length of stay and average lifetime length of stays have continued to increase which is influenced by extremely long length of stays; whereas median (the 50th percentile of patients) has been relatively stable.
- Length of stay estimates vary greatly based on principal diagnosis (e.g., average length of stay for chronic kidney disease was 32.8 days v. 129 for Alzheimer's, Dementia, and Parkinson's)

TABLE 4: Hospice Length of Stay in Days FYs 2019 - 2022

	FY2019	FY2020	FY2021	FY2022
Average Length of Election	77	79	79	80
Median Lifetime Length of Stay	20	19	18	19
Average Lifetime Length of Stay	99	100	100	102

- Live discharge rates have been relatively stable from FY 2023 through FY 2022, approximately 17% per year

- In FY 2022, the reason for a live discharge were:
    - 35% for revocations
    - 36% no longer terminally ill
    - 14.2% beneficiary moved out of the service area without transferring to another hospice
    - 12.9% beneficiary transferred to another hospice
    - 1.9% for cause

Non-Hospice Spending During a Hospice Election

- In FY 2022, Medicare paid over $1.4 billion in non-hospice spending during a hospice election under Parts A, B, and D
    - Medicare paid $883 million in Parts A and B non-hospice spending, an increase of 28.9% from FY 2019

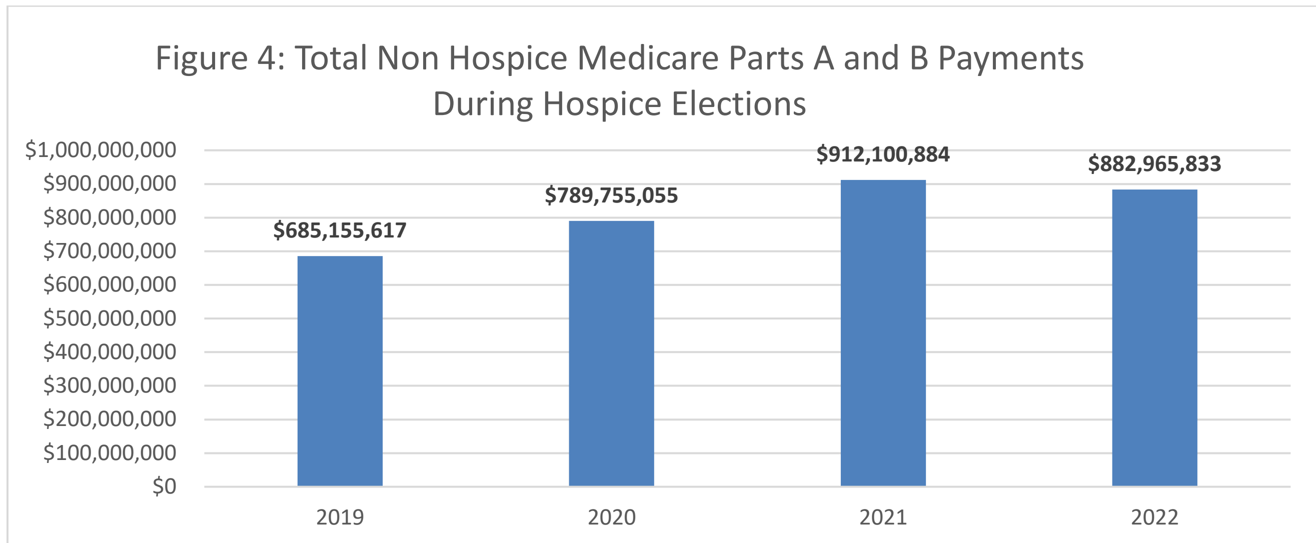


TABLE 6: Total Medicare Spending Outside the Hospice Benefit during Days of Hospice Service (Excluding Admission/Live Discharge Days) By Claim Type [All Beneficiaries], FYs 2019 – 2022

Claim Type	FY 2019	FY 2020	FY 2021	FY 2022
Durable Medical Equipment	$54,366,410	$62,911,894	$53,089,457	$57,214,990
Home Health Agency	$16,274,533	$17,207,271	$16,600,988	$15,391,571
Inpatient	$135,556,881	$152,237,654	$164,126,999	$144,970,909
Outpatient	$134,890,458	$144,512,733	$161,433,749	$150,063,938
Physician Services	$334,867,809	$374,275,518	$459,259,144	$471,598,388
Skilled Nursing Facility	$9,199,526	$38,609,985	$57,590,547	$43,726,037
TOTAL	**$685,155,617**	**$789,755,055**	**$912,100,884**	**$882,965,833**

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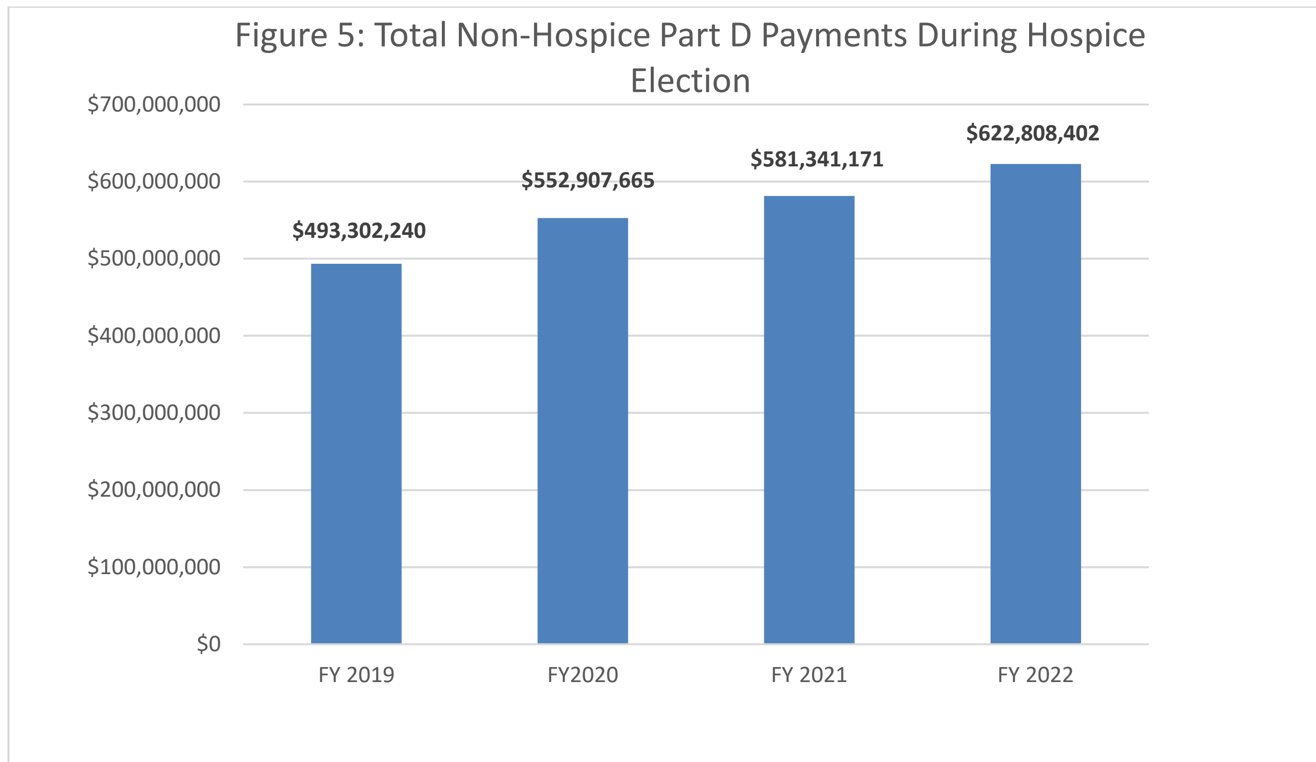
Payments for Non-Hospice Part D during the Hospice Election

- In FY 2022, non-hospice spending for Part D drugs increased in from $493 million in FY 2019 to $623 million.



- While payments for *four classes of drugs subject to prior authorization* – analgesics, anti-nauseants, anti-anxiety and laxatives – declined, payments for maintenance medications increased.

Hospice and End-Stage Renal Disease (ESRD)

- Medicare beneficiaries with ESRD use hospice at a rate approximately half (46.7%) compared to all Medicare beneficiaries.
- For beneficiaries who began hospice within 14 days of their last ESRD claim,
  - The average number of days between the last date of the ESRD service and their day of death is 15.2 days with a median of 11 days.
  - 95% of beneficiaries have 31 or fewer days between their last date of ESRD service and their day of death.

RFI on Hospice Utilization, Non-Hospice Spending, Ownership and Hospice Election – A Chance to Comment

CMS has invited commenters to share information and on the ground experiences about hospice utilization, non-hospice spending, ownership and hospice election, including information on topics such as:

- Barriers to utilizing all 4 levels of care
- Providing palliative chemotherapy, radiation, dialysis when needed by a hospice patient
- Growth in non-hospice spending during a hospice election – why does that occur?

- Use of the addendum
- Should Information about the hospice's staffing levels, frequency of hospice staff encounters, or utilization of higher LOC be provided to help patients and their caregivers make informed decisions about hospice selection? Through what mechanisms?

RFI on Health Equity – A Chance to Comment

CMS adopted the following definition for health equity, "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."

CMS is working to address these disparities is improving data collection to allow for better measurement and reporting on equity across our programs and policies.

To support the ongoing development of activities to improve health equity through data collection, CMS requests comments on the following questions:

- What efforts do hospices employ to measure impact on health equity?
- What factors do hospices observe that influence beneficiaries in electing and accessing hospice care?
- What geographical area indices, beyond urban/rural, can CMS use to assess disparities in hospice?
- What information can CMS collect and share to help hospices serve vulnerable and underserved populations and address barriers to access?
- What sociodemographic and SDOH data should be collected and used to effectively evaluate health equity in hospice settings?
- What are feasible and best practice approaches for the capture and analysis of data related to health equity?
- What barriers do hospices face in collecting information on SDOH and race and ethnicity? What is needed to overcome those barriers?

Conforming Regulations Text Revisions for Telehealth Services

This proposed rule outlines changes to regulatory text which will guide the use of telehealth, both through the end of the COVID-19 Public Health Emergency and beyond. The two primary changes the proposed rule offers are:

- Revising the regulations text at § 418.22(a)(4)(ii) in accordance with Division FF, section 4113(f) of the CAA, 2023, effective January 1, 2024.
- Removing § 418.204(d), effective retroactively to May 12, 2023, to align with the anticipated end of the COVID-19 PHE

This means the regulatory text is now aligned with the *Consolidated Appropriations Act*, 2023, which extended the flexibility of hospice providers to use telehealth for face-to-face encounters prior the recertification for the hospice benefit via telehealth through the end of CY 2024.

Throughout the COVID-19 Public Health Emergency, "Medicare patients [have been able to] continue receiving services that are reasonable and necessary for the palliation and management of a patients'

terminal illness and related conditions." (§ 418.204) This proposed rule also eliminates the flexibility to use telehealth to furnish these services for the routine home care (RHC) level of care during a Public Health Emergency.

Proposals and Updates for HQRP

Payment Penalty Update for Non-Compliance with HQRP

For any hospice that did not comply with the quality data submission requirements in CY 2022, a 4 percent payment penalty applies with the FY2024 APU. Payment penalties for failing to comply with reporting requirements only apply for the specified year. CMS estimates that 18.4% of hospices (an estimated 1,049 of 5,700 hospices) will "fail to receive the full annual percentage." See chart on page 10 for additional information.

Hospice Outcomes and Patient Evaluation (HOPE) Update

HOPE is a patient assessment tool that "by providing data from multiple time points across the hospice stay, [the tool will] provide information to hospice providers to improve practice and care quality."

National beta testing of the HOPE tool was completed in October 2022 and CMS will continue to refine HOPE and solicit feedback from stakeholders. A final version of HOPE will be proposed in future rulemaking, and CMS plans to provide additional information on the results of HOPE field testing results in late Spring 2023.

CMS will continue to use sub-regulatory channels to communicate HOPE updates. Comments about HOPE can be sent to HospiceAssessment@cms.hhs.gov and additional opportunities for stakeholder engagement can be found on the CMS website.

Update on Future Quality Measurement (QM) Development

CMS plans to develop additional quality measures based on information collected by HOPE after it is implemented, including:

- *Timely Reassessment of Pain Impact*
- *Timely Reassessment of Non-Pain Symptoms*

Proposed Health Equity Updates related to HQRP

In the FY 2023 Hospice Wage Index and Quality Reporting proposed rule, CMS solicited public comments via the RFI on a potential health equity structural composite measure in the Hospice Quality Reporting Program. For a summary of the public comments and suggestions received in response to the health equity RFI, refer to FY 2023 Hospice Payment Rate Update final rule (87 FR 45669). Based on the public comments received, CMS decided to convene a health equity technical expert panel to provide additional input to inform the development of health equity quality measures.

Home Health and Hospice Health Equity Technical Expert Panel (TEP)

The TEP was comprised of health equity experts from hospice and home health settings, specializing in quality assurance, patient advocacy, clinical work, and measure development. The TEP was charged with the following:

- providing input on a potential cross-setting health equity structural composite measure concept.
- assessing the face validity and feasibility of the potential structural measure.
- providing input on possible confidential feedback report options to be used for monitoring health equity.
- providing ideas for additional health equity measure concepts or approaches to addressing health equity in hospice and home health settings.

Universal Foundation

CMS leaders have moved towards a building-block approach to streamline quality measures across CMS quality programs for the adult and pediatric populations. The “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.

Possible Future Health Equity Efforts

CMS is developing approaches to meaningfully incorporate the advancement of health equity into the HQRP. One consideration is including social determinants of health into our quality measures and data stratification.

Proposed CAHPS® Hospice Survey Updates

There are no changes to the CAHPS® Hospice Survey process proposed in this rule. CMS continues to evaluate results of a CAHPS® Hospice Survey mode experiment conducted in 2021, which tested a web-mail mode, a revised survey, and modifications to survey administration including a prenotification letter and extended response period. Results from the experiment will be used to inform decisions about potential upcoming changes in CAHPS® Hospice Survey instrument and administration.

Form, Manner, and Timing of Quality Data Submission

There are no new public reporting proposals in this rule. CMS proposes the addition of a paragraph related to data submission requirements for the HQRP to clarify a hospice must “meet or exceed” the data submission compliance threshold of 90% of required Hospice Item Set or successor instrument records. There are no changes to the required data completion thresholds.

Table 14: 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 the Hospice CAHPS® survey 1/1/2022 – 12/31/2022
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 the Hospice CAHPS® survey 1/1/2023 – 12/31/2023
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 the Hospice CAHPS® survey 1/1/2024 – 12/31/2024
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 the Hospice CAHPS® survey 1/1/2025 – 12/31/2025

Establishing Hospice Program Survey and Enforcement Procedures

Hospice Special Focus Program

CMS reports they have "finalized all the CAA provisions in CY 2022 rulemaking except for the special focus program (SFP)." A Technical Expert Panel (TEP) was convened by a CMS contractor, Abt Associates. They provided feedback and consideration on the design and implementation of the Hospice Special Focus Program, including the "development of a methodology to identify hospice poor-performers, as well as graduation and termination criteria and public reporting." The final TEP feedback will be publicly available on the CMS website in April 2023. CMS plans to include a Hospice Special Focus Program proposal in the CY 2024 Home Health Prospective Payment Update Rate proposed rule.

Proposals Regarding Hospice Ordering/Certifying Physician Enrollment

In this proposed rule, CMS has proposed strengthening the provider enrollment process by requiring physicians who order or certify hospice services for Medicare beneficiaries to be enrolled in or validly opted-out of Medicare as a prerequisite for payment of hospice services. This requirement currently applies to DMEPOS and home health services. Adding hospice physicians to this proposed rule will enable CMS to take further action against providers who are:

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1. Engaging (or potentially engaging) in fraudulent or abusive behavior
2. Presenting a risk of harm to Medicare beneficiaries or the Medicare Trust Fund
3. Otherwise unqualified to furnish Medicare services.

CMS cites an OIG report issued in July 2018 entitled "Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity" (OEI-02-16-00570). The report provided examples of hospice fraud schemes, including one who paid recruiters to target beneficiaries who are not eligible for hospice care and others where physicians falsely certifying beneficiaries as terminally ill when they were not. In addition, an October 2019 GAO report entitled "Medicare Hospice Care: Opportunities Exist to Strengthen CMS Oversight of Hospice Providers" (GAO-20-10) stated that in light of the recent growth in hospice, "It is imperative that CMS's oversight of the quality of Medicare hospice care keeps pace with changes so that the agency can ensure the health and safety of these terminally ill beneficiaries."

The proposed changes to § 424.507(b) (underlined) include:

§ 424.507 Ordering covered items and services for Medicare beneficiaries.

(b) Conditions for payment of claims for covered home health 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.

And add:

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

CMS states "each certification (both initial and recertifications) required under § 418.22(c) should be by an enrolled or validly opted-out physician." CMS believes that many hospice certifying physicians are already enrolled in Medicare or have validly opted-out, so no action is necessary for those physicians.

Revisions to 855-A for Additional Information on Ownership Status

On December 15, 2022, CMS proposed an addition to the CMS–855A Medicare Enrollment Application for Institutional Providers to collect additional data about provider and supplier ownership, including for hospices. The data collection includes important data such as (but not limited to):

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

CMS states the information will help CMS "better understand the provider/supplier/hospice's indirect ownership relationships and the types of entities that own it. CMS is also considering "additional provider enrollment measures related to hospice ownership and management as a means of strengthening protections against hospice fraud schemes and to improve transparency."

Next Steps

NHPCO will begin our work preparing formal comments in coordination with the NHPCO Regulatory Committee and the national hospice stakeholder organizations. NHPCO welcomes thoughts, input, and suggestions during this process. Comments are due on **May 30, 2023**.

Watch in NewsBriefs for upcoming NHPCO listening sessions or surveys on the two Requests for Information as we are interested in gathering as much information as possible to include in the NHPCO comments.

Please submit comments or considerations to regulatory@nhpco.org with "FY 2024 Wage Index and Payment Update Comment" 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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